

**WISCONSIN
DEPARTMENT OF
HEALTH SERVICES**

External Quality Review (EQR)
Encounter Data Validation
Submission of Findings

**Group Health Cooperative
of South Central Wisconsin**

June 5, 2025



**MYERS AND
STAUFFER_{LC}**
CERTIFIED PUBLIC ACCOUNTANTS



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Executive Summary

The Wisconsin Department of Health Services (DHS) engaged Myers and Stauffer to perform an External Quality Review (EQR) under Protocol 5, which evaluates the completeness and accuracy of the encounter data submitted by Group Health Cooperative of South Central Wisconsin (GHSCSW). The focus was on data submitted for Medicaid beneficiaries enrolled in the BadgerCare Plus (BCP) program, which includes the Children's Health Insurance Program (CHIP), and the Medicaid Supplemental Security Income (SSI) managed care program.

Wisconsin's Medicaid Managed Care program is delivered across all 72 counties in the state. DHS contracts with multiple managed care organizations (MCOs), including GHSCSW, to provide medical healthcare services to enrolled members across seven (7) counties.¹

The goal of this review was to determine whether the health plan submitted encounter data in accordance with contract requirements for completeness, accuracy, timely claims payment and timely submission of encounter data for calendar year (CY) 2023.

Scope of Review

The assessment included several key data sources:

- Cash Disbursement Journals (CDJs) and sample claims data for two selected sample months.
- Encounter data processed by the state's fiscal agent contractor (FAC).
- 120 randomly sampled medical records related to CY 2023 encounters, as specified by DHS.

A **95% threshold** was used as the benchmark for completeness, accuracy, and medical record validation.

Myers and Stauffer performed this review in accordance with the American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform an audit or examination, and no opinions or assurances were issued regarding the presence of fraud or other irregularities.

Findings and Observations

The following summarizes the health plan's performance across all evaluated areas:

- **Data Completeness**
 - Encounters exceeded the 95% threshold at **100%** when compared to CDJs and showed **100%** completeness when compared to sample claim paid amounts.
 - Encounters were above the 95% threshold, **98.0%**, when compared to sample claim counts.
- **Data Accuracy**
 - The accuracy of the encounter data compared to sample claims data was **95.9%**, above the 95% threshold.
 - Errors involved diagnosis related group (DRG) codes missing from the encounter data,

¹ <https://www.dhs.wisconsin.gov/badgercareplus/member-info.htm#getting-services>



missing and/or mismatching billing provider identifiers.

➤ **Timeliness of Claims Payments and Encounter Submissions**

- **Claims Payment Timeliness:**
 - **99.3%** of claims were paid within 30 days and
 - **99.9%** within 90 days, and
 - **100%** within 180 days.
- **Encounter Submissions:**
 - **100%** of the encounters were submitted within the required 120-day timeframe.

➤ **Medical Record Validation**

- Of the 120 medical records requested, all 120 were submitted.
- A total of **100% of the requested records** were tested.
- Among the records reviewed, the validation rate was **95.0%**, at the 95% threshold.

Conclusion and Recommendations

GHSCW met or exceeded established thresholds for completeness and accuracy for the submission and management of Medicaid encounter data for CY 2023.

Some issues were noted with incomplete medical record documentation. It is recommended that the health plan continue to collaborate with DHS and the FAC to address minor gaps and further improve data quality processes.



Introduction

Wisconsin's Medicaid managed care program, BadgerCare Plus (BCP), includes the Children's Health Insurance Program (CHIP) and the Medicaid Supplemental Security Income (SSI) program. Most BCP beneficiaries are required to enroll in a managed care organization (MCO) to receive healthcare services.

- **BCP** provides healthcare coverage for low-income individuals and families, including children, pregnant women, parents, and certain childless adults, with incomes at or below specific percentages of the Federal Poverty Level (FPL).
- **CHIP** provides healthcare coverage for uninsured children under age 19 who are not eligible for Medicaid.
- The **Medicaid SSI program** offers managed care to eligible adults, age 19 and older, who are blind or disabled, and live in select service areas².

In accordance with the *2016 Medicaid Managed Care Final Rule* and the updated *2020 Centers for Medicare & Medicaid Services (CMS) Final Rule*, states must improve oversight and validation of encounter data submitted by health plans. Key requirements include independent encounter data validations for each health plan, submission of complete and accurate data including allowed and paid amounts, and annual publication of health plans exempt from External Quality Review (EQR).

To meet the requirements under these rules, CMS recommends using EQR Protocol 5, which evaluates the completeness and accuracy of encounter data submitted to the State's fiscal agent contractor (FAC). This validation supports transparency in managed care operations, payment reform and value-based care initiatives, and accurate data submissions to CMS under the Transformed Medicaid Statistical Information System (T-MSIS) project.

The Wisconsin Department of Health Services (DHS) engaged Myers and Stauffer LC (Myers and Stauffer) to perform an independent encounter data validation (EDV) review using Protocol 5. The objective was to determine whether the CY 2023 encounter data submitted by Group Health Cooperative of South Central Wisconsin (GHSCSW), met state and federal standards for:

- Completeness
- Accuracy
- Timeliness
- Conformity with adjudication of claims (paid/denied)

This review helps DHS and the health plan ensure that data used for oversight, rate-setting, quality improvement, and federal reporting is reliable and consistent with the actual services provided.

On March 12, 2020, Wisconsin declared a public health emergency (PHE) in response to the COVID-19 pandemic. Emergency policies temporarily altered the delivery and reporting of healthcare services.

² Wisconsin Medicaid SSI HMO Program Guide: <https://www.dhs.wisconsin.gov/publications/p1/p12770.pdf>



These policies remained in effect until May 11, 2023, when the federal government ended the PHE³. These disruptions may have affected service delivery volumes, encounter submission patterns, and documentation availability. These factors were considered in the analysis of the health plan's CY 2023 encounter data.

Our review was conducted in accordance with the American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform, an audit or examination; therefore, no formal opinion or assurance is expressed regarding the presence of fraud, errors, or other irregularities. Our evaluation included:

- Review of the health plan's internal policies and procedures
- Analysis of data submissions to the State's FAC
- Interviews with subject matter experts
- Review of available documentation and known data limitations

Results are specific to the health plan; however, some issues may originate from systems or processes managed by the FAC.

