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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 UnitedHealthcare Community Plan of Kansas for MY 2021*

Dear Ms. Norris:

Enclosed is KFMC's validation report of the *Percent of Encounter Submissions Within 30 Days* performance measure of UnitedHealthcare Community Plan 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
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Bobbie Graff-Hendrixson, Senior Manager Contracts & Fiscal Agents Operations, KDHE

Enclosure(s)

Percent of Encounter Submissions Within 30 Days – MY 2021
UnitedHealthcare Community Plan 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): UnitedHealthcare Community Plan of Kansas (UnitedHealthcare), Aetna Better Health of Kansas, and Sunflower 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 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. UnitedHealthcare's MY 2021 percentages met the performance target for full incentive payment for all quarters: Q1 (99.55%), Q2 (99.95%), Q3 (99.90), and Q4 (99.75%).

The technical specifications are provided in Table 2.

Table 1. Percent of Encounter Submissions Within 30 Days, MY 2021 – UnitedHealthcare					
2021	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Number of claims paid or denied by the MCO	1,501,864	1,605,513	1,630,753	1,663,238	6,401,368
Number submitted as encounters within 30 days	1,495,127	1,604,654	1,629,076	1,659,026	6,387,883
Percentage	99.55%	99.95%	99.90%	99.75%	99.79%
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.

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

The stratified percentages of encounters submitted within 30 days were greater than 98.00% for all claim types except dental (96.85%).

Quarter 2 and Quarter 3

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

Quarter 4

The stratified percentages of encounters submitted within 30 days were greater than 99.70% for all claim types except dental (97.12%).

Conclusions

UnitedHealthcare's MY 2021 percent of covered service accurately submitted via encounter within 30 days of claim paid date met the performance target for full incentive payment for all four quarters: Q1 (99.55%), Q2 (99.95%), Q3 (99.90), and Q4 (99.75%).

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 2021

UnitedHealthcare

Community Plan of Kansas

Tables Stratified by Type of Claim

Table A1. Encounter Submissions Within 30 Days, MY 2021 – UnitedHealthcare					
All Claim Types*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	1,614,041	1,716,680	1,871,213	1,942,860	7,144,794
Minus duplicates identified by MCO ICN^	-112,177	-111,167	-240,460	-279,622	-743,426
Number of claims represented by an encounter	1,501,864	1,605,513	1,630,753	1,663,238	6,401,368
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	6,737	859	1,677	4,212	13,485
Denominator (claims represented minus exemption)	1,501,864	1,605,513	1,630,753	1,663,238	6,401,368
Numerator (submitted within 30 days)	1,495,127	1,604,654	1,629,076	1,659,026	6,387,883
Percentage	99.55%	99.95%	99.90%	99.75%	99.79%
Physician*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	348,445	394,516	440,253	458,910	1,642,124
Minus duplicates identified by MCO ICN^	-57,735	-73,243	-116,930	-121,876	-369,784
Number of claims represented by an encounter	290,710	321,273	323,323	337,034	1,272,340
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	957	99	90	644	1,790
Denominator (claims represented minus exemption)	290,710	321,273	323,323	337,034	1,272,340
Numerator (submitted within 30 days)	289,753	321,174	323,233	336,390	1,270,550
Percentage	99.67%	99.97%	99.97%	99.81%	99.86%
HCBS and Mental Health*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	340,237	355,695	402,162	407,971	1,506,065
Minus duplicates identified by MCO ICN^	-25,221	-25,777	-68,452	-79,259	-198,709
Number of claims represented by an encounter	315,016	329,918	333,710	328,712	1,307,356
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	654	363	27	904	1,948
Denominator (claims represented minus exemption)	315,016	329,918	333,710	328,712	1,307,356
Numerator (submitted within 30 days)	314,362	329,555	333,683	327,808	1,305,408
Percentage	99.79%	99.89%	99.99%	99.72%	99.85%
Other Professional*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of professional encounters submitted	224,381	243,082	288,266	324,632	1,080,361
Minus duplicates identified by MCO ICN^	-8,717	-8,225	-44,071	-69,115	-130,128
Number of claims represented by an encounter	215,664	234,857	244,195	255,517	950,233
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	1,410	186	44	748	2,388
Denominator (claims represented minus exemption)	215,664	234,857	244,195	255,517	950,233
Numerator (submitted within 30 days)	214,254	234,671	244,151	254,769	947,845
Percentage	99.35%	99.92%	99.98%	99.71%	99.75%

