

FY 2013 PERM Universe Data Submission Instructions

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Section 1: Overview

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) requires the heads of Federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, CMS developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review.

To compute the PERM error rates all of the Medicaid and CHIP claims that were paid or denied during the annual period being evaluated are submitted by each state to the Statistical Contractor (SC) under contract with CMS to develop the PERM error rates. The data requests for PERM are large and complex: the claims and payment data required for PERM include essentially all of a state's Medicaid and CHIP beneficiary-specific payments and many aggregate payments (together referred to as the PERM "universe"), as well as beneficiary and provider information for claims that are sampled for review.

These instructions are intended to guide state staff in the preparation of the claims data that they will have to provide to support to the PERM SC. The instructions include information about PERM program areas that are used to compute PERM measures, data sources, required variables, state quality control checks, and data submission security requirements. Appendices include tables of required fields, a Transmission Cover Sheet for quality control verification, and specific differences between the FY 2010 and FY 2013 PERM cycles.

Each member of the state's PERM team, including both technical and non-technical staff, should receive a copy of these instructions and review them early in the process.

Initial Preparations for PERM

Developing PERM universes is a collaborative process between the states, CMS, and the Statistical Contractor (SC). The SC will provide assistance to each state in interpreting and applying the PERM data submission instructions. CMS will schedule meetings with state staff at the beginning of the PERM cycle to discuss the data request and to learn in detail about how the state adjudicates claims and processes other payments. The SC will continue to work with state staff to be certain that the state submitted all of the required PERM data in the PERM data submissions. States are encouraged to ask questions throughout the process to ensure mutual understanding of the data requirements and specifications.

To help ensure that all required data are included in the PERM submissions, each state should develop a PERM team that includes program, policy, technical and budget staff. From experience, CMS has identified that effective PERM teams include staff with expertise in areas such as:

- Program structure: single state agency and designated state agency functions, stand-alone/Medicaid expansion/combination CHIP program structure, managed care program structure and payment mechanisms, reimbursement policies involving at-risk, partial risk, or cost reconciliation arrangements, state-only funded programs adjudicated in MMIS
- Data sources: MMIS, health insurance premium payment (HIPP) payments, vendor data, other state agencies, county-paid services
- Technical aspects of claims adjudication: treatment of adjustments, denied/voided/rejected claims
- Field selection: reimbursement amounts for services matched with certified public expenditures, application of co-pays, original paid date
- Budget and finance: claims feeds for federal matching fund reports (e.g., quarterly CMS- 64 and CMS-21 reports)

File Development and Submission Timeline

The PERM project cycle is expected to take approximately two years, with claims and payment record collection and sampling activities concentrated in the first four quarters (with states submitting data quarterly beginning January 15, 2013) and error rate calculation occurring at the end of the review cycle.

Exhibit 1 outlines the major activities in the data submission process, with data submission dates highlighted in yellow. To meet the PERM project deadlines, it is important to begin development of the PERM data submissions as early as possible in the cycle. States should expect to spend time in the first quarter of the fiscal year of the measurement (October through December) preparing for the first quarter data submission in January. States should expect to spend time in February and March responding to questions about the PERM universe, resolving any data issues found during data validation and quality control. Subsequent data submissions are due in April, July, and October.

Note that we are implementing one major change to the submission timelines this year: states can choose to postpone submission of quarter 1 managed care universe data until the second quarter data submission due date (April 15, 2013). This option is being offered to allow states to focus on development and review of the fee-for-service universe, which is generally more complex than the managed care data and requires more review. In most cases, managed care samples will be drawn after the quarter 1 fee-for-service universes for a state have been sampled. This option will not delay any Review Contractor activities; both Q1 and Q2 managed care data will be reviewed together and delivered to the RC at the same time. This change will not affect the due dates of the Q2 through Q4 managed care universes.

Exhibit 1: FY 2013 PERM Data Submission Timeline

Date	State Activities	SC/CMS Activities
August 2012	✓ Determine if the state will submit via PERM Plus or routine PERM ✓ Select PERM team	✓ Meet with select states to discuss the PERM Plus submission option ✓ Answer questions about PERM
September 2012	✓ Schedule state orientation meeting	✓ Organize state orientation meeting
October - December 2012	✓ Participate in an orientation meeting ✓ Review Data Submission Instructions ✓ Ask questions and provide feedback	✓ Participate in an orientation meeting ✓ Answer questions from and provide feedback to PERM states
December 2012	✓ Code programs to provide PERM datasets ✓ Ask questions and provide feedback	✓ Answer questions from and provide feedback to PERM states
January 15, 2013	✓ Submit Q1 PERM universe data to the SC (exception: Q1 Managed Care data may be submitted with the Q2 PERM universe data)	✓ Receive Q1 PERM universe data from states
January 15 - February 2013	✓ Work with SC to resolve issues identified during the data validation and QC process	✓ Begin SC data validation and QC process
March-April 2013	✓ Work with SC to resolve issues identified QC of PERM universes	✓ Perform QC review of PERM universes ✓ Select Q1 samples
Within 2 weeks	✓ Submit Q1 PERM details data to the SC within 2 weeks of receipt of the sample	✓ Receive Q1 PERM details data from states, format the data, and review for completeness
Within 30 days	✓ Work with SC to resolve issues	✓ Finalize details data, and transmit the formatted details to the RC
April 15, 2013	✓ Submit Q2 (and any outstanding Q1 Managed Care) PERM universe data to the SC	✓ Receive Q2 (and any outstanding Q1 Managed Care) PERM universe data from states
April 15 - June 2013	✓ Work with SC to resolve issues	✓ Perform QC review of PERM universes ✓ Select Q2 samples
Within 2 weeks	✓ Submit Q2 PERM details data to the SC within 2 weeks of receipt of the sample	✓ Receive Q2 PERM details data from states, format the data, and review for completeness
Within 30 days	✓ Work with SC to resolve issues	✓ Finalize details data, and transmit the formatted details to the RC
July 15, 2013	✓ Submit Q3 PERM universe data to the SC	✓ Receive Q3 PERM universe data from states

