FY 2014 PERM Universe Data Submission Instructions

September 30, 2013

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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. IPERA was amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012, which emphasizes the importance of not only measuring improper payments, but also recovering and reducing 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.[1]

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 2011 and FY 2014 PERM cycles.

Each member of the state's PERM team, including technical and non-technical staff from both the state and any relevant vendors, 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

[1] The FY 2014 PERM cycle will not include an eligibility component review. See State Health Official Letter #13-005 at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-005.pdf

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 their 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 both state and vendor 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; Third Party Administrator (TPA), Pharmacy Benefit Manager (PBM), 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, 2014) 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 (Q1) of the fiscal year of the measurement (October through December 2013) 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 and 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 Q1 managed care universe data until the second quarter data submission due date (April 15, 2014). 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 Q1 fee-for-service universes for a state have been sampled. This option will not delay any Review Contractor (RC) 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 2014 PERM Universe Submission Timeline

Date	State Activities	SC/CMS Activities
August 2013	✓ Determine if the state will submit via PERM Plus or routine PERM ✓ Select PERM team ✓ Provide completed Universe Data Submission Survey and applicable data dictionaries	✓ Meet with select states to discuss the PERM Plus submission option ✓ Answer questions about PERM
September 2013	✓ Schedule state orientation meeting ✓ Participate in PERM 101 education sessions	✓ Organize state Intake Meeting
October - December 2013	✓ Participate in a state Intake Meeting ✓ Review Data Submission Instructions ✓ Ask questions and provide feedback	✓ Participate in state Intake Meetings ✓ Answer questions from and provide feedback to PERM states
December 2013	✓ Code programs to provide PERM data sets ✓ Ask questions and provide feedback	✓ Answer questions from and provide feedback to PERM states
January 15, 2014	✓ 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 2014	✓ Work with SC to revise FFS strata mapping ✓ Work with SC to resolve issues identified during the data validation and QC process	✓ Review FFS strata mapping ✓ Begin SC data validation and QC process ✓
March-April 2014	✓ Work with SC to resolve issues identified during 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, 2014	✓ 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

Date	State Activities	SC/CMS Activities
April 15 – June 2014	✓ 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, 2014	✓ Submit Q3 PERM universe data to the SC	✓ Receive Q3 PERM universe data from states
July 15 – September 2014	✓ Work with SC to resolve issues ✓ Review CMS-64 analysis and provide feedback to SC as necessary	✓ Perform QC review of PERM universes ✓ Select Q3 samples ✓ Conduct CMS-64 comparison and analysis
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, 2014	✓ Submit Q4 PERM universe data to the SC	✓ Receive Q4 PERM universe data from states
October 15- December, 2014	✓ 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, as well as aggregate payments made to providers by the state and determined to part of the PERM universe by the state, the SC, the RC, and CMS. 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 smallest individually-priced payment amount for which the state claims federal match 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 single chance of being sampled for review.

This section defines and discusses three primary PERM universe parameters as well as provides guidance on other areas that are critical to the submission of a complete and accurate PERM universe including: the treatment of denied and zero-paid claims; payments and records excluded from PERM; data sources; and the definition of a PERM sampling unit.

Universe Parameters

The PERM universe data submission is primarily defined by three major parameters that have PERM-specific definitions, each of which is described in more detail below:

- Program Type
- Date
- Paid Amount

Program Type

The PERM data submission can include up to four data universes, depending on the program structure and service delivery system operating in each state. Universes can include: Medicaid fee-for-service (FFS), CHIP FFS, Medicaid managed, and CHIP managed care. How each universe must be defined for PERM can vary from state-specific definitions of each program. Identification of Medicaid and CHIP and the division between FFS and managed care is discussed further in the following sections.

Identifying Medicaid and CHIP for PERM

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 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. If your state has difficulty distinguishing between Title XIX and Title XXI payments, please notify the SC who will work with state staff to find an appropriate solution.

