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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

Follow-up Review: MinnesotaCare Eligibility Determination

April 2007

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

April 2007

Members of the Legislative Audit Commission:

The Office the Legislative Auditor (OLA) has completed a follow-up review to our 2003 report, *MinnesotaCare*. In 2003, we found significant problems with the accuracy of MinnesotaCare eligibility determinations, and we recommended numerous corrective actions. In addition, the 2003 and 2005 Legislatures enacted several changes to state law also intended to improve eligibility decision making.

The Minnesota Department of Human Services (DHS) has implemented most of OLA's recommendations and related legislative mandates. However, DHS audits of fiscal year 2005 and 2006 MinnesotaCare cases show that serious problems persist with the accuracy of eligibility determinations. In 2006, for example, DHS auditors found income determination mistakes in over one-third of MinnesotaCare family cases.

As it did in 2003, DHS asserts that the best solution to improving accuracy lies with "HealthMatch"—an automated eligibility determination system for Minnesota's health care programs. However, development of this system is significantly behind schedule, and successful completion of the system still faces serious risks. We recommend that DHS expedite completion of HealthMatch's design and explore alternative means of improving the accuracy of MinnesotaCare eligibility determinations in the interim.

This report was researched and written by Deborah Parker Junod (project manager) and David Kirchner. During the evaluation, we received full cooperation from the Department of Human Services.

Sincerely,

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Summary

Serious problems persist with the accuracy of MinnesotaCare eligibility determinations, and a new system designed to fix the problems has been significantly delayed.

Major Findings:

- In 2003, OLA reported several problems with MinnesotaCare eligibility determination, including (1) high error rates when staff calculated applicants' income and (2) errors in applicants' self-reported information regarding access to insurance through employers (p. 3).
- The Department of Human Services (DHS) has implemented most of OLA's 2003 recommendations and related changes to state law that were designed to address these problems (pp. 4-7).
- However, DHS's 2006 audit of MinnesotaCare family cases found enrollment errors in 10 to 14 percent of cases and incorrect income determinations in over 30 percent of cases. Incomplete information from clients and mistakes made by workers both contributed to these errors (pp. 7-11).
- "HealthMatch," an automated eligibility system that should improve accuracy, is being developed; but development has taken much longer than expected due to increases in the system's scope, missteps by the contractor and DHS, and other factors (pp. 11-14).
- Successful implementation of HealthMatch still faces serious risks, and a first version of the system is not likely to be released before 2009—four years later than initially expected. The date of full implementation is unknown (pp. 14-18).

Recommendations:

- DHS should expedite consolidation of HealthMatch business requirements and completion of design documents (p. 18).
- DHS should consider taking additional steps to improve the accuracy of MinnesotaCare eligibility determinations while waiting for HealthMatch to be implemented (p. 19).

MinnesotaCare Eligibility Determination

SUMMARY

In 2003, the Office of the Legislative Auditor (OLA) issued a report that criticized the accuracy of MinnesotaCare eligibility determinations and recommended numerous changes to improve program integrity. Although the Department of Human Services (DHS) has implemented most of these recommendations and related legislative mandates, serious problems persist with the accuracy of eligibility decisions. DHS has said that the key to significantly improving MinnesotaCare program integrity lies with implementation of "HealthMatch," an automated health care program eligibility system. However, development of this system has been significantly delayed, and DHS says it cannot set a final implementation date. We recommend that DHS speed completion of HealthMatch's design and explore alternative means of improving the accuracy of MinnesotaCare eligibility determinations in the interim.

In 2003, the Minnesota Office of the Legislative Auditor (OLA) released a report on administration of MinnesotaCare, the state's public health care insurance program for lower-income Minnesotans who do not have access to affordable health insurance.[1] The report documented significant error rates associated with eligibility decisions; more generally, it highlighted deficiencies in the process used to determine MinnesotaCare eligibility. The report recommended numerous actions to address these problems, and the Legislature responded with several significant changes to state laws in 2003 and 2005.

In April 2006, the Legislative Audit Commission directed OLA to provide an update on how the Minnesota Department of Human Services (DHS) has implemented OLA recommendations and related changes in state law. Accordingly, this follow-up review addresses the following questions:

- **What is the status of actions by the Department of Human Services to implement Office of the Legislative Auditor recommendations and related legislative mandates regarding MinnesotaCare eligibility determination?**
- **What are the results of recent Department of Human Services audits of MinnesotaCare eligibility determinations?**
- **What is the status of the automated health care eligibility system, called "HealthMatch," and to what extent is the system expected to improve the accuracy of eligibility decisions?**

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[1] Minnesota Office of the Legislative Auditor, *MinnesotaCare* (St. Paul, 2003).

To answer these questions, we asked DHS to provide a status report on the implementation of OLA's 2003 recommendations and information regarding its implementation of changes to MinnesotaCare statutes. We interviewed DHS health care and compliance staff and reviewed the documents they provided to explain the department's eligibility compliance activities. Regarding HealthMatch, we interviewed representatives of the HealthMatch contractor, DHS project team, Attorney General's Office, and Minnesota Office of Enterprise Technology. Due to the limited nature of this follow-up review, we did not independently review case files to determine the accuracy of MinnesotaCare eligibility decisions or do any work at county human services agencies.

BACKGROUND

MinnesotaCare served about 131,000 people each month in fiscal year 2006.

MinnesotaCare is one of three comprehensive health care programs in Minnesota, each targeted at different subgroups of Minnesota's lower-income population and each with different eligibility criteria. The other two programs are Medical Assistance (MA) and General Assistance Medical Care (GAMC). MA is a joint federal-state health care program for low-income parents, children, elderly, or disabled people. GAMC is a state-funded program providing health care to Minnesotans—primarily childless adults—who do not qualify for MA or other state or federal health care programs. MA and GAMC cases are managed by county human services agencies.

MinnesotaCare is a publicly subsidized health insurance program for lower-income state residents who do not have access to affordable health care coverage. In fiscal year 2006, MinnesotaCare covered an average of about 131,000 individuals each month. Health care expenditures for the program in fiscal year 2006 totaled about $441 million, with 58 percent of funding coming from the state, 34 percent from federal sources, and 8 percent from enrollee premiums.

