



**PERM FFY 2010**

**Medicaid Universe Data**

**Submission Instructions**

## Table of Contents

Section 1: Overview.....	4
Introduction.....	4
Universe Development and Submission Timeline.....	5
Section 2: PERM Medicaid Universe Specifications.....	9
Defining the PERM Universes.....	9
Data Sources.....	9
Identifying a Payment Record.....	12
Sampling Unit.....	12
Beneficiary-Specific Payments Only.....	12
Original Paid Claims.....	13
Denied and Zero-Paid Claims.....	14
Assigning Sampling Units to the PERM Program Areas.....	15
Medicaid vs. CHIP.....	16
FFS vs. MC.....	16
Identifying Payment Level.....	18
Universe Fields.....	22
FFS Program Area Variables.....	24
Fixed Premium Payment Variables.....	29
MC Program Area Variables.....	34
Data Quality and Layout Requirements.....	39
Data Quality.....	39
Comparison to CMS-64 Financial Reports.....	41
Section 3: Data Transmission & Security.....	45
Submission Media.....	45
Submission Formats.....	45
Transmission Cover Sheet and Quality Control Verification.....	45
Privacy.....	46
Data Transmission.....	46
Requirement to meet FIPS 140-2 Standards.....	46
Section 4: After the Universe Submission -Next Steps.....	50
Universe Data Quality.....	50
Sampler.....	50
PERM ID.....	50
Sample FFS Details.....	50
Adjustments (New for FY10).....	51
Glossary.....	53
Definitions.....	53
<b>Appendix A: Treatment of Paid Date for Universe Selection.....</b>	<b>57</b>
<b>Appendix B: Fields for Universe Submission.....</b>	<b>59</b>
<b>Appendix C: Data Transmission Cover Sheet and Quality Control Verification.....</b>	<b>63</b>
<b>Appendix D: An Example of the “Base” Financial Comparison Workbook.....</b>	<b>69</b>

# **Section One**

# **OVERVIEW**

# Section 1: Overview

## *Introduction*

Your state has been selected to participate in the review of improper payments in Medicaid under the Payment Error Rate Measurement (PERM) program for Federal Fiscal Year (FFY) 2010. Livanta LLC, the Statistical Contractor (SC), will work closely with your state program staff to ensure the accuracy and completeness of the Medicaid universe data submission.

These instructions serve as a tool to assist states with the development and submission of the PERM FFY 2010 Medicaid universe data. We encourage each state to ask questions early and often throughout the PERM process. This will certainly help us make sure the universes are compliant with the PERM requirements.

To facilitate the proper flow of the PERM process, states will need to identify and involve appropriate staff persons as members of their PERM team. The team should consist of program, policy, technical, and financial staff. Be certain to have members on your PERM team who understand issues such as:

- Program structure: Medicaid/Medicaid expansion, Managed Care (MC) program structure and payment mechanisms, reimbursement policies involving at-risk, partial risk, or cost reconciliation arrangements, state-only funded programs adjudicated in Medicaid Management Information System (MMIS)
- Data sources: MMIS, Health Insurance Premium Programs (HIPP), vendor data, other state agencies, county-paid services
- Technical aspects of claims adjudication: treatment of adjustments, denied/voided/rejected claims
- Choosing the correct variables for PERM purposes: reimbursement amounts for services matched with certified public expenditures, application of co-pays, original paid date
- Budget and finance: claims used to complete the federal matching fund reports, particularly the quarterly CMS-64 Financial Reports

Please carefully read each section of these instructions to understand what should be included and excluded from your PERM universe data submission. In addition, make certain that each PERM team member receives a copy and has reviewed these instructions. At the end of these instructions, 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. Should you have any questions or problems submitting your FFY 2010 Medicaid universe data, please email us at [FY10PERMSC@Livanta.com](mailto:FY10PERMSC@Livanta.com) or call 240-568-9434.

Livanta SC looks forward to working with your state staff before and after submission of your FFY 2010 Medicaid universe data.

***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 program deadlines, it is important to begin universe development now! For FFY, Quarter 1 (Q1), much of your state’s activity is concentrated in November and December. However, in January and February your state will likely be in frequent contact with staff at Livanta SC, as we quality control check your Q1 universe data submissions and resolve any questions.

<b>FFY 10 Data Submission Timeline</b>		
<b>Date</b>	<b>Your State Responsibility</b>	<b>Livanta SC Responsibility</b>
<b>September 2009</b>	<ul style="list-style-type: none"> <li>• Develop PERM Team</li> <li>• Complete Data Survey</li> <li>• Schedule Orientation/Education session and one-on-one Personalized Requirements Teleconference Call (PRTC)</li> </ul>	<ul style="list-style-type: none"> <li>• Send Data Survey</li> <li>• Schedule Orientation/Education sessions and PRTCs</li> </ul>
<b>October 2009</b>	<ul style="list-style-type: none"> <li>• Participate in Orientation/Education session</li> <li>• Participate in PRTC</li> <li>• Review Medicaid Universe Data Submission Instructions</li> <li>• Identify data sources and classify into PERM universes</li> <li>• Code programs to provide universe data</li> </ul>	<ul style="list-style-type: none"> <li>• Send Medicaid Universe Data Submission Instructions</li> <li>• Receive Data Survey from State and tailor Orientation/Education and PRTCs based on survey responses</li> <li>• Schedule and Conduct Orientation/Education sessions</li> <li>• Schedule and Conduct PRTCs</li> </ul>
<b>November 2009</b>	<ul style="list-style-type: none"> <li>• Participate in Orientation/Education session</li> <li>• Participate in PRTC</li> <li>• Identify data sources and classify into PERM universes</li> <li>• Code and Test programs to provide universe data</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct Orientation/Education sessions</li> <li>• Conduct PRTCs</li> </ul>

### FFY 10 Data Submission Timeline

Date	Your State Responsibility	Livanta SC Responsibility
<b>December 2009</b>	<ul style="list-style-type: none"> <li>Identify data sources and classify into PERM universes</li> <li>Code and test programs to provide universe data</li> <li>Prepare to deliver universe data for Q1 to Livanta SC</li> </ul>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>
<b>January 2010</b>	<ul style="list-style-type: none"> <li><u>Q1 universe data due</u> January 15, 2010 to Livanta SC</li> </ul>	<ul style="list-style-type: none"> <li>Receive <u>Q1 universe data</u> January 15, 2010</li> <li>Perform QC of <u>Q1 universe data</u> and provide feedback to States</li> </ul>
<b>February 2010</b>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>
<b>March 2010</b>	<ul style="list-style-type: none"> <li>Submit details for Q1 sampled data</li> </ul>	<ul style="list-style-type: none"> <li><u>Draw sample from Q1 universe data</u></li> </ul>
<b>April 2010</b>	<ul style="list-style-type: none"> <li><u>Q2 universe data due</u> April 15, 2010 to Livanta SC</li> <li>Submit details for Q1 sampled data</li> </ul>	<ul style="list-style-type: none"> <li><u>Receive Q2 universe data</u> April 15, 2010</li> <li>Perform QC of <u>Q2 universe data</u> and provide feedback to States</li> </ul>
	<ul style="list-style-type: none"> <li>Medical and data processing reviews begin</li> </ul>	<ul style="list-style-type: none"> <li>Medical and data processing reviews begin</li> </ul>
<b>May 2010</b>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>	<ul style="list-style-type: none"> <li><u>Draw sample from Q2 universe data</u></li> </ul>
<b>June 2010</b>	<ul style="list-style-type: none"> <li>Submit details for Q2 sampled data</li> </ul>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>
<b>July 2010</b>	<ul style="list-style-type: none"> <li><u>Q3 universe data due</u> July 15, 2010 to Livanta SC</li> <li>Submit details for Q2 sampled data</li> </ul>	<ul style="list-style-type: none"> <li><u>Receive Q3 universe data</u> July 15, 2010</li> <li>Perform QC of <u>Q3 universe data</u> and provide feedback to States</li> </ul>
<b>August 2010</b>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>	<ul style="list-style-type: none"> <li><u>Draw sample from Q3 universe data</u></li> </ul>
<b>September 2010</b>	<ul style="list-style-type: none"> <li>Submit details for Q3 sampled data</li> </ul>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>
<b>October 2010</b>	<ul style="list-style-type: none"> <li><u>Q4 universe data due</u> October 15, 2010 to Livanta SC</li> <li>Submit details for Q3 sampled data</li> </ul>	<ul style="list-style-type: none"> <li><u>Receive Q4 universe data</u> October 15, 2010</li> <li>Perform QC of <u>Q4 universe data</u> and provide feedback to States</li> </ul>
<b>November 2010</b>	<ul style="list-style-type: none"> <li>Continue Tasks</li> </ul>	<ul style="list-style-type: none"> <li><u>Draw sample from Q4 universe data</u></li> </ul>

### FFY 10 Data Submission Timeline

Date	Your State Responsibility	Livanta SC Responsibility
<b>December 2010</b>	<ul style="list-style-type: none"> <li>• Submit details for Q4 sampled data</li> </ul>	<ul style="list-style-type: none"> <li>• Continue Tasks</li> </ul>
<b>January 2011</b>	<ul style="list-style-type: none"> <li>• Submit details for Q4 sampled data</li> </ul>	<ul style="list-style-type: none"> <li>• Continue Tasks</li> </ul>
<b>February – July 2011</b>	<ul style="list-style-type: none"> <li>• Medical and data processing reviews continue</li> </ul>	<ul style="list-style-type: none"> <li>• Medical and data processing reviews continue</li> </ul>
<b>August 2011</b>	<ul style="list-style-type: none"> <li>• Continue Tasks</li> </ul>	<ul style="list-style-type: none"> <li>• Calculate national and state error rates for Medicaid</li> </ul>
<b>November 2011</b>	<ul style="list-style-type: none"> <li>• Error rate results published</li> </ul>	<ul style="list-style-type: none"> <li>• Error rate results published</li> </ul>

**Section Two**  
**PERM MEDICAID**  
**UNIVERSE**  
**SPECIFICATIONS**

## Section 2: PERM Medicaid Universe Specifications

### *Defining the PERM Universes*

Each state submits quarterly Medicaid universe data to Livanta SC. Universe data files are essentially very long “lists” of all the Medicaid payment records that are matched with Title XIX federal funds and adjudicated by the state during the quarter. These payment records must include any payments that are zero-paid and denied claims. Each submitted 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 two program areas: Medicaid Fee-For-Service (FFS), and Medicaid Managed Care (MC).

<b>Two PERM Program Areas</b>
Medicaid Fee-For-Service
Medicaid 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 ensure that your sample is representative of your state’s payments, each payment matched with federal Medicaid (Title XIX) funds should have one chance, and only one chance, of being sampled for PERM review.

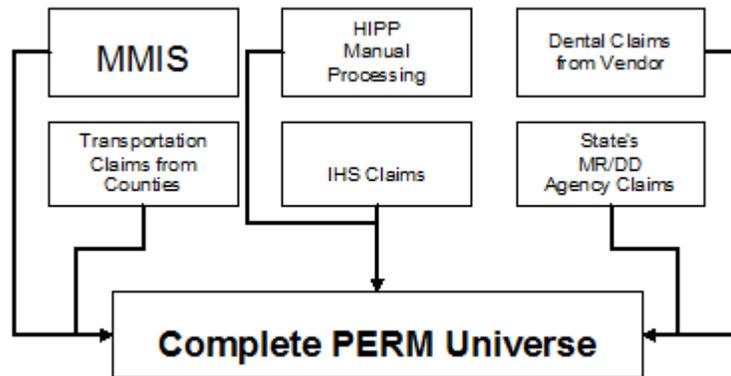
<p align="center"><b>PERM Rule:</b>  <u>All</u> payments matched with Title XIX funds <b>MUST</b>                  be included in the PERM universe.</p>
--

### *Data Sources*

States generally draw a majority of PERM universe data from their MMIS. However, there are often other important sources of data that contain payments matched with Title XIX 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 federally matched payments must be included in the universe data so that each has a chance to be sampled.

## PERM FFY 2010 Universe Data Submission Instructions

### Example X: 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!** Add other data sources that may contain payments matched with Title XIX funds. Below are some data considerations:

- MMIS (including archived, current, and separate tables)
- 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
- Community-based services (e.g., Peer Counseling Services)
- Stand-alone or “manual” systems
- HIPP payments
- Indian Health Service (IHS) clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC)
- Other systems that produce capitation payments (MC, Primary Care Case Management (PCCM), Non-Emergency Transportation (NET) capitations)

**Caution!** If your state uses a Data Warehouse or Decision Support System (DSS), the PERM universe files and subsequent details for sampled claims must come from the same data source.

