2012 PERM Plus Data Submission Instructions

September 30, 2011

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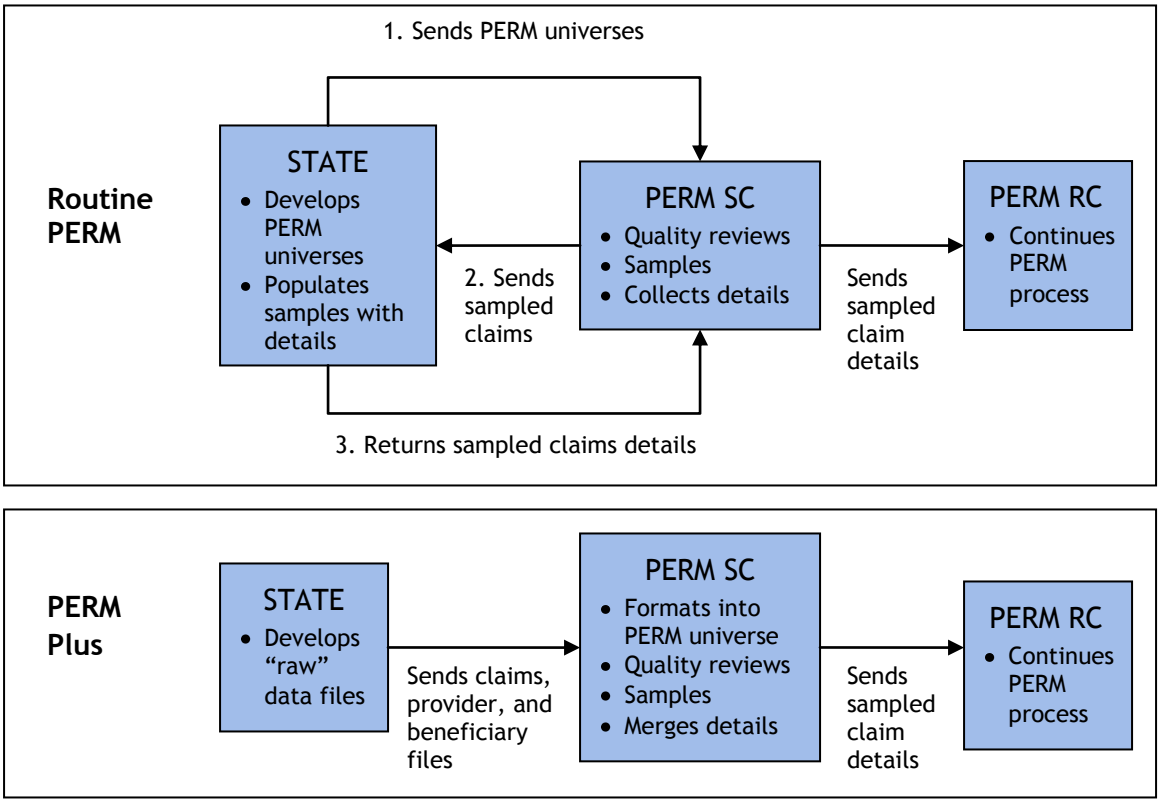
Section 1: Overview

PERM Plus is a new, innovative way for states, CMS, and the CMS PERM contractors to approach data submission for the claims and payments portion of PERM. Select fiscal year (FY) 2012 PERM states will collect data for Medicaid and/or CHIP data using these PERM Plus instructions. States not engaging in PERM Plus will continue to submit claims and payments according to the "routine" PERM instructions, similar to those used in past PERM cycles.[1]

PERM Plus Objectives

Through the PERM Plus initiative, CMS seeks to simplify the PERM data submission process by having states submit claims, beneficiary data, and provider data simultaneously, eliminating the need for states to submit additional information prior to requesting medical records. Exhibit 1 compares data flow for routine PERM and PERM Plus.

Exhibit 1: Data Flow in Routine PERM and PERM Plus



PERM Plus also requires less upfront analysis and data modifications by the state because the PERM Statistical Contractor (SC), not the state, will be responsible for assigning and extracting data as "sampling units" (e.g., figuring out if a claim or payment should be sampled at the

[1] States may select to submit both Medicaid and CHIP under PERM Plus or to submit PERM data using a combination of PERM Plus and routine PERM.

header or line level based on the payment method and removing records that do not qualify for sampling) and dividing the PERM Plus data submissions into fee-for-service and managed care datasets for sampling.

Initial Preparations for PERM Plus

The universe for PERM is 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 called the PERM "universe"), as well as beneficiary and provider information.

Developing PERM Plus universes is a collaborative process between the states, CMS, and the SC. The SC will provide assistance to each state in interpreting and applying the PERM Plus 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. 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 Plus data submissions and that the SC has correctly applied the state's rules to "build" the PERM universes. States are encouraged to ask questions throughout the process to ensure mutual understanding of the data requirements and specifications.

