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April 21, 2022

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

RE: *Percent of Encounter Submissions Within 30 Days Performance Measure of Aetna Better Health of Kansas for MY 2021*

Dear Ms. Norris:

Enclosed to is KFMC's validation report of the *Percent of Encounter Submissions Within 30 Days* performance measure of Aetna Better Health of Kansas, for the 2021 pay-for-performance incentive program.

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: Laura Leistra, EQR Audit Manager/Supervisor, KDHE
Christiane Swartz, Deputy Medicaid Director/Director of Medicaid Operations, KDHE
Theron Platt, 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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Melissa Lawson, Director, Healthcare Quality Management, Aetna
David Livingston, CEO, Aetna
Lisa Baird, COO, Aetna
Marc Shiff, Compliance Officer, Aetna
Dr. Muna Enshiwat, Chief Medical Officer, Aetna
Sarah Fertig, State Medicaid Director, KDHE
Bobbie Graff-Hendrixson, Senior Manager Contracts & Fiscal Agents Operations, KDHE

Enclosure(s)

Percent of Encounter Submissions Within 30 Days – MY 2021
Aetna Better Health of Kansas
April 21, 2022

Background/Objectives

As the external quality review organization 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 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) 2021.

Quarterly Measurements

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. Aetna's Q1 percentage (97.05%) met the performance target for 50% incentive payment, percentages for Q2 (99.62%) and Q4 (99.21%) met the performance target for full incentive payment, but the percentage for Q3 (94.04%) was below the performance targets (see Table 1).

The technical specifications are provided in Table 2.

Table 1. Percent of Encounter Submissions Within 30 Days, MY 2021 – Aetna					
2021	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Number of claims paid or denied by the MCO	1,025,932	1,108,445	1,358,189	1,216,902	4,709,468
Number submitted as encounters within 30 days	995,651	1,104,185	1,277,215	1,207,280	4,584,331
Percentage	97.05%	99.62%	94.04%	99.21%	97.34%
Target (98.00% for 100% payment, 95.00% for 50% payment)	**Met**[50%]	**Met**[100%]	Not Met	**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.

Table 2. Technical Specifications for Encounter Data Submission Within 30 Days, MY 2021	
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 2021 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 2021,
- Encounters removed during deduplication,
- Claim meeting denominator criteria,
- 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.

Preliminary Findings

The following observations (made from Appendix A, Table A1) were reported in the preliminary reports.

Quarter 1

Only facility and pharmacy percentages were below the 98.00% target for Q1: 94.48% for facility and 94.65% for pharmacy. The Q1 percentage for dental was 100%.

Over half of the encounters submitted more than 30 days after adjudication were pharmacy encounters paid on December 23, 2020, and submitted as encounters 51 days later (on February 12, 2021). The second largest batch of late-submitted encounters contain 4,197 denied pharmacy encounters that were received February 24, 2021 (see Table A2).

Quarter 2

The stratified percentages of encounters submitted within 30 days were greater than 98.00% for all claim types.

Quarter 3

On September 16 and September 17, 2021, Aetna submitted 74,036 encounters for pharmacy claims denied between January 2020 and March 2021. The encounters submitted on those two days accounted for 5.5% of the encounters submitted in Q3.

The stratified percentages of encounters submitted within 30 days were greater than 99.00% for all other claim types.

Quarter 4

The stratified percentages of encounters submitted within 30 days for Q4 were greater than 98.00% for all claim types except physician (97.99%).

Conclusions

Aetna's MY 2021 percent of covered service accurately submitted via encounter within 30 days of claim paid date for Q1 (97.05%) met the performance target for 50% incentive payment, percentages for Q2 (99.62%) and Q4 (99.21%) met the performance target for full incentive payment, and the percentage for Q3 (94.04%) was below the performance targets (see Table 1).