Key Observations:

- Encounter data validation is critical for ensuring the accuracy of payment systems and care delivery monitoring.
- Findings reflect both strengths and opportunities for the health plan to improve internal controls and data governance.
- The expectation is for the health plan to collaborate with DHS and the FAC to address any identified issues.

Recommendations are provided to:

- Strengthen data submission protocols.
- Ensure complete and timely medical record documentation.
- Align with CMS and state expectations for encounter data integrity.

The use of EQR Protocol 5 allowed DHS to assess how well the health plan captures and submits encounter data. This process is integral to supporting federal and state compliance, effective managed care oversight, and data-driven quality improvement efforts.

The findings, observations and recommendations in this report provide the health plan with actionable insights to enhance its reporting systems and ensure accurate, complete, and timely data for future submissions.

³ <https://www.dhs.wisconsin.gov/news/releases/042623.htm>



State Requirements – Activity 1

Activity 1 of the EDV process focuses on assessing the adequacy and effectiveness of the State’s policies, contractual language, and operational procedures regarding the collection and submission of encounter data. The objective is to determine whether additional or updated requirements are necessary to ensure data completeness, accuracy, and reliability. As part of this review, the following were evaluated:

- State-specified encounter data submission requirements
- Completeness and Accuracy thresholds
- Acceptable error rates
- DHS’s contract with the health plan
- Regular communication and monthly status meetings with DHS to confirm accurate understanding of systems and policies

The review yielded several key findings and/or observations regarding current practices and policies, which are summarized below along with associated recommendations.

Findings, Observations and Recommendations		
	Findings and Observations	Recommendations
1-A	The FAC currently provides member rosters to health plans twice per month. The initial roster reflects members and disenrollees known at the time the roster is generated, while the final roster captures any members not included in the initial file.	To ensure timely and accurate claims processing, DHS/FAC should consider increasing the frequency of roster updates. Some states utilize incremental daily files supplemented by periodic full membership files, which provide more current and complete member information to health plans.
1-B	Current encounter volume monitoring focuses on identifying variances greater than 10% below expected volumes. No equivalent criteria exist for identifying unusually high encounter volumes.	DHS should revise contract language to include thresholds for both under and over reporting of encounter volume. Specifically, include requirements to identify volume variances exceeding 10% above the expected monthly average. This will enhance the detection of potential data anomalies or billing irregularities.
1-C	Existing contract language does not specify timeframes for the submission of documentation in response to audit requests.	DHS should incorporate explicit timeliness standards into audit requirements. Specifying deadlines for documentation submission will support efficient audit execution and help enforce accountability.
1-D	The following technical processes are used by the FAC to populate missing provider data on professional and dental encounters: - Propagation Logic: Assigns the billing provider as the rendering provider when no certified rendering provider is available. - Provider Reverse Propagation Logic: Applies when no unique billing provider is available. The system attempts to identify a certified	While this logic serves to improve encounter processing and reduce rejections, the logic may mask deficiencies in provider submissions, creating risks to data reliability and transparency. To improve data integrity, the FAC should capture and utilize NPI values as reported by providers and health plans, regardless of the rendering provider’s certification status. Additionally, the FAC should review and assess the use of propagation logic to



Findings, Observations and Recommendations	
Findings and Observations	Recommendations
rendering provider. - Service Location Hierarchy Logic: Searches through all service locations for a submitted national provider identifier (NPI) to determine a matching provider based on encounter details. - Procedure Billing Rule Error Logic: If certain billing rules fail, the FAC applies hierarchy logic to assign a suitable provider location based on the service and rendering provider information.	enhance data quality.

The Activity 1 review highlights aspects of encounter data collection, submission, and policy alignment with CMS requirements. While DHS has implemented policies and system logic to support encounter data accuracy, several improvements are necessary to strengthen oversight, enhance timeliness, and improve the reliability of provider-reported data.



Health Plan Capability – Activity 2

The objective of this review was to evaluate the health plan's information systems and internal controls to determine its ability to collect and submit complete and accurate encounter data. The evaluation methodology included the following:

- Development and distribution of a structured survey instrument (questionnaire)
- Review of documentation requested from the health plan
- Interviews with key health plan personnel

Focus areas of the review included:

- Claims processing workflows
- Data submission procedures
- Enrollment systems
- Data architecture and integration
- Internal controls and quality assurance mechanisms

Supporting documentation provided by the health plan included organizational charts, workflow diagrams, policies and procedures, and system documentation.

Findings and observations made from the reviews are summarized below along with recommendations for DHS, FAC and/or the health plan.

Findings, Observations and Recommendations		
Findings and Observations		Recommendations
2-A	The health plan only reworks/corrects FAC rejected/denied encounters that are over \$1,000.	Approximately 94.7 percent of CY 2023 encounters are less than \$1,000. Depending upon the health plan's encounter rejection/denial rate, this practice could potentially result in the completeness of the encounter data falling below the desired 95 percent threshold. The health plan should rework all FAC rejected/denied encounters, regardless of dollar amounts, to ensure the submitted encounter data is complete.
2-B	For encounter file submissions that are rejected/denied by the FAC, the health plan corrects the rejected/denied encounter(s) directly in the encounter submission file. The corrections do not flow through to the claims processing system and data warehouse.	The health plan should ensure that rejected/denied encounters are corrected through the claims process and are reflected in the data warehouse to ensure an audit trail is in place. Discrepancies between the FAC encounter submissions and the health plan's data warehouse may impact the accuracy of the claims data and encounter reporting.

The review identified gaps with the health plan's handling of rejected or denied encounters, which may affect data completeness and reporting accuracy. Additionally, the practice of correcting



rejected encounters outside the claims system may contribute to discrepancies between submitted data and internal records. Such practices may impact the ability to maintain a consistent and reliable audit trail.



Encounter Data Analysis – Activity 3

Activity 3 of the EDV focuses on analyzing electronic encounter data to verify its completeness and accuracy. This report evaluates the integrity of encounter data submitted to DHS by the health plan through the FAC.