## PERM FFY 2010 Universe Data Submission Instructions

To assess if your state is capturing all of the data sources, we ask you to “follow the money” and **review your state federal financial reports**. For Medicaid, review the data that populates your state’s CMS-64 Financial Report. If there are multiple data sources populating the table 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 Report to determine what should be included in the PERM universe.

***Caution!*** Remember that *not* everything processed in MMIS is matched with Medicaid funds! Do *not* include state-only funded services or services provided with financial funds from any federal programs other than Title XIX in your PERM universe.

Do *not* include any services matched with Title XXI in your Medicaid universe. Pending the start of a FY 2010 CHIP measurement, these payments will be submitted in your CHIP universes and we will issue PERM FY 2010 CHIP Universe Data Submission Instructions to assist you in creating these universes.

States do *not* need to submit Medicare premium payments made on behalf of Medicaid beneficiaries. CMS is providing this data directly to PERM contractors for inclusion in the PERM universe.

### ***Data Sources – Key Points***

- All payments matched with Title XIX 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 Financial Reports.
- Do not include State-Only Funded Services.
- Do not include CHIP services in the Medicaid universe.
- Do not submit Medicare premium payments made on behalf of Medicaid beneficiaries.
- Within MMIS, be sure to review denied, archived, current, and separate tables to include zero and denied 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 payments to be included, determination of each payment level (i.e., claim header level or line item level), treatment of adjustments, and inclusion of denied and zero-paid claims.

### **Sampling Unit**

States must provide universe data at the “sampling unit” level. The smallest individually priced unit paid for a beneficiary is a sampling unit. Each record submitted in the universe is a separate sampling unit.

### **Beneficiary-Specific Payments Only**

#### **What is in...**

All payments included in the PERM universe are submitted at the beneficiary level. Generally this means that you can tie each of these payments to a specific person’s name.

In addition to regular FFS (indemnity) claims, payments made by the state on behalf of beneficiaries are also included in the PERM universe. These include payments such as MC premiums, PCCM, HIPP, and NET payments.

Although gross payments are *not* included in PERM, please note that some aggregate payments or lump sum 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 need to 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 must be included in the PERM universe.

#### **What is not in...**

Gross payments for which the individual beneficiary cannot be identified from any data source are *not* included in PERM

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 beneficiaries, drug rebate reconciliations, and payments for federally matched administrative services for operational costs. 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 a Managed Care Organization (MCO) for services covered under a MC 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 MC 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 FQHCs 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 FFS universe submission.

Beneficiary-Specific Payments?	
Yes! Include in PERM Universe	No! Do Not Include in PERM Universe
<ul style="list-style-type: none"> <li>Regular FFS (indemnity payments)</li> </ul>	<ul style="list-style-type: none"> <li>Disproportionate Share Hospital (DSH) payments</li> </ul>
<ul style="list-style-type: none"> <li>Managed Care premiums/capitated payments</li> </ul>	<ul style="list-style-type: none"> <li>Grants to state agencies, local health departments, and non-profit providers</li> </ul>
<ul style="list-style-type: none"> <li>Other Fixed Premium Payments such as PCCM, NET capitation</li> </ul>	<ul style="list-style-type: none"> <li>Drug rebate reconciliations</li> </ul>
<ul style="list-style-type: none"> <li>Health Insurance Premium Payments (HIPP)</li> </ul>	<ul style="list-style-type: none"> <li>Encounter data for which no payment is made (while beneficiary-specific, these are not payments)</li> </ul>

**Aggregate Payments**

If your state makes aggregate payments matched by Title XIX funds based on a roster, you will need to create individual beneficiary-specific payment records for submission of your state’s PERM universes.

**Original Paid Claims**

Only original claims/payments that have been adjudicated to a paid or denied status should be included in the universe data submission. No adjustments can be included in the universe. Examples of situations in which the record is not considered an original payment are adjusted records, replacement payments, voids, and retroactive or eligibility rate adjustments that replace the original payment.

**Treatment of Adjustments**

Since the 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 identified 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 10/1/2009 for \$100. The provider submits an adjustment to correct the billed amount on 10/5/2009 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

## PERM FFY 2010 Universe Data Submission Instructions

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 12/1/2009 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 must 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 Livanta SC, should 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, 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***

- All payment records submitted must be at the beneficiary level.
- 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.
- Each unique payment should be represented only once in a universe file, and must be included in only one universe file.
- Select only original paid claims. No adjustments or replacement payments.
- Include denied and zero-paid claims.
- Be sure the following are excluded from the PERM universe:
  - State-only funded services or services not matched with Title XIX 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
  - Zero paid informational lines for clinic data
  - Encounter data not representative of actual payments
- While you do *not* have to submit the universe data for Medicare Part A and Part B payments, they will be included in your PERM FFS universe for sampling.

***Assigning Sampling Units to the PERM Program Areas***

For each quarter, states will submit up to two Medicaid PERM universe program areas to Livanta SC. Each of these files includes data for one of the two PERM program areas: Medicaid FFS and Medicaid MC. During the Personalized Requirements Teleconference Call (PRTC) with Livanta SC, we will discuss your state’s Medicaid structure. Please let Livanta SC know if your state is *not* planning to submit data for one of these program areas (e.g., “we are *not* submitting

## PERM FFY 2010 Universe Data Submission Instructions

data for Medicaid MC because we do *not* have MC in our state). Also, please use Livanta SC as a resource if you have questions when dividing claims and payments between FFS and MC.

Two PERM Program Areas
Medicaid Fee-For-Service <ul style="list-style-type: none"><li>• FFS Claim</li><li>• FFS Fixed Payment</li></ul>
Medicaid Managed Care

### Medicaid vs. CHIP

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

When selecting claims for the Medicaid universes, claims should be categorized based on 1) the federal money source, *not* the program design, and 2) time the claim is paid (adjudicated), *not* what the beneficiary's eligibility status is at the time the data is selected. *Therefore, payments for Medicaid expansion-type CHIP programs or Medicaid expansion groups, which are matched by Title XXI FFP, should not be included in Medicaid universes.*

Do *not* include any services matched with Title XXI in your Medicaid universe. Pending the start of a FY 2010 CHIP measurement, these payments will be submitted in your CHIP universes as directed in the PERM FY 2010 CHIP Universe Data Submission Instructions.

**Note:** When states have a single MC program serving both Medicaid and CHIP populations, the capitation payments must be separated into the Medicaid universe based on the federal program providing the match.

**PERM Rule:**  
"Follow the Money"  
When you creating your Medicaid universes, follow the money, not the program structure. For PERM purposes, payments matched by Title XIX = Medicaid. Payments matched with Title XXI (CHIP), Title 5, State-only funds, or other funding sources are not in the Medicaid universe.

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 CHIP. Again, "follow the money"! Look at how a claim is listed on the federal reporting forms (e.g., CMS-64, CMS-21).

### FFS vs. MC

When compiling the PERM universe files, states will also need to evaluate their claims and payments and indicate if the claim belongs in the FFS or MC universe files.

## PERM FFY 2010 Universe Data Submission Instructions

For purposes of the PERM program, the FFS universe file includes FFS claims (indemnity claims) as well as Fixed Premium Payments made on behalf of beneficiaries. Fixed Premium Payments include PCCM, HIPP, NET payments (if *not* made on a per trip FFS claim basis), and fixed beneficiary-specific pharmacy dispensing fees (e.g., if a state pays nursing home pharmacies a monthly fixed amount per beneficiary).

Payments classified in the FFS universe *must* be beneficiary-specific. Claim-specific payments made to MCOs to reimburse the MCO for services rendered are provided outside of the capitated benefit package. For example, one state's MCOs pay pharmacy providers for HIV/AIDS drugs. However, the cost of HIV/AIDS drugs is *not* included in the capitation rate. To reimburse the MCOs for the cost of the drugs, the MCOs submit beneficiary-specific claims to the state. Consequently, these services are paid on a pass through FFS basis by the state to the MCO. These claims should be included in the PERM FFS universe, even though the pay-to-provider is a MCO.

For the purposes of the PERM program, Livanta SC recognizes that there is great variety in states' MC models and provider reimbursement methods. The Livanta SC team will discuss your specific programs with you.

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

The MC universes include regular capitation payments to full-risk and partial risk MCOs, including specialty MC (e.g., behavioral health or dental plans) and the Program of All-Inclusive Care for the Elderly (PACE) payments. The MC universe should also include special payments made to MC plans on behalf of individual MC enrollees. These may include maternity lump sum payments ("kick" payments) or other supplemental payments, and individual reinsurance or stop-loss payments. These types of payments will be discussed in detail with Livanta SC to determine the appropriate universe for your state's universe data submission.

Additionally, if an MCO 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 payments should also be treated as MC. This approach relates to those programs for which cost reconciliation is accomplished well after the period of service delivery.

Some Medicaid programs purchase full-risk indemnity (FFS) coverage for enrollees, usually because of a lack of MC 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 MC universe. **No double counting! Each payment in the PERM universe files must be assigned to FFS or MC, *not* both!**

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

If the state pays a network access fee or a management fee to a MCO, and then reimburses the MCO for each encounter, these encounter 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.

FFS or MC?	
<u>FFS</u> Include in FFS PERM Universes	<u>MC</u> Include in MC PERM Universes
<ul style="list-style-type: none"> <li>• Regular FFS (indemnity payments)</li> <li>• PCCM payments</li> <li>• Payments made to MCOs or other insurers through HIPP programs</li> <li>• NET payments</li> <li>• FFS payments for benefits carved out of a MC capitation rate</li> <li>• Fixed beneficiary-specific pharmacy dispensing fees</li> </ul>	<ul style="list-style-type: none"> <li>• MC capitation payments</li> <li>• Specialty MC capitation payments (behavioral health, dental)</li> <li>• PACE payments</li> <li>• Maternity/delivery kick payments (if not paid on a FFS basis)</li> </ul>

**Note:** If your state’s MC program includes individual beneficiary-level reinsurance or stop-loss payments, please discuss with Livanta SC where these payments should go.

***Assigning Sampling Units to the PERM Program Areas – Key Points***

- There are two Medicaid PERM program areas: Medicaid FFS and Medicaid MC.
- Each claim or payment should be defined into one, and only one, of the two PERM program areas.
- “Follow the Money!” When determining your Medicaid universe, claims must be categorized based on the federal money source, not the program design, and the time the claim is paid (adjudicated), not what the beneficiary’s eligibility status was at the time the data was selected.
- Payments for Medicaid expansion-type CHIP programs or Medicaid expansion groups that are matched by Title XXI FFP should not be included in the Medicaid universe.
- Discuss your MC models and provider reimbursement methods with Livanta SC.

***Identifying Payment Level***

States must provide universe data at the “sampling unit” level. The smallest individually priced unit paid for a beneficiary is a sampling unit. Each record submitted in the universe is a separate sampling unit. A *Header level* sampling unit has a paid amount that is not associated with any specific line or service; rather, it is based on days, groups of services and/or other related information, encounter rates, or point of sale transactions. A *Line level* sampling unit has a paid

## PERM FFY 2010 Universe Data Submission Instructions

amount on the record for a specific service. A *Fixed or Premium Payment* is a FFS sampling unit that is a single payment record for a recipient that is *not* associated with a specific service.

If the payment amount is adjudicated at the claim level, the payment level is at the claim or “header” level. If a payment is adjudicated at the line item or “detail” level, the line item is the payment level. For Fixed Premium Payment, the payment level has a paid amount on a payment record.

Each sampling unit is one record in the universe. H-level records reflect the paid amount for the total claim; L-level records reflect the paid amount for the line item; and a P-level is a single Fixed Premium Payment.

**Note:** If there is one payment made for the claim, regardless of the number of lines or where the payment is carried in your system, it is a header level payment. If each line in a claim stands the chance of being paid or denied individually, these are line level payments.

Accurate identification of the payment level is important to the entire PERM process for a variety of reasons:

- If the wrong level is identified, your universe data will have too many or too few records to sample, thus creating a statistically invalid universe and sample. (e.g., submit 5 L-level lines for a claim rather than a single H-level record.)
- Header and Line level FFS payments require record review; Fixed Premium Payments do *not* undergo medical record review, only data processing review. If a Fixed Premium Payment is identified as an L-level or H-level payment rather than a “P” Fixed Premium Payment, a record will be requested for a payment that is *not* supported by a medical record/documentation and does *not* require record review in PERM.
- All downstream PERM contractor systems have processing and procedures based on the level at which the payment was sampled.
- The PERM ID incorporates the payment level as part of the identifier structure. If the level has to change, then the PERM ID assigned to the sample must also be changed and reconciled throughout all PERM contractors.

### Header Level

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 total computable amount paid for the entire claim. If the state determines that the sampling unit is the header, **do *not* include the records for the detail lines associated with the header in the PERM universe** (often these are zero-paid lines). Similarly, if the inpatient stay is priced as an all-inclusive per diem payment amount, the sampling unit would be at the claim header level.

