

**WISCONSIN
DEPARTMENT OF
HEALTH SERVICES**

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

MHS Health Wisconsin

May 29, 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 Managed Health Services Insurance Corporation, operating as MHS Health Wisconsin (MHS). 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 MHS, to provide healthcare services such as medical, dental and vision care to enrolled members across all 72 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 **99.1%** when compared to CDJs and showed **103.0%** completeness when compared to sample claim paid amounts.
 - Medical encounters fell below the 95% threshold, **81.5%**, when compared to sample claim counts.
- **Data Accuracy**
 - The accuracy of the encounter data compared to sample claims data was **98.8%**, above the 95% threshold.

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



- Errors involved diagnosis related group (DRG) codes missing from the encounter data, missing and/or mismatching billing provider identifiers, and Medicaid Management Information System (MMIS) internal control numbers (ICNs), missing from the sample claims data.

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

- **Claims Payment Timeliness:**
 - **98.6%** of claims were paid within 30 days.
 - **99.7%** within 90 days, and
 - **99.9%** within 180 days.
 - **0.1%** exceeded the 180-day limit.
- **Encounter Submissions:**
 - **95.6%** of encounters were submitted within the required 120-day timeframe.

➤ **Medical Record Validation**

- Of the 120 medical records requested, 119 were submitted.
- A total of **99.2% of the requested records** were tested.
- Among the records reviewed, the validation rate was **94.0%**, less than the 95% threshold.

Conclusion and Recommendations

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

Some issues were noted with timeliness of encounter data submissions, and 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 Managed Health Services Insurance Corporation, operating as MHS Health Wisconsin (MHS), 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.

During the measurement period, the health plan initiated a major upgrade by converting its data integration server to a new integrated data exchange system. The conversion timeline and issues encountered are summarized below:

- May 2023: Encounter submissions were paused following the rate-setting period.
- June 2023: The new data system was launched.
- Post-Go-Live Issues:
 - Encounter submission files initially failed to process through the FAC's acceptance center and were rejected.
 - In August 2023, DHS informed the health plan that the file rejections were due to formatting errors.
 - The health plan corrected the issues and resubmitted the files.
 - Subsequently, the health plan discovered an increasing number of professional and dental encounter files receiving no FAC response.
 - DHS later identified an issue involving the loading of encounter files into the state's data warehouse.
 - The health plan conducted a comprehensive review of all encounter submissions and identified additional files that were submitted but not processed.
 - All impacted files were corrected and resubmitted in late October 2023.



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's system conversion led to temporary delays and submission errors, which were communicated to DHS in a timely manner.	The FAC should provide standardized guidance to health plans undergoing system transitions to reduce encounter data disruption risks and offer real-time technical support to health plans during system changes to expedite error resolution and ensure compliance.
2-B	Encounter files not processed by the FAC were identified through the health plan's internal audit efforts and were subsequently corrected and resubmitted.	The health plan should continue to conduct regular audits of encounter data submissions to ensure data completeness and integrity. Additionally, the health plan should implement enhanced pre-submission validation protocols to detect and resolve format-related issues before transmission to the FAC.
2-C	The health plan demonstrated accountability and transparency throughout the issue resolution process.	The health plan demonstrated appropriate internal processes, including proactive auditing and remediation efforts. The health plan should, however, establish contingency protocols for data submission during future system upgrades or conversions.

No deficiencies were identified in the health plan's ability to collect, manage, and submit encounter data. Despite challenges associated with the conversion during the review period, the health plan responded quickly, and issues were resolved effectively and in collaboration with DHS and the FAC.



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	99.1%	✓ Passed
September	99.2%	✓ Passed
Overall Average	99.1%	✓ Passed

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

The health plan did not submit separate CDJ files for dental and vision vendor data. The health plan provided a summary-level reconciliation comparing the total paid amounts reported in the MMIS encounter data with the total paid amounts reported in the delegated vendors' CDJ data for each sample month.

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 (combined March and September)

Encounter Type	Count Percentage	Paid Amount Percentage	Status (Threshold ≥ 95%)
Medical	81.5%	103.1%	✗ Failed/✓ Passed
Dental	98.3%	100.0%	✓ Passed/✓ Passed
Vision	98.5%	100.3%	✓ Passed/✓ Passed
Overall Average	82.0%	103.0%	✗ Failed/✓ Passed

Dental and vision encounters exceeded the 95% threshold. Medical encounter counts did not meet the 95% threshold and medical encounter paid amounts exceeded the threshold. Detailed results can be found in Appendix B.