State PERM teams are essential to quality data submissions. To help ensure that states identify all required data in their PERM Plus submissions, each state should develop a PERM team that includes program, policy, technical and budget staff. From experience, CMS has identified that the most constructive PERM teams include staff with expertise in areas such as:

- Program structure: stand-alone/ Medicaid expansion/combination CHIP, 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, HIPP, 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 onto federal matching fund reports (such as the quarterly CMS- 64 and CMS-21 reports)

Each member of the state's PERM team should receive a copy of these instructions.

File Development and Submission Timeline

The entire 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 18, 2012) and the error rate calculation occurring at the end of the review cycle.

Exhibit 2 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 the development of the claims, provider, and beneficiary files 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. The SC also requests that states submit PERM Plus data for October of 2011 by December 15, 2011 in order accommodate testing for the new service-type stratification methodology being introduced in the FY 2012 measurement.

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.

Exhibit 2: FY 2012 PERM Plus Data Submission Timeline

Date	State Activities	SC/CMS Activities
August 2011	✓ 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 Plus
September 2011	✓ Schedule state orientation meeting	✓ Organize state orientation meeting
November - December 2011	✓ 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 Plus states
December 2011 -	✓ Code programs to provide PERM Plus datasets ✓ Ask questions and provide feedback	✓ Answer questions from and provide feedback to PERM Plus states
December 15, 2012	✓ Submit October 2011 PERM Plus data to the SC	✓ Receive October 2011 PERM Plus data from states
January 17, 2012	✓ Submit remaining Q1 PERM Plus data to the SC	✓ Receive remaining Q1 PERM Plus data from states
January 18 - February 2012	✓ Work with SC to resolve issues identified during the data validation and QC Process ✓ Review SC plans to build PERM universes	✓ Begin SC data validation and QC Process ✓ Prepare to build PERM universes ✓ Receive state approval for plans to build PERM universes ✓ Build PERM universes
March 2012	✓ Work with SC to resolve issues identified QC of PERM universes ✓ Verify provider information for sampled claims	✓ Perform QC review of PERM universes ✓ Select samples
April 16, 2012	✓ Submit Q2 PERM Plus data to the SC	✓ Receive Q2 PERM Plus data from states

Date	State Activities	SC/CMS Activities
April 16 - June 2012	✓ Work with SC to resolve issues ✓ Verify provider information for sampled claims	✓ Build PERM universes ✓ Perform QC ✓ Select samples
July 16, 2012	✓ Submit Q3 PERM Plus data to the SC	✓ Receive Q3 PERM Plus data from states
July 16 - September 2012	✓ Work with SC to resolve issues ✓ Verify provider information for sampled claims	✓ Build PERM universes ✓ Perform QC ✓ Select samples
October 15, 2012	✓ Submit Q4 PERM Plus data to the SC	✓ Receive Q4 PERM Plus data from states
October 15 - December, 2012	✓ Work with SC to resolve issues ✓ Verify provider information for sampled claims	✓ Build PERM universes ✓ Perform QC ✓ Select samples

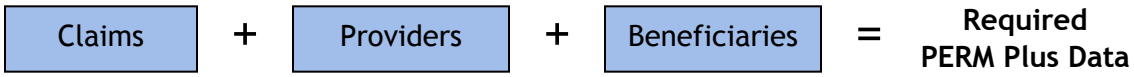
Section 2: PERM Plus Data File Specifications

This section addresses the content of the PERM Plus data submissions, including the structure of the submission, details of the payments to include and not include in the PERM Plus data submissions (which claims are "in" and which are "out"), and descriptions of the required fields and field requirements.

File Structure

For PERM Plus, the states submit to the SC universe files containing all fields needed for claims sampling and the PERM medical record request (see Exhibit 3). States submit PERM Plus data in three files: claim information, beneficiary information, and provider information.

Exhibit 3: Claims, Provider, and Beneficiary Data are Required for PERM Plus Submissions



Claim Header and Claim Detail Files

Generally, states include in the PERM Plus data submission all beneficiary-level Medicaid and CHIP claims and payments that are matched with either federal Title XIX or Title XXI funds. In some cases, states calculate and make payments in aggregate based on beneficiary-level information. States and the SC will work together to determine a plan for submitting aggregate payments.

PERM Plus offers states flexibility in file submission structure. PERM Plus states may submit one file with claim headers and a second file with claim details, submit one file with both claim header and detail data, or submit using another combination (e.g., institutional and practitioner claims in separate files). Each state will work with the SC to determine the most appropriate file structure for the state's data and claims payment system structure.

Caution!

Remember that not everything processed in MMIS is matched with Medicaid or CHIP 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 Plus data.

