Managed Care Organizations: Encounter and Claims Data Reporting

January 2017 through December 2017

August 1, 2018
REPORT 18-10

Financial Audit Division

OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA

Financial Audit Division

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

August 1, 2018

Senator Mary Kiffmeyer, Chair
Legislative Audit Commission

Members of the Legislative Audit Commission

Emily Piper, Commissioner
Department of Human Services

Minnesota Statutes 2017, 3.972, subd. 2b, directs the Office of the Legislative Auditor to audit managed care organizations under contract with the Department of Human Services. This report presents the results of our compliance audit *Managed Care Organizations: Encounter and Claims Data Reporting*. The objective of this audit was to determine if managed care organizations complied with selected legal and contract requirements for reporting encounter and medical claims data to the department.

This audit was conducted by Valerie Bombach (Audit Director); John Haas (Audit Coordinator); Jennyfer Hildre (Senior Auditor); and Robert Timmerman (Senior Auditor).

We received the full cooperation of the managed care organizations' staff while performing this audit.

Sincerely,

James R. Nobles
Legislative Auditor

Christopher P. Buse
Deputy Legislative Auditor

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THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

Table of Contents


THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

Report Summary

The Department of Human Services (DHS) is responsible for overseeing Minnesota's public health care programs, and the department contracts with managed care organizations (MCOs) to provide certain administrative functions and services to program enrollees. For calendar year 2017, eight MCOs reported about $4.8 billion in medical expenses for MinnesotaCare, the Prepaid Medical Assistance Program, and the Special Needs Basic Care program.

The Office of the Legislative Auditor conducted this audit to determine each MCO's compliance with selected legal and contract requirements to report patient encounter and medical claims data to DHS. Our audit scope focused on a sample of encounter data and payments to medical providers reported by the MCOs for these Minnesota health care programs for calendar year 2017.

Conclusions

For the sample encounter records that we tested, HealthPartners, Hennepin Health, Itasca Medical Care, PrimeWest Health, South Country Health Alliance, and UCare Complied with selected DHS reporting requirements, and the payment information was accurate and complete. Blue Plus and Medica also Generally Complied with these requirements, although we found a small number of exceptions.

Findings

- For 1 of 60 claims that we audited (2 percent), Blue Plus did not comply with a Department of Human Services contract requirement to report denied claims for payment.

- For 5 of 60 claims that we audited (8 percent), Medica did not comply with Department of Human Services contract requirements to report paid and denied claims for payments or to submit encounter data timely.


THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

Audit Overview

Minnesota statutes direct the Office of the Legislative Auditor (OLA) to audit managed care organizations (MCOs) that contract with the Department of Human Services (DHS) for Minnesota's public health care programs.[1] This report presents the results of the first of several OLA compliance audits of MCOs' encounter data and medical expenses for Minnesota public health care programs.

We focused on MCOs' encounter and medical claims data for this audit because DHS uses these data for many purposes, including understanding patient medical care, forecasting program costs, and setting future payments by DHS to MCOs for their services and expenses. DHS also sends information about MCO encounter data to the federal Centers for Medicare and Medicaid Services.[2] Audits that examine the accuracy and completeness of the encounter data help determine its usability for these purposes.

For this compliance audit, we tested a sample of each MCO's reported encounter data and payments to medical providers during calendar year 2017.[3] We also reviewed each MCO's performance related to selected indicators of DHS's encounter data quality assurance program.[4]

Program Overview

Department of Human Services

The Department of Human Services is responsible for overseeing Minnesota's public health care programs, which include Medical Assistance (Minnesota's version of the federal Medicaid program) and MinnesotaCare (a federally approved Basic Health Program for individuals who do not qualify for regular Medical Assistance). Our scope of audit work focused on MinnesotaCare and two Medical Assistance programs: Prepaid Medical Assistance Program (PMAP) and Special Needs Basic Care (SNBC).[5]

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[1] *Minnesota Statutes* 2017, 3.972, subd. 2b, directs the Office of the Legislative Auditor to audit managed care organizations that contract with DHS to determine whether they used the public money in accordance with legal requirements and provisions of their contracts.

[2] 42 *CFR*, sec. 438.66 (2017).

[3] *Minnesota Statutes* 2017, 256B.69, subd. 9d(b), requires managed care organizations to report biweekly encounter and claims data to DHS and participate in the department's encounter data quality assurance program.

[4] *Ibid*.

[5] We excluded from our scope of work Medicare services for SNBC and the Medical Assistance programs that serve seniors: Minnesota Senior Health Options and Minnesota Senior Care Plus.

Managed Care Organizations

As specified in federal and state laws, DHS contracts with managed care organizations to provide certain administrative functions and services to enrollees under public health care programs.[6] DHS contracted with eight MCOs to each provide services for one or more of these programs in 2017.[7] These MCOs included five entities certified as health maintenance organizations (Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare) and three "county-based purchasing organizations" (Itasca Medical Care, PrimeWest Health, and South Country Health Alliance).