Data Overview

Time Period Analyzed: CY 2023 (January 1, 2023 – December 31, 2023)

Comparison Sources:

- Encounter Data Extract (encounters processed by the FAC January 1, 2021 – October 11, 2024)
- Cash Disbursement Journals (CDJs) for two selected sample months (March and September 2023)
- Sample Claims Data for two selected sample months (March and September 2023)

Encounter Data Extract

The health plans submit encounter data to DHS via its FAC, Gainwell Technologies⁴. The FAC supports the state’s Medicaid program by maintaining the MMIS systems, processing claims and managing encounters, and supporting the enrollment and management of providers within the Medicaid program.

In 2023, DHS contracted with a privately held software company, SAS⁵, to develop and maintain an enterprise data warehouse (EDW) and provide data analytics and reporting. The EDW manages the central data repository used for analytics, reporting, and decision support by integrating data from multiple internal and external sources (including MMIS, vendor data, etc.), ensuring data quality, integrity and governance, and supporting business intelligence and strategic decision-making.

The FAC and the EDW collaborate closely. The FAC provides raw operational data (e.g., claim and encounter data), which the EDW subsequently collects, integrates, validates, and makes accessible for analytical and reporting purposes.

Myers and Stauffer received encounter data from the EDW in a standardized data extract. Limitations identified within the data are listed below, which may have impacted the results and findings of this validation.

Table 1: Encounter Data Limitations

E-1	The extract provided was a reproduction of the extract provided to the actuary for rate-setting purposes, and not an exact duplicate.
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⁴ <https://www.gainwelltechnologies.com/>

⁵ https://www.sas.com/en_us/home.html



Table 1: Encounter Data Limitations

E-2	The data extract provided for this validation does not align with the data submitted to CMS for T-MSIS. T-MSIS submissions are generated and submitted monthly by the FAC. The extract for this validation was produced by the EDW.
E-3	Potential duplicates not identified as duplicates by the FAC/EDW (e.g., partial payments, actual duplicate submissions, and/or replacement claims without a matching void). Duplication logic was applied to remove duplicates from the analyses.
E-4	Discrepancies between the FAC and the health plan assigned claim status indicator.
E-5	Missing health plan paid dates at the header/detail levels.
E-6	Multiple encounter submissions under the same health plan-assigned internal control number (ICN) with more than one encounter designated as the final or active encounter.
E-7	Missing revenue codes and diagnosis codes for institutional (i.e., inpatient and outpatient) encounters.

Completeness

CDJ vs Encounter Data

The encounter data paid amounts were compared to the paid amounts in the CDJs submitted by the health plan. A threshold of greater than or equal to ($\geq$) 95% was used to determine completeness.

Table 2: CDJ Completion Percentages

Sample Month	Paid Amount Percentage	Status (Threshold $\geq$ 95%)
March	100%	✓ Passed
September	100%	✓ Passed
Overall Average	100%	✓ Passed

Both sample months exceeded the 95% completeness threshold. Detailed results can be found in Appendix A.

Sample Claims vs Encounter Data

The sample claims were traced to encounter data using data elements provided in the health plan-submitted claims data. The encounters were evaluated against the sample claims data based on the criteria noted below. A threshold of $\geq$ 95% was used to determine completeness.

- **Sample Claim Counts:** The number of claims from the sample claims data that were identified in the encounters.
- **Sample Claim Paid Amounts:** Sample claim paid amounts compared to encounter paid amounts.



Table 3: Sample Claims Completion Percentages

Sample Month	Count Percentage	Paid Amount Percentage	Status (Threshold ≥ 95%)
March	98.4%	100%	✓ Passed/✓ Passed
September	97.6%	100%	✓ Passed/✓ Passed
Overall Average	98.0%	100%	✓ Passed/✓ Passed

Both sample months exceeded the 95% threshold. Detailed results can be found in Appendix B.

Accuracy

Certain key data elements on the encounters were validated against the corresponding key data elements on the sample claims. Consistency checks on blank/null data element values were also applied. A threshold of ≥ 95% was used to determine accuracy. The key data elements were evaluated based on the following criteria:

- **Valid Values:** The encounter key data element value matched the sample claim key data element value. If the encounter key data element was blank (or NULL) and the data element in the sample claim was also blank (or NULL), it was considered valid.
- **Missing Values:** The encounter key data element was blank (or NULL) and the data element in the sample claim was populated (i.e., had a value).
- **Erroneous Values:** The encounter key data element had a value (i.e., was populated) and the sample claim key data element value was populated, and the values were not the same.

Table 4: Encounter Accuracy by Encounter Type

Sample Month	Valid Values	Missing Values	Erroneous Values	Status (Threshold ≥ 95%)
March	96.0%	0.0%	4.0%	✓ Passed
September	95.9%	0.3%	3.9%	✓ Passed
Overall Average	95.9%	0.1%	4.0%	✓ Passed

The key data elements evaluated and specific testing results are presented in Appendix C.

Findings, Observations and Recommendations

The findings and observations from the completeness and accuracy analyses of the encounter data are summarized below, including recommendations for DHS, FAC/EDW and/or the health plan.

Findings, Observations and Recommendations		
Findings and Observations		Recommendations
3-A	Completeness: CDJ and sample claim comparisons exceeded the 95% thresholds.	The health plan should continue monitoring encounter-to-CDJ and encounter-to-claim completion rates, investigate the cause of any missing encounters in the encounter data, and address these gaps through timely and accurate FAC submissions.



Findings, Observations and Recommendations		
	Findings and Observations	Recommendations
3-B	Accuracy: Both sample months met or exceeded the 95% accuracy threshold. Most errors involved diagnosis related group (DRG) codes missing from the encounter data, and/or missing and/or mismatching billing provider NPIs.	The health plan should implement targeted quality control measures to address data issues. This may include enhanced validation processes prior to submission, improved data mapping protocols, and periodic audits to ensure that all required data elements are consistently and accurately captured in both the claims and encounter data.
3-D	Data Gaps: DRG codes, diagnosis codes, and billing provider NPI data sometimes were missing from the encounter data or incorrect.	The health plan should conduct a review of data capture and submission processes to identify the causes of missing and/or incorrect data element values. Enhancements to system validation checks, staff training on data entry protocols, and alignment between claims and encounter data sources should be performed to ensure the completeness and accuracy of all required data elements.

