



**MYERS AND  
STAUFFER** LC  
CERTIFIED PUBLIC ACCOUNTANTS

May 15, 2026

Via Electronic Mail

Nebraska Department of Health and Human Services  
Jeremey Brunssen, Deputy Director- Finance and Program Integrity  
301 Centennial Mall South, Lincoln, Nebraska

Re: External Quality Review Validation of Heritage Health Encounter Data

This letter is to inform you that Myers and Stauffer LC has completed the CMS External Quality Review Protocol 5 engagement, Validation of Encounter Data for the period ended December 31, 2024. Molina Healthcare of Nebraska Inc. management declined to provide a formal response to our findings. Therefore, no management responses are included in this report.

Please contact us at the phone number below if you have questions.

Kind Regards,

Myers and Stauffer LC



STATE OF NEBRASKA DEPARTMENT  
OF HEALTH AND HUMAN SERVICES

# **Molina Healthcare of Nebraska Inc**

**External Quality Review Validation of Heritage Health  
Encounter Data of Medicaid Managed Care Entities  
Submission of Findings**

April 13, 2026

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# Executive Summary

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The Nebraska Department of Health and Human Services (DHHS, or “State”), Division of Medicaid and Long-Term Care (MLTC) engaged Myers and Stauffer to perform CMS’ External Quality Review (EQR) Protocol 5, *Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*, to evaluate the completeness and accuracy of the supplemental claims data submitted by Molina Healthcare of Nebraska Inc (Molina or health plan), and used for rate setting for the State’s Medicaid managed care program, Heritage Health. The health plan’s calendar year (CY) 2024 supplemental claims data submitted to Optumas, the State’s actuary, was reviewed for completeness and accuracy. The health plan submitted the following for our validation procedures:

- A sample of two months of cash disbursement journals (CDJs), May 2024 and October 2024, which included payment dates and amounts paid by the health plan to providers.
- Sample claims data which included transactions with payment/adjudication dates within two selected sample months, May 2024 and October 2024.
- Medical records for review, which were random samples from the supplemental claims data with dates of service occurring during CY 2024. A sample of 120 medical records was selected and sent to the health plan for retrieval and submission.

In addition to the data provided by the health plan, Optumas provided the following data:

- A copy of the supplemental claims data submitted to Optumas by the health plan for calendar year 2024, which contained all data received through May 31, 2025.
- A copy of the encounter data extract Optumas received from Healthinteractive (HIA), which included encounters received and processed through May 31, 2025, which was used for informational purposes only in Activities 1 and 2 for this report.

A 95% completeness, accuracy, and validity threshold was used for comparing the supplemental claims data to the CDJs, sample claims data and medical records submitted by the health plan. The 95% percent threshold was established in discussions with the DHHS at the outset of the engagement. Additionally, we compared claims payment dates to the contractual requirements set forth in the Medicaid managed care contract between DHHS and the health plan. Per contract Section V.S.:

### *3. Claims Processing*

*a. Except for claims from pharmacy providers, the MCO must ensure that all provider claims are processed according to the following timeframes:*

*i. Within five business days of receipt of a claim, the MCO must provide an initial screening and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.*

*ii. Process and pay or deny, as appropriate, a minimum of 90% of all clean claims for medical services provided to member within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the claim.*

*iii. Process and pay or deny, as appropriate, a minimum of 99% of all clean claims for medical services provided to members within 60 calendar days of the date of receipt.*

*iv. Fully adjudicate (pay or deny) all other claims within six months of the date of receipt.*

*b. For pharmacy providers, the MCO must establish, at a minimum, a weekly payment cycle so that a minimum of 90% of all claims from pharmacy providers for covered services are paid within seven calendar days of receipt and 99% of all clean claims are paid within 14 calendar days of receipt, except to the extent the providers have agreed to an alternative payment schedule set forth in the provider contract. Any alternative payment schedules must be reported to MLTC within three business days of their implementation.*

We used the guidelines established in 3(a)(ii) through 3(a)(iv) to establish the parameters of our analysis, including the analysis of pharmacy claims, due to the exception language in 3(b) “except to the extent the providers have agreed to an alternative payment schedule”. Due to the volume of pharmacy providers, it was infeasible to identify which pharmacy providers were excluded from the requirement; therefore, the 99% threshold of pharmacy claims processed within 15 business days was used.

Our work was performed 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 audit, examination, or review services. We express no opinion or conclusion related to the procedures performed or the information and documentation we reviewed. In addition, our engagement was not specifically designed for, and should not be relied on, to disclose errors, fraud, or other illegal acts that may exist.

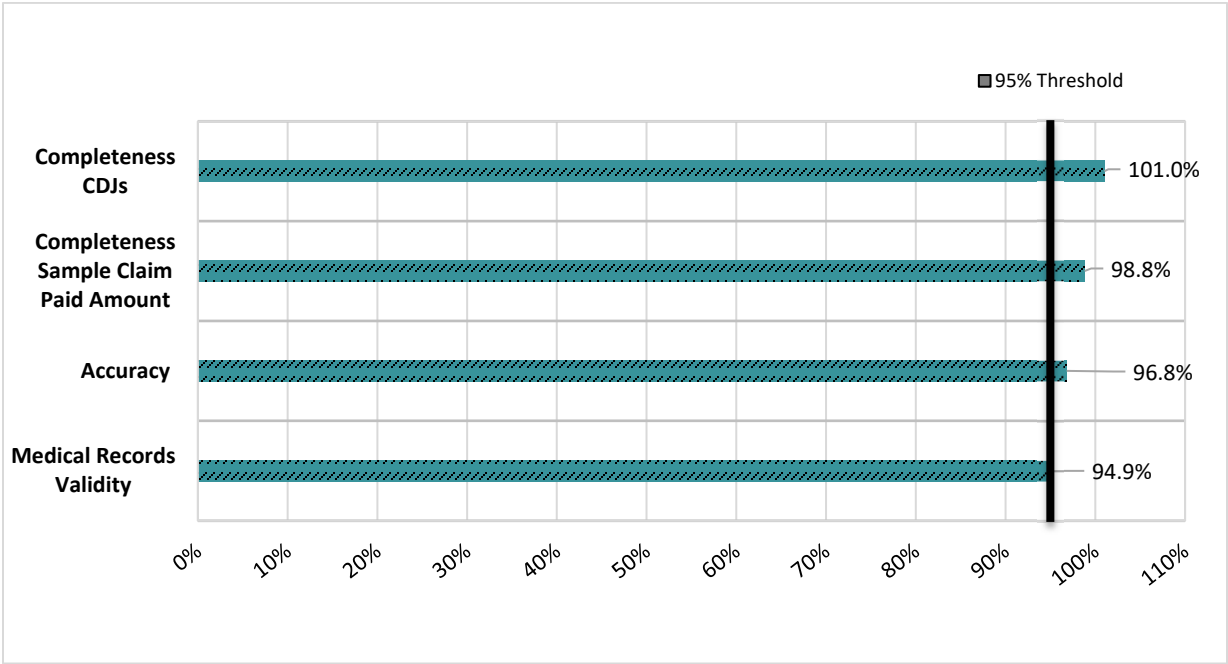
Observations and findings are based on the information provided and known at the time of the review. The health plan should work with DHHS, HIA, and/or Optumas to resolve issues noted within the supplemental claims data or the encounter data.

# Findings

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

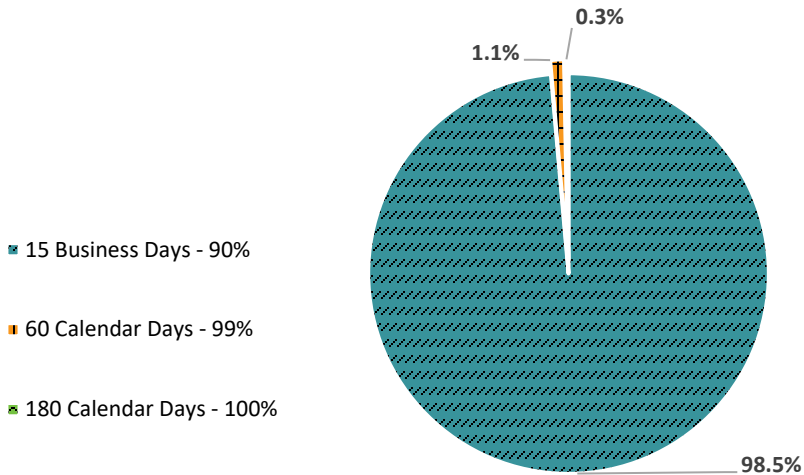
- **Completeness:** The aggregate CDJ completion percentage was over 100 percent (101.0%) and sample claim paid amount completion percentage was above the 95% threshold (98.8%).
- **Accuracy:** The overall accuracy percentage was 96.8% for all claim types and all key data elements reviewed.
- **Medical Record Validation Rates:** Of the 120 medical records requested, 114 were submitted for review. The validation rate for the medical records tested was below the 95% threshold (94.9%).

Figure 1: Bar chart illustrating the completion percentages compared against the 95 percent threshold in evaluated areas listed above.



➤ **Timeliness:** The health plan paid 98.5% of claims to providers within 15 business days, exceeding the threshold of 90%. The health plan exceeded the 99% threshold of paying of claims to providers within 60 calendar days at 99.6%.

Figure 2: Time Claims Payments



We have made recommendations within the report related to the findings and weaknesses identified within the CY 2024 supplemental claims data. These recommendations are intended to improve the integrity of the supplemental claims data that is being used for rate setting purposes. A detailed summary of our findings can be found in the Activity 5 section of the report. The report also includes appendices which provide the detailed analyses supporting the counts, amounts and percentage values reflected in the report.

# Introduction

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Most of Nebraska’s Medicaid and Children’s Health Insurance Program (CHIP) receive health care services through Heritage Health, Nebraska’s Medicaid managed care program. Nebraska Medicaid’s combines physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated program for the state’s Medicaid and Medicaid expansion enrollees. Heritage Health members enroll in one of three statewide health plans to receive their health care benefits<sup>1</sup>.

The Centers for Medicare & Medicaid Services (CMS) established requirements for states to improve the reliability of encounter data collected from managed care health plans. In 2016, the Medicaid managed care final rule implemented a requirement for states to conduct an independent audit of encounter data reported by each managed care health plan at least once every three years. Revisions to the Medicaid managed care regulations in 2020 and 2024 enhanced quality oversight criteria. Under the current Medicaid managed care final rule, encounter data must include allowed and paid amounts and states must annually post on its website health plans that are exempt from external quality review<sup>2</sup>.

CMS indicated that states could meet the independent audit requirement by conducting an encounter data validation study based on EQR Protocol 5<sup>3</sup> (Protocol 5). Protocol 5 assesses the completeness and accuracy of the encounter data that has been adjudicated (i.e., paid or denied) by the health plan and submitted to the State. Although Protocol 5 is a voluntary protocol, CMS strongly encourages states to contract with qualified entities to implement Protocol 5 to meet the audit requirement of the final rule. States may be at risk for loss of federal financial participation/reimbursement if the encounter data is incomplete and/or inaccurate.