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 2021

Aetna Better Health of Kansas

Tables Stratified by Type of Claim

Table A1. Encounter Submissions Within 30 Days, MY 2021 – Aetna					
All Claim Types*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	1,241,566	1,254,488	1,519,298	1,376,608	5,391,960
Minus duplicates identified by MCO ICN^	-215,634	-146,043	-161,109	-159,706	-682,492
Number of claims represented by an encounter	1,025,932	1,108,445	1,358,189	1,216,902	4,709,468
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	30,281	4,260	80,974	9,622	125,137
Denominator (claims represented minus exemption)	1,025,932	1,108,445	1,358,189	1,216,902	4,709,468
Numerator (submitted within 30 days)	995,651	1,104,185	1,277,215	1,207,280	4,584,331
Percentage	97.05%	99.62%	94.04%	99.21%	97.34%
Physician*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	291,978	297,461	351,398	312,751	1,253,588
Minus duplicates identified by MCO ICN^	-104,053	-87,251	-95,993	-73,659	-360,956
Number of claims represented by an encounter	187,925	210,210	255,405	239,092	892,632
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	1,236	671	1,994	4,802	8,703
Denominator (claims represented minus exemption)	187,925	210,210	255,405	239,092	892,632
Numerator (submitted within 30 days)	186,689	209,539	253,411	234,290	883,929
Percentage	99.34%	99.68%	99.22%	97.99%	99.03%
HCBS and Mental Health*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	231,959	238,074	271,456	254,203	995,692
Minus duplicates identified by MCO ICN^	-45,364	-34,854	-37,780	-42,419	-160,417
Number of claims represented by an encounter	186,595	203,220	233,676	211,784	835,275
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	559	466	1,755	1,050	3,830
Denominator (claims represented minus exemption)	186,595	203,220	233,676	211,784	835,275
Numerator (submitted within 30 days)	186,036	202,754	231,921	210,734	831,445
Percentage	99.70%	99.77%	99.25%	99.50%	99.54%
Other Professional*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	167,123	169,313	209,227	196,986	742,649
Minus duplicates identified by MCO ICN^	-24,119	-16,619	-16,399	-18,208	-75,345
Number of claims represented by an encounter	143,004	152,694	192,828	178,778	667,304
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	2,663	1,148	1,870	2,034	7,715
Denominator (claims represented minus exemption)	143,004	152,694	192,828	178,778	667,304
Numerator (submitted within 30 days)	140,341	151,546	190,958	176,744	659,589
Percentage	98.14%	99.25%	99.03%	98.86%	98.84%

* Encounters submitted to the State's fiscal agent in 2021. 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 the first encounter received per combination of claim type, MCO internal control number, and date paid (or denied).

Table A1. Encounter Submissions Within 30 Days, MY 2021 – Aetna (Continued)					
Facility*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of facility encounters submitted	105,900	110,590	138,023	128,071	482,584
Minus duplicates identified by MCO ICN^	-4,226	-6,152	-6,239	-13,578	-30,195
Number of claims represented by an encounter	101,674	104,438	131,784	114,493	452,389
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	5,614	1,253	777	1,361	9,005
Denominator (claims represented minus exemption)	101,674	104,438	131,784	114,493	452,389
Numerator (submitted within 30 days)	96,060	103,185	131,007	113,132	443,384
Percentage	94.48%	98.80%	99.41%	98.81%	98.01%
Dental*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of dental encounters submitted	32,102	33,420	37,133	37,314	139,969
Minus duplicates identified by MCO ICN^	-2,921	-1,120	-3,530	-1,440	-9,011
Number of claims represented by an encounter	29,181	32,300	33,603	35,874	130,958
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	0	190	0	0	190
Denominator (claims represented minus exemption)	29,181	32,300	33,603	35,874	130,958
Numerator (submitted within 30 days)	29,181	32,110	33,603	35,874	130,768
Percentage	100.00%	99.41%	100.00%	100.00%	99.85%
Pharmacy*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of pharmacy encounters submitted	412,504	405,630	512,061	447,283	1,777,478
Minus duplicates identified by MCO ICN^	-34,951	-47	-1,168	-10,402	-46,568
Number of claims represented by an encounter	377,553	405,583	510,893	436,881	1,730,910
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	20,209	532	74,578	375	95,694
Denominator (claims represented minus exemption)	377,553	405,583	510,893	436,881	1,730,910
Numerator (submitted within 30 days)	357,344	405,051	436,315	436,506	1,635,216
Percentage	94.65%	99.87%	85.40%	99.91%	94.47%

* Encounters submitted to the State's fiscal agent in 2021, 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 the first encounter received per combination of claim type, MCO internal control number, and date paid (or denied).

