Department of Human Services

Financial Audit
For the Fiscal Year Ended June 30, 1996

May 1997

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Financial Audit Division
Office of the Legislative Auditor
State of Minnesota

97-25

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Senator Deanna Wiener, Chair
Legislative Audit Commission

Members of the Legislative Audit Commission

Mr. David S. Doth, Commissioner
Department of Human Services

We have audited selected aspects of the Department of Human Services for the fiscal year ended June 30, 1996, 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 1996 financial statements. The Comprehensive Annual Financial Report for the year ended June 30, 1996, includes our opinion thereon dated December 2, 1996. 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.

Finding 14 relates to a special payment the department made to Hennepin County. We do not believe that the department had legislative authority to make the payment. The department maintains that since it budgeted for the item, the Legislature, in fact, approved the expenditure. To resolve this matter, we are referring Finding 14 to the Attorney General pursuant to *Minn. Stat.* Section 3.975.

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 May 7, 1997.

James R. Nobles
Legislative Auditor

John Asmussen, CPA
Deputy Legislative Auditor

End of Fieldwork: February 21, 1997

Report Signed On: April 28, 1997

SUMMARY

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Department of Human Services

Financial Audit
For the Fiscal Year Ended June 30, 1996

Public Release Date: May 7, 1997 No. 97-25

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. The agency's main function is to administer various benefit 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. Ms. Maria Gomez was the DHS commissioner during fiscal year 1996. She resigned effective June 30, 1996. Mr. John Petraborg served the department as acting commissioner until Mr. David Doth was appointed commissioner by the Governor effective October 28, 1996.

Audit Scope and Conclusions

Our audit scope was limited to those activities material to the state of Minnesota's Comprehensive Annual Financial Report or the Single Audit for the year ended June 30, 1996.

In testing the medical assistance program for compliance with federal regulations, we found three instances of noncompliance. The department paid some claims that were beyond the one year limit imposed by federal regulations. It did not accurately complete certain required federal reports. DHS also did not accurately account for its drug rebate accounts receivable or collect drug rebates in accordance with the federal drug contract.

It was not our objective to render an opinion on internal controls over the health care programs. However, we found some weaknesses in DHS's administration of these programs. For example, DHS overpaid a provider approximately $6.2 million, due to an error in the MMIS II manual pricing logic. It also has not resolved three findings concerning the health care programs cited in our last audit report. Although the department needs to resolve these problems, they are not individually or collectively material to the health care programs as a whole.

We found no weaknesses or instances of noncompliance during our audit of the income maintenance programs.

We found that DHS generally complied with federal requirements for cash management. We found, however, that the state lost an estimated $3 million as a result of not requesting federal funds for the Medical Assistance Program as timely as allowed. In addition, we found significant weaknesses in DHS's processing and accounting for receipts. In particular, we found that the department did not adequately safeguard receipts in either the mailroom or the cashier's office.

DHS funded several "revenue maximization" projects during fiscal year 1996. At the end of fiscal year 1996, DHS retained more in this account than permitted by state law.

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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, CISA	Auditor-in-Charge
Lori Kloos, CPA,	Senior Auditor
Carl Otto, CPA, CISA	Senior Auditor
Karen Klein, CPA	Senior Auditor
Steve Johnson	Staff Auditor
Susan Kachelmeyer	Staff Auditor
Eric Wion	Staff Auditor
Trent Usitalo	Student Worker
Ben Reinhardt	Intern

Exit Conference

We discussed the findings and recommendations in this report with the following staff of the Department of Human Services on April 2, 1997:

David Doth	Commissioner
Tom Moss	Deputy Commissioner
Dennis Erickson	Assistant Commissioner for Finance and Management Operations
Jon Darling	Director of Financial Management
Larry Woods	Director of Health Care Operations
Dave Ehrhardt	Director of Internal Audit's Office

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.

Ms. Maria Gomez was the DHS commissioner during fiscal year 1996. She resigned effective June 30, 1996. Mr. John Petraborg served the department as acting commissioner until Mr. David Doth was appointed commissioner by the Governor effective October 28, 1996.

Our audit scope focused on the department's 1996 revenues and expenditures shown in Tables 1-1 and 1-2. These financial activities were material to the state's financial statements and to the Single Audit objectives, explained below.

Table 1-1
Selected Revenue Programs
Fiscal Year 1996

Revenue Area	FY96 Revenues
Residential Treatment Center Cost of Care	$139,210,196
Medical Provider Surcharge	132,131,662
Chemical Dependency Cost of Care	11,741,955

Source: Derived from the Minnesota Accounting and Procurement 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 1996. 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 Financial Report for the year ended June 30, 1996, includes our report, issued thereon, dated December 2, 1996.

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 required 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 systems to provide reasonable assurance that is managing federal financial assistance programs in compliance with applicable laws and regulations.

Table 1-2
Selected Grant Program Expenditures
Fiscal Year 1996

Program Name	Federal	State	Total
Health Care Programs			
Medical Assistance	$1,591,427,451	$1,360,963,108	$2,952,390,559
General Assistance Medical Care	0	143,015,789	143,015,789
MinnesotaCare	0	55,123,411	55,123,411
Income Maintenance Programs			
Family Support (1)	$ 223,238,202	$ 377,253,811	$ 600,492,013
Food Stamps-Cash Benefits (2)	14,602,571	0	14,602,571
Food Stamps-Administration	30,900,821	6,327,246	37,228,067
General Assistance	0	54,041,109	54,041,109
Minnesota Supplemental Aid	0	58,233,157	58,233,157
Other Grants			
Substance Abuse Preventive Treatment	$ 16,524,040	$ 0	$ 16,524,040
Social Services	47,046,619	0	47,046,619
Community Social Services	0	51,017,899	51,017,899
Foster Care	36,325,105	0	36,325,105
JOBS/STRIDE	11,621,703	11,102,932	22,724,635
Child Support Enforcement	47,338,210	4,156,411	51,494,621
Child Care & Child Development	13,367,521	0	13,367,521
Consolidated Chemical Dependency Treatment	0	60,998,368	60,998,368

Note 1: Family Support includes Aid to Families with Dependent Children (AFDC) (including Special Needs and Emergency Assistance) and the Minnesota Family Investment Program (MFIP).

Note 2: In addition to the food stamps provided as cash benefits, DHS also distributed $113,439,173 on food coupons and $94,950,598 through electronic benefits transfer (EBT) transactions during fiscal year 1996.

Sources: Federal financial schedules and the state of Minnesota's financial statements for fiscal year 1996.

The Minnesota Financial and Compliance Report on Federally Assisted Programs for the year ended June 30, 1996, 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 1997. We did not review and evaluate county level controls established to ensure that DHS made payments only on behalf of eligible recipients.

In addition to these primary objectives, we reviewed certain aspects of DHS program operations. Chapter 2 discusses the health care programs. Chapter 3 describes the income maintenance programs. Chapter 4 discusses the department's collection, deposit and recording of various receipts. Chapter 5 discusses selected DHS dedicated accounts. Chapter 6 describes some of DHS's other grant programs and Chapter 7 discusses certain miscellaneous audit areas.

Chapter 2. Medical Assistance and Other Health Care Programs

Chapter Conclusions

The state spent over $3 billion for Medical Assistance, General Assistance Medical Care, and MinnesotaCare during fiscal year 1996. DHS grant expenditures for the health care programs were fairly presented in conformity with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996.

In testing the medical assistance program for compliance with federal regulations, we found three instances of noncompliance. The department paid some claims that were beyond the one year limit imposed by federal regulations. It did not accurately complete certain required federal reports. DHS also did not collect drug rebates in accordance with the federal drug contract.

It was not our objective to render an opinion on internal controls over the health care programs, however, we found some weaknesses in DHS's administration of these programs. For example, DHS overpaid a provider approximately $6.2 million due to an error in the MMIS II manual pricing logic. It also has not resolved three findings cited in our last audit report.

DHS administers three major health care programs:

- Medical Assistance - This is the state's Medicaid 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.

- MinnesotaCare - 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.

Audit Scope and Objectives

We had two primary objectives in auditing the health care programs. The first objective was to determine whether expenditures for the programs, as reported on the state's financial statements, were fairly stated in accordance with generally accepted accounting principles. Our second objective, required by the Single Audit Act, was to determine whether the department complied

with federal laws and regulations relating to the Medical Assistance Program, and whether the department had internal accounting systems to provide reasonable assurance that it managed that program in compliance with applicable federal laws and regulations. We obtained an understanding of the design of relevant policies and procedures at the state level and determined whether they have been placed in operation, and we assessed control risk. 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.

Health Care Program Administration

The Legislature provides money for the health care programs through appropriations. 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.

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

Since 1991, the state has assumed the counties' financial share of the Medical Assistance and General Assistance Medical Care Programs. 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 MinnesotaCare without county financial participation. Many features of these programs are similar; the main distinction is the clientele each serves. Table 2-1 shows the fiscal year 1996 program expenditures for these three programs. DHS estimates that these programs serve approximately 560,000 citizens.

Table 2-1 Health Care Programs
Fiscal Year 1996 Expenditures

Program	FY96 Expenditures
Medical Assistance	$2,952,390,558
General Assistance Medical Care	143,015,789
Minnesota Care	55,123,411
Totals	$3,150,529,758

Source: Minnesota Accounting and Procurement System, on an accrual basis.

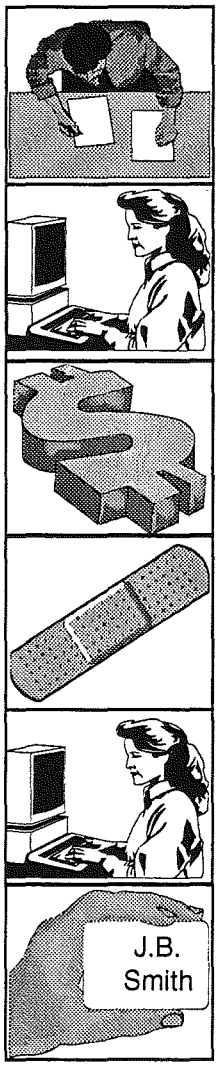
Department of Human Services

DHS must ensure that it makes payments in accordance with the federal regulations for the Medical Assistance Program, and in accordance with statutory provisions for the General Assistance Medical Care and MinnesotaCare programs. DHS uses two computer systems to assist with medical program eligibility and claims processing. The MAXIS computer system determines eligibility for the various income maintenance programs and facilitates eligibility determinations for the health care programs. The MMIS II system processes incoming claims for all of the health care programs DHS administers.

Eligibility Determination

Participation in the health care 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 income maintenance programs, facilitates eligibility determinations for the health care programs, and distributes cash assistance and food stamp benefits. (Chapter 3 provides additional information on the income maintenance programs.) Some of the income maintenance programs automatically qualify the person for Medical Assistance or another health care program. Over half of health care program participants qualify for these programs due to their participation in income maintenance programs such as Aid to Families with Dependent Children. If an applicant does not qualify for health care assistance through an income maintenance program, the county worker determines whether the person qualifies for a health care 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 worker must also enter the eligibility status into the MMIS II system, which is the health care programs' claim processing system. Figure 2-1 shows the major steps used in the health care program eligibility determination process.

Figure 2-1 Health Care 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.