PERM FFY 2010 Universe Data Submission Instructions

Example of Header Level Record						
Payment Level	Claim Type	ICN	Line Number	Date Paid	Amount Paid	Service Code
H	Inpatient	12345678	0	10/1/2009	\$1000.00	DRG

When submitting an H-level record, the line number is not included (Submitted as 0).

Line 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 total computable 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. For example, a procedure code having 2 units should *not* be made into 2 records of one unit each.

Example of Line Level Record						
Payment Level	Claim Type	ICN	Line Number	Date Paid	Amount Paid	Service Code
L	Physician	12345678	1	10/1/2009	\$10.00	HCPCS
L	Physician	12345678	2	10/1/2009	\$15.00	HCPCS
L	Physician	12345678	3	10/1/2009	\$20.00	HCPCS

When submitting an L-level record, the line number is important.

Fixed Premium Payments

Fixed Premium Payments (FP) are made by a Medicaid agency to other insurers or providers for premiums or eligible coverage, *not* for a particular service. For example, some states have PCCM programs where providers are paid a monthly patient management fee of \$3.50 for each eligible participant under their care. This fee is considered a Fixed Premium Payment.

Example of Fixed Payment Record						
Payment Level	Claim Type	ICN	Line Number	Date Paid	Amount Paid	Service Code
P	PCCM	12345678	0	10/1/2009	\$3.00	HCPCS

FP's are single payment records (Line number submitted as 0).

### Troubleshooting: Identifying Payment Level

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.

*FQHC and RHC payments, Medicare crossover claims, and payments made to state-owned facilities:* These payments have been problematic in past PERM years. Information or utilization lines that do not represent a paid or denied adjudicated amount 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.

*Clinics:* The payment methodology for the clinic is what determines the payment level, not how the payment is stored in the system. For example, if an FQHC pays using an all-inclusive encounter rate, and requires that the provider also submit the services as informational lines, then the record in the system may contain five lines. In some systems, the all-inclusive payment may be stored on any of the lines, and the remaining lines are paid a zero amount. The payment methodology; however, is still considered a header-level payment.

Some states may also pay services outside of the encounter rate, and these lines are also included in the clinic claim, but are individually paid or denied, which is considered a line-level payment.

To simplify the universe data submission process, states should examine each line in their clinic claim and perform the following analysis:

- If the line is part of an encounter rate, the line should be marked with an ‘E’ for Encounter in the payment level.
- If the line is not part of the encounter rate, but is individually paid or denied, it should be marked with an ‘L’ in the payment level for line-level.
- If the line is not part of the encounter rate, but is a premium payment made on behalf of an individual, it should be marked with a ‘P’ in the payment level for fixed payment.
- Exclude any line that is not matched with Title XIX funds.
- You may submit your universe for clinic claims with the payment levels marked as indicated above, or you may continue with removing informational lines from all ‘E’ records in the claim:
  - Determine how the encounter payment line can be identified (e.g., T1015 procedure code, D9999 procedure code, separate status indicator, etc.)
  - Each encounter line will be examined to remove informational lines (‘E’ records with a payment amount of zero that are not the encounter payment record).
  - Change the payment level from ‘E’ to ‘H’.

PERM FFY 2010 Universe Data Submission Instructions

Example of All-Inclusive Clinic Claim						
Payment Level	Claim Type	ICN	Line Number	Date Paid	Amount Paid	Service Code
E	Clinic	12345678	1	10/1/2009	\$0.00	HCPCS
E	Clinic	12345678	2	10/1/2009	\$135.00	T1015
E	Clinic	12345678	3	10/1/2009	\$0.00	HCPCS
L	Clinic	12345678	4	10/1/2009	\$15.00	HCPCS

Each clinic payment methodology will be discussed in detail with you to determine the best way to submit these records in the universe.

**PERM Rule:**  
 A sampling unit should never be represented multiple times within a universe file, or included in more than one universe file. (The same sampling unit identifier *cannot* be repeated.)

***Universe Fields***

In this section we review the fields or variables for the PERM universe data. There are three standardized formats for submitting PERM universe data: FFS claims, FFS Fixed Premium Payments, and MC. As an aid for programming, a comparison of the fields in all three layouts is provided in Appendix B.

There are two “paths” for submitting your universes and details:

**Universe Path:** For FFS claims, we require few fields. An extract is submitted for the universe and additional fields for only the selected sample will be requested later.

**Universe/Details Path:** For FFS Fixed Premium Payments and the MC program area, more fields in the universe file are required. The fields, however, also represent details, so no details will be required after sample selection.

Since every state’s field sizes and types are different, the state must provide documentation of the actual layout of each universe file submitted.

The data is requested in the sequence and formats shown in Appendix B. However, it is more important to include all requested fields than to strictly adhere to either the sequence or the formats. If variations or additions are necessary, they need to be included in the state record layout returned with your universe data submission files.

## PERM FFY 2010 Universe Data Submission Instructions

Although you may have multiple data sources and have data extracts in several different layouts, you must consolidate all data into a single standardized format before submitting the universe to Livanta SC.

If any fields are not applicable to your state, and you have agreed with Livanta SC that these fields do not need to be provided, you must do two things:

1. Include the field in the record, but leave it blank
2. Document the reason the field is not being provided in the data dictionary or record layout

When combining files, be careful of differing data types and field lengths that can cause field truncations and missing data.

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

Refer to Appendix B for a table of required Fee-For-Service claim fields, FFS Fixed Premium Payments, and MC fields.

## ***FFS Program Area Variables***

### **ICN (Required)**

- Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For most states, this identifier is ICN (TCN or DCN), and for line level payment records, the ICN and line number. If the ICN/Line Number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used.

If additional fields are necessary to uniquely identify the sampling unit, then those fields must be included in the universe and identified to Livanta SC. For example, if a service code is necessary to distinguish between two PCCM fixed payment records paid on the same day, then the unique sampling identifiers for that record are ICN (required field), Date Paid (required field) and Benefit Type code (added user field).

When combining data from various claims processing or data base systems, first validate that the sampling unit 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 beneficiary, payment type, payment date, and date of service.

No combination of these fields can appear in the universe data more than once.

Batch ICNs should *not* be included in your universe. If your state only has batch ICNs, please discuss with Livanta SC what other fields can be used to uniquely identify the record.

Your state may opt to send additional fields in the user-defined fields to help Livanta SC or the state uniquely identify or locate claims following sampling. Please discuss any additional variables with Livanta SC prior to data submission.

#### **PERM Rule: Unique Sampling Unit**

How do you uniquely find the sampling unit?  
Give us the combination of fields that makes  
the record completely unique.

### **Line Item Number (Required)**

- Line numbers should be submitted as they will be seen in the system by the Review Contractor (RC).
  - If informational lines are removed from the universe, do *not* renumber the line numbers.
  - If non-standard line numbering is used, please let Livanta SC know how your state handles each unique situation.
  - If the state starts line numbers with zero, we ask that you let Livanta SC know in which claim types that case applies.

## PERM FFY 2010 Universe Data Submission Instructions

- For Header level payment records, default the line number to zero.

### Claim Type (Required)

- 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.

Provide documentation to Livanta SC that indicates how to identify Medicare crossovers in your data, if crossovers are NOT identified by claim type. This is important for Livanta SC's quality control process! You may add fields as necessary to identify these payments.

***Remember!*** The state must provide Livanta SC with a data dictionary for the state-defined identifiers such as claim type and provider type.

### Payment Status (Required)

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

### Date Paid (Required)

#### **PERM Rule: Date Paid**

The Date Paid should reflect the date the claim was approved for payment and/or adjudicated (if denied). We are not looking for the check date.

- Sampling units are selected for inclusion in each quarter's data only if the original date paid falls within the federal fiscal quarter. This is regardless of the date of any subsequent adjustments. See Appendix A for illustrations of the selection criteria for paid/adjudication dates and paid amounts.

<b>Federal Fiscal Quarters</b>	
<b>FFY 2010</b>	<b>Date Paid</b>
Q1	October 1 – December 31, 2009
Q2	January 1 – March 31, 2010
Q3	April 1 – June 30, 2010
Q4	July 1, 2009 – September 30, 2010

### Total Computable Amount Paid (Required)

- The amount paid must meet all 4 of the following regulations:
  - 1) *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

## PERM FFY 2010 Universe Data Submission Instructions

the **original amount paid** for the individual sampling unit that is paid to the provider. The universe includes zero-paid claims and line items.

- 2) *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.
- 3) *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.
- 4) *Net Amount Paid:* Amount paid should *not* include non-reimbursed dollars due to patient liability (co-pays or contribution to care) or third-party liability (TPL).

### **PERM Rule: Amount Paid**

*“Follow the Money”*

When selecting an amount paid value, report costs as they are reported to CMS. Amount paid should be the Total Computable Amount and should not contain dollars paid by the beneficiary or other insurers.

#### Service Dates From and To (New for FY10, Optional)

- MM/DD/YYYY
- **Service From Date:** Beginning date of the service. If the sampling unit is paid at the header, this value should represent the claim beginning service date. If the sampling unit is paid at the line level, this value should represent the beginning service date for the detail line.
- **Service To Date:** End date of the service. If the sampling unit is paid at the header, this value should represent the ending service date for the claim. If the claim is paid at the line level, this value should represent the ending service date for the detail line.

#### Provider Number (New for FY10, Optional)

- Identifier of entity which received payment.

#### Provider Type (Required)

- Please submit your state’s provider type on each sampling unit. The state must also submit a data dictionary for the state-defined identifiers such as provider type.

#### Provider Specialty (New for FY10, Required)

- Please submit your state’s provider specialty associated with each sampling unit. The state should also submit a data dictionary which contains the descriptions for state-defined nomenclatures such as provider specialty.

## PERM FFY 2010 Universe Data Submission Instructions

### Payment Level (Required)

- An indicator of whether the claim is paid at the Header level or paid at the Line level.
- The field for each sampling unit can only contain one of the following:
  - H = Sampling unit paid at the Header level
  - L = Sampling unit paid at the Line level

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

*A Line level* sampling unit has a paid amount on the record for a specific service.

### Funding Code (Required)

- Indicates the funding source for the claim or claim line, and should be a data element or combination of data elements that indicates the payment is matched by Title XIX or Title XXI federal funds (e.g., Aid Code = 'A21', Fed Flag = '19'), or is state-only funded. Please provide a decode file if coded values are used.

### Place of Service (Required)

- The place of service code for the sampling unit. The state must provide Livanta SC with a data dictionary for state-defined identifiers such as place of service.

### Service Code (Required)

- For line level sampling units, provide the procedure (HCPCS, CPT, or local) code, revenue code, or NDC code. Should be provided for header level sampling units if paid by DRG or other grouped payment methodology.

### Service Code Type (Optional)

- An indicator that identifies the nomenclature of the service code. If possible, please use one of the standard service code nomenclature indicators:
  - 'P' - CPT or HCPCS code
  - 'R' - Revenue code
  - 'N' - NDC code
  - 'D' - DRG code
  - 'L' - Level of Care code
  - 'O' - Other Service Code Nomenclature

### Category of Service (Required)

- Classification for broad types of state/federal covered services.
- E.g. '13' - Inpatient, '24' - 'Skilled Nursing Facility, '42' - Lab/X-ray, '95' – Children's Mental Health Waiver. Please provide a decode file if coded values are used.

## PERM FFY 2010 Universe Data Submission Instructions

### Source Location (Required)

- The system of origin/location in which the sampling unit was adjudicated; should match the system from which the claim details will be provided and the system that the DP Reviewer will access to perform the review. Examples are 'STARDSP', 'NET', 'HEALTHY KIDS'; each is associated with a physical location of adjudication or claims processing system. The State should provide a crosswalk from the system to the location (e.g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State). Please provide a decode file if coded values are used.

### PERM State (Required)

- Two-character postal abbreviation for the state. Used for data tracking and control.

### Program Code (Required)

- Indicator of the program for universe file: Default to 'M' (Medicaid) or 'C' (CHIP). Used for data tracking and control.

### Sample Year (Required)

- Default to '10'. Used for data tracking and control.

### Sample Quarter (Required)

- Fiscal quarter for data. Default to '1' (Quarter 1), '2' (Quarter 2), '3' (Quarter 3), or '4' (Quarter 4). Used for data tracking and control.

### User Field 1 through User Field 5 (Optional)

- State supplied additional fields. If you populate these fields, please provide information on the meaning of the values in each field.

### ***Fixed Premium Payment Variables***

A *Fixed or Premium Payment* is a FFS sampling unit that is a single payment record for a recipient that is *not* associated with a specific service.

The state must submit their Fixed Premium Payment universe data (*not* Medicare Premium Payments) in a layout that contains all of the details necessary for the other PERM processes.

