Mike Braun, Governor
State of Indiana

Indiana Family and Social Services Administration

402 W. WASHINGTON ST., P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. MITCHELL ROOB JR., SECRETARY

Memorandum: Executive Order 25-60

Date: January 16, 2026
To: Medicaid Oversight Committee
From: E. Mitchell Roob Jr., Secretary, Indiana Family and Social Services Administration
Subject: Executive Order 25-60: Assuring Prudent Use of Taxpayer Funds by Ensuring Integrity in the Indiana Medicaid Program

This report is submitted in response to Indiana Executive Order 25-60 ("EO 25-60"), issued by Governor Mike Braun. The Indiana Family and Social Services Administration (FSSA) is grateful for Governor Braun's visionary leadership and steadfast commitment to protecting taxpayer dollars while strengthening the integrity of Indiana's Medicaid program. His direction under Executive Order 25-60 has empowered FSSA to take bold, proactive steps that ensure Medicaid remains a trusted, sustainable safety net for Hoosiers. This report highlights significant progress under this administration: Indiana has implemented targeted corrective actions to reduce improper payments, enhance provider accountability, and modernize eligibility processes. Key initiatives include improving documentation practices, updating provider enrollment requirements, and refining eligibility determinations through enhanced training and system changes. These efforts, coupled with new enforcement measures and the development of an improved Fraud and Abuse Detection System, reflect Indiana's commitment to transparency, efficiency, and responsible stewardship of public funds. Under Governor Braun's leadership, Indiana is setting a high standard for Medicaid integrity and fiscal responsibility.

Payment Error Rate Measurement (PERM) 2024 Summary

Background

The *Payment Integrity Information Act*, enacted in 2002 and amended in March 2020 under President Trump, directs federal agencies to identify programs susceptible to improper payments and report on actions taken by the agency to mitigate and reduce improper payments. As a result, the Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to monitor and measure payment integrity in Medicaid and the Children's Health Insurance Program (CHIP) and reduce risk for improper payments.

The primary goal of the PERM is to ensure that Medicaid funds are used appropriately, by identifying improper payments - either overpayments, underpayments, or payments with insufficient information to determine whether it was proper - made to healthcare providers or managed care organizations, also referred to as managed care entities (MCEs). In 2024, CMS highlighted that the majority of improper payments were due to insufficient information in which a state or provider missed an administrative step. While this error does not indicate fraud or abuse, it is included in the PERM calculation.[1] PERM findings are utilized to benchmark and track the national, and individual states', error rate, identify root causes contributing to improper payments, and develop corrective action plans (CAPs) to address program areas demonstrating higher rates of waste, fraud, and abuse. The PERM framework holds state governments and federal agencies accountable to being stewards of taxpayer dollars to safeguard the longevity of safety net programs for vulnerable populations, like Medicaid and CHIP.

CMS conducts PERM audits on a three-year cycle, in which CMS evaluates a cohort of 17 states and a sample of Fee-For-Service (FFS) and MCE payments made by the state once every three years. In general, the PERM cycle is comprised of three phases: 1) collection of claims and records; 2) review of those records; and 3) analysis of the results and reporting to the states. The results of the PERM audit inform whether a state is then required to develop and implement a CAP for each identified overpayment. Claims that are selected to be sampled for the PERM, and that are identified and confirmed as overpayments, are subject to financial recoupment by CMS. Funds from claims that are not attributable to overpayment are not eligible for recoupment.

Indiana is included in CMS's Cycle 3 PERM and only FFS claims are reviewed.[2] FFS claims represent less than 0.01% of claims paid by Indiana's Medicaid and CHIP

[1] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2024-improper-payments-fact-sheet

