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December 8, 2021

Shirley Norris
Director of Managed Care
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St., Room 900
Topeka, KS 66612

RE: Percent of Encounter Submissions within 30 Days Performance Measure of Aetna Better Health of Kansas for MY 2020

Dear Ms. Norris:

Enclosed is KFMC's report for the 2020 Percent of Encounter Submissions within 30 Days, a performance measure of Aetna Better Health of Kansas. The report includes the calculation methodology and stratified tables of counts and percentages.

Each MCO received preliminary reports and data files, if requested, so they could conduct root cause analysis and validate preliminary rates. Exemptions to the measure approved by the State are reflected in the rates within this report.

Please contact me, jmcnamee@kfmc.org, if you have any questions or concerns.

Sincerely,

John R. McNamee, Ph.D., MA
Senior Health Data Analyst

Electronic Version: Sheri Jurad, EQR Audit Manager/Supervisor, KDHE
Christiane Swartz, Deputy Medicaid Director/Director of Medicaid Operations, KDHE
Dr. Janice Panichello, Senior Health Data Analyst, KDHE
Stephen Blackwell, Interagency Program Manager, KDHE
Michele Heydon, HCBS Director, KDADS
Mitzie Tyree, HCBS Quality and Program Coordinator, KDADS
Amy Penrod, Commissioner, Aging & Disability Comm. Services & Programs, KDADS
Brad Ridley, Director of Operations, KDADS
Melissa Lawson, Director, Healthcare Quality Management, Aetna
David Livingston, CEO, Aetna
Lisa Baird, COO, Aetna
Marc Shiff, Compliance Officer, Aetna
Dr. Muna Enshiwat, Chief Medical Officer, Aetna
Sarah Fertig, State Medicaid Director, KDHE
Bobbie Graff-Hendrixson, Senior Manager Contracts & Fiscal Agents Operations, KDHE

Enclosure(s)

Percent of Encounter Submissions within 30 Days – MY 2020
Aetna Better Health of Kansas
December 8, 2021

Background/Objectives

As the external quality review organization (EQRO) for the State of Kansas, the KFMC Health Improvement Partners (KFMC) calculated quarterly rates for a set of performance measures for the managed care organizations (MCOs): Aetna Better Health of Kansas (Aetna), Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas. The measures are used for the pay-for-performance (P4P) incentive program. The P4P requirements were defined by the State with input from the MCOs.

Reports of preliminary rates (exemptions approved by the State had not been applied, and validation activities were not fully complete) were previously submitted to the State and MCOs. On request, the MCOs also received files of encounters not meeting numerator criteria. The purpose of the preliminary reports and data files was to

- Aid the MCOs in identification of encounters that may be eligible for exemption from the measure,
- Provide an opportunity for the State and MCOs to offer comments and documentation to support correction of any factual errors, and
- Provide an opportunity for the MCOs to clarify any issues or findings identified by KFMC.

KFMC received the MCOs' comments, and the State completed the process of approving exemptions; rates and findings were revised, where appropriate.

Performance Measure Calculated

The P4P incentive program provides incentives to the MCOs for timely and complete submission of encounter data to the State's fiscal agent. This report details data sources, calculation methods, validation activities, and quarterly rates for the performance measure "Percent of covered service accurately submitted via encounter within 30 days of claim paid date" for measurement year (MY) 2020.

The quarterly percentages of covered service accurately submitted via encounter within 30 days of claim paid date for MY 2020, by quarter, are displayed in Table 1. The percentages reflect exemptions to the denominator approved by the State.

Incentive payments are made based on quarterly measurements. The P4P performance target for each measurement is to achieve or maintain 98.00% for full incentive payment or 95.00% for 50% incentive payment. MY2020 percentages for Aetna are below the payment targets: 93.02% for Q1, 88.09% for Q2, 92.74% for Q3, and 74.63% for Q4.

Table 1. Percent of Encounter Submissions within 30 Days, MY 2020 – Aetna					
2020	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Number of claims paid or denied by the MCO	866,844	894,496	899,293	1,271,342	3,931,975
Number submitted as encounters within 30 days	806,321	787,943	833,966	948,793	3,377,023
Percentage	93.02%	88.09%	92.74%	74.63%	85.89%
Target (98.00% for 100% payment, 95.00% for 50% payment)	Not Met	Not Met	Not Met	Not Met	

The data source is the Medicaid Management Information System (MMIS). The denominator is the number of claims initially submitted to the fiscal agent by the MCO within the measurement quarter. The denominator includes new-day and adjusted encounters from all claim types (professional, institutional, dental, and pharmacy) and has been deduplicated to include only the first submitted encounter record per claim. Submission dates are identified by the MMIS field DTE_BILLED.

