Mike Braun, Governor
State of Indiana

Indiana Family and Social Services Administration

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E. MITCHELL ROOB JR., SECRETARY

Memorandum: Executive Order 25-24

Date: January 12, 2026
To: Legislative Council, State of Indiana
From: E. Mitchell Roob Jr., Secretary, Indiana Family and Social Services Administration
Subject: Executive Order 25-24: Assuring Prudent Use of Taxpayer Funds by Assessing Waste, Fraud, and Abuse in Healthcare Spending

The Indiana Family and Social Services Administration (FSSA) would like to thank Governor Braun, for his leadership and commitment to responsible governance. This report is submitted in response to Indiana Executive Order 25-24 ("EO 25-24"), which was issued by the Governor to strengthen accountability and ensure prudent use of taxpayer funds. Under Governor Braun's direction, FSSA has taken decisive steps to reduce waste, fraud, and abuse in Medicaid spending. Governor Braun's leadership has empowered FSSA to identify multiple strategies that not only bolster program integrity but also deliver significant savings for Hoosier taxpayers—while continuing to provide essential services to those who need them most.

To achieve Governor Braun's vision, FSSA is implementing all recommendations from the independent audit conducted by Health Management Associates to strengthen the integrity of Indiana's Medicaid program. This comprehensive effort focuses on three key areas:

- **System Enhancements:** Partnering with Managed Care Entities to prevent payment errors, reduce waste, and improve fraud detection.

- **Stronger Oversight:** Expanding internal audit and recovery functions and deploying a statewide Fraud and Abuse Detection System with advanced analytics and real-time monitoring.

- **Phased Implementation:** Establishing clear milestones and conducting regular progress reviews to ensure timely results and alignment with strategic objectives.

Additionally, FSSA is pursuing cost efficiency in Pharmacy Benefit Management (PBM) through an independent evaluation of Indiana Medicaid's pharmacy benefit structure. This review will determine the financial and operational impact of adopting a single PBM model or a carve-out approach, with the goal of delivering taxpayer savings while protecting access to essential medications.

EO 25-24 directs FSSA to:

1. **Conduct a Comprehensive Independent Audit**
   FSSA must perform a detailed audit of Medicaid Managed Care Entities (MCEs), including electronic claims data, billing forms, and payment files, to identify improper payments and systemic issues.

2. **Develop Safeguards and Best Practices**
   Using audit findings, FSSA is tasked with creating updated accountability mechanisms and operational safeguards to prevent payment errors and strengthen program integrity.

3. **Implement Cost-Efficient Pharmacy Benefit Management (PBM)**
   FSSA must identify and adopt PBM strategies that reduce Medicaid costs while maintaining or improving quality of care for beneficiaries.

4. **Collaborate on Reporting**
   FSSA, in coordination with the State Personnel Department (SPD) and the Secretary of Health and Family Services, must submit a comprehensive report to the Governor and Legislative Council by November 30, 2025. This report should detail audit findings, corrective actions taken, and measurable progress toward cost savings and fraud reduction.

Comprehensive Independent Audit

Introduction

In accordance with Executive Order (EO) 25-24, Health Management Associates (HMA) conducted an independent audit of encounter data submitted by Indiana Medicaid Managed Care Entities (MCEs), including Anthem, CareSource, MDwise, Managed Health Services (MHS), and UnitedHealthcare (UHC). This audit, commissioned by the Indiana Family and Social Services Administration (FSSA), encompassed the Medicaid managed care programs, named the Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC), and Hoosier Healthwise (HHW).

To fulfill the requirements of EO 2524, HMA assessed the accuracy, validity, and compliance of MCE claims processing with federal and state regulations. The review included a detailed analysis of eligibility records, covered services, and claims-level documentation to ensure integrity and adherence to program standards. This audit was completed by HMA in November 2025.