Date	State Activities	SC/CMS Activities
July 15 - September 2013	✓ Work with SC to resolve issues	✓ Perform QC review of PERM universes ✓ Select Q3 samples
Within 2 weeks	✓ Submit Q3 PERM details data to the SC within 2 weeks of receipt of the sample	✓ Receive Q3 PERM details data from states, format the data, and review for completeness
Within 30 days	✓ Work with SC to resolve issues	✓ Finalize details data, and transmit the formatted details to the RC
October 15, 2013	✓ Submit Q4 PERM universe data to the SC	✓ Receive Q4 PERM universe data from states
October 15-December, 2013	✓ Work with SC to resolve issues	✓ Perform QC review of PERM universes ✓ Select Q4 samples
Within 2 weeks	✓ Submit Q4 PERM details data to the SC within 2 weeks of receipt of the sample	✓ Receive Q4 PERM details data from states, format the data, and review for completeness
Within 30 days	✓ Work with SC to resolve issues	✓ Finalize details data, and transmit the formatted details to the RC

Section 2: Universe File Specifications

Each state in the PERM cycle must submit quarterly universe data to the SC. Universe data files are essentially very long “lists” of nearly all the Medicaid and CHIP beneficiary-specific payment records adjudicated by the state during the quarter, including both paid and denied claims. In the universe submission, each payment record only needs to contain a small number of data elements or fields; most of the fields associated with a claim are submitted only for the claims sampled for review in PERM (as described in Section 3).

The data for a PERM universe file may be compiled from the MMIS, a data warehouse, HIPP payment files, county and state agency systems, vendor payment systems, managed care files, and a variety of other sources. The state must divide the PERM universe data into four program areas: Medicaid fee-for-service, CHIP fee-for-service, Medicaid managed care, and CHIP managed care, and provide the data at the appropriate “payment level” to support consistent sampling and review across states.

The complete universe files are used to select the random sample of claims, line items, or payments for PERM review. To ensure that the sample drawn from the data is truly representative of the state’s payments, each payment matched with federal Medicaid (Title XIX) or CHIP (Title XXI) funds should be included one time in the universe so that each payment has a chance, but only one chance, of being sampled for review.

Universe Parameters

The PERM universe data submission is defined by the following three major parameters, each of which is described in more detail below:

- Date
- Program
- Payment type

This section defines and discusses these three parameters, with specific details around which payments are to be included in the PERM data submission, how adjusted claims, denied claims, and zero-paid claims should be handled, and which types of payments are specifically excluded from the PERM universe.

Date

PERM universes include claims and payments originally processed during the federal fiscal year under review. For example, for the FY 2013 PERM cycle, the state’s PERM universe includes claims and payments with original dates of payment between October 1, 2012 and September 30, 2013.

States submit PERM data quarterly, including all claims with an original date of payment within the federal fiscal quarter. Data are due to the SC fifteen days after the end of each quarter. See Exhibit 2 for the data submission due dates for FY 2013 and the paid claim dates to be included in each quarterly submission.

Exhibit 2: Federal Fiscal Quarters and PERM Data Submission Dates, FY 2013

FY 2013 Quarter	Claim Date Paid	Data Submission Due
Quarter 1	October 1 - December 31, 2012	January 15, 2013
Quarter 2	January 1 - March 31, 2013	April 15, 2013
Quarter 3	April 1 - June 30, 2013	July 15, 2013
Quarter 4	July 1 - September 30, 2013	October 15, 2013

To support consistency across states, PERM relies on the original paid date to determine whether a payment falls within a given cycle measurement. If a state originally paid a claim during the cycle under review, but adjusted the claim after the PERM measurement period, the claim should be included in the PERM data submission based on the original paid date. Conversely, if a claim's original paid date is prior to the PERM measurement period, but an adjustment falls within the PERM measurement period, the claim would **not** be included in the PERM data, again, based on the original paid date.

States may submit the adjudication date instead of the original paid date in the PERM universe as long as the state maintains a consistent date approach throughout all four quarterly submissions. The adjudication date refers to the date that a claim is fully processed and either approved for payment or denied. States may also submit certain types of claims (for example, off-MMIS claims) using a date approach that is different from the other universe claims, as long as the dates for each dataset submitted for those claims are consistent over the course of the year. For example, a state could submit all MMIS claims using paid date but submit all off-MMIS HIPP payments using adjudication date.

States often make managed care capitation payments prospectively (e.g., on the 25th of the month prior to the month of coverage) or retrospectively (e.g., in the month following the month of coverage). Include managed care capitation payments in the PERM data submission based on paid date as well.

- *Prospective example:* A state makes a capitation payment on December 25, 2012 for services in January 2013. The state includes the payment with the PERM quarter 1 data submission.
- *Retrospective example:* A state makes a capitation payment on October 5, 2012 for services in September 2012. The state should include the payment with the PERM quarter 1 data submission.