The technical specifications are provided in Table 2.

Table 2: Technical Specifications for Encounter Data Submission within 30 Days, MY 2020	
Measure Name	Percent of covered service accurately submitted via encounter within 30 days of claim paid date
Population	Covered services for all KanCare members
Specifications	**Denominator**: Encounters for covered services initially submitted to the fiscal agent during the measurement period, excluding encounters that cannot be submitted due to MMIS backlog or State issue to not submit encounters due to backlog in the queue **Numerator:** Encounters meeting denominator criteria where the submission date is within 30 calendar days of the paid date
Timeframe	Calendar year 2020 with calendar quarter measurement periods
Component	**Additional Detail**
Source Data	Data sources used to calculate the numerator and denominator are Medicaid Management Information System (MMIS) encounter tables.
Population	The populations from which the denominators are drawn include: • All claim types (professional, institutional, dental, and pharmacy), • Paid and denied claims, and • New-day and adjusted claims.
Denominator	Submission date (identified by MMIS DTE_BILLED field) is within the calendar quarter. Deduplication is to the first submitted encounter per claim. Deduplication routine queries back three years (to 1/1/2017) for initial submissions (effectively 1/1/2019 for Aetna) Deduplication is stratified by the four claim types. Encounters approved by the State as exemptions due to backlog issues are excluded from the denominator.
Numerator	Calculations use the formula (Submission Date – Paid Date) ≤ 30.
Target	The performance target for each quarter is 98.00 % for 100% of incentive payment or 95.00% for 50% incentive payment.

Validation Activities and Technical Methods

Appendix A, Tables Stratified by Type of Claim, contains additional analytic results, including counts of

- Encounters submitted in 2020,
- Encounters removed during deduplication,
- Claim meeting denominator criteria (before exempt encounters are excluded),

- Claims not meeting numerator criteria, and
- Non-numerator claims, by submission date, with the 10 highest counts displayed per quarter.

Appendix B, Activities and Technical Methods, describes

- Teams and primary contacts,
- Data sources,
- Cleaning and validation of source data,
- Technical methods of measure calculations, and
- Technical methods of post-calculation analysis and reporting.

For each quarter, KFMC provided technical assistance and files of encounters for claims not submitted within 30 days for Aetna to conduct root cause analysis and to identify encounters potentially meeting exemption criteria. After being notified of exemptions approved by the State, quarterly rates were recalculated.

As shown in Appendix A, percentages lower than the target were not isolated to just a few claim types or submission dates. From Table A1, only six percentages have been above 98.00%: Q1, Q2 and Q4 for dental; Q2 and Q4 for HCBS; and Q3 for pharmacy.

The primary driver of low Q4 rates was late submission of denied pharmacy encounters. Previous preliminary reports noted that Aetna had not submitted encounters for denied pharmacy claims for 2019 or 2020 (as of December 11, 2020). Between December 16 and 18, Aetna submitted the bulk of the outstanding encounters for pharmacy claims denied in 2020. Consequently, the Q4 percentage for the pharmacy stratum (47.32%) was exceptionally low.

For each quarter, KFMC provided technical assistance and files of encounters for claims not submitted within 30 days for Aetna to conduct root cause analysis and to identify encounters potentially meeting exemption criteria. After being notified of exemptions approved by the State, quarterly rates were recalculated, and Table 1 and Table A1 were updated (because the purpose of Table A2 was to identify possible exemptions, it was not updated).

Conclusions

Aetna's MY 2020 percentages are below the targets for incentive payment: 93.02% for Q1, 88.09% for Q2, 92.74% for Q3, and 74.63% for Q4. The target is 98.00% for 100% incentive payment or 95.00% for 50% incentive payment.

Recommendations

Continue monitoring data completeness and timeliness of encounter submission for all claim types.

