

Payment Error Rate Measurement (PERM)

Due on the 15th day of the month after the sample month and before the eligibility reviews begin.

| Monthly Sample Selection List | | | | |
|--|------------------------|----------------------------|---------------------------|----------------------|
| State | | | | |
| Date | | | | |
| Program | | | | |
| Sample Month and Year | | | | |
| | Stratum 1 Applications | Stratum 2 Redeterminations | Stratum 3 All Other Cases | Negative Cases |
| Number of cases in universe that month | | | | |
| | Case/Beneficiary ID | Case/ Beneficiary ID | Case/ Beneficiary ID | Case/ Beneficiary ID |
| 1) | | | | |
| 2) | | | | |
| 3) | | | | |
| 4) | | | | |
| 5) | | | | |
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| 21) | | | | |
| 22) | | | | |
| 23) | | | | |

Payment Error Rate Measurement (PERM)

Due within 150 days from the end of each sample month.

| Detailed Active Case Review Findings | |
|---|--|
| State | |
| Date | |
| Program | |
| Sample Month and Year | |

| Case ID | Review Month | Dropped Due to Beneficiary Fraud | Stratum 1,2 or 3 | Review Finding E -eligible EI-eligible with ineligible services NE- not eligible U –undetermined L/O – liability overstated L/U - understated MCE1 – managed care error, ineligible for managed care MCE2 – eligible for managed care but improperly enrolled | Cause of Error, if known Example: excess income, non-resident. |
|----------------|---------------------|---|-------------------------|--|---|
| 1) | | | | | |
| 2) | | | | | |
| 3) | | | | | |
| 4) | | | | | |
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| 20) | | | | | |

Payment Error Rate Measurement (PERM)

Due within 150 days of the end of each sample month.

| Case/ Beneficiary ID | Denial or Termination D – denial T - termination | Review Finding C – correct ID – improper denial IT – improper termination | Cause of Error, if known |
|----------------------------|--|--|-----------------------------|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
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| 22) | | | |
| 23) | | | |

Payment Error Rate Measurement (PERM)
Due within 210 days of the end of each sample month.

| Detailed Payment Review Findings | |
|----------------------------------|--|
| State | |
| Date | |
| Program | |
| Sample Month and Year | |

| Case ID | Dropped Due to Beneficiary Fraud | Stratum 1,2 or 3 | Review Finding E -eligible EI-eligible with ineligible services NE- not eligible U –undetermined L/O – liability overstated L/U - understated MCE1 – managed care error, ineligible for managed care MCE2 – eligible for managed care but improperly enrolled | Payment Amount Correct | Payment Amount in Error |
|---------|----------------------------------|------------------|---|------------------------|-------------------------|
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Payment Error Rate Measurement (PERM)
 Due July 1 following the Federal fiscal year being measured.

| State | | | | | | | | |
|---------------------|---------------------------------|-------------------------|---|--------------------------|----------------------------|------------------------------|--------------------|------------------------|
| Date | | | | | | | | |
| Program | | | | | | | | |
| | Number of Cases in the Universe | Number of Cases Sampled | Number of Cases Excluded from the Universe or Sample due to Beneficiary Fraud | Number of Cases Eligible | Number of Cases Ineligible | Number of Cases Undetermined | Total Dollars Paid | Total Dollars in Error |
| Total | | | | | | | | |
| Active | | | | | | | | |
| Stratum 1 | | | | | | | | |
| Stratum 2 | | | | | | | | |
| Stratum 3 | | | | | | | | |
| Negative | | | | | | | | |
| Denials | | | | | | | | |
| Terminations | | | | | | | | |

| | Dollar Amount | Error Rate | Confidence and Precision | Percentage |
|----------------------------------|---------------|------------|--------------------------|------------|
| Active Payment Error Rate | | | | N/A |
| Active Case Error Rate | N/A | | | N/A |
| Negative Case Error Rate | N/A | | | N/A |
| Undetermined Cases | | N/A | N/A | |

I certify that this information is accurate and that the State will maintain the sampled case records used in the calculation of this reported error rate for a minimum period of three years. I understand that this information may be subject to Federal review and that our sampled case records and calculations are subject to Federal audit.

Signature: _____ Date: _____
 State Medicaid/SCHIP Director or Designee

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