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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 Sunflower Health Plan 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 Sunflower Health Plan. 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
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Kiva Wallace, Project Manager, Sunflower
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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
Sunflower State Health Plan
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): Sunflower 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 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. Sunflower met the target for full incentive payment quarters Q1, Q2, and Q3; the percentage for Q4 was below the target for payment. The percentages for quarters Q1 through Q4 were 99.79%, 99.66%, 99.77%, and 76.87%, respectively.

Table 1. Percent of Encounter Submissions within 30 Days, MY 2020 – Sunflower					
2020	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Number of claims paid or denied by the MCO	1,392,665	1,230,378	1,292,635	1,731,342	5,647,020
Number submitted as encounters within 30 days	1,389,779	1,226,171	1,289,677	1,330,858	5,236,485
Preliminary Percentage	99.79%	99.66%	99.77%	76.87%	92.73%
Target (98.00% for 100% payment, 95.00% for 50% payment)	**Met**[100%]	**Met**[100%]	**Met**[100%]	**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 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.

As shown in Appendix A, Table A1, the stratified percentages of encounters submitted within 30 days were greater than 98.00% each quarter for all claim types except pharmacy. Only 49.19% of pharmacy encounters submitted in Q4 had been submitted within 30 days of the claim paid date; all but one of the pharmacy encounters submitted in Q1 through Q3 had been submitted within 30 days.

KFMC identified during prior validation activities that Sunflower's denied pharmacy claims were missing from the encounter data. The issue was reported to Sunflower and the State multiple times, including in the 2020 Q1 and Q2 preliminary report (August 24, 2020), which stated, "No denied pharmacy claims were submitted between July 27, 2017, and August 14, 2020."

Pharmacy encounters denied in 2020 began to be uploaded into MMIS in December 2020. Between December 15 and December 24, MMIS processed over 390,000 late-submitted pharmacy encounters (22.5% of the Q4 denominator). See Appendix A, Table A2.

Conclusions

Sunflower met the target for 100% of incentive payment for MY 2020 Q1, Q2, and Q3. The percentages for quarters Q1 through Q3 were 99.79%, 99.66%, and 99.77%, respectively.

Sunflower did not meet the target for incentive payment for MY 2020 Q4 due to late submission of denied pharmacy encounters; the Q4 percentage was 76.87%.

