

PERM FFY 2008
Universe Data Submission Instructions

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INTRODUCTION AND TIMELINE

Introduction

These instructions will guide state staff as you define and apply quality control procedures for the PERM 2008 universe data.

The universe for PERM is large and complex. The PERM universe contains essentially all of your state's Medicaid and SCHIP beneficiary-specific payments; however, there are some important exceptions. The PERM universe will include data often processed outside of MMIS, and there are nuances in terms of how specific fields, such as "date paid" and "amount paid," are defined. Creating correct, complete universe data files for PERM is a complicated process.

The Lewin Group is here to help you understand the universe data submission instructions and apply them to your state programs so that you can prepare your universe files. We will also work with your state before and after you submit data to make sure the universes are compliant with the PERM requirements. We know that each state's programs differ and it is not possible to describe every permutation of state Medicaid and SCHIP programs here. Please ask your Lewin team questions. *Each question you ask up front will certainly save all of us time in the coming months.*

Involve program, policy, technical and budget staff now! Make certain that there are members on your PERM team who understand issues such as:

- Program structure: stand-alone/ Medicaid expansion/combination SCHIP, 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
- Variable 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)

In addition, please make certain that each PERM team member receives a copy and has reviewed these instructions.

The instructions include information about data sources, sampling units, the four PERM program areas, required variables, state quality control checks, and data submission and security. We have also developed a number of appendices. There is a glossary of PERM terminology, paid dates for claim selection examples, tables of required fields, and a transmission cover sheet with quality control verification.

The Lewin Group is looking forward to working with your state for PERM 2008.

Universe development and submission timeline

The entire PERM project cycle is expected to take approximately two years, with the universe and sampling activities concentrated in the first four quarters and the error rate calculation occurring at the end of the review cycle.

For your state to adhere to PERM project deadlines, it is important to begin universe development now! For federal fiscal year quarter 1, much of your state’s activity is concentrated in March and April. However, in May and June your state will likely be in frequent contact with staff at Lewin as we apply quality control procedures to your universe data submissions and resolve any questions.

Universe development and submission timeline		
Date	State Responsibility	Lewin Responsibility
February	Put together PERM team; Review instructions; Schedule one-on-one call	Provide instructions; Schedule one-on-one calls
March	Participate in one-on-one call; Prepare Q1 data: <ul style="list-style-type: none"> • Define data sources • Develop programming to select appropriate sampling units, divided claims into PERM program areas, and select required variables; Begin quality checks	Participate in one-on-one call; Respond to state questions
April	Continue and complete state quality control check of universe files; Submit Q1 universe files to Lewin	Receive Q1 data; Begin Lewin QC process
May	Work with Lewin to resolve issues identified during QC	Continue Lewin QC process; Approve data for sampling
June	Work with Lewin to resolve issues identified during QC	Continue Lewin QC process; Approve data for sampling
July and later	Submit Q2/Q3/Q4	Repeat for Q2/Q3/Q4

PERM UNIVERSE SPECIFICATIONS

What is a PERM universe?

Each state submits quarterly universe data to Lewin. Universe data files are essentially very long “lists” of nearly all the Medicaid and SCHIP beneficiary-specific payment records adjudicated by a state during the quarter. These payment records must include any payments equal to \$0 and denied claims. Each payment record contains only a small number of data elements or fields. States compile PERM universe files from MMIS systems, data warehouses, HIPP payment files, county and state agency systems, vendor payment systems, managed care files, and a variety of other sources. States divide their PERM universe data into four program areas: Medicaid fee-for-service, SCHIP fee-for-service, Medicaid managed care, and SCHIP managed care. It is from the universe files that a random sample of claims, line items, or payments will be selected for PERM review.

Four PERM Program Areas	
Medicaid fee-for-service	SCHIP fee-for-service
Medicaid managed care	SCHIP managed care

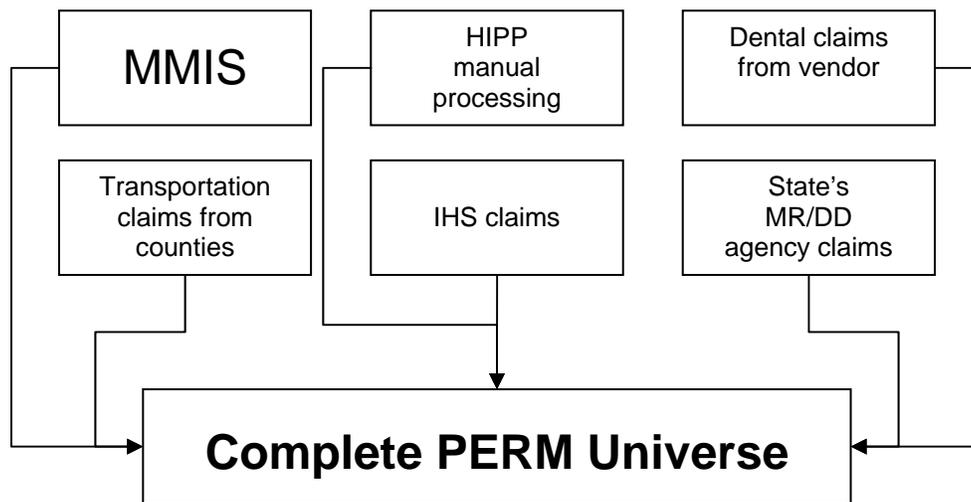
As you review these instructions and develop your PERM universe data, remember that it is from the PERM universe data that your PERM sample is selected. To assure that your sample is representative of your state’s payments, each beneficiary-specific payment matched with federal Medicaid (Title XIX) or SCHIP (Title XXI) funds should have a chance, and only one chance, of being sampled for PERM review.

PERM rule:
Each beneficiary-specific payment matched with Title XIX or Title XXI funds should have a chance, and only one chance, of being sampled for PERM review.

Data sources

States generally draw a majority of PERM universe data from their MMIS. Often, however, there are other important sources of data that contain individual-level claims matched with Title XIX and Title XXI funds. States must often combine data from multiple payments systems to compile their complete PERM universe files. For PERM, it does not matter how few payments are made by the payment system. All beneficiary-specific payment must be included in the universe data so that each has a chance to be sampled.

Example of State's Data Sources for PERM Universes



This example is merely for illustrative purposes, and any given state may have additional or different sources for their payment records.