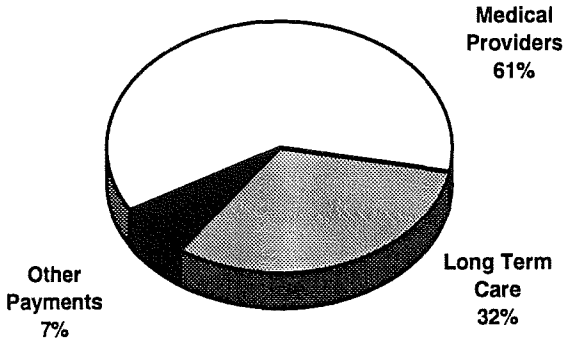
Eligible participant receives a Medical Benefits Card. The participant presents this card when requesting medical services.

Source: Auditor prepared.

Medical Assistance Expenditure Transactions

The Medicaid Management Information System II (MMIS II) processes all medical service claims. The MMIS II system refers nursing home claims to the Long Term Care subsystem for further processing. These systems feed information to the state's MAPS accounting system, which ultimately produces all the warrants that pay the claims of the various health care programs. DHS also records other transactions directly in the state's MAPS accounting system. Figure 2-2 shows the payments made during fiscal year 1996 through each payment process.

Figure 2-2
Health Care Programs
Fiscal year 1996 Expenditures by Payment Process



Source: Auditor prepared from MAPS expenditure data.

Medical Provider Payments

DHS uses the MMIS II system to process claims submitted by medical service providers such as doctors, dentists, hospitals, and health maintenance organizations. DHS developed this system in accordance with federal specifications and implemented it in June 1994. MMIS II determines the payment amounts and passes this data to the state's accounting system (MAPS). MAPS uses the data to generate warrants to medical providers and post the transactions. MMIS II issues remittance advises to the medical providers and benefit statements to the recipients of the care. The MMIS II system processed $1,940,924,934 in payments during fiscal year 1996.

MMIS II has over 900 edits to control claims processing and ensure compliance with intricate federal and state program requirements. For example, these edits are designed to ensure that:

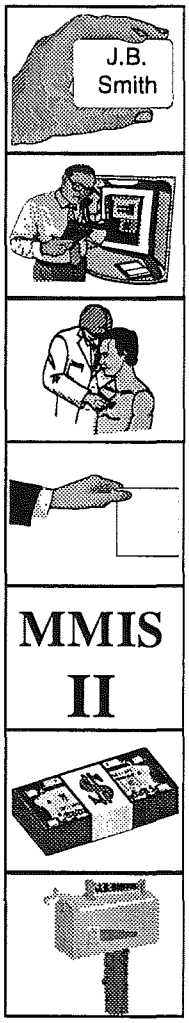
- the medical provider has been approved to participate in the program;
- the person receiving the medical benefit is an eligible participant of the program;
- the medical service is reimbursable under the program guidelines;
- the amount reimbursed is in accordance with approved rates; and
- the provider submitted the claim within the appropriate time limit (within a year from when the medical service was provided).

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

During fiscal year 1996, DHS processed roughly 23 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 HMO monthly fees. Figure 2-3 shows the major steps used for medical claims processing.

Figure 2-3 Health Care 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.

Long Term Care Payments

DHS uses its long term care subsystem to make the recurring monthly payments to nursing homes and other long term care facilities for health care program participants. DHS initially inputs the claims into MMIS II, which performs some edit validations. MMIS II then passes these claims to the long term care subsystem for rate verification and payment determination. The long term care subsystem interfaces with the state's MAPS accounting system to produce the payment warrants and post the transactions to the state's accounting system. The long term care subsystem provides data back to the MMIS II system to update the payment history file. Payments processed through the long term care subsystem during fiscal year 1996 totaled $997,343,575, one-third of all health care program expenditures.

Other Health Care Program Payments

As shown in Figure 2-2, DHS processes about seven percent of all health care program transactions as miscellaneous transactions directly through the state's accounting system (MAPS). These are transactions not processed through the MMIS II system. Table 2-2 shows the most significant of those transactions during fiscal year 1996.

Table 2-2
Other Health Care Program Transactions
Fiscal Year 1996

• DHS transferred funds to DHS's regional treatment centers for residents and chemical dependency program participants who are eligible for the health care programs.	$88,271,318
• DHS transferred funds to certain medical providers for day training and habilitation services.	$77,588,774
• DHS made monthly disproportionate population adjustment payments to the Hennepin County Medical Center and the University of Minnesota hospitals. The payments are intended to compensate these hospitals for the high proportion of health care program participants within their caseloads.	$24,240,000
• DHS collected and distributed federal administrative aids related to the health care programs. DHS paid some of these aids to the counties to reimburse them for their personnel and related costs necessary to determine eligibility and maintain case files. DHS paid other aids to the central state government to reimburse the state for the cost of maintaining its accounting, procurement, and personnel/payroll systems. DHS kept some of the aid to offset the cost of maintaining the MAXIS and MMIS II systems and general program administration.	$47,658,704
• DHS collected rebates for drugs purchased through the Medical Assistance Program. DHS enters these receipts in MAPS as expenditure reductions offsetting health care expenditures. (See further discussion of the drug rebate program later in this chapter.)	$30,318,257
• DHS also collected overpayments made to providers, recoveries from third parties (such as insurance companies or estates), and other types of benefit recoveries. DHS records these receipts in MAPS as revenues credited to the health care programs.	$38,781,737

Source: Auditor analysis of fiscal year 1996 MAPS activities.

Conclusions

DHS's grant expenditures for the health care programs were fairly presented in accordance with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996. Except as explained in Findings 1, 5, and 8, DHS complied, in all material respects, with federal requirements governing the Medical Assistance

Program. We also found certain weaknesses in the DHS administration of the health care programs, as described in Findings 2, 3, 4, 6, and 8.

1. DHS paid health care program provider claims over one year old.

During fiscal year 1996, DHS estimates that it reimbursed medical providers over $5.7 million for claims that they submitted after the one year federal deadline. For some of these claims, providers had originally submitted the claim prior to the one year deadline, but MMIS II had denied or suspended it. Other claims, however, were not submitted within one year, as required by federal regulations. DHS made the decision to pay these claims because of processing problems during the implementation of MMIS II. In some cases, DHS asked medical providers to delay submitting claims past the one year limit, until they could resolve MMIS II processing problems.

DHS does not have the legal authority to make payments to medical providers for claims originally submitted more than a year after the date when medical services were provided. The Code of Federal Regulations for the Medical Assistance Program states that DHS "must require providers to submit all claims no later than 12 months from the date of service." Because medical provider associations expressed concern about delays in paying claims, DHS negotiated a one time exclusion to the one year limit. DHS agreed to process claims for the period from May 1994 through October 1994, and certain claims that MMIS II suspended during the period from November 1994 through March 1995. As a result, DHS estimated that it paid almost 13,000 old claims totaling over $5.7 million to medical providers for these old claims.

The late claims had to meet all program criteria except the timely billing edit. However, at the time DHS processed these claims, it did not perform a detailed analysis on the claims to determine whether all of the claims had been originally submitted within the one year deadline, or that they were claims that DHS had asked providers not to submit. As a result, DHS does not know if any of the amount they paid was in violation of federal regulations.

Recommendations

- *DHS should enforce compliance with the federal one year submission limit. If DHS anticipates difficulty in complying with the requirement, it should ask the federal government to waive the requirement and approve alternative procedures.*

- *DHS should analyze the population of claims paid with service dates over one year old, and determine the volume and value of claims paid that providers did not originally submit within a year after the date when they provided the medical services.*

2. DHS overpaid a provider approximately $6.2 million, due to an error in the MMIS II program logic relating to manually priced claims.

In July 1995, MMIS II erroneously produced and sent a $6,188,667.82 warrant to satisfy a $61.88 medical assistance claim submitted by a medical provider. DHS did not have controls in

place to detect such an overpayment in a timely manner. As a result, DHS did not detect the overpayment. The overpaid provider notified DHS that it had made an error. The provider ultimately returned the funds to DHS, along with interest.

The error occurred because the MMIS II pricing logic over manually priced claims did not prohibit payment in excess of submitted charges. Manually priced claims occur when a medical procedure does not have an established system rate. A DHS claims processor then manually enters a price for the procedure. The claims processor entered erroneous data into the allowable rate field. The system should have limited the payment to the lesser of the provider claimed amount or the program allowable amount. However, the pricing logic allowed payment of the manually entered rate amount, even though it greatly exceeded the actual amount claimed by the medical provider. DHS was not aware that the pricing logic was not functioning as intended.

DHS did not have a system in place to promptly detect this overpayment. Thus, DHS mailed the warrant to the medical provider. DHS only became aware of the error when the provider notified them.

Once they were aware of the error, DHS staff responded by:

- collecting the overpayment and accrued interest totaling $6,867 from the medical provider;

- changing the edit that allowed the overpayment to prevent similar errors from occurring again;

- creating new payment reports to review large payments (DHS now reviews a report of all warrants exceeding $100,000) and provide a quality control review of all manually priced claims; and

- reviewing other manually priced claims since the implementation of the MMIS II system. During this review, the department found an additional 470 overpaid claims totaling approximately $76,000.

DHS is responsible to ensure that the MMIS II system functions appropriately. This includes maintaining a vigilant effort to ensure that controls are in place to prevent or detect material errors and irregularities.

Recommendations

- *DHS should review payment analysis reports after each payment run to promptly detect erroneous payments.*

- *DHS should monitor the MMIS II system and be alert for potential problem areas. The department should put into place improved prevention and timely detection controls to address problem areas.*

3. PRIOR FINDING PARTIALLY RESOLVED: The MAXIS and MMIS II systems contained discrepancies between eligibility status codes.

Reconciliations between MAXIS and MMIS II continue to identify discrepancies in recipient eligibility status. We first reported this issue in our fiscal year 1995 report on DHS. Recipient eligibility discrepancies can result in DHS paying benefits to medical providers on behalf of ineligible people.

County financial workers who determine a person's eligibility on MAXIS 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.

The October 1996 comparison of recipients' eligibility status found 2,424 instances where MAXIS identified the recipient as not eligible for program benefits, while MMIS II showed that same recipient as eligible. Since DHS uses the eligibility code in MMIS II to verify incoming claims, DHS continued to pay medical claims for these potentially ineligible recipients. Also, since the Eligibility Verification System relies on MMIS II data, medical providers may have received inaccurate eligibility information for these people.

The comparison also showed that 830 of the 2,424 instances were recipients enrolled in a managed care program for which DHS pays monthly premiums estimated at $192 per recipient. Given that average rate, DHS may have spent up to $159,000 per month for ineligible participants in managed care alone. Table 2-3 shows the results of DHS's reconciliations between MAXIS and MMIS II since September 1995, when they performed the first reconciliation.

Table 2-3
Reconciliations of MAXIS /MMIS II Recipients' Eligibility Status

Reconciliation Date	MAXIS Inactive / MMIS II Active	Enrolled in Managed Care
September 1995	9,141	914 (est.)
January 1996	5,230	1,407
April 1996	3,734	1,036
July 1996	3,882	1,220
October 1996	2,424	830

Source: DHS MAXIS/MMIS II reconciliation reports.