End of written report

Appendix A

Percent of Encounter Submissions within 30 Days – MY 2020

Aetna Better Health of Kansas

Tables Stratified by Type of Claim

Table A1. Encounter Submissions within 30 Days, MY 2020 – Aetna					
All Claim Types*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	1,273,456	1,243,042	1,045,175	1,426,641	4,988,314
Minus duplicates identified by MCO ICN^	-160,274	-245,438	-140,466	-113,618	-659,796
Minus duplicates identified by selected fields†	-7,160	-6,658	-5,416	-41,681	-60,915
Number of claims represented by an encounter	1,106,022	990,946	899,293	1,271,342	4,267,603
Minus claims with a State-approved exemption	-239,178	-96,450	-0	-0	-335,628
Number submitted over 30 days after paid date	60,523	106,553	65,327	322,549	554,952
Denominator (claims represented minus exemption)	866,844	894,496	899,293	1,271,342	3,931,975
Numerator (submitted within 30 days)	806,321	787,943	833,966	948,793	3,377,023
Percentage	93.02%	88.09%	92.74%	74.63%	85.89%
Physician*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	277,981	224,430	215,193	264,067	981,671
Minus duplicates identified by MCO ICN^	-11,529	-38,739	-32,430	-58,233	-140,931
Minus duplicates identified by selected fields†	-1,732	-1,129	-1,115	-1,090	-5,066
Number of claims represented by an encounter	264,720	184,562	181,648	204,744	835,674
Minus claims with a State-approved exemption	-77,780	-8,834	-0	-0	-86,614
Number submitted over 30 days after paid date	11,772	6,632	16,569	4,106	39,079
Denominator (claims represented minus exemption)	186,940	175,728	181,648	204,744	749,060
Numerator (submitted within 30 days)	175,168	169,096	165,079	200,638	709,981
Percentage	93.70%	96.23%	90.88%	97.99%	94.78%
HCBS and Mental Health*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	264,365	385,279	233,568	215,876	1,099,088
Minus duplicates identified by MCO ICN^	-32,997	-134,489	-47,858	-18,533	-233,877
Minus duplicates identified by selected fields†	-381	-483	-409	-501	-1,774
Number of claims represented by an encounter	230,987	250,307	185,301	196,842	863,437
Minus claims with a State-approved exemption	-64,417	-56,273	-0	-0	-120,690
Number submitted over 30 days after paid date	9,630	2,194	6,368	1,459	19,651
Denominator (claims represented minus exemption)	166,570	194,034	185,301	196,842	742,747
Numerator (submitted within 30 days)	156,940	191,840	178,933	195,383	723,096
Percentage	94.22%	98.87%	96.56%	99.26%	97.35%
Other Professional*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	272,075	191,352	207,225	182,485	853,137
Minus duplicates identified by MCO ICN^	-90,040	-47,611	-50,978	-18,719	-207,348
Minus duplicates identified by selected fields†	-1,214	-865	-490	-4,812	-7,381
Number of claims represented by an encounter	180,821	142,876	155,757	158,954	638,408
Minus claims with a State-approved exemption	-45,313	-17,997	-0	-0	-63,310
Number submitted over 30 days after paid date	4,729	5,056	23,297	10,531	43,613
Denominator (claims represented minus exemption)	135,508	124,879	155,757	158,954	575,098
Numerator (submitted within 30 days)	130,779	119,823	132,460	148,423	531,485
Percentage	96.51%	95.95%	85.04%	93.37%	92.42%

* Encounters submitted to the State's fiscal agent in 2020. Professional encounters were defined as encounters for professional-billed claims (i.e., billed on a CMS-1500 or equivalent claim form). The physician, HCBS, and mental health strata of professional encounters were identified by provider type codes 31, 55, and 11, respectively.

^ Deduplicated to one encounter per combination of member's Medicaid ID, first day of service, MCO internal control number, and date paid (or denied).

† Fields selected for deduplication were member's Medicaid ID, first day of service, billing provider's national provider identification (NPI), billed amount, date paid (or denied), and amount paid.