When reviewing possible data sources, remember to **think outside MMIS!** Here are some data considerations that PERM 2006 and 2007 states have discussed with Lewin in figuring out how to build their Medicaid and SCHIP beneficiary-specific claims universe files:

- MMIS
- Claims paid by separate vendors or third party administrators
 - Pharmacy
 - Dental
 - Vision
- Claims paid by other state agencies (not the Medicaid or SCHIP agency)
- 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
- Community-based services (e.g., peer counseling services)
- Stand-alone or “manual” payment systems for special services
- HIPP payments
- Indian Health Service clinics
- Other systems that produce capitation payments (managed care, PCCM, non-emergency transportation capitations)

To assess if your state is capturing all of the data sources, we suggest you “follow the money” and **review federal reporting**. For Medicaid, review the data that populates the Medicaid portion of your state’s CMS-64. For SCHIP, review the CMS-21 and the SCHIP portion of the CMS-64. If there are multiple data sources populating the tables that creates federal match, you should make sure you evaluate all those sources to see if they should be included in PERM.

PERM rule:

Follow the money:

Evaluate all data sources that populate the CMS-64 and CMS-21 reports. Should these be included in the PERM universe?

CAUTION! Remember that not everything processed in MMIS is matched with Medicaid or SCHIP 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 your PERM universe.

NEW FOR PERM 2008! States do not need to include Medicare Part A, Part B, and Part D premium payments. CMS is providing this data directly to PERM contractors for inclusion in the PERM universe.

Data sources – Key points

- All beneficiary-specific claims matched with Title XIX or Title XXI funds should be included in the PERM universe.
- When defining data sources, think outside MMIS.
- Follow the money. To be sure you have identified all your data sources, review the data inputs to your CMS-64 and CMS-21.
- Do not include state-only funded services.
- Do not include Medicare Part A, Part B, and Part D premium payments.

Identifying a payment record

After your state locates the sources from which you will draw your PERM universe data, you must now determine which claims and payments to select. This section will define and discuss beneficiary-specific payments to be included, determination of the each record type (i.e., claim header level or line item level), treatment of adjustments, and inclusion of denied and zero paid claims.

Beneficiary-specific payments only

Only beneficiary-specific payments are included in the PERM universe. Generally this means that you can tie each of these payments to a specific person’s name. In addition to regular fee-for-service (indemnity) claims, payments made by the state on behalf of beneficiaries are also included in the PERM universe. These include payments such as managed care premiums, primary care case management (PCCM) payments, Health

Insurance Premium Programs (HIPP) (which pay for private health insurance premiums for an individual or family when it is more cost-effective than providing full Medicaid/SCHIP coverage), and non-emergency transportation capitation payments.

Gross payments are not included in PERM. However, please note that some gross payments or gross financial transactions actually do have beneficiary data associated with the transaction in a separate payment system. While the gross transaction itself is excluded from PERM, the underlying details should be included in the PERM universe. For example, a state's MR/DD agency may process and pay all the state's MR/DD claims and then "bill" the Medicaid agency a lump sum amount for the claims that should receive federal match. While the MMIS system may only have the single gross payment (and the gross payment should *not* be included in PERM), the state does have underlying details with individual beneficiary information available in the MR/DD agency and these details should be included in the PERM universe.

Your state will likely have other non-beneficiary level payments such as Disproportionate Share Hospital (DSH) payments, grants to state agencies or local health departments, cost-based reconciliations to non-profit providers not tied to individual claims, drug rebate reconciliations, and payments for federally matched administrative services. None of these should be included in the PERM universe.

Encounter data or "shadow claims" should not be included in the PERM universe. For PERM purposes, encounter data is defined as informational-only records submitted to a state by a provider or MCO for services covered under a managed care capitation payment. These data are often collected by a state in order to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk managed care contractors, but are not claims submitted for payment. While encounter data is beneficiary-specific, encounters do not represent an actual payment made by the state.

Note: Payments to federally qualified health centers and some other providers are sometimes paid on the basis of an all-inclusive visit rate or "encounter rate." These claims should be included in the PERM fee-for-service universe submission.

Beneficiary-specific payments?	
Yes! Include in PERM universe	No! Do not include in PERM universe
Regular fee-for-service (indemnity payments)	Disproportionate Share Hospital (DSH) payments
Managed care premiums	Grants to state agencies, local health departments, and non-profit providers
Other fixed payments such as PCCM, non-emergency transportation capitation	Drug rebate reconciliations
Health Insurance Premium Payments (HIPP)	Federally matched administrative services
	Encounter data (while beneficiary-specific, these are not payments)

Header vs. line

PERM universe data will have one record for each “sampling unit.” A sampling unit is a line item, fixed payment, or other individually-priced service tied to a single beneficiary. If a payment amount is determined at the line item or “detail” level, the line item is the sampling unit. If the payment amount is set at the claim level, the sampling unit is at the claim or “header” level. **States must provide universe data at the sampling unit level.** In discussion and in these instructions, we often use the term “claim” to refer to the sampling unit, but the relevant payment record may be either the claim header or the line item.

For example, for those states using a prospective payment or diagnosis-related groups (DRG) system 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, **do not include in the PERM universe the records for the detail lines** associated with the header (often these are \$0 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.

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 sampling unit.

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.

When developing data specifications for PERM, it is important to carefully review the many types of claims paid by the state so that you can select appropriate header or line level payment. Some states have found it helpful to review each state claim type or other payment indicator to identify claims as header or line level payments.

Please pay particular attention to federally qualified health centers (FQHC) payment, Medicare crossover claims, and payments made to state-owned facilities. These payments have been problematic in past PERM years. The FQHC all-inclusive rate is typically a header payment. In some states, FQHCs also submit unpaid, informational line details with CPT-4 procedure codes. These informational line items should not be included in the PERM universe. Also, please note that Medicare crossover claims are often paid on the basis of the type of service, and your 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 true in your state, be certain to select the appropriate header or line value for your 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.)

Treatment of adjustments

PERM universe files must contain **only original paid claims**. The state must exclude all adjustments from the PERM universe. Information on adjustments made within 60 days of the paid date will be requested *after* the sample has been drawn.