DHS performs these reconciliations on a quarterly basis, comparing the MAXIS recipient file to the MMIS II recipient file, reviewing 20 data elements for consistency. One of the data elements that DHS compares is the recipient's eligibility status code on both systems.

We recognize that, due to timing differences, there will always be some eligibility differences between the two systems. Since the county financial workers maintain the recipient files and determine eligibility, they must resolve many of the discrepancies at the county level. However,

DHS should monitor the results of the counties' resolution of these inconsistencies and verify that the counties are properly resolving any systemic eligibility problems.

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.*

4. PRIOR FINDING NOT RESOLVED: DHS paid for costly medical procedures without first verifying their prior approval.

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.

In response to our finding in the fiscal year 1995 audit report, DHS prepared a report of the admission certification claims processed over the past several years. At the time of our audit, DHS had not begun to analyze the report to determine the extent that providers did not obtain proper authorization. However, the report identified both duplicate procedures and admission certification numbers, indicating that there are some obvious problems with the current process.

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. PRIOR FINDING NOT RESOLVED: DHS did not accurately complete certain required federal reports during fiscal years 1995 and 1996.

During fiscal years 1995 and 1996, MMIS II did not provide DHS with all the information it needed to complete the quarterly federal report required for the Medical Assistance Program. 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 for fiscal years 1995 and 1996. The

reports submitted for those fiscal years have shown most expenditures in the "Other" category. DHS has improved MMIS II's reporting capabilities and, effective in fiscal year 1997, began completing the reports properly. DHS needs to revise the HCFA-64 reports submitted to the federal government for quarters during fiscal years 1995 and 1996.

Recommendation

- *DHS should revise the HCFA-64 Quarterly Reports of Medicaid Expenditures for all quarters during fiscal years 1995 and 1996.*

6. PRIOR FINDING NOT RESOLVED: Certain rates were not set in accordance with statutory provisions.

DHS did 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 more strict than 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.*

Drug Rebates

DHS started the Drug Rebate Program as a result of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). This federal program requires drug labelers to rebate a part of the drug retail price to the Medicaid agencies for drugs purchased through the Medicaid (Medical Assistance) program. The rebates result from the difference between normal retail costs and the negotiated contract prices. Although the drug labelers may not change the negotiated rebate amounts, OBRA '90 does give drug labelers the right to dispute the number of units DHS claims it purchased. Drug rebates offset federal and state medical assistance expenditures. During fiscal year 1996, DHS collected $30,318,257 as rebates from drug labelers.

The program staff consists of a drug rebate manager and an assistant for administrative support, both of whom have pharmaceutical backgrounds. During our review of the drug rebate program, we found the following weaknesses:

7. DHS did not accurately account for its Drug Rebate Program.

DHS did not properly account for the amounts due and collected from drug labelers for drug rebates. DHS did not have an accounting system to account for this activity. Rather, the drug rebate assistant used a computer spreadsheet to record these amounts. DHS did not have a method to periodically reconcile this drug rebate spreadsheet to MMIS II quarterly billing amounts or DHS Financial Management Unit records of drug rebate collections.

The MMIS II system determines the quarterly billable amounts based on pharmacy claims paid for medical assistance participants. The DHS Financial Management Unit records the drug rebate collections in MAPS, the state's accounting system. The drug rebate assistant posts this activity to the drug rebate spreadsheet. The assistant also posts any adjustments and write-offs to this spreadsheet.

DHS did not periodically reconcile the spreadsheet either to MMIS II billing amounts or to deposits of incoming receipts. Since the drug rebate schedule is cumulative, it was not possible to determine when certain adjusting entries took place or to reconcile the schedule for any given time period. Subsequently, the recorded ending balance of $7,033,517 may be in error.

Recommendation

- *DHS should develop a system to account for drug rebates. The system should allow for periodic verifications of the billing and receipt transactions affecting the accounts receivable balances.*

8. DHS did not properly pursue and resolve outstanding drug rebate accounts receivable.

DHS did not bill drug labelers for past due rebate amounts or charge interest on past due bills. In addition, DHS did not collect drug rebates in accordance with the federal drug contract.

DHS did not bill drug labelers for undisputed past amounts due drug rebate amounts or charge interest on those amounts. The quarterly bills sent to labelers are only for the current quarter and do not include previously billed but unpaid amounts. DHS has outstanding rebate billings dating as far back as 1991, when the program began. While drug labelers have disputed some of these outstanding bills, others are simply not paid. The current DHS system of accounting for drug rebate amounts does not readily allow the department to analyze overdue accounts and diligently pursue these amounts with the labelers.

In addition, DHS did not follow the federally prescribed method for resolving disputed accounts receivable. When a drug labeler disputes a bill, the federal drug rebate contract requires that DHS first initiate an internal dispute resolution process which can take up to 240 days. If DHS cannot resolve the dispute, it must initiate an external dispute resolution process no later than one year from the 240th day after a drug labeler disputes a claim. DHS has not used this process for resolving outstanding disputed accounts receivable.

Finally, DHS did not require an authorization or second review of negotiated write-offs of rebate amounts. The DHS drug rebate manager acts alone to negotiate reductions in the billed rebate

amounts. The federal drug rebate contract and DHS policy allow the drug rebate manager to negotiate settlements with drug labelers. The drug rebate manager can discharge up to $10,000 per labeler per quarter, if it is believed it is cost effective. However, the drug rebate manager does not formally document these discharge decisions. In addition, no one other than the drug rebate manager authorizes or reviews discharged rebate amounts.

Recommendations

- *DHS should bill drug labelers for past due balances and should charge interest on these amounts.*
- *DHS should determine all outstanding drug rebate amounts and collect them in compliance with the federal drug rebate agreement.*
- *Someone should authorize or review the rebate amounts discharged by the drug rebate manager through negotiated settlements with labelers.*

Chapter 3. Income Maintenance Programs

Chapter Conclusions

DHS grant expenditures for the income maintenance programs were fairly presented in conformity with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996. DHS complied, in all material respects, with federal requirements governing the AFDC and Food Stamp programs.

As shown in Figure 3-1, DHS administers various income maintenance programs designed to provide a base of income to poor and needy residents. These programs include:

- **Aid to Families with Dependent Children (AFDC)** - This federal/state program provides cash payments to qualifying recipients to meet their needs for food, shelter, clothing, and other daily living needs. The program targets these funds toward needy families with dependent children and to needy aged, blind, or disabled people. AFDC also provides for short term emergency assistance.

- **Minnesota Family Investment Program (MFIP)** - DHS developed this program as a pilot project reform of the AFDC program. MFIP focuses on supporting families while making it more profitable to work than be on welfare. The program provides financial assistance and wage supplements, child care assistance, and employment and training services. The federal government shares the cost of this program with the state.

- **General Assistance** - The General Assistance Program extends income maintenance benefits to persons not qualifying for AFDC or MFIP. These cash payments meet the basic living needs of certain Minnesota residents who have net income and resources below state limits. The state fully funds this program.

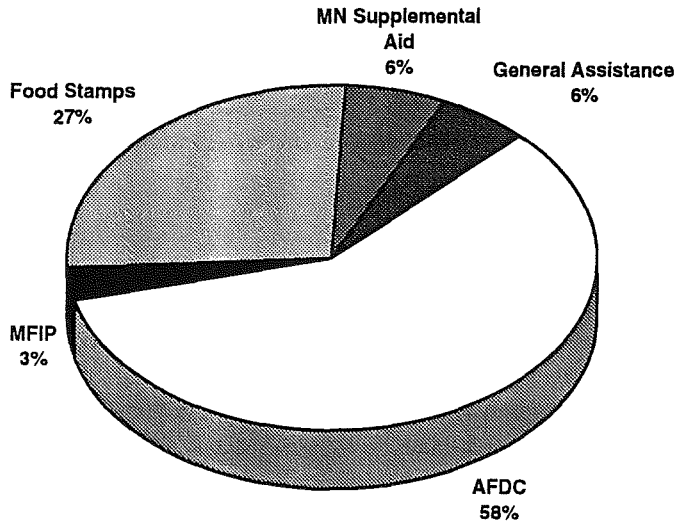
- **Minnesota Supplemental Aid** - This is a state program that supplements the federal Supplemental Security Income Program. The program provides cash benefits to aged, blind, and disabled people who are in financial need.

- **Food Stamps** - Through this program, the federal government hopes to improve the diets of persons living in low-income households by increasing their food purchasing ability. Recipients use their benefits to purchase allowable food products from participating retail stores.

The total cost of the income maintenance programs during fiscal year 1996 was $972,986,688. Program costs include benefits to program recipients and administrative costs incurred by the

department and the counties. Figure 3-1 allocates this total among the various income maintenance programs.

Figure 3-1
Income Maintenance Programs
Fiscal Year 1996



Source: Analysis of payments through the MAPS accounting system and food stamp coupon disbursements for fiscal year 1996.

Audit Scope and Objectives

We had two primary objectives in auditing the income maintenance programs. The first objective was to determine whether 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 AFDC (including MFIP) and the Food Stamp programs, and whether the department had internal accounting systems to provide reasonable assurance that it managed those programs in compliance with applicable federal laws and regulations. We obtained an understanding of the design of relevant policies and procedures at the state level and determined whether they have been placed in operation and we assessed control risk. 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.

Conclusions

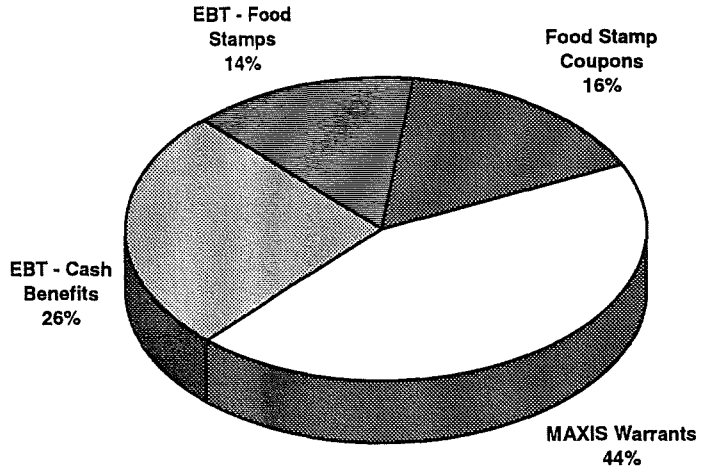
DHS's grant expenditures for the income maintenance programs were fairly presented in accordance with generally accepted accounting principles, in all material respects, in the state of

Minnesota's financial statements for fiscal year 1996. DHS complied, in all material respects, with federal requirements governing the AFDC and Food Stamp programs.

Income Maintenance Program Administration

DHS uses three methods to provide income maintenance benefits to recipients. DHS has traditionally used two of these methods, state warrants and food stamp coupons, to provide these entitlement aids to qualified recipients. In recent years, recipients have also been able to access their benefits electronically through automatic teller machines or point of sale machines at retail stores. Originally available only in Hennepin and Ramsey counties, DHS is phasing in electronic benefit transfer (EBT) transactions statewide and intends to use it to virtually replace the traditional methods of providing benefits. Figure 3-2 shows the income maintenance transactions paid through each process during fiscal year 1996.

Figure 3-2
Income Maintenance Programs
Benefit Distribution Methods



Source: Auditor created from MAPS expenditure and food stamp disbursement data.