Paid amount completion percentages greater than (>) 100% may indicate the following:

- Duplicate encounters
- Missing voids and/or replacement encounters
- Incomplete sample claims data

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 (combined March and September)

Encounter Type	Valid Values	Missing Values	Erroneous Values	Status (Threshold ≥ 95%)
Medical	98.8%	0.5%	0.8%	✓ Passed
Dental	98.4%	0.0%	1.6%	✓ Passed
Vision	99.4%	0.1%	0.5%	✓ Passed
Overall Average	98.8%	0.5%	0.8%	✓ 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 paid amount comparisons exceeded the 95% thresholds. Dental and vision sample claim count comparisons exceeded the threshold, and medical sample claim count comparisons were below the threshold.	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	Overages: Paid amounts over 100% in some areas suggest duplicate, replacement, and/or adjustment issues.	
3-C	Accuracy: All encounter types met or exceeded the 95% accuracy threshold. Most errors involved diagnosis related group (DRG) codes missing from the encounter data, missing and/or mismatching billing provider NPIs, and MMIS ICNs, missing from the sample claims data.	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 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 most metrics meeting or exceeding the 95% validation thresholds. A few data quality issues remain, particularly around over-reported paid amounts and 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:

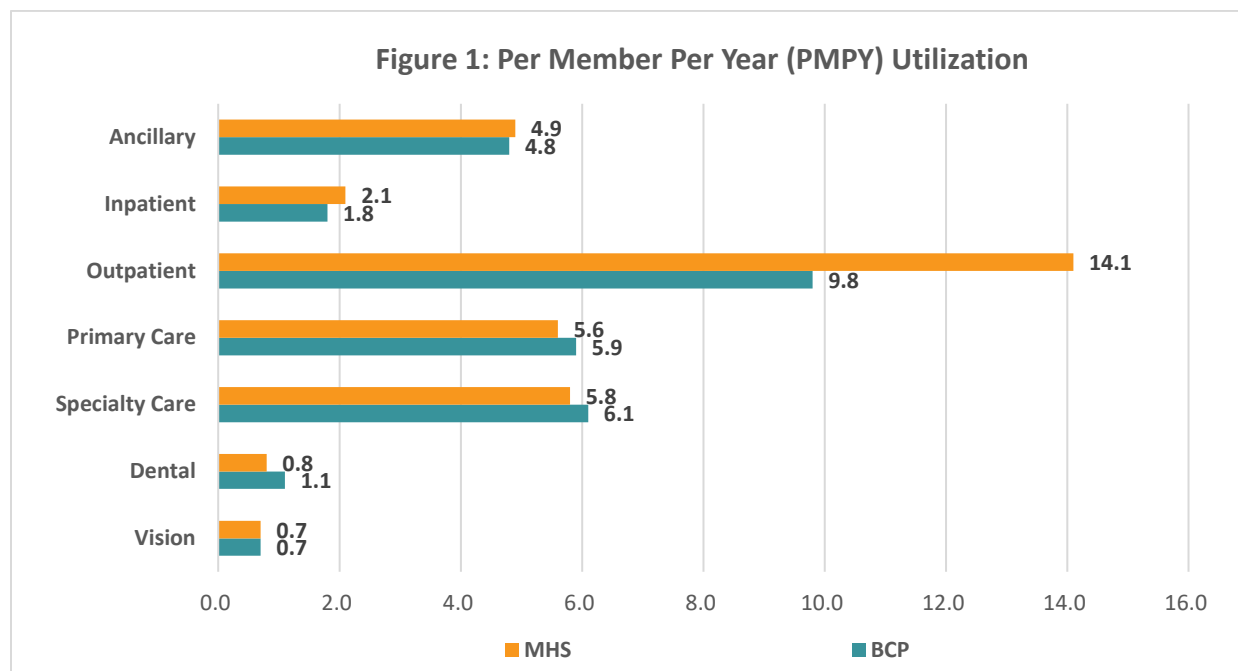
- Member utilization
- Timeliness of claims payments
- Timeliness of encounter submissions



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.



MHS's utilization rates were below BCP benchmarks across professional service categories. In contrast, utilization for institutional related services (i.e., ancillary, inpatient, and outpatient care) 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 MHS is contracted to coordinate and manage care for BCP members across all 72 counties, its enrolled members account for only 6% of the total BCP beneficiary population.

Timeliness Analysis

Timely Payment of Claims

Per the DHS contract⁷, the health plan must meet the following claim adjudication timeframes for clean claims:

- ≥ 90% within 30 days

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.

⁷ Article XV, Section D, 2, 2022-2023.



- ≥ 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.