Here are several common examples of MMIS adjudication of a claim with an adjustment:

Debits and credits: A provider submits a claim which the state pays on 10/1/2007 for \$100. The provider submits an adjustment to correct the billed amount on 10/5/2007 for \$1,000. MMIS credits the original paid amount (-\$100) and then re-processes the claim with a \$1,000 billed amount. MMIS claims tables would have three lines of data for this claim; one for the original payment (\$100), a second for the credit (-\$100), and a third for the paid adjustment amount (\$1000). For PERM, the state should only submit the original paid claim for \$100. (If the state incorrectly submits all three lines of data, this claim will be three times as likely to be selected for PERM review as a claim with no adjustments.)

Void and replace: A provider submits a claim which the state pays on 12/1/2007 for \$500. The payment status for this claim is "Paid". A month later, the provider submits an adjustment to correct the billed amount to \$600. MMIS voids the original payment, changing the payment status on the \$500 payment from "Paid" to "Void". MMIS then processes the \$600 claim, pays the claim, and the payment status is "Paid". MMIS claims tables would have two lines of data for this claim; one for the original payment (for \$500, now with a payment status "Void") and a second with the new payment (\$600, with the payment status "Paid"). For PERM, the state should only submit the **original paid claim**

for \$500. (If the state incorrectly submits both lines of data, this claim will be twice as likely to be selected for PERM review as a claim with no adjustments.

Similarly, if a claim is later voided and not replaced, the original claim should be submitted in the PERM universe.

When defining your state's PERM universe, think about what fields in your payment systems indicate that claims have been adjusted. Look for payment status indicators and original/next ICN pointers or other appropriate fields to identify and exclude adjustments from the universe files.

Denied and zero paid claims

The universe data must contain all fully adjudicated claims, including denied claims and zero paid claims.

Denied claims are claims that are adjudicated in the state's payment system but denied for payment. Denied claims should be submitted as part of the state's universe data. However, states should *not* include claims submitted by providers that are rejected from the claims processing system prior to adjudication. Often claim rejection occurs in a pre-processor or translator and does not get fully processed in the system. Please contact Lewin if you have specific questions about how denials should be defined within the constraints of your processing system.

A zero paid claim is a valid claim for which the state had no financial liability due to, for example, third party liability or a Medicare payment exceeding the state allowable charge. Zero paid claims are included in the PERM universe.

Identifying a payment record – key points

- Only beneficiary-specific payments are included in the PERM universe.
- Payments represented in MMIS as consolidated or aggregated transactions, for which there are beneficiary-specific payments in an outside system, must be reported as beneficiary-specific payments in the PERM universe.
- States must provide universe data at the sampling unit level. This may be a header or a line.
- Each unique payment should be represented only once in a universe file, and must be included in only one universe file across programs or across quarters.
- Select only original paid claims. No adjustments.
- Include denied and zero paid claims.
- Be sure the following are excluded for the PERM universe:
 - State-only funded services or services not matched with Title XIX or Title XXI funds;
 - Adjustment records including credit claims and replacement claims;

- All payments not associated with an individual (HIPP family unit claims are an exception);
- Disproportionate Share Hospital (DSH) payments;
- Gross adjustments which cannot be tied to individual claims;
- Grants to state agencies, local health departments, and non-profit providers for services not tied to individual beneficiaries;
- Drug rebate reconciliations;
- Medicare Part A, Part B, and Part D premium payments; - **NEW FOR 2008**
- Costs for program administration; and
- Encounter data not representative of actual payments.

“Dividing” claims between the PERM program areas

For each quarter, states will submit up to four PERM universe files to Lewin. Each of these files includes data for one of the four PERM program areas: Medicaid fee-for-service, SCHIP fee-for-service, Medicaid managed care, and SCHIP managed care. During the one-on-one call with Lewin, we will discuss your state’s Medicaid and SCHIP structure. Please let Lewin know if your state is not planning to submit data for one of these program areas (e.g., “we are not submitting data for the SCHIP fee-for-service program area because our state’s only SCHIP program is a stand alone, managed care model”). Also, please use Lewin as a resource should you have questions when dividing claims and payments between fee-for-service and managed care.

Four PERM Program Areas	
Medicaid fee-for-service	SCHIP fee-for-service
Medicaid managed care	SCHIP managed care

Medicaid vs. SCHIP

For Medicaid, all health care 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, are included in the Medicaid FFS universe.

For SCHIP, all health service payments that are paid for in whole or in part by Title XXI FFP dollars, as well as claims submitted as Title XXI services but denied, are included in the SCHIP FFS universe.

When dividing claims between the Medicaid and SCHIP program areas, claims should be categorized based on the federal money source, not the program design. ***Therefore, payments for Medicaid expansion-type SCHIP programs or Medicaid expansion groups, which are matched by Title XXI FFP, are included in the SCHIP universe.*** States which have both a FFS Medicaid-expansion type SCHIP program and a stand-alone FFS SCHIP program must combine the claims for these Title XXI programs into a single SCHIP universe.

Note that when states have a single managed care program serving both Medicaid and SCHIP populations, the capitation payments must be separated into the Medicaid and SCHIP universes based on the federal program providing the match.

PERM rule:

Follow the money:

When dividing claims and payments between Medicaid and SCHIP, follow the money, not the program structure. For PERM purposes, payments matched by Title XIX = Medicaid, and payments matched by Title XXI = SCHIP.

Also, be sure claims are designated into a PERM program area based on the time when the *claim is paid*, not what the beneficiary's eligibility status is at the time the data is selected. A beneficiary's eligibility may change between Medicaid and SCHIP. Again, follow the money! How does your state determine the federal matching rate for the service? Look at how a claim feeds into the federal reporting forms (e.g., CMS-64, CMS-21). Follow the money!

Fee-for-service vs. managed care

When compiling the PERM universe files, states will also need to evaluate their claims and payments and designate if the claim belongs in the fee-for-service or managed care universe files.

For purposes of the PERM program, the FFS universe files includes fee-for-service claims (indemnity claims) as well as fixed payments made on behalf of beneficiaries. Fixed payments include primary care case management (PCCM) payments, Health Insurance Premium Programs (HIP) payments, non-emergency transportation capitation and fixed beneficiary-specific pharmacy dispensing fees (for example if a state pays nursing home pharmacies a monthly fixed amount per beneficiary).