Encounter data validation assists states in reaching the goals of transparency and payment reform to support its efforts in quality measurement and improvement. The Medicaid managed care final rule (final rule) strengthens the requirements for state monitoring of managed care programs. Under the final rule, each state Medicaid agency must have a monitoring system that addresses all aspects of the state’s managed care program<sup>4</sup>. Additionally, states are required to provide accurate encounter data to the actuaries, as well as to CMS, as part of the Transformed Medicaid Statistical Information System (T-MSIS) project. Protocol 5 enables states to meet these data validation and monitoring requirements. Protocol 5 evaluates state/department policies, as well as the policies, procedures, and systems of the health plan, and assists states in gauging utilization, identifying potential gaps in services, evaluating

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<sup>1</sup> [Nebraska Dept. of Health and Human Services Heritage Health](#)

<sup>2</sup> [Medicaid & Children’s Health Insurance Program \(CHIP\) Managed Care Final Rule – CMS-2408-F](#)

<sup>3</sup> 81 Federal Regulation 27,489, 27,603 (May 6, 2016)

<sup>4</sup> [Electronic Code of Federal Regulations](#)

program effectiveness, and identifying strengths and opportunities to enhance oversight.

The State of Nebraska's data warehouse, HealthInteractive (HIA), went live in November 2020 to house the Medicaid encounter data from the Heritage Health Plans. The State is in the process of working through known issues with the encounter submission process prior to utilizing the data from the system for rate setting purposes. In order to calculate the 2024 capitation rates, supplemental claims data was provided by the health plans to Optumas for this purpose. The supplemental claims data included final claims with dates of service occurring during calendar year (CY) 2024 and paid through May 31, 2025.

The Nebraska Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care (MLTC) engaged Myers and Stauffer LC (Myers and Stauffer) to perform Protocol 5 to evaluate the completeness and accuracy of the supplemental claims data submitted by Molina for CY 2024 for the State's Medicaid managed care program. CMS guidelines were followed and implemented during the review.

Our work was performed in accordance with American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform audit, examination, or review services. We express no opinion or conclusion related to the procedures performed or the information and documentation we reviewed. In addition, our engagement was not specifically designed for, and should not be relied upon, to disclose errors, fraud, or other illegal acts that may exist.

For each activity, a summary of results and observations are presented along with detailed analysis. Observations and findings are based on the information provided, interviews with subject matter experts, and known data limitations at the time of the review. The recommendations and findings within this report provide an opportunity for the health plan to review its processes to ensure information and data submitted to the State and the State's actuary is complete and accurate. The expectation is for the health plan to work with DHHS and its actuary to resolve issues noted within the supplemental claims data or the encounter data.

# Activity 1: Review State Requirements

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The purpose of Activity 1 is to review information about the State's requirements for collecting and submitting encounter data. This review determines whether additional or updated requirements are needed to ensure encounter data is complete and accurate. DHHS provided Myers and Stauffer with the state-required items (as listed in Protocol 5), as well as acceptable error rates and accuracy and completeness thresholds.

In addition to reviewing the State's requirements, DHHS's contract with the health plan was reviewed in detail. Myers and Stauffer also met with DHHS representatives regularly. Bi-weekly status meetings scheduled with DHHS ensured that our understanding of policies, processes and systems was accurate.

Findings identified based on the work performed are summarized below along with recommendations for DHHS.

## Findings and Recommendations

No deficiencies were identified in the state requirements around the ability to collect, manage, and store encounter data.

## Activity 2: Review Health Plan Capability

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The health plan's information system and controls were evaluated to determine its ability to collect and submit complete and accurate encounter data. Additionally, discussions with the health plan were held about the supplemental claims data that was submitted to Optumas. A survey was developed, requested documentation was reviewed, and interviews were conducted with health plan personnel to gain an understanding of the health plan's structure and processes. The survey and personnel interviews included questions related to claims processing, data submissions of both encounter and supplemental claims data, enrollment, data systems controls and mechanisms<sup>5</sup>. The requested documentation supported workflows, policies and procedures, and organizational structures.

Findings based on the work performed are summarized below along with recommendations for DHHS and the health plan.

### Findings and Recommendations

No deficiencies were identified in the health plan's ability to collect, manage, and submit encounter data.

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<sup>5</sup> Questions found in [Appendix V, attachment B of the Validation of Encounter Data](#) protocol were included in the survey.

# Activity 3: Analyze Electronic Encounter Data

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Activity 3 determines the validity of the encounter data submitted to the State and requires verifying its completeness and accuracy. Nebraska utilizes the supplemental claims data provided to the actuary, Optumas, as the primary source for rate setting and this data was the primary focus of the EQR review. Health plan-submitted cash disbursement journals (CDJs) and sample claims data were compared to the supplemental claims data submitted to Optumas to determine the supplemental claims data's integrity (i.e., completeness and accuracy). Statistical analyses and data distribution reviews were also conducted to validate the accuracy and completeness of the supplemental claims data.

The health plan contracted with third-party vendors to administer its dental, vision, non-emergency medical transportation (NEMT), and pharmacy benefits. CDJs and sample claims data were also submitted by the third-party vendors. These files were separately compared to the supplemental claims data to determine the completeness and accuracy of the data submitted to Optumas by the health plan's delegated vendors.

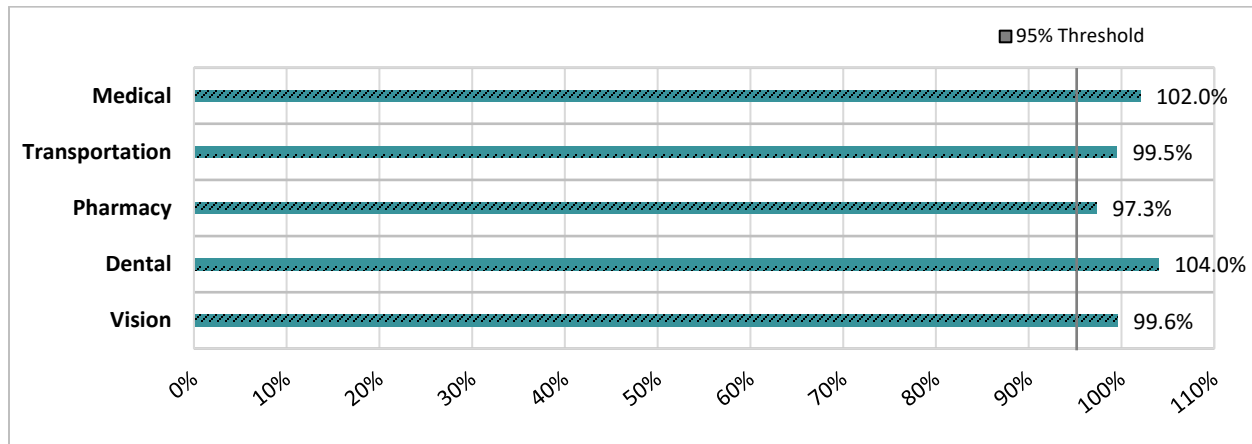
## Completeness

Completeness of the supplemental claims data is important for ensuring that accurate rates can be set from the supplemental claims data. The completeness of the supplemental claims data was evaluated through multiple analyses, including cash disbursement journal and sample claims comparisons.

## Cash Disbursement Journals

Myers and Stauffer received two months of cash disbursements journals (May 2024 and October 2024) from the health plan. The health plan's CY 2024 supplemental claims data was reviewed to determine the data's financial (paid amount) completeness when compared to the CDJ files. **Figure 3** shows the completion percentages for the combination of the two sample months tested for CY 2024. The analysis compares the financial transactions in the CDJ file with claims in the supplemental claims file with dates starting on or after the first day of the sampled month. The completion percentages when comparing the CDJ to the supplement claims data were above 100% for medical and dental for October 2024. Based on analysis, voided records and reversal records within the CDJs that were not accounted for in the supplemental dataset. The health plan should review the process in place for preparing the supplemental claims data to be submitted to Optumas to ensure any void or reversed claims are properly accounted for in supplemental data set.

Figure 3: CDJ Combined Completion Percentages for the Two Sample Months by Claim Type.



## Sample Claims

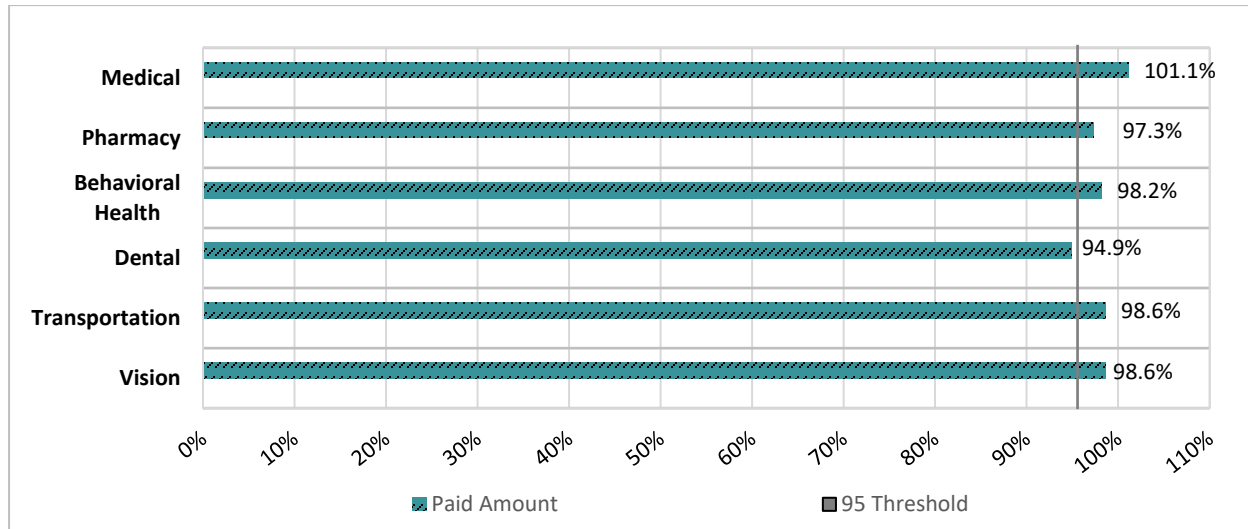
The comparison of the sample claims data to the supplemental claims data by internal control number (ICN) sought to ensure that all sample claims were included in the supplemental claims data. The supplemental claims data was evaluated against the sample claims data based on the following criterion:

- **Sample Claim Paid Amount:** Sample claims data paid amounts compared to supplemental claims data paid amounts.

