# RY 2024 PERM Universe Data Submission Instructions

*May 2022*

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# 1. Overview

The Improper Payments Information Act (IPIA) of 2002[1], as amended, requires federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. Medicaid and the Children's Health Insurance Program (CHIP) were identified as programs at risk for significant improper payments.

CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and CHIP and produce improper payment rates for each program. The improper payment rates are based on reviews of the Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP during the review period.

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

These instructions are intended to guide state staff in the preparation and submission of claims data to the PERM SC. The instructions include information about PERM program areas that are measured, required variables to be submitted, state Quality Control (QC) checks, and data submission security requirements. Appendices include tables of required fields, a Transmission Cover Sheet for QC verification, and specific differences between the Reporting Year (RY) 2021 and RY 2024 PERM cycles.

> **Each member of the state's PERM team, including technical and non-technical staff from the state and any relevant vendors, should receive a copy of these instructions and review them early in the PERM cycle but no later than prior to the state data intake meeting.**

## 1.1 Initial Preparation

It is imperative that correct universe data are provided to the SC during the cycle so that the sampling universe is accurate, contains all required payments, and reflects the data present in the state systems. When inaccurate or incomplete data is provided this results in delays creating samples and details, can lead to oversamples and resamples of universes, and can complicate the eligibility, data processing, and medical records reviews by the other contractors. This document is intended to provide the states with information critical to creating an accurate universe.

All contractors work together with the state during the PERM process. At the start of the cycle, the SC will work closely with the state to:

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[1]   As amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010, the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012, and the Payment Integrity Information Act (PIIA) of 2019.

- Assist each state in interpreting and applying the PERM data submission instructions included in this document.

- Schedule meetings with state staff at the beginning of the PERM cycle to discuss the data request and to learn in detail about how the state adjudicates claims and processes other payments.

- Work with state staff to be certain that the state submitted all of the required PERM data in their data submissions.

- Respond to state questions throughout the process to ensure mutual understanding of the data requirements and specifications.

## 1.2 Developing a State PERM Team to Build the Universe and Ensure its Accuracy

Each state should develop a PERM team that includes program, policy, technical and budget staff. From experience, CMS has identified the characteristics of effective PERM teams, which are summarized in **Exhibit 1**. In addition to the characteristics outlined below, PERM teams should also include budget and finance staff who are responsible for developing and submitting federal matching fund reports (e.g., quarterly CMS-64 and CMS-21 reports).

**Exhibit 1: Capabilities of Effective PERM Teams**

| Program Structure | Data Sources | Technical Aspects of Claim Adjudication |
|---|---|---|
| Includes staff from the single state agency and other designated state agencies who are responsible for and knowledgeable of: | Includes state staff and contractors responsible for the implementation and ongoing support of: | Includes staff knowledgeable of data components and processing and those who can apply PERM requirements to identify necessary fields that indicate certain considerations for PERM, including: |

| Program Structure | Data Sources | Technical Aspects of Claim Adjudication |
|---|---|---|
| ▪ Medicaid and CHIP program administration, development of state regulations and policies, and coordination across the organization(s)<br>▪ Managed care program design, contract administration and oversight, and quality measurement<br>▪ Reimbursement policies for state plan services, rate development for at-risk and/or partial risk contracts, and cost reconciliation arrangements<br>▪ Claims, billing, and payment mechanisms for all federally matched Title XIX and XXI services<br>▪ State-only funded and waiver programs adjudicated in MMIS | ▪ The state's Medicaid Management Information System (MMIS) and any Third Party Administrator (TPA)<br>▪ Health insurance premium payment (HIPP) program and payments<br>▪ Pharmacy Benefit Manager (PBM)<br>▪ Behavioral Health programs<br>▪ Other state agencies, systems, and vendors responsible for claims, payments, adjudications, or data warehousing | ▪ Definition of paid date<br>▪ Treatment of adjustments, denied/voided/rejected claims<br>▪ Services matched with certified public expenditures (CPEs) and the amount<br>▪ Co-pays and Third Party Liability (TPL)<br>▪ Claims billed using local procedure, revenue, or place or service codes<br>▪ Provider contact information for medical and data processing review requests<br>▪ Beneficiary information<br>▪ Original paid date |

## 2. File Development and Submission Timeline

The PERM project cycle is expected to take approximately two years, with claims and payment record collection and sampling activities concentrated in the first four quarters (with states submitting data quarterly beginning October 17, 2022) and improper payment rate calculation occurring at the end of the review cycle.

**Exhibit 2** outlines the major activities in the data submission process. The quarterly data submission dates are:

> Quarter 1: October 17, 2022

> Quarter 2: January 17, 2023

> Quarter 3: April 17, 2023

> Quarter 4: July 17, 2023

To meet the PERM project deadlines, it is important to:

- Begin development of the PERM data submissions as early as possible in the cycle. States should expect to spend time in the first quarter (Q1) of the review period of the

measurement (July through September 2022) preparing for the first quarter data submission in October.

▪ Expect to spend time between October and January responding to questions about the PERM universe and resolving any data issues found during data validation and QC. Subsequent data submissions are due in January, April, and July.

**Exhibit 2: RY 2024 PERM Universe Submission Timeline**

| Date | State Activities | SC/CMS Activities |
|---|---|---|
| **May - June 2022** | ▪ Determine if the state will submit via PERM Plus or routine PERM<br>▪ Select PERM team<br>▪ Provide completed State Information and State Contact Surveys and applicable data dictionaries<br>▪ Participate in PERM 101 education sessions | ▪ Meet with select states to discuss the PERM Plus submission option<br>▪ Answer questions about PERM<br>▪ Send final component sample sizes to each state |
| **June – July 2022** | ▪ Schedule state orientation meeting<br>▪ Participate in a state Intake Meeting<br>▪ Review, update, and approve notes from Intake Meeting<br>▪ Review Data Submission Instructions<br>▪ Ask questions and provide feedback<br>▪ Test SC secure file transfer site | ▪ Organize and participate in state Intake Meeting<br>▪ Develop draft notes from Intake Meeting, modify based on feedback, and send final version<br>▪ Answer questions from and provide feedback to PERM states<br>▪ Request and set up secure file transfer accounts for designated state users |
| **September 2022** | ▪ Code programs to provide PERM data sets<br>▪ Conduct QC review of PERM universe data and submit test data to ensure its compliance with requirements<br>▪ Ask questions and provide feedback | ▪ Answer questions from and provide feedback to PERM states |
| **October 17, 2022** | ▪ Submit Q1 PERM universe data to the SC (exception: Q1 managed care data may be submitted with the Q2 PERM universe data) | ▪ Receive Q1 PERM universe data from states |
| **October 17 – November 2022** | ▪ Work with SC to verify payment levels for each type of claim<br>▪ Work with SC to resolve issues identified during the data validation and QC process | ▪ Confirm payment levels for each type of claim<br>▪ Begin SC data validation and QC process |

