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July 13, 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 2019 – Revised

Dear Ms. Norris:

Enclosed is KFMC's revised report for the 2019 Percent of Encounter Submissions within 30 Days, a performance measure of Aetna Better Health of Kansas. The original report, issued April 13, 2021, failed to recognize that Aetna's Q4 rate met the target for 50% of incentive payment.

The report includes the calculation and validation 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. Since the preliminary report, KFMC received files of exemptions to the measure approved by the State. The exemptions 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
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Melissa Lawson, Healthcare Quality Management Director, Aetna
David Livingston, Chief Executive Officer, Aetna
Lisa Baird, Chief Operations Officer, Aetna
Marc Shiff, Compliance Officer, Aetna
Dr. Muna Enshiwat, Medical Director, 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 – 2019
Aetna Better Health of Kansas
Revised July 13, 2021

Background/Objectives

As the external quality review organization (EQRO) for the State of Kansas, 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 preliminary rates for the performance measure "Percent of covered service accurately submitted via encounter within 30 days of claim paid date" for 2019.

Incentive payments are made based on quarterly measurements. Aetna, whose contract as a KanCare MCO began January 1, 2019, was deemed by the State to have "met the performance target" for 2019 quarters Q1 and Q2. The P4P performance target for Q3 and Q4 incentive payments was to achieve or maintain 98.00% for 100% of incentive payment, or 95.00% for 50% of incentive payment.

For Aetna, the State determined that claims paid before July 1, 2019, were exempt if submitted in Q3, but they would not be exempt if submitted after September 30, 2019. The final percentages of covered service accurately submitted via encounter within 30 days of claim paid date for CY2019, by quarter, are displayed in Table 1. The percentages reflect exemptions to the denominator approved by the State.

Aetna's percentage for Q3 (98.14%) met the 98.00% target for 100% of the incentive payment; the Q4 percentage (97.79%) met the 95.00% target for 50% of incentive payment.

Table 1. Percent of Encounter Submissions within 30 Days, CY2019 – Aetna

2019	Q1	Q2	Q3	Q4	Annual
Number of claims represented by an encounter	0	6,680	1,444,359	1,311,576	2,762,615
Minus claims with a State-approved exemption	-0	-6,680	-1,046,337	-564,297	-1,617,314
Denominator (claims represented minus exemption)	Deemed by the State to be:	Deemed by the State to be:	398,022	747,279	1,145,301
Numerator (submitted within 30 days)			390,603	730,772	1,121,375
Percentage			**98.14%**	**97.79%**	97.91%
Target (98.00% **Met**^{100}, 95.00% **Met**^{50})	**Met**^{100}	**Met**^{100}	**Met**^{100}	**Met**^{50}	

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. Claims paid by Aetna in Q1 or Q2 were exempted by the State from the Q3 denominator, but not from Q4. 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, CY2019

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 2019 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 to 1/1/2013 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 Q3 and Q4 is 98.00% for 100% of incentive payment and 95.00% for 50% of incentive payment.

Validation Activities and Technical Methods

Appendix A, Tables Stratified by Type of Claim, contains additional analytic results intended to be used for measure validation and root cause analysis. Table A2 was not updated after the March 30, 2020, preliminary report. The tables include counts of

- Encounters submitted in 2019,
- 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.

As recommended in the preliminary report, Aetna requested files of non-compliant encounters made available by KFMC and compared the files' MMIS DTE_BILLED values to the submission dates stored within Aetna's system. KFMC provided technical assistance in determining root causes of low percentages and interpreting the technical specifications and methodology documentation.

The State approved a request by Aetna for exemption of 15,170 encounters whose submissions were delayed due to upgrades to MMIS. KFMC received a list of the exempt encounters on April 3, 2020. Analysis showed that some of the encounters were resubmissions of encounters which had been uploaded to MMIS within 30 days of the paid date. Others were initially submitted within 30 days. Only 1,816 of the exempted records were matched to claims submitted in 2019 more than 30 days after the paid date. These 1,816 were removed from the measure's denominators.

Aetna used the data files from KFMC to identify records they believed to be eligible for exclusion from the denominator. The State reviewed Aetna's requests. Final approval of exemptions was completed on March 31, 2021. KFMC subsequently requested and received from Aetna a list of the exempted encounters, and the list was used by KFMC to check for duplicates. Overlap between the exemptions approved in April 2020 and in March 2021 was identified and removed from the calculations shown in Table 1 and Table A1.