Beneficiary and Provider Files

The PERM Review Contractor (RC) requires beneficiary and provider information for sampled claims to request medical records from providers and conduct the medical and data processing reviews. Therefore, states submit beneficiary information (e.g., name, date of birth) and provider information (e.g., address, provider type) as separate files in the PERM Plus submissions. For each sampled claim, the SC will use the beneficiary and provider numbers to "match" to the beneficiary and provider information in the separate files. The SC will use the matched information to populate information for each of the sampled claims and then provide the sampled claims to the RC.

When developing the provider file, states should include all available provider records regardless of the provider's status as an active or inactive provider. If it is not possible to report every active and inactive provider, the state should work with the SC to develop a solution that includes as many providers as possible in the provider file.

When developing the beneficiary file, states may elect to include all beneficiary records or to limit the submission to include only recently active beneficiaries. If a state chooses to include all beneficiaries, the state should extract all beneficiary records available in the MMIS (or other automated processing system) on the day the state extracts the PERM Plus beneficiary file. An alternative method is for the state to limit the beneficiary file by excluding from the submission beneficiaries who have not been actively enrolled in Medicaid for a certain time period (e.g., beneficiaries who have not been enrolled in Medicaid for over two years).

Universe Parameters

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

- Date
- Program
- Payment type

This section defines and discusses payments to be included in the PERM Plus data submission, treatment of adjustments, and inclusion of denied and zero-paid claims. We also describe specific exclusions from the PERM universe.

Date

PERM universes include claims and payments originally paid (or denied) only during the federal fiscal year under review. For example, for the entire FY 2012 PERM cycle, the state's PERM universe includes claims and payments originally paid between October 1, 2011 and September 30, 2012.

States submit PERM Plus data quarterly. States select claims for inclusion in a quarter's data only if the date of payment falls within the federal fiscal quarter. With the exception of the October 2011 submission on December 15, data is due to the SC fifteen days after the end of each quarter. See Exhibit 4 for the data submission due dates for FY 2012 and the paid claim dates to be included in each quarterly submission.

Exhibit 4: Federal Fiscal Quarters and PERM Data Submission Dates, FY 2012

FY 2012 Quarter	Claim Date Paid	Data Submission Due
October 2011	October 1 – October 31, 2011	December 15, 2011
Quarter 1	October 1 – December 31, 2011	January 17, 2012
Quarter 2	January 1 – March 31, 2012	April 16, 2012
Quarter 3	April 1 – June 30, 2012	July 16, 2012
Quarter 4	July 1, 2012 – September 30, 2012	October 15, 2012

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 original claim should be included in the PERM Plus 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 original claim would **not** be included in the PERM Plus data, again, based on the original paid 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 Plus data submission based on **paid date** as well.

- *Prospective example:* A state makes a capitation payment on December 25, 2011 for services in January 2012. The state includes the payment with the PERM Plus quarter 1 data submission.
- *Retrospective example:* A state makes a capitation payment on October 5, 2011 for services in September 2011. The state should include the payment with the PERM Plus quarter 1 data submission.

Program

Generally, states include in their PERM Plus data submissions all beneficiary-level claims and payments and aggregate payments which are based on beneficiary-level information for which the state receives federal financial participation (FFP) through Title XIX or Title XXI. (We discuss limited exclusions in the next 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, health insurance premium program (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 their PERM Plus data submissions. As CMS must report separate error rates for the Medicaid and CHIP programs, the SC will need to distinguish the PERM Plus data submissions between Title XIX and Title XXI. In the PERM Plus "Claim File Required Fields" table, we request that the state populate a field called "FUNDING-CODE" to categorize each claim or payment as either Medicaid or CHIP. States should base this categorization 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 indicate through the "FUNDING-CODE" variable that the claims and payments for both these Title XXI programs as PERM CHIP
2. 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 Plus

Include in the PERM Plus 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. For PERM Plus, consider these Medicaid claims. As described in Appendix A, we request states denote that a claim or payment is Medicaid (Title XIX) using a FUNDING-CODE of "1".

Also include in the PERM Plus claims file all Medicaid expansion and/or stand-alone CHIP payments in the PERM Plus 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. For PERM Plus, consider these payments as CHIP claims. As described in Appendix A, we request states denote that a claim or payment is CHIP (Title XXI) using a FUNDING-CODE of "2".

The table in Appendix A also includes a field called "FUNDING-CODE-STATE". 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 Plus claims file. 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. Claims may be zero-paid due to, for example, 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 Plus claims file.

Adjudicated claims

States should only include "fully" adjudicated claims and payments in the PERM Plus 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 Plus 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.

Fee-For-Service and Managed Care Payments

The SC will need to identify a way to separate each state's fee-for-service and managed care payments (including supplemental managed care payments such as delivery kick payments). For example, states may identify these payment types using the state's "claim type" (field STATE-CLAIM-TYPE in Appendix A), or states may advise the PERM Plus contractor to rely on a combination of fields. The state and SC will work together to decide the best method to identify fee-for-service and managed care payments in the state's PERM Plus data.

Fixed Payments

Appendix A table includes the field, "FIXED-PAYMENT". Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For

example, a state may have a PCCM program where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. PERM considers this fee a fixed payment.