| Date | State Activities | SC/CMS Activities |
|---|---|---|
| **November – December 2022** | ▪ Work with SC to resolve issues identified during QC of PERM universes | ▪ Perform QC review of PERM universes<br>▪ Select Q1 samples<br>▪ Schedule Details Intake Meeting with state |
| **Within 2 weeks** | ▪ Submit Q1 PERM details data to the SC within 2 weeks of receipt of the sample | ▪ Receive Q1 PERM details data from states, format the data, and review for completeness |
| **Within 30 days** | ▪ Work with SC to resolve issues | ▪ Finalize details data and transmit the formatted details to the RC |
| **January 17, 2023** | ▪ Submit Q2 (and any outstanding Q1 managed care) PERM universe data to the SC | ▪ Receive Q2 (and any outstanding Q1 managed care) PERM universe data from states |
| **January 17 – March 2023** | ▪ Work with SC to resolve issues | ▪ Perform QC review of PERM universes<br>▪ Select Q2 samples |
| **Within 2 weeks** | ▪ Submit Q2 PERM details data to the SC within 2 weeks of receipt of the sample | ▪ Receive Q2 PERM details data from states, format the data, and review for completeness |
| **Within 30 days** | ▪ Work with SC to resolve issues | ▪ Finalize details data and transmit the formatted details to the RC |
| **April 17, 2023** | ▪ Submit Q3 PERM universe data to the SC | ▪ Receive Q3 PERM universe data from states |
| **April 17 – June 2023** | ▪ Work with SC to resolve issues<br>▪ Review CMS-64 analysis and provide feedback to SC as necessary | ▪ Perform QC review of PERM universes<br>▪ Select Q3 samples<br>▪ Conduct CMS-64 comparison and analysis |
| **Within 2 weeks** | ▪ Submit Q3 PERM details data to the SC within 2 weeks of receipt of the sample | ▪ Receive Q3 PERM details data from states, format the data, and review for completeness |
| **Within 30 days** | ▪ Work with SC to resolve issues | ▪ Finalize details data and transmit the formatted details to the RC |
| **July 17, 2023** | ▪ Submit Q4 PERM universe data to the SC | ▪ Receive Q4 PERM universe data from states |
| **July 15 – September 2023** | ▪ Work with SC to resolve issues | ▪ Perform QC review of PERM universes<br>▪ Select Q4 samples |
| **Within 2 weeks** | ▪ Submit Q4 PERM details data to the SC within 2 weeks of receipt of the sample | ▪ Receive Q4 PERM details data from states, format the data, and review for completeness |
| **Within 30 days** | ▪ Work with SC to resolve issues | ▪ Finalize details data and transmit the formatted details to the RC |

# 3. Universe File Specifications

In order to proceed through the PERM cycle, states must submit complete and accurate universe data to the SC. To aid the states in putting this information together, we have developed file specifications for states to follow to ensure data are included and identified accurately. This universe data is used to create the sampling universe from which the claims that undergo eligibility, medical record, and data processing reviews are chosen. **Any incomplete or inaccurate information will delay completion of reviews and shorten the length of time the state has to request information from providers to avoid documentation errors.**

Each state in the PERM cycle must submit quarterly universe data to the SC. Universe data files are essentially very long "lists" of nearly all the Medicaid and CHIP beneficiary-specific payment records that are:

- Adjudicated by the state during the quarter

- Include both paid and denied claims

- Include any aggregate payments

- Contains all required fields

The state **must** divide the PERM universe data into four program areas:

- Medicaid FFS

- CHIP FFS

- Medicaid managed care

- CHIP managed care

Data should be submitted at the smallest individually-priced payment amount (typically at the header or line/detail) for which the state claims federal match to support consistent sampling and review across states. These payment levels will be discussed in more detail later in this document. Indicating the payment level of the claim is important to ensure that the sample drawn from the data is truly representative of the state's payments, and that each payment matched with federal Medicaid (Title XIX) or CHIP (Title XXI) funds is included one time and has a single chance of being sampled for review.

## 3.1 Universe Parameters

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

- Program Type

- Date

- Paid Amount (Total Computable Paid Amount)

### 3.1.1    Program Type

The PERM data submission can include up to four data universes, depending on the program structure and service delivery systems operating in each state. Universes can include:

- Medicaid FFS
- CHIP FFS
- Medicaid managed care
- CHIP managed care

How each universe must be defined for PERM may be different than a state's definitions of each program. Identification of Medicaid and CHIP and the division between FFS and managed care is discussed further in the following sections.

### 3.1.2    Identifying Medicaid and CHIP for PERM

States include both Title XIX and Title XXI matched payments in the PERM data submissions. Because CMS must report separate improper payment rates for the Medicaid and CHIP programs, states must separate PERM data submissions between Title XIX and Title XXI and submit these in separate PERM universe files for each quarter. States should separate claims into the Medicaid or CHIP universe based on the following key questions:

> **Where is the money coming from?**
> **Claims are separated based on the source of federal money, <u>not the program design</u>. All payments matched with Medicaid Title XIX Federal Financial Participation (FFP) should be identified as Medicaid and submitted in the PERM Medicaid universe file.** All payments matched with Title XXI FFP should be identified as CHIP and submitted in the CHIP universe file. This includes standalone CHIP (SCHIP) programs and CHIP-funded Medicaid expansion (MCHIP) programs. MCHIP Payments that are considered part of "Medicaid" by the State but matched with Title XXI should be identified as CHIP for PERM purposes. States with SCHIP and MCHIP programs should identify all payments from those programs as CHIP.
>
> **What was the beneficiary's status at the time of <u>payment</u>?**
> **Claims are separated based on the beneficiary's eligibility status during the dates of service at the time the claim was paid (adjudicated), <u>not the beneficiary's eligibility status at the time the state selects the data for PERM</u>.** Since it is possible that individual's eligibility could change from the time a service is received to when the PERM data is pulled based on original paid date, it is imperative that states develop universe programming which identifies the funding source of the claim (XIX or XXI) rather than the beneficiary's program eligibility at the time the PERM universe is pulled for submission.

The "Fields for Universe Submission" table in **Appendix A** also includes a field called "funding code." States may populate this field with any state-specific value that identifies, or helps identify, the state requested federal Title XIX or Title XXI match for the claim or payment. For the PERM claims file, states are required to include all payments that are paid for in whole or in part by Title XIX or Title XXI Federal Financial Participation (FFP) dollars, as well as those payments considered for Title XIX FFP dollars but which were denied by your state. If your state has difficulty distinguishing between Title XIX and Title

> The PERM claims file must include all Medicaid expansion and/or stand-alone CHIP payments in the PERM submission, including payments that are paid for in whole or in part by Medicaid (Title XXI) FFP dollars, as well as payments submitted as CHIP (Title XXI) services but denied. This includes any paid or denied claims that are adjudicated by and/or stored with third party data vendors.

XXI payments in either paid or denied claims, please notify the SC who will work with state staff to find an appropriate solution.

### 3.1.3    Identifying Fee-For-Service and Managed Care for PERM

In addition to separating Medicaid (Title XIX) and CHIP (Title XXI) payments, PERM also measures FFS and managed care payments independently. Referred to as "component" measurements, FFS and managed care have PERM-specific definitions which may differ from how states define each mode of service delivery. PERM also has additional inclusion rules that are necessary to ensure a complete and accurate PERM universe. An overview of PERM definitions for each "component" is included below, along with information on what types of records are included in each "component" universe.

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

### *Fee-For-Service Universe*

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

1) **Traditional FFS claims**
   The FFS universe is comprised of all payments made on a FFS/indemnity basis, including:

   - Traditional FFS payments to physicians, hospitals, pharmacies, home health agencies, Long-Term Care (LTC) facilities, etc.

   - Medicare crossover claims

   - FFS claims for services carved out of managed care

   - FFS claims paid for retroactive eligibility periods

2) **Fixed non-risk payments**
   In addition to "traditional" FFS payments, the PERM FFS universe also includes other types of payments referred to as "fixed" for PERM purposes. These payments are often capitated, Per-Member Per-Month (PMPM) payments. They could also be system-generated, non-medical, or administrative-like payments that – unlike other PERM FFS payments - would

not require a PERM medical record review. Examples of PERM "fixed" payments include a variety of payments made to providers or vendors, such as:

- Monthly Primary Care Case Management (PCCM), Health Homes, or Patient Centered Medical Home (PCMH) fees paid to participating providers

- Health Insurance Premium Payment (HIPP) payments made to purchase or subsidize employer-sponsored insurance

- Capitated non-emergency transportation broker payments

- Fixed beneficiary-specific pharmacy dispensing fees (e.g., a state pays nursing home pharmacies a monthly fixed amount per beneficiary)

- Reinsurance payments

- Managed care stop loss payments

- Supplemental payments made to managed care organizations based on service type (Federally Qualified Health Center (FQHC) for example) or geographic region

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

3) **Aggregate payments**
   While most Medicaid and CHIP payments are paid at the beneficiary level, states may calculate and pay for some services on behalf of a group of beneficiaries. PERM classifies these payments, which are made for a group of beneficiaries. where individual payment records are not readily available or cannot accurately be re-created, as "aggregate payments."