The encounter data submitted by the health plan demonstrates high completeness and accuracy, with metrics meeting or exceeding the 95% validation thresholds. A few data quality issues remain, particularly around certain missing data field values. Continuous monitoring and collaboration with DHS/FAC/EDW are recommended to resolve data integrity concerns.

Statistics and Distributions

This section supports the overall validation of encounter data by analyzing the consistency and reliability of attributes such as:

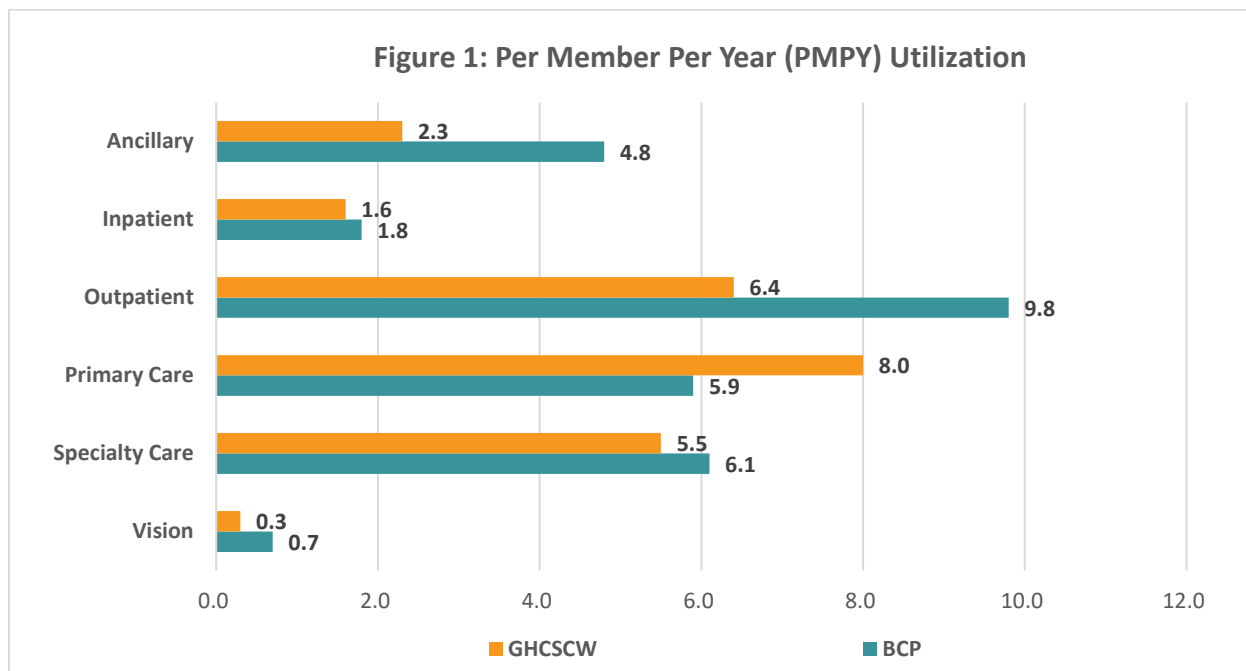
- Member utilization
- Timeliness of claims payments
- Timeliness of encounter submissions

CY 2023 encounter data was compared to Wisconsin Medicaid managed care program benchmarks (BCP Program)⁶ for further evaluation.

Members Utilization Analysis

This analysis compares the utilization (units/services) per member by service type against BCP statewide averages.

⁶ All health plans contracted to provide healthcare services under BadgerCare Plus, Care 4 Kids and Medicaid SSI for Wisconsin Medicaid managed care eligible beneficiaries have been combined for comparative purposes and are referred to as BadgerCare Plus.



GHCSW's utilization rates were below BCP benchmarks for most services. In contrast, utilization for primary care services exceeded expected levels. Detailed results and cost-related data can be found in Appendix D.

Wisconsin's Medicaid Managed Care program operates statewide, encompassing 72 counties. DHS contracts with multiple health plans to deliver healthcare services to beneficiaries across the state. While GHCSW is contracted to coordinate and manage care for BCP members across 7 counties⁷, its enrolled members account for less than 1% of the total BCP beneficiary population.

Timeliness Analysis

Timely Payment of Claims

Per the DHS contract⁸, the health plan must meet the following claim adjudication timeframes for clean claims:

- ≥ 90% within 30 days
- ≥ 99% within 90 days
- 100% within 180 days

Received dates and adjudication (paid) dates from the health plan-submitted sample claims data were used for the analysis. The number of days between these dates determined the percentage of claims adjudicated (paid) by the health plan within the designated timeframes.

⁷ Counties: Columbia, Dane, Grant, Iowa, Jefferson, Lafayette, and Sauk.

⁸ Article XV, Section D, 2, 2022-2023.



Table 5: Claims Payment Timeliness

Sample Month	30 Days – 90%	90 Days – 99%	180 Days – 100%	Status
March	99.5%	99.9%	100%	✓ Passed
September	99.2%	99.8%	100%	✓ Passed
Overall Average	99.3%	99.9%	100%	✓ Passed

Both sample months exceeded the DHS requirements. Detailed results can be found in Appendix E.

Timely Encounter Submissions

Per the DHS contract⁹, adjudicated clean claims must be submitted to the FAC as encounters within:

- **120 days** of adjudication

The adjudication (paid) dates from the health plan-submitted sample claims data and the date the encounter was processed by the FAC were used for the analysis. The number of days between these dates determined the percentage of encounters submitted by the health plan to the FAC within the designated timeframes.

Table 6: Encounter Submission Timeliness (combined March and September)

Sample Month	30 Days	60 Days	90 Days	120 Days	Status
March	95.8%	100%	100%	100%	✓ Passed
September	99.3%	100%	100%	100%	✓ Passed
Overall Average	97.4%	100%	100%	100%	✓ Passed

Both sample months exceeded the 120-day requirement. Detailed results can be found in Appendix F.