The comparison between sample claims data counts and those identified in the supplemental claims data was excluded from our analysis. This was due to the difference in data composition: the Optumas data extract contains only final claims, while the sample claims data includes all iterations of the claims. This disparity would lead to inflated sample claims data counts if compared directly.

Denied (zero dollar paid amounts) claims were not included in the sampled claims because the supplemental claims data only includes final paid claims and denied claims have no impact on total paid amounts. **Figure 4** shows the completion percentages calculated based on the comparison of sample claim paid amounts to supplemental claims data paid amounts for the two sample months combined. Detailed results can be found in the Appendix B series.

Figure 4: Sample Claims Data to Supplemental Claims Data Paid Amount Combined Completion Percentages for the Two Sample Months.



Completion percentages for the supplemental claims data paid amounts when compared to sample claims data paid amounts met the 95% threshold for all claim types except for dental claims (94.9%) for the two sample months of May 2024 and October 2024. Based on analysis of the dental claims, there are potential mismatched claim numbers between the sample claims and the supplemental data set in October 2024. The health plan should review the process in place to prepare both the supplemental claims data submitted to Optumas to ensure all records reflect accurate claim numbers.

## Accuracy

For the purpose of validating supplemental claims data for accuracy, certain key data elements were selected for testing. See Appendix C for key data elements tested by claim type. The analysis was conducted using the matched data set from the completion analysis between the supplemental claims data and the sample claims data. The key data elements of the supplemental claims data were traced and compared to the corresponding key data elements in the sample claims data. Consistency checks on blank or null data element values were also applied. The key data elements were evaluated based on the following criteria:

- **Valid Values:** The supplemental claim's key data element value matched the sample claim's key data element value. If the supplemental claim's key data element was blank (or NULL) and the data element in the sample claim was blank (or NULL), it was considered valid.
- **Missing Values:** The supplemental claim's 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 supplemental claim's 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, or the sample claim's key data element was blank (or NULL) and the data element in the supplemental claim was populated (i.e., had a value).

An analysis was performed to match the billing provider and service provider National Provider Identifiers (NPIs) using the left nine characters in the sample claims data and the right nine characters of the supplemental claims data. This was done because the supplemental claims data had leading zeroes in the NPIs and was missing the last digit of the NPIs. For surgical procedure codes, only line one of each claim was compared due to the supplemental data only having the field populated for line one of the inpatient claims, when applicable.

Accuracy issues concerning health plan paid dates were observed in the supplemental claims data for pharmacy, professional, and behavioral health claims. Additionally, discrepancies were noted in health plan paid amount for professional claims and billing provider NPI for transportation claims. Accuracy percentages for the supplemental claims data are presented in **Table 1** by claim type. The key data elements evaluated and detailed testing results are presented in Appendix C.

**Table 1: Accuracy Percentages -- Key Data Elements Analysis.**

Claim Type	Valid Values	Missing Values	Erroneous Values
Medical	99.0%	0.0%	1.0%
Behavioral Health	99.0%	0.0%	1.0%
Dental	100.0%	0.0%	0.0%
Transportation	87.5%	1.0%	11.5%
Pharmacy	90.0%	0.0%	10.0%
Vision	100.0%	0.0%	0.0%
<b>Total Average</b>	<b>96.8%</b>	<b>0.0%</b>	<b>3.2%</b>

\*Differences in cross footing are due to rounding.

## Findings and Recommendations

The findings from the completeness and accuracy analyses of the supplemental claims data are summarized below, including recommendations for the health plan.

**Table 2: Findings and Recommendations from CDJ analysis and claims matching (completeness) and key data element matching (accuracy).**

Report Section	Findings	Recommendations
3-A	<b>Completeness – CDJs:</b> All claim types included in the supplemental claims data met the 95% threshold for completeness when compared to the CDJ data transaction amounts. However, for Medical and Dental claim types the completion percentage exceeded 100 percent.	The health plan should continue to monitor completion percentages to ensure the supplemental claims data is complete and accurately reflects the services rendered and payments made to providers. The health plan should ensure that voids and adjustments are properly included within the supplement claims data.

Report Section	Findings	Recommendations
3-B	<b>Completeness – Sample Claims Paid Amount:</b> Dental – The paid amount was below the 95% threshold at 94.9%, specifically in October 2024 (92.8%), due to missing supplemental claims data or potential mismatched claim numbers.	The health plan should review its process for capturing dental claim numbers in its supplemental claims data submitted to Optumas to ensure the claim numbers are accurate.
3-C	<b>Accuracy – Paid Dates:</b> <i>Behavioral Health, Professional, and Pharmacy</i> – The paid dates were populated in both the sample and supplemental claims data, but the values do not agree. For behavioral health and professional, the accuracy percentages were below the 95% threshold.	The health plan should review its process for capturing behavioral health, professional, and pharmacy paid dates in its supplemental claims data submitted to Optumas to ensure accurate paid dates for the claims are being reported.
3-D	<b>Accuracy – Health Plan Paid Amounts:</b> <i>Professional</i> – The health plan paid amounts were populated in the sample claims data and supplemental claims data, but their values do not agree.	The health plan should review its process for capturing professional paid amounts in its supplemental claims data submitted to Optumas to ensure accurate paid amounts are being reported.
3-E	<b>Accuracy – Billing Provider NPI:</b> <i>Transportation</i> – The billing provider NPI fields are populated in both the sample and supplemental claims data, but the values do not agree. It appears that the actuarial data is populated with service provider NPIs.	The health plan should review its process for compiling the billing provider NPI field within the supplemental claims data to ensure it is complete and accurate.

## Statistics and Distributions

To further support the supplemental claims data validation process, supplemental claims data with CY 2024 dates of service were analyzed for consistency among attributes such as member utilization and paid amounts. The sample claims data was analyzed to determine the health plan’s timeliness in adjudication of claims submitted by providers.

## Members, Utilization and Paid Amounts

The total number of utilized services (i.e., procedures) and total paid amounts in CY 2024 were divided by the number of unique members receiving services for the measurement period to determine per member utilization. **Table 3, Table 4 and Table 5** below show the resulting utilization and paid amounts per member. For **Table 5**, positive/negative percentage differences in the count and paid amount columns indicate that the health plan’s per member per year (PMPY) counts and/or paid amounts are greater than/less than counts and/or paid amounts of Heritage Health as a program. Detailed results can be found in the Appendix D series.

The health plan’s membership represented 33.0% of Heritage Health’s members receiving services in 2024. The health plan’s total per member utilization and total per member paid amounts were less than Heritage Health’s utilization and total per member paid amounts.

**Table 3: Distinct member count receiving services based on supplemental claims data – CY 2024.**

Heritage Health	Molina	Percentage of Heritage Health
385,140	127,196	33.0%

**Table 4: Heritage Health Average Per Member Utilization and Paid Amounts by Service Type, CY 2024.**

Service Type	Utilization	Per Member Utilization	Total Paid	Per Member Paid Amount
Ancillary	1,101,268	2.9	\$93,130,238	\$249
Dental	966,086	2.6	\$57,040,172	\$152
Inpatient	606,822	1.6	\$416,832,140	\$1,114
Outpatient	3,238,688	8.7	\$469,818,928	\$1,255
Pharmacy	4,502,719	12.0	\$495,130,735	\$1,323
Primary Care	2,546,245	6.8	\$167,946,493	\$449
Specialty	2,129,425	5.7	\$218,707,385	\$584
Transportation	355,171	0.9	\$24,640,430	\$66
Vision	399,749	1.1	\$14,817,637	\$40
<b>Total Health Plan Services</b>	<b>15,846,173</b>	<b>42.3</b>	<b>\$1,958,064,157</b>	<b>\$5,231</b>

\*Differences in footing are due to rounding.

**Table 5: Molina Average Per Member Utilization and Paid Amounts by Service Type, CY 2024.**

Service Type	Utilization	Per Member Utilization	Total Paid	Per Member Paid Amount	Utilization	Paid Amount
Ancillary	293,636	2.4	\$12,590,510	\$103	-18.4%	-58.6%
Dental	237,026	1.9	\$14,296,613	\$117	-24.9%	-23.3%
Inpatient	179,522	1.5	\$138,493,586	\$1,133	-9.4%	1.7%
Outpatient	930,695	7.6	\$120,748,684	\$987	-12.0%	-21.3%
Pharmacy	1,143,632	9.4	\$142,542,399	\$1,166	-22.3%	-11.9%
Primary Care	309,388	2.5	\$22,864,939	\$187	-62.8%	-58.3%
Specialty	865,243	7.1	\$97,783,829	\$800	24.4%	36.9%
Transportation	83,408	0.7	\$7,399,601	\$61	-28.1%	-8.1%
Vision	82,526	0.7	\$3,309,110	\$27	-36.8%	-31.6%
<b>Total Health Plan Services</b>	<b>4,125,076</b>	<b>33.7</b>	<b>\$560,029,270</b>	<b>\$4,580</b>	<b>-20.3%</b>	<b>-12.4%</b>

## Timely Payment of Claims

This analysis measured the compliance of the health plan and delegated vendors in paying or denying claims submitted by providers for payment timely. The contract between DHHS and the health plan requires that the health plan pay or deny at least 90% of all claims within 15 business days of receipt, 99% within 60 calendar days of the date of receipt and all claims within six months of receipt. Table 8 shows the results of the analysis. Detailed results can be found in Appendix E.

**Table 6: Timely Payment of Claims.**

Claim Type	15 Business Days 90% Threshold	60 Calendar Days 99% Threshold	180 Calendar Days 100% Threshold	Average Days
Inpatient	92.3%	99.5%	99.9%	8
Outpatient	98.3%	99.9%	100.0%	4
Professional	98.0%	98.7%	99.9%	6
Behavioral Health	98.7%	99.6%	100.0%	4
Vision	92.8%	99.8%	100.0%	7
Pharmacy	100.0%	100.0%	100.0%	0
Dental	99.9%	100.0%	100.0%	4
<b>Overall Average</b>	<b>98.5%</b>	<b>99.6%</b>	<b>100.0%</b>	<b>3</b>

The health plan received dates and health plan paid (adjudicated) dates from the two sample claims months that were used for the analysis. The number of days between these dates were used to determine the percentage of claims paid (adjudicated) by the health plan within the designated timeframes. Transportation claims were excluded from the analysis due to all received dates occurring later than the paid dates. The transportation claims paid dates matched 100 percent between the sample claims data and the supplement claims data therefore the issue was determined to be related to the inaccuracy of the received dates within the sample claims data.

## Findings and Recommendations

The findings from the timeliness analysis are presented below, including recommendations for the health plan.

**Table 7: Timely Payment of Claims Findings and Recommendations**

Report Section	Findings	Recommendations
3-F	<b>Timely Payment of Claims:</b> All claim types in the supplemental claims data met the 15 business day, 60 calendar day and 180 calendar day claims payment timeliness thresholds.	The health plan should continue to monitor to ensure their claims are adjudicated promptly to meet the timeliness requirements established within the contract between the DHHS and the health plan.