Identifying Fee-for-Service and Managed Care for PERM

In addition to separately measuring Medicaid (Title XIX) and CHIP (Title XXI), PERM also independently measures fee-for-service (FFS) and managed care, as applicable, for each state. Referred to as "component" measurements, FFS and managed care have PERM-specific definitions which may differ from how states define each mode of service delivery. Further, PERM also has additional inclusion rules that are necessary to ensure a complete and accurate PERM universe. Below is an overview of how PERM defines each "component" as well as information on what types of records are included in each "component" universe.

During each state's one-on-one intake discussion, the SC will discuss these component definitions in more detail with the state to ensure that data provided is consistent and compliant with PERM guidance as well as to support the state in determining where specific payments should be assigned for PERM purposes.

Fee-for-Service Universe

The PERM FFS universe includes three primary types of Medicaid and CHIP payments.

Traditional fee-for-service claims

The FFS universe is comprised of all payments made on a fee-for-service/indemnity basis, including:

- 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

Capitated non-risk payments

In addition to "traditional" FFS payments, the PERM FFS universe also includes other types of payments referred to as "fixed" for PERM purposes. These payments are often capitated, per member per month payments and could be system-generated, non-medical, and/or administrative-like payments that would not require a PERM medical record review like other PERM FFS payments but also are not considered to be "full risk" like managed care payments (defined in the Managed Care Universe section, below). Examples of PERM "fixed" payments include a variety of payments made to providers or vendors such as:

- Monthly primary care case management (PCCM) fees paid to participating providers
- HIPP 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 FFS 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. As state Medicaid and CHIP programs evolve and payment methodologies change on an ongoing basis, it is critical that states raise all possible aggregate payments to CMS and the SC for discussion so that

Managed Care Universe

Managed care payments are typically at-risk capitation 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 (see *Capitated Non-Risk Payments*, above). 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.

Date

PERM universes include claims and payments originally paid during the federal fiscal year under review. 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 based on the original paid date. For the FY 2014 PERM cycle, the state's PERM universe includes claims and payments with original dates of payment between October 1, 2013 and September 30, 2014.

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 15 days after the end of each quarter. See ***Exhibit 2*** for the data submission due dates for FY 2014 and the paid claim dates to be included in each quarterly submission.

Exhibit 2. Federal Fiscal Quarters and PERM Data Submission Dates, FY 2014

FY 2014 Quarter	Claim Date Paid	Data Submission Due
Quarter 1	October 1 – December 31, 2013	January 15, 2014
Quarter 2	January 1 – March 31, 2014	April 15, 2014
Quarter 3	April 1 – June 30, 2014	July 15, 2014
Quarter 4	July 1 – September 30, 2014	October 15, 2014

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 data set 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. The SC will review the dates are included for each data source with the state at the beginning of the cycle and will work with the state to identify the best date field for determining the PERM universe for each quarter.

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). Managed care capitation payments should be included in the PERM data submission based on paid date as well.

- *Prospective example:* A state makes a capitation payment on December 25, 2013 for services in January 2014. The state includes the payment with the PERM Q1 data submission.
- *Retrospective example:* A state makes a capitation payment on October 5, 2013 for services in September 2013. The state should include the payment with the PERM Q1 data submission.

Paid Amount

The paid amount for each claim and payment in PERM should reflect the original, non-adjusted total computable paid amount. The total computable paid amount is the federal share plus the state and/or local share of the payment. The total computable paid amount should not include beneficiary cost sharing amounts, such as patient liability (co-pays, contribution to care), third party liability (TPL), or any other non-Title XIX or Title XXI matched dollars (e.g., taxes paid on waiver services). For certified public expenditures (CPEs) such as school-based services or payments to public hospital, the state must provide both the federal and state/local share for the PERM paid amount even if the paid amount in the payment system only reflects the federal share for which match is claimed. Please discuss any CPEs or other payments with the SC where the paid amount in the state's payment system might not reflect the PERM-defined total computable paid amount.

Additional PERM Universe Specifications

In addition to the three main parameters identified above, PERM universes must also meet additional specifications

Denied and Zero-Paid Claims

In both the FFS and managed care universes, as defined above, states should include the following types of records, as applicable.