Findings, Observations and Recommendations

The findings and observations from the timeliness analyses are presented below, including recommendations for DHS, FAC/EDW and/or the health plan.

Findings, Observations and Recommendations		
	Findings and Observations	Recommendations
3-E	Utilization: PMPY utilization rates for most service categories were lower than benchmarks and primary care services exceeded expected levels.	The health plan should review services exceeding benchmarks for potential over-utilization or benefit design differences.
3-F	Payment of Claims: The claims for both sample months were paid within contractual timeframes.	The health plan should continue monitoring claims processing and encounter submissions.
3-G	Encounter submissions: Encounter submissions for both sample months exceeded the 120-day requirement.	

The health plan demonstrated compliance in claims payment and encounter submission timeliness.

⁹ Article XII, Section D, 1, g, 2022-2023.



WISCONSIN MEDICAID MANAGED CARE EQR Encounter Data Validation

SUBMISSION OF FINDINGS

Group Health Cooperative
of South Central Wisconsin

Higher than average primary care service utilization warrants process enhancements and monitoring to ensure comprehensive care delivery and reporting.



Medical Records Review – Activity 4

Activity 4 of the EDV process was conducted to confirm and support the findings from the Activity 3 analysis. The objective was to validate key data elements reported in the encounter data by comparing them to source documentation available in provider medical records. This step ensures the integrity and accuracy of the encounter data submitted by the health plan.

The population for this validation activity consisted of encounter data with dates of service within the designated measurement period. From this population, a sample of 120 medical records was selected for review using non-statistical¹⁰, random sampling, as prescribed by DHS.

On December 13, 2024, Myers and Stauffer forwarded the selected encounter sample to the health plan. The health plan was instructed to retrieve the corresponding medical records from the billing providers. Accompanying the request was a detailed guide outlining documentation expectations. The deadline for submitting complete medical records to Myers and Stauffer was February 3, 2025. Records that were incomplete or contained incorrect dates of service were excluded from the validation process.

Table 7: Summary of Medical Record Submissions

Description	Number of Medical Records	Percentage
Requested	120	100%
Missing (not submitted)	0	0%
<i>Received and Tested</i>	<i>120</i>	<i>100%</i>

Validation

Each of the 120 medical records received was reviewed to validate the corresponding encounter data. Certain key data elements were compared between the encounter and the information found in the medical record documentation. Each data element was classified as:

- **Supported:** The medical record confirmed the encounter data element.
- **Unsupported:** The medical record either lacked the required information or contradicted the encounter data.

A total of 1,175 key data elements were evaluated across the 120 medical records. The results are presented in the table below.

¹⁰ Non-statistical sampling is the selection of a test group, such as sample size, that is based on the examiner's judgement, rather than a formal statistical method. <https://www.accountingtools.com/articles/non-statistical-sampling.html>



Table 8: Medical Record Validation Results

Description	Number of Data Elements	Percentage	Status (Threshold ≥ 95%)
Tested	1,175	100.0%	N/A
Unsupported	59	5.0%	✓ Passed
Supported	1,116	95.0%	✓ Passed

The 95% threshold was met. The data elements tested and the specific results are presented in Appendix G.

The unsupported values were primarily due to missing member dates of birth and/or the absence of servicing provider details in the submitted medical record documentation.

Findings, Observations and Recommendations

The findings from the encounter data testing against medical records are presented below, including recommendations for DHS, FAC/EDW and/or the health plan.

Findings, Observations and Recommendations		
Findings and Observations		Recommendations
4-A	The overall supported rate of 95.0% met the required 95% threshold.	The health plan should continue provider training and communication efforts to ensure claims and encounter submissions accurately reflect the medical record.
4-B	The key issues contributing to unsupported elements were documentation deficiencies related to servicing provider information and member dates of birth.	The health plan should emphasize the accurate entry/inclusion of member dates of birth and servicing provider information. The health plan should also consider establishing internal audit protocols to identify and address (potential) missing data and/or discrepancies before submitting encounters to the DHS/FAC.

This validation activity reinforces the role of accurate and complete medical record documentation in ensuring the integrity of the encounter data. The health plan is encouraged to address the identified issues and continue collaborative efforts with providers to improve future data quality and compliance with state requirements.



Submission of Findings – Activity 5

Activity 5 summarizes the findings, observations and recommendations identified in Activity 1 through Activity 4. The table below contains finding numbers corresponding to the activity and sequential findings within each section of the report.

Findings, Observations and Recommendations		
Findings and Observations		Recommendations
State Requirements – Activity 1		
1-A	The FAC currently provides member rosters to health plans twice per month. The initial roster reflects members and disenrollees known at the time the roster is generated, while the final roster captures any members not included in the initial file.	DHS/FAC should consider increasing the frequency of roster updates. Some states utilize incremental daily files supplemented by periodic full membership files, which provide more current and complete member information to health plans.
1-B	Current encounter volume monitoring focuses on identifying variances greater than 10% below expected volumes. No equivalent criteria exist for identifying unusually high encounter volumes.	DHS should revise contract language to include thresholds for both under and over reporting of encounter volume. Specifically, include requirements to identify volume variances exceeding 10% above the expected monthly average. This will enhance the detection of potential data anomalies or billing irregularities.
1-C	Existing contract language does not specify timeframes for the submission of documentation in response to audit requests.	DHS should incorporate explicit timeliness standards into audit requirements. Specifying deadlines for documentation submission will support efficient audit execution and help enforce accountability.
1-D	The following technical processes are used by the FAC to populate missing provider data on professional and dental encounters: - Propagation Logic: Assigns the billing provider as the rendering provider when no certified rendering provider is available. - Provider Reverse Propagation Logic: Applies when no unique billing provider is available. The system attempts to identify a certified rendering provider. - Service Location Hierarchy Logic: Searches through all service locations for a submitted national provider identifier (NPI) to determine a matching provider based on encounter details. - Procedure Billing Rule Error Logic: If certain billing rules fail, the FAC applies hierarchy logic to assign a suitable provider location based on the service and rendering provider information.	While this logic serves to improve encounter processing and reduce rejections, the logic may mask deficiencies in provider submissions, creating risks to data reliability and transparency. To improve data integrity, the FAC should capture and utilize NPI values as reported by providers and health plans, regardless of the rendering provider's certification status. Additionally, the FAC should review and assess the use of propagation logic to enhance data quality.