Report Section	Findings	Recommendations
3-G	<b>Received Dates:</b> The health plan received dates supplied by the transportation vendor exceeded the paid date on the claim.	The health plan should work with its transportation vendor to ensure valid received dates are being recorded and can be supplied when requested for validation purposes by the State or its designated contractor.

## Activity 4: Review of Medical Records

Activity 4 provides supporting information for the findings detailed in the Activity 3 analysis of supplemental claims data. This is done by tracing certain key data elements from the supplemental claims data to the member’s medical record obtained from the service provider. Supplemental claims data with dates of service during the measurement period were used for the selection of sample records for review. A non-statistical<sup>6</sup>, random sampling of 120 records was selected from the supplemental claims data for review.

The supplemental claims data records selected for review were provided to the health plan on September 29, 2025 for retrieval of the medical records. The notification to the health plan stated that medical records were due to Myers and Stauffer no later than October 31, 2025. The deadline was extended to November 24, 2025 at the request of the health plan. Of the 120 records requested 114 records were received. **Table 8** details the number of records requested versus the number of records received and provides reasons for the differences between the requested and received amounts.

**Table 8: Medical Records Testing Summary**

Description	Inpatient	Outpatient	Professional (includes Vision and NEMT)	Pharmacy	Total
Requested	27	26	42	25	120
Missing	1	2	2	1	6
Incorrect Record Submitted	0	0	0	0	0
Replaced	0	0	0	0	0
Medical Records Received and Tested	26	24	40	24	114
<b>Percentage of Requested Records Tested</b>	<b>96.3%</b>	<b>92.3%</b>	<b>95.2%</b>	<b>96.0%</b>	<b>95.0%</b>

### Validation

The medical records were reviewed and compared to the supplemental claims data to validate that key data elements were supported by the medical record documentation. Each key data element was independently evaluated against the medical record and deemed supported or unsupported (i.e., the

<sup>6</sup> Non-statistical sampling is the selection of a test group, such as sample size, that is based on the accountant’s judgement, rather than a formal statistical method.

medical record supported or did not support the supplemental claims data key element value). The validation was categorized in the following manner:

- **Supported:** Supplemental claims data for which the medical records supported the key data element(s).
- **Unsupported:** Supplemental claims data for which the medical records included information that was different from the supplemental claims key data element(s) and/or supplemental claims data for which the medical record did not include the information to support the supplemental claims key data element(s).

Validity issues were noted with all claim types within the supplemental claims data. **Table 9** reflects the validation rates from the medical record key data element review. The analysis excluded member date of birth due to the data field not being included in the supplemental claims dataset. The detailed analysis is included in the Appendix F series.

**Table 9: Medical Records Validation Rates.**

Claim Types	Supported Validation Rate	Unsupported Validation Rate
Inpatient	95.0%	5.0%
Outpatient	95.1%	4.9%
Professional	95.4%	4.6%
Dental	100.0%	0.0%
Transportation	100.0%	0.0%
Vision	100.0%	0.0%
Pharmacy	91.6%	8.4%
<b>Total</b>	<b>94.9%</b>	<b>5.1%</b>

## Findings and Recommendations

The findings from the supplemental claims data testing against medical records are presented below, including recommendations for the health plan.

**Table 10 Medical Record Review Findings and Recommendations**

Report Section	Findings	Recommendations
4-A	The health plan was not able to provide a medical record to support six of the 120 records requested.	The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested.
4-B	Overall, the plan did not meet the 95% accuracy threshold for the 114 records that were tested (94.9 percent). Validation rates for pharmacy were below the 95% accuracy threshold (91.6 percent) driven primarily by unsupported quantity dispensed amounts.	The health plan should review the unsupported claims issues and determine the root cause of unsupported claims data, then develop a plan to address the issue with adjustment to its processes.

# Activity 5: Submission of Findings

Activity 5 summarizes the findings 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. No findings were noted in Activity 1 or 2.

**Table 11: Activity 3—Analyze Supplemental Claims Data.**

Report Section	Findings	Recommendations
3-A	<b>Completeness – CDJs:</b> All claim types included in the supplemental claims data met the 95% threshold for completeness when compared to the CDJ data transaction amounts. However, for Medical and Dental claim types the completion percentage exceeded 100 percent.	The health plan should continue to monitor completion percentages to ensure the supplemental claims data is complete and accurately reflects the services rendered and payments made to providers. The health plan should ensure that voids and adjustments are properly included within the supplement claims data.
3-B	<b>Completeness – Sample Claims Paid Amount:</b> Dental – The paid amount was below the 95% threshold at 94.9%, specifically in October 2024 (92.8%), due to missing supplemental claims data or potential mismatched claim numbers.	The health plan should review its process for capturing dental claim numbers in its supplemental claims data submitted to Optumas to ensure the claim numbers are accurate.
3-C	<b>Accuracy – Paid Dates:</b> <i>Behavioral Health, Professional, and Pharmacy</i> – The paid dates were populated in both the sample and supplemental claims data, but the values do not agree. For behavioral health and professional, the accuracy percentages were below the 95% threshold.	The health plan should review its process for capturing behavioral health, professional, and pharmacy paid dates in its supplemental claims data submitted to Optumas to ensure accurate paid dates for the claims are being reported.
3-D	<b>Accuracy – Health Plan Paid Amounts:</b> <i>Professional</i> – The health plan paid amounts were populated in the sample claims data and supplemental claims data, but their values do not agree.	The health plan should review its process for capturing professional paid amounts in its supplemental claims data submitted to Optumas to ensure accurate paid amounts are being reported.
3-E	<b>Accuracy – Billing Provider NPI:</b> <i>Transportation</i> – The billing provider NPI fields are populated in both the sample and supplemental claims data, but the values do not agree. It appears that the actuarial data is populated with service provider NPIs.	The health plan should review its process for compiling the billing provider NPI field within the supplemental claims data to ensure it is complete and accurate.
3-F	<b>Timely Payment of Claims:</b> All claim types in the supplemental claims data met the 15 business day, 60 calendar day and 180 calendar day claims payment timeliness thresholds.	The health plan should continue to monitor to ensure their claims are adjudicated promptly to meet the timeliness requirements established within the contract between the DHHS and the health plan.

Report Section	Findings	Recommendations
3-G	<b>Received Dates:</b> The health plan received dates supplied by the transportation vendor exceeded the paid date on the claim.	The health plan should work with its transportation vendor to ensure valid received dates are being recorded and can be supplied when requested for validation purposes by the State or its designated contractor.

**Table 12: Activity 4 – Review of Medical Records**

Report Section	Findings	Recommendations
4-A	The health plan was not able to provide a medical record to support six of the 120 records requested.	The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested.
4-B	Overall, the plan did not meet the 95% accuracy threshold for the 114 records that were tested (94.9 percent). Validation rates for pharmacy were below the 95% accuracy threshold (91.6 percent) driven primarily by unsupported quantity dispensed amounts.	The health plan should review the unsupported claims issues and determine the root cause of unsupported claims data, then develop a plan to address the issue with adjustment to its processes.

# Glossary

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**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 (e.g., 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 who 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.

**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).

**Delegated Vendor** – A vendor to whom the health plan has contractually assigned responsibility for the provision and oversight of approval, payment, and administration of medical services to the Medicaid health plan’s members. Also known as a subcontractor.

**Department of Health and Human Services (DHHS)** – The department that oversees services that assist the elderly, low income individuals and those with disabilities and provide safety to abused and/or neglected children and vulnerable adults within the state of Nebraska.

**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.

**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 their 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).

**Heritage Health** – Combines Nebraska Medicaid’s physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated program for the state’s Medicaid and Children’s Health Insurance Program (CHIP) enrollees. Heritage Health members enroll in one of the three statewide health plans to receive their health care benefits.

**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 (e.g., 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.

**Medicaid and Long-Term Care (MLTC)** – Oversees the Nebraska Medicaid program, home and community-based services, and the State Unit of Aging.

**Outpatient Services** – Care or treatment that can be provided in a few hours at a facility without an overnight stay. Patients continue to work or attend school while interacting and living their lives during treatment. Outpatient services include rehabilitation services such as counseling and/or substance use disorder treatment.

**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.

**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 preventive 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 management, endocrinology, optometry, and behavioral health.

**Sub-Capitated Provider** – A health care provider that is paid on a capitated or per member per month (PMPM) basis and has contracted with a health plan paid under a capitated system and shares a portion of the health plan’s capitated premium.

**Supplemental Claims Data** – The claims data set received by Optumas annually and used on as the basis for rate setting. Myers and Stauffer receive an extract of this data directly from Optumas, which is evaluated throughout the report.

**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.

# Appendices

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## Appendix A: Cash Disbursement Journal (CDJ) Completeness

### Medical CDJ Completeness

CDJ Completeness Breakdown	May 2024	October 2024	Total
CDJ Paid Amount Total	\$39,451,996	\$48,091,315	\$87,543,311
Reconciling Adjustment	\$0	\$0	\$0
<b>Net CDJ Data Paid Amount Total</b>	<b>\$39,451,996</b>	<b>\$48,091,315</b>	<b>\$87,543,311</b>
Supplemental Paid Amount Total	\$39,216,677	\$51,185,238	\$90,401,914
Payment Adjustments	(\$600,458)	(\$502,820)	(\$1,103,277)
<b>Net Supplemental Paid Amount Total</b>	<b>\$38,616,219</b>	<b>\$50,682,418</b>	<b>\$89,298,637</b>
<b>Supplemental Completeness Percentage</b>	<b>97.9%</b>	<b>105.4%</b>	<b>102.0%</b>

### Dental CDJ Completeness

CDJ Completeness Breakdown	May 2024	October 2024	Total
CDJ Paid Amount Total	\$1,595,716	\$2,199,303	\$3,795,019
Reconciling Adjustment	\$0	\$0	\$0
<b>Net CDJ Data Paid Amount Total</b>	<b>\$1,595,716</b>	<b>\$2,199,303</b>	<b>\$3,795,019</b>
Supplemental Paid Amount Total	\$1,596,588	\$2,349,559	\$3,946,147
Payment Adjustments	\$455	\$1,644	\$2,098
<b>Net Supplemental Paid Amount Total</b>	<b>\$1,597,042</b>	<b>\$2,351,203</b>	<b>\$3,948,245</b>
<b>Supplemental Completeness Percentage</b>	<b>100.1%</b>	<b>106.9%</b>	<b>104.0%</b>