> **States may also make payments in aggregate based on beneficiary-level information. States and the SC will work together to determine a plan for submitting this payment information.**

Unless otherwise specified by CMS, all payments for services to beneficiaries are included in the PERM universe, regardless of whether the state claims FFP at the medical services match rate or as an allowable administrative cost. The SC will work with the state to determine whether certain payments should be classified as aggregate payments for the purposes of PERM. Examples of aggregate payments seen in previous cycles include:

- Reimbursement to counties for non-emergency transportation services provided to all Medicaid beneficiaries residing in that county.

- Contractual payment to a broker for services (e.g. transportation) that cannot be identified at the beneficiary level.

- Fees paid to a case management vendor based on the number of beneficiaries enrolled in the Medicaid program each month.

- Monthly premium payments made to behavioral health organizations at the aggregate level which are not maintained in the state's MMIS system.

In some cases, states may determine payment at the individual level but maintain payment records at the aggregate level. CMS and the SC will work with the state to determine how aggregate payments should be submitted and reviewed for PERM. For example, some states make supplemental payments for FQHC services provided to beneficiaries in a Managed Care Organization (MCO). While these payments are typically made at the beneficiary level, states may only have the payment data available at the MCO level. In this case the payments would be moved to the FFS fixed payments strata for sampling. It is critical that states inform CMS and the SC of all possible aggregate payments so that all payments required for PERM review are included in a universe.

**Other Payments**
States may need to submit other types of payments as part of the PERM universe:

- **Incentive Payments**: A number of states have implemented new programs that make supplemental or "bump" payments for certain types of services. Examples of these payments include difficulty of care payments made to Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IIDs), "bump" payments made to clinic claims to increase them to the Medicare allowable, and health home incentive payments. These are usually small dollar payments that can be tied to individual beneficiaries and services. In rare instances, these payments are made to providers on the aggregate level.

> Not all incentive payments meet the requirements for inclusion in the PERM universe. States that make these payments need to provide the following information to the SC: Who receives the payment and the basis of the payment.

- **Financial Transactions**: The SC usually sees this type of payment for services that are not submitted via the MMIS and for which records are usually kept on paper or spreadsheets. There are numerous situations in which a payment may be made via this method, including payments for services given to qualified aliens, reimbursements for transportation to caregivers, payments for interpreter services, and reimbursements for out-of-pocket expenses.

In these types of situations, the state needs to discuss these payments with the SC to determine what the payments are for, if they should be included in the sampling universe, the payment level of the claim, and what information the state will need to submit in the universe data for these payments.

- **Wrap-around payments**: This is a supplemental payment, usually made to an MCO to increase the reimbursement for certain types of services. We see this most often with FQHC/Rural Health Clinics (RHC) services. These wrap around payments provide for supplemental payments from states to FQHCs and RHCs equal to the amount or difference between the payment under the FFS methodology and the payment provided under the managed care contract.

If your state makes these types of payments, you need to notify the SC during the intake meeting process.

- **ASO programs**: Payments made to an organization under an Administrative Services Only (ASO) arrangement would be included in the FFS universe. ASOs generally are contracted

to manage claims and benefits while bearing little or no risk for the cost of delivering care. There are typically two different scenarios for ASO payments:

- Scenario 1: ASOs receive an Advance PMPM for patient care. Providers bill the ASO for services received by the beneficiaries. The PMPM payment is used by the ASO to pay claims incurred by members. In many cases the payments are later reconciled with the state to the actual claim amounts. In these cases, the state maintains the risk.

- Scenario 2: The ASO is budgeted for a target amount for a set period of time (e.g., a year), but goes over the set amount in reimbursement of services. The ASO will be reimbursed for the difference by the state, and therefore all the risk is maintained by the state.

The SC will work with each state and CMS to evaluate state programs and determine if program payments conform to the PERM managed care definition or if the payments should be included in the FFS universe instead. Please be prepared to discuss any ASO arrangements in your state with the SC during the Intake Meeting.

## *Managed Care Universe*

For the purposes of PERM, the managed care universe consists of payments made by the state to "at-risk" organizations that provide services to their assigned beneficiaries. These payments are not individual claim payments or reimbursements for individual claims payments. These are typically capitation payments that cover multiple services for which the organization, and not the state, maintain financial risk. These payments, and not the claim payments made by the organizations, are subject to federal match, and are therefore reviewed under PERM.

These payments include:

Premiums for "capitated" or "full risk" arrangements, such as payments to Health Maintenance Organizations (HMOs), MCOs, Pre-paid Inpatient Hospital Plans (PIHPs), and Health Insurance Organizations (HIOs).

- Payments to service-specific providers paid as part of capitated arrangements (e.g., PBMs, behavioral health MCOs).

- Condition-specific capitation payments for special needs beneficiaries (e.g., at-risk payments for services provided to people living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) who are enrolled in a specialized managed care program.

- Certain non-capitated, beneficiary-specific payments made to MCOs such as newborn delivery supplemental payments or "kick" payments, which include multiple services, are paid at a negotiated rate and not paid on a FFS basis.

While full-risk payments to MCOs are clearly part of the managed care universe, payments associated with certain types of capitated programs may be more appropriately included in the FFS universe (see Capitated Non-Risk Payments, above). The PERM SC will discuss each state program during the data intake process and will work with the state to determine the appropriate universe (FFS or managed care) for each type of payment.

The RC can only accept single-line managed care claims. Inform the SC about claims for any type of program that have multiple lines (e.g. one line to reflect a behavioral health payment and another to reflect a physical health payment) so that the SC can determine the best way to create a sampling universe and supply the RC with all the information needed to complete the data processing review.

> **Full Risk Managed Care Program**
>
> A provider organization, or group of organizations, receive from the payer a set payment per patient for specified medical services. In this way, the provider takes on 100% of the insurance risk for the covered patient and services.
>
> **Partial Risk Managed Care Program**
>
> Managed care plan pays providers prospectively for a subset of services, such as case management or crisis services, with other services reimbursed on a FFS basis. The plan may be at risk for costs or gains that exceed a predetermined cost for the services covered under the partial risk program.

### 3.1.4    Date

PERM universes include claims and payments originally paid during the review period. For RY 2024 those dates are July 1, 2022 to June 30, 2023. To support consistency across states, PERM relies on the **original paid date** to determine whether a payment falls within a given cycle measurement.

- If a state originally paid a claim during the cycle under review, but adjusted the claim after the PERM measurement period, the claim should be included in the PERM data submission based on the original paid date.

- Conversely, if a claim's original paid date is prior to the PERM measurement period, but an adjustment falls within the PERM measurement period, the claim would not be included in the PERM data based on the original paid date.

For the RY 2024 PERM cycle, the state's PERM universe includes claims and payments with original dates of payment between July 1, 2022 and June 30, 2023.

States submit PERM data quarterly, including all claims with an original date of payment within the review quarter. Data are due to the SC 15 days after the end of each quarter. See **Exhibit 3** for the data submission due dates for RY 2024 and the paid claim dates to be included in each quarterly submission.

**Exhibit 3: RY 2024 Quarterly PERM Data Submission Dates**

| RY 2024 Quarter | Claim Date Paid | Data Submission Due |
|---|---|---|
| Quarter 1 | July 1 – September 30, 2022 | October 17, 2022 |
| Quarter 2 | October 1 – December 31, 2022 | January 17, 2023 |
| Quarter 3 | January 1 – March 31, 2023 | April 17, 2023 |
| Quarter 4 | April 1 – June 30, 2023 | July 17, 2023 |

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

- Prospective example: A state makes a capitation payment on December 25, 2022 for services in January 2023; the state includes the payment with the PERM Q2 data submission.

- Retrospective example: A state makes a capitation payment on October 5, 2022 for services in September 2022; the state should include the payment with the PERM Q2 data submission.

**Important notes about the dates used in the sampling universe**:

States may submit the adjudication date instead of the original paid date in the PERM universe as long as the state maintains a consistent date approach throughout all four quarterly submissions. The adjudication date refers to the date that a claim is fully processed and either approved for payment or denied. The state should discuss this approach with the SC during the data intake meeting.

*States may also submit certain types of claims (e.g., off-MMIS claims) using a date approach that is different from the other universe claims, as long as the dates for each data set submitted for those claims are consistent over the course of the year*. For example, a state could submit all MMIS claims using adjudication date but submit all off-MMIS waiver claims from sister agencies using paid date.