Findings, Observations and Recommendations		
Findings and Observations		Recommendations
Health Plan Capability – Activity 2		
2-A	The health plan only reworks/corrects FAC rejected/denied encounters that are over \$1,000.	Approximately 94.7 percent of CY 2023 encounters are less than \$1,000. Depending upon the health plan's encounter rejection/denial rate, this practice could potentially result in the completeness of the encounter data falling below the desired 95 percent threshold. The health plan should rework all FAC rejected/denied encounters, regardless of dollar amounts, to ensure the submitted encounter data is complete.
2-B	For encounter file submissions that are rejected/denied by the FAC, the health plan corrects the rejected/denied encounter(s) directly in the encounter submission file. The corrections do not flow through to the claims processing system and data warehouse.	The health plan should ensure that rejected/denied encounters are corrected through the claims process and are reflected in the data warehouse to ensure an audit trail is in place. Discrepancies between the FAC encounter submissions and the health plan's data warehouse may impact the accuracy of the claims data and encounter reporting.
Encounter Data Analysis – Activity 3		
3-A	Completeness: CDJ and sample claim comparisons exceeded the 95% thresholds.	The health plan should continue monitoring encounter-to-CDJ and encounter-to-claim completion rates, investigate the cause of any missing encounters in the encounter data, and address these gaps through timely and accurate FAC submissions.
3-B	Accuracy: Both sample months met or exceeded the 95% accuracy threshold. Most errors involved diagnosis related group (DRG) codes missing from the encounter data, and/or missing and/or mismatching billing provider NPIs.	The health plan should implement targeted quality control measures to address data issues. This may include enhanced validation processes prior to submission, improved data mapping protocols, and periodic audits to ensure that all required data elements are consistently and accurately captured in both the claims and encounter data.
3-C	Data Gaps: DRG codes, diagnosis codes, and billing provider NPI data sometimes were missing from the encounter data or incorrect.	The health plan should conduct a review of data capture and submission processes to identify the causes of missing and/or incorrect data element values. Enhancements to system validation checks, staff training on data entry protocols, and alignment between claims and encounter data sources should be performed to ensure the completeness and accuracy of all required data elements.
3-D	Utilization: PMPY utilization rates for most service categories were lower than benchmarks and primary care services exceeded expected levels.	The health plan should review services exceeding benchmarks for potential over-utilization or benefit design differences.
3-E	Payment of Claims: The claims for both sample months were paid within contractual timeframes.	The health plan should continue monitoring claims processing.



Findings, Observations and Recommendations		
Findings and Observations		Recommendations
3-F	Encounter submissions: Encounter submissions for both sample months exceeded the 120-day requirement.	The health plan should continue monitoring claims encounter submissions.
Medical Records Review – Activity 4		
4-A	The overall supported rate of 95.0% met the required 95% threshold.	The health plan should continue provider training and communication efforts to ensure claims and encounter submissions accurately reflect the medical record.
4-B	The key issues contributing to unsupported elements were documentation deficiencies related to servicing provider information and member dates of birth.	The health plan should emphasize the accurate entry/inclusion of member dates of birth and servicing provider information. The health plan should also consider establishing internal audit protocols to identify and address (potential) missing data and/or discrepancies before submitting encounters to the DHS/FAC.



Glossary

834 file – HIPAA-compliant benefit enrollment and maintenance documentation.

835 file – HIPAA-compliant health care claim payment/advice documentation.

837 file – The standard format used by institutional providers and health care professionals and suppliers to transmit health care claims electronically.

Adjudication – The process of determining whether a claim should be paid or denied.

American Institute of Certified Public Accountants (AICPA) – The national professional organization of Certified Public Accountants.

Ancillary Services – Supplies and equipment, laboratory and diagnostic tests, therapies (i.e., physical, occupational and speech) and home health services requested by a health care provider as a supplement to fundamental services.

Capitation – A payment arrangement for health care services that pays a set amount for each enrolled member assigned to a provider and/or health plan.

Cash Disbursement Journal (CDJ) – A journal used to record and track cash payments by the health plan or other entity.

Centers for Medicare & Medicaid Services (CMS) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

Centers for Medicare & Medicaid Services (CMS) Medicaid and the Children's Health Insurance Program (CHIP) Managed Care Final Rule – On April 25, 2016 CMS published the Medicaid and CHIP Managed Care Final Rule which modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns many of the rules governing Medicaid managed care with those of other major sources of coverage; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity.

Certified Public Accountant (CPA) – A designation given by the AICPA to individuals that pass the uniform CPA examination and meet the education and experience requirements. The CPA designation helps enforce professional standards in the accounting industry.

CFR – Code of Federal Regulations.

Children's Health Insurance Program (CHIP) - Insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance.

Data Warehouse (DW) – A central repository for storing, retrieving, and managing large amounts of current and historical electronic data. Data stored in the warehouse is uploaded from the operational



systems and may pass through additional processing functions before it is stored in the warehouse. Also known as an enterprise data warehouse (EDW).

Department of Health Services (DHS) – The department within the state of Wisconsin that oversees and administers Medicaid.

Encounter – A health care service rendered to a member, by a unique provider, on a single date of service, whether paid or denied by a coordinated care organization. One patient encounter may result in multiple encounter records.

Encounter Data – Claims that have been adjudicated by the health plan or subcontracted vendor(s), if applicable, for providers that have rendered health care services to members enrolled with the health plan. These claims are submitted to DHS via the FAC for use in rate setting, federal reporting, program oversight and management, tracking, accountability, and other ad-hoc analyses.

Enterprise Data Warehouse (EDW) - A centralized repository for storing and managing historical business data from various sources within an organization. It is a database, or collection of databases, designed to consolidate and organize data for analysis, reporting, and decision-making across an enterprise.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR §438.354 and performs external quality review or other EQR-related activities as set forth in 42 CFR §438.358, or both.

