Kansas Foundation for Medical Care, Inc.

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URAC ACCREDITED Independent Review Organization: External Expires 06/01/2021

September 25, 2020

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 Sunflower Health Plan for 2019**

Dear Ms. Norris:

Enclosed is KFMC's report for the 2019 Percent of Encounter Submissions within 30 Days, a performance measure of Sunflower Health Plan. The report includes the calculation and validation methodology and stratified tables of counts and percentages.

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
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Bobbie Graff-Hendrixson, Senior Manager Contracts & Fiscal Agents Operations, KDHE

Enclosure(s)

Percent of Encounter Submissions within 30 Days – 2019
Sunflower State Health Plan
September 25, 2020

Background/Objectives

As the external quality review organization (EQRO) for the State of Kansas, the Kansas Foundation for Medical Care (KFMC) calculated quarterly rates for a set of performance measures for the managed care organizations (MCOs): Sunflower State Health Plan (Sunflower), Aetna Better Health of Kansas, 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 final rates for the performance measure "Percent of covered service accurately submitted via encounter within 30 days of claim paid date" for 2019.

The quarterly 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.

Incentive payments are made based on quarterly measurements. The P4P performance target for each measurement is to achieve or maintain 98.00%. Sunflower met this target for each quarter. The respective percentages for quarters Q1 through Q4 were 98.63%, 98.14%, 99.39%, and 99.71%.

Table 1. Percent of Encounter Submissions within 30 Days, CY2019 – Sunflower					
2019	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Number of claims paid or denied by the MCO	1,451,244	1,432,935	1,347,491	1,482,323	5,713,993
Number submitted as encounters within 30 days	1,431,424	1,406,329	1,339,330	1,478,079	5,655,162
Percentage	98.63%	98.14%	99.39%	99.71%	98.97%
Target (98.00%)	**Met**	**Met**	**Met**	**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, 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 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%.

Validation Activities and Technical Methods

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

No areas of concern were identified by KFMC during validation activities.

The State approved an exemption request by Sunflower for 26,262 encounters whose submission was delayed due to upgrades to MMIS. 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 submitted in 2020 and are approved exemptions for 2020. Only 27 of the exempted records were matched to claims submitted in 2019 more than 30 days after the paid date. These 27 were removed from the measure's denominators.

Conclusions

Sunflower met the quarterly target or incentive payment (98.00%) for each quarter of measurement year 2019. The respective rates for quarters Q1 through Q4 were 98.63%, 98.14%, 99.39%, and 99.71%.

Recommendations

KFMC has no recommendations.

End of written report

Appendix A

Percent of Encounter Submissions within 30 Days – 2019

Sunflower Health Plan

Tables Stratified by Type of Claim

Kansas Foundation for Medical Care, Inc
URAC ACCREDITED
Independent Review Organization: External
Expires 06/01/2021