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

Sunflower Health Plan

Tables Stratified by Type of Claim

Table A1. Encounter Submissions within 30 Days, MY 2020 – Sunflower					
All Claim Types*	**Q1**	**Q1**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	1,773,123	1,557,971	1,632,789	2,183,179	7,147,062
Minus duplicates identified by MCO ICN^	-372,499	-318,110	-332,205	-394,821	-1,417,635
Minus duplicates identified by selected fields†	-7,953	-9,483	-7,949	-57,016	-82,401
Number of claims represented by an encounter	1,392,671	1,230,378	1,292,635	1,731,342	5,647,026
Minus claims with a State-approved exemption	-6	-0	-0	-0	-6
Number submitted over 30 days after paid date	2,886	4,207	2,958	400,484	410,541
Denominator (claims represented minus exemption)	1,392,665	1,230,378	1,292,635	1,731,342	5,647,020
Numerator (submitted within 30 days)	1,389,779	1,226,171	1,289,677	1,330,858	5,236,485
Percentage	99.79%	99.66%	99.77%	76.87%	92.73%
Physician*	**Q1**	**Q1**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	406,870	320,705	355,116	454,147	1,536,838
Minus duplicates identified by MCO ICN^	-107,526	-79,769	-93,832	-170,468	-451,595
Minus duplicates identified by selected fields†	-1,228	-1,673	-1,416	-1,703	-6,020
Number of claims represented by an encounter	298,116	239,263	259,868	281,976	1,079,223
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	917	654	940	1,540	4,051
Denominator (claims represented minus exemption)	298,116	239,263	259,868	281,976	1,079,223
Numerator (submitted within 30 days)	297,199	238,609	258,928	280,436	1,075,172
Percentage	99.69%	99.73%	99.64%	99.45%	99.62%
HCBS and Mental Health*	**Q1**	**Q1**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	485,709	496,872	498,141	453,749	1,934,471
Minus duplicates identified by MCO ICN^	-150,524	-159,133	-149,214	-128,765	-587,636
Minus duplicates identified by selected fields†	-703	-1,060	-1,037	-1,064	-3,864
Number of claims represented by an encounter	334,482	336,679	347,890	323,920	1,342,971
Minus claims with a State-approved exemption	-6	-0	-0	-0	-6
Number submitted over 30 days after paid date	641	2,137	1,200	5,037	9,015
Denominator (claims represented minus exemption)	334,476	336,679	347,890	323,920	1,342,965
Numerator (submitted within 30 days)	333,841	334,542	346,690	318,883	1,333,956
Percentage	99.81%	99.37%	99.66%	98.44%	99.33%
Other Professional*	**Q1**	**Q1**	**Q3**	**Q4**	**MY 2020**
Number of professional encounters submitted	307,905	233,551	254,480	279,366	1,075,302
Minus duplicates identified by MCO ICN^	-101,064	-68,932	-66,539	-79,295	-315,830
Minus duplicates identified by selected fields†	-492	-1,112	-890	-927	-3,421
Number of claims represented by an encounter	206,349	163,507	187,051	199,144	756,051
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	751	1,070	555	2,901	5,277
Denominator (claims represented minus exemption)	206,349	163,507	187,051	199,144	756,051
Numerator (submitted within 30 days)	205,598	162,437	186,496	196,243	750,774
Percentage	99.64%	99.35%	99.70%	98.54%	99.30%

* 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 – Sunflower (Continued)					
Facility*	**Q1**	**Q1**	**Q3**	**Q4**	**MY 2020**
Number of facility encounters submitted	147,453	118,677	125,552	132,677	524,359
Minus duplicates identified by MCO ICN^	-8,579	-10,264	-7,543	-6,136	-32,522
Minus duplicates identified by selected fields†	-502	-627	-461	-480	-2,070
Number of claims represented by an encounter	138,372	107,786	117,548	126,061	489,767
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	549	330	253	739	1,871
Denominator (claims represented minus exemption)	138,372	107,786	117,548	126,061	489,767
Numerator (submitted within 30 days)	137,823	107,456	117,295	125,322	487,896
Percentage	99.60%	99.69%	99.78%	99.41%	99.62%
Dental*	**Q1**	**Q1**	**Q3**	**Q4**	**MY 2020**
Number of dental encounters submitted	42,948	19,201	53,037	42,537	157,723
Minus duplicates identified by MCO ICN^	-461	-12	-15,077	-10,157	-25,707
Minus duplicates identified by selected fields†	-56	-66	-35	-39	-196
Number of claims represented by an encounter	42,431	19,123	37,925	32,341	131,820
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	34	15	10	103	162
Denominator (claims represented minus exemption)	42,431	19,123	37,925	32,341	131,820
Numerator (submitted within 30 days)	42,397	19,108	37,915	32,238	131,658
Percentage	99.92%	99.92%	99.97%	99.68%	99.88%
Pharmacy*	**Q1**	**Q1**	**Q3**	**Q4**	**MY 2020**
Number of pharmacy encounters submitted	382,238	368,965	346,463	820,703	1,918,369
Minus duplicates identified by MCO ICN^	-4,345	-0	-0	-0	-4,345
Minus duplicates identified by selected fields†	-4,972	-4,945	-4,110	-52,803	-66,830
Number of claims represented by an encounter	372,921	364,020	342,353	767,900	1,847,194
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	0	1	0	390,164	390,165
Denominator (claims represented minus exemption)	372,921	364,020	342,353	767,900	1,847,194
Numerator (submitted within 30 days)	372,921	364,019	342,353	377,736	1,457,029
Percentage	100.00%	100.00%	100.00%	49.19%	78.88%

* 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: Q1 counts and percentages in Table A2 were calculated without excluding State-approved exemptions.