Conclusions

As written in the measure's technical specifications, the State deemed 2019 Q1 and Q2 met the target for payment incentive. Aetna's percentage for Q3 (98.14%) met the 98.00% target for 100% of the incentive payment; the Q4 percentage (97.79%) met the 95.00% target for 50% of incentive payment.

Recommendations

Recommendations made in the preliminary report were followed. KFMC has no additional recommendations.

End of written report

Appendix A

Percent of Encounter Submissions within 30 Days – 2019

Aetna Better Health of Kansas

Tables Stratified by Type of Claim

Table A1. Encounter Submissions within 30 Days, CY2019 – Aetna					
All Claim Types*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	0	6,692	1,457,145	1,395,526	2,859,363
Minus duplicates identified by MCO ICN^		-0	-1,956	-77,530	-79,486
Minus duplicates identified by selected fields†		-12	-10,830	-6,420	-17,262
Number of claims represented by an encounter		6,680	1,444,359	1,311,576	2,762,615
Minus claims with a State-approved exemption‡		-6,680	-1,046,337	-564,297	-1,617,314
Number submitted over 30 days after paid date		0	7,419	16,507	23,926
Denominator (claims represented minus exemption)	0	0	398,022	747,279	1,145,301
Numerator (submitted within 30 days)	0	0	390,603	730,772	1,121,375
Percentage	NA	NA	98.14%	97.79%	97.91%
Physician*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	0	1,505	270,620	317,316	589,441
Minus duplicates identified by MCO ICN^		-0	-500	-30,157	-30,657
Minus duplicates identified by selected fields†		-5	-676	-1,202	-1,883
Number of claims represented by an encounter		1,500	269,444	285,957	556,901
Minus claims with a State-approved exemption‡		-1,500	-200,672	-135,843	-338,015
Number submitted over 30 days after paid date		0	4,169	8,051	12,220
Denominator (claims represented minus exemption)	0	0	68,772	150,114	218,886
Numerator (submitted within 30 days)	0	0	64,603	142,063	206,666
Percentage	NA	NA	93.94%	94.64%	94.42%
HCBS and Mental Health*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	0	452	235,924	367,525	603,901
Minus duplicates identified by MCO ICN^		-0	-33	-29,465	-29,498
Minus duplicates identified by selected fields†		-1	-411	-554	-966
Number of claims represented by an encounter		451	235,480	337,506	573,437
Minus claims with a State-approved exemption‡		-451	-183,650	-177,565	-361,666
Number submitted over 30 days after paid date		0	1,537	5,558	7,095
Denominator (claims represented minus exemption)	0	0	51,830	159,941	211,771
Numerator (submitted within 30 days)	0	0	50,293	154,383	204,676
Percentage	NA	NA	97.03%	96.52%	96.65%
Other Professional*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	0	1,545	145,173	277,027	423,745
Minus duplicates identified by MCO ICN^		-0	-290	-6,242	-6,532
Minus duplicates identified by selected fields†		-1	-281	-1,739	-2,021
Number of claims represented by an encounter		1,544	144,602	269,046	415,192
Minus claims with a State-approved exemption‡		-1,544	-104,907	-147,942	-254,393
Number submitted over 30 days after paid date		0	1,671	1,400	3,071
Denominator (claims represented minus exemption)	0	0	39,695	121,104	160,799
Numerator (submitted within 30 days)	0	0	38,024	119,704	157,728
Percentage	NA	NA	95.79%	98.84%	98.09%

* Encounters submitted to the State's fiscal agent in 2019. 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, and MCO internal control number.

† 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.

‡ As approved by the State, claims paid by Aetna before July 1, 2019, were exempted from Q1, Q2, and Q3 percentages.