Table 5: Claims Payment Timeliness (combined March and September)

Encounter Type	30 Days – 90%	90 Days – 99%	180 Days – 100%	Status
Medical	98.6%	99.7%	99.9%	✓ Passed
Dental	100.0%	100.0%	100.0%	✓ Passed
Vision	100.0%	100.0%	100.0%	✓ Passed
Overall Average	98.6%	99.7%	99.9%	✓ Passed

All claim types met or exceeded the DHS requirements. Detailed results can be found in Appendix E.

Timely Encounter Submissions

Per the DHS contract⁸, 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)

Encounter Type	30 Days	60 Days	90 Days	120 Days	Status
Medical	91.4%	94.7%	95.2%	95.7%	✗ Failed
Dental	83.8%	86.2%	86.2%	86.3%	✗ Failed
Vision	98.6%	99.3%	99.4%	99.4%	✗ Failed
Overall Average	91.4%	94.7%	95.1%	95.6%	✗ Failed

Encounter submissions fell below the 120-day requirement. Detailed results can be found in Appendix F.

The health plan's conversion of its data integration system may have impacted the encounter submission rates, as issues were identified with the loading of encounter files into the state's MMIS. The health plan corrected and resubmitted all impacted files. The conversion began in May 2023 and encounter corrections and resubmission took place through October 2023 (see Activity 2 section above for further explanation).

⁸ Article XII, Section D, 1, g, 2022-2023.



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 across professional service categories were lower than benchmarks and institutional services (i.e., ancillary, inpatient and outpatient care) exceeded expected levels.	The health plan should review services for potential over-utilization or benefit design differences.
3-F	Payment of Claims: All claim types were paid within contractual timeframes.	The health plan should continue monitoring claims processing and encounter submissions (including delegated vendor claim processing and/or encounter submissions) and implement automated alerts and regular audits to ensure timely payment of claims and encounter submissions and expedite resolution of FAC-rejected encounters.
3-G	Encounter submissions: Encounter submissions were below the 120-day requirement.	

The health plan demonstrated compliance in the majority of claims payment timeliness and atypical utilization patterns when benchmarked against statewide Medicaid managed care performance. Gaps with encounter submission timelines and higher than average service utilization, warrant 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-statistical⁹, 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	100.0%
Missing (not submitted)	1	0.8%
<i>Received and Tested</i>	<i>119</i>	<i>99.2%</i>

Validation

Each of the 119 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 1,141 key data elements were evaluated across the 119 medical records. The results are presented in the table below.

⁹ 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	1,141	100.0%	N/A
Unsupported	69	6.0%	X Failed
Supported	1,072	94.0%	X Failed

The 95% threshold was not met. The data elements tested and the specific results are presented in Appendix G.

The unsupported values were primarily due to missing servicing provider details and/or the absence or incorrect use of procedure modifiers 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 94% was below the required 95% threshold.	The health plan should strengthen provider training and communication 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 procedure modifiers.	The health plan should emphasize the accurate entry/inclusion of servicing provider information and correct use and documentation of procedure modifiers. The health plan should also consider establishing internal audit protocols to identify and address (potential) 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's system conversion led to temporary delays and submission errors, which were communicated to DHS in a timely manner.	The FAC should provide standardized guidance to health plans undergoing system transitions to reduce encounter data disruption risks and offer real-time technical support to health plans during system changes to expedite error resolution and ensure compliance.
2-B	Encounter files not processed by the FAC were identified through the health plan's internal audit efforts and were subsequently corrected and resubmitted.	The health plan should continue to conduct regular audits of encounter data submissions to ensure data completeness and integrity. Additionally, the health plan should implement enhanced pre-submission validation protocols to detect and resolve format-related issues before transmission to the FAC.
2-C	The health plan demonstrated accountability and transparency throughout the issue resolution process.	The health plan demonstrated appropriate internal processes, including proactive auditing and remediation efforts. The health plan should, however, establish contingency protocols for data submission during future system upgrades or conversions.
Encounter Data Analysis – Activity 3		
3-A	Completeness: CDJ and sample claim paid amount comparisons exceeded the 95% thresholds. Dental and vision sample claim count comparisons exceeded the threshold, and medical sample claim count comparisons were below the threshold.	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	Overages: Paid amounts over 100% in some areas suggest duplicate, replacement, and/or adjustment issues.	
3-C	Accuracy: All encounter types met or exceeded the 95% accuracy threshold. Most errors involved diagnosis related group (DRG) codes missing from the encounter data, missing and/or mismatching billing provider NPIs, and MMIS ICNs, missing from the sample claims data.	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 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.