Encounter and Claims Data Reporting

As part of program oversight, federal regulations require states to include in their contracts with MCOs certain requirements for reporting program costs and medical services.[8] In particular, MCOs must submit "encounter data" to the appropriate state agency (DHS). Encounter data are individual electronic records that document each enrollee's medical visit, the medical care received by the patient, and the provider's medical claim and payment by the MCO, among other information.

Minnesota law supplements the federal reporting mandate by requiring the MCOs to provide to DHS biweekly encounter data and claims data for public health care programs.[9] The volume of encounter records sent by MCOs to DHS is significant; in 2017, total claims processed through DHS's Medicaid Management Information System (MMIS) exceeded 49.6 million claims.

Given the importance of encounter data in oversight of the public health care programs, state law requires the MCOs to participate in a DHS quality assurance program that verifies the timeliness and completeness of the data through a series of quality assurance protocols.[10] DHS staff actively monitor and evaluate encounter data submitted to the state and, within MMIS, DHS has an automated system of edits to read and code encounter records, based on the accuracy or completeness of the data. For example, DHS currently has 37 specific edits—including edits related to claim payment values or duplicate records—that will flag an encounter record if it does not align with expected parameters. DHS will exclude these flagged encounter records when it determines future payments for MCOs. DHS also imposes monetary penalties against MCOs if they do not correct specified errors on submitted encounter records. Based on our work on this audit, we think that the

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[6] 42 *CFR*, sec. 438 (2017); and *Minnesota Statutes* 2017, 256B.035; and 256B.69, subd. 5a.

[7] *Minnesota Statutes* 2017, 62D.04, subd. 5; 256B.0644; and 256B.692.

[8] 42 *CFR*, sec. 438.604 (2017).

[9] *Minnesota Statutes* 2017, 256B.69, subd. 9d(b).

[10] For information about a recent evaluation of this program, see Deloitte Consulting, LLP, *Department of Human Services, Encounter Data Quality Assurance Protocol Review* (St. Paul, June 2017), https://mn.gov/dhs/assets/2017-06-encounter-data-quality-assurance-protocols-report_tcm1053-321058.pdf, accessed July 30, 2018.

DHS encounter data quality assurance program has had a positive impact on improving the overall integrity of encounter data.

MCOs are responsible for managing all aspects of the claims process and encounter data submission to DHS. The process for submitting provider claims for payment and reporting the encounter data is lengthy and involves multiple steps. Some of the eight MCOs wholly manage this process; others contract with third-party administrators for various functions. We illustrate and describe this process in more detail in the appendix of this report.

Financial Activity and Enrollment

For calendar year 2017, the eight MCOs administering public health care programs reported $4.8 billion in hospital and medical expenses for MinnesotaCare, PMAP, and SNBC. As shown in Exhibit 1, the average monthly enrollment in these three programs during this same period was about 877,390 individuals for all MCOs.

Exhibit 1: MinnesotaCare, PMAP, and SNBC Medical Expenses and Enrollment, by Managed Care Organization, Calendar Year 2017

Managed Care Organization	Total Medical Expenses (in thousands)[a]	Average Monthly Enrollment
Blue Plus	$1,630,359	344,179
HealthPartners	725,056	133,334
Hennepin Health	199,547	25,529
Itasca Medical Care	41,473	8,002
Medica	693,450	115,910
PrimeWest Health	205,341	38,613
South Country Health Alliance	190,832	36,164
UCare	1,088,256	175,659
Total Medical Expenses and Enrollment	$4,774,314	877,390

NOTE: Expenses and enrollment figures exclude members enrolled in a senior program.

[a] Includes hospital and medical expenses.

SOURCES: Office of the Legislative Auditor summary of each managed care organization's *2017 Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and Department of Human Services, *Minnesota Health Care Programs Managed Care Enrollment Totals* (St. Paul, December 2017), 56-58.

Audit Scope

This compliance audit focused on verifying a sample of DHS encounter data and payments to medical providers that were reported by the MCOs for public health care programs, as required by certain legal and DHS contract provisions.[11] We reviewed compliance with selected reporting requirements by all eight MCOs under contract with DHS for MinnesotaCare, PMAP, and SNBC, for the period from January 2017 through June 2017.

Audit Objective

The objective of this compliance audit was to answer the following questions:

- Did the managed care organizations comply with significant legal and contract requirements for reporting encounter and medical claims data to the Department of Human Services?

- Were the managed care organizations' reported claim payments to providers for medical services accurate and complete?