Program

Generally, states include in the PERM data submissions all beneficiary-level claims and payments and certain aggregate payments for services provided to individual beneficiaries for which the state receives federal financial participation (FFP) through Title XIX or Title XXI (limited exclusions are discussed in a later section). States include claims and payments in PERM regardless if the state requested service or administrative match for the claims. Specific examples of claims and payments included in the PERM universe are:

- Regular fee-for-service (indemnity) claims
- Managed care premium payments
- Other payments made by the state on behalf of beneficiaries, including primary care case management (PCCM) payments, HIPP payments, capitated non-emergency transportation (NET) payments, and other capitated payments
- Payments made on the basis of an all-inclusive visit rate or “encounter rate.” States often make these types of payments to federally qualified health centers (FQHCs) and certain other providers
- Payments made to a provider in aggregate for which the underlying rate calculation methodology is based on individual beneficiaries

Identifying Medicaid and CHIP

States include both Title XIX and Title XXI matched payments in the PERM data submissions. As CMS must report separate error rates for the Medicaid and CHIP programs, the state must separate PERM data submissions between Title XIX and Title XXI and submit these in separate PERM universe files for each quarter. States should separate claims into the Medicaid or CHIP universe based on:

- 1) The federal money source, not the program design. Payments for Medicaid expansion-type CHIP programs or Medicaid expansion groups that are matched by Title XXI federal financial participation are included as CHIP claims or payments. States having both a Medicaid-expansion type CHIP program and a stand-alone CHIP program would include claims and payments from both Title XXI programs in the PERM CHIP universe file.
- 2) The beneficiary’s eligibility status during the dates of service at the time the claim was paid (adjudicated), not the beneficiary’s eligibility status at the time the state selects the data for PERM.

Include in the PERM claims file all payments that are paid for in whole or in part by Title XIX federal financial participation (FFP) dollars, as well as those payments considered for Title XIX FFP dollars but denied.

Also include in the PERM claims file all Medicaid expansion and/or stand-alone CHIP payments in the PERM submission, including payments that are paid for in whole or in part by Title XXI FFP dollars, as well as payments submitted as Title XXI services but denied.

The Fields for Universe Submission table in Appendix A also includes a field called “Funding code.” States may populate this field with any state-specific value that identifies, or helps identify, that the state requested federal Title XIX or Title XXI match for the claim or payment.

Service expenditures and administrative expenditures (both Title XIX and Title XXI)

PERM universes include only payments representing services paid or denied (or for managed care, a capitation payment purchasing a package of services). PERM includes payments made for services received by individual beneficiaries that are matched either at the medical services match rate or that receive FFP as an allowable administrative cost.

PERM universes do not include payments solely made for administrative functions, such as payments to fiscal agents, salaries of state employees, or funding for program outreach. In instances where rates blend administrative and service payments, the entire payment is included in the PERM universe.

Payment Type

Denied claims

Denied claims are claims that are adjudicated in the state's payment system but denied for payment. States submit denied claims as part of the state's PERM universe. In some instances, states may not be able to determine if a denied claim should be assigned to the Title XIX or the Title XXI program (e.g., a claim that is denied due to an invalid beneficiary identifier). Please discuss treatment of these denied claims with the SC.

Zero-paid claims

A zero-paid claim is a claim for which the state had no financial liability. For example, claims may be zero-paid due to third party liability, a Medicare crossover payment exceeding the state allowable charge, or for spenddown beneficiaries who have not met their financial obligations. Include zero-paid claims in the PERM universe submissions.

Adjudicated claims

States should only include fully adjudicated claims and payments in the PERM submissions. Claims that are submitted by providers that are "rejected" from the claims processing system prior to adjudication are not part of the PERM review. Often claim rejection occurs in a pre-processor or translator prior to the system assigning the claim an internal control number.

Beneficiary-level claims and payments

PERM data submissions will largely be comprised of beneficiary-level claims and payments. These include fee-for-service, managed care, and fixed payments, as discussed below. States submit separate universes for fee-for-service (which includes fixed payments) and managed care payments, and the SC draws a separate sample from the fee-for-service and managed care universes. (Claims and payments excluded from PERM are addressed in the following section.)

Fee-For-Service Payments

Fee-for-service payments are all payments made on a fee-for-service/indemnity basis. These include:

- Traditional fee-for-service payments to physicians, hospitals, pharmacies, home health agencies, LTC facilities, etc.
- Medicare crossover claims
- Fee-for-service claims for services carved out of managed care
- Fee-for-service claims paid for retroactive eligibility periods

Managed Care Payments

Managed care payments are fully and partially capitated payments. These include::

- Premiums for “full risk” indemnity insurance such as payments to HMOs, MCOs, PIHPs, HIOs
- Payments to service-specific providers paid on a capitated/at-risk basis (e.g., pharmacy, mental health)
- Condition-specific managed care payments for special needs beneficiaries (e.g., at-risk payments for HIV/AIDS)
- Certain non-capitated, beneficiary-specific payments made to managed care organizations such as delivery supplemental payments or “kick” payments which are paid at a negotiated rate

While full-risk payments to managed care organizations are clearly part of the managed care universe, payments associated with certain types of capitated programs may be more appropriately included in the fee-for-service universe. The SC will work with each state to evaluate state programs and determine if program payments conform to the PERM managed care definition or if the payments should be included in the fee-for-service universe instead.

Fixed Payments

Certain payments are included in the PERM fee-for-service universe for sampling but are not subject to medical review like other fee-for-service claims. These payments, referred to as “fixed payments” for PERM purposes, include a variety of payments made to providers or vendors such as:

- Monthly primary care case management (PCCM) fees paid to participating providers
- HIPPP payments made to purchase or subsidize employer-sponsored insurance
- Capitated non-emergency transportation vendor payments
- Fixed beneficiary-specific pharmacy dispensing fees (e.g., a state pays nursing home pharmacies a monthly fixed amount per beneficiary)

The SC will work with the state to evaluate state programs and services and determine if any meet the PERM fixed payment definition and should be included in the fee-for-service universe.