Findings, Observations and Recommendations		
Findings and Observations		Recommendations
3-E	Utilization: PMPY utilization rates across professional service categories were lower than benchmarks and institutional services (i.e., ancillary, inpatient and outpatient care) exceeded expected levels.	The health plan should review services for potential over-utilization or benefit design differences.
3-F	Payment of Claims: All claim types were paid within contractual timeframes.	The health plan should continue monitoring claims processing and encounter submissions (including delegated vendor claim processing and/or encounter submissions) and implement automated alerts and regular audits to ensure timely payment of claims and encounter submissions and expedite resolution of FAC-rejected encounters.
3-G	Encounter submissions: Encounter submissions were below the 120-day requirement.	
Medical Records Review – Activity 4		
4-A	The overall supported rate of 94% was below the required 95% threshold.	The health plan should strengthen provider training and communication 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 procedure modifiers.	The health plan should emphasize the accurate entry/inclusion of servicing provider information and correct use and documentation of procedure modifiers. The health plan should also consider establishing internal audit protocols to identify and address (potential) 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	\$15,226,346	\$10,622,947	\$25,849,293
Reconciling Adjustment	(\$3,383)	(\$4,909)	(\$8,292)
Net CDJ Data Paid Amount Total	\$15,222,962	\$10,618,039	\$25,841,001
Encounter Data			
Encounter Paid Amount Total	\$20,720,690	\$15,922,934	\$36,643,624
Payment Adjustments	(\$5,165,669)	(\$5,143,918)	(\$10,309,586)
Potential Duplicates	(\$476,585)	(\$242,682)	(\$719,267)
Net Encounter Paid Amount Total	\$15,078,436	\$10,536,334	\$25,614,771
Encounter Completeness Percentage	99.1%	99.2%	99.1%



Appendix B: Completeness - Sample Claims

Description	Medical						Dental					
	March 2023		September 2023		Total		March 2023		September 2023		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	295,197	\$13,345,513	244,842	\$12,048,973	540,039	\$25,394,487	4,821	\$219,993	4,559	\$211,144	9,380	\$431,138
Reconciling Adjustment(s)	0	\$0	0	\$0	0	\$0	(1)	\$0	(4)	\$0	(5)	\$0
Net Claims Sample Total	295,197	\$13,345,513	244,842	\$12,048,973	540,039	\$25,394,487	4,820	\$219,993	4,555	\$211,144	9,375	\$431,138
Encounter Data												
Total Matched Encounters	253,142	\$14,875,888	204,439	\$12,135,450	457,581	\$27,011,338	4,761	\$220,293	4,487	\$211,087	9,248	\$431,380
Less Surplus Encounters	(8,985)	(\$409,855)	(8,277)	(\$427,405)	(17,262)	(\$837,260)	(18)	(\$300)	(10)	(\$92)	(28)	(\$392)
Payment Adjustments	0	\$15,301	0	(\$4,702)	0	\$10,600	0	\$0	0	\$0	0	\$0
Net Matched Encounters	244,157	\$14,481,334	196,162	\$11,703,344	440,319	\$26,184,678	4,743	\$219,993	4,477	\$210,995	9,220	\$430,988
Encounter Completeness Percentage	82.7%	108.5%	80.1%	97.1%	81.5%	103.1%	98.4%	100.0%	98.3%	99.9%	98.3%	100.0%



Description	Vision						Total					
	March 2023		September 2023		Total		March 2023		September 2023		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	3,835	\$80,086	3,634	\$68,460	7,469	\$148,546	303,853	\$13,645,593	253,035	\$12,328,577	556,888	\$25,974,170
Reconciling Adjustment	(231)	(\$65)	(281)	(\$1,579)	(512)	(\$1,644)	(232)	(\$65)	(285)	(\$1,579)	(517)	(\$1,644)
Net Claims Sample Total	3,604	\$80,021	3,353	\$66,881	6,957	\$146,902	303,621	\$13,645,528	252,750	\$12,326,998	556,371	\$25,972,526
Encounter Data												
Total Matched Encounters	3,610	\$84,879	3,251	\$71,048	6,861	\$155,926	261,513	\$15,181,060	212,177	\$12,417,584	473,690	\$27,598,644
Less Surplus Encounters	(6)	(\$113)	0	\$0	(6)	(\$113)	(9,009)	(\$410,268)	(8,287)	(\$427,497)	(17,296)	(\$837,764)
Payment Adjustments	0	(\$4,745)	0	(\$3,696)	0	(\$8,440)	0	\$10,557	0	(\$8,397)	0	\$2,160
Net Matched Encounters	3,604	\$80,021	3,251	\$67,352	6,855	\$147,373	252,504	\$14,781,349	203,890	\$11,981,691	456,394	\$26,763,040
Encounter Completeness Percentage	100.0%	100.0%	97.0%	100.7%	98.5%	100.3%	83.2%	108.3%	80.7%	97.2%	82.0%	103.0%