Audit Methodology and Criteria

To answer the audit objective questions, we reviewed federal and state laws, contract requirements, and DHS guidance to MCOs on how to administer public health care programs and report encounter data to DHS. To gain an understanding of the end-to-end medical claims and encounter data submission processes, we interviewed DHS staff, representatives of each MCO, and MCOs' vendors who process claims and encounter data. We reviewed summary financial and medical expense data reported by each MCO to DHS.

We also reviewed documentation and MCO data related to DHS's encounter data quality assurance program. Specifically, we examined MCO compliance in 2017 with certain DHS benchmarks for correctly reporting provider and program recipient identification numbers and for not reporting duplicate claims. We also reviewed the MCOs' corrections of encounter data errors and related penalties imposed by DHS on MCOs in 2017.

To assess each MCO's compliance with selected legal and DHS contract requirements, we obtained encounter records from DHS that represented the final outcomes of medical claims submitted by providers to each MCO for payment. Using a combination of sampling methods, we selected and tested for each MCO a sample of 60 final claim records reported to DHS as either paid to providers or

[11] For this audit, we focused on claims for payment for hospital, outpatient, and professional services, and excluded specific provider types, including dental, pharmacy, personal care attendants, transportation, durable medical equipment, and some others.

denied during 2017. Overall, we reviewed a total of 480 medical claims from 308 providers (or their claims billing administrator) to determine the accuracy and completeness of the payment information and the timeliness of MCO reporting.[12] Our sample sizes were intended for audit control and compliance purposes and were not large enough to be representative of the claims of each individual MCO.[13] We then obtained source documents—including bank statements, explanation of payments, and remittance advices—directly from providers to independently verify actual claim payments (or denials) against DHS encounter data, and to confirm that the encounter record reflected services that appeared to be medical in nature. We also independently verified certain recipient information against information contained within the DHS MMIS warehouse.

Conclusions

For the sample encounter records that we tested, HealthPartners, Hennepin Health, Itasca Medical Care, PrimeWest Health, South Country Health Alliance, and UCare Complied with selected DHS reporting requirements, and the payment information was accurate and complete. Blue Plus and Medica also Generally Complied with these requirements, although we found a small number of exceptions.

The following *Findings and Recommendations* section provides further explanation about these instances of noncompliance.

[12] Many providers or billing entities in our sample population contracted with some or all of the eight MCOs. For these providers, our audit methods included verification of claims data reporting by each MCO.

[13] American Institute of Certified Professional Accountants (AICPA), *Audit Guide: Government Auditing Standards and Single Audit* (Durham, NC: American Institute of Certified Professional Accountants, 2018), 280-285. AICPA suggests a minimum sample size of 60 for control testing when high inherent risk has been assessed and for compliance testing when a high level of assurance is desired (AICPA guidance AAG-GAS 11.61 and AAG-GAS 11.64).


THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

Findings and Recommendations

FINDING 1

For 1 of 60 claims that we audited (2 percent), Blue Plus did not comply with a Department of Human Services contract requirement to report denied claims for payment.

Among the 60 samples we tested, Blue Plus generally complied with legal and contract requirements to report to DHS the total amounts that Blue Plus paid or denied to providers for their medical services, with one exception.[14] For one claim, Blue Plus did not report that it had denied payment for some services, which resulted in underreporting of denied claims for services that were not allowed under the public health care program. The amount billed by the provider for these denied services totaled $11.60.

DHS relies on encounter data for many purposes, and accurate and complete claim records are critical to support the useability of the information.

RECOMMENDATION

Blue Plus should comply with the Department of Human Services contract requirement to report denied claims for payment.

FINDING 2

For 5 of 60 claims that we audited (8 percent), Medica did not comply with Department of Human Services contract requirements to report paid and denied claims for payment or to submit encounter data timely.

Among the 60 samples we tested, Medica generally complied with legal and contract requirements to report to DHS the total amounts that Medica paid or denied to providers for their medical services, with two exceptions.[15] Medica did not report to DHS the full payment amount for one claim, resulting in underreporting of

[14] *Minnesota Statutes* 2017, 256B.69, subd. 9d(b); and Minnesota Department of Human Services, *Contract for Medical Assistance and MinnesotaCare Services with Blue Plus* (2017), Article 3.6.1(B)(2), which states, "The MCO shall submit encounter data that includes all paid lines and all MCO-denied lines associated with the claim."

[15] *Minnesota Statutes* 2017, 256B.69, subd. 9d(b); and Minnesota Department of Human Services, *Contract for Medical Assistance and MinnesotaCare Services with Medica Health Plans* (2016), Article 3.6.1(B)(2), which states, "The MCO shall submit encounter data that includes all paid lines associated with the claim…. All denied claims…must be submitted to the State."

medical expenses by $184.90.[16] DHS also directs MCOs to use particular codes to identify claims in which they deny payment.[17] Medica did not comply with this provision for one other claim, which resulted in underreporting $262.46 in denied payments for medical services not allowed for under the public health care program.