Aggregate Payments

While most Medicaid and CHIP payments for services are paid at the beneficiary level, states also calculate and pay for some services on behalf of a group of beneficiaries. PERM broadly refers to these as “aggregate payments.” Unless otherwise specified by CMS, aggregate payments for services to beneficiaries are included in the PERM universe. Aggregate payments are included in the PERM universe regardless of whether the state claims FFP at the medical services match rate or as an allowable administrative cost.

Examples of aggregate payments are pay-for-performance incentive payments made to individual providers based on the claims experience of a group of beneficiaries; reimbursement to counties for non-emergency transportation services provided to all Medicaid beneficiaries residing in that county; and fees paid to a case management vendor based on the number of beneficiaries enrolled in the Medicaid program each month. In some cases, states may determine payment at the individual level but maintain payment records at the aggregate level.

CMS and the SC will work with the state to determine how aggregate payments should be submitted and reviewed for PERM.

Claims and Payments to Exclude from PERM

Some claims and payments for which states receive FFP through Title XIX or Title XXI are explicitly excluded from PERM either by regulation or in accordance with established policy. States should not include the following claims or payments in the PERM submission when the payment is not beneficiary-specific:

- Disproportionate share hospital (DSH) payments
- Drug rebates
- Grants to state agencies or local health departments
- Cost-based reconciliations to not-for-profit providers or federally qualified health centers
- Gross payments
- Mass adjustments

In addition, states should not include Medicare Part A and Part B premium payments (“buy-in”) in the PERM data submission. The SC will collect these payments from CMS to include in each state’s universe prior to sampling.

Encounter data

States should not include encounter data or “shadow claims” in the PERM submissions. For PERM purposes, encounter data is defined as informational-only records submitted to a state by a provider or a managed care organization (MCO) for services covered under a managed care capitation payment. States often collect this data in order to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk managed care contractors. However, these are not claims submitted for payment. While encounter data are beneficiary-specific, encounters do not represent an actual payment made by the state.

Payments for administrative functions

As noted above, PERM claims and payments represent services to beneficiaries. Payments made entirely for administrative functions are not included in the PERM review and states should not include these in the PERM submissions. These include payments such as state staff salaries, fiscal agents and other administrative vendors, and outreach funding. In cases in which a state blends dollars for beneficiary services with administrative payments into a single reimbursement rate, the state should submit the entire payment for PERM review.

Adjusted Claims

States are required to remove claim or payment adjustments from the PERM data submissions. Only the original paid amount should be submitted in the PERM universe.

Data Sources

States generally draw a majority of PERM data from their MMIS. However, states often maintain other payment systems that record payments matched with Title XIX or Title XXI funds (and for which the state does not also maintain a payment recorded in MMIS). States must include all payments, including those from non-MMIS systems, in the PERM data submissions. PERM affords states flexibility to submit data from systems outside MMIS as separate files from the MMIS data.

When reviewing possible data sources, states are advised to consider sources such as:

- Claims paid by separate vendors or third party administrators
 - Pharmacy
 - Dental
 - Vision
- Claims paid by state agencies (not the Medicaid agency)
- Mentally Retarded/Developmentally Disabled (MR/DD) services
- State-owned facilities such as nursing homes
- Waiver services (including consumer-directed individualized budgets)
- Claims paid by counties
- Transportation provider payment systems
- Case management costs
- Stand-alone or “manual” systems
- HIPP payments
- Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Indian Health Service (IHS) clinics and facilities
- Systems that produce payments such as PCCM payments and non-emergency medical transportation broker capitation payments

State staff should “follow the money” by reviewing the state’s federal financial reports to determine if a state is capturing payments from all of the data sources. If a state determines that data from multiple sources populates the CMS-64 and/or CMS-21 Financial Reports, the state should evaluate these data sources to identify claims and payments to include in the PERM data submission.

Note that not all claims processed in MMIS are matched with Title XIX or Title XXI funds. Do not include state-only funded services or services provided with financial funds from any federal programs other than Title XIX or Title XXI in the PERM submissions.

Sampling Units in the PERM Submission

PERM universe data will have one record for each “sampling unit.” States must provide universe data at the sampling unit level. A sampling unit is a line item, fixed payment, or other individually-priced service tied to a single beneficiary. If a payment amount is determined at the detail item or “line” level, the line item is the sampling unit. If the payment amount is set at the claim level, the sampling unit is at the claim or “header” level.

A header level sampling unit has a paid amount that is not associated with any specific line or service; rather, it is based on days, groups of services and/or other related information, encounter rates, or point of sale transactions. A line level sampling unit has a paid amount on the record for a specific service.

Please note, if payment amount determination is made for the entire claim, regardless of the number of lines or where the payment is carried in the system, it is a header level payment. If each line in a claim stands the chance of being paid or denied individually, these are line level payments.

When developing data specifications for PERM, it is important to carefully review the many types of claims paid by the state so that the appropriate header or line level payment is selected. Some states have found it helpful to review each state claim type or other payment indicator to identify claims as header or line level payments (but also be aware of exceptions to the claim type payment “rules”).

Header Level Example

For those states using a prospective payment or diagnosis-related groups (DRG) systems for inpatient stays, the smallest independently priced item is the DRG itself. In this case, the DRG (or claim header) is the sampling unit. When the DRG is the sampling unit, the universe file would include a single record for each inpatient hospital claim, with the amount paid field equal to the amount paid for the entire claim. If the state determines that the sampling unit is the header, the state should not include in the PERM universe the records for the detail lines associated with the header (often these are zero-paid lines). Similarly, if the inpatient stay is priced as an all-inclusive per diem payment amount, the sampling unit would be at the claim header level. Exhibit 3 provides an example of a header level sampling unit.

