

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 UnitedHealthcare Community Plan 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 UnitedHealthcare Community Plan 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
Kasey Mullins, Sr. Director of Clinical Quality, UnitedHealthcare
Todd Carlon, Kansas Compliance Officer, UnitedHealthcare
Anna Purcell, Assoc. Director of Business Process, UnitedHealthcare
Jon Hamdorf, COO, UnitedHealthcare
Dr. Teresa Wesley, Chief Medical Officer, UnitedHealthcare
Audrey Masoner, CFO, UnitedHealthcare
Katelin May, Sr. Clin. Practice Consultant, UnitedHealthcare
UHC Compliance Mailbox
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
UnitedHealthcare Community Plan of Kansas
December 8, 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): UnitedHealthcare Community Plan of Kansas (UnitedHealthcare), Aetna Better Health of Kansas, and Sunflower State Health Plan. 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 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. UnitedHealthcare met the target for full incentive payment each quarter. The respective percentages for quarters Q1 through Q4 were 99.31%, 99.84%, 99.95%, and 99.98%.

Table 1. Percent of Encounter Submissions within 30 Days, MY 2020 – UnitedHealthcare					
2020	Q1	Q2	Q3	Q4	Annual
Number of claims paid or denied by the MCO	1,560,101	1,380,581	1,445,500	1,507,794	5,893,976
Number submitted as encounters within 30 days	1,549,373	1,378,327	1,444,829	1,507,424	5,879,953
Percentage	99.31%	99.84%	99.95%	99.98%	99.76%
Target (98.00% for 100% payment, 95.00% for 50% payment)	Met ^{100%}	Met ^{100%}	Met ^{100%}	Met ^{100%}	

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	<p>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</p> <p>Numerator: Encounters meeting denominator criteria where the submission date is within 30 calendar days of the paid date</p>
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	<p>The populations from which the denominators are drawn include:</p> <ul style="list-style-type: none"> All claim types (professional, institutional, dental, and pharmacy), Paid and denied claims, and New-day and adjusted claims.
Denominator	<p>Submission date (identified by MMIS DTE_BILLED field) is within the calendar quarter. Deduplication is to the first submitted encounter per claim.</p> <p>Deduplication is stratified by the four claim types.</p> <p>Encounters approved by the State as exemptions due to backlog issues are excluded from the denominator.</p>
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.

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

As shown in Appendix A, Table A1, the percentages stratified by claim type were above 99.7% except for Q1 and Q2 dental encounters. The four-quarter 2020 aggregate percentage was 99.76%.

Conclusions

UnitedHealthcare met the quarterly target for 100% of incentive payment (98.00%) for each quarter of measurement year 2020. The percentages for quarters Q1 through Q4 were respectively 99.31%, 99.84%, 99.95%, and 99.98%.

Recommendations

UnitedHealthcare's encounter submission and monitoring processes have been effectively meeting the performance target. There are no additional recommendations.

End of written report

Appendix A

**Percent of Encounter Submissions
within 30 Days – MY 2020**

UnitedHealthcare

Community Plan of Kansas

Tables Stratified by Type of Claim

Percent of Encounter Submissions within 30 Days – MY 2020 – UnitedHealthcare
Appendix A – Tables Stratified by Type of Claim