For three other claims that we tested, Medica did not comply with DHS contract requirements for timely reporting of claims records.[18] DHS requires MCOs to submit original encounter claims no later than 30 days after the date the MCO adjudicates the claim. Medica submitted these three claims later than the required timeframe.

DHS relies on encounter data for many purposes, and accurate and complete claim records are critical to support the useability of the information.

RECOMMENDATION

Medica should comply with the Department of Human Services contract requirements to report paid and denied claims for payment and to submit encounter data timely.

[16] DHS, *Contract for Medical Assistance and MinnesotaCare Services with Medica Health Plans*, Article 3.6.1(B)(5), which states, "The MCO shall submit on the encounter claim...the Provider allowed and paid amounts. For purposes of this section, 'paid amount' is defined as the amount paid to the Provider excluding Third Party Liability, Provider withhold and incentives, and Medical Assistance cost-sharing."

[17] Minnesota Department of Human Services, *Remittance Advice Remark Code Guide, Revised: 03/15/17* (2017), 75.

[18] DHS, *Contract for Medical Assistance and MinnesotaCare Services with Medica Health Plans*, Article 3.6.1(C); and Minnesota Department of Human Services, *Contract for Special Needs Basic Care Program Services for People with Disabilities with Medica Health Plans* (2017), Article 3.4.1(C), which states, "The MCO shall submit original submission encounter claims no later than thirty (30) days after the date the MCO adjudicates the claim…. The MCO's submission of claim adjustments must be done by voiding and submitting a corrected claim, within forty-five (45) days of the date adjusted at the MCO." For the three claims referenced here, the claim records were submitted 47, 48, and 83 days after adjudication.

Appendix: Encounter and Claims Data Reporting Process

Managed care organizations (MCOs) must report "encounter data" to the Department of Human Services (DHS).[19] Encounter data are electronic records that document an enrollee's medical event or visit to a doctor, hospital, or other medical provider. Encounter records provide a broad range of information pulled from providers' claims for payments and other sources, such as patient demographics; service dates; medical procedure and diagnosis detail; and charges billed and paid.

The process to report encounter and medical claims data to DHS is lengthy and involves multiple entities and steps, from the time an enrollee receives medical care to the point at which the managed care organization reports the information to DHS.[20] As shown in Exhibit 1A on the next page, multiple entities make processing decisions, and these entities transfer claims data several times. The entities can reject and return a claim to a previous process if additional information is required.

Patient Encounter and Claims Process

The patient encounter and claims reporting process begins with a patient visit to a medical provider, after which the provider seeks reimbursement for services from the MCO. A health care provider or billing entity submits a claim to the MCO through which their patient is enrolled in a public health care program.

Most providers first submit their claims through a "clearinghouse," where claims data are prepared to be sent to and further processed by the MCO. MCOs maintain contractual relationships with multiple clearinghouses, as providers can choose the clearinghouse they prefer to use.

In some instances, a provider will submit a claim directly to an MCO. If an MCO receives a paper claim directly, the MCO either will return the claim to the provider or may manually enter the claim data into the MCO's claim processing system, depending on the MCO's policy.

Each MCO verifies certain information before a claim enters its claims processing system for payment. These preliminary reviews look for high-level, easily identifiable information, such as member and provider eligibility. MCOs will reject a claim and return it to the provider if it does not pass this preliminary review.