Exhibit 3: Example of a Header Level Sampling Unit

<i>Payment Level</i>	<i>Claim Type</i>	<i>ICN</i>	<i>Line Number</i>	<i>Date Paid</i>	<i>Amount Paid</i>	<i>Service Code</i>
H	Inpatient	12345678	0	10/1/2012	\$1000.00	DRG

Line Level Example

Most physician claims are paid by individually-priced procedure codes recorded at the line or detail level. In these cases, the state would submit the physician claims in the universe file at the line level. Each record or sampling unit will represent a claim line/detail and the amount paid for that line/detail. For a lab claim with several separately priced tests, each line item on the claim would be defined as a sampling unit and sampled separately. A claim for lab tests paid on a bundled basis would be treated as a single line level sampling unit. For claims submitted at the line level, the state should not also include a header level record (this would essentially “double” the paid amount associated with the claim in the PERM universe). Exhibit 4 provides an example of line level sampling units.

Multiple units of service recorded on a single line should not be divided into multiple sampling units if the units were priced and paid on the same line. For example, a procedure code having 2 units should *not* be made into 2 records of one unit each.

Exhibit 4: Examples of Line Level Sampling Units

Payment Level	Claim Type	ICN	Line Number	Date Paid	Amount Paid	Service Code
L	Physician	12345678	1	10/1/2012	\$10.00	HCPCS
L	Physician	12345678	2	10/1/2012	\$15.00	HCPCS
L	Physician	12345678	3	10/1/2012	\$20.00	HCPCS

Payment Level and Third Party Liability

Third party liability (TPL) is the portion of the allowed Medicaid/CHIP reimbursement that is paid by other insurance or the beneficiary. In most cases, a state only knows the share of the header paid amount paid by third-party insurance. The state does not have any information on how the third-party insurance payment is distributed to the individual claim services. The state will report the header paid amount to include TPL for a claim. However, no TPL will be assigned to the paid amounts of the individual claim details.

To accurately report the amount that Medicaid or CHIP paid for services excluding TPL for PERM, states should submit line level claims, such as physician claims, where TPL is reported at the header level as header level sampling units. For most states, only the claims with TPL would be reported as header level sampling units. Claims without TPL should be reported as line level sampling units.

Payment Level Identification Challenges

For certain types of claims and payments, it can be difficult to accurately identify the appropriate “payment level” for PERM purposes. States should pay particular attention to FQHC payments and other clinic payments: Medicare crossover claims, payments made to state-owned facilities or out-of-state facilities, and compounded drugs, which may be atypical from other payments for similar services. In some states, FQHCs also submit unpaid or \$0 paid

informational line details with procedure codes. These informational line items should not be included in the PERM universe. Medicare crossover claims are often paid on the basis of the type of service, and the universe file will need to capture these payments at the header or line item level, as appropriate to each payment. Some states pay state-owned facilities differently than private providers. If this is the case, be certain to select the appropriate header or line value for the PERM universe.

A sampling unit should never be represented multiple times within a universe file, or included in more than one universe file across programs or across quarters. (The same ICN and line number combination should not repeat.) If a claim is included at the header level, the associated lines should not be included in the universe. Likewise, if a claim is included at the line level, the associated header should not be included in the universe.

Again, the SC will work with the state to evaluate payments and help determine if the state should include the payment in the PERM universe at the line level or the header level.

Fields in the PERM Universe Submission

As noted above, while the universe must contain a record for every payment that meets the PERM universe criteria, each payment record in the fee-for-service universe only needs to contain a relatively small number of data elements or fields. After the SC samples fee-for-service claims for review, the state will then submit a larger number of fields, including beneficiary and provider information, only for the sampled claims. The sampled claim details submission is described in Section 3.

For the managed care universe, we require states to submit all of the fields needed for review as part of the universe submission. Therefore, the managed care universe submission contains more required fields than the fee-for-service universe. However, because the managed care universe already contains the fields needed to review sampled managed care claims, states generally do not need to submit a second detail submission for sampled managed care claims.

Appendix A contains a list of the fields required for each payment record in the fee-for-service and managed care universe submissions. Some of these fields, such as ICN, line number, and source location allow the state, SC, and RC to identify the sampled payment in the state's system. Many fields, such as date paid, amount paid, claim type, provider type, managed care program indicator, and payment status are used by the SC to validate that the universe is complete and accurate. Some of the required fields, such as funding code and fixed payment indicator, are used to ensure that payments are assigned to the appropriate PERM universe prior to sampling. Many of the managed care-specific fields such as beneficiary ID, rate indicator, aid category, and coverage location are used by the RC to conduct the managed care payment review. States may also submit state-defined fields with the data if desired.

Please carefully review the tables and Appendix A, including the "Notes/Suggestions" column. This column provides information essential to understanding the PERM field requirements.

Section 3: Sampled Claim Details File

The Medicaid and CHIP fee-for-service universes include an extract of the claims information for all adjudicated sampling units (paid claims and denials) for each quarter. From the universe claims extract, the SC will select a random sample of payments. The SC will return the sampled claims to the state. For the sampled fee-for-service claims, the state will then provide to the SC a file with details for the sampled payments. This sampled claim details submission will contain information needed to assist the RC in requesting records, and the provider in identifying and submitting the medical record associated with each sampled claim. The details submission instructions, including the file layout specifications, are provided in a separate document by the SC, titled “FY13 PERM Details Submission Instructions.”

Sampled Claim Details Data

States will return to the SC detailed information on each sampled claim. The detailed information should include complete header and line information for the sample. For example, if a claim pays on a line basis and the SC sampled line 2, the information returned by the state should include information from the header and all lines associated with that claim header, including line 2 and all other lines. Likewise, if the SC sampled a payment provided in the universe as a header level claim, the state should return in the details submission all lines associated with that claim, as well as the sampled claim header.