The SC will review the dates that are included for each data source with the state at the beginning of the cycle and will work with the state to identify the best date field for determining the PERM universe for each quarter. This information will be relayed to the RC and ERC for use during the data processing and eligibility reviews.

### 3.1.5    Paid Amount

The paid amount for each claim and payment in PERM should reflect the **original, non-adjusted total computable paid amount**. The total computable paid amount is the federal share plus the

> The total computable paid amount should not include beneficiary cost sharing amounts, such as patient liability (co-pays, contribution to care), TPL, or any other non-Title XIX or Title XXI matched dollars (e.g., taxes paid on waiver services).

state and/or local share of the payment. CHIP and Medicaid are jointly funded by the federal and state governments. As such, both funding sources should be represented in the total computable paid amount.

For certified public expenditures (CPEs) such as school-based services or payments to public hospitals, the state must provide both the federal and state/local share for the PERM paid amount even if the paid amount in the payment system only reflects the federal share for which match is claimed. **Please discuss with the SC any CPEs or other payments where the paid amount in the state's payment system might not reflect the PERM-defined total computable paid amount.**

## 3.2 Additional PERM Universe Specifications

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

### 3.2.1 Denied and Zero-Paid Claims

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

#### Denied Claims

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

#### Zero-Paid Claims

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

### 3.2.2 Service Expenditures Matched at the Administrative Rate

PERM includes payments made for medical services received by individual beneficiaries that are matched either at the medical Federal Medical Assistance Percentage (FMAP) or that receive FFP as an allowable administrative cost. The most common medical services that may be matched with administrative funds include NET or HIPP payments.

Please discuss with the SC any services that are considered an allowable administrative cost, but could be considered a medical service to determine if the service payments should be reported for PERM.

In addition, Fiscal Management Services (FMS) are services and functions that assist the Medicaid beneficiary or his/her family to:

- (1) Manage and direct the disbursement of funds contained in the participant-directed budget and

- (2) Facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll; withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and performing fiscal accounting and making expenditure reports to the Medicaid beneficiary or family and state authorities.

For any self-directed/consumer-directed personal care services in your state, if the expenses were incurred under an arrangement with a FMS vendor, you will need to determine how your state claimed the cost.

- If the cost was incurred as an expense for a direct medical service and claimed via the applicable FMAP, these claims need to be included in the PERM submission.

- If the cost was claimed as a state program administrative expenditure, please notify the SC and do not submit these payments in the PERM submission.

### 3.2.3    Claims and Payments Excluded from the PERM Universe

Below we provide some specific guidance regarding what types of payments, claims, and records are excluded from the PERM universe. Certain claims and payments for which states receive FFP through Title XIX or Title XXI are explicitly excluded from PERM either by regulation or in accordance with established policy. During the intake meeting, the SC will discuss these exclusions in more detail with each state to ensure that each state's specific data submission is compliant with PERM requirements regarding excluded data. *It is vital that all excluded claims are removed from the universe data submission to ensure there is a valid sampling universe. Failure to do so can result in dropped samples, oversamples, and resamples that increase the work required by the state and contractors*.

### 3.2.4    Payments Excluded by Regulation

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

- Disproportionate Share Hospital (DSH) payments

- Drug rebates

- Grants to state agencies or local health departments

- Cost-based reconciliations to not-for-profit providers or FQHCs

- Mass adjustments

- Lump-sum Graduate Medical Education (GME) payments

- Express Lane Eligibility (ELE) claims are excluded from eligibility reviews. States should identify these claims in the universe data files so they are only sampled for the applicable

reviews. If the state cannot provide this information in the universe file, please work with the SC to determine how ELE can be determined for sampled claims.

### 3.2.5    *State-only and Other Non-Title XIX /Non-Title XXI Payments*

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

### 3.2.6    *Medicare Part A and Part B Premium Payments*

States must not include Medicare Part A and Part B premium payments in the PERM data submission. The SC will collect these payments from CMS to include in each state's universe prior to sampling.

**When states receive their Medicaid FFS samples, a**ny premium payments that are sampled **will be sent to the states in a separate file and are subject to data processing review.** Please be sure to share these samples with any state staff who work with Medicare Premiums and will be providing the documentation needed for completion of DP reviews. Along with the Medicare Premium sample, the SC also provides a file layout which contains the variable names, descriptions, format, and position of each variable. This sample also includes SSNs which can be used to locate the premium payment beneficiaries. The RC will notify the states about what information needs to be provided for these claims during their reviews.

### 3.2.7    *Informational-only Data*

States **must not include** informational-only data in the routine PERM universe data submissions. Informational-only data is defined as records maintained in the state or vendor payment system that do not represent actual payment to a provider. Examples include:

- Supporting service lines submitted with an inpatient hospital claim paid via Diagnosis-Related group (DRG) payment.
- FQHC claims with informational-only procedure codes billed in addition to the T1015 procedure code.
- Bundled claims that list out all billed procedure codes when only one code was adjudicated.

### 3.2.8    Encounter Data

States must not include encounter data or "shadow claims" in the PERM submissions. For PERM purposes, encounter data is defined as informational-only records submitted to a state by managed care contractors under an at-risk contract with the State. The records include claims for services covered under a managed care capitation payment. States often collect this data in order to track utilization, assess access to care, and possibly compute risk adjustment factors for use in risk-adjusting capitation payments. While encounter data records are beneficiary-specific, they do not represent an actual payment made by the state. As a result, these claims are not subject to FFP, and as a result, not included in PERM.

> **Data Issues Caused by Inclusion of Excluded Claims or Lines in the Sampling Universe:**
>
> - Any of these claims that are sampled have to be dropped
> - Dropped samples are addressed in two possible ways:
>     - Replacement samples are drawn
>     - Universe is resampled after excluded lines are removed from the sampling universe
> - This situation creates extra work for the states and all contractors (SC/RC/ERC)

### 3.2.9    Rejected Claims

States must only include fully adjudicated claims and payments in the PERM submissions. Claims that are submitted by providers that are "rejected" from the claims processing system prior to adjudication are not part of the PERM review. Often claim rejection occurs in a pre-processor or translator prior to the system assigning the claim an internal control number. During the intake discussion, states should raise any concerns regarding the distinction between denials and rejections.

### 3.2.10    Payments for Administrative Functions

As noted above, PERM claims and payments represent services to beneficiaries. Payments made entirely for administrative functions are not included in the PERM review and states should not include these in the PERM submissions. These include payments such as:

- State staff salaries
- Fiscal agents and other administrative vendors
- Outreach funding

*For cases in which a state blends dollars for beneficiary services with administrative payments into a single reimbursement rate, the state should submit the entire payment for PERM review.*

### 3.2.11    Adjusted Claims

States are required to remove claim or payment adjustments (individual and mass adjustments) and refunds from the PERM data submissions. Only the original paid amount should be submitted in the PERM universe. **Please notify the SC if your state uses a void and replace system**.

### 3.2.12 Void and Replace Claims

States should notify the SC if they utilize a void and replace system. Claims that are voided should be excluded from the sampling universe as they are not reviewable by the RC. Voided claims

should either be removed from the universe data submission or logic should be provided so the SC may remove them.

## 3.3   Data Sources

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

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

- Claims paid by separate vendors or third party administrators
  - Pharmacy
  - Dental
  - Vision
- Behavioral health
- Claims paid by sister state agencies (not the Medicaid agency)
- Services for Individuals with Intellectual Disabilities or Developmental Disabilities (ID/DD)
- State-owned facilities such as nursing homes
- Waiver services (including consumer-directed individualized budgets)
- Claims paid by counties
- Transportation provider payment systems
- Case management costs
- Stand-alone or "manual" systems
- HIPP payments
- FQHCs, RHC, Indian Health Service (IHS) clinics and facilities
- Systems that produce payments such as PCCM payments and non-emergency medical transportation broker capitation payments

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

## 3.4    Payment Level in the PERM Submission

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

> **Correctly identifying how claims are paid is important for sampling claims at the correct level; errors at this stage can lead to oversamples late in the cycle.**

Individual beneficiary-level FFS claims are typically submitted at the line or claim (header) level. A broad definition is provided below and more detail is provided in the following sections.