Payments classified in the fee-for-service universe may also be beneficiary-specific, claim-specific payments to managed care organizations made to reimburse the managed care organization for services provided outside of the capitated benefit package. For example, one state's managed care organizations pay pharmacy providers for HIV/AIDS drugs. However, the cost of HIV/AIDS drugs is not included in the capitation rate. To reimburse the managed care organizations for the cost of the drugs, the managed care organizations submit beneficiary-specific claims to the state. Consequently, these services are paid on a pass through fee-for-service basis by the state to the managed care organization. Because these claims to the state are beneficiary-specific, these claims should be included in the PERM fee-for-service universe, even though the pay-to-provider is a managed care organization.

The managed care universes include regular capitation payments to full-risk and partial risk managed care organizations, including specialty managed care (e.g., behavioral health or plans) and PACE payments. The managed care universe should also include special

payments made to managed care plans on behalf of individual managed care enrollees. These may include maternity “kick” payments or other supplemental payments and individual reinsurance or stop-loss payments.

Fee-for-service or Managed Care?	
Fee-for-service! Include in FFS PERM universes	Managed care! Include in managed care PERM universes
Regular fee-for-service (indemnity payments) Primary care case management (PCCM) payments Payments made to managed care organizations through HIPP programs Management fees or access fees paid with Medicaid or SCHIP service funds Non-emergency transportation capitation payments Fee-for-service payments for benefits carved out of a managed care capitation rate	Managed care capitation payments Specialty managed care capitation payments (behavioral health, dental) PACE payments Maternity/delivery kick payments

If your state’s managed care program includes individual beneficiary-level reinsurance or stop-loss payments, please discuss with Lewin where these payments should go.

Defining managed care: Here we discuss definitions for PERM managed care. Lewin recognizes that there is great variety in states’ managed care models and provider reimbursement methods. Your Lewin team will discuss your specific programs with you.

Generally, payments should be included in the managed care universe if the managed care provider assumes full or partial risk for the cost of health care services included in the managed care program.

Additionally, if a managed care organization is paid prospectively for health care costs on a capitated basis, but the state later undertakes a cost reconciliation process for actual costs incurred by the organization following the end of the contract period, these claims should also be treated as managed care. This approach relates to those programs for which cost reconciliation is accomplished well after the period of service delivery.

Some Medicaid and SCHIP programs purchase full-risk indemnity (FFS) coverage for enrollees, usually because of a lack of managed care options. If the insurer is at risk for coverage of a certain benefit package, the premiums should be treated as capitation payments for the purpose of inclusion in the PERM managed care universe.

Specialty managed care programs for which the capitated provider is at risk (e.g., PACE programs, capitated behavioral health managed care programs) are included in the PERM managed care universe.

If the state pays a network access fee or a management fee to a managed care organization, and then reimburses the managed care organization for each encounter, these payments are in the FFS universe. (Management fees for which the state seeks federal financial participation on an administrative cost basis are excluded from the PERM program.)

“Dividing” claims between the PERM program areas – key points

- There are four PERM program areas: Medicaid fee-for-service, SCHIP fee-for-service, Medicaid managed care, SCHIP managed care.
- Each claim or payment should be defined into one, and only one, of the four PERM program areas.
- Follow the money! When dividing claims between the Medicaid and SCHIP program areas, claims must be categorized based on the federal money source, not the program design.
- Payments for Medicaid expansion-type SCHIP programs or Medicaid expansion groups that are matched by Title XXI FFP are included in the SCHIP universe.
- Review the table “Fee-for-service or Managed Care?”.
- Discuss your managed care models and provider reimbursement methods with Lewin.

Required fields

In this section we review the required fields or variables for the PERM universe data. For fee-for-service, we require few fields. Additional fields for only the selected sample will be requested later. The managed care program area requires more fields in the universe file but few, if any, additional details will be required after sample selection.

MMIS systems often contain multiple options when selecting fields such as “paid date” or “paid amount”. The definitions and discussion below will help your state select the appropriate field. Again, use Lewin as a resource as you make your data field selections.

See Appendix C for a table of required fee-for-service and managed care fields.

Fee-for-service program area required variables

- Unique payment record identifier: (ICN/TCN and line number)

Each line of PERM universe data must contain a unique claim identifier. For most states this is an ICN (TCN) and line number. The line number can be filled with “0” if sampling unit is at the header level.

When combining data from various claim processing or data base systems, first validate that the claim identifiers will remain unique when combined within the universe file. Sometimes when pulling data from a non-MMIS payment source, your state may have to “create” an ICN. If doing so, be certain all unique identifiers tie back to an individual client, payment type, payment date, and date of service.

No ICN and line number combination can appear in the universe data more than once.

Your state may opt to send additional fields to help Lewin or the state uniquely identify or locate claims following sampling. Please discuss any additional variables with Lewin prior to data submission.

- Date paid

Sampling units are selected for inclusion in each quarter’s data only if the original date of payment or adjudication (for denied claims) falls within the federal fiscal quarter. This is regardless of the date of any subsequent adjustments. See Appendix B for illustrations of the selection criteria for paid/adjudication dates and paid amounts.

Federal fiscal quarters	
FFY 2008 Quarter	Date paid
Quarter 1	October 1 – December 31, 2007
Quarter 2	January 1 – March 31, 2008
Quarter 3	April 1 – June 30, 2008
Quarter 4	July 1, 2008 – September 30, 2008

- Amount paid

Original amount paid only: Only original paid claims and denied claims are to be included in the universe. Paid amount, for sampling purposes, is defined as the **original amount paid** for the individual sampling unit that is paid to the provider. The universe includes zero-paid claims and line items.

Amount paid corresponds to the sampling unit: The paid amount provided with each sampling unit must be the amount corresponding to that sampling unit. This could be a header paid amount if the header is the sampling unit or a line paid amount if the line is the sampling unit.

Amount paid is the total computable amount: Amount paid is the total computable amount paid and includes both the state share and the federal match. For claims in which the state share is a certified public expenditure, be certain the amount paid is the total computable and not the federal dollars only as remitted to the provider.

Net amount paid: Amount paid should also not include non-reimbursed dollars due to patient liability (co-pays or contribution to care).

PERM rule:

Follow the money:

When selecting an amount paid value, report costs as they are reported to CMS. Amount paid should be the total computable amounts and should not report dollars paid by the beneficiary.

- Provider type

Please provide your state's provider type on each sampling unit. The state will provide Lewin a data dictionary for the state-defined identifiers such as provider type.