As noted above, the sampled claim details submission intends to include all fields necessary for the RC to request a medical record from the provider and for the provider to identify and submit the associated record. Identifiers for both the billing provider and the performing provider should be included for all fee-for-service claims in the sample, along with the providers’ addresses and telephone numbers. Note that if a required medical record cannot be obtained from the provider, the payment will be considered fully in error. Therefore, states are advised to provide complete and up-to-date provider contact information. In some cases, such as when the billing provider in MMIS is a state agency or other organization, the state may need to locate additional information on the performing provider and submit the additional information for the associated sampled claim. Therefore, we strongly recommend reviewing sampled claim detail information to validate that the provider information submitted with each sample is the correct provider for the RC to contact to obtain the record that supports the claim.

States will not be required to submit adjustments with their sampled claim details. The RC will collect any adjustments made within 60 days to sampled claims during the review process. This applies to both fee-for-service and managed care samples. While state policies generally allow adjustments to be made more than 60 days after the original paid date, only the adjustments made within 60 days will be considered for PERM review purposes, per federal regulation. The RC will work with each state to identify mechanisms and data fields to appropriately account for adjustments during the review.

Section 4: Quality Review

States are responsible for performing a quality review of their PERM data submissions each quarter before submitting files to the SC. Quality review saves time and resources for both the state and CMS contractors by identifying data problems early in the PERM process. Exhibit 5 contains suggested minimal quality control checks for states to complete.

Exhibit 5: Minimum Universe Submission Quality Control Checks

Quality Review	Suggested Tests
1) Ensure all required fields are reported in the universe file	○ Prepare a list of all fields in the universe file and compare it to the list of fields in Appendix A ○ Identify any missing fields ○ Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file
2) Check that key fields are properly formatted	○ Check that key fields are not truncated or contain extra data. Review fields such as: - ICN/TCN - Line number - Paid Amount
3) Check that the paid date for all records is for the appropriate quarter for FY 2013	○ Review the values in the paid date field
4) Confirm Medicaid (Title XIX) and CHIP (Title XXI) claims are appropriately allocated to the correct universe	○ Review programming logic and outputs to make certain that claims in the Medicaid universe were matched with Title XIX funds and claims in the CHIP universe were matched with Title XXI funds
5) Confirm that fee-for-service and managed care claims are appropriately allocated to the correct universe	○ Review programming logic and outputs to make certain that claims are allocated to the correct universe ○ Review notes from intake discussion and subsequent communications with the SC and CMS to ensure the universes contain the required types of claims and payments
6) Each payment is represented only one time in the universe	○ Confirm that there are no ICN-line number combinations repeated in the universe
7) Conduct a comparison of the CMS-64/21 reports to the PERM universe submissions	○ Compare PERM universe totals to either two previous quarters' CMS-64/21 reports, or to the current quarter's CMS-64/21 reports ○ Look for major dips or spikes or "significant" differences ○ Submit comparison results to the SC for each quarterly PERM universe submission

State PERM Universe Data Quality Guidance

States should compare their Medicaid and CHIP PERM universes to CMS-64 and CMS-21 Financial Reports, respectively, to ensure that the universes are complete and accurate.

Comparing the universe data to the CMS Financial Reports ensures that no programs (likely not in MMIS) that appear on the CMS Financial Reports have been omitted from the universe data and that the state is capturing all necessary data sources in the PERM universe. The CMS-64 and CMS-21 forms may not be finalized until after the PERM data are submitted, so we ask that states conduct these comparisons after the forms are finalized, and inform the SC of any major discrepancies.

We recommend that states identify the portions of the CMS-64 and CMS-21 Financial Reports that are not appropriate to compare to PERM universes (excluded claims, drug rebates, adjustments, etc.), remove these from the CMS-64 and CMS-21 Financial Report Totals, and separate the CMS-64 and CMS-21 totals between fee-for-service (FFS) and managed care. States should then compare the CMS-64 and CMS-21 Financial Report totals to their FFS and managed care PERM universes. The state should confirm that no programs that appear on the CMS Financial Reports have been omitted from the universe. In addition, significant differences between PERM universes and Financial Reports, as defined by the state, should be reported to the SC.

Section 5: Data Transmission and Security

This section discusses the PERM data submission media, PERM data submission formats, Transmission Cover Sheet and quality control verification, and data transmission and security.

Submission Media

The SC's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, portable hard drives). It is preferred that states send their data via secure FTP (SFTP). However, if this is not an option, state may submit data on a CD or DVD. Do not send PERM data via email.

See the Data Transmission section below for information on passwords and encryption.

Submission Formats

The SC prefers receiving data in one of three formats: SAS dataset, delimited file, or flat file.

- SAS dataset: PC-based SAS dataset
- Delimited file: comma delimited (.csv) or tab delimited text (.txt)
- Flat file: a universal text format with a single fixed record length and layout (also called a "flat format" or "ASCII format"). If the state submits text files, except for the first row of the field names, do not include any log or summary information at the beginning or at the bottom of the data file.

Transmission Cover Sheet

The state must submit a Transmission Cover Sheet with every data submission. Examples of the Medicaid fee-for-service and Medicaid managed care data Transmission Cover Sheet are provided in Appendix B. The state may include the Transmission Cover Sheet on the CD or DVD with the data, email the cover sheet to the SC, or submit as a separate file through SFTP.

Privacy

The SC is committed to protecting the confidentiality, integrity, and accessibility of sensitive data. PERM states should comply with HIPAA Privacy and Security Rules, CMS Business Partners Systems Security Manual rules for sensitive data transfer, and state privacy and security rules. Any data that includes protected health information (PHI) and/or personally identifiable information (PII), such as beneficiary ID numbers, is considered sensitive data.