Table A1. Encounter Submissions within 30 Days, MY 2020 – Aetna (Continued)					
Facility*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2020**
Number of facility encounters submitted	148,267	92,993	104,527	111,774	457,561
Minus duplicates identified by MCO ICN^	-2,205	-7,834	-5,419	-4,270	-19,728
Minus duplicates identified by selected fields†	-340	-240	-330	-127	-1,037
Number of claims represented by an encounter	145,722	84,919	98,778	107,377	436,796
Minus claims with a State-approved exemption	-50,844	-13,346	-0	-0	-64,190
Number submitted over 30 days after paid date	5,700	5,130	15,039	4,593	30,462
Denominator (claims represented minus exemption)	94,878	71,573	98,778	107,377	372,606
Numerator (submitted within 30 days)	89,178	66,443	83,739	102,784	342,144
Percentage	93.99%	92.83%	84.77%	95.72%	91.82%
Dental*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2020**
Number of dental encounters submitted	31,106	30,630	35,842	44,621	142,199
Minus duplicates identified by MCO ICN^	-3,897	-16,739	-3,737	-13,830	-38,203
Minus duplicates identified by selected fields†	-53	-56	-101	-88	-298
Number of claims represented by an encounter	27,156	13,835	32,004	30,703	103,698
Minus claims with a State-approved exemption	-824	-0	-0	-0	-824
Number submitted over 30 days after paid date	0	8	4,000	129	4,137
Denominator (claims represented minus exemption)	26,332	13,835	32,004	30,703	102,874
Numerator (submitted within 30 days)	26,332	13,827	28,004	30,574	98,737
Percentage	100.00%	99.94%	87.50%	99.58%	95.98%
Pharmacy*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2020**
Number of pharmacy encounters submitted	279,662	318,358	248,820	607,818	1,454,658
Minus duplicates identified by MCO ICN^	-19,606	-26	-44	-33	-19,709
Minus duplicates identified by selected fields†	-3,440	-3,885	-2,971	-35,063	-45,359
Number of claims represented by an encounter	256,616	314,447	245,805	572,722	1,389,590
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	28,692	87,533	54	301,731	418,010
Denominator (claims represented minus exemption)	256,616	314,447	245,805	572,722	1,389,590
Numerator (submitted within 30 days)	227,924	226,914	245,751	270,991	971,580
Percentage	88.82%	72.16%	99.98%	47.32%	69.92%

* Encounters submitted to the State's fiscal agent in 2020, by claim type; facility encounters were defined as encounters for institutionally-billed claims (i.e., billed on a UB-04 or equivalent claim form), dental encounters were defined as encounters for claims billed on an American Dental Association (ADA) dental claim form, and pharmacy encounters were defined as encounters for claims billed through the MCO's pharmacy benefits manager.

^ Deduplicated to one encounter per combination of member's Medicaid ID, first day of service, and MCO internal control number.

† Fields selected for deduplication of non-pharmacy encounters were member's Medicaid ID, first day of service, billing provider's NPI, billed amount, date paid (or denied), and amount paid. For pharmacy encounters, fields selected for deduplication were member's Medicaid ID, dispense date, billing provider's NPI, billed amount, date paid (or denied), amount paid, dispensed quantity, and days' supply.

Note: counts and percentages in Table A2 were calculated without excluding State-approved exempt encounters.

Table A2. Dates with Highest Incidence of Late Submissions, MY 2020 – Aetna

Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2020 Q1	Physician	1/30/2020	41,075	13.71%	3.71%
Denominator: 1,106,022	HCBS/MH	3/6/2020	37,785	12.61%	3.42%
Numerator: 806,321	Other Professional	1/30/2020	23,206	7.74%	2.10%
Percent: 72.90%	Physician	2/20/2020	20,357	6.79%	1.84%
	Pharmacy	1/14/2020	18,531	6.18%	1.68%
All Over 30 Days: 299,701	Facility	1/10/2020	13,329	4.45%	1.21%
Percent: 27.10%	HCBS/MH	2/20/2020	11,848	3.95%	1.07%
	Facility	3/2/2020	11,732	3.91%	1.06%
	Physician	2/13/2020	9,674	3.23%	0.87%
	Facility	1/31/2020	8,713	2.91%	0.79%
	Total of Top 10		**196,250**	**65.48%**	**17.74%**
2020 Q2	Pharmacy	5/19/2020	54,405	26.80%	5.49%
Denominator: 990,946	HCBS/MH	4/3/2020	51,800	25.52%	5.23%
Numerator: 787,943	Pharmacy	5/20/2020	13,457	6.63%	1.36%
Percentage: 79.51%	Pharmacy	5/14/2020	10,935	5.39%	1.10%
	Other Professional	4/24/2020	8,859	4.36%	0.89%
All Over 30 Days: 203,003	Pharmacy	4/1/2020	6,859	3.38%	0.69%
Percentage: 20.49%	Facility	6/8/2020	5,558	2.74%	0.56%
	Physician	6/30/2020	5,537	2.73%	0.56%
	Facility	5/5/2020	4,786	2.36%	0.48%
	Other Professional	5/15/2020	3,838	1.89%	0.39%
	Total of Top 10		**166,034**	**81.79%**	**16.76%**
2020 Q3	Other Professional	9/11/2020	8,296	12.70%	0.92%
Denominator: 899,293	Facility	7/16/2020	7,352	11.25%	0.82%
Numerator: 833,966	Other Professional	7/16/2020	6,068	9.29%	0.67%
Percentage: 92.74%	Physician	7/16/2020	4,060	6.21%	0.45%
	Dental	7/10/2020	3,957	6.06%	0.44%
All Over 30 Days: 65,327	Physician	8/25/2020	2,749	4.21%	0.31%
Percentage: 7.26%	Physician	8/28/2020	2,416	3.70%	0.27%
	Other Professional	7/17/2020	2,022	3.10%	0.22%
	Other Professional	7/1/2020	1,849	2.83%	0.21%
	Facility	7/27/2020	1,818	2.78%	0.20%
	Total of Top 10		**40,587**	**62.13%**	**4.51%**
2020 Q4	Pharmacy	12/17/2020	130,373	40.42%	10.25%
Denominator: 1,271,342	Pharmacy	12/16/2020	98,910	30.67%	7.78%
Numerator: 948,793	Pharmacy	12/18/2020	72,367	22.44%	5.69%
Percentage: 74.63%	Other Professional	12/18/2020	7,168	2.22%	0.56%
	Other Professional	10/23/2020	1,390	0.43%	0.11%
All Over 30 Days: 322,549	Physician	11/4/2020	1,123	0.35%	0.09%
Percentage: 25.37%	Facility	12/8/2020	1,010	0.31%	0.08%
	Facility	12/29/2020	948	0.29%	0.07%
	Other Professional	12/31/2020	814	0.25%	0.06%
	Physician	11/4/2020	799	0.25%	0.06%
	Total of Top 10		**314,902**	**97.63%**	**24.77%**

