

## **FY 2010 Contractor Roles and Responsibilities**

### **FY 2010 Statistical Contractor (SC) - Livanta LLC**

Each quarter throughout the fiscal year, the SC collects the universe of claims data for Medicaid and CHIP FFS and managed care from the states. The universe includes claims that are paid with Federal Financial Participation (FFP) for Medicaid and CHIP services, including payments made outside of the state's Medicaid Management Information System (MMIS) and payments made at the local level. Many states have benefit programs that are financed by state-only funds with no Federal money involved. Only claims with FFP should be included in the universe.

The SC draws a random sample of claims from the quarterly universes submitted by the states. The base sample size is approximately 500 claims per program for FFS and 250 claims per program for managed care. Since claims data is submitted quarterly by the states, each quarter is treated as a separate universe and sampled accordingly. Thus, the annual base sample size is subdivided into fourths, so that FFS claims will have a sample size of approximately 130 for each of the four quarters of data. Managed care samples will be approximately 70 for each of the four quarters.

PERM uses a stratified random sampling design. The universe is stratified by payment amount into five or more strata, and an equal number of claims are selected from each strata. This approach guarantees that strata with a large number of claims will not be over represented and strata with a small number of claims will be adequately represented.

After drawing the samples, the SC sends the samples to the Review Contractor (RC). The sample list contains minimum data information because it is less burdensome on states to provide minimum universe data and enhance the information on the sampled claims (called "populating the sample"). The SC also sends the States a list of their sampled claims, and the states populate the claims.

After the samples are populated and returned to the SC, the SC standardizes the format of the claims data and sends it to the RC for medical records requests.

### **FY 2010 Review Contractor (RC) – Undecided Contractor**

While the SC is collecting universe data, the RC begins requesting state Medicaid and CHIP policies that are used for the medical and data processing reviews.

When the RC receives the sample list from the SC, the RC schedules on-site data processing reviews with each of the states. For FFS claims, the data processing review includes examining line items in each claim to validate that it was processed correctly. The RC also performs data processing reviews on managed care claims for the accuracy of the processing of the capitation payment or premium.

When the RC receives standardized full claims data from the SC, the RC contacts those providers whose FFS claims were sampled to obtain copies of medical records for the claims in question. Providers have 60 calendar days to comply and send copies of medical records for the selected claims. If the provider does not respond, the state is notified of an error due to no documentation.

The RC also begins medical reviews on FFS claims. Managed care claims are not subject to medical reviews because there is no specific service rendered on which to make a medical necessity determination. The RC examines the medical record to ensure there is documentation that supports medical necessity and to verify coding accuracy. If the record does not contain sufficient documentation, then the provider has a new timeframe of 15 calendar days to provide the missing documentation. This new timeframe is not part of the original 60 days that the provider initially had to submit the medical records. Once the reviews are completed, the findings are posted to the RC's secure Web site, which can be reviewed by the individual States.