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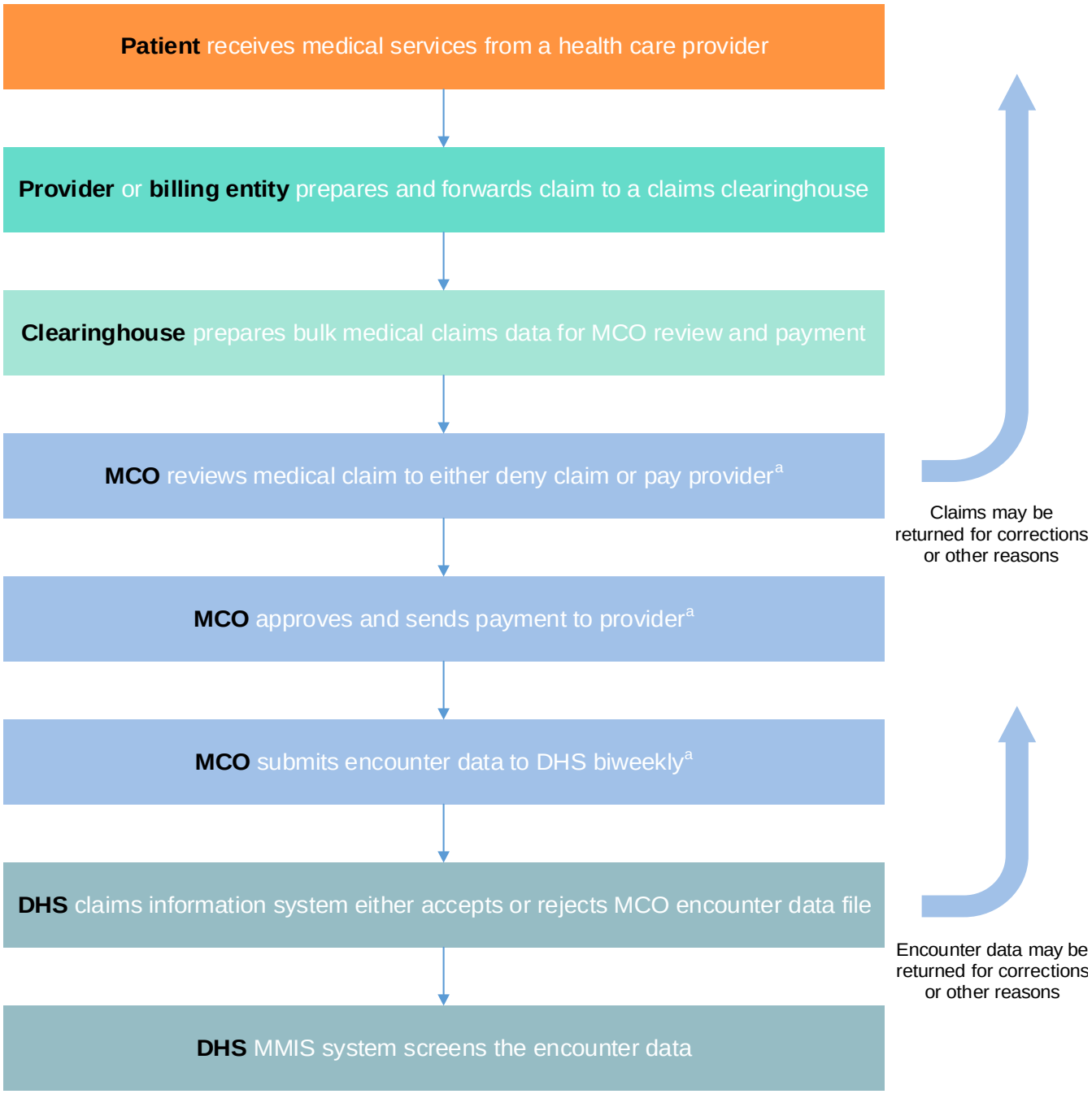
[19] *Minnesota Statutes* 2017, 256B.69, subd. 9d(b).

[20] An MCO is responsible for managing all aspects of their claims and encounter data submission process. Some MCOs wholly manage these functions. Others contract with third-party administrators for various functions.

Exhibit 1A: Example of Medical Claims Process and Encounter Data Reporting to the Department of Human Services



NOTES: This exhibit represents the flow of a claim that does not contain errors or other information requiring additional review. If a claim has errors or needs further examination, the processing entity will review, deny, or return the claim to a previous process. Managed care organizations (MCOs) use claims information systems to automatically approve or deny payments. If an MCO's claims information system is unable to automatically approve or deny payment, a claims examiner will manually review the claim to approve or deny payment.

[a] An MCO is responsible for managing all aspects of the claims process and encounter data submission process. Some MCOs wholly manage these functions; others contract with third-party administrators for various functions such as processing claims or payments or submitting encounter data to DHS.

SOURCE: Office of the Legislative Auditor.

MCOs rely on claims processing information systems that automatically determine approval or denial of a claim by reviewing such criteria as:

- Member benefits and services covered under the plan.
- Provider contract terms and fees.
- Agreement of diagnosis and procedure codes.
- Evidence of a duplicate claim.
- Procedures appropriately match a member's gender.
- Preauthorization requirements.

If an MCO's claims processing system is unable to automatically make a decision to pay or deny a claim, a claims examiner manually processes the claim.

When an MCO approves a claim, it will send to the provider a payment and remittance advice that explains details of the payment. Alternatively, if the MCO denies a claim, it will send a remittance advice to the provider that details the reason for denial. Providers may appeal claim or claim line denials to the MCO.

Reporting Encounter Data to DHS

MCOs prepare encounter data for reporting to DHS by extracting two weeks of claims data from their claims processing system or data warehouse. Each of the eight MCOs serving Minnesota public health care programs has a different process to review its data for completeness. DHS has criteria that defines the acceptable format of the bulk data for submission to the department's system, and also system edits within its Medicaid Management Information System (MMIS) for reading the data for inconsistencies and completeness.

After an MCO submits encounter data to DHS, DHS sends back an automated response indicating the batch file was either accepted or rejected by its system. DHS will reject a batch file if it does not pass formatting requirements. If DHS rejects the file, the MCO must correct the error and resubmit the encounter data file.