Appendix C: Accuracy - Key Data Element Matching

Medical																					
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	10,377	10,125	97.6%	252	2.4%	0	0.0%	8,398	8,352	99.5%	46	0.5%	0	0.0%	18,775	18,477	98.4%	298	1.6%	0	0.0%
Bill Type (digits 1 and 2)	115,844	115,844	100.0%	0	0.0%	0	0.0%	102,712	102,712	100.0%	0	0.0%	0	0.0%	218,556	218,556	100.0%	0	0.0%	0	0.0%
Billed Charges	253,142	253,142	100.0%	0	0.0%	0	0.0%	204,439	204,439	100.0%	0	0.0%	0	0.0%	457,581	457,581	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	253,142	241,632	95.5%	9,551	3.8%	1,959	0.8%	204,439	196,273	96.0%	7,052	3.4%	1,114	0.5%	457,581	437,905	95.7%	16,603	3.6%	3,073	0.7%
Diagnosis Codes	137,298	137,298	100.0%	0	0.0%	0	0.0%	101,727	101,727	100.0%	0	0.0%	0	0.0%	239,025	239,025	100.0%	0	0.0%	0	0.0%
Date of Service	253,142	253,140	100.0%	0	0.0%	2	0.0%	204,439	204,439	100.0%	0	0.0%	0	0.0%	457,581	457,579	100.0%	0	0.0%	2	0.0%
DRG Codes	10,377	7,794	75.1%	1,906	18.4%	677	6.5%	8,398	5,919	70.5%	2,181	26.0%	298	3.5%	18,775	13,713	73.0%	4,087	21.8%	975	5.2%
Health Plan Paid Amount	253,142	251,928	99.5%	0	0.0%	1,214	0.5%	204,439	202,339	99.0%	0	0.0%	2,100	1.0%	457,581	454,267	99.3%	0	0.0%	3,314	0.7%
MMIS ICN	253,142	228,175	90.1%	0	0.0%	24,967	9.9%	204,439	204,419	100.0%	0	0.0%	20	0.0%	457,581	432,594	94.5%	0	0.0%	24,987	5.5%
Medicaid Member ID	253,142	252,913	99.9%	0	0.0%	229	0.1%	204,439	204,300	99.9%	0	0.0%	139	0.1%	457,581	457,213	99.9%	0	0.0%	368	0.1%
Place of Service	137,298	137,298	100.0%	0	0.0%	0	0.0%	101,727	101,727	100.0%	0	0.0%	0	0.0%	239,025	239,025	100.0%	0	0.0%	0	0.0%
Procedure Code	242,765	242,763	100.0%	0	0.0%	2	0.0%	196,041	196,041	100.0%	0	0.0%	0	0.0%	438,806	438,804	100.0%	0	0.0%	2	0.0%
Procedure Code Modifiers	242,765	242,504	99.9%	0	0.0%	261	0.1%	196,041	195,681	99.8%	0	0.0%	360	0.2%	438,806	438,185	99.9%	0	0.0%	621	0.1%
Total	2,415,576	2,374,556	98.3%	11,709	0.5%	29,311	1.2%	1,941,678	1,928,368	99.3%	9,279	0.6%	4,031	0.2%	4,357,254	4,302,924	98.8%	20,988	0.5%	33,342	0.8%



Dental																		
Key Data Element	March 2023						September 2023						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		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	Count	Percent
Billed Charges	4,761	100.0%	0	0.0%	0	0.0%	4,487	100.0%	0	0.0%	0	0.0%	9,248	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	4,078	85.7%	0	0.0%	683	14.3%	3,767	84.0%	0	0.0%	720	16.0%	7,845	84.8%	0	0.0%	1,403	15.2%
Date of Service	4,753	99.8%	0	0.0%	8	0.2%	4,474	99.7%	0	0.0%	13	0.3%	9,227	99.8%	0	0.0%	21	0.2%
Health Plan Paid Amount	4,761	100.0%	0	0.0%	0	0.0%	4,487	100.0%	0	0.0%	0	0.0%	9,248	100.0%	0	0.0%	0	0.0%
MMIS ICN	4,761	100.0%	0	0.0%	0	0.0%	4,484	99.9%	0	0.0%	3	0.1%	9,245	100.0%	0	0.0%	3	0.0%
Medicaid Member ID	4,752	99.8%	0	0.0%	9	0.2%	4,467	99.6%	0	0.0%	20	0.4%	9,219	99.7%	0	0.0%	29	0.3%
Place of Service	4,761	100.0%	0	0.0%	0	0.0%	4,487	100.0%	0	0.0%	0	0.0%	9,248	100.0%	0	0.0%	0	0.0%
Procedure Code	4,761	100.0%	0	0.0%	0	0.0%	4,484	99.9%	0	0.0%	3	0.1%	9,245	100.0%	0	0.0%	3	0.0%
Tooth Number	4,760	100.0%	N/A		1	0.0%	4,487	100.0%	N/A		0	0.0%	9,247	100.0%	N/A		1	0.0%
Tooth Surface	4,737	99.5%	N/A		24	0.5%	4,487	100.0%	N/A		0	0.0%	9,224	99.7%	N/A		24	0.3%
Total	46,885	98.5%	0	0.0%	725	1.5%	44,111	98.3%	0	0.0%	759	1.7%	90,996	98.4%	0	0.0%	1,484	1.6%
Total Records in the Encounter Dataset	4,761							4,487							9,248			
Number of Key Data Element Evaluated	10							10							10			
Maximum Count	47,610	100.0%							44,870	100.0%							92,480	100.0%