To be eligible for MinnesotaCare, applicants must meet a complex set of criteria related to income, assets, access to other health insurance, residency, and citizenship. MinnesotaCare does not restrict eligibility on the basis of existing or previous health conditions. Coverage is available to families and to single adults and married couples who do not have children in their households, though eligibility rules vary by type of household. MinnesotaCare enrollees must pay a monthly premium for coverage and can be dropped from the program if they fail to pay.

Historically, day-to-day administration of MinnesotaCare applications and renewals has been handled primarily through a centralized unit within DHS, called "MinnesotaCare Operations." County human services agencies can process MinnesotaCare cases if they choose to do so, and a recent change in state law further involved counties by requiring some GAMC recipients to be converted to MinnesotaCare.[2] As of January 2007, the MinnesotaCare Operations unit at DHS processed 92 percent of MinnesotaCare applications and

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[2] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 52. Codified in *Minnesota Statutes* 2006, 256D.03, subd. 3.

renewals, excluding the transitional GAMC cases (including the GAMC cases, MinnesotaCare Operations processed about 72 percent of cases).[3]

In 2003, the Office of the Legislative Auditor (OLA) reported serious problems with the accuracy of MinnesotaCare eligibility determinations.

As shown in Table 1, OLA reported serious problems with the accuracy of MinnesotaCare eligibility determinations in 2003. The report recommended that DHS improve policies and procedures for estimating annual wage income, revise the health care program application to collect more detailed information about eligibility criteria, encourage more supervisory review of eligibility decisions at MinnesotaCare Operations, and review eligibility compliance more frequently. In addition, at the time we did our original review, DHS was developing an automated eligibility computer system called "HealthMatch." Because HealthMatch appeared to be the best means of systematically improving the accuracy of eligibility determinations, we recommended that DHS expedite implementation of this system.

Table 1: Key Findings From *MinnesotaCare*, 2003

- In about one-third of cases reviewed, state and county staff made errors when determining MinnesotaCare applicants' income.
- Income determination errors resulted in many enrollees paying the wrong premium and, in a small proportion of cases, incorrect enrollment decisions.
- Estimates of annual income determined for MinnesotaCare eligibility frequently did not match income reported to other sources, often because individuals' incomes changed after the initial estimates. As a result, participants may have underpaid premiums by an estimated $5 million to $22 million.
- Many applicants misreported information on insurance available from their employers.
- Weaknesses in the Department of Human Services' computer systems, compliance activities, and other means of overseeing MinnesotaCare contributed to eligibility determination errors.

SOURCE: Office of the Legislative Auditor, *MinnesotaCare* (St. Paul, 2003).

The Minnesota Legislature made changes to state law to address some of OLA's findings and recommendations.[4] Among other changes related to benefit sets and eligibility criteria, the Legislature required (1) more frequent renewal of MinnesotaCare eligibility, (2) premium adjustments between renewals when enrollees report increases in income, (3) verification of unearned income, and (4) better information for verifying access to employer-subsidized insurance. In addition, the Legislature made several changes in law to align eligibility criteria among MA, GAMC, and MinnesotaCare to support HealthMatch. These changes

[3] At the time OLA released its previous report in 2003, MinnesotaCare Operations processed about 93 percent of applications and renewals.

[4] As we discuss later in the report, the Legislature enacted one provision in 2005 (granting DHS flexibility in the methods used to calculate wage income) that was counter to an OLA recommendation (narrowing the range of methods used to calculate wage income in order to improve consistency and accuracy).

will become effective August 1, 2007, or when HealthMatch is implemented, whichever is later.

STATUS OF OLA RECOMMENDATIONS AND CHANGES TO STATE LAW

As discussed above, OLA recommended and the Legislature mandated that DHS take numerous actions to improve MinnesotaCare eligibility decision making. We assessed the status of DHS's response and found that:

- **The Department of Human Services has implemented most OLA recommendations and legislative directives aimed at improving the accuracy of MinnesotaCare eligibility determinations, but key recommendations regarding income determination and timely development of an automated eligibility system have not been fully implemented.**

The Department of Human Services (DHS) implemented most of OLA's 2003 recommendations.

As shown in Table 2, DHS has implemented recommendations to improve the information it collects from applicants, apply insurance-related eligibility rules more accurately, and provide improved training and supervision. For example, DHS significantly revised the Health Care Programs Application to collect more information on household members' income and access to other health insurance.[5] The department corrected mistakes in its health care program manual to properly implement a statutory provision related to insurance eligibility. DHS also began requiring applicants to provide name and contact information to verify access to employer-subsidized health insurance, although it did so seven months after the effective date of the state law mandating this change.[6] Finally, DHS has increased training for MinnesotaCare Operations eligibility staff and improved both the extent and nature of supervisory case review.

DHS has also responded to OLA's findings and recommendations regarding eligibility compliance reviews and fraud investigation. In 2003, we reported that DHS was not complying with a state law requiring the department to perform random audits to verify reported income and eligibility. In response, DHS established a new unit to audit health care eligibility, and starting in fiscal year 2003, the unit has conducted random audits of MinnesotaCare cases. (The results of these audits are discussed in detail in the next section.) In addition, in 2003, DHS appointed a supervisor and an investigator to develop a fraud detection and

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[5] DHS has revised the Health Care Programs Application several times since 2003. While earlier revisions partially addressed some of the concerns we reported in 2003, our concerns were not fully addressed until DHS released a substantially revised and expanded application in September 2006.

[6] In 2003, we found errors in the program manual regarding a statutory requirement that prohibits applicants from receiving MinnesotaCare benefits if they had access to employer-subsidized insurance from a current employer within 18 months of applying (OLA, *MinnesotaCare* [2003], 37-38). The statutory provision requiring applicants to submit names and contact information to verify eligibility for employer-subsidized insurance was effective September 1, 2005 (*Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 65). According to DHS, it did not release the bulletin implementing the new policy until April 2006 because it needed House and Senate leaders to clarify legislative intent.