External Quality Review (EQR) – The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that health plans, or its contractors, furnish to Medicaid recipients.

Fiscal Agent Contractor (FAC) – A contractor selected to design, develop, and maintain the claims processing Medicaid Management Information System (MMIS). Gainwell Technologies is the current FAC for Wisconsin. Also known as a fiscal intermediary (FI).

Health Plan – A private organization that has entered a contractual arrangement with DHS to obtain and finance care for enrolled Medicaid members. Health plans receive a capitation or per member per month (PMPM) payment from DHS for each enrolled member. Also referred to as Health Maintenance Organization (HMO), specific to contract language.

Health Insurance Portability and Accountability Act (HIPAA) – A set of federal regulations designed to protect the privacy and maintain security of protected health information (PHI).

Information Systems Capabilities Assessment (ISCA) – A tool for collecting facts about a health plan's information system to ensure that the health plan maintains an information system that can accurately and completely collect, analyze, integrate and report data on member and provider attributes, and services furnished to members. An ISCA is a required part of multiple mandatory External Quality Review protocols.

Internal Control Number (ICN) - A numerical mechanism used to track health care claims and encounters. Also referred to as Transaction Control Number (TCN) or Document Control Number (DCN).

Inpatient Services - Care or treatment provided to members who are extremely ill, have severe trauma, are unable to care for themselves or have physical illnesses whose condition requires admission for at



least one overnight stay. Lengths of stay are generally short and patients are provided 24-hour care in a safe and secure facility.

Key Data Element – A fundamental unit of information that has a unique meaning and distinct units or values (i.e., numbers, characters, figures, symbols, a specific set of values, or range of values) defined for use in performing computerized processes.

Medicaid Management Information System (MMIS) – The claims processing system used by the FAC to adjudicate Wisconsin Medicaid claims. Health plan-submitted encounters are loaded into this system and assigned a unique claim identifier.

Outpatient Services - Care or treatment that can be provided in a few hours at a facility without an overnight stay. Patients continue working or attend school, interacting and living their lives while receiving treatment. Outpatient services include rehabilitation services such as counseling and/or substance abuse.

Per Member Per Month (PMPM) – The amount paid to a health plan each month for each person for whom the health plan is responsible for providing health care services under a capitation agreement.

Potential Duplicate (PDUP) – An encounter that Myers and Stauffer LC has identified as being a potential duplicate of another encounter in the FAC's data warehouse.

Primary Care Services - Medical providers in family and general practice, obstetrics and gynecology (for preventive and maternity care), pediatrics (without other subspecialties), and internal medicine (without other sub-specialties) are generally considered primary care providers. Federally qualified health clinics and rural health clinics are included, as these clinics provide comprehensive primary and preventative care to underserved areas or populations. Primary care services provide a range of preventive and restorative care, and primary care providers generally coordinate all the care that a member receives.

Specialty Care Services - Specialists are medical providers who devote attention to a particular branch of medicine (i.e., any type of medical provider who is not considered a primary care provider) in which they have extensive training and education. Specialty care includes services such as cardiology, diabetes and endocrinology, optometry, and behavioral health.

Validation – The review of information, data, and procedures to determine the extent to which encounter data is accurate, reliable, free from bias, and in accord with standards for data collection and analysis.



Appendix A: Completeness - Cash Disbursement Journals (CDJs)

	March 2023	September 2023	Total
CDJ Data			
CDJ Paid Amount Total	\$2,729,440	\$824,987	\$3,554,427
Reconciling Adjustment	(\$2,140,939)	(\$660,600)	(\$2,801,538)
Net CDJ Data Paid Amount Total	\$588,501	\$164,387	\$752,888
Encounter Data			
Encounter Paid Amount Total	\$588,501	\$164,470	\$752,971
Payment Adjustments	\$0	(\$83)	(\$83)
Potential Duplicates	\$0	\$0	\$0
Net Encounter Paid Amount Total	\$588,501	\$164,387	\$752,888
Encounter Completeness Percentage	100.0%	100.0%	100.0%



Appendix B: Completeness - Sample Claims

Description						
	March 2023		September 2023		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data						
Claims Sample Total	19,397	\$1,101,354	17,422	\$1,445,367	36,819	\$2,546,721
Reconciling Adjustment	0	\$0	0	\$0	0	\$0
Net Claims Sample Total	19,397	\$1,101,354	17,422	\$1,445,367	36,819	\$2,546,721
Encounter Data						
Total Matched Encounters	19,089	\$1,101,354	16,996	\$1,445,367	36,085	\$2,546,721
Less Surplus Encounters	0	\$0	0	\$0	0	\$0
Payment Adjustments	0	\$0	0	\$0	0	\$0
Net Matched Encounters	19,089	\$1,101,354	16,996	\$1,445,367	36,085	\$2,546,721
Encounter Completeness Percentage	98.4%	100.0%	97.6%	100.0%	98.0%	100.0%