Vision																		
Key Data Element	March 2023						September 2023						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		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	Count	Percent
Billed Charges	3,610	100.0%	0	0.0%	0	0.0%	3,251	100.0%	0	0.0%	0	0.0%	6,861	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	3,497	96.9%	0	0.0%	113	3.1%	3,062	94.2%	55	1.7%	134	4.1%	6,559	95.6%	55	0.8%	247	3.6%
Diagnosis Codes	3,610	100.0%	0	0.0%	0	0.0%	3,251	100.0%	0	0.0%	0	0.0%	6,861	100.0%	0	0.0%	0	0.0%
Date of Service	3,610	100.0%	0	0.0%	0	0.0%	3,251	100.0%	0	0.0%	0	0.0%	6,861	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	3,599	99.7%	0	0.0%	11	0.3%	3,243	99.8%	0	0.0%	8	0.2%	6,842	99.7%	0	0.0%	19	0.3%
MMIS ICN	3,536	98.0%	0	0.0%	74	2.0%	3,251	100.0%	0	0.0%	0	0.0%	6,787	98.9%	0	0.0%	74	1.1%
Medicaid Member ID	3,610	100.0%	0	0.0%	0	0.0%	3,251	100.0%	0	0.0%	0	0.0%	6,861	100.0%	0	0.0%	0	0.0%
Place of Service	3,610	100.0%	0	0.0%	0	0.0%	3,250	100.0%	0	0.0%	1	0.0%	6,860	100.0%	0	0.0%	1	0.0%
Procedure Code	3,610	100.0%	0	0.0%	0	0.0%	3,251	100.0%	0	0.0%	0	0.0%	6,861	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	3,610	100.0%	N/A		0	0.0%	3,251	100.0%	N/A		0	0.0%	6,861	100.0%	N/A		0	0.0%
Total	35,902	99.5%	0	0.0%	198	0.5%	32,312	99.4%	55	0.2%	143	0.4%	68,214	99.4%	55	0.1%	341	0.5%
Total Records in the Encounter Dataset	3,610						3,251						6,861					
Number of Key Data Element Evaluated	10						10						10					
Maximum Count	36,100	100.0%						32,510	100.0%				68,610	100.0%				