Table A1. Encounter Submissions within 30 Days, CY2019 – Sunflower					
All Claim Types*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	1,669,181	1,625,047	1,603,029	1,775,112	6,672,369
Minus duplicates identified by MCO ICN^	-206,573	-181,877	-247,315	-285,912	-921,677
Minus duplicates identified by selected fields†	-11,364	-10,225	-8,213	-6,870	-36,672
Number of claims represented by an encounter	1,451,244	1,432,945	1,347,501	1,482,330	5,714,020
Minus claims with a State-approved exemption	-0	-10	-10	-7	-27
Number submitted over 30 days after paid date	19,820	26,606	8,161	4,244	58,831
Denominator (claims represented minus exemption)	1,451,244	1,432,935	1,347,491	1,482,323	5,713,993
Numerator (submitted within 30 days)	1,431,424	1,406,329	1,339,330	1,478,079	5,655,162
Percentage	98.63%	98.14%	99.39%	99.71%	98.97%
Physician*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	346,193	328,538	334,039	388,277	1,397,047
Minus duplicates identified by MCO ICN^	-55,900	-30,689	-48,268	-64,717	-199,574
Minus duplicates identified by selected fields†	-1,399	-1,554	-1,416	-1,615	-5,984
Number of claims represented by an encounter	288,894	296,295	284,355	321,945	1,191,489
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	966	792	1,629	414	3,801
Denominator (claims represented minus exemption)	288,894	296,295	284,355	321,945	1,191,489
Numerator (submitted within 30 days)	287,928	295,503	282,726	321,531	1,187,688
Percentage	99.67%	99.73%	99.43%	99.87%	99.68%
HCBS and Mental Health*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	386,983	427,552	471,084	502,785	1,788,404
Minus duplicates identified by MCO ICN^	-52,022	-75,499	-120,640	-119,199	-367,360
Minus duplicates identified by selected fields†	-1,223	-739	-928	-731	-3,621
Number of claims represented by an encounter	333,738	351,314	349,516	382,855	1,417,423
Minus claims with a State-approved exemption	-0	-10	-1	-7	-18
Number submitted over 30 days after paid date	1,031	1,670	1,776	1,998	6,475
Denominator (claims represented minus exemption)	333,738	351,304	349,515	382,848	1,417,405
Numerator (submitted within 30 days)	332,707	349,634	347,739	380,850	1,410,930
Percentage	99.69%	99.52%	99.49%	99.48%	99.54%
Other Professional*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	217,192	283,871	258,905	299,254	1,059,222
Minus duplicates identified by MCO ICN^	-34,172	-64,775	-59,478	-83,961	-242,386
Minus duplicates identified by selected fields†	-1,443	-1,593	-503	-651	-4,190
Number of claims represented by an encounter	181,577	217,503	198,924	214,642	812,646
Minus claims with a State-approved exemption	-0	-0	-9	-0	-9
Number submitted over 30 days after paid date	904	8,543	1,493	213	11,153
Denominator (claims represented minus exemption)	181,577	217,503	198,915	214,642	812,637
Numerator (submitted within 30 days)	180,673	208,960	197,422	214,429	801,484
Percentage	99.50%	96.07%	99.25%	99.90%	98.63%

* 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.

Table A1. Encounter Submissions within 30 Days, CY2019 – Sunflower (Continued)					
Facility*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of facility encounters submitted	133,862	137,847	132,603	151,386	555,698
Minus duplicates identified by MCO ICN^	-6,172	-4,606	-4,857	-4,426	-20,061
Minus duplicates identified by selected fields†	-236	-268	-294	-324	-1,122
Number of claims represented by an encounter	127,454	132,973	127,452	146,636	534,515
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	166	1,282	797	307	2,552
Denominator (claims represented minus exemption)	127,454	132,973	127,452	146,636	534,515
Numerator (submitted within 30 days)	127,288	131,691	126,655	146,329	531,963
Percentage	99.87%	99.04%	99.37%	99.79%	99.52%
Dental*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of dental encounters submitted	55,781	49,155	38,644	49,085	192,665
Minus duplicates identified by MCO ICN^	-9,014	-3,620	-15	-1,193	-13,842
Minus duplicates identified by selected fields†	-41	-87	-95	-36	-259
Number of claims represented by an encounter	46,726	45,448	38,534	47,856	178,564
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	1,794	995	1,119	1,130	5,038
Denominator (claims represented minus exemption)	46,726	45,448	38,534	47,856	178,564
Numerator (submitted within 30 days)	44,932	44,453	37,415	46,726	173,526
Percentage	96.16%	97.81%	97.10%	97.64%	97.18%
Pharmacy*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of pharmacy encounters submitted	529,170	398,084	367,754	384,325	1,679,333
Minus duplicates identified by MCO ICN^	-49,293	-2,688	-14,057	-12,416	-78,454
Minus duplicates identified by selected fields†	-7,022	-5,984	-4,977	-3,513	-21,496
Number of claims represented by an encounter	472,855	389,412	348,720	368,396	1,579,383
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	14,959	13,324	1,347	182	29,812
Denominator (claims represented minus exemption)	472,855	389,412	348,720	368,396	1,579,383
Numerator (submitted within 30 days)	457,896	376,088	347,373	368,214	1,549,571
Percentage	96.84%	96.58%	99.61%	99.95%	98.11%

* 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.