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. Denied claims from vendor payment systems must be included in the state's PERM universe if the claims are program claims that are not found in the state MMIS. 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

Service Expenditures Matched at the Administrative Rate

PERM includes payments made for medical services received by individual beneficiaries that are matched either at the medical federal medical assistance percentage (FMAP) or that receive federal financial participation (FFP) as an allowable administrative cost. The most common medical services that may be matched with administrative funds include non-emergency transportation or health insurance premium program (HIPP) payments. Please discuss with the SC any services that are considered an allowable administrative cost, but could be considered a medical service to determine if the service payments should be reported for PERM.

Claims and Payments Excluded from the PERM Universe

Below we provide some specific guidance regarding what types of payments, claims and records are excluded from the PERM universe. 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. During the one-on-one intake meeting, the SC will discuss these exclusions in more detail with each state to ensure that each state's specific data submission is compliant with PERM requirements regarding excluded data.

Payments Excluded by Regulation

The PERM regulation explicitly excludes a small number of specific payment types from the universe, when not paid at the individual beneficiary-level..

- 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

State-only and Other Non-Title XIX /Non-Title XXI Payments

Not all claims processed in MMIS are matched with Title XIX or Title XXI funds. States should 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.

Medicare Part A and Part B Premium Payments

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.

Informational-only Data

States should not include informational-only data in the PERM submissions. Informational-only data is defined as records maintained in the state or vendor payment system that do not represent actual payment to a provider. Examples include supporting service lines submitted with an inpatient hospital claim paid via DRG or with an encounter rate from a Federally-qualified health clinic (FQHC). In both examples, states should only submit the record that was the basis for payment (e.g., DRG or T1015 encounter rate).

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.

Rejected 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.

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 (individual and mass 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 appropriate 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.

Sampling Units in the PERM Submission

PERM defines a sampling unit as the smallest, individually priced and paid unit available. The PERM universe will have one record for each sampling unit. States must provide universe data at the sampling unit level.

For individual beneficiary-level sampling units paid via FFS, states typically submit claims at the line or header level. If a payment amount is determined at the detail item or "line" level, the line item is the sampling unit as that is the level at which the paid amount is recorded for the specific service provided. 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.

Please note that 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.

For managed care payments made to full-risk entities and for payments made to partial-risk or non-risk entities on a per member per month (PMPM) basis, the sampling unit is typically the capitated amount that is paid each month on behalf of the Medicaid or CHIP enrollee. When an actual payment to an entity spans multiple months of coverage, the sampling unit would be the total amount paid to the entity for the enrollee at one time.

For aggregate payments, CMS, the SC and the RC will work with your state on each payment identified to determine the smallest paid amount available for electronic submission. For example, an aggregate payment sampling unit could be a monthly payment to a county for all transportation provided to Medicaid enrollees in that month or a quarterly pay-for-performance payment to a provider based on the provision of a certain number or set of services provided to individual enrollees.

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 sampling unit is determined. A few

states have found it helpful to review each state claim type or other payment indicator to identify claims as header or line level payments. However, be aware of possible exceptions to the claim type payment "rules."

Header Level Example

For those states using a prospective payment or diagnosis-related group (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

Payment Level	*Claim Type*	*ICN*	*Line Number*	*Date Paid*	*Amount Paid*	*Service Code*
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.

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

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.

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 certain types of claims for which the payment level might differ from other payments for similar services, such as: FQHC payments and other clinic payments; Medicare crossover claims; payments made to state-owned facilities or out-of-state facilities: and compounded drugs. 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 (as discussed in *Claims and Payments Excluded from the PERM Universe*, above). 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: 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 2014	○ 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

CMS-64 and CMS-21 Report Comparison to PERM Universe Data

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. The state should confirm that no programs that appear on the CMS Financial Reports have been omitted from the universe. If after this comparison the state identifies Medicaid or CHIP dollars that were excluded from the universe, the state should notify the SC to coordinate the submission of the missing data.