Total																					
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	10,377	10,125	97.6%	252	2.4%	0	0.0%	8,398	8,352	99.5%	46	0.5%	0	0.0%	18,775	18,477	98.4%	298	1.6%	0	0.0%
Bill Type (digits 1 and 2)	115,844	115,844	100.0%	0	0.0%	0	0.0%	102,712	102,712	100.0%	0	0.0%	0	0.0%	218,556	218,556	100.0%	0	0.0%	0	0.0%
Billed Charges	261,513	261,513	100.0%	0	0.0%	0	0.0%	212,177	212,177	100.0%	0	0.0%	0	0.0%	473,690	473,690	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	261,513	249,207	95.3%	9,551	3.7%	2,755	1.1%	212,177	203,102	95.7%	7,107	3.3%	1,968	0.9%	473,690	452,309	95.5%	16,658	3.5%	4,723	1.0%
Diagnosis Codes	140,908	140,908	100.0%	0	0.0%	0	0.0%	104,978	104,978	100.0%	0	0.0%	0	0.0%	245,886	245,886	100.0%	0	0.0%	0	0.0%
Date of Service	261,513	261,503	100.0%	0	0.0%	10	0.0%	212,177	212,164	100.0%	0	0.0%	13	0.0%	473,690	473,667	100.0%	0	0.0%	23	0.0%
DRG Codes	10,377	7,794	75.1%	1,906	18.4%	677	6.5%	8,398	5,919	70.5%	2,181	26.0%	298	3.5%	18,775	13,713	73.0%	4,087	21.8%	975	5.2%
Health Plan Paid Amount	261,513	260,288	99.5%	0	0.0%	1,225	0.5%	212,177	210,069	99.0%	0	0.0%	2,108	1.0%	473,690	470,357	99.3%	0	0.0%	3,333	0.7%
MMIS ICN	261,513	236,472	90.4%	0	0.0%	25,041	9.6%	212,177	212,154	100.0%	0	0.0%	23	0.0%	473,690	448,626	94.7%	0	0.0%	25,064	5.3%
Medicaid Member ID	261,513	261,275	99.9%	0	0.0%	238	0.1%	212,177	212,018	99.9%	0	0.0%	159	0.1%	473,690	473,293	99.9%	0	0.0%	397	0.1%
Place of Service	145,669	145,669	100.0%	0	0.0%	0	0.0%	109,465	109,464	100.0%	0	0.0%	1	0.0%	255,134	255,133	100.0%	0	0.0%	1	0.0%
Procedure Code	251,136	251,134	100.0%	0	0.0%	2	0.0%	203,779	203,776	100.0%	0	0.0%	3	0.0%	454,915	454,910	100.0%	0	0.0%	5	0.0%
Procedure Code Modifiers	246,375	246,114	99.9%	0	0.0%	261	0.1%	199,292	198,932	99.8%	0	0.0%	360	0.2%	445,667	445,046	99.9%	0	0.0%	621	0.1%
Tooth Number	4,761	4,760	100.0%	0	0.0%	1	0.0%	4,487	4,487	100.0%	0	0.0%	0	0.0%	9,248	9,247	100.0%	0	0.0%	1	0.0%
Tooth Surface	4,761	4,737	99.5%	0	0.0%	24	0.5%	4,487	4,487	100.0%	0	0.0%	0	0.0%	9,248	9,224	99.7%	0	0.0%	24	0.3%
Total	2,489,764	2,447,846	98.3%	11,709	0.5%	30,209	1.2%	2,010,084	1,995,817	99.3%	9,334	0.6%	4,933	0.2%	4,499,848	4,443,663	98.8%	21,043	0.5%	35,142	0.8%



Appendix D: Per Member Utilization and Paid Amounts

CY 2023											
Description	BCP				MHS				Percentage of BCP		
Members											
Total member Months	13,251,592				795,108				6.0%		
Average Number of Members ¹	1,104,299				66,259						
Service Type	Count	PMPY ²	Paid	PMPY ²	Count	PMPY ²	Paid	PMPY ²	Percentage Variance		
		Count	mount	Amount		Count	Count	mount	Amount	Count	Paid Amount
Ancillary	5,247,205	4.8	\$208,628,720	\$189	325,556	4.9	\$11,963,342	\$181	2.1%	-4.2%	
Dental	1,169,823	1.1	\$57,385,450	\$52	50,208	0.8	\$2,410,324	\$36	-27.3%	-30.8%	
Inpatient	1,985,866	1.8	\$740,109,175	\$670	139,552	2.1	\$52,009,828	\$785	16.7%	17.2%	
Outpatient	10,844,934	9.8	\$492,364,582	\$446	932,109	14.1	\$40,600,943	\$613	43.9%	37.4%	
Primary Care	6,533,229	5.9	\$193,546,572	\$175	372,106	5.6	\$10,897,651	\$164	-5.1%	-6.3%	
Specialty	6,694,149	6.1	\$345,279,712	\$313	384,317	5.8	\$17,763,334	\$268	-4.9%	-14.4%	
Vision	789,774	0.7	\$20,684,756	\$19	45,257	0.7	\$1,258,460	\$19	0.0%	0.0%	
Total Services	33,264,980	30.2	\$2,057,998,967	\$1,864	2,249,105	34.0	\$136,903,883	\$2,066	12.6%	10.8%	

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

March 2023													
Encounter Type	30 Days - 90%		90 Days - 99%			180 Days - 100%			Over 180 Days			Average Days	
	Count	Percentage	Count	Percentage		Count	Percentage		Count	Percentage			
		Absolute		Absolute	Cumulative		Absolute	Cumulative		Absolute	Cumulative		Total
Medical	93,887	98.1%	1,537	1.6%	99.7%	113	0.1%	99.8%	169	0.2%	100.0%	95,706	10
Dental	1,271	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	1,271	7
Vision	1,260	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	1,260	10
Total	96,418	98.1%	1,537	1.6%	99.7%	113	0.1%	99.8%	169	0.2%	100.0%	98,237	9