Table A2 was reported to Sunflower on March 30, 2020, to assist with identification of encounters that met exclusion criteria. It does not reflect the 27 exclusions approved after that date.

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

Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2019 Q1	Pharmacy	2/25/2019	13,468	67.95%	0.93%
Denominator: 1,451,244	Dental	1/8/2019	1,683	8.49%	0.12%
Numerator: 1,431,424	Pharmacy	1/2/2019	1,476	7.45%	0.10%
Percent: 98.63%	HCBS/MH	1/30/2019	624	3.15%	0.04%
	Physician	1/30/2019	477	2.41%	0.03%
All Over 30 Days: 19,820	Physician	1/28/2019	384	1.94%	0.03%
Percent: 1.37%	Other Professional	3/15/2019	298	1.50%	0.02%
	HCBS/MH	2/20/2019	290	1.46%	0.02%
	Other Professional	1/30/2019	163	0.82%	0.01%
	Other Professional	3/1/2019	138	0.70%	0.01%
	Total of Top 10		**19,001**	**95.87%**	**1.31%**
2019 Q2	Pharmacy	4/25/2019	13,255	49.80%	0.93%
Denominator: 1,432,945	Other Professional	6/4/2019	7,074	26.58%	0.49%
Numerator: 1,406,329	Other Professional	6/26/2019	791	2.97%	0.06%
Percentage: 98.14%	HCBS/MH	6/14/2019	640	2.40%	0.04%
	Facility	5/29/2019	506	1.90%	0.04%
All Over 30 Days: 26,616	Physician	6/28/2019	480	1.80%	0.03%
Percentage: 1.86%	Dental	5/16/2019	474	1.78%	0.03%
	HCBS/MH	6/21/2019	474	1.78%	0.03%
	Other Professional	6/28/2019	422	1.59%	0.03%
	HCBS/MH	6/7/2019	329	1.24%	0.02%
	Total of Top 10		**24,445**	**91.84%**	**1.71%**
2019 Q3	Pharmacy	7/3/2019	1,217	14.89%	0.09%
Denominator: 1,347,501	Physician	8/15/2019	1,147	14.04%	0.09%
Numerator: 1,339,330	HCBS/MH	9/19/2019	778	9.52%	0.06%
Percentage: 99.39%	Facility	9/19/2019	661	8.09%	0.05%
	Other Professional	7/24/2019	643	7.87%	0.05%
All Over 30 Days: 8,171	Other Professional	8/15/2019	621	7.60%	0.05%
Percentage: 0.61%	Dental	7/12/2019	452	5.53%	0.03%
	HCBS/MH	7/17/2019	307	3.76%	0.02%
	HCBS/MH	8/21/2019	287	3.51%	0.02%
	HCBS/MH	9/12/2019	265	3.24%	0.02%
	Total of Top 10		**6,378**	**78.06%**	**0.47%**
2019 Q4	HCBS/MH	10/2/2019	1,037	24.39%	0.07%
Denominator: 1,482,330	HCBS/MH	10/15/2019	683	16.07%	0.05%
Numerator: 1,478,079	Dental	11/7/2019	388	9.13%	0.03%
Percentage: 99.71%	Dental	11/14/2019	288	6.77%	0.02%
	Dental	10/24/2019	275	6.47%	0.02%
All Over 30 Days: 4,251	Physician	11/1/2019	259	6.09%	0.02%
Percentage: 0.29%	HCBS/MH	10/25/2019	205	4.82%	0.01%
	Facility	11/1/2019	119	2.80%	0.01%
	Pharmacy	11/7/2019	96	2.26%	0.01%
	Facility	10/15/2019	95	2.23%	0.01%
	Total of Top 10		**3,445**	**81.04%**	**0.23%**

* 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.

^ 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

Sunflower Health Plan

Activities and Technical Methods

Kansas Foundation for Medical Care, Inc
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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	External Quality Review Audit Manager/Supervisor, KDHE
Janice Panichello	Senior Health Data Analyst, KDHE
Sunflower	
Beau Winfrey	Director, Data Analytics & Reporting
Michael Stephens	Chief Executive Officer

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.