* The denominator is the number of claims initially submitted as an encounter record to the State fiscal agent by the MCO in 2020. The count "All Over 30 Days" is the number of encounters in the denominator that were submitted over 30 days after the MCO paid or denied the claim, that is, the number of claims not meeting numerator criteria.

^ Claim types for encounters included: facility (billed on a UB-04 or equivalent claim form), professional (billed on a CMS-1500 or equivalent claim form), dental (billed on an American Dental Association dental claim form, and pharmacy (billed through the MCO's pharmacy benefits manager). Professional encounters were subset into physician, HCBS, and mental health (MH) claims identified by provider type codes 31, 55, and 11, respectively.

Appendix B

Percent of Encounter Submissions within 30 Days – MY 2020

Aetna Better Health of Kansas

Activities and Technical Methods

Description of Activities

Teams and Primary Contacts

Table B1 lists members of the KFMC measure calculation and validation team, and Table B2 lists State and MCO staff members serving as primary contacts for validation of this measure.

Table B1. KFMC Measure Calculation and Validation Team

Name	Title
John McNamee, PhD, MA	Senior Health Data Analyst

Table B2. State and MCO Primary Contacts

Name	Title
State	
Shirley Norris	Director of Managed Care, KDHE
Sheri Jurad	EQR Audit Manager/Supervisor, KDHE
Janice Panichello, PhD	Senior Health Data Analyst, KDHE
Aetna	
Melissa Lawson	Director of Healthcare Quality Management

Data Sources

The primary source of encounter data was the reporting warehouse of the Medicaid Management Information System (MMIS). For external quality review and other State-contracted activities, KFMC routinely downloads and archives MMIS encounter data. For MY 2020 percentages, all encounters were queried from KFMC's archived tables.

MMIS stores encounter records in four sets, depending on type of claim. The calculation and reporting of the performance measure were stratified to match MMIS's sets of encounters. The claim types used for stratification were:

- **Facility** – encounters for institutionally-billed claims (i.e., billed on a UB-04 or equivalent form);
- **Dental** – encounters for claims billed on an American Dental Association (ADA) dental claim form;
- **Pharmacy** – encounters for claims billed through the MCO's pharmacy benefits manager; and
- **Professional** – encounters for professional-billed claims (i.e., billed on a CMS-1500 or equivalent claim form). For reporting, the professional encounters were subdivided based on provider type:
  - **Physician** – encounters having provider type code 31;
  - **Home and Community Based Services (HCBS) and Mental Health** – encounters having provider type codes 55 or 11; and
  - **Other Professional** – encounters not having provider type codes 11, 31, or 55.