Table A1. Encounter Submissions within 30 Days, MY 2020 – UnitedHealthcare					
All Claim Types*	Q1	Q2	Q3	Q4	MY 2020
Number of professional encounters submitted	2,199,208	1,850,282	1,886,434	1,656,237	7,592,161
Minus duplicates identified by MCO ICN [^]	-601,099	-443,224	-416,649	-138,311	-1,599,283
Minus duplicates identified by selected fields [†]	-38,008	-26,477	-24,285	-10,132	-98,902
Number of claims represented by an encounter	1,560,101	1,380,581	1,445,500	1,507,794	5,893,976
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	10,728	2,254	671	370	14,023
Denominator (claims represented minus exemption)	1,560,101	1,380,581	1,445,500	1,507,794	5,893,976
Numerator (submitted within 30 days)	1,549,373	1,378,327	1,444,829	1,507,424	5,879,953
Percentage	99.31%	99.84%	99.95%	99.98%	99.76%
Physician*	Q1	Q2	Q3	Q4	MY 2020
Number of professional encounters submitted	434,788	384,822	360,720	368,750	1,549,080
Minus duplicates identified by MCO ICN [^]	-102,567	-83,713	-67,662	-66,987	-320,929
Minus duplicates identified by selected fields [†]	-976	-1,146	-1,051	-1,144	-4,317
Number of claims represented by an encounter	331,245	299,963	292,007	300,619	1,223,834
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	84	141	68	7	300
Denominator (claims represented minus exemption)	331,245	299,963	292,007	300,619	1,223,834
Numerator (submitted within 30 days)	331,161	299,822	291,939	300,612	1,223,534
Percentage	99.97%	99.95%	99.98%	100.00%	99.98%
HCBS and Mental Health*	Q1	Q2	Q3	Q4	MY 2020
Number of professional encounters submitted	511,192	483,497	461,455	350,421	1,806,565
Minus duplicates identified by MCO ICN [^]	-214,911	-162,929	-148,057	-32,028	-557,925
Minus duplicates identified by selected fields [†]	-421	-1,030	-908	-938	-3,297
Number of claims represented by an encounter	295,860	319,538	312,490	317,455	1,245,343
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	95	84	52	32	263
Denominator (claims represented minus exemption)	295,860	319,538	312,490	317,455	1,245,343
Numerator (submitted within 30 days)	295,765	319,454	312,438	317,423	1,245,080
Percentage	99.97%	99.97%	99.98%	99.99%	99.98%
Other Professional*	Q1	Q2	Q3	Q4	MY 2020
Number of professional encounters submitted	491,123	332,745	282,504	251,486	1,357,858
Minus duplicates identified by MCO ICN [^]	-270,576	-151,030	-77,452	-23,090	-522,148
Minus duplicates identified by selected fields [†]	-18,276	-10,682	-14,535	-521	-44,014
Number of claims represented by an encounter	202,271	171,033	190,517	227,875	791,696
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	191	537	244	152	1,124
Denominator (claims represented minus exemption)	202,271	171,033	190,517	227,875	791,696
Numerator (submitted within 30 days)	202,080	170,496	190,273	227,723	790,572
Percentage	99.91%	99.69%	99.87%	99.93%	99.86%

* 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.

Percent of Encounter Submissions within 30 Days – MY 2020 – UnitedHealthcare
Appendix A – Tables Stratified by Type of Claim

Table A1. Encounter Submissions within 30 Days, MY 2020 – UnitedHealthcare (Continued)					
Facility*	Q1	Q2	Q3	Q4	MY 2020
Number of facility encounters submitted	149,631	126,300	251,122	145,947	673,000
Minus duplicates identified by MCO ICN [^]	-4,810	-6,318	-119,188	-5,398	-135,714
Minus duplicates identified by selected fields [†]	-226	-233	-120	-100	-679
Number of claims represented by an encounter	144,595	119,749	131,814	140,449	536,607
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	78	244	105	28	455
Denominator (claims represented minus exemption)	144,595	119,749	131,814	140,449	536,607
Numerator (submitted within 30 days)	144,517	119,505	131,709	140,421	536,152
Percentage	99.95%	99.80%	99.92%	99.98%	99.92%
Dental*	Q1	Q2	Q3	Q4	MY 2020
Number of dental encounters submitted	65,415	41,882	46,721	44,249	198,267
Minus duplicates identified by MCO ICN [^]	-3,984	-15,963	-3,988	-1,409	-25,344
Minus duplicates identified by selected fields [†]	-9,177	-5,115	-142	-361	-14,795
Number of claims represented by an encounter	52,254	20,804	42,591	42,479	158,128
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	10,235	1,151	104	10	11,500
Denominator (claims represented minus exemption)	52,254	20,804	42,591	42,479	158,128
Numerator (submitted within 30 days)	42,019	19,653	42,487	42,469	146,628
Percentage	80.41%	94.47%	99.76%	99.98%	92.73%
Pharmacy*	Q1	Q2	Q3	Q4	MY 2020
Number of pharmacy encounters submitted	547,059	481,036	483,912	495,384	2,007,391
Minus duplicates identified by MCO ICN [^]	-4,251	-23,271	-302	-9,399	-37,223
Minus duplicates identified by selected fields [†]	-8,932	-8,271	-7,529	-7,068	-31,800
Number of claims represented by an encounter	533,876	449,494	476,081	478,917	1,938,368
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	45	97	98	141	381
Denominator (claims represented minus exemption)	533,876	449,494	476,081	478,917	1,938,368
Numerator (submitted within 30 days)	533,831	449,397	475,983	478,776	1,937,987
Percentage	99.99%	99.98%	99.98%	99.97%	99.98%

* 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.