- Claim type

In the universe data, states must also include a claim type identifier to distinguish between claims types such as inpatient, outpatient, prescription, professional, Medicare crossover, etc.

Verify there is a way for Lewin to identify Medicare crossovers. Also, if your state makes any "special" fee-for-service payments, such as PCCM payments or HIPP premiums, please include a way for Lewin to identify these payments. This is important for Lewin's quality control process!

We ask the state provide Lewin a data dictionary for the state-defined identifiers such as claim type and provider type.

Note: For FFY 2008, states do not need to include MSIS categorizations.

- Payment status

States must distinguish denied claims from paid claims in the universe. If, for any reason, a state has a positive paid amount in their system for denied claims, the state should default the paid amount to \$0 for the PERM universe or make Lewin aware of the situation.

- Payment level - **NEW FOR 2008**

An indicator of whether the claim is paid at the header level, paid at the line level, or is a fixed premium or capitated payment (such as PCCM, HIPP, or non-emergency transportation capitation payments). The field for each sampling unit must contain only one of the following values:

- H = Sampling unit paid at the header level

- L = Sampling unit paid at the line level
 - F = Sampling unit is a fixed payment
- Place of service - **NEW FOR 2008**

Please provide your state's place of service code on each sampling unit. The state must provide Lewin a data dictionary for the state-defined identifiers such as place of service.

- Service code - *Line Level Sampling Units Only* - **NEW FOR 2008**

For line level sampling units only, please provide the procedure code or revenue code.

Managed care program area required variables

- Unique claim indicator: ICN

Each line of PERM universe data must contain a unique claim identifier. For most managed care data this is an ICN (TCN) and sometimes a line number.

When combining data from various claim processing or data base systems, first validate that the claim identifiers will remain unique when combined within the universe file.

No ICN and line number combination can appear in the universe data more than once.

Your state may opt to send additional fields to help Lewin or the state uniquely identify or locate claims following sampling. Please discuss any additional variables with Lewin prior to data submission.

- Date paid

Sampling units are selected for inclusion in each quarter's data only if the original date of payment falls within the federal fiscal quarter.

Managed care capitation payments are often made 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). For PERM purposes, payments should be included in the quarter according to the date the payment was actually made, not the date or period for which the coverage was purchased.

Prospective example: If a capitation payment was made on December 25, 2007 for services in January 2008, the state should include the payment with the PERM quarter 1 data submission.

Retrospective example: If a capitation payment was made on October 5, 2007 for services in September 2007, the state should include the payment with the PERM quarter 1 data submission.

Federal Fiscal Quarters	
FFY 2008 Quarter	Date Paid
Quarter 1	October 1 – December 31, 2007
Quarter 2	January 1 – March 31, 2008
Quarter 3	April 1 – June 30, 2008
Quarter 4	July 1, 2008 – September 30, 2008

- Amount paid

Paid amount, for sampling purposes, is defined as the original amount paid for each beneficiary-specific payment. (Even if a managed care organization receives a single payment each month for all enrolled beneficiaries, the paid amount for PERM purposes will be the capitation amount for each enrolled beneficiary.)

Include original payments only; no adjustments.

- Managed care program indicator

Include a field to indicate the program such as “TANF HMO”, PACE, LTC, Behavioral health, Dental.

- Payment type

Include a field to indicate the payment type such as monthly capitation, delivery kick payment, individual reinsurance payment.

- Provider ID

- Recipient ID

- Recipient name

- Recipient rate indicator (“procedure code” or other rate cohort indicator)

- Recipient date of birth

- Recipient gender

- Recipient county

- Service area indicator

If the managed care program's geographic service areas are not at the county level, indicate the recipient's service area.

- Coverage period (coverage month or "from" and "to" service dates)
- Claim status

Some states have "denied" payments for the managed care universe. Therefore, Lewin will need a paid or denied indicator in the managed care universe files.

Required fields - key points

- The PERM universe data submission requires few fields or variables.
- MMIS may have several options for variables such as amount paid. Be sure to select the appropriate field.
- Consult with your Lewin team for variable selection advice.
- Each sampling unit should be uniquely identified (often using ICN and line number).
- Data is submitted quarterly. Quarters are defined using the federal fiscal quarters.
- Submit only the original, unadjusted amount paid. Amount paid is the total computable amount (state and federal share) and should not include dollars paid by the beneficiary.
- Payments are included in the quarter according to the paid date. For managed care, this means the data should be submitted in the quarter the claim was paid, not the date or period for which the coverage was purchased.

DATA TRANSMISSION AND SECURITY

The section discusses the universe data submission media, universe data submission formats, transmission cover sheet and quality control verification, and data transmission and security.

Submission media

Lewin's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, cartridge tapes, portable hard drives). Lewin expects most states will send their data on CDs or DVDs.

States should submit two copies of each submission media. If your state is submitting data on CD, send two copies of each CD, one labeled "original" and one labeled "duplicate."

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

Submission formats

The state will provide Lewin with up to four universe files per quarter. The state should submit one file for each of the PERM program areas: Medicaid fee-for-service, SCHIP fee-for-service, Medicaid managed care, and SCHIP managed care. (Please discuss with Lewin if your state must send more than one file per universe).

States must provide universe data in either a universal text format with a single fixed record length and layout (also called a "flat format" or "ASCII format") or in a PC-based SAS dataset. If you submit a text file, *except for the first row of the field names, please do not include any log or summary information at the beginning or the bottom of the data file*. If your state uses a PC-based SAS server or IBM mainframe, you may send claims data in a PC-based SAS dataset. (In fact, we prefer files in SAS.)

For the universe data, Lewin will not provide states with a specific record layout. However, each data submission must be accompanied by a detailed record layout. This layout may be in a flat text file, MS Windows SAS format, or parsed and fully labeled in an Excel spreadsheet.

States also must provide a data dictionary containing the definitions for any fields with state-defined values (e.g., provider type, claim status, managed care program identifier).

Transmission cover sheet and quality control verification

Due to the large number of quarterly universe files Lewin receives from the states, *Lewin asks that the states submit a transmission cover sheet with every data submission*. You will find a copy of the transmission cover sheet and quality control verification in Appendix D. We will also email an Excel version of this file to the state PERM contacts. The transmission cover sheet can be burned on the CD or DVD with the data or emailed to permsc.2008@lewin.com the day the data is sent.