After DHS accepts the file, DHS processes the encounter data through MMIS for validation against certain preprogrammed edits. DHS notifies MCOs when claims and individual claim lines data are accepted or denied. If DHS rejects any claims data, MCOs are required to correct the data and resubmit the information.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Blue Cross and Blue Shield of Minnesota and Blue Plus

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(651) 662-8000 / (800) 382-2000

BlueCross BlueShield Minnesota

July 26, 2018

VIA ELECTRONIC MAIL

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

Re: Final Audit Report: Managed Care Organizations: Encounter and Claims Data Reporting: CY January 1, 2017 through December 31, 2017

Dear Mr. Nobles:

HMO Minnesota d/b/a Blue Plus ("Blue Plus") appreciates the opportunity to provide comments on the Managed Care Organizations: Encounter and Claims Data Final Audit Report dated July 25, 2018 ("Report").

In the Report, the OLA found that "among the 60 samples we tested, Blue Plus generally complied with legal and contract requirements to report to DHS the total amounts that Blue Plus paid or denied to providers for their medical services, with one exception." (See Report, Blue Plus Finding and Recommendation). Blue Plus appreciates the opportunity to provide this response to address the exception noted in the Report as follows:

Finding: The Report states that for one claim, "Blue Plus did not report that it had denied payment for some services, which resulted in underreporting of denied claims for services that were not allowed under Minnesota Health Care Programs ("MHCP"). The amount billed by the provider for these denied services totaled $11.60." (See Report, Blue Plus Finding and Recommendation).

Blue Plus Response: This item related to the denial of payment for two claim lines of a claim. One claim line was for services in the amount of $6.40 and the other in the amount of $5.20, totaling $11.60. The OLA identified that the denial of payment for these claim lines was not reported in the encounter data submitted to DHS in connection with this claim. Blue Plus researched this item and identified that reporting of these denied claim lines were impacted by an issue with the programming logic related to certain denial codes used for reporting. As of June 20, 2018, Blue Plus implemented a system update to fix the programming error. This claim has also been resubmitted to DHS to reflect the denied claim lines.

Thank you for the opportunity to comment.

Sincerely,

Frank Fernández
President & Chief Executive Officer
HMO Minnesota d/b/a Blue Plus

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Minneapolis, MN 55440-1309

July 30, 2018

James Nobles
Legislative Auditor
Centennial Office Building, Room 140
658 Cedar Street
Saint Paul, MN 55155-1603

Dear Mr. Nobles:

HealthPartners appreciates the opportunity to review and respond to the report *Managed Care Organizations: Encounter and Claims Data Reporting* completed by the Office of the Legislative Auditor ("OLA"). We appreciate the thoroughness and professionalism of the OLA team members who conducted the audit.

HealthPartners is pleased with the report's conclusion that we complied with the legal and contract requirements to report encounter and claims data to the Department of Human Services, and that our reported claim payments to providers for medical services were accurate and complete. We believe this audit affirms our effective processes and controls related to claims and encounter data reporting.

HealthPartners continues to work hard to comply with all requirements while keeping in mind the need to minimize administrative costs and complexity so our focus can be on improving the health of our members and patients. That's the expectation Minnesotans have of our organization, and we take that responsibility seriously. We are proud to serve Minnesota Health Care Programs members, and look forward to continuing to work with the State to improve the system for the good of all Minnesotans.

Once again, we appreciate the efforts of the OLA and the audit team that performed this audit.

Sincerely,

David A. Dziuk
Senior Vice President and Chief Financial Officer


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Hennepin Health
Minneapolis Grain Exchange Building
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July 30, 2018

Jim Nobles, Legislative Auditor
Office of the Legislative Auditor
Finance Division
140 Centennial Building
658 Cedar Street
Saint Paul, Minnesota 55155

Re: Managed Care Organizations Encounter and Claims Data Reporting

Dear Mr. Nobles,

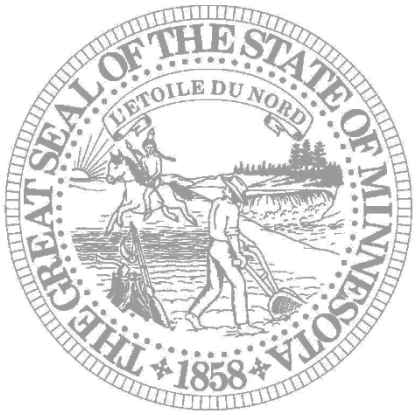
Hennepin Health was engaged by the Office of the Legislative Auditor (OLA) through a notice of intent to audit dated November 16, 2017. This notice informed Hennepin Health of OLA's intent to conduct an audit related to medical expense data reported to the Minnesota Department of Human Services (DHS) via encounter data.