### Transportation CDJ Completeness

CDJ Completeness Breakdown	May 2024	October 2024	Total
CDJ Paid Amount Total	\$406,162	\$469,340	\$875,503
Reconciling Adjustment	\$0	\$0	\$0
<b>Net CDJ Data Paid Amount Total</b>	<b>\$406,162</b>	<b>\$469,340</b>	<b>\$875,503</b>
Supplemental Paid Amount Total	\$404,864	\$466,072	\$870,935
Payment Adjustments	\$0	\$0	\$0
<b>Net Supplemental Paid Amount Total</b>	<b>\$404,864</b>	<b>\$466,072</b>	<b>\$870,935</b>
<b>Supplemental Completeness Percentage</b>	<b>99.7%</b>	<b>99.3%</b>	<b>99.5%</b>

Pharmacy CDJ Completeness

CDJ Completeness Breakdown	May 2024	October 2024	Total
CDJ Paid Amount Total	\$13,582,044	\$12,944,986	\$26,527,030
Reconciling Adjustment	\$396,154	\$320,540	\$716,694
<b>Net CDJ Data Paid Amount Total</b>	<b>\$13,978,198</b>	<b>\$13,265,527</b>	<b>\$27,243,725</b>
Supplemental Paid Amount Total	\$13,562,797	\$12,935,987	\$26,498,784
Payment Adjustments	\$0	\$0	\$0
<b>Net Supplemental Paid Amount Total</b>	<b>\$13,562,797</b>	<b>\$12,935,987</b>	<b>\$26,498,784</b>
<b>Supplemental Completeness Percentage</b>	<b>97.0%</b>	<b>97.5%</b>	<b>97.3%</b>

Vision CDJ Completeness

CDJ Completeness Breakdown	May 2024	October 2024	Total
CDJ Paid Amount Total	\$281,303	\$353,920	\$635,223
Reconciling Adjustment	\$0	\$0	\$0
<b>Net CDJ Data Paid Amount Total</b>	<b>\$281,303</b>	<b>\$353,920</b>	<b>\$635,223</b>
Supplemental Paid Amount Total	\$279,114	\$350,352	\$629,466
Payment Adjustments	(\$75)	\$3,083	\$3,007
<b>Net Supplemental Paid Amount Total</b>	<b>\$279,038</b>	<b>\$353,435</b>	<b>\$632,473</b>
<b>Supplemental Completeness Percentage</b>	<b>99.2%</b>	<b>99.9%</b>	<b>99.6%</b>

Total CDJ Completeness

CDJ Completeness Breakdown	May 2024	October 2024	Total
CDJ Paid Amount Total	\$55,317,221	\$64,058,865	\$119,376,086
Reconciling Adjustment	\$396,154	\$320,540	\$716,694
<b>Net CDJ Data Paid Amount Total</b>	<b>\$55,713,375</b>	<b>\$64,379,406</b>	<b>\$120,092,780</b>
Supplemental Paid Amount Total	\$55,060,039	\$67,287,208	\$122,347,247
Payment Adjustments	(\$600,079)	(\$498,093)	(\$1,098,172)
<b>Net Supplemental Paid Amount Total</b>	<b>\$54,459,960</b>	<b>\$66,789,115</b>	<b>\$121,249,075</b>
<b>Supplemental Completeness Percentage</b>	<b>97.8%</b>	<b>103.7%</b>	<b>101.0%</b>

## Appendix B: Sample Claims Completeness

### Medical Claim Completeness

Claims Completeness Breakdown	May 2024	October 2024	Total
Claims Sample Total	\$22,168,097	\$26,745,896	\$48,913,993
Total Denied in Claims Sample Data	\$0	\$0	\$0
Multiple Claim Lines/Other	(\$5,975,255)	(\$9,310,472)	(\$15,285,727)
<b>Net Claims Sample Total</b>	<b>\$16,192,842</b>	<b>\$17,435,424</b>	<b>\$33,628,266</b>
Total Matched Supplemental Claims	\$16,241,425	\$17,927,455	\$34,168,879
Less Payment Adjustment	(\$184,300)	\$0	(\$184,300)
<b>Net Matched Supplemental Claims</b>	<b>\$16,057,125</b>	<b>\$17,927,455</b>	<b>\$33,984,580</b>
<b>Completeness Percentage</b>	<b>99.2%</b>	<b>102.8%</b>	<b>101.1%</b>

### Pharmacy Claim Completeness

Claims Completeness Breakdown	May 2024	October 2024	Total
Claims Sample Total	\$12,143,301	\$13,584,764	\$25,728,065
Total Denied in Claims Sample Data	\$0	\$0	\$0
Total Void in Claims Sample Data*	\$4,800,768	\$4,933,721	\$9,734,489
Multiple Claim Lines/Other	(\$4,384,324)	(\$4,611,524)	(\$8,995,848)
<b>Net Claims Sample Total</b>	<b>\$12,559,746</b>	<b>\$13,906,961</b>	<b>\$26,466,706</b>
Total Matched Supplemental Claims	\$12,157,041	\$13,583,908	\$25,740,949
Less Payment Adjustment	\$0	\$0	\$0
<b>Net Matched Supplemental Claims</b>	<b>\$12,157,041</b>	<b>\$13,583,908</b>	<b>\$25,740,949</b>
<b>Completeness Percentage</b>	<b>96.8%</b>	<b>97.7%</b>	<b>97.3%</b>

\*Void claims were removed from the pharmacy claims analysis only. Since the supplemental claims data contains only the final iteration, including the voids from the sample claims affects the completion percentage.

**Behavioral Health Claim Completeness**

Claims Completeness Breakdown	May 2024	October 2024	Total
Claims Sample Total	\$17,264,703	\$21,832,918	\$39,097,621
Total Denied in Claims Sample Data	\$0	\$0	\$0
Multiple Claim Lines/Other	(\$4,685,311)	(\$6,837,195)	(\$11,522,506)
<b>Net Claims Sample Total</b>	<b>\$12,579,391</b>	<b>\$14,995,723</b>	<b>\$27,575,115</b>
Total Matched Supplemental Claims	\$12,756,894	\$14,543,768	\$27,300,662
Less Payment Adjustment	(\$212,310)	\$0	(\$212,310)
<b>Net Matched Supplemental Claims</b>	<b>\$12,544,584</b>	<b>\$14,543,768</b>	<b>\$27,088,352</b>
<b>Completeness Percentage</b>	<b>99.7%</b>	<b>97.0%</b>	<b>98.2%</b>

**Dental Claim Completeness**

Claims Completeness Breakdown	May 2024	October 2024	Total
Claims Sample Total	\$1,631,367	\$2,834,863	\$4,466,230
Total Denied in Claims Sample Data	\$0	\$0	\$0
Multiple Claim Lines/Other	(\$3,757)	(\$303,129)	(\$306,886)
<b>Net Claims Sample Total</b>	<b>\$1,627,610</b>	<b>\$2,531,734</b>	<b>\$4,159,344</b>
Total Matched Supplemental Claims	\$1,596,588	\$2,349,559	\$3,946,147
Less Payment Adjustment	\$0	\$0	\$0
<b>Net Matched Supplemental Claims</b>	<b>\$1,596,588</b>	<b>\$2,349,559</b>	<b>\$3,946,147</b>
<b>Completeness Percentage</b>	<b>98.1%</b>	<b>92.8%</b>	<b>94.9%</b>

Transportation Claim Completeness

Claims Completeness Breakdown	May 2024	October 2024	Total
Claims Sample Total	\$416,072	\$486,571	\$902,643
Total Denied in Claims Sample Data	\$0	\$0	\$0
Multiple Claim Lines/Other	(\$7,745)	(\$14,320)	(\$22,064)
<b>Net Claims Sample Total</b>	<b>\$408,327</b>	<b>\$472,251</b>	<b>\$880,578</b>
Total Matched Supplemental Claims	\$404,525	\$463,978	\$868,503
Less Payment Adjustment	\$0	\$0	\$0
<b>Net Matched Supplemental Claims</b>	<b>\$404,525</b>	<b>\$463,978</b>	<b>\$868,503</b>
<b>Completeness Percentage</b>	<b>99.1%</b>	<b>98.2%</b>	<b>98.6%</b>

Vision Claim Completeness

Claims Completeness Breakdown	May 2024	October 2024	Total
Claims Sample Total	\$273,443	\$349,308	\$622,751
Total Denied in Claims Sample Data	\$0	\$0	\$0
Multiple Claim Lines/Other	\$0	\$0	\$0
<b>Net Claims Sample Total</b>	<b>\$273,443</b>	<b>\$349,308</b>	<b>\$622,751</b>
Total Matched Supplemental Claims	\$269,632	\$344,550	\$614,182
Less Payment Adjustment	\$0	\$0	\$0
<b>Net Matched Supplemental Claims</b>	<b>\$269,632</b>	<b>\$344,550</b>	<b>\$614,182</b>
<b>Completeness Percentage</b>	<b>98.6%</b>	<b>98.6%</b>	<b>98.6%</b>

**Total Claim Completeness**

Claims Completeness Breakdown	May 2024	October 2024	Total
Claims Sample Total	\$53,896,982	\$65,834,320	\$119,731,302
Total Denied in Claims Sample Data	\$0	\$0	\$0
Total Void in Claims Sample Data*	\$4,800,768	\$4,933,721	\$9,734,489
Multiple Claim Lines/Other	(\$15,056,392)	(\$21,076,639)	(\$36,133,031)
<b>Net Claims Sample Total</b>	<b>\$43,641,359</b>	<b>\$49,691,401</b>	<b>\$93,332,760</b>
Total Matched Supplemental Claims	\$43,426,105	\$49,213,218	\$92,639,323
Less Payment Adjustment	(\$396,610)	\$0	(\$396,610)
<b>Net Matched Supplemental Claims</b>	<b>\$43,029,495</b>	<b>\$49,213,218</b>	<b>\$92,242,713</b>
<b>Completeness Percentage</b>	<b>98.6%</b>	<b>99.0%</b>	<b>98.8%</b>

*\*Void claims were removed from the pharmacy claims analysis only. Since the supplemental claims data contains only the final iteration, including the voids from the sample claims affects the completion percentage.*

## Appendix C: Key Data Element Matching

### Medical May 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	15,470	15,470	100.0%			0	0.0%
Bill Type (digits 1 and 2)	44,829	44,829	100.0%			0	0.0%
Billed Charges	109,459	109,458	100.0%	0	0.0%	1	0.0%
Billing Provider NPI/Number	109,459	109,459	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	109,459	109,459	100.0%	0	0.0%	0	0.0%
Date of Service	109,459	109,459	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	109,459	100,816	92.1%	0	0.0%	8,643	7.9%
Health Plan Paid Date	109,459	93,653	85.6%	0	0.0%	15,806	14.4%
Member ID (Medicaid)	109,459	109,429	100.0%	0	0.0%	30	0.0%
Place of Service	64,630	64,630	0.0%	0	0.0%	0	0.0%
Procedure Code	93,989	93,988	0.0%	0	0.0%	1	0.0%
Procedure Code Modifiers	93,989	93,989	0.0%			0	0.0%
Revenue Code	44,829	44,829	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	109,459	109,447	100.0%	0	0.0%	12	0.0%
Surgical Procedure Codes	1,279	1,279	100.0%			0	0.0%
<b>Total</b>	<b>1,234,687</b>	<b>1,210,194</b>	<b>98.0%</b>	<b>0</b>	<b>0.0%</b>	<b>24,493</b>	<b>2.0%</b>