Other examples of fixed payments include HIPP, capitated NET payments (not made on a per trip fee-for-service claim basis), and 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 states to understand the PERM fixed payment definition and help the state determine when the state should indicate in the PERM Plus data that a claim or payment is a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined "medical record" associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.

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 data submissions. Aggregate payments are included in the PERM universe regardless if 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. In these cases, 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 Plus

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 Plus submission when the payment is not beneficiary-specific:[2]

- Disproportionate share hospital (DSH) payments
- Drug rebates
- Grants to state agencies or local health departments

[2] States may include these in the PERM Plus submissions if the payments are readily identifiable and the state instructs the SC to remove the payments prior to sampling.

- Cost-based reconciliations to not-for-profit providers or federally qualified health centers
- Gross payments
- Mass adjustments

In addition, states should not include Medicare premium payments ("buy-in") in the PERM Plus 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 Plus 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 Plus 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 not required to remove claim or payment adjustments from the PERM Plus data submissions. Adjustments have to be identified in the data via the 'Adjustment Indicator' variable.

Data Sources

States generally draw a majority of PERM Plus 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 Plus data submissions. PERM Plus 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

To determine if a state is capturing payments from all of the data sources, we suggest state staff "follow the money" by reviewing the state's federal financial reports. 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 Plus data submission.

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

Sampling Units in the PERM Plus Submission

In the routine PERM submission, there is much emphasis on states submitting PERM data at the correct "sampling unit" (i.e., states submit at the header or line based on how the claim is priced and paid). To simplify the PERM process, in PERM Plus, states should submit both header and details (e.g., lines) for all claims. The SC, not the state, is responsible for establishing the correct sampling unit for each claim or payment.

When submitting claim records, the state will identify each line of data as either a header record or a detail record using the field "RECORD-TYPE" (described in Appendix A).

Submitting all of the header and detail information for a claim is a key difference between the PERM Plus data submission and the routine PERM data submission. The SC will discuss with states the various claims payments to understand how different types of claims are adjudicated and paid.

Section 3: Quality Review

States are responsible for performing a quality review of their PERM Plus data submissions each quarter before submitting files to the SC. State quality review saves time and resources for both the state and CMS contractors by identifying data problems early in the PERM process. Exhibits 5, 6, and 7 are suggested minimal quality control checks for states to complete.

Exhibit 5: Minimum Claims File Quality Control Checks

Quality Review	Suggested Tests
1) Ensure all required fields are reported in the claims file	○ Prepare a list of all fields in the state's claims file and compare it to the list for the claims file in the "PERM Plus Fields" section ○ Identify any missing fields ○ Determine why the field the field is missing and locate the missing data. ○ 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 - BILLING-PROV-NUM - MEMBER-IDENTIFICATION-NUMBER - TOTAL-PAID-AMT
3) Check that the ADJUDICATION-DATE for all records is for the appropriate quarter for FY 2012	○ Only include payments that were adjudicated in the appropriate quarter for FY 2012
4) Confirm that the SC can identify claims as Medicaid (Title XIX) or CHIP (Title XXI)	○ Confirm that data is present and documentation is available that would allow the SC to assign claims to Medicaid or CHIP PERM universes
5) Confirm that the SC can identify claims as Fee-for-Service or Managed Care	○ Confirm that data is present and documentation is available that would allow the SC to assign claims to fee-for-service or managed care universes
6) Check that the following payment records can be identified by the SC: - Adjustments and voids - State-only claims - Gross adjustments - Claims matched with federal funds other than Title XIX or Title XXI	○ Confirm that data is present and documentation is available that would allow the SC to identify and remove these records

Quality Review	Suggested Tests
7) Each payment is represented only one time in the claims file	○ Confirm there are no ICN-line number combinations that are repeated in the claims file
8) Confirm that no encounter claims data is submitted in the claims file	○ Remove all encounter records
9) Prepare to review the SC's comparison of the CMS-64/21 reports to the PERM universe submissions	○ The SC will conduct a comparison of PERM universe totals to either two previous quarters' CMS-64/21 reports, or to the current quarter's CMS-64/21 reports ○ Prepare for reviewing the comparison by including finance staff on your PERM team

Exhibit 6: Minimum Beneficiary File Quality Control Checks

Quality Control Check	Suggested Tests
1) Make sure all required fields are reported in the beneficiary file	○ Prepare a list of all fields in the state's claims file and compare it to the list for the beneficiary file in the "PERM Plus Fields" section ○ Identify any missing fields ○ Determine why the field the field is missing and locate the missing data. ○ If the state does not report a field, let the SC know when submitting the file
2) Check that the MEMBER-IDENTIFICATION-NUMBER field is properly formatted	○ Check that the MEMBER-IDENTIFICATION-NUMBER field is not truncated or has additional data ○ Replace the data in the MEMBER-IDENTIFICATION-NUMBER field if formatting problems are found
3) Confirm that the beneficiary file has both active and inactive beneficiaries	○ Beneficiary file should include records of all beneficiaries who were active at any point in the last two years.