Percent of Encounter Submissions within 30 Days – MY 2020 – UnitedHealthcare
Appendix A – Tables Stratified by Type of Claim

Table A2. Dates with Highest Incidence of Late Submissions, MY 2020 – UnitedHealthcare					
Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2020 Q1 Denominator: 1,560,101 Numerator: 1,549,373 Percent: 99.31% All Over 30 Days: 10,728 Percent: 0.69%	Dental	3/24/2020	7,633	71.15%	0.49%
	Dental	3/16/2020	2,228	20.77%	0.14%
	Dental	3/2/2020	118	1.10%	0.01%
	Dental	3/23/2020	105	0.98%	0.01%
	Dental	3/25/2020	88	0.82%	0.01%
	HCBS/MH	1/10/2020	72	0.67%	0.00%
	Facility	3/3/2020	67	0.62%	0.00%
	Other Professional	3/3/2020	63	0.59%	0.00%
	Dental	3/26/2020	56	0.52%	0.00%
	Physician	3/3/2020	56	0.52%	0.00%
	Total of Top 10			10,486	97.74%
2020 Q2 Denominator: 1,380,581 Numerator: 1,378,327 Percentage: 99.84% All Over 30 Days: 2,254 Percentage: 0.16%	Dental	5/1/2020	453	20.10%	0.03%
	Dental	5/11/2020	397	17.61%	0.03%
	Other Professional	5/11/2020	259	11.49%	0.02%
	Dental	4/24/2020	237	10.51%	0.02%
	Other Professional	5/18/2020	134	5.94%	0.01%
	Physician	4/15/2020	112	4.97%	0.01%
	Facility	6/2/2020	93	4.13%	0.01%
	HCBS/MH	5/21/2020	63	2.80%	0.00%
	Facility	4/9/2020	62	2.75%	0.00%
	Pharmacy	6/17/2020	57	2.53%	0.00%
	Total of Top 10			1,867	82.83%
2020 Q3 Denominator: 1,445,500 Numerator: 1,444,829 Percentage: 99.95% All Over 30 Days: 671 Percentage: 0.05%	Other Professional	8/18/2020	141	21.01%	0.01%
	Dental	7/15/2020	85	12.67%	0.01%
	Other Professional	9/3/2020	53	7.90%	0.00%
	Pharmacy	7/20/2020	44	6.56%	0.00%
	Pharmacy	7/6/2020	42	6.26%	0.00%
	Physician	8/6/2020	40	5.96%	0.00%
	Facility	8/13/2020	29	4.32%	0.00%
	Facility	8/25/2020	24	3.58%	0.00%
	Facility	8/6/2020	19	2.83%	0.00%
	HCBS/MH	7/16/2020	18	2.68%	0.00%
	Total of Top 10			495	73.77%
2020 Q4 Denominator: 1,507,794 Numerator: 1,507,424 Percentage: 99.98% All Over 30 Days: 370 Percentage: 0.02%	Pharmacy	10/20/2020	112	30.27%	0.01%
	Other Professional	11/6/2020	68	18.38%	0.00%
	Other Professional	10/6/2020	67	18.11%	0.00%
	HCBS/MH	12/17/2020	23	6.22%	0.00%
	Facility	12/16/2020	14	3.78%	0.00%
	Pharmacy	10/19/2020	13	3.51%	0.00%
	Other Professional	12/17/2020	10	2.70%	0.00%
	Dental	10/19/2020	7	1.89%	0.00%
	Facility	12/23/2020	6	1.62%	0.00%
	Pharmacy	11/6/2020	6	1.62%	0.00%
	Total of Top 10			326	88.11%

* 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**

UnitedHealthcare

Community Plan 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
UnitedHealthcare	
Kasey Mullins	Senior Director of Clinical Quality
Todd Carlon	Kansas Compliance 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 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.