Medical October 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	16,798	16,798	100.0%			0	0.0%
Bill Type (digits 1 and 2)	49,244	49,244	100.0%			0	0.0%
Billed Charges	117,085	117,085	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	117,085	117,085	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	117,085	117,083	100.0%	0	0.0%	2	0.0%
Date of Service	117,085	117,085	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	117,085	117,085	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	117,085	117,085	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	117,085	117,021	99.9%	0	0.0%	64	0.1%
Place of Service	67,841	67,841	100.0%	0	0.0%	0	0.0%
Procedure Code	100,287	100,287	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	100,287	100,287	100.0%			0	0.0%
Revenue Code	49,244	49,244	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	117,085	117,068	100.0%	0	0.0%	17	0.0%
Surgical Procedure Codes	1,182	1,182	100.0%			0	0.0%
<b>Total</b>	<b>1,321,563</b>	<b>1,321,480</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>83</b>	<b>0.0%</b>

Total Medical KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	32,268	32,268	100.0%			0	0.0%
Bill Type (digits 1 and 2)	94,073	94,073	100.0%			0	0.0%
Billed Charges	226,544	226,543	100.0%	0	0.0%	1	0.0%
Billing Provider NPI/Number	226,544	226,544	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	226,544	226,542	100.0%	0	0.0%	2	0.0%
Date of Service	226,544	226,544	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	226,544	217,901	96.2%	0	0.0%	8,643	3.8%
Health Plan Paid Date	226,544	210,738	93.0%	0	0.0%	15,806	7.0%
Member ID (Medicaid)	226,544	226,450	100.0%	0	0.0%	94	0.0%
Place of Service	132,471	132,471	100.0%	0	0.0%	0	0.0%
Procedure Code	194,276	194,275	100.0%	0	0.0%	1	0.0%
Procedure Code Modifiers	194,276	194,276	100.0%			0	0.0%
Revenue Code	94,073	94,073	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	226,544	226,515	100.0%	0	0.0%	29	0.0%
Surgical Procedure Codes	2,461	2,461	100.0%			0	0.0%
<b>Total</b>	<b>2,556,250</b>	<b>2,531,674</b>	<b>99.0%</b>	<b>0</b>	<b>0.0%</b>	<b>24,576</b>	<b>1.0%</b>

Behavioral Health May 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	255	255	100.0%			0	0.0%
Bill Type (digits 1 and 2)	59,127	59,127	100.0%			0	0.0%
Billed Charges	125,516	125,516	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	125,516	125,516	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	125,516	125,516	100.0%	0	0.0%	0	0.0%
Date of Service	125,516	125,516	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	125,516	115,827	92.3%	0	0.0%	9,689	7.7%
Health Plan Paid Date	125,516	105,012	83.7%	0	0.0%	20,504	16.3%
Member ID (Medicaid)	125,516	125,477	100.0%	0	0.0%	39	0.0%
Place of Service	66,389	66,389	100.0%	0	0.0%	0	0.0%
Procedure Code	125,261	125,260	100.0%	0	0.0%	1	0.0%
Procedure Code Modifiers	125,261	125,261	100.0%			0	0.0%
Revenue Code	59,127	59,127	100.0%	0	0.0%	0	0.0%
Service/Rendering Provider NPI	125,516	125,481	100.0%	0	0.0%	35	0.0%
Surgical Procedure Codes	255	255	100.0%			0	0.0%
<b>Total</b>	<b>1,439,803</b>	<b>1,409,535</b>	<b>97.9%</b>	<b>0</b>	<b>0.0%</b>	<b>30,268</b>	<b>2.1%</b>

Behavioral Health October 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	158	158	100.0%			0	0.0%
Bill Type (digits 1 and 2)	73,694	73,694	100.0%			0	0.0%
Billed Charges	129,739	129,739	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	129,739	129,739	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	129,739	129,739	100.0%	0	0.0%	0	0.0%
Date of Service	129,739	129,739	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	129,739	129,739	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	129,739	129,739	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	129,739	129,727	100.0%	0	0.0%	12	0.0%
Place of Service	56,045	56,045	100.0%	0	0.0%	0	0.0%
Procedure Code	129,581	129,581	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	129,581	129,581	100.0%			0	0.0%
Revenue Code	73,694	73,694	100.0%	0	0.0%	0	0.0%
Service/Rendering Provider NPI	129,739	129,642	100.0%	0	0.0%	97	0.1%
Surgical Procedure Codes	158	150	100.0%			8	5.1%
<b>Total</b>	<b>1,500,823</b>	<b>1,500,706</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>117</b>	<b>0.0%</b>

Total Behavioral Health KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	413	413	100.0%			0	0.0%
Bill Type (digits 1 and 2)	132,821	132,821	100.0%			0	0.0%
Billed Charges	255,255	255,255	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	255,255	255,255	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	255,255	255,255	100.0%	0	0.0%	0	0.0%
Date of Service	255,255	255,255	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	255,255	245,566	96.2%	0	0.0%	9,689	3.8%
Health Plan Paid Date	255,255	234,751	92.0%	0	0.0%	20,504	8.0%
Member ID (Medicaid)	255,255	255,204	100.0%	0	0.0%	51	0.0%
Place of Service	122,434	122,434	100.0%	0	0.0%	0	0.0%
Procedure Code	254,842	254,841	100.0%	0	0.0%	1	0.0%
Procedure Code Modifiers	254,842	254,842	100.0%			0	0.0%
Revenue Code	132,821	132,821	100.0%	0	0.0%	0	0.0%
Service/Rendering Provider NPI	255,255	255,123	99.9%	0	0.0%	132	0.1%
Surgical Procedure Codes	413	405	98.1%			8	1.9%
<b>Total</b>	<b>2,940,626</b>	<b>2,910,241</b>	<b>99.0%</b>	<b>0</b>	<b>0.0%</b>	<b>30,385</b>	<b>1.0%</b>

Dental May 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	27,349	27,349	100.0%	0	0.0%	0	0.0%
Date of Service	27,349	27,349	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	27,349	27,349	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	27,349	27,349	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	27,349	27,349	100.0%	0	0.0%	0	0.0%
Place of Service	27,349	27,349	100.0%	0	0.0%	0	0.0%
Procedure Code	27,349	27,349	100.0%	0	0.0%	0	0.0%
Service/Rendering Provider NPI	27,349	27,241	99.6%	0	0.0%	108	0.4%
Tooth Number	27,349	27,349	100.0%			0	0.0%
Tooth Surface	27,349	27,349	100.0%			0	0.0%
<b>Total</b>	<b>273,490</b>	<b>273,382</b>	<b>99.5%</b>	<b>0</b>	<b>0.0%</b>	<b>108</b>	<b>0.0%</b>

Dental October 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	37,506	37,506	100.0%	0	0.0%	0	0.0%
Date of Service	37,506	37,506	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	37,506	37,506	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	37,506	37,506	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	37,506	37,506	100.0%	0	0.0%	0	0.0%
Place of Service	37,506	37,506	100.0%	0	0.0%	0	0.0%
Procedure Code	37,506	37,506	100.0%	0	0.0%	0	0.0%
Service/Rendering Provider NPI	37,506	37,492	100.0%	0	0.0%	14	0.0%
Tooth Number	37,506	37,506	100.0%			0	0.0%
Tooth Surface	37,506	37,506	100.0%			0	0.0%
<b>Total</b>	<b>375,060</b>	<b>375,046</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>14</b>	<b>0.0%</b>

Total Dental KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	64,855	64,855	100.0%	0	0.0%	0	0.0%
Date of Service	64,855	64,855	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	64,855	64,855	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	64,855	64,855	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	64,855	64,855	100.0%	0	0.0%	0	0.0%
Place of Service	64,855	64,855	100.0%	0	0.0%	0	0.0%
Procedure Code	64,855	64,855	100.0%	0	0.0%	0	0.0%
Service/Rendering Provider NPI	64,855	64,733	99.8%	0	0.0%	122	0.2%
Tooth Number	64,855	64,855	100.0%			0	0.0%
Tooth Surface	64,855	64,855	100.0%			0	0.0%
<b>Total</b>	<b>648,550</b>	<b>648,428</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>122</b>	<b>0.0%</b>

Transportation May 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	6,624	6,624	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	6,624	0	0.0%	397	6.0%	6,227	94.0%
Date of Service	6,624	6,624	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	6,624	6,624	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	6,624	6,624	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	6,624	6,624	100.0%	0	0.0%	0	0.0%
Procedure Code	6,624	6,624	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	6,624	6,624	100.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>52,992</b>	<b>46,368</b>	<b>87.5%</b>	<b>397</b>	<b>0.7%</b>	<b>6,227</b>	<b>11.8%</b>

Transportation October 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	7,605	7,605	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	7,605	0	0.0%	757	10.0%	6,848	94.0%
Date of Service	7,605	7,605	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	7,605	7,605	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	7,605	7,605	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	7,605	7,605	100.0%	0	0.0%	0	0.0%
Procedure Code	7,605	7,605	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	7,605	7,605	100.0%			0	0.0%
<b>Total</b>	<b>60,840</b>	<b>53,235</b>	<b>87.5%</b>	<b>757</b>	<b>1.2%</b>	<b>6,848</b>	<b>11.3%</b>

Total Transportation KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	14,229	14,229	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	14,229	0	0.0%	1,154	8.1%	13,075	91.9%
Date of Service	14,229	14,229	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	14,229	14,229	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	14,229	14,229	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	14,229	14,229	100.0%	0	0.0%	0	0.0%
Procedure Code	14,229	14,229	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	14,229	14,229	100.0%			0	0.0%
<b>Total</b>	<b>113,832</b>	<b>99,603</b>	<b>87.5%</b>	<b>1,154</b>	<b>1.0%</b>	<b>13,075</b>	<b>11.5%</b>

Vision May 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	6,207	6,207	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	6,207	6,207	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	6,207	6,207	100.0%	0	0.0%	0	0.0%
Date of Service	6,207	6,207	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	6,207	6,207	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	6,207	6,207	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	6,207	6,207	100.0%	0	0.0%	0	0.0%
Place of Service	6,207	6,207	100.0%	0	0.0%	0	0.0%
Procedure Code	6,207	6,207	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	6,207	6,207	100.0%			0	0.0%
Service/Rendering Provider NPI	6,207	6,205	100.0%	0	0.0%	2	0.0%
<b>Total</b>	<b>68,277</b>	<b>68,275</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>2</b>	<b>0.0%</b>