The following fields are required for FFS Fixed Premium Payment universes:

#### ICN (Required)

- Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For most states, this identifier is ICN (TCN or DCN), and for line level payment records, the ICN and line number. If the ICN/Line Number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used.

If additional fields are necessary to uniquely identify the sampling unit, then those fields must be included in the universe and identified to Livanta SC. For example, if a service code is necessary to distinguish between two PCCM fixed payment records paid on the same day, then the unique sampling identifiers for that record are ICN (required field), Date Paid (required field) and Benefit Type code (added user field).

When combining data from various claims processing or data base systems, first validate that the sampling unit 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 beneficiary, payment type, payment date, and date of service.

No combination of these fields can appear in the universe data more than once.

Batch ICNs should *not* be included in your universe. If your state only has batch ICNs, please discuss with Livanta SC what other fields can be used to uniquely identify the record.

Your state may opt to send additional fields in the user-defined fields to help Livanta SC or the state uniquely identify or locate claims following sampling. Please discuss any additional variables with Livanta SC prior to data submission.

**PERM Rule: Unique Sampling Unit**

How do you uniquely find the sampling unit?  
Give us the combination of fields that makes  
the record completely unique.

#### Line Item Number (New for FY10, Required)

- Since fixed premium payments are usually single records, line numbers are not expected, and can be defaulted to ‘0’. However, if the state’s processing system assigns line numbers to these payment records, they should be provided in the universe.

## PERM FFY 2010 Universe Data Submission Instructions

### Payment Type (Required)

- The type of payment for the payment record, such as Health Insurance Premium Payment (HIPP) or Primary Care Capitation Management (PCCM). Please provide a decode file if coded values are used.

### Payment Status (Required)

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

### Date Paid (Required)

#### **PERM Rule: Date Paid**

The Date Paid should reflect the date the claim was approved for payment and/or adjudicated (if denied). We are not looking for the check date.

- Sampling units are selected for inclusion in each quarter's data only if the original date paid 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.

<b>Federal Fiscal Quarters</b>	
<b>FFY 2010</b>	<b>Date Paid</b>
Q1	October 1 – December 31, 2009
Q2	January 1 – March 31, 2010
Q3	April 1 – June 30, 2010
Q4	July 1, 2009 – September 30, 2010

### Total Computable Amount Paid (Required)

- The amount paid must meet all 4 of the following regulations:
  - 1) *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.
  - 2) *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.

## PERM FFY 2010 Universe Data Submission Instructions

- 3) *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.
- 4) *Net Amount Paid:* Amount paid should not include non-reimbursed dollars due to patient liability (co-pays or contribution to care) or TPL.

### **PERM Rule: Amount Paid**

#### *“Follow the Money”*

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

#### Payment Period From and To (Required)

- MM/DD/YYYY
- Payment Period From Date: Beginning date of the coverage period this payment represents.
- Payment Period To Date: Ending date of the coverage period this payment represents.

For a covered month, default to the first and last day of the month, otherwise specify the first date and last date, even if it is a single date.

#### Provider Number (New for FY10, Required)

- Identifier of entity who received payment.

#### Provider Type (New for FY10, Required)

- The type of entity that received payment. The state must also submit a data dictionary for the state-defined identifiers such as provider type.

#### Provider Specialty (New for FY10, Optional)

- The provider or entity specialty associated with the sampling unit, if applicable and available. The state should also submit a data dictionary which contains the descriptions for state-defined nomenclatures such as provider specialty.

#### Payment Level (Required)

- An indicator that the claim is a Fixed Premium Payment. Please default to ‘P’.

#### Funding Code (Required)

- Indicates the funding source for the claim or claim line, and should be a data element or combination of data elements that indicates the payment is matched by Title XIX or Title

## PERM FFY 2010 Universe Data Submission Instructions

XXI federal funds (e.g., Aid Code = 'A21', Fed Flag = '19'), or is state-only funded. Please provide a decode file if coded values are used.

### Place of Service (New for FY10, Optional)

- The place of service code for the sampling unit, if applicable and available. The state must provide Livanta SC with a data dictionary for state-defined identifiers such as place of service.

### Service Code (New for FY10, Optional)

- The procedure (HCPCS, CPT, or local) code, revenue code, DRG, NDC code, or any other service code associated with the sampling unit, if available.

### Service Code Type (New for FY10, Optional)

- An indicator that identifies the nomenclature of the service code, if available. If possible, please use one of the standard service code nomenclature indicators:
  - 'P' - CPT or HCPCS code
  - 'R' - Revenue code
  - 'N' - NDC code
  - 'D' - DRG code
  - 'L' - Level of Care code
  - 'O' - Other Service Code Nomenclature

### Category of Service (Required)

- Classification for broad types of state/federal covered services, if available for FP.
- Please provide a decode file if coded values are used.

### Source Location (Required)

- The system of origin/location in which the sampling unit was adjudicated; should match the system from which the claim details will be provided and the system that the DP Reviewer will access to perform the review. Examples are 'STARDSP', 'NET', 'HEALTHY KIDS'; each is associated with a physical location of adjudication or claims processing system. The State should provide a crosswalk from the system to the location (e.g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State). Please provide a decode file if coded values are used.

### PERM State (Required)

- Two-character postal abbreviation for the state. Used for data tracking and control.

### Program Code (Required)

- Indicator of the program for universe file: Default to 'M' (Medicaid) or 'C' (CHIP). Used for data tracking and control.

### Sample Year (Required)

- Default to '10'. Used for data tracking and control.

## PERM FFY 2010 Universe Data Submission Instructions

### Sample Quarter (Required)

- Fiscal quarter for data. Default to '1' (Quarter 1), '2' (Quarter 2), '3' (Quarter 3), or '4' (Quarter 4). Used for data tracking and control.

### Recipient ID (Required)

- State identifier for recipient.

### Recipient Name (Required)

- Full name of the recipient, in the format of (Last, First MI); Livanta SC will add this if universe data contains three separate fields for recipient name.

### Recipient Date of Birth (Required)

- MM/DD/YYYY

### Recipient Gender (Required)

- Please provide a decode file if coded values are used.

### Recipient County (Optional)

- Please provide a decode file if coded values are used.

### Recipient Aid Category (Required)

- Eligibility Type. Please provide a decode file if coded values are used.

### User Field 1 through User Field 5 (Optional)

- State supplied additional fields. If you populate these fields, please provide information on the meaning of the values in each field.

### ***MC Program Area Variables***

The state must submit their MC universe data in a layout that contains all of the details necessary for the other PERM processes.

The following fields are required for MC payment universes:

#### ICN (Required)

**PERM Rule: Unique Sampling Unit**  
How do you uniquely find the sampling unit?  
Give us the combination of fields that makes the record completely unique.

- Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For most states, this identifier is ICN (TCN or DCN). If there is no ICN in the data, the state may need to create it. If the ICN alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used.

If additional fields are necessary to uniquely identify the sampling unit, then those fields must be included in the universe and identified to Livanta SC. For example, if benefit type is necessary to distinguish between two managed care payment records paid on the same day, then the unique sampling identifiers for that record are ICN (required field), Date Paid (required field) and Benefit Type (added user field).

When combining data from various claims processing or data base systems, first validate that the sampling unit 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 beneficiary, payment type, payment date, and date of service.

No combination of these fields can appear in the universe data more than once.

Your state may opt to send additional fields in the user-defined fields to help Livanta SC or the state uniquely identify or locate claims following sampling. Please discuss any additional variables with Livanta SC prior to data submission.

#### Line Item Number (New for FY10, Required)

- Since managed care payments are usually single records, line numbers are not expected, and can be defaulted to ‘0’. However, if the state’s processing system assigns line numbers to these payment records, they should be provided in the universe.

#### Payment Type (Required)

- Include a field to indicate the payment type such as monthly capitation, delivery kick payment, and individual reinsurance payment. Please provide a decode file if coded values are used.

## PERM FFY 2010 Universe Data Submission Instructions

### Payment Status (Required)

- Some states have “denied” payments for the MC universe; therefore, Livanta SC requires a paid or denied indicator in the MC universe files.

### Date Paid (Required)

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

MC 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).

#### **PERM Rule: Date Paid**

The Date Paid should reflect the date the claim was approved for payment and/or adjudicated (if denied). We are not looking for the check date or coverage period.

For PERM purposes, payments should be included in the quarter according to the date the payment was adjudicated, not the date or period for which the coverage was purchased.

*Prospective example:* If a capitation payment was made on December 25, 2009 for services in January 2010, the state should include the payment with the PERM Q1 data submission.

*Retrospective example:* If a capitation payment was made on October 5, 2009 for services in September 2009, the state should include the payment with the PERM Q1 data submission.

<b>Federal Fiscal Quarters</b>	
<b>FFY 2010</b>	<b>Date Paid</b>
Q1	October 1 – December 31, 2009
Q2	January 1 – March 31, 2010
Q3	April 1 – June 30, 2010
Q4	July 1, 2009 – September 30, 2010

### Total Computable Amount Paid (Required)

- Paid amount, for sampling purposes, is defined as the original amount paid for each sampling unit. (Even if a MCO 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.

## PERM FFY 2010 Universe Data Submission Instructions

### Coverage Period From and To (Required)

- MM/DD/YYYY
- Coverage Period From Date: Beginning date of the period of coverage this payment represents.
- Coverage Period To Date: Ending date of the period of coverage this payment represents.
- For a covered month, default to the first and last day of the month, otherwise specify the first date and last date, even if it is a single date.

### Provider Number (Required)

- Identifier of entity who received payment, generally an MCO

### Managed Care Program Indicator (Required)

- Include a field to indicate the program such as “TANF HMO”, PACE, LTC, Behavioral Health, Dental. Please provide a decode file if coded values are used.

### Provider Specialty (New for FY10, Optional)

- The provider or entity specialty associated with the sampling unit, if applicable and available. The state should also submit a data dictionary which contains the descriptions for state-defined nomenclatures such as provider specialty.

### Payment Level (New for FY10, Required)

- An indicator that the claim is a Managed Care Payment. Please default to ‘H’.

### Funding Code (Required)

- Indicates the funding source for the claim or claim line, and should be a data element or combination of data elements that indicates the payment is matched by Title XIX or Title XXI federal funds (e.g., Aid Code = 'A21', Fed Flag = '19'), or is state-only funded. Please provide a decode file if coded values are used.

### Place of Service (New for FY10, Optional)

- The place of service code for the sampling unit, if applicable and available. The state must provide Livanta SC with a data dictionary for state-defined identifiers such as place of service.

### Recipient Rate Indicator (Required)

- “Procedure code” or other rate cohort indicator. Please provide a decode file if coded values are used.

### Service Code Type (New for FY10, Optional)

- An indicator that identifies the nomenclature of the procedure or rate cohort code, if available. If possible, please use one of the standard service code nomenclature indicators:
  - 'P' - CPT or HCPCS code
  - 'R' - Revenue code

## PERM FFY 2010 Universe Data Submission Instructions

- 'N' - NDC code
- 'D' - DRG code
- 'L' - Level of Care code
- 'O' - Other Service Code Nomenclature

### Category of Service (New for FY10, Required)

- Classification for broad types of state/federal covered services, if available for MC. Please provide a decode file if coded values are used.

### Source Location (Required)

- The system of origin/location in which the sampling unit was adjudicated; should match the system from which the claim details will be provided and the system that the DP Reviewer will access to perform the review (e.g., 'PACE', 'MCO001', 'BHO'); state should provide a crosswalk from the system to the location, (e.g., 'MCO001' = City, State, 'MCO002' = Different City, State). Please provide a decode file if coded values are used.

### PERM State (Required)

- Two-character postal abbreviation for the state, used for data tracking and control.

### Program Code (Required)

- Indicator of the program for universe file: Default to 'M' (Medicaid) or 'S' (CHIP), used for data tracking and control.

### Sample Year (Required)

- Default to '09', used for data tracking and control.

### Sample Quarter (Required)

- Fiscal quarter for data; Default to '1' (Quarter 1), '2' (Quarter 2), '3' (Quarter 3), or '4' (Quarter 4), used for data tracking and control.

### Recipient ID (Required)

- State identifier for recipient.

### Recipient Name (Required)

- Full name of the recipient, in the format (Last, First MI); Livanta SC will add this if universe data contains three separate fields for recipient name.

### Recipient Date of Birth (Required)

- MM/DD/YYYY

### Recipient Gender (Required)

- Please provide a decode file if coded values are used.

## PERM FFY 2010 Universe Data Submission Instructions

### Recipient County (Optional)

- Please provide a decode file if coded values are used.

### Recipient Aid Category (Required)

- Eligibility Type. Please provide a decode file if coded values are used.

### Recipient Service Area Indicator (Optional)

- If the MC program's geographic service areas are *not* at the county level, indicate the recipient's service area and provide a decode file if coded values are used.