Table 2: DHS Action on Statute Changes and OLA Recommendations, March 2007

Income Determination	
Narrow the range of acceptable procedures to verify and calculate wage income (OLA)	Not applicable[a]
Require eligibility renewal at six-month intervals (state law, 2003)	Not implemented[b]
Adjust premiums between renewals when income increases or decreases (state law, 2005)	Implemented
Require verification of unearned income	Implemented
Access to Other Insurance	
Correct policies on the 18-month insurance rule (OLA)	Implemented
Require applicants to provide names and contact information to verify eligibility for employer-subsidized insurance (state law, 2005)	Implemented
Application Forms	
Revise applications to obtain more detailed income and insurance information (OLA)	Implemented
Oversight	
Use more frequent, targeted refresher training (OLA)	Implemented
Increase supervisory review of eligibility decisions (OLA)	Implemented
Review eligibility compliance more frequently (OLA)	Implemented
Establish MinnesotaCare fraud program (state law, 2005)	Implemented
HealthMatch	
Expedite implementation (OLA)	Not implemented

[a] In 2005, DHS sought and received a statutory change that codified its existing wage calculation policies and allowed significantly more flexibility than we recommended. Hence, DHS did not implement OLA's recommendation, although its current policies now align with state law. *Minnesota Statutes* 2006, 256L.01, subd. 5(b).

[b] DHS implemented six-month renewals in October 2004, but the department discontinued them about two months later because the workload overwhelmed available staff and delays processing applications became unacceptably long.

SOURCES: Minnesota Office of the Legislative Auditor, *MinnesotaCare* (St. Paul, 2003); *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12; *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8; and Office of the Legislative Auditor analysis of DHS documents and interviews with department staff.

In particular, DHS initiated compliance audit and fraud investigation programs that are specific to MinnesotaCare.

prevention program specific to MinnesotaCare. In 2005, DHS requested and received additional funding authority from the Legislature for a MinnesotaCare fraud prevention initiative. DHS currently has four investigators, hired between December 2005 and February 2007, assigned to the initiative. As shown in Table 3, the fraud program has resulted in some cost savings by preventing erroneous payments and recovering benefits paid in error. In 2006, these savings totaled $63,000.

Table 3: MinnesotaCare Fraud Investigation Results, 2004-06

	2004	2005	2006
Investigations completed	173	146	186
Investigations resulting in reduced benefits or case closure	11	27	15
Savings from cost avoidance[a]	$32,000	$63,000	$14,000
Investigations resulting in clients being billed for overpayments	22	12	15
Total amount of overpayments	$54,000	$65,000	$122,000
Amount of overpayments collected	$45,000	$15,000	$49,000
Total Savings	$77,000	$78,000	$63,000

NOTE: Data are for calendar years. A case may be counted twice if investigators identified a past overpayment of benefits and also determined that, going forward, the case should be closed or benefits reduced. Overpayment collection data are as of March 14, 2007.

[a] Amount reflects anticipated program savings from adjusting or ending eligibility as a result of the investigation.

SOURCE: Department of Human Services data.

The department has not fully implemented changes in response to our findings on the accuracy of income determinations. In 2003, we reported that eligibility workers used a variety of methods to estimate annual wage income, resulting in inequitable treatment of applicants with similar incomes. We recommended tighter constraints on those procedures to improve accuracy and consistency among workers.[7] In 2005, however, the Legislature modified state law, at DHS's request, to allow greater flexibility (essentially, putting DHS's existing practice into law).[8] The law now states that DHS should "use reasonable methods to calculate gross earned and unearned income including, but not limited to, projecting income based on income received within the past 30 days, the last 90 days, or the last 12 months."[9] DHS requested the change to align MinnesotaCare income determination requirements with those for Medical Assistance.

[7] OLA, *MinnesotaCare* (2003), 25-27 and 45.

[8] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 56.

[9] *Minnesota Statutes* 2006, 256L.01, subd. 5(b).

According to DHS, this legislative change does not address ongoing concerns about inequitable treatment of applicants with similar incomes; however, the department plans to use the rulemaking process to further define and clarify the methods eligibility workers should use to estimate annual income and the circumstances in which each method should be applied.

DHS implemented a 2003 law requiring six-month eligibility reviews, but discontinued the reviews within two months because the added workload overwhelmed available staff.

DHS has not fully implemented one of two legislative changes designed to allow more frequent updates to household income so that premiums and benefits better reflect actual income. First, in 2003, the Legislature mandated that MinnesotaCare be renewed every six months, rather than annually.[10] DHS implemented this policy in October 2004 but discontinued it about two months later. According to DHS officials, the workload overwhelmed available staff, and delays in processing applications soon became unacceptably long. At the time the legislation was enacted in 2003, DHS had expected that HealthMatch would be operational by October 2004; as a result, the department did not request additional funding for staff to process renewals at six-month intervals. Second, in 2005, the Legislature modified state law to direct DHS to adjust premiums upward between renewals when an enrollee reports an increase in income (under prior law, DHS could not increase the premium until the next renewal).[11] DHS has implemented this provision.

Overall, DHS has implemented changes that address most of OLA's key findings and recommendations related to training, supervision, policies, and procedures. However, as we discuss in the next section, the actual impact of these efforts on the accuracy of MinnesotaCare eligibility determinations is discouraging. DHS has maintained that implementation of the HealthMatch system is the key to addressing problems with accurate and efficient processing of MinnesotaCare applications. But, as we discuss in detail later, HealthMatch implementation has been significantly delayed.

RESULTS OF DHS ELIGIBILITY AUDITS

As we recommended in 2003, DHS has implemented an ongoing program to evaluate the accuracy of MinnesotaCare eligibility decisions.[12] The department's evaluations measure error rates, identify factors that contribute to errors, and recommend corrective actions. We reviewed the results of DHS compliance evaluations for fiscal years 2003-06 and found that:

- **Despite efforts to improve, MinnesotaCare eligibility determinations continue to have serious and persistent accuracy problems.**

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[10] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12, sec. 75. Codified in *Minnesota Statutes* 2006, 256L.05, subd. 3a(b).

[11] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 74. Codified in *Minnesota Statutes* 2006, 256L.15, subd. 2.

[12] DHS is required to audit the accuracy of MinnesotaCare eligibility determinations by state law and federal regulation. *Minnesota Statutes* 2006, 256L.05, subd. 2, requires DHS to conduct random audits to verify MinnesotaCare eligiblity. In addition, federal regulations for the Medicaid Eligibility Quality Control (MEQC) program (42 CFR 431.800+) require DHS to conduct targeted quality control audits for health care program recipients funded with federal Medicaid dollars. MinnesotaCare families are federally-funded recipients and may be included in MEQC audits.