The transmission cover sheet includes information for the state to input:

- Control totals, by claim type, for each dataset;
- Quality control testing verification;
- Written additional information about the datasets; and
- Technical contact information.

States must perform quality control checks on the universe prior to submitting the data to Lewin. The transmission cover sheet lists the minimum tests. There is a “check box” next to each test to assure that the test has been performed and the results are satisfactory. *The state is responsible for quality control testing the universe data prior to submission.* Involve your entire PERM team in reviewing the test results (not only the data or technical staff).

In our experience, states that do not perform sufficient quality control testing prior to submission expend considerable time and expense correcting data errors later. This may result in a state falling behind schedule in PERM measurement.

Save time and money!

Perform sufficient quality control testing before submitting data to Lewin.

Data transmission and security

The Lewin Group is committed to protecting the confidentiality, integrity and availability 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 their own state privacy and security rules. Any data that includes protected health information (PHI) and/or beneficiary ID numbers is sensitive data.

The Lewin Group will only accept data files sent on hard media (e.g., CD, DVD) through the mail or via secure FTP transmission. Do not send universe data via email.

Follow these steps if mailing data:

- Encrypt and password-protect the data files and copy to a CD or DVD. Label the CD or DVD “CMS Sensitive Information.”
- Mail the CD or DVD via a private overnight delivery service (such as FedEx or UPS) or the USPS.
- Label the envelope “To be opened by addressee only.”
- Address the envelope to Lewin at:

Payment Error Rate Measurement Program, c/o Moira Forbes
The Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

- E-mail the transmission cover sheet and password(s) for the data to permsc.2008@lewin.com.

Data submission – Quick checklist for mailing data
<ul style="list-style-type: none"> ▪ Data <ul style="list-style-type: none"> ○ Text or SAS format ○ Zipped, encrypted, password-protected ○ Two copies of the CD or DVD, one “original” and one “duplicate” ○ Disk labeled “CMS Sensitive Information”
<ul style="list-style-type: none"> ▪ File layouts (copied onto the CD/DVD or emailed)
<ul style="list-style-type: none"> ▪ Data dictionary for all state-defined fields (e.g., provider type, claim type), (copied onto the CD/DVD or emailed)
<ul style="list-style-type: none"> ▪ Transmission cover sheet (copied onto the CD/DVD or emailed) <ul style="list-style-type: none"> ○ QC checks performed on data ○ Control totals ○ Additional information noted ○ “Signed”
<ul style="list-style-type: none"> ▪ Package labeled “To be opened by addressee only”
<ul style="list-style-type: none"> ▪ Email password to Lewin at permsc.2008@lewin.com

Follow these steps if FTPing the data:

- Encrypt, password-protect, and zip the data files.
- Contact Lewin to discuss FTP site.
- E-mail the transmission cover sheet, password(s) for the data, file layouts, and data dictionary to permsc.2008@lewin.com.

APPENDIX A

Definitions

Adjudicated claim: In reference to denied claims, an adjudicated claim is one that has been accepted and reviewed by the claim processing system and the decision to deny the claim has been made. In reference to paid claims, an adjudicated claim refers to a submitted claim that has been accepted and fully reviewed and a positive determination has been made regarding the payment amount. For denied claims, the adjudication date should be used to determine whether a claim is included in a fiscal quarter if the state system does not capture a “paid date” for these claims. For paid claims, the date paid should be used for this determination.

Adjustment: Change to a previously submitted claim that is linked to the original claim.

Capitation: A fixed payment, usually made on a monthly basis, for each beneficiary enrolled in a managed care plan or for each beneficiary eligible for a specific service or set of services.

Claim: A request for payment, on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services.

Denied claim or line item: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment and not approved for payment in whole or in part.

Encounter data: Encounter data or “shadow claims” are defined as informational-only records submitted to a state by a provider or MCO for services covered under a managed care capitation payment. These data are often collected by a state in order to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk managed care contractors, but are not claims submitted for payment.

Fee-for-service (FFS): A traditional method of paying for medical services under which providers are paid for each service rendered.

FFS processing error: A payment error that can be determined from the information available from the claim or from other information available in the state Medicaid/SCHIP system (exclusive of medical reviews and eligibility reviews).

Health Insurance Premium Payment (HIPP): A program allowing states to choose to have Medicaid or SCHIP pay beneficiaries’ private health insurance premiums when it is more cost-effective than paying for the full cost of Medicaid or SCHIP services.

Individual reinsurance: In the context of PERM managed care universe files, individual reinsurance payments are those payments made by the state to a managed care plan for an individual beneficiary whose cost of care has exceeded a predetermined maximum amount, usually measured on an annual basis or on the basis of a specific episode of care. Such payment by the state typically represents a cost sharing arrangement with a managed care plan for extremely high-cost enrollees. Individual reinsurance may be based on the costs associated with all services provided by the managed care plan, or may be limited to excessive costs associated

with certain services (e.g., transplants). (Note: providers whose payment rates are fully reconciled for actual costs incurred, on a retrospective basis, are considered to be FFS.)

Kick payment: A term used in reference to a supplemental payment over and above the capitation payment made to managed care plans for beneficiaries utilizing a specified set of services or having a certain condition.

Line item: An individually-priced service presented on a claim for payment. Items individually listed but priced in a bundled service rather than being priced individually are not considered “line items.”

Managed care: A system where the state contracts with health plans on a prospective full-risk or partial-risk basis to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for services delivered.

Managed Care Organization (MCO): An MCO is an entity that has entered into a risk contract with a state Medicaid and/or SCHIP agency to provide a specified package of benefits to Medicaid and/or SCHIP enrollees. The MCO assumes financial responsibility for services delivered and is responsible for contracting with and reimbursing servicing providers. State payments to MCOs are typically done on the basis of a monthly capitation payment per enrolled beneficiary.

Medicaid: A jointly funded federal and state program that provides health care to people with low incomes and limited resources.

Medicaid Statistical Information System (MSIS): The MSIS, housed by CMS, collects statistical data from each of the states on an annual basis (using form HCFA-2082). The system includes aggregated statistical data on recipients, services, and expenditures during a Federal fiscal year (i.e., October 1 through September 30).

Medical review error: An error that is determined from a review of the medical documentation in conjunction with state medical policies and information presented on the claim.