Exhibit 7: Minimum Provider File Quality Control Checks

Quality Control Check	Suggested Tests
1) Make sure all required fields are reported in the provider file	○ Prepare a list of all fields in the state's claims file and compare it to the list for the claims file in the "PERM Plus Fields" section ○ Identify any missing fields ○ Determine why the field the field is missing and locate the missing data. ○ If the state does not report a field, let the SC know when

Quality Control Check	Suggested Tests
	submitting the file
2) Check that key fields are properly formatted	○ Check that the PROVIDER-ID-NUMBER or the PROVIDER-NPI-NUM field is not truncated or has additional data depending on which field the state uses to identify providers ○ Replace the data in the PROVIDER-ID-NUMBER or the PROVIDER-NPI-NUM field if formatting problems are found
3) Confirm that the provider file has all active and inactive providers on the file	○ All providers, both active and inactive, must be included in the provider file. Please contact the SC group if you have problems with reporting records for inactive providers

State PERM Universe Data Quality Guidance

CMS requires a comparison performed to review Medicaid and CHIP PERM universes against 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 universe data and that the state is capturing all necessary data sources in the PERM universe.

Statistical Contractor Comparison

The goal of the PERM Plus data submission method is to reduce state burden. The PERM Statistical Contractor, not the state, is responsible for assigning and extracting data as "sampling units" and dividing the PERM Plus data submissions into fee-for-service and managed care datasets for sampling. Because the Statistical Contractor will build a state's PERM universe for sampling, CMS has assigned responsibility for conducting the PERM universe to CMS Financial Reports comparison to the Statistical Contractor.

State Requirements

The Statistical Contractor will send its comparison results for each quarterly PERM universe submission to the state for verification. The state should confirm that no programs that appear on the CMS Financial Reports have been omitted from the universe and address any significant variance the Statistical Contractor may have found.

Section 4: Data Transmission and Security

This section discusses the PERM Plus data submission media, PERM Plus 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 Plus 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. 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 Plus 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 Plus 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 Plus 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 Plus 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

Appendices: PERM Plus Fields

Appendices A, B, and C provide fields for states to include with the PERM Plus data submissions. Unlike routine PERM, PERM Plus data submissions include provider, beneficiary, and additional claim information. Therefore, states do not need to submit "detail" information after claim sampling. However, this does require the inclusion of more fields in the initial PERM Plus submissions—similar to the field requirements in the routine PERM detail submission.

PERM Plus fields are described in three tables: A) claims (covering the claim header and claim detail submissions), B) beneficiary, and C) provider. PERM Plus attempts to "standardize" the field names by using field names and definitions that are closely aligned with MSIS. States may find it helpful or necessary to vary or add to the fields. States should discuss these changes with the SC.

The PERM Plus field tables also include the column "Notes/ Suggestions" which discusses important notes for mapping the PERM Plus field to the states MMIS or other claims processing system. States and the SC will review these notes to clarify.

Appendix D contains the state-specific codes for which states will be asked to provide code definitions to the SC.

Appendix A
Claim Fields for Universe Submissions

Claim File Fields

Standard Field Name	Standard Field Description	FFS	MC	Suggested Cobol Pic[3]	Notes/Suggestions
ADJUDICATION-DATE-HEADER	The date on which the payment status of the claim was finally adjudicated (paid or denied) by the State.	X	X	9(08)	
ADJUDICATION-DATE-LINE	For those Medicaid systems that have adjudication dates at the line level (because they adjudicate each line separately), the date adjudicated for the specified line.	X		9(08)	
ADJUSTMENT-IND	Code indicating type of adjustment record claim represents (e.g. original claim, void, credit, debit, etc.	X	X	9(01)	
ADMISSION-DATE	The date on which the beneficiary was admitted to a hospital or long term care facility.	X		9(08)	
BEGINNING-DATE-OF-SERVICE-HEADER	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim began. For capitation premium and other fixed payments, the date on which the period of coverage related to this payment began.	X	X	9(08)	
BEGINNING-DATE-OF-SERVICE-LINE	For services received during a single encounter with a provider, the date the service covered by this line was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this line began.	X		9(08)	
BILLING-PROV-NUM	A unique identification number assigned by the state to a provider or capitation plan. This should represent the entity billing for the service. This number must match a PROV-NPI-NUM or PROVIDER-ID in the PERM Plus provider file.	X	X	X(*)	Use state-specific values
CLAIM-STATUS-HEADER	Claim status, either paid or denied of the header level record.	X	X	X(*)	Use state-specific values

[3] If a Cobol Pic field is in the format "X(*)", submit alphanumeric data of any length.