Appendix C: Accuracy - Key Data Element Matching

Key Data Element	March 2023							September 2023							Total						
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent		
Admission Date	591	591	100.0%	0	0.0%	0	0.0%	878	878	100.0%	0	0.0%	0	0.0%	1,469	1,469	100.0%	0	0.0%	0	0.0%
Bill Type (digits 1 and 2)	5,868	5,868	100.0%	0	0.0%	0	0.0%	5,292	5,292	100.0%	0	0.0%	0	0.0%	11,160	11,160	100.0%	0	0.0%	0	0.0%
Billed Charges	19,089	19,089	100.0%	0	0.0%	0	0.0%	16,996	16,996	100.0%	0	0.0%	0	0.0%	36,085	36,085	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	19,089	12,312	64.5%	6	0.0%	6,771	35.5%	16,996	10,805	63.6%	16	0.1%	6,175	36.3%	36,085	23,117	64.1%	22	0.1%	12,946	35.9%
Diagnosis Codes	13,221	13,221	100.0%	0	0.0%	0	0.0%	11,704	11,704	100.0%	0	0.0%	0	0.0%	24,925	24,925	100.0%	0	0.0%	0	0.0%
Date of Service	19,089	19,089	100.0%	0	0.0%	0	0.0%	16,996	16,996	100.0%	0	0.0%	0	0.0%	36,085	36,085	100.0%	0	0.0%	0	0.0%
DRG Codes	591	524	88.7%	67	11.3%	0	0.0%	878	620	70.6%	255	29.0%	3	0.3%	1,469	1,144	77.9%	322	21.9%	3	0.2%
Health Plan Paid Amount	19,089	19,089	100.0%	0	0.0%	0	0.0%	16,996	16,996	100.0%	0	0.0%	0	0.0%	36,085	36,085	100.0%	0	0.0%	0	0.0%
MMIS ICN	19,089	19,089	100.0%	0	0.0%	0	0.0%	16,996	16,996	100.0%	0	0.0%	0	0.0%	36,085	36,085	100.0%	0	0.0%	0	0.0%
Medicaid Member ID	19,089	19,077	99.9%	1	0.0%	11	0.1%	16,996	16,995	100.0%	0	0.0%	1	0.0%	36,085	36,072	100.0%	1	0.0%	12	0.0%
Place of Service	13,221	12,666	95.8%	0	0.0%	555	4.2%	11,704	11,394	97.4%	0	0.0%	310	2.6%	24,925	24,060	96.5%	0	0.0%	865	3.5%
Procedure Code	18,498	18,482	99.9%	16	0.1%	0	0.0%	16,118	16,106	99.9%	12	0.1%	0	0.0%	34,616	34,588	99.9%	28	0.1%	0	0.0%
Procedure Code Modifiers	18,498	18,498	100.0%	0	0.0%	0	0.0%	16,118	16,118	100.0%	0	0.0%	0	0.0%	34,616	34,616	100.0%	0	0.0%	0	0.0%
Total	185,022	177,595	96.0%	90	0.0%	7,337	4.0%	164,668	157,896	95.9%	283	0.3%	6,489	3.9%	349,690	335,491	95.9%	373	0.1%	13,826	4.0%



Appendix D: Per Member Utilization and Paid Amounts

CY 2023										
Description	BCP				GHCSCW				Percentage of BCP	
Members										
Total member Months	13,251,592				99,255				0.7%	
Average Number of Members ¹	1,104,299				8,271					
Service Type	Count	PMPY ²	Paid	PMPY ²	Count	PMPY ²	Paid	PMPY ²	Percentage Variance	
		Count	mount	Amount		Count	Count	mount	Amount	Count
Ancillary	5,247,205	4.8	\$208,628,720	\$189	18,828	2.3	\$1,066,701	\$129	-52.1%	-31.7%
Inpatient	1,985,866	1.8	\$740,109,175	\$670	12,991	1.6	\$5,620,796	\$680	-11.1%	1.5%
Outpatient	10,844,934	9.8	\$492,364,582	\$446	53,050	6.4	\$2,310,617	\$279	-34.7%	-37.4%
Primary Care	6,533,229	5.9	\$193,546,572	\$175	66,189	8.0	\$1,554,469	\$188	35.6%	7.4%
Specialty	6,694,149	6.1	\$345,279,712	\$313	45,507	5.5	\$2,173,563	\$263	-9.8%	-16.0%
Vision	789,774	0.7	\$20,684,756	\$19	2,765	0.3	\$91,972	\$11	-57.1%	-42.1%
Total Services	32,095,157	29.1	\$2,000,613,517	\$1,812	199,330	24.1	\$12,818,119	\$1,550	-17.2%	-14.5%

¹ Total member months divided by the number of months in the measurement period.

² Per member per year counts and/or paid amount divided by the average number of members.



Appendix E: Timely Payment of Claims

Sample Month	30 Days - 90%		90 Days - 99%			180 Days - 100%			Over 180 Days				Average Days
	Count	Percentage	Count	Percentage		Count	Percentage		Count	Percentage		Total	
		Absolute		Cumulative	Absolute		Cumulative	Absolute		Cumulative			
March 2023	9,527	99.5%	44	0.5%	99.9%	4	0.0%	100.0%	1	0.0%	100.0%	9,576	15
September 2023	8,064	99.2%	54	0.7%	99.8%	15	0.2%	100.0%	0	0.0%	100.0%	8,133	14
Total	17,591	99.3%	98	0.6%	99.9%	19	0.1%	100.0%	1	0.0%	100.0%	17,709	15



Appendix F: Timely Encounter Submissions

Sample Month	30 Days		60 Days			90 Days			120 Days			Over 120 Days				Total	Average Days
	Count	Percentage	Count	Percentage		Count	Percentage		Count	Percentage		Count	Percentage				
		Absolute		Cumulative	Absolute		Cumulative	Absolute		Cumulative	Absolute		Cumulative				
March 2023	9,175	95.8%	400	4.2%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	9,575	10	
September 2023	8,078	99.3%	55	0.7%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	8,133	9	
Total	17,253	97.4%	455	2.6%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	17,708	9	



Appendix G: Medical Records Validity Rate

Key Data Element	Total Elements Sampled	Supported Elements		Unsupported Elements	
		Count	Percent	Count	Percent
Member Date of Birth	120	104	86.7%	16	13.3%
Admit Date	1	1	100.0%	0	0.0%
Dates of Service	127	124	97.6%	3	2.4%
Diagnosis Codes	195	187	95.9%	8	4.1%
Billing Provider	120	115	95.8%	5	4.2%
Type of Bill Code	14	14	100.0%	0	0.0%
Revenue Code	31	31	100.0%	0	0.0%
Place of Service	106	101	95.3%	5	4.7%
Procedure Code	226	214	94.7%	12	5.3%
Procedure Modifiers	114	114	100.0%	0	0.0%
Servicing Provider	120	110	91.7%	10	8.3%
Surgical Procedure Codes	1	1	100.0%	0	0.0%
Total	1,175	1,116	95.0%	59	5.0%

Note: All of the 120 medical records requested (100%) were submitted and tested.



Health Plan Response

The health plan was provided an opportunity to submit a response to the draft report. GHCSCW stated it was not submitting a response.