- **Line level:** If a payment amount is determined to be at the "line" level for each specific service provided, the sampling unit is the line level; each clam line has an opportunity to be sampled; this applies to most physician and outpatient claims that have multiple paid lines on each claim.

- **Header level:** If the payment amount is determined to be at the claim level, the sampling unit is at the claim or "header" level; a header level sampling unit has a paid amount that is not associated with any specific line or service; rather, it is based on days, groups of services and/or other related information, encounter rates, or point of sale transactions; this applies primarily to inpatient and pharmacy claims where there are no separate line-level payments. If a claim is paid at the header level, only the header line should be submitted as part of the universe submission.

**Important notes about payment level determinations:**

- For FFS claims note that if payment amount determination is made for the claim as a whole, regardless of the number of lines, and the individual lines are informational but not used for payment, it is a header level payment. If each line in a claim stands the chance of being paid or denied individually, these are line level payments.

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

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

When developing data specifications for PERM, it is important to carefully review the many types of claims paid by the state so that the appropriate sampling unit is determined. A few states have found it helpful to review each state claim type or other payment indicator to identify claims as

header or line level payments. However, be aware of possible exceptions to the claim type payment "rules."

### 3.4.1    Header Level Example

For those states using a prospective payment or DRG systems for inpatient stays, the smallest independently priced item is the DRG itself. In this case, the DRG (or claim header) is the sampling unit. When the header is the sampling unit, there would be a single record for each inpatient hospital claim, with the amount paid field equal to the amount paid for the entire claim. If the state determines that the sampling unit is the header, the state should not include in the PERM universe the records for the detail lines associated with the header (often these are zero-paid lines). Similarly, if the inpatient stay is priced as an all-inclusive per diem payment amount, the sampling unit would be at the claim header level. **Exhibit 4** provides an example of a header level sampling unit.

**Exhibit 4: Example of a Header Level Claim Fields**

| clm_id_icn | line_number | dos_from_clm | dos_to_clm | diag_code_1 | diag_code_2 | rev_code | place_of_svc |
|---|---|---|---|---|---|---|---|
| 1234567 | 0 | 09012012 | 09302012 | 43889 | 431 | 0191 | 2 |
| 1234567 | 1 | 09012012 | 09302012 | 43889 | 431 | 0250 | 2 |
| 1234567 | 2 | 09012012 | 09302012 | 43889 | 431 | 0258 | 2 |
| 1234567 | 3 | 09012012 | 09302012 | 43889 | 431 | 0300 | 2 |
| 1234567 | 4 | 09012012 | 09302012 | 43889 | 431 | 0301 | 2 |
| 1234567 | 5 | 09012012 | 09302012 | 43889 | 431 | 0430 | 2 |
| 1234567 | 6 | 09012012 | 09302012 | 43889 | 431 | 0434 | 2 |
| 1234567 | 7 | 09012012 | 09302012 | 43889 | 431 | 0460 | 2 |

### 3.4.2    Line Level Example

Most professional claims are paid through individually-priced procedure codes recorded at the line level. In these cases, the state would submit the provider claims in the universe file at the line level. Each record or sampling unit will represent a claim line and the amount paid for that line. For a lab claim with several separately priced tests, each line item on the claim would be defined as a sampling unit and sampled separately. A claim for lab tests paid on a bundled basis would be treated as a single line level sampling unit. For claims submitted at the line level, the state should not include a header level record (this would essentially "double" the paid amount associated with the claim in the PERM universe). **Exhibit 5** provides an example of line level sampling units.

**Exhibit 5: Example of Line Level Claim fields**

| clm_id_icn | diag_code_1 | diag_code_2 | dos_from_clm | line_number | proc_code_line | units_of_svc_paid | amt_paid_line |
|---|---|---|---|---|---|---|---|
| 1234567 | 43889 | 431 | 09012012 | 0 | A4253 | 2 | 100.00 |
| 1234567 | 43889 | 431 | 09012012 | 1 | A4256 | 1 | 150.00 |
| 1234567 | 43889 | 431 | 09012012 | 2 | E0607 | 1 | 100.00 |

### 3.4.3    Payment Level and Third Party Liability

TPL is the portion of the allowed Medicaid/CHIP reimbursement that is paid by other insurance or the beneficiary.

> **As mentioned earlier in this document, the total computable amount submitted in the claims universe should not contain any TPL payments. Including this amount in the 'Paid Amount' field can result in claims being sampled in the incorrect strata if the TPL is taken out at a different level than the one at which the claim is typically paid. Correctly identifying how claims are paid is important for sampling claims at the correct level; errors at this stage can lead to oversamples or resamples late in the cycle.**

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

**The state should review with the SC any beneficiary cost-sharing policies and requirements – such as co-pays and deductibles – before preparing data submissions**. The state will need to identify how cost-sharing is reflected in the data and at what level federal match is provided (i.e., claim paid amount or individual line paid amount) to ensure the total computable paid amount is accurately identified. Identification of claims with TPL is vital to ensuring that claims are both sampled at the correct level and accurately reflect the total computable amount.

### 3.4.4    Payment Level Identification Challenges

For certain types of claims and payments, it can be difficult to accurately identify the appropriate "payment level" for PERM purposes. States should pay particular attention to certain types of claims for which the payment level might differ from other payments for similar services. Examples are discussed below.

- **Bundled payments:** In some states, providers submit unpaid denied or $0 paid informational line details with claims that are paid at a bundled rate. These informational line items should be excluded from the universe data submission but must be included in the details.

- **Medicare crossover claims:** Medicare crossover claims are often paid on the basis of the type of service, and the universe file will need to capture these payments at the header or line item level, as appropriate to each payment. States need to provide the SC direction about the best way to identify crossover claims in the universe data.

- **Payments made to state-owned facilities or out-of-state facilities:** Some states pay state-owned facilities differently than private providers. If this is the case, be certain to select the appropriate header or line value for the PERM universe.

- **Compound drugs:** Many times the payment rate for compound drugs is different than for other pharmacy claims. Please be sure to verify the payment level for these claims and ensure that, at the details stage, all billed NDCs can be provided to the SC.

- **Clinic claims:** Clinic claims paid under an all-inclusive code (i.e. T1015) are treated similarly to header level claims. Only the line with the all-inclusive code will be eligible for sampling. All other lines are informational only and should not be subject to sampling.

- **Multiple units of service:** 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.

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

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

## 3.5    Fields in the PERM Universe Submission

As noted above, while the universe must contain a record for every payment that meets the PERM universe criteria, each payment record in the FFS universe only needs to contain a relatively small number of data elements or fields. After the SC samples FFS claims for review, the state will then submit a larger number of fields, including beneficiary and provider information, only for the sampled claims. (Note that these fields are not required for fixed payments.) The sampled claim details submission is described in the Details Submission Instructions document.

For the managed care universe, we require states to submit all of the fields needed for review as part of the universe submission. Please note these now include additional beneficiary fields. Therefore, the managed care universe submission contains more required fields than the FFS universe. However, because the managed care universe already contains the fields needed to review sampled managed care claims, states generally do not need to submit a second detail submission for sampled managed care claims.

**Appendix A** contains a list of the fields required for each payment record in the FFS and managed care universe submissions.

- Some of these fields – such as Internal Control Number (ICN), line number, and source location – allow the state, SC, and RC to identify the sampled payment in the state's system.

- Many fields – such as date paid, amount paid, claim type, provider type, managed care program indicator, and payment status – are used by the SC to validate that the universe is complete and accurate.

- Some of the required fields, such as funding code and fixed payment indicator, are used to ensure that payments are assigned to the appropriate PERM universe prior to sampling

- Many of the managed care-specific fields – such as beneficiary ID, rate indicator, aid category, and coverage location – are used by the RC to conduct the managed care payment review.

- States may also submit state-defined fields with the data if desired.