Vision October 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	8,143	8,143	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	8,143	8,143	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	8,143	8,140	100.0%	0	0.0%	3	0.0%
Date of Service	8,143	8,143	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	8,143	8,143	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	8,143	8,143	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	8,143	8,143	100.0%	0	0.0%	0	0.0%
Place of Service	8,143	8,143	100.0%	0	0.0%	0	0.0%
Procedure Code	8,143	8,143	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	8,143	8,143	100.0%			0	0.0%
Service/Rendering Provider NPI	8,143	8,141	100.0%	0	0.0%	2	0.0%
<b>Total</b>	<b>89,573</b>	<b>89,568</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>5</b>	<b>0.0%</b>

Total Vision KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	14,350	14,350	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	14,350	14,350	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	14,350	14,347	100.0%	0	0.0%	3	0.0%
Date of Service	14,350	14,350	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	14,350	14,350	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	14,350	14,350	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	14,350	14,350	100.0%	0	0.0%	0	0.0%
Place of Service	14,350	14,350	100.0%	0	0.0%	0	0.0%
Procedure Code	14,350	14,350	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	14,350	14,350	100.0%			0	0.0%
Service/Rendering Provider NPI	14,350	14,346	100.0%	0	0.0%	4	0.0%
<b>Total</b>	<b>157,850</b>	<b>157,843</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>7</b>	<b>0.0%</b>

Pharmacy May 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	98,088	98,088	100.0%	0	0.0%	0	0.0%
Fill Date	98,088	98,088	100.0%	0	0.0%	0	0.0%
Days Supply	98,088	98,088	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	98,088	98,088	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	98,088	0	0.0%	0	0.0%	98,088	100.0%
Member ID (Medicaid)	98,088	98,080	100.0%	0	0.0%	8	0.0%
NDC	98,088	98,088	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	98,088	98,088	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	98,088	98,088	100.0%	0	0.0%	0	0.0%
Refill Number	98,088	98,088	100.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>980,880</b>	<b>882,784</b>	<b>90.0%</b>	<b>0</b>	<b>0.0%</b>	<b>98,096</b>	<b>10.0%</b>

Pharmacy October 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	104,095	104,095	100.0%	0	0.0%	0	0.0%
Fill Date	104,095	104,095	100.0%	0	0.0%	0	0.0%
Days Supply	104,095	104,095	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	104,095	104,095	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	104,095	0	0.0%	0	0.0%	104,095	100.0%
Member ID (Medicaid)	104,095	104,077	100.0%	0	0.0%	18	0.0%
NDC	104,095	104,095	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	104,095	104,095	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	104,095	104,095	100.0%	0	0.0%	0	0.0%
Refill Number	104,095	104,095	100.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>1,040,950</b>	<b>936,837</b>	<b>90.0%</b>	<b>0</b>	<b>0.0%</b>	<b>104,113</b>	<b>10.0%</b>

Total Pharmacy KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Billed Charges	202,183	202,183	100.0%	0	0.0%	0	0.0%
Fill Date	202,183	202,183	100.0%	0	0.0%	0	0.0%
Days Supply	202,183	202,183	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	202,183	202,183	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	202,183	0	0.0%	0	0.0%	202,183	100.0%
Member ID (Medicaid)	202,183	202,157	100.0%	0	0.0%	26	0.0%
NDC	202,183	202,183	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	202,183	202,183	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	202,183	202,183	100.0%	0	0.0%	0	0.0%
Refill Number	202,183	202,183	100.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>2,021,830</b>	<b>1,819,621</b>	<b>90.0%</b>	<b>0</b>	<b>0.0%</b>	<b>202,209</b>	<b>10.0%</b>

Total May 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	15,725	15,725	100.0%			0	0.0%
Bill Type (digits 1 and 2)	103,956	103,956	100.0%			0	0.0%
Billed Charges	373,243	373,242	100.0%	0	0.0%	1	0.0%
Billing Provider NPI/Number	247,806	241,182	97.3%	397	0.2%	6,227	2.5%
Diagnosis Codes	241,182	241,182	100.0%	0	0.0%	0	0.0%
Date of Service	275,155	275,155	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	373,243	354,911	95.1%	0	0.0%	18,332	4.9%
Health Plan Paid Date	373,243	238,845	64.0%	0	0.0%	134,398	36.0%
Member ID (Medicaid)	373,243	373,166	100.0%	0	0.0%	77	0.0%
Place of Service	164,575	164,575	100.0%	0	0.0%	0	0.0%
Procedure Code	259,430	259,428	100.0%	0	0.0%	2	0.0%
Procedure Code Modifiers	232,081	232,081	100.0%			0	0.0%
Revenue Code	103,956	103,956	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	268,531	268,374	99.9%	0	0.0%	157	0.1%
Surgical Procedure Codes	1,534	1,534	100.0%			0	0.0%
Date Filled	98,088	98,088	100.0%	0	0.0%	0	0.0%
Days Supply	98,088	98,088	100.0%	0	0.0%	0	0.0%
National Drug Code (NDC)	98,088	98,088	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	98,088	98,088	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	98,088	98,088	100.0%	0	0.0%	0	0.0%
Refill Number	98,088	98,088	100.0%	0	0.0%	0	0.0%
Tooth Number	27,349	27,349	100.0%			0	0.0%
Tooth Surface	27,349	27,349	100.0%			0	0.0%
<b>Total</b>	<b>4,050,129</b>	<b>3,890,538</b>	<b>96.1%</b>	<b>397</b>	<b>0.0%</b>	<b>159,194</b>	<b>3.9%</b>

October 2024 KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	16,956	16,956	100.0%			0	0.0%
Bill Type (digits 1 and 2)	122,938	122,938	100.0%			0	0.0%
Billed Charges	404,173	404,173	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	262,572	254,967	97.1%	757	0.3%	6,848	2.6%
Diagnosis Codes	254,967	254,962	100.0%	0	0.0%	5	0.0%
Date of Service	300,078	300,078	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	404,173	404,173	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	404,173	300,078	74.2%	0	0.0%	104,095	25.8%
Member ID (Medicaid)	404,173	404,079	100.0%	0	0.0%	94	0.0%
Place of Service	169,535	169,535	100.0%	0	0.0%	0	0.0%
Procedure Code	283,122	283,122	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	245,616	245,616	100.0%			0	0.0%
Revenue Code	122,938	122,938	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	292,473	292,343	100.0%	0	0.0%	130	0.0%
Surgical Procedure Codes	1,340	1,332	99.4%			8	0.6%
Date Filled	104,095	104,095	100.0%	0	0.0%	0	0.0%
Days Supply	104,095	104,095	100.0%	0	0.0%	0	0.0%
National Drug Code (NDC)	104,095	104,095	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	104,095	104,095	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	104,095	104,095	100.0%	0	0.0%	0	0.0%
Refill Number	104,095	104,095	100.0%	0	0.0%	0	0.0%
Tooth Number	37,506	37,506	100.0%			0	0.0%
Tooth Surface	37,506	37,506	100.0%			0	0.0%
<b>Total</b>	<b>4,388,809</b>	<b>4,276,872</b>	<b>97.4%</b>	<b>757</b>	<b>0.0%</b>	<b>111,180</b>	<b>2.5%</b>

Grand Total KDE

Key Data Element	Number Evaluated	Valid Values Count	Valid Values Percent	Missing Values Count	Missing Values Percent	Erroneous Values Count	Erroneous Values Percent
Admission Date	32,681	32,681	100.0%			0	0.0%
Bill Type (digits 1 and 2)	226,894	226,894	100.0%			0	0.0%
Billed Charges	777,416	777,415	100.0%	0	0.0%	1	0.0%
Billing Provider NPI/Number	510,378	496,149	97.2%	1,154	0.2%	13,075	2.6%
Diagnosis Codes	496,149	496,144	100.0%	0	0.0%	5	0.0%
Date of Service	575,233	575,233	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	777,416	759,084	97.6%	0	0.0%	18,332	2.4%
Health Plan Paid Date	777,416	538,923	69.3%	0	0.0%	238,493	30.7%
Member ID (Medicaid)	777,416	777,245	100.0%	0	0.0%	171	0.0%
Place of Service	334,110	334,110	100.0%	0	0.0%	0	0.0%
Procedure Code	542,552	542,550	100.0%	0	0.0%	2	0.0%
Procedure Code Modifiers	477,697	477,697	100.0%			0	0.0%
Revenue Code	226,894	226,894	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	561,004	560,717	99.9%	0	0.0%	287	0.1%
Surgical Procedure Codes	2,874	2,866	99.7%			8	0.3%
Date Filled	202,183	202,183	100.0%	0	0.0%	0	0.0%
Days Supply	202,183	202,183	100.0%	0	0.0%	0	0.0%
National Drug Code (NDC)	202,183	202,183	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	202,183	202,183	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	202,183	202,183	100.0%	0	0.0%	0	0.0%
Refill Number	202,183	202,183	100.0%	0	0.0%	0	0.0%
Tooth Number	64,855	64,855	100.0%			0	0.0%
Tooth Surface	64,855	64,855	100.0%			0	0.0%
<b>Total</b>	<b>8,438,938</b>	<b>8,167,410</b>	<b>96.8%</b>	<b>1,154</b>	<b>0.0%</b>	<b>270,374</b>	<b>3.2%</b>

# Appendix D: Average Per Member Utilization and Paid Amounts by Service Type

Distinct Member Count Receiving services based on supplemental claims data for CY 2024

Heritage Health	Molina	Percentage of Heritage Health
374,325	122,282	32.7%

Percentage difference Molina vs Heritage Health

Service Type	Count	Percentage
Ancillary	-18.4%	-58.6%
Dental	-24.9%	-23.3%
Inpatient	-9.4%	1.7%
Outpatient	-12.0%	-21.3%
Pharmacy	-22.3%	-11.9%
Primary Care	-62.8%	-58.3%
Specialty	24.4%	36.9%
Transportation	-28.1%	-8.1%
Vision	-36.8%	-31.6%
<b>Total Services</b>	<b>-20.3%</b>	<b>-12.4%</b>

**Heritage Health Average Per Member Utilization and Paid Amounts by Service Type**

Service Type	Count	PMPY <sup>1</sup>	Paid Amount	PMPY <sup>1</sup>
Ancillary	1,101,268	2.9	\$93,130,238	\$249
Dental	966,086	2.6	\$57,040,172	\$152
Inpatient	606,822	1.6	\$416,832,140	\$1,114
Outpatient	3,238,688	8.7	\$469,818,928	\$1,255
Pharmacy	4,502,719	12.0	\$495,130,735	\$1,323
Primary Care	2,546,245	6.8	\$167,946,493	\$449
Specialty	2,129,425	5.7	\$218,707,385	\$584
Transportation	355,171	0.9	\$24,640,430	\$66
Vision	399,749	1.1	\$14,817,637	\$40
<b>Total Services<sup>2</sup></b>	<b>15,846,173</b>	<b>42.3</b>	<b>\$1,958,064,157</b>	<b>\$5,231</b>

<sup>1</sup> Paid amount divided by the average number of members receiving services.