In fiscal year 2006, DHS auditors found enrollment errors in 10 to 14 percent of family cases and income determination errors in over 30 percent of cases.

As shown in Table 4, DHS has audited cases representing various subgroups of MinnesotaCare applicants and has continued to find high rates of error. Inaccuracies included enrollment errors (the applicant was not actually eligible for MinnesotaCare benefits) and errors determining the household's income (primarily affecting the premium paid or the benefit set received).

Overall, the 2006 DHS evaluation results show that error rates have not changed since OLA's review of cases in 2002, and DHS senior managers have acknowledged that health care program error rates remain unacceptably high. Among applications and renewals submitted in fiscal year 2006, DHS auditors found inaccurate household income determinations in at least 33 percent of family cases.[13] Among cases with income determination errors, many enrollees were charged the wrong premium, some enrollees were assigned the wrong benefit set, and a few individuals should not have been enrolled. In addition, among the 10 to 14 percent of family cases in which at least one household member should not have been enrolled in MinnesotaCare at all, about two-thirds of the enrollment errors involved insurance-related eligibility criteria.[14] Enrollment and income determination error rates for income-earning adults without children were nearly as high as those for families.

According to DHS data, the source of these errors lies with both recipients and eligibility workers. In summarizing the MinnesotaCare eligibility audit findings for 2003-06, DHS reported that the two most important elements underlying errors were: (1) DHS's failure to ask for better, more detailed information on the application and (2) workers' incomplete analysis of information provided by applicants.[15] For example, although the primary factor contributing to enrollment error cases in fiscal year 2005 was the applicants' failure to provide accurate and complete information on assets and income, DHS auditors also reported that eligibility workers often did not properly review applications and request additional information. In addition, workers made many errors in calculating household income because they did not properly interpret and count income data or do the math correctly. The report concluded that "inconsistency across workers (both in the central office and at the county level) is obvious, as is the unacceptable frequency of miscalculation."[16]

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[13] The sample of audited cases for families with children was drawn from families scheduled for renewal and whose benefits were funded in part with federal funding.

[14] The fiscal year 2006 audits were completed before implementation of a new requirement that applicants provide names and contact information to verify eligibility for employer-subsidized insurance. In its fiscal year 2007 audit that is currently underway, DHS is evaluating the impact of this verification requirement on the accuracy of insurance-related eligibility determinations.

[15] In part because of audit findings, DHS substantially revised and expanded the health care program application in September 2006 (after DHS's fiscal year 2006 eligibility audits were completed). While the new application aids program integrity by collecting more specific information from applicants, DHS has reported that some client advocate groups and legislators are concerned that it is too long and creates a barrier for potentially eligible people.

[16] Minnesota Department of Human Services, *Medicaid Eligibility Quality Control 2005* (St. Paul, August 2006), 14.

Table 4: Select Results From DHS's MinnesotaCare Eligibility Verification Audits, Fiscal Years 2003-06

Fiscal Year	Recipient Group Audited	Percentage of Cases With an Enrollment Error	Percentage of Cases With Income Incorrectly Determined	Percentage of Cases Resulting in a Fraud Referral
2003[a]	Families (cases processed by DHS)	10%	--	--
	Families (cases processed by counties)	17	--	--
	Adults without children (cases processed by DHS)	3	--	--
	Adults without children (cases processed by counties)	2	--	--
2005[b]	Families	3	25%	2%
2006[c]	Children ages 18, 19, and 20	3	21	4
	Families with wage income	14	37	7
	Families with self-employment income	10	33	4
	Adults (without children) reporting some income	10	30	6
	Adults (without children) reporting no income	4	18	8

NOTE: Fiscal year refers to the year in which DHS conducted the audit. In 2004, DHS did not audit a statistically valid sample of MinnesotaCare cases. Enrollment errors refer to cases in which at least one individual in the case was enrolled in MinnesotaCare but should not have been. Errors determining the household's income may affect overall eligibility, the premium paid, or the benefit set received.

[a] The audit scope in 2003 was limited to the accuracy of decisions regarding insurance-related eligibility criteria. As a result, enrollment error percentages do not reflect mistakes that may have been made related to other eligibility criteria, such as income or household composition. Also, DHS's MinnesotaCare fraud-referral process was being developed during fiscal year 2003; thus, DHS does not have complete fraud-referral data for the cases audited that fiscal year.

[b] The audit scope in 2005 was limited to the accuracy of decisions regarding applicants' income, assets, and household composition. As a result, percentages for enrollment errors and fraud referrals do not reflect any mistakes that may have been made related to other eligibility criteria, such as access to other insurance.

[c] The audit scope in 2006 included all eligibility criteria. Audits of families were limited to enrolled families scheduled for renewal and whose benefits were funded in part with federal dollars. Two-thirds of the enrollment errors among families involved insurance-related eligibility criteria; however, the 2006 audit was conducted before DHS implemented mandatory verification of employer-subsidized insurance.

SOURCE: Office of the Legislative Auditor compilation of DHS eligibility verification audit results.

DHS auditors have recommended a variety of actions to address problems with MinnesotaCare eligibility determination; these recommendations parallel those made by OLA in 2003. DHS's fiscal year 2005 audit report, for example, included the following recommendations:[17]

- **Implement corrective actions in cases identified by auditors.** DHS auditors recommended that eligibility staff (1) disenroll persons found ineligible for MinnesotaCare and those who chose not to cooperate with the audit[18] and (2) adjust MinnesotaCare premiums and benefit sets, as needed, based on corrected household income. Auditors also referred some cases for fraud investigation.
- **Improve training for eligibility workers.** DHS auditors recommended additional classroom training on procedures for counting income and assets to supplement available online training. They also encouraged MinnesotaCare Operations to develop a refresher curriculum for current staff, saying that "restricting eligibility training to new staff is neither sufficient nor effective."[19]
- **Clarify policies and procedures.** DHS auditors recommended that the department revise the policy manual and occasionally redistribute policy interpretation memoranda that provide detailed examples of how and when to apply income and asset calculation methods.
- **Enhance eligibility determination procedures.** DHS auditors recommended that workers verify household composition, all assets, and all income, including reports of no income, even though such verification would be time-consuming. According to auditors, "enrollment errors and fraudulent applications would be substantially reduced if critical information were verified and additional inquiries were made about missing or conflicting information on the application."[20]
- **Develop and enhance information systems.** DHS auditors recommended continued development of HealthMatch, citing its potential to improve administrative consistency, accuracy, and efficiency.