Warrants and Coupons

DHS uses the MAXIS computer system to accumulate recipient data and calculate the income maintenance benefits available to recipients. Following the process outlined in the first four steps of Figure 2-1, county financial workers enter recipient data into MAXIS from the Combined Application Form. The MAXIS system uses this data to determine the programs that the recipient qualifies for and the amount of aid the recipient is eligible to receive. The MAXIS system then sends payment data to the department's Issuance Operations Center.

The Issuance Operations Center controls the distribution of both warrants and food stamp coupons for income maintenance recipients. The Issuance Operations Center prints and mails state warrants for the income maintenance programs. MAXIS authorizes most benefits at the beginning of each month. The payments made on most other days of the month are for recipients just entering the programs who are not yet on a monthly payment cycle.

DHS distributes food stamp coupons to program recipients who do not receive their benefits electronically. The Issuance Operation Center maintains inventory records showing additions to and withdrawals from the inventory of food stamp coupons. The state receives its stock of food stamp coupons from the federal government and uses the MAXIS system, interacting with the Issuance Operations Center, to distribute the coupons through the mail. The federal government redeems food stamps directly with the vendors. The federal government fully funds the food stamp benefit costs. Fiscal year 1996 expenditures of food stamps coupons totaled $113,439,173.

Electronic Benefit Transfer (EBT) Transactions

Most Hennepin and Ramsey County income maintenance program recipients obtain benefits (including food stamp benefits) through point of sale machines located at grocery stores or automatic teller machines. Recipients receive debit cards and can withdraw benefits when they need them. The department believes that this process helps residents safeguard their benefits, yet still allows continuous access to the benefits. Starting in July 1997, DHS will gradually expand the use of electronic benefits transfer (EBT) statewide.

DHS contracts with a private vendor to process EBT transactions and report those transactions to DHS daily. The MAXIS system provides the vendor with benefit availability data on a daily basis. Each day, the vendor provides DHS with a report of the amount of cash withdrawals for the previous day. These reports are the basis for a wire transfer to reimburse the vendor for the withdrawals and the basis for MAPS expenditure input. The federal government directly reimburses the vendor for electronic food stamp withdrawals. DHS does not record food stamp benefits accessed by EBT on MAPS since no cash flows through the state's system. During fiscal year 1996, income maintenance recipients accessed cash benefits totaling $183,419,905 through the EBT process. In addition, recipients accessed food stamp benefits totaling $94,950,598 through EBT.

Chapter 4. Selected Departmental Revenues

Chapter Conclusions

DHS's federal revenues, drug rebate revenues, medical provider surcharges, health care program refunds and third party recoveries, and regional treatment cost of care revenues were fairly presented in conformity with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996.

We found that DHS generally complied with federal requirements for cash management. We found, however, that the state lost an estimated $3 million as a result of not requesting federal funds for the Medical Assistance Program as timely as possible.

In addition, we found significant weaknesses in DHS's processing and accounting for receipts. In particular, we found that the department did not adequately safeguard receipts in either the mailroom or the cashier's office.

Audit Scope and Objectives

We had two primary objectives in auditing the revenue areas listed in Table 4-1. The first objective was to determine whether the revenues, as reported on the state's financial statements, were fairly stated in accordance with generally accepted accounting principles. Our second objective was to determine whether DHS complied with the cash management provisions of the Single Audit Act, and whether the department had internal accounting systems to provide reasonable assurance that it monitored federal cash management in compliance with applicable laws and regulations. We also examined DHS's process to record and deposit centrally collected receipts. These included drug rebates, recoveries from third parties, health care program fees and refunds, and medical provider surcharges. To reach our conclusions, we examined some aspects of the department's internal control structure and its compliance with finance-related legal provisions. We interviewed department employees, reviewed its policies and procedures, and observed the department's processes and controls.

Table 4-1
Material Revenue Areas
Fiscal Year 1996

Type of Revenue	Amount
Federal Revenue	
Health Care Programs	$1,591,427,451
Income Maintenance Programs	223,238,202
Other Major Federal Programs	217,726,590
Drug Rebates	30,318,258
Medical Provider Surcharges	132,131,662
Health Care Program Refunds and Third Party Recoveries	38,781,737
Regional Treatment Center (RTC) Cost of Care	139,210,196
RTC Chemical Dependency Cost of Care	11,741,955

Sources: Federal financial schedules and the state of Minnesota's financial statements for fiscal year 1996.

Conclusions

The revenues shown on Table 4-1 were fairly presented in accordance with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996. However, we found that the department was not requesting federal Medical Assistance funding in accordance with the cash management agreement between the federal government and the state. DHS also did not change the AFDC federal reimbursement rate used by the electronic benefits vendor, resulting in some federal funds being requested too early. We found that DHS had deposited certain regional treatment center Medical Assistance payments into the wrong state fund. Finally, DHS needs to improve controls over centralized receipts, including adequate safeguarding of receipts, creating a log of receipts, and depositing receipts promptly.

Federal Revenue

DHS receives federal funds for many of their programs. Pursuant to the Federal Cash Management Improvement Act of 1990, the state has entered into an agreement with the federal government citing when state agencies are allowed to request federal funds for their various programs. The agreement allows DHS to request Medical Assistance funds from the federal government three days after the state mails out Medical Assistance payment checks.

9. DHS did not request its federal funding for the Medical Assistance Program in accordance with the state's cash management agreement with the federal government.

DHS typically requested federal funds twice a month for the Medical Assistance Program, even though it processes payments for the program weekly. According to the state's cash management agreement with the federal government, DHS should request federal funds so that the funds are received on the third day after the state mails Medical Assistance warrants (the average clearance day). We found that, at several times during the year, the amount the federal government owed

DHS for the Medical Assistance Program exceeded $100 million. We estimate that these delays in requesting federal funds cost the state $3 million in lost investment income.

DHS is required to report the amount of lost interest income on federal programs to the Department of Finance each year. However, DHS reported that there were no delays in the receipt of federal funds for the Medical Assistance Program during fiscal year 1996. The Department of Finance requires DHS to report any delays in the receipt of federal funds so that the state can determine interest due or owed the federal government. The Cash Management Improvement Act of 1990 requires states to monitor federal draws and determine whether they received the federal funds on time. If a state draws the funds early, it owes the federal government interest. If the federal government pays the funds late, it owes the state interest. DHS should have reported the number of days delay between the average clearance day and when it deposited the federal funds. Finance could then have requested interest on the funds drawn late to offset the state's lost investment income.

Recommendations

- *DHS should request federal funds for Medical Assistance so that it receives the federal funds in accordance with the federal cash management agreement.*

- *DHS should report to the Department of Finance all delays in the receipt of federal funds, including those resulting from late reimbursement requests.*

10. DHS did not change the AFDC federal reimbursement rate used by the electronic benefits vendor, resulting in federal funds being drawn too early.

DHS bases its request for federal reimbursement for AFDC EBT benefits on a daily report it receives from its EBT services vendor. The daily report identifies the EBT disbursements by program and allocates them to the federal and state funding sources. On October 1, 1995, the vendor should have changed the federal participating rate for the AFDC program to 53.93 percent. Instead, the vendor continued to allocate AFDC EBT disbursements at the old participating rate of 54.27 percent until January 1996. We estimate that this error resulted in DHS requesting $141,500 of federal funds too early. DHS identified and corrected the overdraw during the year end reconciling procedures.

Recommendation

- *DHS should verify that it uses the proper federal reimbursement rates to request federal funds.*

Cost of Care Revenues

The seven DHS regional treatment centers, two state nursing homes, and numerous other state operated community based programs collect revenues for the cost of care provided by those facilities. Each state facility is responsible for collecting these cost of care receipts. Historically, the statutes directed DHS to deposit cost of care receipts into the state's General Fund. This, in

effect, reimbursed the state for some of the operating costs of the facilities that are funded through General Fund appropriations.

Legislative changes in the 1995 session directed DHS to deposit all cost of care receipts from "nonstate sources" into an account dedicated to the repayment of specific bond obligations. We found that DHS deposited the state share of the regional treatment center Medical Assistance payments into this dedicated account, as well as the cost of care receipts from nonstate sources.

11. DHS deposited certain Medical Assistance payments to the regional treatment centers into the wrong fund.

DHS deposited the state share, as well as the federal share, of Medical Assistance payments to the regional treatment centers into a fund dedicated to the repayment of bond obligations. During fiscal year 1996, DHS deposited $36,426,006 of state funded Medical Assistance payments into a special fund dedicated to the repayment of certain bond obligations. DHS should have only deposited receipts from "nonstate sources" into this dedicated account. Cost of care receipts from nonstate sources include federal Medical Assistance reimbursements, but not the state share of cost of care. DHS should have deposited the state share into the state's General Fund. When DHS tried to correct the error, it found that insufficient funds remained in the account to allow the department to correct the erroneous deposits.

Recommendations

- *DHS should deposit cost of care receipts in accordance with statutory provisions.*

- *DHS should work with the Department of Finance to collect the remaining overpayment made to the dedicated bond account and deposit the recovered funds into the General Fund.*

Medical Surcharge Payments

Medical providers who wish to conduct business in Minnesota must pay a surcharge to the state. The medical providers, including physicians, hospitals, nursing homes, and health maintenance organizations, pay this surcharge to DHS on an annual or monthly basis. Statutes require physicians to pay a $400 annual surcharge at the time they renew their licenses. Nursing homes annually pay $625 per licensed bed as a surcharge. The statutes require hospitals and health maintenance organizations to pay a certain percentage of their net patient revenues or premium payments.

In addition to the surcharges, the statutes also require certain government run hospitals and nursing homes to make payments to the state. During fiscal year 1996, the University of Minnesota Hospital and the Hennepin County Medical Center paid the state a total of $2,020,000 per month. Nursing homes operated by certain counties pay the state $5,723 per bed on an annual basis. DHS deposits all of these receipts into the state's General Fund. For fiscal year 1996, medical surcharge receipts and other receipts from hospitals totaled $132,131,662.

Department of Human Services

Department Receipt Process

In addition to the work we did to verify the reasonableness of selected revenues for DHS, we reviewed the department's centralized receipts process. The volume of incoming receipts into DHS has grown substantially over the last few years, especially since the implementation and growth of the MinnesotaCare Program. Many of these receipts come through the mail. The DHS mailroom opens and sorts the receipts based on the color of the envelope. Two or three times during the day, the mailroom staff give the receipts to the cashier's office. The cashier distributes the receipts among staff so that the receipts can be posted to the various accounts receivable systems. Receipts stay in the cashier's unit until they are posted to the systems. At the end of the day, staff put all the receipts into the safe. The cashier deposits posted receipts the next working day.

We found that DHS needs to improve controls over centralized receipts, including safeguarding of receipts, creating a log of receipts, and depositing receipts promptly. DHS's internal audit staff completed an audit specifically of the MinnesotaCare receipt processing. Our audit confirmed the weaknesses noted in their report, dated February 13, 1997.

12. The department did not adequately safeguard receipts in either the mailroom or the cashier's office.

DHS did not adequately safeguard incoming receipts. Employees had unnecessary access to receipts. The department did not deposit all receipts promptly.