### User Field 1 through User Field 5 (Optional)

- State supplied additional fields. If you populate these fields, please provide information on the meaning of the values in each field.

## ***Data Quality and Layout Requirements***

### ***Data Quality and Layout Requirements***

**For FFY 2010, states are expected to have a greater role and new data submission responsibilities. To ensure the completeness and accuracy of the universe data, we have implemented the following changes:**

- States will need to adhere to standard submission layouts provided by Livanta. (Refer to Appendix B.)
- States will need to combine data from multiple sources into a single data submission file (e.g., Pharmacy, Institutional and Professional claims processed by separate systems must be submitted in a single universe file).
- States will need to supply Livanta SC with evidence of their comparison of the prior quarters' financial reports to the universe files submitted.
- States will need to complete a quality control checklist as part of the data submission process.
- Additional fields are included in the universe layout to help both the state and Livanta SC ensure the accuracy and completeness of each universe.

## **Data Quality**

### **Standardized Submission Format**

The standardized format means that you must account for every field requested as follows:

- Extract all of the fields that apply to your data
- Include place holders (blanks) for data that does *not* apply to your system
- Document fields provided or the reason why the field does *not* apply to your system

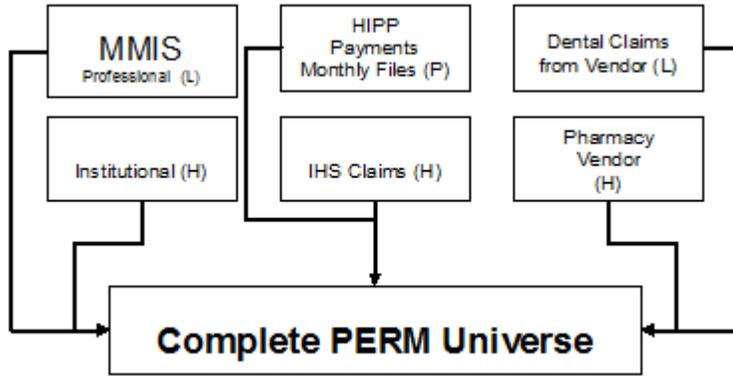
Standardized does *not* mean:

- Exactly the same sequence of fields (variables)
- The same data types or field lengths (alphanumeric, numeric, dates, money, text)
- The same column names (recip dob, Date of Birth, Bene Birth Dt)

**Combine Data Sources**

You must combine all data files from your multiple data sources into a single file, according to the payment level and payment type, and the layout associated with whether it is a FFS claim, FFS Fixed Premium Payment, or MC payment. An example of this is shown below:

**Example X: State’s Data Sources for PERM Universes**



*In this example, there will be two standard layouts- Fee-For-Service Claims and Fixed Premium Payments*

**Add Fields for Data Quality**

Several fields have been included in the universe layouts to help you ensure the accuracy and completeness of your universe data submission. You are encouraged to add state-specific fields to help you accomplish accuracy and completeness, if necessary.

**Run State-Specific Data Quality Reports**

Produce standard data quality reports and create state-specific universe quality control reports based on the information that is unique to your state which should also be included in the universe. Examples include:

- Universe Statistics
  - Claim type
  - Provider type
  - Payment level
  - Payment Status
  - Paid date
  - Mismatches: levels, paid amounts, claim types
  - Compare to State Transmission Sheet control totals
- Volume and dollar amount reports by
  - Claim type and Provider type or Category of service
  - Claim type and Payment status
- Trends by

## PERM FFY 2010 Universe Data Submission Instructions

- Claim type and payment level
- Paid date by month
- Provider type or Category of service

### **Review Data Transmission Quality Control Verification Checklists**

Refer to the M-FFS Checklist and M-MC Checklist tabs in the Data Transmission EXCEL Template For State. Refer to Appendix C for examples of the FFS and Managed Care Quality Control Verification Checklists.

Please provide to Livanta SC the fields and reports you used to validate your universe data.

### **Comparison to CMS-64 Financial Reports**

#### **Instructions**

- Comparison to CMS-64 Financial Reports

The CMS-64 Financial Report is the State's request for reimbursement for Medicaid (Title XIX) expenditures that is submitted to the Federal Government.

To assess if your state is capturing all of the data sources in your PERM universes, we ask you to "follow the money" and **review your state federal financial reports**. States are required to compare their Medicaid PERM universes to CMS-64 Financial Reports to ensure that the universes are complete and accurate. One valuable reason for comparing the universe data to the CMS Financial Reports is to ensure that no small or unusual programs (likely *not* in MMIS) that appear on the CMS Financial Reports have been omitted from the universe data.

CMS-64 Forms should be finalized 30 days after the end of the quarter. The PERM universe data submissions are due 15 days after the end of the quarter. States will therefore be required to compare a quarter's universe submission to the *two previous quarters'* CMS-64 Financial Reports. The table below describes the timeframe for which these reports are completed. For example: FY 2010 Q1 Universe Data Submission (Oct.-Dec., 2009) must be compared to Q3 (Apr.-June, 2009) and Q4 (July-Sept., 2009) Financial Reports.

<b>Universe Data Submission Timeframe</b>	<b>CMS-64 Financial Reports for Comparison</b>
FY10 Q1	FY09 Q3 & FY09 Q4
FY10 Q2	FY09 Q4 & FY10 Q1
FY10 Q3	FY10 Q1 & FY10 Q2
FY10 Q4	FY10 Q2 & FY10 Q3

- CMS-64 Financial Report Quality Control

## PERM FFY 2010 Universe Data Submission Instructions

As you begin to review and compare your state CMS-64 Financial Reports, it is imperative to understand the comparison methodology that will be used for quality control purposes.

For Quality Control (QC) purposes, when comparing to PERM data; be sure to exclude the following from your CMS-64 Financial Report totals:

- State only claims
- Claims *not* paid at the beneficiary level (for example DSH)
- Drug rebates
- Depending on the state, remove other amounts that should *not* be included in the PERM universe
- Payments from the prior quarter that are included because of timing
- Adjustment amounts provided by the state

Also be sure to include the following in your CMS-64 Financial Report totals:

- Any claims that should be in PERM but for some reason were *not* included on the CMS-64 Financial Reports (for example, claims under a certain amount)
- Payments recorded on the next quarter report because of timing

### **Methodology**

The CMS-64 Financial Reports have a lot of lines that basically break down the body of payments by some kind of service type, like inpatient hospital, outpatient, physicians and clinics, long-term care, and the like.

The general model of the payment processing system, usually an MMIS, is that a payment is made to either a provider or MCO for the benefit of a particular enrollee.

These payments from the MMIS are “rolled up” and summarized as entries on the reimbursement form.

There are quite a few payments that appear on the CMS-64 Financial Reports that don’t happen in the MMIS. You should identify where any non-MMIS payments might be found.

Determine what data elements and information in your state are necessary to compare the payments from the universe data to the CMS-64 Financial Reports. Then, compare the universe data submission information to the information in the two previous CMS-64 Financial Report quarters, noting any variances or unexpected trends. All significant variances should be researched and explained, and the results submitted to Livanta SC.

The analysis is a ballpark comparison. States should be looking for major dips or spikes or “significant” changes as defined by each state. In the results submitted to Livanta SC, the state should confirm that no programs that appear on the CMS Financial Reports have been omitted from the universe.

**Note:** If the payment is on the CMS Financial Report and qualifies for the PERM universe, it must be reflected in the universe data.

### **Submission Requirements**

## PERM FFY 2010 Universe Data Submission Instructions

States will submit their comparison results to Livanta SC at the time of their universe data submission.

### **Livanta SC Financial Comparison**

As a part of the QC process, Livanta SC will compare your universe data submission to the *same* quarter's CMS-64 Financial Reports. If there is a significant difference, your State will be asked to research and explain the variance.

The CMS-64 Financial Reports will be tailored to reflect grouping of lines on how each State claims its federal match, to the degree possible based on information produced by the State. An example of the "base" Financial Comparison workbook is contained in Appendix D.

**Section Three**  
**DATA**  
**TRANSMISSION**  
**& SECURITY**

## Section 3: Data Transmission & Security

This 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*

Livanta SC's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, portable hard drives). Livanta SC would prefer that states send their data via FTP. However, if this is *not* an option, we are prepared to accept your data on a CD or DVD.

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

### *Submission Formats*

The state will provide Livanta SC with up to three Medicaid universe files per quarter. The state should submit up to two files for the PERM FFS program areas: Medicaid FFS and Medicaid FFS Fixed Premium Payments. The state should submit one file for Medicaid MC.

States may provide universe data in one of three formats: SAS dataset, delimited file, or flat file.

- SAS dataset (preferred): a PC-based SAS dataset. If your state uses a PC-based SAS server or IBM mainframe, you may send claims data in a PC-based SAS dataset.
- Delimited file:: comma delimited (.csv) and tab delimited text (.txt) are the most common
- Flat file: a universal text format with a single fixed record length and layout (also called a "flat format" or "ASCII format") 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 at the bottom of the data file.*** (In fact, we prefer files in SAS.)

States must provide universe data in one of three layouts: FFS claims, Fixed Premium Payments (part of FFS universe), or MC payments.

States also must provide a data dictionary containing the definitions for any fields with state-defined values (e.g., payment type, funding code, MC program identifier).

### *Transmission Cover Sheet and Quality Control Verification*

Due to the large number of quarterly universe files that will be received from the states, Livanta SC ***asks that you 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 B. 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 [FY10PERMSC@Livanta.com](mailto:FY10PERMSC@Livanta.com) on the same day that the data is sent to Livanta SC.

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

- Record counts, by claim type, for each dataset

## PERM FFY 2010 Universe Data Submission Instructions

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

States must perform quality control checks on the universes prior to submitting the data to Livanta SC. 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.*** The transmission cover sheet must be signed. Involve your entire PERM team in reviewing the test results (not only the data or technical staff).

***From past 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 Livanta SC.

### ***Privacy***

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

### ***Data Transmission***

#### **Requirement to meet FIPS 140-2 Standards**

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

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

The preferred method of data transmission is via secure FTP. Since the site is secure and password protected, each file does not have to contain passwords.

#### **Livanta LLC Secure FTP Instructions**

The following instructions will help you install, authenticate, and send files to our location securely. Due to the sensitive nature of files being transferred, Livanta’s FTP service utilizes FTPS which is more secure. The FTP server Livanta uses has FIPS 140-2 validation.

## PERM FFY 2010 Universe Data Submission Instructions

With Federal Information Processing Standards (FIPS) 140-2 validation, our customers can transfer files knowing the embedded Cryptographic Module has met the highest possible security standards. This ensures that your file transfers are protected to the highest standards.

Client: First, you will need to download and install a secure FTP client. Please check with your security department to determine your standards.

Security: For security reasons, data that has been sent cannot be retrieved again. Please do *not* share your username or password with anyone and keep it confidential. To mitigate the risk of malicious software being introduced into our systems, the following file types have been blocked from being uploaded to our server:

\*.adp, \*.bas, \*.bat, \*.chm, \*.cmd, \*.com, \*.cpl, \*.crt, \*.dll, \*.exe, \*.hlp, \*.hta, \*.inf, \*.ins, \*.isp, \*.js, \*.jse, \*.lnk, \*.mdb, \*.mde, \*.msc, \*.msi, \*.msp, \*.mst, \*.ocx, \*.pcd, \*.pif, \*.pot, \*.reg, \*.scr, \*.sct, \*.shb, \*.shs, \*.sys, \*.url, \*.vb, \*.vbe, \*.vbs, \*.wsc, \*.wsf, and \*.wsh.

All data transmissions to Livanta must comply with HIPAA law and Privacy Rules. If you are unaware of what these are, please review them at <http://www.hhs.gov/ocr/hipaa>.

Connection Information for PERM SC FY10: Please contact Livanta SC for your specific connection information.

**Server:**

**Type:**

**Mode:**

**Username:**

### **Follow these Steps to FTP Data:**

- 1) Establish a secure FTP connection with Livanta LLC
- 2) Build a universe package with all files for each universe to be sent
- 3) Include Transmission Sheet and Data Dictionary documents with files
- 4) Zip all files into a single encrypted zip file
- 5) Email the Transmission Cover Sheet to Livanta LLC at [FY10PERMSC@Livanta.com](mailto:FY10PERMSC@Livanta.com) to indicate that the universe package is ready to FTP

### **Follow these Steps if Mailing Data:**

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

PERM FFY 2010 Universe Data Submission Instructions

Payment Error Rate Measurement Program  
Kathryn Fauth  
Livanta LLC  
PERM Statistical Contractor  
9175 Guilford Road, Suite 102  
Columbia, Maryland 21046

- 5) E-mail the transmission cover sheet and password(s) for the data to [FY10PERMSC@Livanta.com](mailto:FY10PERMSC@Livanta.com).