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

## 3.6 Identifying Strata for Sampling Stratification

For RY 2024, the SC will use payment-based stratification. The FFS universe is stratified into five dollar-weighted strata with an additional stratum for claims that cannot receive Medical Review. The managed care universe will continue to be stratified by payment amount only. The SC will assign each payment in the FFS PERM universe to one of six strata, which include:

- Fixed Payment Strata (MEDICAID) – Stratum will include fixed payments, Medicare premium payments, aggregate payments, and Medicare crossover claims. The count of sampled claims from this stratum will be capped at no more than 10% of the sampled payments for each quarter.

- Fixed Payment Strata (CHIP) – Stratum will include fixed payments, aggregate payments, and Medicare crossover claims (if applicable).

- Five (1-5) Payment-Weighted Strata (MEDICAID AND CHIP) – All FFS claims that do not fall into one of the strata listed above will be classified into one of five payment strata. *The count of sampled claims from each payment-weighted stratum will be 2 claims at a minimum for each quarter.*

## 4. Changes to the Reporting Year (RY) 2024 PERM Data Submission Instructions from RY 2021

There have been updates to the required managed care and FFS fields since the RY 2021 cycle which are outlined in **Exhibit 6.**

**Exhibit 6: Changes to the RY 2024 PERM Data Submission Instructions from RY 2021**

| General Fields | |
|---|---|
| **Beneficiary Type** | For KICK payments in the Managed Care universe, the Beneficiary Type indicates if the beneficiary information given on the claim belongs to the mother or the baby. This information is used to determine which individual is under review on the claim. |
| **EAPG Rate Code** | Enhanced Ambulatory Patient Grouper rate code (EAPG) or regular Ambulatory Patient Grouper (APG) rate code used by state to bundle outpatient services for payment. This is required for any Outpatient services that use bundling by EAPG/APG codes. |
| **COVID-19 Indicator** | Indicates if the service is related to COVID-19 |
| **Emergency Services Indicator** | Indicates if the service was provided for a qualified alien. |

| Eligibility Fields | |
|---|---|
| **Express Lane Eligibility (ELE) Indicator (if applicable)** | This field contains the indicator for beneficiaries with Express Lane Eligibility (ELE). Data decodes must be provided in the data dictionary. Beneficiaries with ELE do not qualify for eligibility review, but may qualify for medical record or data processing review. |

# 5.    Quality Review

States are responsible for performing a quality review of their PERM data submissions each quarter before submitting files to the SC. Quality review saves time and resources for both the state and CMS contractors by identifying data problems early in the PERM process. **Exhibit 7** contains suggested minimal QC checks for states to complete.

**Exhibit 7: Minimum Universe Submission Quality Control Checks**

| Quality Review | Suggested Tests |
|---|---|
| 1)   Ensure all required fields are reported in the universe file | ▪ Prepare a list of all fields in the universe file and compare it to the list of fields in Appendix A<br>▪ Identify any missing fields<br>▪ Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file |
| 2)   Check that key fields are properly formatted and have valid values | ▪ Check that key fields are not truncated or contain extra data. Review fields such as<br>  • ICN/TCN;<br>  • Line number;<br>  • Paid amount; and<br>  • Date of payment. |
| 3)   Check that the paid date for all records is for the appropriate quarter for RY 2024 | ▪ Review the values in the paid date field<br>▪ Only include payments that were adjudicated in the appropriate quarter of RY 2024 |
| 4)   Confirm Medicaid (Title XIX) and CHIP (Title XXI) claims are appropriately allocated to the correct universe | ▪ Review programming logic and outputs to make certain that claims in the Medicaid universe were matched with Title XIX funds and claims in the CHIP universe were matched with Title XXI funds. This check includes sharing funding source information so that the SC can identify Title XIX FFP or Title XXI FFP.<br>▪ Please note, Medicaid expansion (M-CHIP) claims reimbursed with Title XXI funds belong in the CHIP universe for PERM purposes.<br>▪ Any logic that your state uses to create a Medicaid/CHIP indicator or to separate out CHIP and M-CHIP claims may be useful to document for the SC to recreate. |

| Quality Review | Suggested Tests |
|---|---|
| 5) Confirm that FFS and managed care claims are appropriately allocated to the correct universe | ▪ Review programming logic and outputs to make certain that claims are allocated to the correct universe<br>▪ Review notes from intake discussion and subsequent communications with the SC and CMS to ensure the universes contain the required types of claims and payments<br>▪ If PERM "fixed" payments will be submitted with the managed care data, be sure to notify the SC and provide guidance on how to identify the payments so they can be moved to FFS |
| 6) Each payment is represented only one time in the universe | ▪ Confirm that there are no ICN-line number combinations repeated in the universe |
| 7) Compare the universe size to previous quarterly submissions | ▪ Sum number of claim lines and paid amount between quarters<br>▪ Note the reason for any significant changes |
| 8) Prepare to review the SC's comparison of the CMS-64/21 reports to the PERM universe submissions | ▪ Compare PERM universe totals to either two previous quarters' CMS-64/21 reports, or to the current quarter's CMS-64/21 reports<br>• Look for major dips or spikes or "significant" differences |

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

States should compare their PERM+ data submissions to CMS-64 and CMS-21 Financial Reports, respectively, to ensure that the universes are complete and accurate. Comparing the PERM+ data to the CMS Financial Reports ensures that no programs (likely not in MMIS) that appear on the CMS Financial Reports have been omitted from the PERM+ data and that the state is capturing all necessary data sources in the PERM+ data submission.

This comparison may identify data which does not fit cleanly into the definitions previously discussed in these submission instructions. For example, the CMS Financial Reports include non-beneficiary-specific payments, such as aggregate provider reconciliations. When aggregate or similar payments are identified on the CMS Financial Reports, we ask that states bring this to the attention of the SC so that we can investigate whether these should be included in the PERM+ data on a case-by-case basis. Lewin begins these comparisons as soon as Quarter 1 data is sampled.

If after this comparison the state identifies Medicaid or CHIP dollars that were excluded from the PERM+ data, the state should notify the SC to coordinate the submission of the missing data. The CMS-64 and CMS-21 forms may not be finalized until after the PERM+ data are submitted, so we ask that states conduct these comparisons after the forms are finalized and as necessary review forms submitted from previous quarters to see if any adjustments were made after the initial submission that will need to be communicated to the SC during reconciliation.

The comparison that the states are asked to do is separate from the in-depth comparison that the SC will conduct throughout the cycle. The SC will identify the portions of the CMS-64 and CMS-21 Financial Reports that are not appropriate to compare to PERM universes (excluded claims, drug rebates, adjustments, etc.), remove these from the CMS-64 and CMS-21 Financial Report Totals, and separate the CMS-64 and CMS-21 totals between FFS and managed care. If significant differences, as defined by CMS – 15% per quarter and 5% overall, between PERM universes and the Financial Reports are identified, the SC will contact the state to resolve the differences. **Please note that if significant differences are found, the SC may halt sampling and details work on impacted universes until the discrepancies are resolved.**

> All claims submitted to the SC under the CHIP program should be matched with Title XXI funds; these are reported on three forms, 64.21U, 64.21U-Waiver, CMS-21. If you believe some CHIP claims submitted for PERM review are reported on any other forms, please notify the SC. No Title XXI matched claims should be included in the PERM Medicaid universe.

# 6. Data Transmission and Security

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

## 6.1 Submission Media

The SC's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, portable hard drives). It is preferred that states send their data via Secure File Transfer Protocol (SFTP). SFTP instructions will be sent to the states before the first required data submission. Any files sent via SFTP need to be encrypted and password protected. If submission via SFTP is not an option, states may submit data on an encrypted CD or DVD. **Do not send PERM data via email.**

States planning to use the SFTP will be required to test their access prior to the first data submission. Please note that the Lewin SFTP has been updated since the last cycle. It now has two-factor authentication for increased security. Once the user names and passwords for your state are assigned, you will receive instructions on how to access the new SFTP site. States are encouraged to test access as early in the cycle as they are able.

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

## 6.2 Submission Formats

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

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

### 6.2.1    Transmission Cover Sheet

The state must submit a Transmission Cover Sheet with every universe data submission. The Transmission Cover Sheet is used to ensure that all the data sent by the state is received by the SC, and to compare the control totals and to correct any potential data transmission errors before processing and sampling the data. Examples of the Medicaid FFS and Medicaid managed care data Transmission Cover Sheets are provided in **Appendix A**. The state may include the Transmission Cover Sheet on the CD or DVD with the data, email the cover sheet to the SC, or submit as a separate file through the SFTP. The SC will not process the data further until the control totals match.