The mailroom staff did not keep receipts in a secure area. Staff kept receipts in an unlocked drawer until delivered to the cashier. After the mailroom brought receipts to the cashier, the cashier's staff did not store receipts in a safe place while posting the receipts to the computer system. Staff did not restrictively endorse receipts until they posted the receipts in the computer system. The department is more susceptible to theft when staff do not immediately restrictively endorse and deposit checks.

In addition, the cashier did not deposit checks in a timely manner. Employees use the checks to post transactions in the system. If the employees were unable to finish posting the receipts to the system that day, the cashier kept the receipts in the safe until they were entered in the computer system. The department is exposing receipts to unnecessary theft by not depositing the receipts immediately. The cashier could prepare a log of receipts and give the list to staff to make the appropriate posting to the computer system.

The cashier's office gave the Benefits Recovery Unit unnecessary access to receipts. The cashier forwarded checks that appear to be benefit recoveries to the Benefits Recovery Unit for review. Once the Benefit Recovery Unit properly identified the source of the receipt, it returned the check to the cashier. Employees of the Benefits Recovery Unit do not need direct access to these checks in order to perform their job responsibilities.

Finally, the department did not use an armored truck service to transport receipts to the bank. The department should keep receipts secure until the receipts are deposited.

Recommendations

- *The department needs to adequately safeguard receipts in the mailroom by keeping receipts physically secure, restrictively endorsing checks immediately, and preparing a log of all receipts.*

- *The cashier should promptly deposit receipts. Receipts should not be routed outside of the cashier's unit.*

- *DHS should provide adequate security over the receipts while they are being transported to the bank.*

Chapter 5. Selected Dedicated Accounts

Chapter Conclusions

The financial activity of the Consolidated Chemical Dependency Treatment Fund was fairly presented in conformity with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996. DHS complied, in all material respects, with federal requirements governing Federal Substance Abuse program expenditures made from the Consolidated Chemical Dependency Treatment Fund.

DHS funded several "revenue maximization" projects under its authority in Minn. Stat. Section 256.01 Subd. 2(15), including projects to identify and pursue third party Medical Assistance payers, and to review and resolve disputed drug rebate amounts. At the end of fiscal year 1996, DHS retained $465,974 more in this account then permitted by state law.

DHS accounts for some of its financial activity in the state's Special Revenue Fund. Accounts within the Special Revenue Fund differ from accounts in the state's General Fund since receipts are dedicated to the account and can be used again without direct appropriation from the Legislature. Also, funds remaining at the end of the fiscal year carry forward to the next fiscal year rather than canceling back to the General Fund. Table 5-1 shows selected department Special Revenue Fund accounts.

Scope and Objectives

Our examination of DHS's special revenue accounts had three primary objectives. The first objective was to determine whether the Consolidated Chemical Dependency Treatment Fund was fairly stated in accordance with generally accepted accounting principles within the state's financial statements. The second objective was to determine whether the department complied with federal rules and regulations relating to expenditures the department made from the Consolidated Chemical Dependency Treatment Fund which were funded by the federal Substance Abuse Program. Finally, our third objective was to provide an overview of other selected Special Revenue Fund accounts. In this chapter, we profile the Consolidated Chemical Dependency Treatment Fund, the MMIS II Operations account, and the Revenue Maximization account. These accounts were chosen due to their materiality or their unique nature.

In order to achieve these objectives, we obtained an understanding of the design of relevant policies and procedures at the state level and determined whether they have been placed in operation and we assessed control risk. We did not review and evaluate county level controls. The counties are responsible for determining eligibility of program recipients. To reach our

conclusions, we interviewed various DHS personnel, examined agency documentation, and tested selected transactions.

Table 5-1
Selected Special Revenue Fund Accounts
Fiscal Year 1996

Account Name	Beginning Balance	Receipts/ Transfers In	Expenditures/ Transfers Out	Ending Balance
Consolidated CD Treatment	$4,163,748	$76,320,587	$64,526,149	$15,958,186
MMIS II Operations *	460,895	31,563,747	26,788,657	5,235,985
MAXIS General / Administration *	8,756,841	28,693,608	28,863,415	8,587,034
MMIS Upgrade Revolving *	0	10,657,000	10,657,000	0
Child Support Enforcement System *	1,709,362	8,659,089	7,916,763	2,451,688
Child Support Enforcement - PRISM *	585,932	7,246,364	4,749,539	3,082,757
Electronic Benefit Administration *	0	5,943,506	4,031,060	1,912,446
Revenue Maximization	1,535,354	2,570,050	2,639,430	1,465,974
Social Service Information System *	119,698	1,586,793	1,243,810	462,681

* Indicates a computer system development or operational account.

Source: Inquiries into the MAPS accounting system on January 22, 1997, central office accounts only.

Conclusions

The financial activity of the Consolidated Chemical Dependency Treatment Fund was fairly presented in conformity with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996. DHS complied, in all material respects, with federal requirements governing Federal Substance Abuse Program expenditures made from the Consolidated Chemical Dependency Treatment Fund.

Consolidated Chemical Dependency Treatment Fund

The Consolidated Chemical Dependency Treatment Fund combines revenue from various sources and uses those funds to reimburse chemical dependency treatment centers for care provided to eligible recipients. The fund receives money from three main sources. It receives funding from the federal government through the Federal Substance Abuse Grant. It also receives reimbursements from the state's health care programs (Medical Assistance, General Assistance Medical Care, and MinnesotaCare) for chemical dependency care provided to program recipients. Finally, counties are required to reimburse the fund for 15 percent of chemical dependency treatment expenditures made for residents of their counties.

The Consolidated Chemical Dependency Treatment Fund makes direct payments to providers of chemical dependency treatment. DHS maintains a computer system that processes provider invoices. This system interfaces with the state's accounting system to produce payments and post summary accounting entries.

Department of Human Services

MMIS II Operations Account

Many of the DHS Special Revenue Fund accounts are for the development or operation of computer systems. Minnesota Statutes 256.014 states that money collected by DHS for its computer systems must be deposited in separate state systems accounts. DHS has established these accounts in the Special Revenue Fund to segregate systems costs from other operational costs.

As explained in Chapter 2, the Minnesota Medicaid Information System (MMIS II) processes payments for the health care programs. DHS developed this system following federal government specifications which were tailored to DHS's needs. The federal government provided much of the funding to develop the system, reimbursing the state for 90 percent of the development costs. They continue to share in the cost of operating the system, reimbursing DHS for 75 percent of the system operating costs.

The majority of the operating expenditures for MMIS II operations are for salaries and computer mainframe costs, as well as printing and mailing remittance advices to medical providers and monthly benefit statements to program recipients. The various components of the MMIS II Operations Account are shown in Table 5-2.

Revenue Maximization Account

As shown in Table 5-1, DHS spent $2,639,430 on various revenue maximization projects during fiscal year 1996. We examined this activity to determine what types of projects the department funded during fiscal year 1996 and whether those projects appeared to be appropriate under the authority given to the department by the Legislature within Minn. Stat. Section 256.01, Subd. 2(15).

In response to DHS's requests for appropriation increases for administrative areas, the Legislature enacted Minn. Stat. Section 256.01, Subd. 2(15). The provision reads:

> (15) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited into the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

Table 5-2
MMIS II Operating Expenditures
Fiscal Year 1996

• **Centralized Disbursements** includes most nonsalary operating costs, such as consultant contracts, Intertech services, and supplies.	$15,457,932
• **Information Policy System** records costs for the system analysts who make software changes to MMIS II, including its 14 subsystems.	2,278,510
• **Claims Processing** reviews the claims "suspended" by MMIS II. Staff review suspended claims and any special attachments, resolve errors, and thereby allow processing to continue.	2,613,397
• **MMIS II Administration** is the general administration of the MMIS II system.	406,321
• **Document Center** provides support for the MMIS II claims processing, including opening and sorting the mail.	498,154
• **Benefit Recovery** coordinates the recovery of benefit costs from third parties, such as private insurance companies and estates.	1,140,545
• **County Support** provides a help desk for county workers to resolve questions about program eligibility.	1,417,857
• **Electronic Data Interchange** encourages providers to use electronic billing and eligibility systems. This account includes payroll and operating costs for this effort.	561,299
• **Customer Services** makes applicable laws and standards available to providers. It also is responsible for training medical providers on how to properly prepare and submit a claim.	1,923,926
• **Provider Manual** is the cost of publishing and communicating information to medical providers.	187,324
• **County Waiver Support** helps county workers to understand, monitor, and use cost effective nontraditional benefits, allowing recipients to stay in the communities rather than being institutionalized.	303,392
Total MMIS II Operating Expenditures	$26,788,657

Source: Inquiries into the MAPS accounting system.

During fiscal year 1996, DHS conducted various projects under this statutory provision. Revenues came from four main sources: federal reimbursements, disputed drug rebate collections, county social service time studies, and regional treatment center special projects. Expenditures charged to the revenue maximization accounts consisted mainly of salaries and salary related costs. The following is a recap of the revenue maximization projects that DHS funded during fiscal year 1996:

- DHS contracted with an accounting firm to identify and pursue Medical Assistance collections from third party payers not identified through the state's normal identification methods.

- The department paid for supplemental drug rebate employees to review and resolve disputed drug rebate amounts. Labelers can dispute the unit quantities used to calculate rebates. (See Chapter 2 for a further discussion of the drug rebate process.)

- DHS implemented various time studies to identify time staff spent on grants for which DHS could claim federal administrative expense reimbursements. These time studies were conducted in the department's Financial Management, Children and Family Services, and the Health Care Administration Divisions.
- DHS also contracted for computer programming and consulting services to enhance the administration of the AFDC, Foster Care, and Social Service programs.
- The department reviewed and updated the method used to allocate county income maintenance administrative costs. The goal was to develop a flexible allocation method to let counties maximize their federal reimbursement and to develop the cost allocation methodology for MAXIS operations.
- DHS developed a project to review old reports from the regional treatment centers and determine whether the department took advantage of all available federal reimbursements.
- The department reviewed Medicare and Medicaid bills for the Ah-Gwah-Ching Nursing Home. The department was concerned that the home's staff had not properly identified residents who were eligible for participation in these programs. Consequently, the resident's care was paid entirely with state funds. By identifying residents who were eligible for these federally participating programs, DHS was able to claim the federal share of their cost of care.
- DHS developed a process to identify Social Security recipients who were eligible for old age, survivors, disability, health insurance and Medicare benefits. For those eligible, the monthly cash benefit and Medicare coverage would decrease state expenditures in Medical Assistance, General Assistance Medical Care, General Assistance, and Minnesota Supplemental Aid.

13. DHS improperly retained more in a special account then permitted by state law.

As can be seen in Table 5-1, DHS had $1,465,974 remaining in its revenue maximization account at the end of fiscal year 1996, which it carried forward into its fiscal year 1997 account. The balance in the account also exceeded $1,000,000 at the end of fiscal year 1995. In addition, at the end of four months during fiscal year 1996, the account had a cash balance that exceeded $1,000,000.

Minn. Stat. Section 256.01, Subd. 2(15) states "When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited to the General Fund." The statute does not define how the balance should be determined. It could be construed as the cash balance, the year end amount carried forward, or some other amount. Although during fiscal year 1996, the department transferred $1.2 million to the General Fund. We believe the department may owe an additional amount to the General Fund.