Methodology and Limitations

The audit used structured snapshots of Indiana Medicaid claims and eligibility data from January 2022 through December 2024. Rigorous data validation and cleansing ensured consistency and integrity across more than three billion records, enabling the audit team to link claims to eligibility and provider data, verify payments, and analyze trends to assess program integrity.

Two complementary audit approaches were used:

- **Systematic Audit**: A comprehensive, data-driven review of claims, eligibility, and provider data across MCE programs. This analysis evaluated payment accuracy and service integrity to support the objectives of EO 25-24.

- **Manual Audit**: A statistically valid sample of claims was selected. Auditors reviewed health records against electronic claims to verify proper documentation and billing accuracy. Industry-standard methods were used to randomly sample claims paid in 2024

Several constraints shaped the scope and interpretation of the audit, including:

- **Audit Timeframe (Focused and Efficient Review):** The audit required record collection between May and August 2025 to meet the November completion deadline. This condensed schedule enabled a concentrated review of key documentation within a short period. While the timeframe limited opportunities for extended follow-up with providers on missing or inaccurate records, the results

offer a strong preliminary baseline. Future audits with additional time for provider engagement could further enhance accuracy and strengthen MCE error rate scores.

- **Data and Payment Source Bias:** HMA was unable to evaluate some indicators, such as level of care and third-party liability, in this systematic review. HMA's analysis centered on MMIS-paid claims and MCE paid encounters. They omitted claims that resulted in nonpayment to providers.

- **Document Submission:** The manual audit is limited to files received promptly, which could be opened and reviewed. Some file transfer issues limited the total number of files received, as some were password protected or otherwise corrupted.

These limitations reflect the practical boundaries of the audit and should be considered when interpreting findings and applying recommendations.

Data Sources

HMA's audit drew from the following primary datasets:

- **Encounter Data**: MCE paid encounter claim records for Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect. The FSSA data warehouse receives and stores 837 and 835 transaction data submitted by the MCEs to FSSA via the encounter submission process. This audit met the EO 25-24 requirement to review 837 and 835 transactions by receiving the encounter data from the FSSA data warehouse and using this data as the claims billing and claims payment source for the audit.

- **Eligibility Files:** Member enrollment and coverage data to validate service authorization.

- **Reference and Provider Data:** Clinical coding tables and provider credentials for service classification and tracking.

Summary of Audit Findings

The independent audit conducted by Health Management Associates (HMA) in response to Executive Order 25-24 found that Indiana Medicaid's claims processing and oversight systems have room for improvement, with an urgent need to establish clear and consistent documentation standards for MCEs and to strengthen MCE audit and review readiness. The MCEs must establish robust systems and processes to prevent the payment and processing errors that exist. Also, substantial documentation issues, specifically lack of documentation and insufficient documentation, may have masked the

identification of trends. Subsequent audits should allow time to follow up on documentation errors.

Phase 1: Systematic Audit – Member Eligibility for Service Delivery
In Phase 1, Medicaid member enrollment was compared with claims payment for enrollees to determine whether Medicaid payers are providing coverage that aligns with the individual's eligibility. Systematic reviews showed that over 99.9% of claims aligned with active member eligibility. When type of coverage provided was considered for those active coverage spans, alignment remained above 99.8%. The error rate is not indicative of systemic issues in Indiana's Medicaid enrollment or claims processing controls. The data pertaining to Phase 1 is included in Tables 1, 2, and 3 of the appendix.

Phase 2: Systematic Audit – Service Coverage Alignment
In Phase 2, HMA's analysis checked services paid and provider specialty requirements. Compliance rates were close to 98%, which is below the 3% error rate that federal audits target, and no MCE had more than a 3% error rate in aggregate. Though within acceptable limits, this error rate fluctuated by provider type with notable discrepancies—particularly among nonemergency transportation services, allowing room for improvement in aligning providers and billing codes. The data related to Phase 2 is included in Tables 4 and 5 of the appendix.