Table A1. Encounter Submissions within 30 Days, CY2019 – Aetna (Continued)					
Facility*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of facility encounters submitted	0	1,590	68,199	151,859	221,648
Minus duplicates identified by MCO ICN^		-0	-119	-504	-623
Minus duplicates identified by selected fields†		-0	-52	-219	-271
Number of claims represented by an encounter		1,590	68,028	151,136	220,754
Minus claims with a State-approved exemption‡		-1,590	-45,573	-100,220	-147,383
Number submitted over 30 days after paid date		0	42	1,498	1,540
Denominator (claims represented minus exemption)	0	0	22,455	50,916	73,371
Numerator (submitted within 30 days)	0	0	22,413	49,418	71,831
Percentage	NA	NA	99.81%	97.06%	97.90%
Dental*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of dental encounters submitted	0	1,600	77,527	39,782	118,909
Minus duplicates identified by MCO ICN^		-0	-1,005	-3,350	-4,355
Minus duplicates identified by selected fields†		-5	-224	-58	-287
Number of claims represented by an encounter		1,595	76,298	36,374	114,267
Minus claims with a State-approved exemption‡		-1,595	-52,437	-2,727	-56,759
Number submitted over 30 days after paid date		0	0	0	0
Denominator (claims represented minus exemption)	0	0	23,861	33,647	57,508
Numerator (submitted within 30 days)	0	0	23,861	33,647	57,508
Percentage	NA	NA	100.00%	100.00%	100.00%
Pharmacy*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of pharmacy encounters submitted	0	0	659,702	242,017	901,719
Minus duplicates identified by MCO ICN^			-9	-7,812	-7,821
Minus duplicates identified by selected fields†			-9,186	-2,648	-11,834
Number of claims represented by an encounter			650,507	231,557	882,064
Minus claims with a State-approved exemption			-459,098	-0	-459,098
Number submitted over 30 days after paid date‡			0	0	0
Denominator (claims represented minus exemption)	0	0	191,409	231,557	422,966
Numerator (submitted within 30 days)	0	0	191,409	231,557	422,966
Percentage	NA	NA	100.00%	100.00%	100.00%

* Encounters submitted to the State's fiscal agent in 2019, 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.

‡ As approved by the State, claims paid by Aetna before July 1, 2019, were exempted from Q1, Q2, and Q3 percentages.

Table A2 was reported to Aetna on March 30, 2020, to assist with identification of encounters that met exclusion criteria. It does not reflect exclusions approved after that date.

Table A2. Dates with Highest Incidence of Late Submissions, CY2019 – Aetna

Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2019 Q3	Pharmacy	8/12/2019	33,815	39.43%	7.10%
Denominator: 476,370	Physician	9/12/2019	7,541	8.79%	1.58%
Numerator: 390,603	HCBS/MH	9/19/2019	6,302	7.35%	1.32%
Percentage: 82.00%	Physician	8/9/2019	4,231	4.93%	0.89%
	HCBS/MH	9/12/2019	4,198	4.89%	0.88%
All Over 30 Days: 85,767	HCBS/MH	8/13/2019	3,400	3.96%	0.71%
Percentage: 18.00%	Physician	8/15/2019	2,735	3.19%	0.57%
	Physician	9/19/2019	2,723	3.17%	0.57%
	HCBS/MH	8/15/2019	2,423	2.83%	0.51%
	HCBS/MH	9/26/2019	2,283	2.66%	0.48%
	Total of Top 10		**69,651**	**81.21%**	**14.62%**
2019 Q4	HCBS/MH	10/8/2019	71,225	12.26%	5.43%
Denominator: 1,311,576	Other Professional	12/23/2019	36,640	6.31%	2.79%
Numerator: 730,772	HCBS/MH	12/31/2019	33,305	5.73%	2.54%
Percentage: 55.72%	Facility	11/20/2019	32,127	5.53%	2.45%
	Facility	12/13/2019	28,711	4.94%	2.19%
All Over 30 Days: 580,804	Physician	12/12/2019	27,257	4.69%	2.08%
Percentage: 44.28%	Physician	11/20/2019	27,073	4.66%	2.06%
	Physician	10/8/2019	24,217	4.17%	1.85%
	Physician	11/15/2019	23,755	4.09%	1.81%
	Facility	12/12/2019	23,666	4.07%	1.80%
	Total of Top 10		**327,976**	**56.47%**	**25.01%**

* The denominator is the number of claims initially submitted as an encounter record to the State fiscal agent by the MCO in 2019. 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. The Q3 counts exclude claims paid by Aetna before July 1, 2019.

^ 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 – 2019

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	Senior Health Data Analyst, KDHE
Aetna	
Melissa Lawson	Interim QM Director
Jennifer Quon	Manager, Healthcare QM

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 CY2019 percentages, all 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 2019 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 2019, all potential earlier submissions were identified by matching the records submitted in 2019 to MMIS encounter records submitted prior to 2019 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 populated on the replacement encounter but not on the original).

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. Table A2 was reported to the MCO on March 30, 2020. It does not reflect exclusions approved by the State after that date.