Table A2. Dates with Highest Incidence of Late Submissions, MY 2021 – Aetna

Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2021 Q1	Pharmacy	2/12/2021	15,497	51.18%	1.51%
Denominator: 1,025,932	Pharmacy	2/24/2021	4,197	13.86%	0.41%
Numerator: 995,651	Facility	2/23/2021	1,276	4.21%	0.12%
Percent: 97.05%	Other Professional	3/30/2021	881	2.91%	0.09%
	Facility	1/28/2021	867	2.86%	0.08%
All Over 30 Days: 30,281	Facility	2/25/2021	815	2.69%	0.08%
Percent: 2.95%	Facility	3/31/2021	696	2.30%	0.07%
	Facility	1/12/2021	686	2.27%	0.07%
	Other Professional	1/5/2021	439	1.45%	0.04%
	Facility	3/25/2021	260	0.86%	0.03%
	Total of Top 10		**25,614**	**84.59%**	**2.50%**
2021 Q2	Facility	4/29/2021	372	8.73%	0.03%
Denominator: 1,108,445	Facility	6/25/2021	284	6.67%	0.03%
Numerator: 1,104,185	Other Professional	4/27/2021	282	6.62%	0.03%
Percentage: 99.62%	Physician	4/5/2021	276	6.48%	0.02%
	HCBS/MH	4/29/2021	213	5.00%	0.02%
All Over 30 Days: 4,260	Dental	6/17/2021	189	4.44%	0.02%
Percentage: 0.38%	Other Professional	4/5/2021	177	4.15%	0.02%
	Facility	4/5/2021	161	3.78%	0.01%
	Other Professional	5/27/2021	150	3.52%	0.01%
	Other Professional	5/24/2021	149	3.50%	0.01%
	Total of Top 10		**2,253**	**52.89%**	**0.20%**
2021 Q3	Pharmacy	9/16/2021	72,849	89.97%	5.36%
Denominator: 1,358,189	Pharmacy	9/17/2021	1,200	1.48%	0.09%
Numerator: 1,277,215	Physician	9/30/2021	1,104	1.36%	0.08%
Percentage: 94.04%	Other Professional	9/30/2021	981	1.21%	0.07%
	HCBS/MH	9/30/2021	970	1.20%	0.07%
All Over 30 Days: 80,974	HCBS/MH	8/31/2021	328	0.41%	0.02%
Percentage: 5.96%	Physician	9/27/2021	229	0.28%	0.02%
	HCBS/MH	9/27/2021	179	0.22%	0.01%
	Other Professional	7/1/2021	147	0.18%	0.01%
	Facility	8/12/2021	141	0.17%	0.01%
	Total of Top 10		**78,128**	**96.49%**	**5.75%**
2021 Q4	Physician	12/20/2021	4,342	45.13%	0.36%
Denominator: 1,216,902	Facility	12/20/2021	1,101	11.44%	0.09%
Numerator: 1,207,280	Other Professional	12/20/2021	1,011	10.51%	0.08%
Percentage: 99.21%	HCBS/MH	12/20/2021	588	6.11%	0.05%
	Other Professional	12/13/2021	545	5.66%	0.04%
All Over 30 Days: 9,622	HCBS/MH	12/30/2021	282	2.93%	0.02%
Percentage: 0.79%	Other Professional	12/9/2021	141	1.47%	0.01%
	Physician	12/30/2021	140	1.45%	0.01%
	Other Professional	12/30/2021	113	1.17%	0.01%
	Physician	10/28/2021	111	1.15%	0.01%
	Total of Top 10		**8,374**	**87.03%**	**0.69%**

* The denominator is the number of claims initially submitted as an encounter record to the State fiscal agent by the MCO in 2021. 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 2021

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
Laura Leistra	EQR Audit Manager/ Supervisor
Aetna	
Melissa Lawson	Healthcare Quality Management Director

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 (MY) 2021 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 2021 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 2021, potential earlier submissions were identified by matching the records submitted in 2021 to MMIS encounter records submitted from January 1, 2018, through December 31, 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.

The deduplication was based on the MCO ICN field and paid (or denied) date. Encounters with the same claim type, MCO ICN, and paid date were assumed to represent the same claim. If the MCO ICN field was not populated, 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.

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.