Phase 3: Systematic Audit—Pharmacy Expected and Actual Amounts
In Phase 3, HMA compared pharmacy encounter claim expected and actual payment amounts. This analysis confirmed no notable pharmacy pricing discrepancies for 3 of the 5 MCEs. It appears that 2 MCEs use different methodologies when populating the paid and allowed amounts for the encounters. The complete dataset is included in Table 6 of the appendix.

For example, Anthem data shows a slight pricing discrepancy (2–3%). This small difference is indicative of how third-party payments are captured for Anthem's pharmacy encounters. Anthem confirmed their methodology for populating these amounts, and when third-party payments are considered any indication of a pricing discrepancy based on pharmacy encounter data disappears.

MDwise pharmacy encounters show a discrepancy between the paid and allowed amounts, which could indicate pharmacy pricing issues. Additional review of the data to look for a root cause of the discrepancy finds that the majority of the encounters for MDwise that show the pricing discrepancy are paid by MDwise but in a rejection status by the Medicaid system that accepts pharmacy encounters. This observation indicates issues in the encounter submission process or in quality of the data. MDwise also had a higher per encounter average cost than the other MCEs, although compared with the other MCEs, MDwise processed more durable medical equipment and physician-administered drugs through its pharmacy benefit, which could account for some of the observed variation in average cost.

In meeting with MDwise to explore the cause of the pricing discrepancy, MDwise representatives indicated that it may be related to their methodology for the allowed amount on the pharmacy encounters, but they were unable to confirm the exact cause as of the completion of this report. Based on pharmacy encounter data as received, HMA cannot confirm that MDwise does not practice spread pricing. To fully explore the pricing discrepancy in the paid and allowed amounts on the MDwise pharmacy encounters, additional analysis using data other than encounter data would be required.

Phase 4: Manual Audit Claims Audit via Medical Records Review

HMA selected a random sample of claims and claim lines for each MCE and program. Results from a total of 11 distinct samples are represented, with oversampling of claims for Applied Behavior Analysis and those paid at more than $50,000. Each MCE was provided with the applicable data for which provider records and payer documentation were needed.

HMA's manual claims audit focused on 3,349 claims selected across MCEs in the Hoosier Care Connect, Hoosier Healthwise, and Healthy Indiana Plan programs. Of these, HMA received documentation for 2,420 claim lines, which were scored for potential payment errors. Overall documentation was missing for 27.7% of claim lines; the percentage with no documentation was higher than average for an audit of this scope.

When only considering claim lines for which reviewable documentation was received, the review identified issues with documentation and billing requirements that may have resulted in improper payments in 16.2% (352/2,172 lines) of claim lines. The high error rate highlights the need for improved provider record-keeping, processes for responding to audit requests, and provider education on provider manual requirements and documentation expectations. It also highlights the need for the following recommendations to be implemented immediately. The complete dataset for Phase 4 is included in Tables 7-10 of the appendix.

Based on the findings of this audit, HMA recommended the following actions to prevent waste, fraud, and abuse:

1. *Establish Clear and Consistent Documentation Standards*
    a. Develop a unified, systemwide policy outlining documentation expectations and minimum standards for all service types.
    b. Include requirements for:
        i. Assessment and treatment plan documentation.
        ii. Minimum progress note standards.
    c. Consolidate and cross-reference provider manuals to eliminate redundancy and ensure alignment with current FSSA operational and payment policies.
2. *Strengthen MCE Audit and Review Readiness*

a. Ensure MCEs fully understand audit requirements, timelines, and record submission protocols.
b. Implement internal readiness checks.
c. Adopt the **"**golden thread" approach, ensuring clinical documentation flows logically from assessment to treatment plan to progress notes, demonstrating medical necessity and compliance.

3. *Enhance Provider Training and Guidance*
    a. Develop educational materials and quick-reference guides for providers on:
        i. Documentation standards;
        ii. Audit responsiveness; and
        iii. Coverage policies for high-error services.