This comparison is separate from the in-depth comparison that the SC will conduct throughout the cycle. The SC will 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 FFS and managed care. If significant differences, as defined by CMS, between PERM universes and the Financial Reports are identified, the SC will contact the state to resolve the differences.

Section 4: 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). SFTP instructions will be sent to the states before the first required data submission. Any files sent via SFTP need to be encrypted and password protected. If submission via SFTP is not an option, states may submit data on an encrypted CD or DVD. Do not send PERM data via email.

States planning to use the SFTP will be required to test their access prior to the first data submission.

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 data set, delimited file, or flat file.

- **SAS data set**: PC-based SAS data set
- **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. The Transmission Cover Sheet is used to ensure that all the data sent by the state is received by the SC, and to compare the control totals and correct any potential data transmission errors before processing and sampling the data. Examples of the Medicaid fee-for-service and Medicaid managed care data Transmission Cover Sheets 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 the SFTP.

File Layouts

States are required to submit file layouts to inform the SC of the field name, field length, and field contents (numeric versus character). File layouts are especially useful to the SC when infiling each state's quarterly data submissions.

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. Data that include 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 an 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
    - Note: For very large files, more than one zip file may be necessary. Additionally, states with very large files may use third-party software to transmit data. Contact the SC for more information.
- Upload the zipped file to the SFTP
- 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)	Required 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 *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used.
Line number	Line item number	Required Indicate in documentation the line item number for headers (e.g., header line = 0)
Date paid	Original date of payment or adjudication	Required Please format dates as "mm/dd/yyyy" if possible
Amount paid	Total computable amount paid on the line or header	Required Total Computable Amount = Federal Share + State and/or Local Share
Service date from	Beginning date of service for the claim or claim line	Required for any PERM "fixed" payments (e.g., NET, HIPP, PCCM) Optional for other FFS claims Please format dates as "mm/dd/yyyy" if possible

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**
Service date through	Ending date of service for the claim or claim line	Required for any PERM "fixed" payments (e.g., NET, HIPP, PCCM) Optional for other FFS claims 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	Required State data dictionary required
Funding code	Indicates the funding source for the claim or claim lines (e.g., Title XIX, Title XXI)	Required State data dictionary required
Category of service	Classification for broad types of state/federal covered services	Required State data dictionary required
Payment status	Indicator if the claim is paid or denied	Required 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	Required Suggest using Y= Fixed Payment, N= Not a Fixed Payment
Payment level	Header level, line level	Required H = Sampling unit paid at the Header level L = Sampling unit paid at the Line level
Billing provider name	Name of billing provider for a claim	Required
Billing provider legacy ID	The state legacy provider ID number for the billing provider of a claim	Required, if available

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**
Billing provider NPI	The NPI number for the billing provider of a claim	Required, if available
Performing provider name	Name of performing provider for a claim	Required, if available
Performing provider legacy ID	The state legacy provider ID number for the performing provider of a claim	Required, if available
Performing provider NPI	The NPI number for the performing provider of a claim	Required, if available
Referring provider name	Name of referring provider for a claim	Required
Referring provider legacy ID	The state legacy provider ID number for the referring provider of a claim	Required, if available
Referring provider NPI	The NPI number for the referring provider of a claim	Required, if available
Provider type	Provider type or MSIS category or other similar variable	Required State data dictionary required
Provider specialty	Provider specialty code for the claim or claim line	Required State data dictionary required
Service code	Procedure code, revenue code, or other payment code (often for, but not exclusive to, line level sampling units)	Required, if available
Source location	The system of origin/location in which the sampling unit was adjudicated	Required, if applicable 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

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**
Beneficiary ID	Beneficiary Medicaid/CHIP number	Required for any PERM "fixed" payments (e.g., NET, HIPP, PCCM) Optional for other FFS claims
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	Optional