<b>Data Submission – Quick Checklist for Mailing Data</b>
Data file <ul style="list-style-type: none"><li>• SAS, Delimited, or Flat</li><li>• Zipped, encrypted, password-protected</li><li>• CD or DVD</li><li>• Disk labeled “CMS Sensitive Information”</li></ul>
File layouts (copied onto the CD/DVD or emailed)
Data dictionary for all state-defined fields (e.g., provider type, claim type), (copied onto the CD/DVD or emailed)
Transmission cover sheet (copied onto the CD/DVD or emailed) <ul style="list-style-type: none"><li>• QC checks performed on data</li><li>• Add record counts and payment amounts</li><li>• Additional information noted</li><li>• “Signed”</li></ul>
Package labeled “To be opened by addressee only”
Email password to <a href="mailto:FY10PERMSC@Livanta.com">FY10PERMSC@Livanta.com</a>

**Section Four**  
**AFTER THE UNIVERSE**  
**SUBMISSION**  
**-NEXT STEPS**

## Section 4: After the Universe Submission -Next Steps

### *Universe Data Quality*

Once you have submitted your universe data to Livanta SC, we will ensure the accuracy and completeness of those universes through an extensive QC process. As the data passes through these QC stages, you will be contacted for questions, clarifications, or issues with your data that are identified. We request that you prioritize the resources necessary to resolve these issues so your universe data can be approved and sampled as efficiently as possible.

### *Sampler*

After the universe has been approved, Livanta SC creates the sample file. This sample file will contain all of the fields you submitted in your universe, as well as additional variables for each sampled unit, such as the PERM ID and Stratum.

### *PERM ID*

Each sampling unit selected, whether FFS header/line, MC, Fixed Premium Payment, or Eligibility, will be assigned a unique PERM ID by Livanta SC. The PERM ID has intelligence built in and will follow the sampling unit throughout the entire PERM process. The PERM ID will represent the sampled unit in the sample and detail files, as well as on the RC website.

FY10 PERM ID					
State ID:	TX	Texas – Standard Postal 2-Char State Abbreviation			
Program:	M	M – Medicaid, C - CHIP			
Year:	10	Federal Fiscal Year Period of Performance			
Timeframe:	01	FY Quarter of data source for claims; Month for eligibility sampling units			
Type:	F	FFS Claims = F, MC (Managed Care) = M, Fixed Premium Payment = P, Eligibility Record = E			
Sequence Number:	001	Sequential number in the sample beginning with 001			
Example: <b>TXM1001F001</b> Decodes to					
<b>State</b>	<b>Program</b>	<b>Year</b>	<b>Timeframe</b>	<b>Type</b>	<b>Seq. No.</b>
TX	M	10	01	F	001
Texas	Medicaid	2010	Q1	FFS	001

*This example is merely for illustrative purposes.*

### *Sample FFS Details*

For sampled FFS claims, Livanta SC will send to your state a Data Request Package that includes the FFS sample file and a request for claim details to facilitate the documentation

## PERM FFY 2010 Universe Data Submission Instructions

request and medical review processes. For each sampled unit, your state must supply all the lines for the claim that contains that sampled unit.

- If all of the detailed information requested in the layout was provided, then no additional requests will be made by Livanta SC for FP Payments that were sampled.
- If all of the detailed information requested in the layout was provided, then no additional requests will be made by Livanta SC for MC Payments that were sampled.

### ***Adjustments (New for FY10)***

Adjustments made within 60 days of the original paid date will be collected by the RC during the DP review.

# **GLOSSARY**

# Glossary

## *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/CHIP system (exclusive of medical reviews and eligibility reviews).

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

## PERM FFY 2010 Universe Data Submission Instructions

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:** 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 (MC):** 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 entity that has entered into a risk contract with a state Medicaid and/or CHIP agency to provide a specified package of benefits to Medicaid and/or CHIP 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.

***Program of All-Inclusive Care for the Elderly (PACE):*** A benefit that states may at their option offer to Medicaid beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility. Qualifying beneficiaries receive all Medicaid-covered services through the PACE provider in which they enroll. PACE providers must meet minimum federal standards and are paid on a capitation basis.

***Risk-Based Managed Care:*** The 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.

# **APPENDICES**

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

**FFS Example**  
**Selection of Sampling Units for FFY2010, Quarter 2 (Jan - Mar)**  
**Application of Payment Date and Payment Amount Criteria**

	<b>Claim #1</b>	<b>Claim #2</b>	<b>Claim #3</b>	<b>Claim #4</b>	<b>Claim #5</b>
<b>December</b>					Original payment December 15; \$45
<b>January</b>	Original payment January 12; \$45		Original payment January 6; \$280		
<b>February</b>	Adjusted February 27; new final paid amount \$60	Original payment February 28; \$1,200			Adjusted February 2; new final paid amount \$60
<b>March</b>	Adjusted March 25; new final paid amount \$70			Original payment March 31; \$500	
<b>April</b>		Adjusted April 20; new final paid amount \$960			
<b>May</b>			Adjusted May 12; new final payment \$375	Adjusted May 20; new final payment \$450	
<b>Included in Q2 universe file provided 4/15:</b>	<b>Paid date = January 12; amount paid = \$45</b>	<b>Paid date = February 28; amount paid = \$1,200</b>	<b>Paid date = January 6; amount paid = \$280</b>	<b>Paid date = March 31; amount paid = \$500</b>	<b>Not included in Q2, original paid date prior to quarter</b>
<b>If claim selected for sample, RC applies adjustment:</b>	February 27 adjustment applied; March 25 adjustment not applied because adjustment occurred more than 60 days after January 12	Adjustment made on April 20 applied (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 applied (since this is within 60 days of original payment date of March 31)	N/A

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

**MC Example**  
**Selection of Sampling Units for FFY 2010, Quarter 2 (Jan - Mar)**  
**Application of Payment Date and Payment Amount Criteria**

	Claim #1	Claim #2	Claim #3	Claim #4	Claim #5
<b>December</b>	Capitation payment on 12/15 for Managed Care program enrollee for service period January				
<b>January</b>		Capitation payment on 1/14 for enrollee in Managed Mental Health Care Plan for November 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		
<b>February</b>	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
<b>March</b>					
<b>April</b>					
<b>Included in Q2 universe file provided 4/15:</b>	<b>Not included with Q2; it was included in Q1 submission due 1/15</b>	<b>State would include in Q2 universe</b>	<b>State would include in Q2 universe</b>	<b>State would include in Q2 universe</b>	<b>State would include in Q2 universe</b>
<b>If claim selected for sample, RC applies adjustment:</b>	If claim had been selected in the Q1 sample, the February adjustment would be applied	No adjustment made	No adjustment made	No adjustment made	No adjustment made

**APPENDIX B**  
**Fields for Universe Submission**  
**States Send Universe Data to Livanta SC**

When submitting the universe data to Livanta SC, states are required to provide all of the fields listed in the tables below. The first table contains the FFS fields. The second lists the Fixed Premium Payment fields, and the third lists the MC fields.

<b>FY10 FEE FOR SERVICE UNIVERSE LAYOUT (New FY10 Fields Highlighted in Yellow)</b>			
<b>Seq Num - FFS Univ</b>	<b>Standard Field Name</b>	<b>Universe Field Description</b>	<b>Required?</b>
1	ICN	Claim control number assigned by state.	Y
2	Line Item Number	Claim line item number. Do not renumber for line level sampling units; default to zero for header level sampling units.	Y
3	Claim Type	Claim type identifier to distinguish between claim types such as inpatient institutional, outpatient institutional, prescription, professional, Medicare crossover, etc. State should provide decodes.	Y
4	Payment Status	Paid or Denied indicator for each claim or claim line. State should provide decodes.	Y
5	Date Paid	Date claim or claim line was adjudicated or paid; not the check date (unless there is no adjudication date).	Y
6	Total Computable Amount Paid	Total computable amount paid for the claim or claim line. Total Computable Amount = Federal Share + State Share, excluding any copay/TPL/deductible amount.	Y
7	Service Date From	Beginning date of service for the claim or claim line.	N
8	Service Date Through	Ending date of service for the claim or claim line.	N
9	Provider Number	Provider identification number associated with the claim or claim line.	N
10	Provider Type	Provider type for the claim or claim line. State should provide decodes.	Y
11	Provider Specialty	Provider specialty for the claim or claim line. State should provide decodes.	Y
12	Payment Level	An indicator of whether the claim is paid at the Header level, paid at the Line level, or is a Fixed Premium Payment. Default to 'H' for header or 'L' for Line.	Y
13	Funding Code	Indicates the funding source for the claim or claim line. State should provide decodes.	Y
14	POS	Place of service code for claim or claim line.	Y
15	Service Code	The service that was paid. For line level sampling units, provide the procedure (HCPCS) code, revenue code, or NDC code. For header level sampling units, provide the DRG or other grouped payment methodology, level of care, revenue code, procedure code or other claim service indicator value. State should provide decodes if not using national code values.	Y
16	Service Code Type	Code that identifies the kind of service code provided for the claim or claim line. If possible, please use the following set of service type codes: 'P' - CPT or HCPCS code 'R' - Revenue code 'N' - NDC code 'D' - DRG code 'L' - Level of Care code 'O' - Other Service Code Nomenclature  If additional service code types are used, please provide the decodes.	N
17	Category of Service	Classification for broad types of state/federal covered services. States should provide decodes.	Y
18	Source Location	The system of origin/location in which the sampling unit was adjudicated; should match the system from which the claim details will be provided and the system in which the DP Reviewer will access the system to perform the review. Examples: 'STARDSP', 'NET', 'HEALTHY KIDS'; each is associated with a physical location of an adjudication or claims processing system. State should provide a crosswalk from the system to the location, e.g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State.	Y
19	PERM State	2-char postal abbreviation for the state.	Y
20	Program Code	Indicator of program for universe file: Default to 'M' (Medicaid) or 'C' (CHIP)	Y
21	Sample Year	Default to '10'.	Y
22	Sample Quarter	Fiscal quarter for data. Default to '1' (Quarter 1), '2' (Quarter 2), '3' (Quarter 3), or '4' (Quarter 4).	Y
23	User Field 1	State supplied additional field 1. Optional.	N
24	User Field 2	State supplied additional field 2. Optional.	N
25	User Field 3	State supplied additional field 3. Optional.	N
26	User Field 4	State supplied additional field 4. Optional.	N
27	User Field 5	State supplied additional field 5. Optional.	N

**APPENDIX B**  
**Fields for Universe Submission**  
**States Send Universe Data to Livanta SC**

<b>FY10 FIXED PREMIUM PAYMENT UNIVERSE LAYOUT (New FY10 Fields Highlighted in Yellow)</b>			
<b>Seq Num- FP Univ</b>	<b>Standard Field Name</b>	<b>Universe Field Description</b>	<b>Required?</b>
1	ICN	Claim or internal control number assigned by state for the payment record or claim.	Y
2	Line Item Number	Claim line item number. If line numbers are not available, default to '0'.	Y
3	Payment Type	Payment type for the claim or payment record, such as Medicare Buy-in, HIPP, PCCM, or capitated premium payment. State should provide decodes.	Y
4	Payment Status	Paid or Denied indicator for each line of the claim or payment record. State should provide decodes.	Y
5	Date Paid	Date claim was adjudicated or paid; not the check date (unless there is no adjudication date).	Y
6	Total Computable Amount Paid	Total computable amount paid for the claim or claim line. Total Computable Amount = Federal Share + State Share, excluding any copay/TPL/deductible amount.	Y
7	Payment Period From Date	Beginning date of the period of coverage this payment or claim represents.	Y
8	Payment Period To Date	Ending date of the period of coverage this payment or claim represents.	Y
9	Provider Number	Provider identification number associated with the claim or payment record.	Y
10	Provider Type	Provider type for the claim or payment record. State should provide decodes.	Y
11	Provider Specialty	Provider specialty for the claim or payment record. State should provide decodes. If not applicable, leave blank.	N
12	Payment Level	Default to 'P' for Fixed Premium Payment.	Y
13	Funding Code	Indicates the funding source for the claim or payment record. State should provide decodes.	Y
14	POS	Place of service code for claim or payment record. If not applicable, leave blank.	N
15	Service Code	Procedure (HCPCS) code, revenue code, NDC code, or other type of service code, if applicable.	N
16	Service Code Type	If applicable, code that identifies the kind of service code provided for the claim or claim line. If possible, please use the following set of service type codes: 'P' - CPT or HCPCS code 'R' - Revenue code 'N' - NDC code 'D' - DRG code 'L' - Level of Care code 'O' - Other Service Code Nomenclature  If additional service code types are used, please provide the decodes.	N
17	Category of Service	Classification for broad types of state/federal covered services. States should provide decodes.	Y
18	Source Location	The system of origin/location in which the sampling unit was adjudicated; should match the system from which the claim details will be provided and the system in which the DP Reviewer will access the system to perform the review. Examples: 'STARDSP', 'NET', 'HEALTHY KIDS'; each is associated with a physical location of an adjudication or claims processing system. State should provide a crosswalk from the system to the location, e.g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State.	Y
19	PERM State	2-char postal abbreviation.	Y
20	Program Code	Indicator of program for universe file: Default to 'M' (Medicaid) or 'C' (CHIP)	Y
21	Sample Year	Default to '10'.	Y
22	Sample Quarter	Fiscal quarter for data. Default to '1' (Quarter 1), '2' (Quarter 2), '3' (Quarter 3), or '4' (Quarter 4).	Y
23	Recipient ID	Recipient Medicaid/CHIP number.	Y
24	Recipient First Name	Recipient First Name. May be blank if state chooses to submit recipient name in a single full-name field.	Y
25	Recipient Middle Initial	Recipient Middle Initial. May be blank if state chooses to submit recipient name in a single full-name field.	Y
26	Recipient Last Name	Recipient Last Name. May be blank if state chooses to submit recipient name in a single full-name field.	Y
27	Recipient Full Name	Full name of the recipient, in the format Last, First MI. SC will add this if universe data contains three separate fields for recipient name. State may leave blank if submitting recipient name information separately as first, MI, and last.	Y
28	Recipient DOB	Recipient date of birth.	Y
29	Recipient Gender	Recipient gender code.	Y
30	Recipient County	Recipient county. State should provide decodes.	N
31	Recip Aid Category	Eligibility type. State should provide decodes.	Y
32	User Field 1	State supplied additional field 1. Optional.	N
33	User Field 2	State supplied additional field 2. Optional.	N
34	User Field 3	State supplied additional field 3. Optional.	N
35	User Field 4	State supplied additional field 4. Optional.	N