<sup>2</sup> Differences are due to rounding.

**Molina Health Average Per Member Utilization and Paid Amounts by Service Type**

Service Type	Count	PMPY <sup>1</sup> Count	Paid Amount	PMPY Amount
Ancillary	293,636	2.4	\$12,590,510	\$103
Dental	237,026	1.9	\$14,296,613	\$117
Inpatient	179,522	1.5	\$138,493,586	\$1,133
Outpatient	930,695	7.6	\$120,748,684	\$987
Pharmacy	1,143,632	9.4	\$142,542,399	\$1,166
Primary Care	309,388	2.5	\$22,864,939	\$187
Specialty	865,243	7.1	\$97,783,829	\$800
Transportation	83,408	0.7	\$7,399,601	\$61
Vision	82,526	0.7	\$3,309,110	\$27
<b>Total Services</b>	<b>4,125,076</b>	<b>33.7</b>	<b>\$560,029,270</b>	<b>\$4,580</b>

## Appendix E: Timely Payment of Claims

Timely Payment of Claims by Absolute Percentages

Service Type	15 Business Days / 90% Count	15 Business Days / 90% Absolute Percentage	60 Calendar Days / 99% Count	60 Calendar Days / 99% Absolute Percentage	180 Calendar Days / 100% Count	180 Calendar Days / 100% Absolute Percentage	Over 180 Calendar Days / 100% Count	Over 180 Calendar Days / 100% Absolute Percentage
Inpatient	35,033	92.3%	2,722	7.2%	157	0.4%	35	0.1%
Outpatient	94,530	98.3%	1,584	1.6%	58	0.1%	0	0.0%
Professional	185,987	98.0%	1,235	0.7%	2,306	1.2%	236	0.1%
Behavioral Health	370,984	98.7%	3,189	0.8%	1,641	0.4%	42	0.0%
Vision	68,155	92.8%	5,178	7.0%	122	0.2%	12	0.0%
Pharmacy	462,381	100.0%	0	0.0%	0	0.0%	0	0.0%
Dental	32,857	99.9%	27	0.1%	0	0.0%	0	0.0%
<b>Total</b>	<b>1,249,927</b>	<b>98.5%</b>	<b>13,935</b>	<b>1.1%</b>	<b>4,284</b>	<b>0.3%</b>	<b>325</b>	<b>0.0%</b>

Timely Payment of Claims by Cumulative Percentages

Service Type	15 Business Days / 90% Cumulative Count	15 Business Days / 90% Percentage	60 Calendar Days / 99% Cumulative Count	60 Calendar Days / 99% Cumulative Percentage	180 Calendar Days / 100% Cumulative Count	180 Calendar Days / 100% Cumulative Percentage	Over 180 Calendar Days / 100% Cumulative Count	Over 180 Calendar Days / 100% Cumulative Percentage
Inpatient	35,033	92.3%	37,755	99.5%	37,912	99.9%	37,947	100.0%
Outpatient	94,530	98.3%	96,114	99.9%	96,172	100.0%	96,172	100.0%
Professional	185,987	98.0%	187,222	98.7%	189,528	99.9%	189,764	100.0%
Behavioral Health	370,984	98.7%	374,173	99.6%	375,814	100.0%	375,856	100.0%
Vision	68,155	92.8%	73,333	99.8%	73,455	100.0%	73,467	100.0%
Pharmacy	462,381	100.0%	462,381	100.0%	462,381	100.0%	462,381	100.0%
Dental	32,857	99.9%	32,884	100.0%	32,884	100.0%	32,884	100.0%
<b>Total</b>	<b>1,249,927</b>	<b>98.5%</b>	<b>1,263,862</b>	<b>99.6%</b>	<b>1,268,146</b>	<b>100.0%</b>	<b>1,268,471</b>	<b>100.0%</b>

Timely Payment of Claims Total Counts and Average Paid in Calendar Days

Service Type	Total Count	Average Calendar Days
Inpatient	37,947	8
Outpatient	96,172	4
Professional	189,764	6
Behavioral Health	375,856	4
Vision	73,467	7
Pharmacy	462,381	0
Dental	32,884	4
<b>Total</b>	<b>1,268,471</b>	<b>3</b>

## Appendix F: Medical Records Validity Rate

### Inpatient Medical Records Validity Rate

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Admit Date	26	24	92.3%	2	7.7%
Billing Provider	26	26	100.0%	0	0.0%
Diagnosis Codes	90	85	94.4%	5	5.6%
First DOS	26	25	96.2%	1	3.8%
Last DOS	26	24	92.3%	2	7.7%
Member Name	26	26	100.0%	0	0.0%
Revenue Code	323	304	94.1%	19	5.9%
Servicing Provider	26	26	100.0%	0	0.0%
Surgical Procedure Codes	44	41	93.2%	3	6.8%
Type of Bill Code	26	26	100.0%	0	0.0%
<b>Total</b>	<b>639</b>	<b>607</b>	<b>95.0%</b>	<b>32</b>	<b>5.0%</b>

Note: 26 of the 27 medical records requested were tested.

Note: Member DOB was not submitted in the supplemental claims data.

Outpatient Medical Records Validity Rate

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Billing Provider	24	24	100.0%	0	0.0%
Diagnosis Codes	41	41	100.0%	0	0.0%
DOS	24	24	100.0%	0	0.0%
Member Name	24	24	100.0%	0	0.0%
Procedure Code	113	104	92.0%	9	8.0%
Procedure Code Modifiers	25	25	100.0%	0	0.0%
Revenue Code	106	96	90.6%	10	9.4%
Servicing Provider	24	24	100.0%	0	0.0%
Type of Bill Code	24	23	95.8%	1	4.2%
<b>Total</b>	<b>405</b>	<b>385</b>	<b>95.1%</b>	<b>20</b>	<b>4.9%</b>

Note: 24 of the 26 medical records requested were tested.

Note: Member DOB was not submitted in the supplemental claims data.

Professional Medical Records Validity Rate

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Billing Provider	34	29	85.3%	5	14.7%
Diagnosis Codes	46	45	97.8%	1	2.2%
DOS	34	32	94.1%	2	5.9%
Member Name	34	34	100.0%	0	0.0%
Place of Service	34	31	91.2%	3	8.8%
Procedure Code	65	64	98.5%	1	1.5%
Procedure Modifiers	24	24	100.0%	0	0.0%
Servicing Provider	34	32	94.1%	2	5.9%
<b>Total</b>	<b>305</b>	<b>291</b>	<b>95.4%</b>	<b>14</b>	<b>4.6%</b>

Note: 34 of the 36 medical records requested were tested.

Note: Member DOB was not submitted in the supplemental claims data.

Vision Records Validity Rate

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Billing Provider	2	2	100.0%	0	0.0%
Diagnosis Codes	2	2	100.0%	0	0.0%
Date of Service	2	2	100.0%	0	0.0%
Member Name	2	2	100.0%	0	0.0%
Place of Service	2	2	100.0%	0	0.0%
Procedure Code	2	2	100.0%	0	0.0%
Procedure Code Modifiers	2	2	100.0%	0	0.0%
Servicing Provider	2	2	100.0%	0	0.0%
<b>Total</b>	<b>16</b>	<b>16</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>

Note: 2 of the 2 medical records requested were tested.

Note: Member DOB was not submitted in the supplemental claims data.

Transportation Records Validity Rate

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Billing Provider	1	1	100.0%	0	0.0%
Date of Service	1	1	100.0%	0	0.0%
Member Name	1	1	100.0%	0	0.0%
Procedure Code	1	1	100.0%	0	0.0%
Servicing Provider	1	1	100.0%	0	0.0%
<b>Total</b>	<b>5</b>	<b>5</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>

Note: 1 of the 1 medical records requested were tested.

Note: Member DOB was not submitted in the supplemental claims data.

**Dental Records Validity Rate**

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Billing Provider	3	3	100.0%	0	0.0%
Diagnosis Codes	0	0	0.0%	0	0.0%
Date of Service	3	3	100.0%	0	0.0%
Member Name	3	3	100.0%	0	0.0%
Place of Service	3	3	100.0%	0	0.0%
Procedure Code	8	8	100.0%	0	0.0%
Procedure Code Modifiers	0	0	0.0%	0	0.0%
Servicing Provider	3	3	100.0%	0	0.0%
<b>Total</b>	<b>23</b>	<b>23</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>

Note: 3 of the 3 medical records requested were tested.

Note: Member DOB was not submitted in the supplemental claims data.

**Pharmacy Records Validity Rate**

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Billing Provider	24	23	95.8%	1	4.2%
Days Supply	24	13	54.2%	11	45.8%
DOS	24	22	91.7%	2	8.3%
Member Name	24	24	100.0%	0	0.0%
Nation Drug Code (NDC)	24	24	100.0%	0	0.0%
Prescribing Provider	23	23	100.0%	0	0.0%
Quantity Dispensed	24	24	100.0%	0	0.0%
<b>Total</b>	<b>167</b>	<b>153</b>	<b>91.6%</b>	<b>14</b>	<b>8.4%</b>

Note: 24 of the 25 medical records requested were tested.

Note: Member DOB was not submitted in the supplemental claims data.

Total Records Validity Rate

Key Data Element	Total Elements Sampled Count	Supported Elements Count	Supported Elements Percent	Unsupported Elements Count	Unsupported Elements Percent
Admit Date	26	26	100.0%	0	0.0%
Billing Provider	114	110	96.5%	4	3.5%
Days Supply	24	13	54.2%	11	45.8%
Diagnosis Codes	504	474	94.0%	30	6.0%
First Date of Service/DOS	204	196	96.1%	8	3.9%
Last Date of Service	26	25	96.2%	1	3.8%
Member Name	114	107	93.9%	7	6.1%
Nation Drug Code (NDC)	24	24	100.0%	0	0.0%
Place of Service	39	37	94.9%	2	5.1%
Prescribing Provider	23	23	100.0%	0	0.0%
Procedure Code	153	144	94.1%	9	5.9%
Procedure Code Modifiers	64	61	95.3%	3	4.7%
Quantity Dispensed	24	24	100.0%	0	0.0%
Revenue Code	50	50	100.0%	0	0.0%
Servicing Provider	77	77	100.0%	0	0.0%
Surgical Procedure Codes	44	41	93.2%	3	6.8%
Type of Bill Code	50	48	96.0%	2	4.0%
<b>Total</b>	<b>1,560</b>	<b>1,480</b>	<b>94.9%</b>	<b>80</b>	<b>5.1%</b>