Data Transmission

All data transmissions containing PHI or PII must conform to the FIPS 140-2 standards and comply with proper password protection and encryption procedures.

The SC will only accept data files via SFTP transmission or sent on hard media (e.g. CD, DVD) through the mail. Do not send PERM data via email.

The preferred method of data transmission is via SFTP.

Follow these steps if sending data via SFTP:

- Contact the SC to discuss the SFTP site, establish a SFTP connection, and test the SFTP prior to data submission
- Encrypt and password-protect data files
- Zip all PERM data files, including the Transmission Cover Sheet and file layouts, into a single zip file
- SFTP the zipped file
- Email a copy of the Transmission Cover Sheet and password(s) to the SC to indicate that the PERM data is available on the SFTP site

Follow these steps if mailing data:

- Zip files, as needed, based on file size
- Encrypt and password-protect data files, copy to a CD or DVD
- Label the CD or DVD “CMS Sensitive Information”
- Label the envelope “To be opened by addressee only”
- Address the envelope to the SC
- Mail the CD or DVD via a private delivery service (such as FedEx or UPS) or the USPS
- E-mail the Transmission Cover Sheet and password(s) for the data to the SC

Appendix A

Fields for Universe Submissions

When submitting the universe data to the SC, states are required to provide all of the fields listed in the tables below. The first table contains the fee-for-service fields. The second lists the managed care fields. Note that in the fee-for-service universe file, all fields are mandatory. This means every data element for every line item should be populated with a valid value.

Universe - Medicaid Fee-For-Service and CHIP Fee-For-Service (including Fee-For-Service Fixed Payments)		
Standard Field Name	Standard Field Description	Notes/Suggestions
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For “dummy” claims, be sure the ICN information can tie back to the payment. If the ICN/Line Number alone is <i>not</i> sufficient to uniquely identify the sampling unit, the state must define those fields that can be used.
Line number	Line item number	Indicate in documentation the line item number for headers (e.g., header line = 0)
Date paid	<u>Original</u> date of payment or adjudication	Please format dates as “mm/dd/yyyy” if possible
Amount paid	Total computable amount paid on the line or header	Total Computable Amount = Federal Share + State Share
Service Date From	Beginning date of service for the claim or claim line	Please format dates as “mm/dd/yyyy” if possible
Service Date Through	Ending date of service for the claim or claim line	Please format dates as “mm/dd/yyyy” if possible
Claim type	State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim.	State data dictionary required

Appendix A
Fields for Universe Submissions

Universe - Medicaid Fee-For-Service and CHIP Fee-For-Service (including Fee-For-Service Fixed Payments)		
Standard Field Name	Standard Field Description	Notes/Suggestions
Funding code	Indicates the funding source for the claim or claim lines (e.g., Title XIX, Title XXI)	State data dictionary required
Category of Service	Classification for broad types of state/federal covered services	State data dictionary required
Payment status	Indicator if the claim is paid or denied	Paid or denied indicator for each claim or claim line as it was originally adjudicated. Should not reflect an adjusted payment status. “P” for paid, “D” for denied
Fixed payment indicator	Indicates where a payment is fixed	Suggest using Y= Fixed Payment, N= Not a Fixed Payment
Payment level	Header level, line level	H = Sampling unit paid at the Header level L = Sampling unit paid at the Line level
Provider ID	Provider identification number associated with the claim or claim line	
Provider type	Provider type or MSIS category or other similar variable	State data dictionary required
Provider specialty	Provider specialty code for the claim or claim line	State data dictionary required
Service code	Procedure code, revenue code, or other payment code (often for, but not exclusive to, line level sampling units)	

Appendix A
Fields for Universe Submissions

Universe - Medicaid Fee-For-Service and CHIP Fee-For-Service (including Fee-For-Service Fixed Payments)		
Standard Field Name	Standard Field Description	Notes/Suggestions
Source location	The system of origin/location in which the sampling unit was adjudicated	If system operated outside the MMIS, the state should provide a crosswalk from the system to the location, e. g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State
Beneficiary ID	Beneficiary Medicaid/CHIP number	Optional, but strongly recommended
Referring Provider Name	Name of referring provider for a claim	Optional, but strongly recommended
Referring Provider NPI	The NPI number for the referring provider of a claim	Optional, but strongly recommended
Type of service	Indicates type of service a claim is billed for	Optional
Federal claim category	MSIS Code, CMS 64 line, or other state mapping into a federal claim category	Optional
User option fields 1-10	State supplied additional fields	

Appendix A

Fields for Universe Submissions

Universe - Medicaid Managed Care and CHIP Managed Care		
Standard Field Name	Standard Field Description	Notes/Suggestions
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For “dummy” claims, be sure the ICN information can tie back to the payment. If the ICN/Line Number alone is <i>not</i> sufficient to uniquely identify the sampling unit, the state must define those fields that can be used.
Date paid	<u>Original date</u> of payment or adjudication	Please format dates as “mm/dd/yyyy” if possible
Amount paid	Total computable amount paid of the payment	Total Computable Amount = Federal Share + State Share
Managed care program indicator	Indicator of the program (TANF, PACE, LTC, Behavioral health)	State data dictionary required
Payment type	E.g., monthly capitation, delivery kick payment or other beneficiary-specific supplemental payment, individual reinsurance payment	State data dictionary required
Funding code	Indicates the funding source for the claim or claim lines (e.g., Title XIX, Title XXI)	State data dictionary required