4. *Standardize Paid and Allowed Amount Methodology*
    a. Require MCEs to use a consistent methodology for populating paid and allowed amounts on all encounter claims.
    b. This standardization will:
        i. Simplify analysis;
        ii. Support monitoring of pharmacy payment policies; and
        iii. Ensure compliance with state payment requirements.

5. *Align Provider Type with Services Billed*
    a. Address discrepancies in provider specialties and billed services, ensuring scope of practice is appropriate.
    b. Confirm documentation and billing requirements by provider type.
    c. Prevent payment for procedure codes outside allowable ranges.

Implementation of Independent Audit Recommendations

Following Governor Braun's leadership and commitment to accountability, FSSA is partnering closely with Managed Care Entities (MCEs) to immediately implement all recommendations from Health Management Associates. This collaborative effort is focused on building stronger systems to prevent payment and processing errors, reduce administrative waste, and proactively detect and deter fraud and abuse across Indiana's Medicaid program.

To reinforce program integrity, FSSA is enhancing its internal audit and recovery functions, expanding capacity to identify and recoup provider overpayments. Additionally, FSSA is procuring a specialized vendor to deploy a statewide Fraud and Abuse Detection System. Leveraging advanced analytics and real-time monitoring, this system will strengthen oversight, ensure compliance, and drive greater accountability among providers and MCEs. Implementation will follow a phased approach with clear milestones and regular progress reviews to ensure timely results and alignment with strategic goals.

Pharmacy Benefit Management (PBM) Cost Efficiency

In line with the Governor's vision for cost-effective, high-quality care, FSSA is engaging an independent third-party evaluator to conduct a comprehensive analysis of Indiana Medicaid's pharmacy benefit structure. This review will assess both financial and operational impacts of transitioning to a single PBM model or carving out the pharmacy benefit. The goal is to identify the most efficient, sustainable approach to managing pharmacy services—delivering savings for Hoosier taxpayers while maintaining access to essential medications.

Appendix

Table 1. 2022–2024 Payment Error Rate by Eligibility Test

Test	Error Rate	Analysis
A.1. Claims Paid Without Active Medicaid Eligibility	0.07%	Error rates by MCE and program varied from .00% to .30%
A.2 Claims Paid Under Wrong Benefit Plan	0.12%	Error rates by MCE and program varied from .00% to .21%

Table 2. 2022–2024 A.1. Payment Error Rate by MCE & Program

Payer	Program	2022	2023	2024	Total
Anthem	**Total**	**0.02%**	**0.02%**	**0.02%**	**0.02%**
	HCC	0.00%	0.00%	0.00%	0.00%
	HHW	0.07%	0.05%	0.03%	0.05%
	HIP	0.01%	0.02%	0.02%	0.02%
CareSource	**Total**	**0.01%**	**0.02%**	**0.03%**	**0.02%**
	HHW	0.04%	0.02%	0.02%	0.03%
	HIP	0.00%	0.03%	0.03%	0.02%
MDwise	**Total**	**0.02%**	**0.13%**	**0.54%**	**0.23%**
	HHW	0.05%	0.08%	0.03%	0.05%
	HIP	0.01%	0.15%	0.74%	0.30%
MHS	**Total**	**0.02%**	**0.01%**	**0.02%**	**0.01%**
	HCC	0.05%	0.01%	0.01%	0.02%
	HHW	0.01%	0.01%	0.05%	0.02%
	HIP	0.01%	0.00%	0.00%	0.00%
UHC	**Total**	**0.01%**	**0.00%**	**0.00%**	**0.00%**
	HCC	0.01%	0.00%	0.00%	0.00%
Total		**0.02%**	**0.05%**	**0.15%**	**0.07%**