DHS efforts to improve training, policy guidance, and eligibility determination procedures have not improved accuracy.

More recently, DHS compliance officials said that fiscal year 2006 audit results, combined with those of fiscal year 2005, clearly show that action on past OLA and DHS recommendations—which focused on training, policy guidance, and procedure changes—has not had a significant impact on the accuracy of eligibility decisions. DHS cited several systemic problems that have undermined

[17] As of March 2007, DHS auditors had not yet developed a corrective action plan based on the fiscal year 2006 audit results.

[18] Under *Minnesota Rules* 2006, 9506.0060 and 9505.0080, MinnesotaCare recipients are required to cooperate with audits and quality control reviews, and DHS is required to disenroll those who do not cooperate.

[19] DHS, *Medicaid Eligibility Quality Control 2005*, 14.

[20] *Ibid*, 15.

these efforts to improve accuracy. First, health care program eligibility requirements have grown more complex, and with added complexity, staff and applicants have more opportunities to make mistakes.[21] Second, calculating household income for MinnesotaCare is still a mostly manual process using a paper worksheet. Third, turnover among MinnesotaCare Operations staff is a continuing problem in spite of several actions on DHS's part to improve retention. In 2005 and again in 2006, about one-third of enrollment worker positions turned over. Hence, DHS has many inexperienced staff making complex eligibility determinations.

STATUS OF HEALTHMATCH

"HealthMatch"—an automated eligibility system for Minnesota health care programs—is currently being developed.

"HealthMatch" is a web-based computer system currently under development that will provide automated eligibility determinations for nearly all health care programs administered by DHS. When implemented statewide, HealthMatch should substantially improve the consistency and accuracy of eligibility and premium determinations. By relying on the system, DHS and county workers will no longer have to spend as much time tracking frequent rule changes in the state's many programs, and simple mathematical errors should be eliminated altogether. If HealthMatch functions as intended, errors in eligibility determinations and premium calculations should be limited to instances in which incorrect data are entered into the system.

In 2003, we reported that DHS planned to implement HealthMatch in mid-2004. We recommended that DHS do what it could to expedite HealthMatch development, citing the system's potential to address weaknesses in the MinnesotaCare eligibility determination process.[22] However, in examining the progress of HealthMatch development since 2003, we found that:

- **Development of HealthMatch has been significantly delayed due to increases in project scope, missteps by DHS and its contractor, and other factors.**

As described in more detail later in this section, the system's design was substantially modified twice, and each change lengthened HealthMatch development. However, the project has also repeatedly failed to meet scheduled benchmarks, even when these scope changes are taken into account. In our view, both DHS and its contractor, Albion,[23] share responsibility for project setbacks.

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[21] We discussed the issue of program complexity and its impact on human services administration in a recent report. Minnesota Office of the Legislative Auditor, *Human Services Administration* (St. Paul, 2007), 22-24.

[22] OLA, *MinnesotaCare* (2003), 39 and 45.

[23] Albion, Inc., has gone through a number of corporate changes during the HealthMatch project. At the time of the initial contract with DHS in 2003, Albion had been bought by SSi North America, and the contract was between DHS and SSi. However, SSi itself merged with the Scandent Group in 2004, and the Albion brand name was resurrected. In January 2007, Affiliated Computer Services (ACS) announced that it was attempting to acquire the assets of Albion. For the sake of clarity, we refer to the contractor as "Albion" throughout this report.

Decisions in 2005 to expand HealthMatch extended its development timelines.

Changes in Project Scope

DHS has twice changed the scope of the HealthMatch project to expand the functionality of the system. According to DHS and Albion project staff, both changes significantly lengthened the HealthMatch development process.

Initially, HealthMatch was designed to determine eligibility for families and individuals applying for MinnesotaCare, MA, and GAMC, excluding individuals who were elderly or disabled. However, DHS and Albion soon realized that it made little sense to maintain information on elderly and disabled recipients separate from the information in HealthMatch. Consequently, DHS and Albion agreed in a May 2005 contract amendment to expand HealthMatch to cover eligibility for all participants in the three major health care programs.

DHS initiated a second major change in project scope after the Legislature enacted several significant changes to health care program eligibility rules in 2005.[24] Most notably, over a third of Minnesotans served by GAMC were transferred to MinnesotaCare. Other changes affected premium calculation formulas and the amount of independent verification required to support information provided by applicants. DHS and the contractor addressed the new laws in a second contract amendment dated December 2005.

Other Factors Contributing to Project Delays

Several missteps and unforeseen events have contributed to the project's inability to meet scheduled deadlines. Although each has accepted some responsibility, DHS and Albion administrators disagree vehemently over the relative importance of various factors in causing delays. We present below some of the principal reasons for delays in HealthMatch development.

DHS and its contractor also underestimated how hard it would be to automate Minnesota's complex set of health care programs.

- **Initial underestimates of project complexity.** Among the states, Minnesota has an unusually complex set of health care programs. Individuals who apply for benefits may fall into any of 115 different eligibility categories derived from state and federal law, each of which has specifically defined eligibility criteria, benefits, funding sources, and costs to enrollees. Albion did not fully comprehend how complicated Minnesota's system was until the project was fully underway. Given the complexity of Minnesota's health care programs, Albion's initial time estimates proved to be unrealistic and were eventually abandoned. In addition, Albion's unfamiliarity with Minnesota's programs caused it to schedule some of the most complex design and programming tasks later in the project, instead of beginning them as early as possible.

  DHS also underestimated the project's complexity. Staff and administrators assigned to HealthMatch did not anticipate how difficult and time-consuming it would be to convert the state's eligibility policies into the programmable series of yes/no outcomes that Albion required. Further, as it became clear that many decisions touched upon multiple health care programs and other information systems, DHS identified

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[24] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8.

many policy and technical staff who needed to be involved. Gathering input from so many different perspectives within DHS has often been laborious and time consuming.

After four years, the design of HealthMatch is still not complete, and the project has experienced significant problems.