Recommendation

- *DHS should work with the Department of Finance to determine an appropriate way to measure the balance in the revenue maximization account and transfer additional fiscal year 1996 amounts if determined necessary.*

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Chapter 6. Other Grant Programs

Chapter Conclusions

DHS expenditures for community social services were fairly presented in accordance with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996. DHS complied, in all material respects, with federal requirements governing the major federal programs discussed in this chapter. However, we found one weakness in DHS's administration of these other grant programs. DHS paid Hennepin County a $463,000 supplement to the Community Social Service Block Grant without legal authority.

In addition to the health care and income maintenance programs discussed in Chapters 2 and 3, DHS administers many other federal and state grant programs. Some of these programs are significant enough to be material to the state's financial statements. Others exceed the $10 million threshold that the Federal Single Audit Act defines as a major federal program for the state of Minnesota. Table 6-1 lists other grant programs which we audited for fiscal year 1996.

Table 6-1
Other Grant Programs
Fiscal Year 1996 Federal and State Expenditures

Program	FY96 Expenditures	Audit Coverage: Financial Statement	Audit Coverage: Single Audit
Child Support IV-D Grants	$51,494,621	√	√
Community Social Services	$51,017,899	√	
Social Service Block Grants (Title XX)	$47,046,619		√
Foster Care Grants	$36,325,105		√
JOBS/STRIDE	$22,724,635		√
Substance Abuse	$16,524,040		√
Child Care Development Block Grants	$13,367,521		√

Sources: Federal financial schedules and the state of Minnesota financial statements for fiscal year 1996.

Audit Scope and Objectives

We had two primary objectives in auditing these other grant areas. The first objective was to determine whether the expenditures of these programs were fairly stated in accordance with generally accepted accounting principles in the state's financial statements for fiscal year 1996. Our second objective was to determine whether DHS complied with provisions of the Single

Audit Act, and whether the department had internal accounting and other systems to provide reasonable assurance that it monitored compliance with applicable laws and regulations.

For each of these programs, we obtained an understanding of the design of relevant policies and procedures at the state level and determined whether they have been placed in operation, and we assessed control risk. To reach our conclusions, we interviewed various DHS personnel, examined agency documentation, and tested selected transactions. The remainder of this chapter discusses each of these material programs.

Conclusions

Grant expenditures for community social services were fairly presented in conformity with generally accepted accounting principles, in all material respects, in the state of Minnesota's financial statements for fiscal year 1996. DHS complied, in all material respects, with federal requirements governing the Child Support Enforcement IV-D, Social Services Block, Foster Care, JOBS/STRIDE, Substance Abuse, and Child Care Development Block Grant programs. As discussed in Finding 14, we found a weakness in the administration of the Community Social Service Block Grant, a state funded program.

Child Support Enforcement Services - Title IV-D Grants - This federal grant program reimburses the state and counties for support enforcement expenditures used in collecting support payments from non-custodial parents. This program requires DHS to administer county and state level services to locate absent parents, to establish paternity, and to enforce support obligations. Recipients receiving AFDC, Medicaid, and certain federally funded foster care maintenance must assign their support rights to the state. In addition, non-AFDC individuals who authorize Title IV-D agency to continue support enforcement services must sign a written application for support enforcement services.

The federal government participates in the program's costs at various rates. Support enforcement involves both state and county level services. All of Minnesota's 87 counties collect and disburse child support funds and therefore are eligible for administrative cost reimbursement. Determination of eligibility is at the county level. Operating costs associated with this program and reimbursed by the federal government during fiscal year 1996 totaled approximately $37 million at the county level and $10 million at the state level. The state incurred an additional $4 million of program costs.

Community Social Service Act State Grants - This is a state program for counties to provide community social services. This program operates in conjunction with the Federal Social Service Block Grant program discussed below. The county board is responsible for administration, planning, and funding of community social services. Each county must prepare a social services plan and shall update the plan biennially. Counties must submit a county board approved plan to DHS to receive the state block grant funds.

DHS distributes state community social service grants to counties. To receive reimbursement for expenditures, the counties must submit to DHS a financial accounting of expenditures on a quarterly basis. DHS distributes the funds to the counties based on the average monthly county caseloads for AFDC, general assistance, and medical assistance, the number of persons residing

in the county, and the number of county residents who are 65 years old or older. During fiscal year 1996 DHS distributed approximately $51.0 million to the counties under the Community Social Service Act state grant program. We found the following weakness in DHS's administration of this program:

14. DHS did not allocate Community Social Service grants in accordance with statutory provisions.

In fiscal year 1996, DHS paid Hennepin County $463,000 as a supplement to the Community Social Service Block Grant (in violation of the county allocation formula established in the statutes). The supplemental payment to Hennepin County reduced the grant funds available to allocate to other counties. The Legislature specifically provided for a supplemental payment to Hennepin County in fiscal year 1995. Laws of 1993, First Special Session, Chapter 1, Article 1, Subd. 5, states:

> For the fiscal year ending June 30, 1995, $268,000 is transferred from general assistance grant and $195,000 is transferred from the Minnesota Supplemental Aid grant to the Hennepin County social services grants.

The appropriation for fiscal year 1996, however, states that the "increased appropriation available in fiscal year 1996 and thereafter must be used to increase each county's aid proportionately over the aid received in calendar year 1994." Pursuant to Minn. Stat. Section 3.975, we are referring this matter to the Attorney General for final disposition.

Recommendation

- *DHS should recover the $463,000 paid to Hennepin County and allocate it to all counties based on the statutory allocation formula.*

Social Service Block Grants - Title XX - Federal Social Service Block Grants provide funding to states for many social programs. The state, in turn, distributes the funds to the counties. This program operates in conjunction with the state community social service act grant program discussed above. Counties must submit a county board approved plan to DHS to receive the block grant funds. To receive reimbursement for expenditures, the counties must submit to DHS a financial accounting of expenditures on a quarterly basis. DHS distributes block grant money to the counties following the same formula as the state community social service grants. During fiscal year 1996, DHS distributed approximately $47.5 million in federal funds to counties under the Social Service Block Grant program.

Foster Care - Title IV-E Grants - This federal grant program provides federal assistance for state and local payments on behalf of children needing care away from their families and for reasonable training and administration costs. Eligible children are those who are eligible under AFDC, in need of foster care, and in the care of the administering state agency or public agency under agreement with the state agency. The federal share of payments is equal to the medical assistance percentage for the state. The federal share of training and other administrative expenditures are 75 and 50 percent, respectively.

Department of Human Services

The state administers the foster care program for the federal government. Counties determine recipient eligibility for this program. Federal foster care expense participation for fiscal year 1996 totaled approximately $36 million.

JOBS/STRIDE Grants - This is a federal and state grant program to the counties. A state agency, as a condition of participation in the AFDC program, must operate a JOBS/STRIDE program. The JOBS/STRIDE program assures that needy families with children obtain the education, training, and employment that will help avoid long-term welfare dependence. For this program, the counties serve as the main contact with the program recipients. The counties meet with the recipients and determine recipient needs and eligibility. DHS pays the counties four advance payments and a final settlement payment. Federal and state expense participation for fiscal year 1996 totaled approximately $11.6 million and $11.1 million, respectively.

Substance Abuse Block Grant - The federal government provides these funds to assist states in the treatment and rehabilitation of alcohol and drug abusers. In addition to treatment programs, the federal government has designated some of the block grant funds for prevention programs and specific populations. DHS used $4,591,000 of this grant to directly reimburse providers of substance abuse treatment. DHS also paid $11,933,037 from this grant into the state's Consolidated Chemical Dependency Treatment Fund, which is discussed in Chapter 5.

Child Care Development Block Grants - This federal block grant program helps to assist low-income families with child care services. These services include early childhood development programs, before and after school programs, and other child care programs. Beneficiaries of this program are children under age 13 or disabled children up to age 19. Eligible children must reside with a family whose income does not exceed 75 percent of the state median income for similar families. In addition, a parent must be working or attending a job training or educational program, or be in need of receiving protective services.

Chapter 7. Other Audit Areas

Chapter Conclusions

The Department of Human Services uses several computer systems to conduct its operations. We performed a selected review of certain computer security issues and found the following weaknesses:

- ***DHS gave six security officers the high level ACF2 "security" privilege.***
- ***The department did not delete unused logon IDs after 365 days of inactivity.***

The Department of Human Services uses several computer systems to conduct its operations. DHS runs many of 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.

Intertech and the Department of Human Services jointly administer security for the human service computer systems. 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. 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.

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 the Long Term Care system. The application security programs secure access to the data and resources for each system.

ACF2 uses unique logon IDs and passwords to control access to the system. Each user must enter a unique logon ID and password to access one of the state's central mainframes. ACF2 compares this user information to data stored in its logon ID database. The software denies access to users with unknown logon IDs or incorrect passwords. It also denies access to users with canceled or suspended logon IDs.

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.

15. PRIOR FINDING NOT RESOLVED: DHS gave six security officers the high level ACF2 "security" privilege.

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 lead security officer. The ACF2 lead security officer then writes ACF2 rules to implement those security decisions. There are six DHS security officers with the high level ACF2 "security" privilege. Four of these security officers have the ability to write dataset rules. Only two of these security officers currently use the ACF2 security privilege to perform their duties. The other security officers should not have the same abilities, since they conflict with their programmer analyst duties.

Recommendation

- *The Department of Human Services should only allow the "security" privilege for those security officers who need it to fulfill their job responsibilities.*

16. PRIOR FINDING NOT RESOLVED: DHS did not delete unused logon IDs after 365 days of inactivity.

The Department of Human Services did not delete ACF2 logon IDs that have been unused for more than 365 days. The security officers assign ACF2 logon IDs to agency and county users to access the computer system in order to perform their job duties. The security officers monitor the logon 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 logon session. Intertech policies require that unused logon IDs for 90 days be suspended and unused logon IDs be deleted after 365 days. The security officers have the authority to suspend and unsuspend these logon IDs, as well as to delete them.

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

Recommendation

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

Minnesota Department of **Human Services**

April 25, 1997

James R. Nobles
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 financial and compliance audit conducted by your office for the year ended June 30, 1996. 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,

David S. Doth
Commissioner

Enclosure

cc: Jeanine Leifeld
Cecile M. Ferkul

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Audit Finding #1

DHS paid health care program provider claims over one year old.

Audit Recommendation #1-1

DHS should enforce compliance with the federal one year submission limit. If DHS anticipates difficulty in complying with the requirement, it should ask the federal government to waive the requirement and approve alternative procedures.

Department Response #1-1

DHS does enforce the one year claim submission limit as required by federal law. The claims identified in the audit report were paid outside the federal guidelines in response to a legislative initiative arising out of the 1996 session. DHS agreed to work with medical providers to allow a structured exemption to the one year time limit, because of implementation issues in MMIS II. The department agrees with the audit recommendation to solicit a waiver of federal guidelines if future difficulties are anticipated.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

Completed

Audit Recommendation #1-2

DHS should analyze the population of claims paid with service dates over one year old, and determine the volume and value of claims paid that providers did not originally submit within a year after the date when they provided the medical services.

Department Response #1-2

DHS concurs with the recommendation. However, it will be very difficult to match claims one for one if the provider has merged several claims into one

claim, or if lines of a previously submitted multiple line form were previously adjudicated.

Person Responsible:

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date:

October 31, 1997

Audit Finding #2

DHS overpaid a provider approximately $6.2 million, due to an error in the MMIS II program logic relating to manually priced claims.