Appendix A
Fields for Universe Submissions

Universe - Medicaid Managed Care and CHIP Managed Care		
Standard Field Name	Standard Field Description	Notes/Suggestions
Provider ID	Medicaid/CHIP ID for the managed care organization	
Beneficiary ID	Beneficiary Medicaid/CHIP number	
Beneficiary name		State may submit according to state preference (e.g., can submit multiple variables for first, middle, and last name or a single variable containing beneficiaries full names)
Beneficiary rate indicator	Rate cell or rate group used to determine the payment for the recipient to the managed care plan	State data dictionary required
Beneficiary aid category	Eligibility type	State data dictionary required
Beneficiary DOB	Beneficiary date of birth	Please format dates as mm/dd/yyyy
Beneficiary gender		State data dictionary required
Beneficiary county		State data dictionary required
Service area indicator	Indicator for the geographic service area if the service area is not the county	State data dictionary required

Appendix A
Fields for Universe Submissions

Universe - Medicaid Managed Care and CHIP Managed Care		
Standard Field Name	Standard Field Description	Notes/Suggestions
Source location	The system of origin/location in which the sampling unit was adjudicated	If system operated outside the MMIS, the state should provide a crosswalk from the system to the location, e. g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State
Coverage Period From	Beginning date of the coverage period or date of service for the claim line, typically the first of the month	Please format dates as “mm/dd/yyyy”
Coverage Period To	Beginning date of the coverage period or date of service for the claim line, typically, the first of the month	Please format dates as “mm/dd/yyyy”
Payment status	Indicator if the claim is paid or denied	Please format as “P” for paid and “D” for denied if possible If not formatted as “P” or “D” state data dictionary required
User option fields 1-10	State supplied additional fields	

Appendix B
Transmission Cover Sheet

Medicaid Fee-For-Service, Quarter 1

Complete and submit this cover sheet with every PERM data submission.

State:				
Date:				
Quarter:				
Contact person for data questions:				
Name:				
Phone:				
Email:				
Title:				
Organization:				
Data Descriptions <i>Complete information below. Please include a row describing the data documentation. Add more rows as necessary.</i>				
		File Format (e.g., text, Excel, SAS)	File Media (e.g., CD, DVD, FTP)	Password Protected? (send password separately)
Data Description (e.g., Q1 Medicaid FFS; data documentation)	Data Filename			
(Add rows if necessary)				

Appendix B Transmission Cover Sheet

Control Totals <i>Add more tables as necessary.</i> NOTE: List the lines count and total \$\$ by CLAIM TYPE, not universe totals. Add more rows as necessary to reflect each claim type.								
Data filename:								
Month October			Month November			Month December		
Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$
(Add rows if necessary)								
Data filename:								
Month October			Month November			Month December		
Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$
(Add rows if necessary)								

Appendix B Transmission Cover Sheet

Medicaid Managed Care, Quarter 1

Complete and submit this cover sheet with every PERM data submission.

State:				
Date:				
Quarter:				
Contact person for data questions:				
Name:				
Phone:				
Email:				
Title:				
Organization:				
Data Descriptions <i>Complete information below. Please include a row describing the data documentation. Add more rows as necessary.</i>				
Data Description (e.g., Q1 Medicaid MC; data documentation)	Data Filename	File Format (e.g., text, Excel, SAS)	File Media (e.g., CD, DVD, FTP)	Password Protected? (send password separately)
(Add rows if necessary)				

Appendix B Transmission Cover Sheet

Control Totals <i>Add more tables as necessary.</i> NOTE: List the lines count and total \$\$ by managed care program area, not universe totals. Add more rows as necessary to reflect each claim type.								
Data filename:								
Month October			Month November			Month December		
Program	Total Lines	Total \$\$	Program	Total Lines	Total \$\$	Program	Total Lines	Total \$\$
(Add rows if necessary)								
Data filename:								
Month October			Month November			Month December		
Program	Total Lines	Total \$\$	Program	Total Lines	Total \$\$	Program	Total Lines	Total \$\$
(Add rows if necessary)								

Appendix C
Differences Between the FY 2010 and FY 2013 PERM Cycles

Variable Comparison for Medicaid and CHIP FFS Universe Submission (including FFS Fixed Payments)

	2010	2013	Change
ICN	required	required	
Line number	required	required	
Date paid	required	required	
Amount paid	required	required	
Service Date From	optional	required	√
Service Date Through	optional	required	√
Claim type	required	required	
Funding code	required	required	
Category of Service	required	required	
Payment status	required	required	
Fixed payment indicator		new, required	√
Payment level	required	required	
Provider ID		new, required	√
Provider type	required	required	
Provider specialty		new, required	√
Service code	required	required	
Source location	required	required	
Beneficiary ID		new, optional	√
Referring Provider Name		new, optional	√
Referring Provider NPI		new, optional	√
Type of Service		new, optional	√
Federal Claim Category		new, optional	√
User option fields 1-10	optional	optional	

Appendix C
Differences Between the FY 2010 and FY 2013 PERM Cycles

Variable Comparison for Medicaid and CHIP Managed Care Universe Submission

	2010	2013	Change
ICN	required	required	
Date paid	required	required	
Amount paid	required	required	
Managed care program indicator	required	required	
Payment type	required	required	
Funding code	required	required	
Provider ID	required	required	
Beneficiary ID	required	required	
Beneficiary name	required	required	
Beneficiary rate indicator	required	required	
Beneficiary aid category	required	required	
Beneficiary DOB	required	required	
Beneficiary gender	required	required	
Beneficiary county	optional	required	√
Service area indicator	optional	required	√
Source location	required	required	
Coverage Period From	required	required	
Coverage Period To	required	required	
Payment status	required	required	
User option fields 1-10	optional	optional	