**APPENDIX B**  
**Fields for Universe Submission**  
**States Send Universe Data to Livanta SC**

<b>FY10 MANAGED CARE UNIVERSE LAYOUT (New FY10 Fields Highlighted in Yellow)</b>			
<b>Seq Num- MC Univ</b>	<b>Standard Field Name</b>	<b>Universe Field Description</b>	<b>Required?</b>
1	ICN	Internal control number assigned by state for the payment record.	Y
2	Line Item Number	Claim line item number. If line numbers are not available, default to '0'.	Y
3	Payment Type	Type of payment, such as monthly capitation, or individual reinsurance payment. State should provide decodes.	Y
4	Payment Status	Paid or Denied indicator for each sampling unit. State should provide decodes.	Y
5	Date Paid	Date sampling unit was adjudicated or paid; not the check date (unless there is no adjudication date).	Y
6	Total Computable Amount Paid	Total computable amount paid for the claim or claim line. Total Computable Amount = Federal Share + State Share, excluding any copay/TPL/deductible amount.	Y
7	Coverage Period From Date	Beginning date of the period of coverage this payment represents. Typically, a managed care payment is made for a single month.	Y
8	Coverage Period To Date	Ending date of the period of coverage this payment represents. Typically, a managed care payment is made for a single month.	Y
9	Provider Number	Provider identification number associated with the claim or payment record.	Y
10	Managed Care Program Indicator	Type of managed care program. Examples: TANF, PACE, LTC, Behavioral Health. State should provide decodes.	Y
11	Provider Specialty	Provider specialty for the claim or payment record. State should provide decodes. If not applicable, leave blank.	N
12	Payment Level	Default to 'H' for Managed Care.	Y
13	Funding Code	Indicates the funding source for the payment record. State should provide decodes.	Y
14	POS	Place of service code for claim or payment record. If not applicable, leave blank.	N
15	Recipient Rate Indicator	"Procedure code" or other rate cohort indicator used in determining the payment. State should provide decodes.	Y
16	Service Code Type	If applicable, code that identifies the kind of procedure or rate cohort indicator provided for the claim or claim line. If possible, please use the following set of service type codes: 'P' - CPT or HCPCS code 'R' - Revenue code 'N' - NDC code 'D' - DRG code 'L' - Level of Care code 'O' - Other Service Code Nomenclature	N
17	Category of Service	Classification for broad types of state/federal covered services. States should provide decodes.	Y
18	Source Location	The system of origin/location in which the sampling unit was adjudicated; should match the system from which the claim details will be provided and the system in which the DP Reviewer will access the system to perform the review. Examples: 'PACE', 'NET', 'BHO'. State should provide a crosswalk from the system to the location, e.g., 'MCO001' = City, State, 'MCO002' = Different City, State.	Y
19	PERM State	2-char postal abbreviation.	Y
20	Program Code	Indicator of program for universe file: Default to 'M' (Medicaid) or 'C' (CHIP)	Y
21	Sample Year	Default to '10'.	Y
22	Sample Quarter	Fiscal quarter for data. Default to '1' (Quarter 1), '2' (Quarter 2), '3' (Quarter 3), or '4' (Quarter 4).	Y
23	Recipient ID	Recipient Medicaid/CHIP number.	Y
24	Recipient First Name	Recipient First Name. May be blank if state chooses to submit recipient name in a single full-name field.	Y
25	Recipient Middle Initial	Recipient Middle Initial. May be blank if state chooses to submit recipient name in a single full-name field.	Y
26	Recipient Last Name	Recipient Last Name. May be blank if state chooses to submit recipient name in a single full-name field.	Y
27	Recipient Full Name	Full name of the recipient, in the format Last, First MI. SC will add this if universe data contains three separate fields for recipient name. State may leave blank if submitting recipient name information separately as first, MI, and last.	Y
28	Recipient DOB	Recipient date of birth.	Y
29	Recipient Gender	Recipient gender code.	Y
30	Recipient County	Recipient county.	N
31	Recip Aid Category	Eligibility type. State should provide decodes.	Y
32	Recipient Service Area	Indicator of area in which the recipient received the service. State should provide decodes.	N
33	User Field 1	State supplied additional field 1. Optional.	N
34	User Field 2	State supplied additional field 2. Optional.	N
35	User Field 3	State supplied additional field 3. Optional.	N
36	User Field 4	State supplied additional field 4. Optional.	N
37	User Field 5	State supplied additional field 5. Optional.	N

**APPENDIX B**  
**Fields for Universe Submission**  
**States Send Universe Data to Livanta SC**

<b>COMPARISON OF FY10 UNIVERSE LAYOUTS FOR FFS CLAIM, FFS FP AND MC</b>		
<b>FFS Claim</b>	<b>FFS FP</b>	<b>MC</b>
ICN	ICN	ICN
Line Item Number	Line Item Number	Line Item Number
Claim Type	Payment Type	Payment Type
Payment Status	Payment Status	Payment Status
Date Paid	Date Paid	Date Paid
Total Computable Amount Paid	Total Computable Amount Paid	Total Computable Amount Paid
Service Date From	Payment Period From Date	Coverage Period From Date
Service Date Through	Payment Period To Date	Coverage Period To Date
Provider Number	Provider Number	Provider Number
Provider Type	Provider Type	Managed Care Program Indicator
Provider Specialty	Provider Specialty	Provider Specialty
Payment Level	Payment Level	Payment Level
Funding Code	Funding Code	Funding Code
POS	POS	POS
Service Code	Service Code	Recipient Rate Indicator
Service Code Type	Service Code Type	Service Code Type
Category of Service	Category of Service	Category of Service
Source Location	Source Location	Source Location
PERM State	PERM State	PERM State
Program Code	Program Code	Program Code
Sample Year	Sample Year	Sample Year
Sample Quarter	Sample Quarter	Sample Quarter
User Field 1	User Field 1	User Field 1
User Field 2	User Field 2	User Field 2
User Field 3	User Field 3	User Field 3
User Field 4	User Field 4	User Field 4
User Field 5	User Field 5	User Field 5
	Recipient ID	Recipient ID
	Recipient First Name	Recipient First Name
	Recipient Middle Initial	Recipient Middle Initial
	Recipient Last Name	Recipient Last Name
	Recipient Full Name	Recipient Full Name
	Recipient DOB	Recipient DOB
	Recipient Gender	Recipient Gender
	Recipient County	Recipient County
	Recip Aid Category	Recip Aid Category
		Recipient Service Area

## APPENDIX C

### Data Transmission Cover Sheet and Quality Control Verification

These forms are examples of the Medicaid FFS and Medicaid MC Transmission Cover Sheet and Quality Control Verification. Be sure to add control and payment total amounts for all program types submitted quarterly. Please submit these to Livanta SC using the Excel version emailed with the data submission instructions.

Transmission Cover Sheet and Quality Control Verification									
<b>Medicaid Fee-For-Service, Quarter X</b>									
Complete and submit this cover sheet with every PERM data submission.									
<b>State:</b>									
<b>Date:</b>									
<b>Quarter:</b>									
<b>Contact person for data questions:</b>									
<b>Name:</b>					Alternate contact				
<b>Phone:</b>									
<b>Email:</b>									
<b>Title:</b>									
<b>Organization:</b>									
<b>Data Descriptions</b> Complete information below. Please include a row describing your data documentation. Add more rows as necessary.									
Data Description			Data Filename			File Format	File Media	Password Protected? (Y/N)	
(e.g., Q1 Medicaid FFS; data documentation) (Add rows if necessary)			(e.g., st_qtr_medicaid_FFS.sas7bdat)			(e.g., text, Excel,SAS)	(e.g., CD,DVD,	(if yes, send password)	
<b>Control Totals</b> Add more tables as necessary.									
<b>NOTE:</b> List the lines cont and total \$\$ by CLAIM TYPE, not universe totals. Add more rows as necessary to reflect each claim type.									
<b>Data filename: (e.g., st_qtr_medicaid_ffs_1.sas7bdat)</b>									
Month									
October			Novemeber			December			
Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Total \$\$
<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>			
<b>GRAND TOTAL (Mon):</b>			<b>GRAND TOTAL (Mon):</b>			<b>GRAND TOTAL (Mon):</b>			
	-	\$		-	\$		-	\$	-
<b>GRAND TOTAL (Qtr):</b>			<b>GRAND TOTAL (Qtr):</b>			<b>GRAND TOTAL (Qtr):</b>			
	-	\$		n/a			n/a		
<b>Data filename: (e.g., st_qtr_medicaid_ffs_2.sas7bdat)</b>									
Month									
October			November			December			
Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Total \$\$
<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>			
<b>GRAND TOTAL (Mon):</b>			<b>GRAND TOTAL (Mon):</b>			<b>GRAND TOTAL (Mon):</b>			
	-	\$		-	\$		-	\$	-
<b>GRAND TOTAL (Qtr):</b>			<b>GRAND TOTAL (Qtr):</b>			<b>GRAND TOTAL (Qtr):</b>			
	-	\$		n/a			n/a		

## APPENDIX C

### Data Transmission Cover Sheet and Quality Control Verification

Quality Control Verification - Medicaid Fee-For-Service				
Quarter X				
States are responsible for quality control checking each dataset prior to submitting the data to Livanta SC. 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	Y/N	Suggested Test	Comments	Your Name
Title XIX Fee-for-Service claims (as defined in the instructions)		Does your programming designate a claim as Title XIX or Title XXI?		
		Does your programming designate a claim as FFS or managed care?		
State-Only Claims.		Did your programming eliminate state-only funded services? Please specify how.		
Paid dates from FFY 2010 Q1.		Payment test dates. Are all original paid dates between October 1, 2009 and December 31, 2009?		
FFS fixed payments (as defined in the instructions)		Did you include HIPP, PCCM, and other fixed payments in the data submission? Were these found in non-MMIS payment systems?		
Duplicate Fixed Payments.		Are there multiple payments for the same beneficiary for the same coverage period? If yes, verify that they are valid.		
Data represents only original paid claims.		Are there any replacement payments initiated by the provider or the state in your data? Are there any adjustments in your data?		
		Did you isolate only original paid claims in the programming? If yes, explain how.		
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?		
Unusual Payment Amounts.		Are there any <b>negative payments</b> in your data? If yes, explain why they are valid.		
		Are there any <b>extremely high payments</b> ? If so, verify that they are valid.		
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.		
Paid Amounts are total computable amounts without copay/TPL/patient liability.		Are Paid Amounts are total computable amounts without copay/TPL/patient liability included? Please indicate how (1) TPL was applied to the paid amount in your universe and (2) how copays were applied to the paid amounts in your universe, and (3) if patient liability was applied?		
Zero-Paid Claims.		Are you including zero paid claims in the data?		
Denied Claims.		Are you including denied claims in the data? Do your denied claims have payment amounts greater than \$0?		