### 6.2.2    File Layouts

States are required to submit file layouts to inform the SC of the field name, length, and type (numeric versus character), and valid values as applicable. File layouts are required to the SC ahead of the state's first quarterly data submission and any time there is a change made to the initial file layout. If files are submitted from multiple sources or in multiple formats the state should submit a separate file layout for each of the files. Failure to provide this documentation will delay the SC's work on the state data submission. This is critically important in processing the files. Failure to submit correct and complete file layouts may lead to:

- Truncation of data

- Missing required fields

- Inability to remove non-PERM compliant records from the universe, which may in turn lead to oversampling

- Delay in reviews

### 6.2.3    Data Dictionary

States are required to submit a file in Excel, CSV, Word, or other text detailing the values in each variable field and what they stand for. For example, claim type variable can have values, such as: "I", "O", "3", "6", and data dictionary would indicate "I" = "Inpatient", "O" = "Outpatient", "3" = "Clinics", and "6" = "Fixed Payment". If the field has standard codes, like ICD9/10, diagnosis codes, or procedure modifiers, these variable values do not need to be provided in the data dictionary. States must ensure that valid values listed in the data dictionary match the values in the claims data. The state should submit a data dictionary for each data source.

**Required** tabs/pages in the data dictionary:

- FFS
  - Claim Type
  - Provider Type
  - Billing Provider Specialty
  - Service Category
  - Place of Service

- Local Codes (procedure, revenue, place of service, etc.)
- Beneficiary Aid Category/Beneficiary Eligibility Category
- Funding Code
- Beneficiary County (if county names are not used)

■ Managed care
- Payment Type
- Program Type
- Beneficiary Rate Indicator
- Beneficiary Aid Category/Beneficiary Eligibility Category
- Funding Code
- Beneficiary County (if county names are not used)

### 6.2.4    Privacy

The SC is committed to protecting the confidentiality, integrity, and accessibility of sensitive data. PERM states should comply with HIPAA Privacy and Security Rules, CMS Business Partners Systems Security Manual rules for sensitive data transfer, and state privacy and security rules. Data that include Protected Health Information (PHI) and/or Personally Identifiable Information (PII), such as beneficiary ID numbers, is considered sensitive data.

### 6.2.5    Data Transmission

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

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

The preferred method of data transmission is via SFTP.

**Follow these steps if sending data via SFTP.**
1) Contact the SC to discuss the SFTP site, establish an SFTP connection, and test the SFTP prior to data submission.
2) Encrypt and password-protect data files.
3) Zip all PERM data files, including the Transmission Cover Sheet, data dictionary, file layouts, into a single zip file.
    ■ Note: For very large files, more than one zip file may be necessary. Contact the SC for more information.
4) Upload the zipped file to the SFTP.

5) Email a copy of the Transmission Cover Sheet and password(s) to PERMSC.2024@Lewin.com to indicate that the PERM data is available on the SFTP site.

**Follow these steps if mailing data.**

1) Zip files, as needed, based on file size.

2) Encrypt and password-protect data files, copy to a CD or DVD.

3) Label the CD or DVD "CMS Sensitive Information".

4) Label the envelope "To be opened by addressee only".

5) Address the envelope to the "PERM Statistical Contractor" and use the following address:

   - 3160 Fairview Park Drive, Suite 600, Falls Church, VA 22042

6) Mail the CD or DVD via a private delivery service (such as FedEx or UPS) or the USPS.

7) E-mail the Transmission Cover Sheet and password(s) for the data to the SC.

# 7. Common PERM Data Issues

**Exhibit 8** lists common PERM data issues faced in prior cycles and outlines each state's responsibility to mitigate these issues.

**Exhibit 8: Common PERM Data Issues**

| PERM Data Issue | State Responsibility |
|---|---|
| Vendor Data | ▪ Ensure that all state vendors participate in the SC intake meetings and data from all state vendors is included in the data submission<br>▪ Send the file layout and data dictionary for each data source to the SC ahead of the Quarter 1 data submission<br>▪ Notify the SC if the claims information in the vendor system (paid dates, paid amounts, payment status, etc.) differs from what is provided in the universe data<br>▪ Notify SC if claims information in the vendor system is stored in another system (i.e., MMIS or data warehouse)<br>▪ Ensure that all vendor data dictionaries are sent to the SC |
| M-CHIP and S-CHIP Claims | ▪ Notify the SC if your state has a Medicaid expansion program<br>▪ Provide the SC with the information needed to identify these expansion claims in the universe data<br>▪ Verify the match type that these claims receive and provide that information to the SC<br>▪ Provide the SC with the logic that your state uses to create the Medicaid/CHIP indicator or to separate out S-CHIP and M-CHIP claims so the SC can recreate these indicators |

| PERM Data Issue | State Responsibility |
|---|---|
| CMS 64/21 Reconciliation | ▪ Ensure that the data and financial staff attend the 64/21 intake meeting<br>▪ Work with financial staff to ensure that all federally matched data is included in the universe<br>▪ Check the quarterly 64/21 reports to ensure that all required data is being submitted to PERM<br>▪ If you receive notification that the 64/21 reconciliation numbers are outside the allowed threshold, provide information needed to address the differences within the timeframes requested by the SC |
| Missing Provider and/or Beneficiary Information | ▪ Review universe data submission and verify that all required provider and beneficiary fields are populated<br>▪ Send an explanation to the SC for any fields that are blank (not always present on denied claims, not applicable for aggregate claims, will be provided only for sampled claims, etc.)<br>▪ Notify SC if provider/beneficiary information reside in multiple systems – for example at the vendor and at the state/MMIS |
| Timeliness | ▪ States need to review the cycle timelines as well as the state-specific timelines sent over by your Data Manager<br>▪ If the state anticipates any delays – in submitting data, responding to questions, or providing information needed for details – the SC should be notified as soon as possible<br>▪ Delays in completion of sample and detail files cause delays in the start of reviews by the ERC and RC |

## Appendix A. Fields for Universe Submissions

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

### Universe – Medicaid Fee-For-Service and CHIP Fee-For-Service (including Fee-For-Service Fixed Payments)

| Standard Field Name | Standard Field Description | Notes/Suggestions |
|---|---|---|
| ICN | Unique claim identifier (e.g., ICN, TCN, other state-issued number) | Required. Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For "dummy" claims, be sure the ICN information can tie back to the payment. If the ICN/line number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used. |
| Line Number | Line item number | Required. Indicate in documentation the line item number for headers (e.g., header line = 0). |
| Date Paid | **Original date** of payment or adjudication | Required. Please format dates as "mm/dd/yyyy" if possible. |
| Amount Paid | Total computable amount paid on the line or header | Required. Total Computable Amount = Federal Share + State and/or Local Share. |
| Service Date From | Beginning date of service for the claim or claim line | Required for all claims. Please format dates as "mm/dd/yyyy" if possible. |
| Service Date Through | Ending date of service for the claim or claim line | Required for all claims. Please format dates as "mm/dd/yyyy" if possible. |
| Claim Type | State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim | Required. State data dictionary required. |
| Funding Code | Indicates the funding source for the claim or claim lines (e.g., Title XIX, Title XXI) | Required. State data dictionary required. |
| Category of Service | Classification for broad types of state/federal covered services | Required. State data dictionary required. |