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)	Required 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 *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used.
Date paid	Original date of payment or adjudication	Required Please format dates as "mm/dd/yyyy" if possible
Amount paid	Total computable amount paid of the payment	Required Total Computable Amount = Federal Share + State Share
Managed care program indicator	Indicator of the program (TANF, PACE, LTC, behavioral health)	Required State data dictionary required
Payment type	E.g., monthly capitation, delivery kick payment or other beneficiary-specific supplemental payment, individual reinsurance payment	Required State data dictionary required
Funding code	Indicates the funding source for the claim or claim lines (e.g., Title XIX, Title XXI)	Required State data dictionary required
Provider ID	Medicaid/CHIP ID for the managed care organization	Required

Appendix A
Fields for Universe Submissions

Universe – Medicaid Managed Care and CHIP Managed Care		
Standard Field Name	**Standard Field Description**	**Notes/Suggestions**
Beneficiary ID	Beneficiary Medicaid/CHIP number	Required
Beneficiary name		Required 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	Required State data dictionary required
Beneficiary aid category	Eligibility type	Required State data dictionary required
Beneficiary DOB	Beneficiary date of birth	Required Please format dates as mm/dd/yyyy
Beneficiary gender		Required State data dictionary required
Beneficiary county		Required State data dictionary required
Service area indicator	Indicator for the geographic service area if the service area is not the county	Required 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	Required, if applicable 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	Required Please format dates as “mm/dd/yyyy”
Coverage period to	End date of the coverage period or date of service for the claim line, typically, the first of the month	Required Please format dates as “mm/dd/yyyy”
Payment status	Indicator if the claim is paid or denied	Required 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	Optional

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 *Complete information below. Please include a row describing the data documentation. Add more rows as necessary.*				
Data Description (e.g., Q1 Medicaid FFS; data documentation)	**Data File Name**	**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 *Add more tables as necessary*. **NOTE:** List the lines count and total $$ by CLAIM TYPE, not universe totals. Add more rows as necessary to reflect each claim type.								
Data file name:								
Month October			**Month** November			**Month** December		
Claim Type	**Total Lines**	**Total $$**	**Claim Type**	**Total Lines**	**Total $$**	**Claim Type**	**Total Lines**	**Total $$**
(Add rows if necessary)								
Data file name:								
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 *Complete information below. Please include a row describing the data documentation. Add more rows as necessary.*				
Data Description (e.g., Q1 Medicaid MC; data documentation)	**Data File Name**	**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 *Add more tables as necessary.* **NOTE:** List the lines count and total $$ by managed care program area, not universe totals. Add more rows as necessary to reflect each claim type.								
Data file name:								
Month October			**Month** November			**Month** December		
Program	**Total Lines**	**Total $$**	**Program**	**Total Lines**	**Total $$**	**Program**	**Total Lines**	**Total $$**
(Add rows if necessary)								
Data file name:								
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 2011 and FY 2014 PERM Cycles

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

Field Name	2011	2014	Change
ICN	required	required	
Line number	required	required	
Date paid	required	required	
Amount paid	required	required	
Service date from		new, required for "fixed" fixed payments, otherwise options	√
Service date through		new, required for "fixed" fixed payments, otherwise options	√
Claim type	required	required	
Funding code	required	required	
Category of service	required	required	
Payment status	required	required	
Fixed payment indicator	required	required	
Payment level	required	required	
Billing provider name		required	√
Billing provider legacy/state ID		required, if available	√
Billing provider NPI		required, if available	√
Performing provider name		required	√
Performing provider legacy/state ID		required, if available	√
Performing provider NPI		required, if available	√
Referring provider name		required, if available	√
Referring provider legacy/state ID		required, if available	√
Referring provider NPI		required, if available	√
Provider type	required	required	
Provider specialty	required	required	
Service code	required	required, if available	
Source location	required	required, if applicable	

Appendix C
Differences Between the FY 2011 and FY 2014 PERM Cycles

Field Name	2011	2014	Change
Beneficiary ID		new, required for "fixed" fixed payments, otherwise optional	√
Type of service		new, optional	√
Federal claim category		new, optional	√
User option fields 1-10	optional	optional	

Appendix C
Differences Between the FY 2011 and FY 2014 PERM Cycles

Variable Comparison for Medicaid and CHIP Managed Care Universe Submission

Field Name	2011	2014	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	required	required	
Service area indicator	required	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	