Throughout the duration of the audit, Hennepin Health provided all information requested by the OLA in a timely manner. Hennepin Health has had an opportunity to review the preliminary audit findings provided to Hennepin Health on June 25, 2018, and to discuss these findings with the OLA on June 29, 2018. The final report was issued to Hennepin Health on July 25, 2018. Hennepin Health has had the opportunity to review the final audit report as well. The OLA has concluded that Hennepin Health has complied with DHS' reporting requirements and all payment information was complete and accurate. Hennepin Health agrees with this conclusion.

Hennepin Health appreciates the opportunity to have the OLA review our processes and values the feedback provided by your staff during the audit process and in the final report. Please let us know if we may provide any additional information or otherwise be of assistance to the OLA as you complete your work on medical expense data.

Sincerely,

Anne Kanyusik Yoakum
Interim Chief Executive Officer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Visit us at: www.imcare.org

July 3, 2018

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

Dear Mr. Nobles:

This letter serves as response to the draft report *Managed Care Organizations: Encounter and Claims Data Reporting* dated June 25, 2018. IMCare has reviewed the results of the draft report and we are in agreement with the report at this time.

Sincerely,

Sarah Duell
Itasca Medical Care - CEO
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Minneapolis, MN 55440-9310

MEDICA®

July 27, 2018

James R. Nobles
Legislative Auditor
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St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to submit a letter for inclusion in your audit of Managed Care Organizations: Encounter and Claims Data Reporting. We appreciate the attention your staff gave to the comments we have provided throughout the process. A number of those comments were taken into account in finalizing the finding and recommendation. Some of them are noted here for the record.

Comment 1: Reporting of Full Payment Amount for One Paid and One Denied Claim

Medica processes a vast number of claims and, at times, there is a valid reason for variation. For the paid claim, due to an incomplete encounter, only a partial submission was passed to the State to ensure the clean detail lines were acknowledged. To address claims that fall into this scenario and to ensure timely submission of the data to DHS, Medica uses front end edits on the provider submission process to require and capture this data. The provider community is aware of this edit via Medica's standard provider communication channels.

For the denied claim, the claim denied correctly, however, it was incorrectly passed on as an encounter. In the Spring of 2017, a system issue occurred between the communication of the claim processing system and the encounter processing system. As a result, the encounter processing system did not identify a denial code in the expected location and, therefore, passed the encounter to the State as a paid $0 encounter instead of a denial. The system issue has been corrected.

Comment 2: Timely Reporting of Three Claims Records

The three claims identified by the OLA included unit values exceeding 999 and were stopped in Medica's encounter system for additional validation on the units submitted to ensure accuracy. This intervention ensures the payment and the units are accurately reflected and reported to DHS.

Medica is aware of the requirement for the bi-weekly submission of encounters within the thirty day timeframe. The three claims identified during the audit included claims that upon transition to encounters did not meet the DHS reporting requirements for valid encounter submission. Therefore, Medica had to validate and secure the appropriate information to ensure that the encounters were valid prior to submission. Medica makes every effort to do this within the thirty day timeframe. We will continue to work with DHS to ensure that Medica submits encounters in a timely manner.

We value our partnership with the State, and the coverage and service we are able to provide for our members. To that end, we are dedicated to following regulatory and contractual requirements and in producing encounter data that are accurate and complete. Given the complexity of this work, we know that small errors will occur and that there will be areas of disagreement. We view this audit, and all those we participate in, as an opportunity to improve our performance and strengthen our partnerships.

Sincerely,

Thomas Lindquist
Senior Vice President
Medica Government Programs

PrimeWest HEALTH
A greater Minnesota health plan™

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June 29, 2018

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Room 140 Centennial Building
658 Cedar Street
St. Paul, MN 55155-1603

Dr. Mr. Nobles:

PrimeWest Health has reviewed the June 25, 2018, draft of the audit report titled *Managed Care Organizations: Encounter and Claims Data Reporting*. PrimeWest Health agrees with the conclusions regarding PrimeWest Health, and we have no additional comments.

Thank you for the opportunity to review the draft report prior to finalization and for the professional manner in which the audit was conducted.

Sincerely,

James A. Przybilla, Chief Executive Officer
PrimeWest Health


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SOUTH COUNTRY
HEALTH ALLIANCE
Bringing Wellness Home

July 26, 2018

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
State of Minnesota
Room 140 Centennial Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

We appreciate receipt of the *Managed Care Organizations: Encounter and Claims Data Reporting* final report and the conclusion that, for the sample encounter records tested, South Country Health Alliance complied with selected DHS reporting requirements and the payment information was accurate and complete.

We would also like to acknowledge the preparedness and professionalism of the audit staff led by Valerie Bombach during this audit.