| Standard Field Name | Standard Field Description | Notes/Suggestions |
|---|---|---|
| Payment Status | Indicator if the claim is paid or denied | Required.<br>Paid or denied indicator for each claim or claim line as it was originally adjudicated. Should not reflect an adjusted payment status.<br>"P" for paid, "D" for denied. |
| Medicare Crossover Indicator | Indicates if a claim has Medicare as primary payer and Medicaid as secondary payer. | Required.<br>"Y"= Crossover<br>"N"= Not a Crossover<br>Ensure all values are coded as "Y" or "N" and the field is populated for all records |
| Fixed Payment Indicator | Indicates where a payment is fixed | Required.<br>Suggest using Y= Fixed Payment, N= Not a Fixed Payment. |
| Payment Level | Header level, line level | Required.<br>H = Sampling unit paid at the Header level.<br>L = Sampling unit paid at the Line level. |
| Billing Provider Name | Name of billing provider for a claim | Required. |
| Billing Provider Legacy ID | The state legacy provider ID number for the billing provider of a claim | Required, if available. |
| Billing Provider National Provider Identifier (NPI) | The NPI number for the billing provider of a claim | Required, if available. |
| Performing Provider Name | Name of performing provider for a claim. | Required, if available. |
| Performing Provider Legacy ID | The state legacy provider ID number for the performing provider of a claim. | Required, if available. |
| Performing Provider NPI | The NPI number for the performing provider of a claim. | Required, if available. |
| Referring Provider Name | Name of referring provider for a claim. | Required, if available. |
| Referring Provider Legacy ID | The state legacy provider ID number for the referring provider of a claim. | Required, if available. |
| Referring Provider NPI | The NPI number for the referring provider of a claim. | Required, if available. |

| Standard Field Name | Standard Field Description | Notes/Suggestions |
|---|---|---|
| Billing Provider Type | Provider type or MSIS category or other similar variable | Required.<br>State data dictionary required. |
| Provider Specialty | Provider specialty code for the claim or claim line | Required.<br>State data dictionary required. |
| Service Code | Procedure code on the line (HCPCS, CPT, or other proprietary payment code) as it was adjudicated (often for, but not exclusive to, line level sampling units)<br>If proprietary codes are used, State must indicate as such and provide necessary decode information. | Required, if available.<br>State data dictionary required if values are proprietary codes. |
| Source Location | The system of origin/location in which the sampling unit was originally adjudicated | Required, if applicable.<br>If system operated outside the MMIS, the state should provide a crosswalk from the system to the location, e.g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State. |
| Beneficiary ID | Beneficiary Medicaid/CHIP number<br>Can be Medicaid ID or system-specific ID | Required for all PERM claims. |
| Beneficiary Name | Beneficiary Full Name | Required for all PERM claims. Order of names should be: last name, first name mi |
| Beneficiary Date of Birth | Beneficiary date of birth | Required for all PERM claims. |
| Beneficiary Gender | Beneficiary gender code | Required for all PERM claims.<br>State data dictionary required. |
| Beneficiary County | Beneficiary county | Required, if available.<br>State data dictionary required. |
| Service Area Indicator | Indicator for the geographic service area if the service area is not the county | Required if beneficiary county is not available.<br>State data dictionary required. |
| Beneficiary Eligibility Category | The specific benefit the beneficiary qualifies for, which is used in adjudication of the service(s) on the claim. | Required, if available.<br>State data dictionary required. |
| Place of Service | Indicates place of service. | Required, if available.<br>State data dictionary required. |

| Standard Field Name | Standard Field Description | Notes/Suggestions |
|---|---|---|
| Type of Service | Indicates type of service a claim is billed for | Required, if available. State data dictionary required. |
| Federal Claim Category | MSIS Code, CMS 64 line, or other state mapping into a federal claim category | Required, if available. State data dictionary required. |
| Express Lane Eligibility (ELE) Indicator | Indicator for beneficiaries with Express Lane Eligibility (ELE) | State-specific values, if applicable and available. Required for states with ELE: AL, CO, GA, IA, LA, MD, MA, NJ, NY, OR, PA, SC, SD, and UT. |
| EAPG Rate Code | EAPG or regular APG rate code used by state to bundle outpatient services for payment. | Required for outpatient services that pay via EAPG bundling, if available. |
| Beneficiary Type | For labor and delivery payments, this indicates if the beneficiary information given on the claim belongs to the mother or the baby. | Provide data dictionary if decodes do not match standard field format. |
| COVID-19 Indicator | A Yes/No indicator indicating a COVID-19 claim. | Required, if available  *Y = claim contains diagnosis or treatment of COVID-19  *N = claim has no COVID-19 diagnosis or treatment |
| Emergency Services Indicator | Indicator for emergency services rendered to qualified aliens. | *Y = Yes, emergency services rendered for qualified alien  *N = No, emergency services not rendered for qualified alien |
| User Option Fields 1-10 | State supplied additional fields | Optional. |

## Universe – Medicaid Managed Care and CHIP Managed Care

| Standard Field Name | Standard Field Description | Notes/Suggestions |
|---|---|---|
| ICN | Unique claim identifier (e.g., ICN, TCN, other state-issued number) | Required.<br>Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For "dummy" claims, be sure the ICN information can tie back to the payment.<br>If the ICN/line number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used. |
| Date Paid | **Original date** of payment or adjudication | Required.<br>Please format dates as "mm/dd/yyyy" if possible. |
| Amount Paid | Total computable amount paid of the payment | Required.<br>Total Computable Amount = Federal Share + State Share. |
| Managed Care Program Indicator | Name of the managed care program or plan (TANF, PACE, LTC, behavioral health) | Required.<br>State data dictionary required. |
| Payment Type | E.g., monthly capitation, delivery kick payment or other beneficiary-specific supplemental payment, individual reinsurance payment | Required.<br>State data dictionary required. |
| Funding Code | Indicates the funding source for the claim or claim lines (e.g., Title XIX, Title XXI) | Required.<br>State data dictionary required. |
| Provider ID | Medicaid/CHIP ID for the MCO | Required. |
| Beneficiary ID | Beneficiary Medicaid/CHIP number | Required. |
| Beneficiary Name | Beneficiary Full Name | Required.<br>State may submit according to state preference (e.g., can submit multiple variables for first, middle, and last name or a single variable containing beneficiaries full names). |
| Beneficiary Rate Indicator | Rate cell or rate group used to determine the payment for the beneficiary to the managed care plan | Required.<br>State data dictionary required. |
| Beneficiary Aid Category | Aid code used to identify beneficiaries rate cell and what payment is made to MCO (not the same as eligibility type/group) | Required.<br>State data dictionary required. |
| Beneficiary DOB | Beneficiary date of birth | Required.<br>Please format dates as mm/dd/yyyy. |

| Standard Field Name | Standard Field Description | Notes/Suggestions |
|---|---|---|
| Beneficiary Gender | Beneficiary gender code | Required.<br>State data dictionary required. |
| Beneficiary County | Beneficiary county | Required.<br>State data dictionary required. |
| Service Area Indicator | Indicator for the geographic service area if the service area is not the county | Required.<br>State data dictionary required. |
| Beneficiary Eligibility Category | The specific benefit the beneficiary qualifies for, which is used in adjudication of the service(s) on the claim. | Required, if available.<br>State data dictionary required. |
| Beneficiary Date of Death | Date of death of beneficiary as stored in the state's adjudication system | Required, if applicable.<br>Please format dates as "mm/dd/yyyy" if possible. |
| Source Location | The system of origin/location in which the sampling unit was adjudicated | Required, if applicable.<br>If system operated outside the MMIS, the state should provide a crosswalk from the system to the location, e.g., 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State. |
| Coverage Period From | Beginning date of the coverage period or date of service for the payment, typically the first of the month | Required.<br>Please format dates as "mm/dd/yyyy". |
| Coverage Period To | End date of the coverage period or date of service for the payment, typically, the end of the month | Required.<br>Please format dates as "mm/dd/yyyy". |
| Payment Status | Indicator if the claim is paid or denied | Required.<br>Please format as "P" for paid and "D" for denied if possible.<br>If not formatted as "P" or "D" state data dictionary required. |
| Beneficiary Type | For KICK payments, indicating if the beneficiary information given on the claim belongs to the mother or the baby. | Required for KICK payments.<br>Please format as "M" for mother and "B" for baby if possible.<br>If not formatted as "M" or "B" state data dictionary is required. |
| Express Lane Eligibility (ELE) Indicator | Indicator for beneficiaries with Express Lane Eligibility (ELE) | State-specific values, if applicable and available. Required for states with ELE: AL, CO, GA, IA, LA, MD, MA, NJ, NY, OR, PA, SC, SD, and UT. |
| User Option Fields 1-10 | State supplied additional fields | Optional. |