Medicare: The federal health insurance program for people 65 years of age or older and certain younger people with disabilities or End Stage Renal Disease. Beneficiaries must pay (or have paid on their behalf) premiums for the two main portions of Medicare: Part A (hospital) and Part B (physician) services.

Non-claims based sampling unit: Sampling units that are not related to a particular service provided, such as Medicare Part A or Part B premiums.

Overpayment: Overpayments occur when the state pays more than the amount the provider was entitled to receive or paid more than its share of cost.

Paid claim: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, determined to be a covered service eligible for payment, and for which a payment was issued or was determined to result in a zero payment due to circumstances such as payment by a third party insurer.

Partial error: Partial errors are those that affect only a portion of the payment on a claim.

Primary Care Case Management (PCCM): A program in which beneficiaries are linked to a primary care provider who coordinates their health care. Providers receive small additional payments to compensate for care management responsibilities, typically on a per member per month basis. Providers are not at financial risk for the services they provide or authorize.

Risk-based managed care: The managed care organization (MCO) assumes either partial or full financial risk, and is paid a fixed monthly premium per beneficiary.

Sampling unit: The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in a managed care plan or a monthly Medicare premium). Depending on the universe (e.g., fee for service or managed care), the sampling unit includes: claim, line item, premium payment, or capitation payment.

Stop-loss: See “Individual Reinsurance,” above.

Supplemental payments for specific services or events: These are payments that may be made by the state to a managed care organization on behalf of a particular enrollee in the managed care plan, based on the provision of a particular service or the occurrence of a particular event, such as childbirth.

Third Party Liability (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. In cases of available TPL, Medicaid is payer of last resort.

Underpayment: Underpayments occur when the state pays less than the amount the provider was entitled to receive or less than its share of cost.

Universe: The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the error rate is inferred from the sample. The term “claim” is used interchangeably with the term “sampling unit.”

Zero-paid claim: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles, or other causes.

APPENDIX B
Treatment of Paid Date for Universe Selection

Fee-for-Service Example
Selection of Sampling Units for FY2007, Quarter 2 (Jan - Mar)
Application of Payment Date and Payment Amount Criteria

	Claim #1	Claim #2	Claim #3	Claim #4	Claim #5
December					Original payment December 15; \$45
January	Original payment January 12; \$45		Original payment January 6; \$280		
February	Adjusted February 27; new final paid amount \$60	Original payment February 28; \$1,200			Adjusted February 2; new final paid amount \$60
March	Adjusted March 25; new final paid amount \$70			Original payment March 31; \$500	
April		Adjusted April 20; new final paid amount \$960			
May			Adjusted May 12; new final payment \$375	Adjusted May 20; new final payment \$450	
Included in Q2 universe file provided 4/15:	Paid date = January 12; amount paid = \$45	Paid date = February 28; amount paid = \$1,200	Paid date = January 6; amount paid = \$280	Paid date = March 31; amount paid = \$500	Not included in Q2, original paid date prior to quarter
If claim selected for sample, state provides updates upon request:	February 27 adjustment information provided; March 25 adjustment not provided because adjustment occurred more than 60 days after January 12	Adjustment made on April 20 provided (since this is within 60 days of original payment date of February 28)	No update; adjustment occurred more than 60 days after original payment date	Adjustment made on May 20 provided (since this is within 60 days of original payment date of March 31)	N/A

**APPENDIX B
Treatment of Paid Date for Universe Selection**

**Managed Care Example
Selection of Sampling Units for FFY2007, Quarter 2 (Jan - Mar)
Application of Payment Date and Payment Amount Criteria**

	Claim #1	Claim #2	Claim #3	Claim #4	Claim #5
December	Capitation payment on 12/15 for managed care program enrollee for service period January 2007				
January		Capitation payment on 1/14 for enrollee in managed mental health plan for November 2006 service period	Individual stop-loss payment on 1/12 to managed mental health care plan for catastrophic costs incurred for beneficiary over prior six months		
February	Adjustment on 2/4 for capitation payment recovery due to death of enrollee on November 30			Delivery kick-payment on 2/15 for delivery in December	Capitation payment on 2/26 for managed care enrollee
March					
April					
Included in Q2 universe file provided 4/15:	Not included with Q2; it was included in Q1 submission due 1/15	State would include in Q2 universe	State would include in Q2 universe	State would include in Q2 universe	State would include in Q2 universe
If claim selected for sample, state provides additional details:	If claim had been selected in the Q1 sample, the February adjustment would be provided with the additional Q1 detail on sampled claims	No adjustment made	No adjustment made	No adjustment made	No adjustment made

APPENDIX C
Fields for Universe Submission
States send universe data to Lewin

When submitting the universe data to Lewin, 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 FFS universe file, all fields are mandatory. This means every data element for every line item should be populated with a valid value.

Universe – Medicaid FFS and SCHIP FFS			
Field	Description	Mandatory for all sampling units	Notes
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Mandatory	For “dummy” claims, be sure the ICN information can tie back to the payment.
Line Number	Line item number	Mandatory ; if not imbedded in ICN.	Indicate in documentation the line item number for headers (e.g., header line = 0)
Date paid	Original date of payment	Mandatory	
Amount paid	Amount of the original payment	Mandatory	Adjustments made within 60 days of original payment date will be requested after the sample is drawn; \$0 for denied claims
Provider type	Provider type or MSIS category or other similar variable	Mandatory	<i>State data dictionary required</i>
Claim type	Distinguish, for example, between inpatient, outpatient, professional, prescription, Medicare crossover, etc.	Mandatory	<i>State data dictionary required</i>
Payment status	Indicator if the claim is paid or denied	Mandatory	
Payment level	Header level, line level, or fixed payment indicator	Mandatory	H = Sampling unit paid at the Header level L = Sampling unit paid at the Line level F = Sampling unit is a fixed payment
Place of service	Indicator of where the service was performed	Mandatory	<i>State data dictionary required</i>
Service code	Procedure code or revenue code for line level sampling units	Mandatory for line level sampling units	