- **Delays completing the system's design.** In a software development project, the "business requirements" are the specifications provided by the client to the software developer that describe in detail the tasks and decisions the system must perform. The developer uses these requirements to design each individual module of the system; the resulting "design documents" are then presented to the client for approval. As of April 2007, about four years after the project's start, this requirements-to-design process was not complete. There is considerable dispute between DHS and Albion about the causes of this shortcoming and the extent of its impact on the project.

  According to DHS, problems with requirements and design stem primarily from a flawed initial assessment by Albion that its designers and programmers could work with the broad requirements that DHS originally provided. This error was compounded when Albion chose to move ahead with design before more detailed requirements were completed. DHS and Albion did not fully understand the level of detail needed for requirements and design until the programming process began in early 2005, and the HealthMatch design process has been catching up ever since.

DHS and its contractor blame each other for the project's problems.

  Albion staff contend that even if faulty decisions were made early in the project, since then, poor management at DHS has allowed the process of developing fully detailed business requirements to drag out indefinitely. Albion also contends that DHS has made an excessive number of changes to already-approved design documents, forcing programmers to redo segments of the system. DHS's process for reviewing and approving business requirements and design documents is complex, and a DHS manager acknowledged that some decisions have had to be reopened because particular DHS constituents were unhappy with the outcomes of those decisions.

  In correspondence with DHS administrators, Albion's president wrote, "this churn in design, as the state defines its business processes or resolves policy issues, is the root cause of the project delays and the code rework."[25] Albion claims that it cannot accurately estimate a project completion date until DHS finishes its outstanding design documents and stops revising them so that programmers can complete their work. DHS administrators, however, view ongoing updates to design documents as a normal part of any software development project.

  A related issue is that DHS has not consolidated its detailed business requirements into a centralized, cross-referenced document. Instead,

[25] Rob Marchant, Albion President, letter to Larry Woods, DHS Director of Health Care Operations, and Kathleen Henry, DHS Director of Health Care Eligibility and Access, dated February 12, 2007.

DHS policy staff have documented requirements in several different forms, including revisions to design documents. However, further clarifications and changes have not always been placed in these same documents, nor have they been carefully cross-referenced to one another. While DHS staff agree that a detailed, consolidated requirements document would be preferable, its creation has taken a back seat to other priorities. A manager of the DHS business requirements team told us that the department is unlikely to complete a consolidated requirements document before HealthMatch is implemented.

- **Unexpected staffing problems and performance shortcomings by the contractor.** Turnover among Albion staff has been an obstacle. Nearly every important project management position has had at least one change. For instance, Albion is currently employing its third project manager and fifth deputy project manager since 2003. Both Albion and DHS staff told us that Albion's frequent personnel changes have contributed to project delays.

  Serious deficiencies in the quality of programming work done by a satellite Albion facility located in Chennai, India, also delayed HealthMatch. As originally envisioned, combining the work of this offshore facility with the programming done in St. Paul would enable Albion to reduce costs and take advantage of a 24-hour development schedule. However, the need to continually find and fix errors in the programming code completed offshore consumed so much time that a senior member of Albion's project management team termed the entire experience a "disaster." Albion eventually stopped using the offshore facility to do HealthMatch work in September 2006 and concentrated all programming work in St. Paul.

- **Overly-optimistic timeline estimates.** As shown in Table 5, HealthMatch project development has consistently failed to meet scheduled timeline benchmarks. While the problems we cite above have contributed to delays, some mid-level managers at both Albion and DHS suggested that many missed deadlines were caused not by project difficulties but by overly optimistic timelines that could not realistically be met. One frustrated Albion manager faulted senior management on both sides, explicitly stating that poor time estimates were due to "politically acceptable constraints and reluctance to deal with reality."

Current Status

As of April 3, 2007, HealthMatch development was in the twelfth of sixteen projected construction phases. However, the impact of the various scope changes, disputes, and delays has been substantial. Based in part upon the assessments of senior executives at both DHS and Albion, we found that:

- **Unresolved problems could threaten successful, timely implementation of HealthMatch.**

At least three serious problems could further delay, or even derail, HealthMatch development: (1) senior executives at DHS and Albion cannot agree on the most

Table 5: HealthMatch Implementation Estimates, 2002-07

Early estimates that did not reflect the project's current scope[a]

Date Estimate Was Made	Estimated Pilot Implementation[b]	Source of Estimate
October 2002	mid-2004	DHS information provided for the 2003 *MinnesotaCare* report.
May 2003	June 2004	Initial contract between DHS and contractor.
October 2004	November 2005	DHS update on the implementation status of OLA's 2003 report recommendations.
May 2005	December 2005	First amendment to contract between DHS and contractor. (Estimate includes the first major expansion of project scope.)

Estimates reflecting the project's current scope

Date Estimate Was Made	Estimated Pilot Implementation	Source of Estimate
December 2005	March 2007	Second amendment to contract between DHS and contractor. (Estimate includes the first and second expansions of project scope and is the baseline for current assessments of the project's status.)
June 2006	September 2007	Revised project timeline.
February 2007	Fall 2008	DHS testimony before the Senate Finance Committee, Health and Human Services Budget Division on February 1, 2007.
April 2007	Unknown[c]	Interview with DHS executives.

[a] These early estimates were made before major changes in the system's design; therefore, they are not directly comparable with the second set of estimates, all of which relate to HealthMatch as currently envisioned.

[b] Pilot implementation will be the first use of the system to process actual applications and will be limited to a subset of health care cases. DHS will evaluate the outcomes from pilot implementation and address any problems before moving forward with full statewide implementation.

[c] DHS executives currently estimate that a limited version of HealthMatch will begin pilot implementation between late 2008 and mid-2009, depending on how any changes resulting from the 2007 legislative session are incorporated into the system. This initial version of HealthMatch will not include all planned functionality. As of April 2007, DHS executives could not set a date for implementing HealthMatch with all of the promised functionality.

SOURCE: Office of the Legislative Auditor analysis of HealthMatch documents, legislative testimony, and interviews with DHS executives.

urgent problems and how they should be resolved; (2) DHS may not be ready to test the system once construction is complete; and (3) given the lack of consolidated system requirements, the demands of the implementation process could strain the capacity of DHS's small number of senior policy experts and lead to further delays.