* 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 – UnitedHealthcare (Continued)					
Facility*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of facility encounters submitted	141,276	145,399	162,820	160,295	609,790
Minus duplicates identified by MCO ICN^	-7,643	-2,440	-8,385	-9,108	-27,576
Number of claims represented by an encounter	133,633	142,959	154,435	151,187	582,214
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	761	10	623	29	1,423
Denominator (claims represented minus exemption)	133,633	142,959	154,435	151,187	582,214
Numerator (submitted within 30 days)	132,872	142,949	153,812	151,158	580,791
Percentage	99.43%	99.99%	99.60%	99.98%	99.76%
Dental*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of dental encounters submitted	50,438	46,383	45,038	46,963	188,822
Minus duplicates identified by MCO ICN^	-3,676	-1,433	-2,339	-169	-7,617
Number of claims represented by an encounter	46,762	44,950	42,699	46,794	181,205
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	1,474	183	517	1,350	3,524
Denominator (claims represented minus exemption)	46,762	44,950	42,699	46,794	181,205
Numerator (submitted within 30 days)	45,288	44,767	42,182	45,444	177,681
Percentage	96.85%	99.59%	98.79%	97.12%	98.06%
Pharmacy*	**Q1**	**Q2**	**Q3**	**Q4**	**MY 2021**
Number of pharmacy encounters submitted	509,264	531,605	532,674	544,089	2,117,632
Minus duplicates identified by MCO ICN^	-9,185	-49	-283	-95	-9,612
Number of claims represented by an encounter	500,079	531,556	532,391	543,994	2,108,020
Minus claims with a State-approved exemption					
Number submitted over 30 days after paid date	1,481	18	376	537	2,412
Denominator (claims represented minus exemption)	500,079	531,556	532,391	543,994	2,108,020
Numerator (submitted within 30 days)	498,598	531,538	532,015	543,457	2,105,608
Percentage	99.70%	100.00%	99.93%	99.90%	99.89%

* 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 – UnitedHealthcare

Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2021 Q1	Pharmacy	1/28/2021	1,406	20.87%	0.09%
Denominator: 1,501,864	Dental	3/11/2021	1,360	20.19%	0.09%
Numerator: 1,495,127	Other Professional	2/10/2021	548	8.13%	0.04%
Percent: 99.55%	Physician	3/10/2021	530	7.87%	0.04%
	HCBS/MH	2/10/2021	480	7.12%	0.03%
All Over 30 Days: 6,737	Facility	2/9/2021	448	6.65%	0.03%
Percent: 0.45%	Other Professional	3/10/2021	377	5.60%	0.03%
	Physician	2/10/2021	193	2.86%	0.01%
	Facility	1/8/2021	156	2.32%	0.01%
	Other Professional	3/16/2021	155	2.30%	0.01%
	Total of Top 10		**5,653**	**83.91%**	**0.38%**
2021 Q2	HCBS/MH	5/28/2021	343	39.93%	0.02%
Denominator: 1,605,513	Other Professional	5/28/2021	161	18.74%	0.01%
Numerator: 1,604,654	Dental	4/20/2021	68	7.92%	0.00%
Percentage: 99.95%	Physician	6/30/2021	50	5.82%	0.00%
	Physician	5/28/2021	41	4.77%	0.00%
All Over 30 Days: 859	Dental	6/7/2021	20	2.33%	0.00%
Percentage: 0.05%	Dental	5/17/2021	15	1.75%	0.00%
	Dental	5/6/2021	14	1.63%	0.00%
	Other Professional	6/30/2021	14	1.63%	0.00%
	Dental	5/10/2021	13	1.51%	0.00%
	Total of Top 10		**739**	**86.03%**	**0.05%**
2021 Q3	Facility	9/30/2021	601	35.84%	0.04%
Denominator: 1,630,753	Dental	9/3/2021	434	25.88%	0.03%
Numerator: 1,629,076	Pharmacy	8/27/2021	326	19.44%	0.02%
Percentage: 99.90%	Physician	8/6/2021	52	3.10%	0.00%
	Dental	9/9/2021	33	1.97%	0.00%
All Over 30 Days: 1,677	Pharmacy	8/31/2021	30	1.79%	0.00%
Percentage: 0.10%	Physician	9/30/2021	24	1.43%	0.00%
	HCBS/MH	8/6/2021	19	1.13%	0.00%
	Other Professional	8/6/2021	19	1.13%	0.00%
	Facility	8/6/2021	17	1.01%	0.00%
	Total of Top 10		**1,555**	**92.73%**	**0.10%**
2021 Q4	Dental	11/1/2021	886	21.04%	0.05%
Denominator: 1,663,238	HCBS/MH	12/6/2021	603	14.32%	0.04%
Numerator: 1,659,026	Other Professional	12/21/2021	441	10.47%	0.03%
Percentage: 99.75%	Pharmacy	10/18/2021	434	10.30%	0.03%
	Physician	12/21/2021	351	8.33%	0.02%
All Over 30 Days: 4,212	HCBS/MH	12/21/2021	295	7.00%	0.02%
Percentage: 0.25%	Physician	12/6/2021	262	6.22%	0.02%
	Other Professional	12/6/2021	252	5.98%	0.02%
	Dental	12/27/2021	195	4.63%	0.01%
	Dental	11/3/2021	118	2.80%	0.01%
	Total of Top 10		**3,837**	**91.10%**	**0.23%**

* 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

UnitedHealthcare

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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
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 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.