APPENDIX C
Fields for Universe Submission
States send universe data to Lewin

Medicaid managed care and SCHIP managed care			
Field	Description	Mandatory for all sampling units	Notes
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Mandatory	Some states will need to use several variables to create a unique claim identifier.
Date paid	Original date of payment	Mandatory	
Amount paid	Amount paid	Mandatory	
Managed care program indicator	Indicator of the program (TANF, PACE, LTC, Behavioral health)	Mandatory	<i>State data dictionary required</i>
Payment type	E.g., monthly capitation, delivery kick payment or other beneficiary-specific supplemental payment, individual reinsurance payment	Mandatory	<i>State data dictionary required</i>
Provider ID	Medicaid/SCHIP ID for the managed care organization	Mandatory	
Recipient ID	Recipient Medicaid/SCHIP number	Mandatory	
Recipient name		Mandatory	
Recipient rate indicator	“Procedure code” or other rate cohort indicator	Mandatory	<i>State data dictionary required</i>
Recipient date of birth		Mandatory	
Recipient gender		Mandatory	<i>State data dictionary required</i>
Recipient county		Mandatory	<i>State data dictionary required</i>
Service area indicator	Indicator for the geographic service area if the service area is not the county	Mandatory, if service areas is not the county	<i>State data dictionary required</i>
Coverage period	Period of coverage this payment represents	Mandatory	May be prospective, concurrent, or retrospective
Claim status	Paid or denied	Mandatory	

APPENDIX D

Data transmission cover sheet and quality control verification

We have provided examples here of the Medicaid fee-for-service and Medicaid managed care data transmission cover sheet and quality control verification. Please submit these to Lewin using the Excel version emailed with the data submission instructions.

Transmission Cover Sheet and Quality Control Verification

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 your data documentation. Add more rows as necessary.			
Data Description (e.g., Q1 Medicaid FFS; data documentation)	Data Filename	File Format (e.g., text, Excel, SAS)	File Media (e.g., CD, DVD, FTP)
			Password Protected? (Y/N) (if yes, send password separately)
(Add rows if necessary)			

APPENDIX D
Data transmission cover sheet and quality control verification

Quality Control Verification - FFS States are responsible for quality control checking each dataset prior to submitting the data to Lewin. These are the minimum required checks. Please provide the name of the person "signing off" on each QC check. By placing your name in this box, you are verifying that your state performed the quality control check and the results have been reviewed and are acceptable.

Quality Control Check	Suggested Test	Your Name
Data include only Title XIX FFS claims (as defined in the instructions)	How does your programming designate a claim as Title XIX or Title XXI? How does your programming designate a claim as FFS or managed care?	
Data with paid dates from FFY 2008 Q1.	Test dates of service. Are all original paid dates between October 1, 2007 and December 31, 2008?	
Data represent only original paid claims.	Are there any adjustments in your data? Are there any negative payments in your data? How did you isolate only original paid claims in the programming?	
Each payment is represented in only one universe, and only once in each universe.	Are there any ICN-line combinations across the data and in each dataset that repeat?	
State-only paid services are removed from the data.	How did your programming eliminate state-only funded services?	
Records reflect the smallest independently priced service level, which may be header, line, or fixed payment.	How did your state decide if the sampling unit is the header or the line (e.g., using claim type)? Were there any special instructions for FQHC payments?	
Include FFS fixed payments (as defined in the instructions) in data.	Did you include HIPP, PCCM, and other fixed payments in the data submission? Were these found in non-MMIS payment systems?	
Data do not include gross payments (non-beneficiary specific) to providers.	How did you eliminate gross payments in your programming? Review the highest paid amounts in your data to be sure they are beneficiary-level payments.	

APPENDIX D
Data transmission cover sheet and quality control verification

Zero-paid claims and denied claims are included in the data.	Count the number of zero-paid claims and denied claims. Are you including them? Do your denied claims have payment amounts greater than \$0?	
All required fields are included and each field is populated with a value.	Review instruction appendix for list of required fields. Are there any missing values for any of the fields? Have you included the data dictionary for any state-specific fields?	

Identification of Potential Data Discrepancies or Other Information: *Please indicate whether there have been any major changes since the last quarter (e.g., introduction of a large managed care program, significant benefit changes or limitations introduced this quarter) that substantially impact the total dollars in the universe or distribution of dollars by claim type, compared to previous quarters. If possible, provide an estimate of the impact of the changes (e.g., 10% decrease in overall FFS spending in Q3). Also, please use this space to share other important information about your data submissions.*

Transmission Cover Sheet and Quality Control Verification
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:

APPENDIX D
Data transmission cover sheet and quality control verification

Title:
Organization:

Data Descriptions Complete information below. Please include a row describing your data documentation. Add more rows as necessary.				
Data Description (e.g., Q1 Medicaid MC; data documentation)	Data Filename	File Format (e.g., text, Excel, SAS)	File Media (e.g., CD, DVD, FTP)	Password Protected? (Y/N) (if yes, send password separately)
(Add rows if necessary)				

Control Totals Add more tables as necessary. NOTE: List the lines cont and total \$\$ by managed care program area, not universe totals. Add more rows as necessary to reflect each claim type.								
Data filename:			0					
Month October			Month November			Month December		
Program	Total Lines	Total \$\$	Program	Total Lines	Total \$\$	Program	Total Lines	Total \$\$
(Add rows if necessary)								

APPENDIX D
Data transmission cover sheet and quality control verification

State-only paid services are removed from the data.	How did your programming eliminate state-only funded services?	
Include maternity kick payments.	Did you include maternity kick payments? Where these on your managed care file, or did you have to select them from another data source?	
Include PACE payments.	Did you include PACE capitation payments? Where these on your managed care file, or did you have to select them from another data source?	
Data do not include gross payments (non-beneficiary specific) to providers.	How did you eliminate gross payments in your programming? Review the highest paid amounts in your data to be sure they are beneficiary-level payments.	
Zero-paid claims and denied claims are included in the data.	In your state, can managed care claims be denied or zero paid? Count the number of zero-paid claims and denied claims. Are you including them? Do your denied claims have payment amounts greater than \$0?	
All required fields are included and each field is populated with a value.	Review instruction appendix for list of required fields. Are there any missing values for any of the fields? Have you included the data dictionary for any state-specific fields?	

Identification of Potential Data Discrepancies or Other Information: *Please indicate whether there have been any major changes since the last quarter (e.g., introduction of a large managed care program, significant benefit changes or limitations introduced this quarter) that substantially impact the total dollars in the universe or distribution of dollars by claim type, compared to previous quarters. If possible, provide an estimate of the impact of the changes (e.g., 10% decrease in overall FFS spending in Q3). Also, please use this space to share other important information about your data submissions.*