DHS and its contractor also disagree on how problems should be resolved.

In an exchange of correspondence in January and February 2007, DHS and Albion executives agreed that ongoing problems needed to be urgently fixed and that the project itself was at an "unacceptable level of risk."[26] However, their letters offered very different views of the issues to be addressed. DHS insisted that Albion meet agreed-upon design, construction, and testing deadlines; make realistic time estimates tied to resources available; develop contingency plans for product testing delayed by late delivery of Albion programming; and resolve staff turnover and communication issues. Albion dismissed DHS's concerns as unrelated to the real causes of delay, and it recommended that DHS replace its senior project staff, reorganize its process for completing and approving business requirements, supplement its requirements development team, and streamline its decision-making processes. While it is beyond the scope of this review to fully evaluate the competing claims of the two sides, we are troubled by the extent of disagreement among the project's most important decision makers.

In addition, DHS may not be adequately prepared to test the system before it is implemented.

Project staff at both DHS and Albion expressed serious concerns about the readiness of the state to test the HealthMatch system after the construction phase is finished. In a standard software development project, the testing teams use the completed business requirements to design tests and check whether the system produces correct results. However, the lack of updated, consolidated, and detailed business requirements has handicapped DHS's efforts to prepare for testing. DHS policy staff recently prepared a set of summary requirements to be used for testing, but DHS's testing manager described them as "poor and incomplete." The testing manager is hoping to proceed with a different process that will require constant communication with DHS's senior policy analysts in lieu of testing HealthMatch performance against written requirements. However, she regards this as a less efficient and potentially less effective method of testing HealthMatch. A Minnesota Office of Enterprise Technology expert who has consulted on the HealthMatch project stated that this approach is acceptable as a stop-gap measure but does not reduce the risks of continuing without fully documented requirements. Because DHS also expressed misgivings about the quality and thoroughness of Albion's testing processes, we believe it is essential that DHS's testing of the final product be comprehensive and thorough.[27]

Although DHS is preparing over 40 additional staff to train, support, and advise counties during the HealthMatch implementation process, DHS will also need to rely heavily on a handful of senior policy analysts. As described earlier, current

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[26] Brian Osberg, DHS Assistant Commissioner for Health Care, letter to Rob Marchant, Albion President, dated January 23, 2007; and Rob Marchant, letter to Brian Osberg, dated February 12, 2007.

[27] DHS maintains that it will not implement HealthMatch without thoroughly and successfully testing the system. It has added two one-month evaluation periods into the project timeline for full assessment of completed testing. At these junctures, DHS and Albion will determine whether the next phase of implementation can begin as scheduled.

DHS and county eligibility workers frequently make errors in determining eligibility. Thus, when workers begin using HealthMatch, the system will likely produce outcomes other than what workers expect. Because DHS lacks a complete, consolidated set of HealthMatch business requirements, DHS senior policy staff will be ultimately responsible for determining whether these inconsistencies are due to problems in the system. A few unexpected staff departures from this small group—combined with incomplete business requirements and potentially inadequate testing—could jeopardize the efficiency of HealthMatch implementation.

In early 2007, DHS invited outside firms to submit proposals for an independent, comprehensive review of the entire HealthMatch project. The review is primarily intended to ensure that HealthMatch will work as designed, but it will also examine the effectiveness of management processes at both DHS and Albion. Given the difficulties the project has encountered to date, we endorse DHS's decision to contract for this review.

As discussed earlier, the HealthMatch project has consistently failed to meet scheduled benchmarks. We asked DHS to provide us with a current project completion estimate. We found that:

- **DHS currently cannot set a final implementation date for HealthMatch.**

DHS now plans to implement HealthMatch in stages, with a pilot version tentatively scheduled for release between November 2008 and mid-2009.

As of April 3, 2007, DHS and Albion had not agreed on a revised HealthMatch timeline. DHS executives currently estimate that pilot implementation of HealthMatch will begin between November 2008 and mid-2009, depending on how any 2007 legislative changes are incorporated into the system. However, unlike earlier HealthMatch timelines (estimates made from December 2005 through February 2007, as shown in Table 5), these estimates reflect DHS's current plan to release an initial version of the program that would perform the system's most important functions—eligibility determination and premium calculation—but would not include all of the system's planned functionality.[28] At this point, DHS cannot estimate how long it will take to implement the functions excluded from the initial release, nor can it estimate how legislative changes in 2008, 2009, or even 2010 might affect the full implementation of HealthMatch.[29]

The timing of full HealthMatch implementation is further complicated because Affiliated Computer Services (ACS), a Fortune 500 information technology company, announced in January 2007 that it was attempting to acquire Albion's assets. As of April 2007, DHS, Albion, and ACS administrators were negotiating

[28] If DHS moves forward with its plan to release HealthMatch in stages, the major postponed components would include (1) the public web site that would allow Minnesotans to apply for benefits online and clients to view their own information, (2) the connection to DHS's computer system supporting cash and food assistance programs, and (3) the connection to DHS's computer system for child support enforcement.

[29] Due to the nature of software development, incorporating policy changes after the program is completed should be much less complex and time consuming than adding changes during the design and construction phases. DHS and Albion staff do not anticipate major difficulties in updating the system with new legislative changes once development is complete.

an agreement under which ACS would assume responsibility for the HealthMatch contract. DHS administrators are hopeful that ACS will be able to devote more resources to HealthMatch and facilitate faster completion of the project. As of yet, however, the impact of the ownership change on HealthMatch is unclear.

Project costs

DHS expects HealthMatch costs to total about $46 million through 2009, but the contractor has asked for additional compensation.

DHS had spent $21.3 million on HealthMatch development as of January 31, 2007. This figure includes $8.3 million in payments to Albion, but also DHS staff salaries, payments to other contractors, equipment costs, and other expenditures. DHS's contract with Albion is fixed-price; Albion is paid only after completing specific tasks, each of which is tied to a payment amount. DHS anticipates spending a total of $46.2 million on HealthMatch development through 2009, including $22.4 million in total payments to Albion. Of the total projected $46.2 million project cost, $22.5 million would come from federal sources.