Data Cleaning and Validation

Encounter records queried for the measure underwent data cleaning and validation steps prior to rate calculation, including:

- Records were counted stratified by MCO, claim type, and MCO paid date. Records with missing or invalid MCO paid date values were removed from analysis;
- Records with missing billing provider NPI were counted stratified by MCO, claim type, and provider type;

- Records without an MCO ICN number were counted by MCO and claim type and then assigned a unique, dummy MCO ICN number for deduplication purposes; and
- MCO ICN numbers associated with multiple members, dates of service, billing providers, and payment amounts were analyzed for potential integrity issues.

Integrate Data into Repository

The source data were queried using SAS software and subsequently stored as SAS datasets. Data cleaning, validation analysis, and rate calculations were also performed using SAS code and datasets.

Technical Methods of Measure Calculation

The following paragraphs contain the technical details related to final calculations for the percent of covered service accurately submitted via encounter within 30 days of claim paid date measure. Because all three MCOs' data underwent the same processes, the paragraphs are not MCO-specific.

Initial Data

Two sets of encounters were initially queried from the source data tables. First, all encounters submitted by the MCOs to MMIS during 2020 were drawn. These records were flagged as potential denominator records. Many of these records were resubmissions of claims, which were considered duplicates and not included in the denominator. Because the earliest encounter submitted for a claim may have occurred before 2020, all potential earlier submissions were identified by matching the records submitted in 2020 to MMIS encounter records submitted prior to 2020 on member's Medicaid ID, date of service, and MCO paid date. At this stage, the encounters underwent the previously described data cleaning and validation steps.

Deduplicating

In certain circumstances, MCOs will need to modify an encounter record for a claim using a void-and-replace process. Both the original encounters and the replacement encounters were intentionally included in the output of the initial queries. The technical specifications state that the first submitted encounter for a claim is to be used for calculating the number of days from paid date to submission date. The encounters submitted secondarily were considered duplicates and removed from analysis. Deduplication was done in two stages.

The first stage of deduplication was based on the MCO ICN field. Encounters with the same claim type, member Medicaid ID, first date of service (or dispense date), paid date, and MCO ICN were assumed to represent the same claim. If the MCO ICN field was not populated (the field was not required before early 2015), a unique dummy value was assigned to bypass the deduplication. Duplicate encounters were moved from the dataset of potential denominator records to a new dataset.

The second stage deduplicated using a combination of fields. For professional, facility, and dental encounters, two encounters were considered to represent the same claim if they had the same claim type, member Medicaid ID, first date of service, billing provider NPI, amount billed, paid date, and amount paid. The records were sorted by these fields plus submission date and MMIS ICN. The first record representing the claim was retained and the duplicates were moved to a different dataset. The list of fields differed slightly for pharmacy encounters. Two pharmacy encounters were considered to represent the same claim if they had the same member Medicaid ID, dispense date, billing provider NPI, amount billed, paid date, and amount paid, quantity supplied, and days supplied.

The two stages of deduplication were designed to complement each other. Using the MCO ICN, duplicates caused by replacing an encounter with one having a different billing provider NPI could be eliminated (the encounters were not always populated with the NPI submitted on the claim form). The second stage could remove duplicates submitted during the transition period for the MCO ICN field (e.g., the MCO ICN may have been unpopulated on the original encounter but populated on the replacement encounter).

Calculating Preliminary Percentages

After deduplication, exemptions approved by the state were removed. The number of records that remained is the stratum's preliminary denominator.

For each remaining record, the difference between the submission date and the paid date was calculated. If submission date minus paid date was less than or equal to 30, the record was counted for the stratum's preliminary numerator.

After percentages were calculated for each stratum, the stratified preliminary numerators and denominators were summed to obtain the preliminary numerator and denominator for all claim types.

Files for MCO Validation

Records meeting denominator criteria in which the submission date minus paid date was greater than 30 were subsequently exported into text files and made available to MCOs, on request, for identifying encounters potentially meeting exclusion criteria or processes that could be improved.

Technical Methods of Post-Calculation Analysis and Reporting

This section describes validation and root-cause analysis performed by KFMC after calculation of the preliminary percentages for the performance measure.

Counts During Measure Calculation

Stratified counts of records at major stages of measure calculation are reported in Appendix A, Table A1.

Submission Dates

Stratified counts of encounters submitted over 30 days after the paid date were calculated to assist MCOs in identifying dates on which submission issues occurred. Counts were stratified by MCO, quarter, claim type, and submission date. For each quarter, the 10 submission dates with the highest counts are displayed in Appendix A, Table A2. For each submission date in Table A2, the percentage of all claims submitted over 30 days and their percentage of the denominator that were submitted on that date are also displayed.