Audit Recommendation #2-1

DHS should review payment analysis reports after each payment run to promptly detect erroneous payments.

Department Response #2-1

The erroneous claims outlined in the audit report were identified and resolved, with full recovery of all state funds, on August 31, 1995. Pricing logic was reviewed and modified by September 25, 1995. Daily and bi-weekly payment analysis reports to identify potential erroneous payments were completed on September 1, 1995. The payment analysis reports are reviewed on a daily or bi-weekly basis depending on the report.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

Completed September 25, 1995

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Audit Recommendation #2-2

DHS should monitor the MMIS II system and be alert for potential problem areas. The department should put into place improved prevention and timely detection controls to address problem areas

Department Response #2-2

DHS does monitor the MMIS II system to identify potential problem areas. This includes a series of quality control measures to ensure the identification of potential problems. First, the federal Systems Performance Review (SPR) routinely conducted by the Regional Office of the Health Care Financing Administration applies explicit performance standards on certified Medicaid Management Information Systems. DHS is currently in the SPR process, and has scored 100% in all factors reviewed as of April 1997.

In addition to SPR, the department's Quality Initiatives Division operates a federally approved Claims Processing Assessment System (CPAS) in conjunction with the annual SPR. The CPAS is a quality control review on the claims payment segment of MMIS for the payment accuracy review. The federally approved threshold for error is 1%. MMIS scored 0.009% error rate in the last review period.

Further, the department's Surveillance and Integrity Review utilization profiling system and audit capability provides an ongoing post-payment review mechanism that can identify potential payment conflicts on an immediate as well as retrospective basis.

Finally, the Health Care Operations Division has initiated a periodic review process to check, and verify the integrity of edit dispositions. The process was initiated as a result of the 1995 Legislative Audit and continues at this time.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

Completed

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Audit Finding #3

PRIOR FINDING PARTIALLY RESOLVED: The MAXIS and MMIS II systems contained discrepancies between eligibility status codes.

Audit Recommendation #3

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 #3

Although we agree with their recommendation, the Legislative Auditor's report did not accurately state our continuing efforts to reduce the number of eligibility codes discrepancies between MMIS II and MAXIS. The Department will develop a full interface between MAXIS and MMIS II. This project's estimated completion date is January 1, 2000. Until the interface is completed the Department will continue monitoring the problem. We have added the following procedures:

Monthly report. In September 1996, the Department began issuance of a monthly report of MAXIS/MMIS eligibility status discrepancies to counties. Until September 1996, the report was issued on a quarterly basis only, and reconciled 19 other data elements in addition to eligibility status. The monthly "Status only" discrepancy report is issued in the two intervening months between the quarterly full reconciliation reports.

The purpose of the monthly report is to bring the discrepancies to county attention prior to occurrence of a payment error. The monthly report has reduced the number of discrepancies that "carry over" from one month to the next. For July 1996, the number of discrepancies in which MAXIS was not active and MMIS was active sent to local agencies was 3,961. By April 1997, the amount had declined **45%** to 1,964.

Corrective action. The Department created two reports for the DHS MMIS User Services and Managed Care units which identify and sort status discrepancies by county worker. Using these reports, DHS staff can determine which county workers continually generate large numbers of discrepancies.

For example, during March 1997 staff in the MMIS User Services Section contacted 45 county financial workers who had six or more MAXIS Inactive/MMIS Active eligibility status discrepancies issued to them. User Services staff request that the county financial worker give the report urgent attention along with advising them to contact the MMIS County Help Desk if they required assistance. Since the number of discrepancies reported have declined in the past three months, we believe that this work with counties is having the desired effect. DHS staff in both MMIS User Services and the Managed Care areas are participating in this effort.

County awareness. Each month when the report is mailed, county staff are notified by MAXIS E-mail of its issuance. In this E-mail, emphasis is placed on the urgent need to resolve discrepancies and the deadlines for resolution are announced.

MAXIS prompt. MAXIS has installed a "reminder prompt" for county workers when they approve or close eligibility in MAXIS. This pop-up window reminds the county worker to update MMIS screens.

Actions Proposed for 1997

The Department will continue to issue a monthly report to counties. We will also continue the corrective action efforts outlined above, as they seem to be reducing the number of reported discrepancies. We note that in comparing the total number of medically eligible recipients as of October 1996 (460,132) with the total number of discrepancies in eligibility (2,424), the discrepant eligibles total 0.5% of the total medical recipient population.

The Department will also explore the possibility of expanding the interface between MAXIS and MMIS to automatically close eligibility on the MMIS when it is closed on MAXIS.

Person Responsible

Kathie Henry, Director. Eligibility Division

Estimated Completion Date

Completed

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Audit Finding #4

PRIOR FINDING NOT RESOLVED: 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.

Person Responsible

Paul Olson, Director, Payment Policy Division

Estimated Completion Date

September 30, 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

Person Responsible

Paul Olson, Director, Payment Policy Division

Estimated Completion Date

September 30, 1997

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Audit Finding #5

PRIOR FINDING NOT RESOLVED: DHS did not accurately complete certain required federal reports during fiscal years 1995 and 1996.

Audit Recommendation #5-1

DHS should issue revised HCFA-64 Quarterly Reports of Medicaid Expenditures for all quarters during fiscal years 1995 and 1996.

Department Response #5-1

The department agrees with the recommendation. Since July 1996, the Department has provided HCFA with Medical Assistance information in accordance with the reporting requirements for the HCFA-64 form. In addition, we have revised previously submitted HCFA-64 forms through September 30, 1994. The remaining reports should be revised by July 1997.

Person Responsible

Dan Schivone, Director, MMIS

Estimated Completion Date

July 31, 1997

Audit Finding #6

PRIOR FINDING NOT RESOLVED: 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 of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Department Response #6

We agreed that the statute should be changed. In January 1997, we submitted an amendment to MN 256B.0626 in our health care bill. Our current Health and Human Services appropriation bill (SF 1908) contains this amendment.

Person Responsible

Paul Olson, Director, Payment Policy Division

Estimated Completion Date

Completed

Audit Finding #7

DHS did not accurately account for its Drug Rebate Program.

Audit Recommendation #7

DHS should develop a system to account for drug rebates. The system should allow for periodic verifications of the billing and receipt transactions affecting the accounts receivable balances.

Department Response #7

The current spreadsheet system is derived, and directly populated from the MMIS II quarterly invoice amounts, and allows for verification of billing as well as all receipt transactions affecting accounts receivable balances.

MMIS II's Drug Rebate Program quarterly invoice system is currently active and has been used to produce invoices since 1994. Other MMIS II system functions, to include accounts receivable (remittance advise) and dispute resolution are currently being populated with data, updated with program rules and tested for functionality.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

December 31, 1997

Audit Finding #8

DHS did not properly pursue and resolve outstanding drug rebate accounts receivable.

Audit Recommendation #8-1

DHS should bill drug labelers for past due balances and should charge interest on these amounts.

Department Response #8-1

Over 99 percent of the past amounts due are not unpaid invoices, but rather disputed amounts. The majority of the unpaid balance amounts are under the $50.00 tolerance threshold permitted under federal program guidelines. Steps have been taken to include separate invoices for unpaid balances and interest, with the quarterly invoices for drug rebate. This process will continue with activation of the MMIS II Drug Rebate Program accounting functions.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

December 31, 1997

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Audit Recommendation #8-2

DHS should determine all outstanding drug rebate amounts and collect them in compliance with the federal drug rebate agreement.

Department Response #8-2

DHS has the ability to determine all outstanding drug rebate amounts and makes every effort to collect them in compliance with the federal drug rebate agreement. To increase our ability, the department developed in January 1997 a summary report showing amounts due in open accounts by time period and labeler. The dispute resolution process is complicated by the lack of clear federal guidelines for resolution. The federal government has made efforts to organize regional dispute resolution meetings involving states, manufacturers and HCFA. DHS appears far ahead of other states at resolving disputed amounts.

In order to improve the dispute resolution process, DHS has instituted procedures to resolve all disputed amounts immediately after the end of the quarter.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

Completed

Audit Recommendation #8-3

Someone should authorize or review the rebate amounts discharged by the drug rebate manager throughnegotiatedd settlements with drug labelers.

Department Response #8-3

DHS had previously determined that this was within the functionality of the Drug Rebate Coordinator acting under program guidelines. Amounts are simply not discharged but rather units invoiced are corrected to reflect actual utilization under the program.

However, the Drug Rebate Program will consult with the DHS Internal Audits Office to develop a review process for discharged rebate amounts

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

August 31, 1997

Audit Finding #9

DHS did not request its federal funding for the Medical Assistance Program in accordance with the state's cash management agreement with the federal government.

Audit Recommendation #9-1

DHS should request federal funds for Medical Assistance so that it receives the federal funds in accordance with the federal cash management agreement.

Department Response #9-1

The department values this first ever review of the State's Federal Cash Management Improvement Act policies and procedures. We believe that this is the first review, statewide, since its implementation. The department agrees with the recommendation.

We dispute the amount of interest determined by the auditors. The auditors used a 6 percent interest rate rather than the fiscal year 1996 average invested treasurers cash rate of 5.5 percent. We calculated the interest at issue as $2.78 million.

Three separate problems caused this finding. The first problem was an interpretation issue regarding the specific day upon which to make the draw. The department's policies intended that draws be made on the "average clearance day". We believed that our draws were being timed correctly based on initial implementation meetings and negotiations with the Federal government and the Department of Finance. Their audit points out that the agreement, as written,

implies that the actual draw should be make on the day before the "average clearance day" so that the cash is in the state's account on the "average clearance day". The department will agree with their interpretation of the agreement and move the timing of the draw to the day before the "average clearance day".

The second problem resulted from a change in the cash management agreement made between the Federal government and the Department of Finance. We were not aware of the change that allowed the department to draw all of the Medical Assistance funds during a single transaction. Once the department was informed of the new requirements, we started to fully draw all of the Medical Assistance monies the day before the "average clearance day".

The third problem was that the department was not consistently drawing the funds in a timely manner. The department has developed and implemented procedures to assure ourselves that Medical Assistance draws will be made timely on the day prior to the "average clearance day". We are also in the process of establishing an ongoing monitoring procedure as an internal control function to ascertain that program accountants are requesting draws timely across all federal programs.

Person Responsible

Jon Darling, Director, Financial Management Division

Estimated Completion Date

July 31, 1997

Audit Recommendation #9-2

DHS should report to the Department of Finance all delays in the receipt of federal funds, including those resulting from late reimbursement requests.

Department Response #9-2

The Department agrees with this recommendation. We have already initiated contact with the Department of Finance to attempt recovery of lost interest.

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1996

Person Responsible

Jon Darling, Director, Financial Management Division

Estimated Completion Date

July 31, 1997

Audit Finding #10

DHS did not change the AFDC federal reimbursement rate used by the electronic benefits vendor, resulting in federal funds being drawn too early.

Audit Recommendation #10

DHS should verify that it uses the proper federal reimbursement rates to request federal funds.

Department Response #10

DHS concurs with the recommendation. DHS discovered the error, and immediately took steps to correct the percentage drawn from the federal grant. We will continue to verify that the correct percentage is applied.