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

Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2020 Q1	Physician	1/3/2020	691	23.89%	0.05%
Denominator: 1,392,671	HCBS/MH	1/3/2020	479	16.56%	0.03%
Numerator: 1,389,779	Other Professional	2/4/2020	401	13.87%	0.03%
Percent: 99.79%	Facility	1/3/2020	215	7.43%	0.02%
	Facility	2/14/2020	215	7.43%	0.02%
All Over 30 Days: 2,892	Other Professional	1/3/2020	159	5.50%	0.01%
Percent: 0.21%	HCBS/MH	2/14/2020	87	3.01%	0.01%
	Other Professional	2/14/2020	78	2.70%	0.01%
	Physician	2/4/2020	78	2.70%	0.01%
	Physician	2/14/2020	56	1.94%	0.00%
	Total of Top 10		**2,459**	**85.03%**	**0.18%**
2020 Q2	HCBS/MH	6/12/2020	1,154	27.43%	0.09%
Denominator: 1,230,378	HCBS/MH	4/17/2020	975	23.18%	0.08%
Numerator: 1,226,171	Other Professional	4/17/2020	575	13.67%	0.05%
Percentage: 99.66%	Physician	4/17/2020	502	11.93%	0.04%
	Other Professional	6/12/2020	446	10.60%	0.04%
All Over 30 Days: 4,207	Facility	4/17/2020	224	5.32%	0.02%
Percentage: 0.34%	Physician	6/12/2020	150	3.57%	0.01%
	Facility	5/15/2020	53	1.26%	0.00%
	Facility	5/29/2020	33	0.78%	0.00%
	Facility	6/12/2020	17	0.40%	0.00%
	Total of Top 10		**4,129**	**98.15%**	**0.34%**
2020 Q3	Physician	9/8/2020	526	17.78%	0.04%
Denominator: 1,292,635	HCBS/MH	9/18/2020	483	16.33%	0.04%
Numerator: 1,289,677	HCBS/MH	7/17/2020	479	16.19%	0.04%
Percentage: 99.77%	Physician	7/17/2020	284	9.60%	0.02%
	Other Professional	9/9/2020	259	8.76%	0.02%
All Over 30 Days: 2,958	HCBS/MH	9/4/2020	215	7.27%	0.02%
Percentage: 0.23%	Other Professional	7/17/2020	141	4.77%	0.01%
	Physician	9/18/2020	95	3.21%	0.01%
	Facility	9/4/2020	92	3.11%	0.01%
	Other Professional	9/4/2020	59	1.99%	0.00%
	Total of Top 10		**2,633**	**89.01%**	**0.20%**
2020 Q4	Pharmacy	12/23/2020	107,949	26.95%	6.23%
Denominator: 1,731,342	Pharmacy	12/19/2020	86,993	21.72%	5.02%
Numerator: 1,330,858	Pharmacy	12/24/2020	65,178	16.27%	3.76%
Percentage: 76.87%	Pharmacy	12/22/2020	47,953	11.97%	2.77%
	Pharmacy	12/21/2020	37,048	9.25%	2.14%
All Over 30 Days: 400,484	Pharmacy	12/18/2020	33,678	8.41%	1.95%
Percentage: 23.13%	Pharmacy	12/15/2020	11,320	2.83%	0.65%
	HCBS/MH	12/23/2020	4,556	1.14%	0.26%
	Other Professional	12/23/2020	1,883	0.47%	0.11%
	Physician	12/23/2020	1,235	0.31%	0.07%
	Total of Top 10		**397,793**	**99.33%**	**22.98%**

* 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

Sunflower Health Plan

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
Sunflower	
Gena Hyatt	Director, Quality Improvement
Jane Clark	Manager, Analytics & Outcomes
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 measurement year 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.