Table 3. 2022-2024 A.2. Payment Error Rate by MCE and Program

Payer	Program	2022	2023	2024	Total
Anthem	**Total**	**0.10%**	**0.15%**	**0.09%**	**0.11%**
	HCC	0.02%	0.00%	0.00%	0.01%
	HHW	0.06%	0.11%	0.04%	0.07%
	HIP	0.13%	0.20%	0.12%	0.15%
CareSource	**Total**	**0.16%**	**0.11%**	**0.12%**	**0.13%**
	HHW	0.08%	0.06%	0.05%	0.06%
	HIP	0.19%	0.13%	0.15%	0.15%
MDwise	**Total**	**0.12%**	**0.15%**	**0.24%**	**0.17%**
	HHW	0.08%	0.09%	0.08%	0.08%
	HIP	0.14%	0.18%	0.30%	0.21%
MHS	**Total**	**0.08%**	**0.08%**	**0.10%**	**0.09%**
	HCC	0.03%	0.01%	0.01%	0.02%
	HHW	0.12%	0.03%	0.08%	0.07%
	HIP	0.09%	0.13%	0.15%	0.12%
UHC	**Total**	**0.45%**	**0.05%**	**0.11%**	**0.18%**
	HCC	0.45%	0.05%	0.11%	0.18%
Total		**0.11%**	**0.13%**	**0.13%**	**0.12%**

Table 4. Error Analysis for Procedure Codes

Test	Error	Analysis
B.1. Procedure Code Billed by Qualified Provider	2.4%	Error rates by MCE varied from 1.1% to 2.9%.

Table 5. Procedure Codes Errors by MCE

Payer	Potentially Erroneous Codes	Total Codes	Total
Anthem	228,898	7,828,899	2.9%
CareSource	10,747	942,174	1.1%
MDwise	56,133	2,666,073	2.1%
MHS	41,651	2,686,054	1.6%
UHC	3,590	235,673	1.5%
Total	**341,019**	**14,358,873**	**2.4%**

Table 6. 2024 Pharmacy Pricing by MCE & Program

Payer	Program	Percentage Paid vs. Percentage Allowed
Anthem	**Total**	**98%**
	HCC	99%
	HHW	96%
	HIP	97%
Anthem	**Total**	**101%**
*Plus third-party payments	**HCC**	101%
	HHW	101%
	HIP	101%
CareSource	**Total**	**100%**
	HHW	100%
	HIP	100%
MDwise	**Total**	**72%**
	HHW	70%
	HIP	73%

Payer	Program	Percentage Paid vs. Percentage Allowed
MHS	**Total**	**100%**
	HCC	100%
	HHW	100%
	HIP	100%
UHC	**Total**	**104%**
	HCC	104%
Total		**89%**

Table 7. Error Percent by Program

Documentation Received	Hoosier Care Connect	Hoosier Healthwise	Healthy Indiana Plan	Average
Documented Lines (All MCEs)	16%	15%	17%	16%
Anthem	16%	14%	15%	15%
CareSource	N/A	14%	15%	14%
MDwise	N/A	18%	21%	19%
MHS	17%	15%	18%	17%
UHC	16%	N/A	N/A	16%

Table 8. Insufficient Documentation Error Percent by Program and MCE

Managed Care Entity	Hoosier Care Connect	Hoosier Healthwise	Healthy Indiana Plan	Average
Anthem	7%	9%	7%	8%
CareSource	N/A	7%	8%	7%
MDwise	N/A	8%	9%	8%
MHS	10%	6%	7%	8%
UHC	14%	N/A	N/A	14%

Table 9. All Other Error Percent by Program and MCE

Managed Care Entity	Hoosier Care Connect	Hoosier Healthwise	Healthy Indiana Plan	Average
Anthem	10%	7%	9%	8%
CareSource	N/A	8%	9%	9%
MDwise	N/A	12%	14%	13%
MHS	12%	10%	15%	13%
UHC	5%	N/A	N/A	5%

Table 10. Claim Lines Reviewed per MCE/Program

Managed Care Entity	Hoosier Care Connect	Hoosier Healthwise	Healthy Indiana Plan
Anthem	200	228	210
CareSource	N/A	209	179
MDwise	N/A	298	266
MHS	182	191	200
UHC	255	N/A	N/A