Appendix A
Claim Fields for Universe Submissions

Claim File Fields

Standard Field Name	Standard Field Description	FFS	MC	Suggested Cobol Pic[3]	Notes/Suggestions
CLAIM-STATUS-LINE	Claim status, either paid or denied of the line level record.	X		X(*)	Use state-specific values
ICD-9-PROC-CODE-1	ICD9 surgical procedure code 1	X		X(08)	
ICD-9-PROC-CODE-2	ICD9 surgical procedure code 2	X		X(08)	
ICD-9-PROC-CODE-3	ICD9 surgical procedure code 3	X		X(08)	
ICD-9-PROC-CODE-4	ICD9 surgical procedure code 4	X		X(08)	
ICD-9-PROC-CODE-5	ICD9 surgical procedure code 5	X		X(08)	
ICD-9-PROC-CODE-6	ICD9 surgical procedure code 6	X		X(08)	
DATE-PRESCRIBED	Date the drug, device or supply was prescribed by the physician or other practitioner. This should not be confused with the DATE-FILLED which represents the date the prescription was actually filled by the provider.	X		9(08)	
DIAGNOSIS-CODE-1	The ICD-9/10-CM code for the principal diagnosis for this claim. Principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered.	X		X(08)	
DIAGNOSIS-CODE-2	Second ICD-9/10-CM code found on the claim.	X		X(08)	
DIAGNOSIS-CODE-3	Third ICD-9/10-CM code that appears on the claim.	X		X(08)	
DIAGNOSIS-CODE-4	Fourth ICD-9/10-CM code that appears on the claim.	X		X(08)	
DIAGNOSIS-CODE-5	Fifth ICD-9/10-CM code that appears on the claim.	X		X(08)	
DIAGNOSOS-CODE-6	Sixth ICD-9/10-CM code that appears on the claim.	X		X(08)	
DIAGNOSIS-RELATED-GROUP (DRG)	Code representing the Diagnosis Related Group (DRG) that is applicable for the inpatient services being rendered.	X		9(04)	

Appendix A
Claim Fields for Universe Submissions

Claim File Fields

Standard Field Name	Standard Field Description	FFS	MC	Suggested Cobol Pic[3]	Notes/Suggestions
ENDING-DATE-OF-SERVICE-HEADER	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended. For capitation premium and other fixed payments, the date on which the period of coverage related to this payment ends/ended.	X	X	9(08)	
ENDING-DATE-OF-SERVICE-LINE	For services received during a single encounter with a provider, the date the service covered by this line was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this line ended.	X		9(08)	
FIXED-PAYMENT	Indicator if the claim or payment conforms to the PERM FFS fixed payment definition. Refer to the PERM FFS fixed payment discussion in the PERM Plus Data Submission Instructions. FFS fixed payments are not subject to medical record review.	X		9(01)	0 - Not a Fixed Payment 1 - FFS Fixed Payment
FUNDING-CODE	Indicator identifying the payment as either a Medicaid (Title XIX) or CHIP (Title XXI) payment.	X	X	9(01)	1 - Medicaid (Title XIX) 2 - CHIP (Title XXI)
FUNDING-CODE-STATE	Code that indicates if the claim was matched with Title XIX, Title XXI, local funds, or other funding source.	X	X	X(*)	Use state-specific values
ICN	State assigned internal control number (ICN) or transaction control number (TCN) of the claim.	X	X	X(*)	
ICN-FORMER	For adjustment claims, the state assigned internal control number (ICN) or transaction control number (TCN) of the claim that the current claim is adjusting.	X	X	X(*)	
LINE-NUMBER	A unique number to identify the transaction line number.	X		9(03)	
LINE-NUMBER-FORMER	For adjustment claims, a unique number to identify the transaction line number for the claim that the current claim is adjusting.	X		9(03)	

Appendix A
Claim Fields for Universe Submissions

Claim File Fields

Standard Field Name	Standard Field Description	FFS	MC	Suggested Cobol Pic[3]	Notes/Suggestions
MEDICARE-INDICATOR-HEADER	Indicator that the claim is a Medicaid crossover payment.	X		X(*)	
MEDICARE-INDICATOR- -LINE	Indicator that the claim is a Medicaid crossover payment.	X		X(*)	
MEMBER-IDENTIFICATION-NUMBER	Unique personal identification number for an eligible beneficiary that is assigned by the State. Some States use social security numbers as unique personal identification numbers. All other States create their own unique identification numbers according to some systematic scheme that is approved by CMS. This number must match a MEMBER-IDENTIFICATION-NUMBER in the PERM Plus beneficiary file.	X	X	X(*)	Use state-specific values
NATIONAL-DRUG-CODE	A code indicating the drug, device or medical supply covered by this claim, in National Drug Code (NDC) format.	X		X(12)	
PAID-SERVICE-UNITS	The number of units of service deemed eligible for payment before the application of cost-sharing and third-party liability (TPL).	X		S9(03)V99	
PLACE-OF-SERVICE	A code indicating where the service was performed. CMS 1500 values are used for this data element.	X		9(02)	
PRE-AUTHORIZATION-NUM	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also called Prior Authorization or Referral Number).	X		X(*)	
PRESCRIPTION-NUM	The unique identification number assigned by the pharmacy or supplier to the prescription.	X		X(*)	
PROGRAM-INDICATOR	Indicator of the type of managed care program (TANF, PACE, LTC, Behavioral health). This field shows the type of managed care program for which claims are reported.		X	X(*)	Use state-specific values