These figures do not reflect a February 2007 request by Albion that the state pay the firm an additional $10.9 million to address work not covered in the contract. In March 2007, DHS said that the work Albion wanted additional payment for was, in fact, work included in the contract and existing payment terms. As a result, DHS denied Albion's request. The department suggested that DHS and Albion executives meet to discuss this and other project issues. As of April 3, 2007, Albion and DHS had not agreed whether the total compensation paid to the firm would increase.

RECOMMENDATIONS

RECOMMENDATION

DHS should expedite consolidation of HealthMatch business requirements and completion of design documents.

DHS needs to streamline its processes for defining and approving HealthMatch's design.

Automating MinnesotaCare eligibility determination is a sound strategy for improving program integrity. But in order to finish HealthMatch construction and test its performance, it is essential to consolidate the system's business requirements and finalize its design. Although the complexity of Minnesota's health care programs and the wide scope of the HealthMatch system make these tasks very difficult, the continued delays in the requirements and design processes pose a serious risk to timely completion and successful implementation of the project. In our view, although DHS's extensive internal review process is intended to limit the risk of HealthMatch programming errors, at this point DHS needs to proceed with greater urgency.

To streamline its decision-making process, we think DHS executives should (1) identify one administrative team that will make decisions regarding business requirements and design documents, (2) require all input from other divisions of

the agency to reach that team by clearly specified deadlines, and (3) ensure that final decisions of the team stand until work begins on future HealthMatch updates.[30] Further, DHS executives should direct enough resources to the business team to ensure that a master document detailing all HealthMatch requirements can be compiled as rapidly as possible. Such a document is crucial for adequately testing the system, and it will also reduce the burden that implementation will place on key policy staff.

RECOMMENDATION

DHS should consider taking additional steps to improve the accuracy of MinnesotaCare eligibility determinations while waiting for HealthMatch to be implemented.

If HealthMatch can be deployed as currently envisioned, it will likely improve the accuracy of health care program eligibility decision making. It is clear, however, that full implementation of HealthMatch is likely to be at least two to three years away, and we think DHS needs to take interim actions—beyond changes to training, policies, and procedures—to improve MinnesotaCare eligibility determination. Areas of opportunity include improving automated tools, stabilizing the MinnesotaCare Operations workforce, and stepping up compliance activities.

DHS needs to consider other means of improving the accuracy of MinnesotaCare eligibility determinations while waiting for HealthMatch.

We discussed these options with DHS's director of health care eligibility, and the department will be pursuing various options. For example, DHS internal auditors developed an automated tool to help calculate household income (rather than using the paper worksheet), and the department may be able to use it for processing MinnesotaCare applications and renewals. The department is also considering additional workforce-related actions, including (1) having workers specialize in certain aspects of the eligibility process, such as evaluating access to employer-subsidized insurance or determining self-employment income; (2) establishing a MinnesotaCare application processing center outside of the Twin Cities metropolitan area; (3) reviewing the key enrollment staff position to ensure that the salary is commensurate with the difficulty of the work; and (4) determining whether DHS can offer incentives to highly qualified and productive eligibility staff. We also believe that DHS should consider expanding its compliance activities, perhaps adding an ongoing field audit program to supplement its annual eligibility verification audits. As with audits in the tax system, the ongoing possibility of audit may create an incentive for applicants and enrollees to be more forthcoming with accurate information.

DHS received additional funding in 2005 to initiate a "business process reengineering" effort to assess and improve health care program delivery. As part of this process, DHS is specifically addressing certain workforce issues and the health care application process itself. But in the short term, DHS pointed out that the cost of implementing other solutions—such as increasing compliance audits or purchasing automated tools—while waiting for HealthMatch needs to

[30] This administrative team should also aggressively manage any revisions to requirements and design necessitated by legislative changes.

be weighed against actual cost savings for the state. We agree, but the state also needs to consider the impact of MinnesotaCare eligibility mistakes on clients' premiums and benefits. Given the error rates documented in the past few years, we think DHS should aggressively pursue cost-effective opportunities to make improvements.

April 9, 2007

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Nobles:

We thank you for the opportunity to respond to your final report, "Follow-up Review: MinnesotaCare Eligibility Determination." The Department of Human Services appreciates your willingness to incorporate a number of our comments into the final draft report. Overall, we agree with the report's major findings. Our comments will be focused on the recommendations and other general comments.

Recommendations

1. *DHS should expedite completion and consolidation of HealthMatch business designs.*

   The department agrees with this recommendation. In addition to completing HealthMatch business designs, the department will continue to manage the HealthMatch project through a very critical period of potential change in the project's vendor. DHS has gone to great length to carefully manage the assignment of the current contract with the potential new vendor without exposing the state to liability. At the same time, we must assess the appropriateness of any changes to the current contract. At least one other management hurdle remains.

   The potential new vendor must still secure assignment of Albion's contracts from three other states before the sale of Albion's assets can be completed. We are optimistic that the sale of Albion's assets to a potential new vendor will take us over the remaining hurdles to completion of the HealthMatch project. However, because there remain some outstanding issues for the potential new vendor, we expect to continue managing the relationship with the current vendor and a potential new vendor prudently.

   Finally, we are considering important organizational changes and project structure changes to complete the final phases of the HealthMatch project.

2. *DHS should consider taking additional steps to improve the accuracy of MinnesotaCare eligibility determinations while waiting for HealthMatch to be implemented.*

   The department agrees with this recommendation. While awaiting the completion of HealthMatch, the department has begun to undertake new efforts to reduce eligibility errors and improve our performance on eligibility determinations for MinnesotaCare program. We will review and implement complementary actions recommended by the OLA. Additionally, we are undertaking a business process redesign effort to consider the many program changes made in recent years and determine the appropriate process changes that should follow these program changes.

Additional Summary Comments

Although we believe the OLA has worked to balance the presentation of the development and progress of HealthMatch, we remain concerned about a conclusion reached by the OLA on page 11. Although prefaced with "In our view…," the OLA suggests that it found both DHS and Albion share responsibility for project setbacks. Without further legal analysis, the fair and proportional sharing of any responsibility remains undetermined and at issue.

Our department's policy is to evaluate the findings and recommendations to determine an appropriate corrective action plan to resolve the findings. The department will monitor the progress in correcting the problems until full resolution has occurred. If you have any further questions, please contact David Ehrhardt, Internal Audit Director, at (651) 431-3619.

Sincerely,

Cal R. Ludeman
Commissioner

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