Sincerely,

Leota Lind

Leota Lind
CEO

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July 27, 2018

James R. Nobles
Legislative Auditor

Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Re: Response to Managed Care Organizations: Encounter and Claims Data Reporting Audit Report

Dear Mr. Nobles:

Thank you for the opportunity to review the Office of the Legislative Auditor's (OLA) report dated July 25, 2018 titled *Managed Care Organizations: Encounter and Claims Data Reporting* for Minnesota's public health care programs. The encounter and claims data reporting process has an integral role in supporting the operation and integrity of the state's various health care programs.

We have reviewed the report and are pleased with OLA's conclusion that for the encounter records tested, UCare complied with the selected Department of Human Services reporting requirements and related payment information was accurate and complete. The encounter and claims data reporting process is highly complex and UCare has made significant investments in the people, systems and processes that support this reporting.

Thank you for the opportunity to review and comment on this report.

Sincerely,

UCare

Beth Monsrud

Beth Monsrud

Chief Financial Officer


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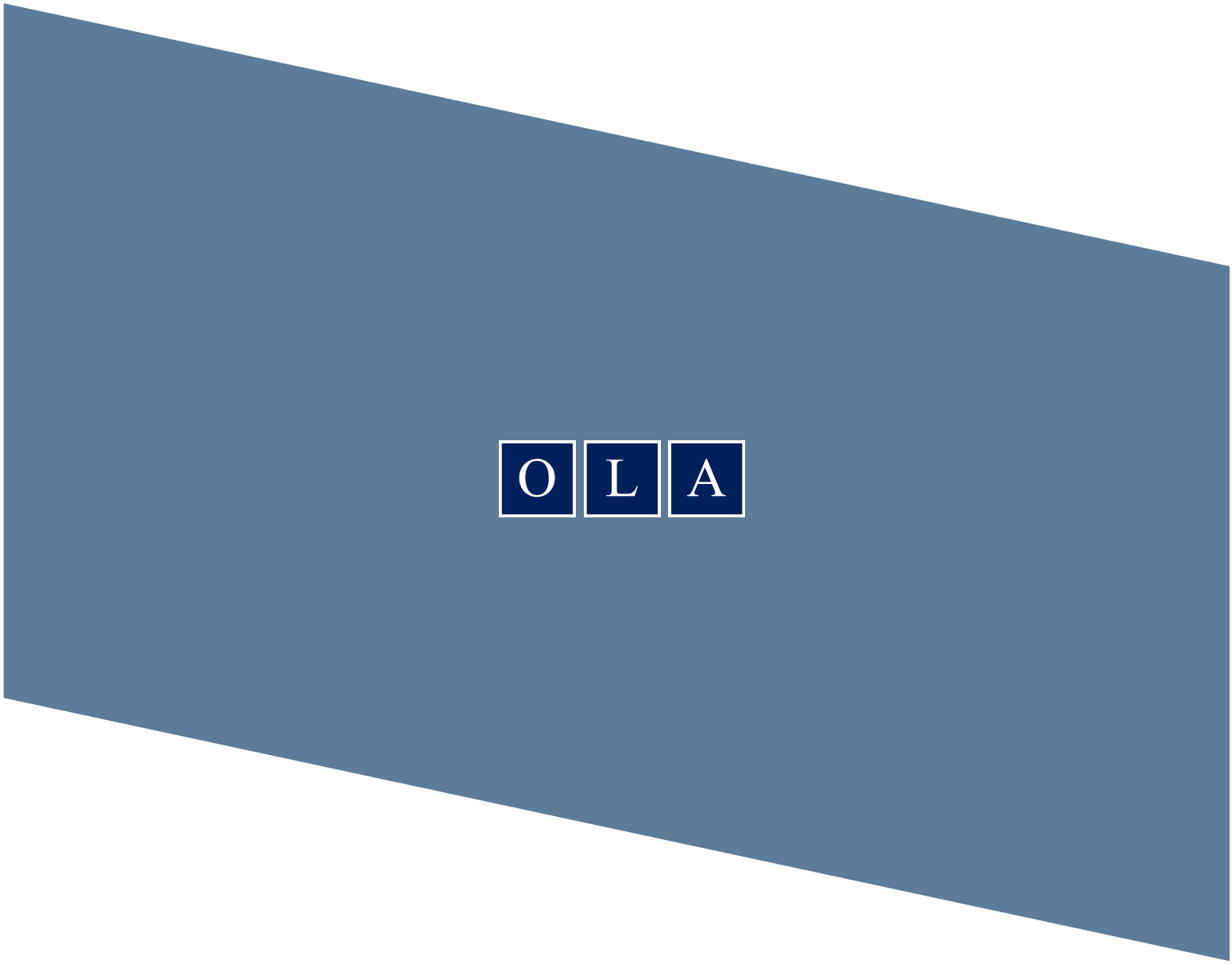

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