Appendix A
Claim Fields for Universe Submissions

Claim File Fields

Standard Field Name	Standard Field Description	FFS	MC	Suggested Cobol Pic[3]	Notes/Suggestions
RECORD-TYPE	The code used to denote if the record is a header or a detail.	X	X	X(02)	
SERVICE-LINE-PROCEDURE-CODE (Fee-for-Service Payments) OR BENEFICIARY-RATE-INDICATOR (Managed care or fixed payments)	The code used by the State to indicate the service provided during the period covered by this claim. This data element is reported for claim details only. For managed care or other fixed payments, report BENEFICIARY-RATE-INDICATOR here.	X	X	X(08)	
SERVICE-LINE-PROCEDURE-CODE-MOD-1	A service code modifier can be used to enhance the Service Code. (e.g., anesthesia or surgical assistance services billed separately from actual procedure)	X		X(02)	
SERVICE-LINE-PROCEDURE-CODE-MOD-2	A service code modifier can be used to enhance the Service Code. (e.g., anesthesia or surgical assistance services billed separately from actual procedure)	X		X(02)	
SERVICING-PROV-NUM	A unique number to identify the provider who treated the beneficiary (as opposed to the provider "billing" for the service, see BILLING-PROV-NUM). This number must match a PROV-NPI-NUM or PROVIDER-ID in the PERM Plus provider file.	X		X(*)	Use state-specific values
SERVICE-TRACKING-TYPE	The field indicates the type of service tracking claim.	X		X(*)	Optional field
TYPE-OF-SERVICE	The field denotes for which service a claim was billed.	X		X(*)	Optional field

Appendix A
Claim Fields for Universe Submissions

Claim File Fields

Standard Field Name	Standard Field Description	FFS	MC	Suggested Cobol Pic[3]	Notes/Suggestions
FEDERAL-CLAIM-CATEGORY	This field could include MSIS code, CMS 64 line, or any other state mapping of a claim into a federal claim category.	X		X(*)	Optional field
SOURCE-LOCATION	The field denotes the claim payment system from which the claim was extracted.	X	X	9(02)	Use state-specific values
STATE-CLAIM-TYPE	The category of claim submitted (e.g. Inpatient, Outpatient, Long Term Care, Physician, Pharmacy, etc.).	X	X	X(*)	Use state-specific values
TOTAL-PAID-AMOUNT	The total computable amount paid for the line (detail) record or claim header record for either Medicaid or CHIP. This value must include both the federal and state share of the payment.	X	X	S9(11)V99	The formula to determine the Total Computable Amount is: Total Computable Amount = Federal Share + State Share
TPL-AMT-HEADER	Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. This is the total amount denoted at the claim header level paid by the third party.	X		S9(11)V99	
TPL-AMT-LINE	Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. This is the total amount denoted at the claim detail level paid by the third party.	X		S9(11)V99	
TYPE-OF-SERVICE	A code indicating the type of service being billed (e.g. Hospital Inpatient, Home Health Services, Dental, Lab/Xray).	X	X	9(02)	
UB-92-REVENUE-CODE	A code which identifies a specific accommodation, ancillary service or billing calculation. (as defined by UB-04 Billing Manual, form locator 42).	X		9(04)	
USER-FIELD-1	An optional data element for individual states that have data elements which are necessary or helpful for PERM Plus and are not otherwise mentioned in the data request.	X	X	X(*)	Optional field; use state-specific values

Appendix A
Claim Fields for Universe Submissions

Claim File Fields

Standard Field Name	Standard Field Description	FFS	MC	Suggested Cobol Pic[3]	Notes/Suggestions
USER-FIELD-2	An optional data element for individual states that have data elements which are necessary or helpful for PERM Plus and are not otherwise mentioned in the data request.	X	X	X(*)	Optional field; use state-specific values
USER-FIELD-3	An optional data element for individual states that have data elements which are necessary or helpful for PERM Plus and are not otherwise mentioned in the data request.	X	X	X(*)	Optional field; use state-specific values
USER-FIELD-4	An optional data element for individual states that have data elements which are necessary or helpful for PERM Plus and are not otherwise mentioned in the data request.	X	X	X(*)	Optional field; use state-specific values
USER-FIELD-5	An optional data element for individual states that have data elements which are necessary or helpful for PERM Plus and are not otherwise mentioned in the data request.	X	X	X(*)	Optional field; use state-specific values