September 2023													
Encounter Type	30 Days - 90%		90 Days - 99%			180 Days - 100%			Over 180 Days			Average Days	
	Count	Percentage	Count	Percentage		Count	Percentage		Count	Percentage			
		Absolute		Absolute	Cumulative		Absolute	Cumulative		Absolute	Cumulative		Total
Medical	76,150	99.2%	414	0.5%	99.7%	165	0.2%	99.9%	59	0.1%	100.0%	76,788	9
Dental	1,154	99.9%	1	0.1%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	1,155	7
Vision	1,148	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	1,148	10
Total	78,452	99.2%	415	0.5%	99.7%	165	0.2%	99.9%	59	0.1%	100.0%	79,091	9

Total													
Encounter Type	30 Days - 90%		90 Days - 99%			180 Days - 100%			Over 180 Days			Average Days	
	Count	Percentage	Count	Percentage		Count	Percentage		Count	Percentage			
		Absolute		Absolute	Cumulative		Absolute	Cumulative		Absolute	Cumulative		Total
Medical	170,037	98.6%	1,951	1.1%	99.7%	278	0.2%	99.9%	228	0.1%	100.0%	172,494	9
Dental	2,425	100.0%	1	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	2,426	7
Vision	2,408	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	2,408	10
Total	174,870	98.6%	1,952	1.1%	99.7%	278	0.2%	99.9%	228	0.1%	100.0%	177,328	9



Appendix F: Timely Encounter Submissions

March 2023																
Encounter Type	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		Absolute	Cumulative		Absolute	Cumulative		Absolute	Cumulative		Absolute	Cumulative		
Medical	84,496	88.3%	5,278	5.5%	93.8%	419	0.4%	94.2%	470	0.5%	94.7%	5,043	5.3%	100.0%	95,706	25
Dental	1,075	84.6%	51	4.0%	88.6%	0	0.0%	88.6%	1	0.1%	88.7%	144	11.3%	100.0%	1,271	52
Vision	1,238	98.3%	10	0.8%	99.0%	1	0.1%	99.1%	0	0.0%	99.1%	11	0.9%	100.0%	1,260	11
Total	86,809	88.4%	5,339	5.4%	93.8%	420	0.4%	94.2%	471	0.5%	94.7%	5,198	5.3%	100.0%	98,237	25

September 2023																
Encounter Type	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		Absolute	Cumulative		Absolute	Cumulative		Absolute	Cumulative		Absolute	Cumulative		
Medical	73,119	95.2%	511	0.7%	95.9%	375	0.5%	96.4%	357	0.5%	96.8%	2,426	3.2%	100.0%	76,788	19
Dental	957	82.9%	8	0.7%	83.5%	1	0.1%	83.6%	1	0.1%	83.7%	188	16.3%	100.0%	1,155	37
Vision	1,136	99.0%	8	0.7%	99.7%	0	0.0%	99.7%	1	0.1%	99.7%	3	0.3%	100.0%	1,148	8
Total	75,212	95.1%	527	0.7%	95.8%	376	0.5%	96.2%	359	0.5%	96.7%	2,617	3.3%	100.0%	79,091	19

Total																
Encounter Type	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			
Medical	157,615	91.4%	5,789	3.4%	94.7%	794	0.5%	95.2%	827	0.5%	95.7%	7,469	4.3%	100.0%	172,494	22
Dental	2,032	83.8%	59	2.4%	86.2%	1	0.0%	86.2%	2	0.1%	86.3%	332	13.7%	100.0%	2,426	45
Vision	2,374	98.6%	18	0.7%	99.3%	1	0.0%	99.4%	1	0.0%	99.4%	14	0.6%	100.0%	2,408	9
Total	162,021	91.4%	5,866	3.3%	94.7%	796	0.4%	95.1%	830	0.5%	95.6%	7,815	4.4%	100.0%	177,328	23



Appendix G: Medical Records Validity Rate

Key Data Element	Total Elements Sampled	Supported Elements		Unsupported Elements	
		Count	Percent	Count	Percent
Member Date of Birth	119	111	93.3%	8	6.7%
Admit Date	1	1	100.0%	0	0.0%
Date of Service - First	119	117	98.3%	2	1.7%
Diagnosis Codes	176	167	94.9%	9	5.1%
Billing Provider	119	112	94.1%	7	5.9%
Type of Bill Code	18	18	100.0%	0	0.0%
Revenue Code	22	22	100.0%	0	0.0%
Place of Service	101	98	97.0%	3	3.0%
Procedure Code	211	199	94.3%	12	5.7%
Procedure Modifiers	131	117	89.3%	14	10.7%
Servicing Provider	119	107	89.9%	12	10.1%
Surgical Procedure Codes	3	3	100.0%	0	0.0%
Tooth Number	2	0	0.0%	2	100.0%
Total	1,141	1,072	94.0%	69	6.0%

Note: 119 of the 120 medical records requested (99.2%) were submitted and tested.



Health Plan Response

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