**APPENDIX C**  
**Data Transmission Cover Sheet and Quality Control Verification**

All required fields are included and each field is populated with a value.	Are there any missing values for any of the fields? Review instruction Appendix for list of required fields.		
	Have the descriptions/decodes for all values have been provided to Livanta SC.		
FQHC, RHC, and Indian Health Services clinics have all been submitted in accordance with their individual payment methodology: FQHC is paid _____ RHC is paid _____ IHS is paid _____	Are there informational lines for encounter rate clinics in the universe data submission? If yes, explain why they are valid.		
	Are there informational lines for encounter rate clinics in the universe data submission? If yes, explain why they are valid.		
	Are there informational lines for encounter rate clinics in the universe data submission? If yes, explain why they are valid.		
<b>Please indicate any 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).</b>			
<b>Significant Changes to Universe Data</b>	<b>Comments</b>	<b>Your Name</b>	
List any programming or policy changes. Please indicate how to identify new programs.			
List any programs or services that were included or excluded from this data submission. Please indicate how to identify new programs.			

**APPENDIX C**  
**Data Transmission Cover Sheet and Quality Control Verification**

Transmission Cover Sheet and Quality Control Verification								
<b>Medicaid Managed Care, Quarter X</b>								
Complete and submit this cover sheet with every PERM data submission.								
<b>State:</b>								
<b>Date:</b>								
<b>Quarter:</b>								
<b>Contact person for data questions:</b>								
<b>Name:</b>		Alternate contact						
<b>Phone:</b>								
<b>Email:</b>								
<b>Title:</b>								
<b>Organization:</b>								
<b>Data Descriptions</b> Complete information below. Please include a row describing your data documentation. Add more rows as necessary.								
Data Description	Data Filename	File Format	File Media	Password Protected? (Y/N)				
(e.g., Q1 Medicaid Managed Care; data documentation) (Add rows if necessary)	(e.g., st_qtr_medicaid_mc.sas7bdat)	(e.g., text, Excel, SAS)	(e.g., CD, DVD)	(if yes, send password)				
<b>Control Totals</b> Add more tables as necessary.								
<b>NOTE:</b> List the lines cont and total \$\$ by CLAIM TYPE, not universe totals. Add more rows as necessary to reflect each claim type.								
<b>Data filename: (e.g., st_qtr_medicaid_mc_1.sas7bdat)</b>								
Month								
October			November			December		
Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$
<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>		
<b>GRAND TOTAL (Mon):</b>	-	\$ -	<b>GRAND TOTAL (Mon):</b>	-	\$ -	<b>GRAND TOTAL (Mon):</b>	-	\$ -
<b>GRAND TOTAL (Qtr):</b>	-	\$ -	n/a			n/a		
<b>Data filename: (e.g., st_qtr_medicaid_mc_2.sas7bdat)</b>								
Month								
October			November			December		
Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$	Claim Type	Total Lines	Total \$\$
<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>			<i>(Add rows if necessary)</i>		
<b>GRAND TOTAL (Mon):</b>	-	\$ -	<b>GRAND TOTAL (Mon):</b>	-	\$ -	<b>GRAND TOTAL (Mon):</b>	-	\$ -
<b>GRAND TOTAL (Qtr):</b>	-	\$ -	n/a			n/a		

**APPENDIX C**  
**Data Transmission Cover Sheet and Quality Control Verification**

<b>Quality Control Verification - Medicaid Managed Care</b>				
<b>Quarter X</b>				
<i>States are responsible for quality control checking each dataset prior to submitting the data to Livanta SC. These are the minimum required checks. Please provide the name of the person "signing off" on each QC check. <b>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.</b></i>				
Quality Control Check	Y/N	Suggested Test	Comments	Your Name
Data include only Title XIX managed care claims (as defined in the instructions)		Does your programming designate a claim as Title XIX or Title XXI?		
		Does your programming designate a claim as FFS or managed care?		
State-only paid services are removed from the data.		Did your programming eliminate state-only funded services? Please specify how.		
Data with paid dates from FFY 2010 Q1.		Payment test dates. Are all original paid dates between October 1, 2009 and December 31, 2009?		
Duplicate Capitated Payments		Are there multiple payments for the same beneficiary for the same coverage period? If yes, verify that they are valid.		
Data represents only original paid claims.		Are there any replacement payments initiated by the provider or the state in your data? Are there any adjustments in your data?		
		Did you isolate only original paid claims in the programming? If yes, explain how.		
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?		
Unusual Payment Amounts.		Are there any <b>negative payments</b> in your data? If yes, explain why they are valid.		
		Are there any <b>extremely high payments</b> ? If so, verify that they are valid.		
Zero-paid claims and denied claims are included in the data.		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?		

**APPENDIX C**  
**Data Transmission Cover Sheet and Quality Control Verification**

All required fields are included and each field is populated with a value.	Are there any missing values for any of the fields? Review instruction Appendix for list of required fields.		
	Did you include maternity kick payments? Please indicate if these claims were selected from another data source.		
	Have you included the data dictionary for any state-specific fields?		
<b><i>Please indicate any 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).</i></b>			
<b>Policy or Programming Changes</b>	<b>Comments</b>		<b>Your Name</b>
List any programming or policy changes. Please indicate how to identify new programs.			
List any programs or services that were included or excluded from this data submission. Please indicate how to identify new programs.			

**APPENDIX D**  
**An Example of the “Base” Financial Comparison Workbook**

Financial Comparison Summary				
Total	PERM Data	Total CMS	Difference	%Diff
Q1	\$320,444,461	\$312,615,765	\$7,828,696	2.50%
Q2	\$340,111,082	\$325,496,078	\$14,615,004	4.49%
Q3	\$328,223,595	\$324,771,787	\$3,451,808	1.06%
Q4	\$0	\$0	\$0	#DIV/0!
*Make sure to check the State's Matrix to determine the split between FFS/FP & MC programs. This may change how the FFS and MC totals within the PERM data are calculated. When checked, change the lines below to "verified".				
FFS	PERM Data	Total CMS	Difference	%Diff
Q1	\$313,333,349	\$305,449,803	\$7,883,546	2.58%
Q2	\$332,222,440	\$317,653,554	\$14,568,886	4.59%
Q3	\$320,222,805	\$316,562,134	\$3,660,671	1.16%
Q4	\$0	\$0	\$0	#DIV/0!
Managed Care	PERM Data	Total CMS	Difference	%Diff
Q1	\$7,111,112	\$7,165,962	(\$54,850)	-0.77%
Q2	\$7,888,642	\$7,842,524	\$46,118	0.59%
Q3	\$8,000,790	\$8,209,653	(\$208,863)	-2.54%
Q4	\$0	\$0	\$0	#DIV/0!

## APPENDIX D

### An Example of the “Base” Financial Comparison Workbook

64.9 Base			64.9 Waivers			64F		
1A - Inpatient Hospital Services - Regular Payments	State	\$50,795,384	1A - Inpatient Hospital Services - Regular Payments	State	\$0	6.A. - From For State		0
1B - Inpatient Hospital Service - DSH Adjustment Payments	State	\$0	1B - Inpatient Hospital Service - DSH Adjustment Payments	State	\$0	EXCLUDED FROM CALCULATION	6.A.1. - From For State	0
2A - Mental Health Facility Services - Regular Payments	State	\$3,182,634	2A - Mental Health Facility Services - Regular Payments	State	\$0		6.B. - From For State	0
2B - Mental Health Facility Services - DSH Adjustment Payments	State	\$0	2B - Mental Health Facility Services - DSH Adjustment Payments	State	\$0	EXCLUDED FROM CALCULATION	6.C. - From For State	0
3 - Nursing Facility Services	State	\$39,281,611	3 - Nursing Facility Services	State	\$0			
4A - Intermediate Care Facility Services - Mentally Retarded: Public Providers	State	\$4,882,193	4A - Intermediate Care Facility Services - Mentally Retarded: Public Providers	State	\$0			
4B - Intermediate Care Facility Services - Mentally Retarded: Private Providers	State	\$10,234,372	4B - Intermediate Care Facility Services - Mentally Retarded: Private Providers	State	\$0			
5 - Physicians' Services	State	\$17,679,635	5 - Physicians' Services	State	\$0			
6 - Outpatient Hospital Services	State	\$12,859,561	6 - Outpatient Hospital Services	State	\$0			
7 - Prescribed Drugs	State	\$28,641,283	7 - Prescribed Drugs	State	\$0			
7A1 - Drug Rebate Offset - National Agreement	State	(\$15,683,608)	7A1 - Drug Rebate Offset - National Agreement	State	\$0	EXCLUDED FROM CALCULATION		
7A2 - Drug Rebate Offset - State Sidebar Agreement	State	(\$2,729,902)	7A2 - Drug Rebate Offset - State Sidebar Agreement	State	\$0	EXCLUDED FROM CALCULATION		
8 - Dental Services	State	\$3,378,073	8 - Dental Services	State	\$0			
9 - Other Practitioners' Services	State	\$9,650,093	9 - Other Practitioners' Services	State	\$0			
10 - Clinic Services	State	\$20,264,715	10 - Clinic Services	State	\$0			
11 - Laboratory And Radiological Services	State	\$5,408,309	11 - Laboratory And Radiological Services	State	\$0			
12 - Home Health Services	State	\$1,543,430	12 - Home Health Services	State	\$0			
13 - Sterilizations	State	\$664,853	13 - Sterilizations	State	\$0			
14 - Abortions No.	State	\$0	14 - Abortions No.	State	\$0			
15 - EPSDT Screening Services	State	\$3,941,443	15 - EPSDT Screening Services	State	\$0			
16 - Rural Health Clinic Screening	State	\$1,009,405	16 - Rural Health Clinic Screening	State	\$0			
17A - Medicare Health Insurance Payments - Part A Premiums	State	\$844,687	17A - Medicare Health Insurance Payments - Part A Premiums	State	\$0	EXCLUDED FROM CALCULATION		
17B - Medicare Health Insurance Payments - Part B Premiums	State	\$6,863,103	17B - Medicare Health Insurance Payments - Part B Premiums	State	\$0	EXCLUDED FROM CALCULATION		
17C1 - 120% - 134% Of Poverty	State	\$302,247	17C1 - 120% - 134% Of Poverty	State	\$0	EXCLUDED FROM CALCULATION		
17C2 - 135% - 175% Of Poverty	State	\$0	17C2 - 135% - 175% Of Poverty	State	\$0	EXCLUDED FROM CALCULATION		
17D - Coinsurance And Deductibles	State	\$0	17D - Coinsurance And Deductibles	State	\$0			
18A - Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	State	\$0	18A - Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	State	\$0			
18B1 - Prepaid Ambulatory Health Plan	State	\$5,981,656	18B1 - Prepaid Ambulatory Health Plan	State	\$0			
18B2 - Prepaid Inpatient Health Plan	State	\$0	18B2 - Prepaid Inpatient Health Plan	State	\$0			
18C - Medicaid Health Insurance Payments: Group Health Plan Payments	State	\$1,079,306	18C - Medicaid Health Insurance Payments: Group Health Plan Payments	State	\$0			
18D - Medicaid Health Insurance Payments: Coinsurance And Deductibles	State	\$0	18D - Medicaid Health Insurance Payments: Coinsurance And Deductibles	State	\$0			
18E - Medicaid Health Insurance Payments: Other	State	\$0	18E - Medicaid Health Insurance Payments: Other	State	\$0			
19 - Home And Community-Based Services	State	\$0	19 - Home And Community-Based Services	State	\$37,835,276			
20 - Home And Community-Based Care For Functionally Disabled Elderly	State	\$0	20 - Home And Community-Based Care For Functionally Disabled Elderly	State	\$0			
22 - Programs Of All-Inclusive Care Elderly	State	\$100,000	22 - Programs Of All-Inclusive Care Elderly	State	\$5,000			
23 - Personal Care Services	State	\$3,654,091	23 - Personal Care Services	State	\$0			
24 - Targeted Case Management Services	State	\$3,495,920	24 - Targeted Case Management Services	State	\$0			
25 - Primary Care Case Management Services	State	\$3,904,247	25 - Primary Care Case Management Services	State	\$0			
26 - Hospice Benefits	State	\$2,535,549	26 - Hospice Benefits	State	\$0			
27 - Emergency Services Undocumented Aliens	State	\$2,890,178	27 - Emergency Services Undocumented Aliens	State	\$0			
28 - Federally-Qualified Health Center	State	\$2,755,402	28 - Federally-Qualified Health Center	State	\$0			
29 - Other Care Services	State	\$34,962,146	29 - Other Care Services	State	\$0			
30 - Total	State	\$264,372,016	30 - Total	State	\$37,840,276			
	FFS	\$267,614,527		FFS	\$37,835,276	check to make sure the programs summed here match the state's matrix. Only needed Q1, Q2-Q4 will be the same.		
	MC	\$7,160,962		MC	\$5,000			
		\$274,775,489			\$37,840,276			