Appendix B
Beneficiary Fields for Universe Submissions

Beneficiary File Fields

Standard Field Name	Standard Field Description	Cobol Pic[4]	Notes/Suggestions
COUNTY-CODE	FIPS code indicating eligible's county of residence.	9(03)	
DATE-OF-BIRTH	Eligible's Date of Birth.	9(08)	
ELIGIBLE-FIRST-NAME	The first name of the individual to whom the services were provided.	X(*)	
ELIGIBLE-LAST-NAME	The last name of the individual to whom the services were provided.	X(*)	
ELIGIBLE-MIDDLE-INIT	The middle initial of the individual to whom the services were provided.	X(01)	
MEMBER-IDENTIFICATION-NUMBER	Unique personal identification number for an eligible beneficiary that is assigned by the State. Some States use social security numbers as unique personal identification numbers. All other States create their own unique identification numbers according to some systematic scheme that is approved by CMS. This number must match a MEMBER-IDENTIFICATION-NUMBER in the PERM Plus beneficiary file.	X(*)	
SEX-CODE	The eligible's gender.	X(01)	Use state-specific values

[4] If a Cobol Pic field is in the format "X(*)", submit alphanumeric data of any length.

Appendix C
Provider Fields for Universe Submissions

Provider File Fields

Standard Field Name	Standard Field Description	Cobol Pic[5]	Notes/Suggestions
PROV-NPI-NUM	Provider's NPI (National Provider Identifier) The PERM Plus contractor will use the PROV-NPI-NUM or PROVIDER-ID to match to the BILLING-PROV-NUM and SERVICING-PROV-NUM in the PERM Plus claims file.	X(12)	
PROV-TAXONOMY	Provider taxonomy code.	X(12)	
PROVIDER-ADDRESS-LINE-1	Provider address first line	X(*)	
PROVIDER-ADDRESS-LINE-2	Provider address second line	X(*)	
PROVIDER-ADDRESS-LINE-3	Provider address third line	X(*)	
PROVIDER-CITY	Provider city	X(*)	
PROVIDER-FAX	Provider fax number	X(10)	
PROVIDER-ID-NUMBER	A unique identification number assigned by the state to a provider or capitation plan. The PERM Plus contractor will use the PROV-NPI-NUM or PROVIDER-ID to match to the BILLING-PROV-NUM and SERVICING-PROV-NUM in the PERM Plus claims file.	X(*)	Use state-specific values
PROVIDER-NAME	Provider name	X(*)	
PROVIDER-PHONE	Provider phone	X(10)	
PROVIDER-SPECIALITY-CODE-1	Provider specialty code 1	X(*)	Use state-specific values

[5] If a Cobol Pic field is in the format "X(*)", you may submit alphanumeric data of any length.

Appendix C
Provider Fields for Universe Submissions

Provider File Fields

Standard Field Name	Standard Field Description	Cobol Pic[5]	Notes/Suggestions
PROVIDER-SPECIALITY-CODE-2	Provider specialty code 2	X(*)	Use state-specific values
PROVIDER-SPECIALITY-CODE-3	Provider specialty code 3	X(*)	Use state-specific values
PROVIDER-STATE	Provider state	X(02)	
PROVIDER-TYPE	Provider type	X(*)	Use state-specific values
PROVIDER-ZIP-CODE	Provider zip code	9(09)	

Appendix D
State Specific Codes

State Specific Codes – List of Codes to be Provided by State

Several data fields submitted as part of the PERM Plus are based on state-specific codes. For each of these data elements, states will be asked to provide code definitions to the SC. These fields include:

- BILLING-PROV-NUM – Format logic to be provided by states
- CLAIM-STATUS-HEADER
- CLAIM-STATUS-LINE
- FUNDING-CODE-STATE
- MEMBER-IDENTIFICATION-NUMBER – Provide format of ID numbers
- PROGRAM-INDICATOR
- PROVIDER-ID-NUMBER – Format logic to be provided by states
- PROVIDER-SPECIALITY-CODE-1
- PROVIDER-SPECIALITY-CODE-2
- PROVIDER-SPECIALITY-CODE-3
- PROVIDER-TYPE
- SERVICE-LINE-PROCEDURE-CODE – If procedure codes are not based on a recognized national standard (e.g., ICD-9-CM, HCPCS), state to provide code definitions
- SERVICE-LINE-PROCEDURE-CODE-MOD-1 – If modifiers are not based on a recognized national standard (e.g. CPT, HCPCS), state to provide code definitions
- SERVICE-LINE-PROCEDURE-CODE-MOD-2 – If modifiers are not based on a recognized national standard (e.g. CPT, HCPCS), state to provide code definitions
- SERVICING-PROV-NUM - Format logic to be provided by states
- SEX-CODE
- SOURCE-LOCATION
- STATE-CLAIM-TYPE
- USER-FIELD-1
- USER-FIELD-2
- USER-FIELD-3
- USER-FIELD-4
- USER-FIELD-5