Person Responsible

Jon Darling, Director, Financial Management Division

Estimated Completion Date

Completed

Audit Finding #11

DHS deposited certain Medical Assistance payments to the regional treatment centers into the wrong fund.

Audit Recommendation #11-1

DHS should deposit cost of care receipts in accordance with statutory provisions.

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Department Response #11-1

The department followed the Department of Finance (DOF) instructions regarding the Cambridge Repayment Fund. Their 1996 budgeting instructions instructed DHS to deposit revenue sources from the regional treatment centers directly into the Cambridge Repayment Fund. We had no reason to review the statutes establishing the fund.

When DOF subsequently instructed the department to deposit only the federal sources of reimbursement from the regional treatment centers, we complied immediately. We are currently following these instructions.

Person Responsible

Jon Darling, Director, Financial Management Division

Estimated Completion Date

Completed

Audit Recommendation #11-2

DHS should work with the Department of Finance to collect the remaining overpayment made to the dedicated bond account and deposit the recovered funds into the General Fund.

Department Response #11-2

The department agrees with this recommendation. The Department of Finance informed the Department of Human Services that they had already recovered the incorrectly deposited state funds during fiscal year 1996.

Person Responsible

Jon Darling, Director, Financial Management Division

Department of Human Services
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Estimated Completion Date

Completed

Audit Finding #12

The department did not adequately safeguard receipts in either the mailroom or the cashier's office.

Audit Recommendation #12-1

The department needs to adequately safeguard receipts in the mailroom by keeping receipts physically secure, restrictively endorsing checks immediately, and preparing a log of all receipts.

Department Response #12-1

DHS is ordering locked carts for delivery of the mail from mailroom to cashier, with one key available to mailroom and one with the head cashier.

Complying with the recommendation to endorse and log all receipts would require the addition of 1-2 staff persons in the mail room, dedicated solely to opening, endorsing and logging receipts. Additional handling of the enclosed checks and cash may pose further risks to the department, in the loss of receipts, misplacement of attachments as the checks are endorsed, and the resulting delay and/or inaccuracy of posting.

Instead, we propose to take the following steps, sequentially:

1) Purchase an automated mail extraction machine. We have ordered the machine and it should be operation by May 1997.

2) Purchase an automated receipt encoder machine. We have ordered the machine and it should be operation by May 1997.

3) Pursue electronic funds transfer processing, to decrease the need for receipt processing. A manually run system will be operating by May 1997. The development of an automated main frame file transfer system will possibly begin in September 1997. Each revenue system must be developed separately, to allow for screen entry of the customer's banking information

and file transfer of this data from the revenue system to the bank. This should be completed by June 1998.

4) By December 1997, we will obtain a separate post office box at the St. Paul Post office, to be used for direct mailing of receipts. New envelopes will have to be ordered by all DHS Revenue managers, including MMIS MinnesotaCare, MMIS Client Option Spend down, MMIS Third Part Liability, MMIS Alternative Care Premiums, Drug Rebate, Staff Development, MAPS A/R, Surcharge, Licensing, Reimbursements Cost of Care and Poor Relief, etc.

5) After the Post Office Box is purchased and return envelopes are printed, all departmental billing notices will have to be changed to direct the mail to the separate post office box,. We will have this completed by December 1997.

6) Contract with an armored car for delivery of mail from post office directly to cashier will be completed by January 1998. Sorting by mail room will no longer be needed.

7) Move the cashiers to a secured area, where all receipts may be processed centrally without interruption will be completed by June 1998.

8) Pursue the purchase of an automated receipts processing system that will batch and stamp each receipt with a trace number, endorse, image, tape, provide optical character reading of the invoice stub and check, and interface with each revenue accounting system and MAPS. Will be completed by June 1998.

Steps 1 - 6 are not contingent upon a move of the cashier staff to another location. However, they do require coordination with all revenue managers.

Person Responsible

Jon Darling, Director, Financial Management Division
Ron Lang, Director, Management Services Division

Estimated Completion Date

June 30, 1998

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Audit Recommendation #12-2

The cashier should promptly deposit receipts. Receipts should not be routed outside of the cashier's unit.

Department Response #12-2

In order to deposit checks upon receipt, we must pursue an automated receipting process that will image the check and corresponding attachments and coordinate the development of a remittance stub to be sent with all departmental invoices, whenever possible. Imaging is necessary to allow for accurate and prompt posting of a receipt. Often, essential posting information is contained on the check, such as: the case number, invoice number, patient account number; bank and routing numbers. The "pay to the order of" name, remitter name, and remitter address is used to match against payor look-ups. Currently, 12% of our receipts are mailed without an identifiable invoice stub, invoice number, or deposit indicators. It would be inefficient to photocopy each check or copy all essential information from a check onto another piece of paper and would further delay prompt deposit. Shipping the check off to the bank, prior to posting, puts the department at risk of delayed and/or incorrect posting of the receipt.

In order to post and deposit all checks received by end of day and have them delivered to the bank by end of day we will need additional staff on peak processing days and an end of day delivery to the bank. Ultimately, we will need a receipting process that will deposit the receipts most efficiently, without requiring substantial staff increases. Until the imaging alternative is functional, we have made other steps to comply with this recommendation. Four additional intermittent, temporary positions have been approved to meet staffing requirements on peak days. Currently, one position has been filled. The delivery to the bank was changed in March 1997 to 3:00 PM from 9:00 AM. This allows for at least one half days work to be received, posted, delivered and honored by the bank on the same day. A 3:00 PM pick-up will meet the bank cut-off of 4:00 PM, for same day processing. To arrange for another pick-up at end of day would be cost prohibitive. An automated receipting process is being pursued at this time, with the development of an RFI and a steering committee, with representation from all revenue program managers.

In order to eliminate review of potential Benefit Recovery receipts by Benefit Recovery, the cashier would be required to copy all receipts that are preliminarily interpreted to be Benefit Recovery receipts. This would include(all insurance and

provider receipts that are not payable to a Regional Treatment Center. After Benefit Recovery's review any incorrect deposits would require a deposit correction. This deposit procedure was used prior to 1992 and was judged inefficient since it resulted in delayed postings to the proper account, delayed deposits, and additional handling of the receipts. We believe that routing of checks outside of the cashier's unit for identification purposes is acceptable if adequate internal controls are in place. In all instances, when checks are routed outside the cashier's unit, checks are batched and taped. Procedures dictate that the batches be returned intact and in total, the same day.

We agree that our current process could be improved. We will begin to endorse all receipts prior to review by Benefit Recovery. We will ask Benefit Recovery to do their review in our area, rather than on the 6th floor. We will continue our taping, transmittal and reconciliation process. An automated receipting process will allow for immediate deposit of receipts, since all receipts will be imaged. This automated receipting process will not, in itself, eliminate the occurrence of incorrect deposits. To further eliminate deposit corrections, Benefit Recovery must provide return envelopes with their Health Insurance Claim forms, change the claim form to include a returnable invoice stub, rent a separate Post Office Box for remittance of their receipts, and/or instruct payers to make their checks payable to "DHS Benefit Recovery" instead of just "Department of Human Services". Each of these suggestions will be pursued with Benefit Recovery in the next month. The purchase of an automated receipting process is being pursued at this time.

Person Responsible

Jon Darling, Director, Financial Management Division

Estimated Completion Date

June 30, 1998

Audit Recommendation #12-3

DHS should provide adequate security over the receipts while they are being transported to the bank.

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Department Response #12-3

We agree with the recommendation. The department has a contract with Loomis, Fargo & Co. for armored car delivery of receipts to the bank, effective March 1997.

Person Responsible

Ron Lang, Director, Management Services Division

Estimated Completion Date

Completed

Audit Finding #13

DHS improperly retained more in a special account then permitted by state law.

Audit Recommendation #13

DHS should work with the Department of Finance to determine an appropriate way to measure the balance in the revenue maximization account and transfer additional fiscal year 1996 amounts if determined necessary.

Department Response #13

The Department disagrees with the finding that DHS had $1,465,974 in the revenue maximization account at the end of fiscal year 1996. Fiscal reports produced from the MAPS information warehouse show a cash balance on hand of $999,999.98 on June 30, 1996. This amount was split between two fiscal years with $591,999.98 in fiscal year 1996 and $408,000.00 in fiscal year 1997. (Note: $500,000 was carried forward into fiscal year 1997 but a transfer out per M.S. 257.0769 was processed for $92,000 on June 28, 1996, thus reducing the cash on hand.)

Although the statutory authority authorizing this account is silent on the definition of "balance", DHS believes that it is proper and reasonable to define "balance" as actual cash on hand at any one time. DHS will work with the Department of

Finance to confirm that our definition is correct and to determine a method to more frequently monitor and transfer any excess cash balance in the revenue maximization account to the General Fund.

Person Responsible

Jon Darling, Director, Financial Management Division

Estimated Completion Date

July 31, 1997

Audit Finding #14

DHS did not allocate Community Social Service grants in accordance with statutory provisions.

Audit Recommendation #14

DHS should recover the $463,000 paid to Hennepin County and allocate it to all counties based on the statutory allocation formula.

Department Response #14

The Department does not agree with this finding and recommendation. We believe that legislative intent is clear. In the biennial budget process, the department budgeted the $463,000 as a separate amount and in a separate account labeled as Hennepin County funding. The legislature appropriated the funds in accordance with our budget request. The fiscal year 1996 appropriation language discussing the "increased appropriation" pertains to the inflation factor from the Local Government Trust Fund contribution to the Community Social Services Act Block Grant under Minnesota Statutes 256E.

To further clarify that the department acted according to legislative intent, legislation has been added to the current Health and Human Services Omnibus Budget Bill. This language has passed the Senate and is waiting approval on the House floor at this writing.

Department of Human Services
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Person Responsible

Jon Darling, Director, Financial Management Division

Estimated Completion Date

May 20, 1997

Audit Finding #15

PRIOR FINDING NOT RESOLVED: DHS gave six security officers the high level ACF2 "security" privilege.

Audit Recommendation #15

The Department of Human Services should only allow the "security" privilege for those security officers who need it to fulfill their job responsibilities.

Department Response #15

The department believes that the number of staff given security privileges should be a management decision of the agency. While we agree that security privileges need to be closely monitored and reviewed often, we do not agree that there is an exact right number of people.

At one time we did have a larger number of staff people assigned ACF2 write/change authority in order to assure both primary and backup support among the large DHS information systems, particularly as we were developing and implementing these new major information systems and needing to revise rules to accommodate the varying access needs of the 5000 statewide users of our DHS information systems.

Currently, we have reduced the number of staff people assigned ACF2 write/change authority to four and are currently taking the initiative to further reduce that number down to two, one primary and one secondary.

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Person Responsible

Ken Hasledalen, Director, Information Resources and Policy Division
Tom Rowland, Manager, Information and Technology Strategies

Estimated Completion Date

July 31, 1997

Audit Finding #16

PRIOR FINDING NOT RESOLVED: DHS did not delete unused log-on IDs after 365 days of inactivity.

Audit Recommendation #16

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

Department Response #16

We agree with the recommendation. As of March 1997, all unused log-on IDs inactive after 365 days were deleted.

Person Responsible

Ken Hasledalen, Director, Information Resources and Policy Division
Tom Rowland, Manager, Information and Technology Strategies

Estimated Completion Date

Completed