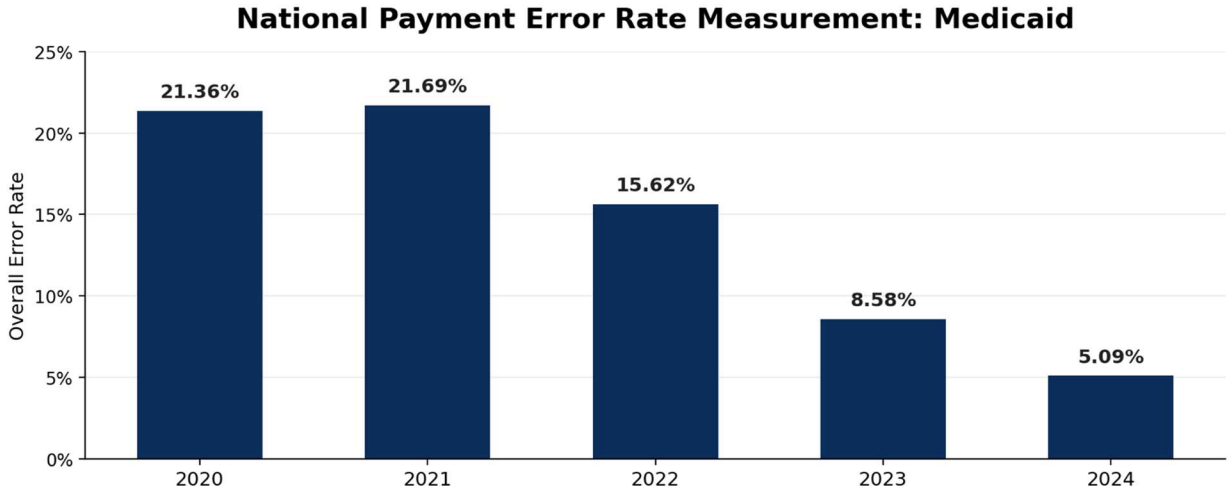
[2] Due to the structure of the managed care entities taking on the risk of the claims, MCE claims are not reviewed as part of PERM.

program. In general, the majority of payments made by Indiana's Medicaid and CHIP programs are to MCEs. While Indiana's CHIP program is predominantly managed by MCEs, limited CHIP claims—such as mental health rehabilitation services and high-cost prescriptions—are covered as FFS and, therefore, included in the PERM review.

The last complete PERM cycle conducted by CMS that included Indiana concluded in December 2024, for a lookback period of claims spanning from 2021 through 2024. Results from each of the three annual cycles are weighted and calculated to determine the national Medicaid and CHIP improper payment rates. Currently, Indiana is in the early stages of the 2027 cycle. Claims will be gathered from July 2025 through June 2026. After CMS review and analysis, the final findings report will be published in late 2027, with a corrective action plan fully developed after the release of the report.

PERM 2024 Cycle Findings

CMS's 2024 PERM cycle results showed that the national Medicaid improper payment rate was 5.09 percent, totaling an estimated $31.1 billion in federal funds. Notably, CMS clarified that nearly three-quarters of the identified improper payments, roughly $23.4 billion, resulted from insufficient documentation, rather than over or under payments.[3] The 2024 national Medicaid improper payment rate, 5.09 percent, shows a year over year decline since 2021. The chart below, with data from CMS[4], shows the national payment error rate for Medicaid from 2020 through 2024.



[3] https://ccf.georgetown.edu/2025/03/13/medicaid-fraud-the-improper-use-of-improper-payments/
[4] https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm/perm-error-rate-findings-and-reports

CMS's 2024 PERM cycle ended in December 2024 and included data from a random sample of Indiana Medicaid claims gathered from July 2023 through June 2024. CMS reviewed approximately 2,000 claims from Indiana's Medicaid program during this cycle, representing less than 0.05 percent of the approximately 43.8 million claim lines during the sample period. In total, CMS identified 257 errors in their audit of Indiana Medicaid claims. Of note, some claims may be deemed to have more than one error, while others have none. In all, the claims identified as improper payments amounted to $441,166.43 in the federal share.

The Indiana Office of Medicaid Policy and Planning (OMPP) made progress in correcting the improper payment rate in 2024, meeting or exceeding all targets established by CMS after the 2021 cycle. However, much of the reduction from 2021 to 2024 in the Medicaid improper payment rate was due to flexibilities granted to states during the COVID-19 public health emergency ending. For example, states were required to keep people continuously enrolled in Medicaid regardless of whether their eligibility status changed. This progress has been supported by 12-month continuous eligibility for children and women post-partum. The attached appendix includes a percentage representation of findings against all claims reviewed and other overpayment rate details.

Of note, an improper payment is not indicative of fraud. The improper payments identified by CMS largely constitute "incomplete documentation or no documentation provided" (as further discussed below). Using this category as an example, often the request for records does not reach the proper billing department of the provider's practice, including where multiple locations use a common billing office to keep administrative costs low. Both CMS and OMPP are responsible for contacting the provider to attempt to get these records. However, CMS and OMPP are not always successful in obtaining this information during the PERM process time period. While this is still considered an improper payment under PERM, it is not indicative of provider efforts to intentionally defraud Indiana Medicaid.

The Program Integrity Team coordinated the development of the CAP for all errors identified in the PERM Audit. Each claim identified as having an improper payment was reviewed and a plan to correct the error was developed. Key categories of errors were established to capture the root cause issue associated with improper payments. Understanding the root causes contributing to improper payments ensures that OMPP can comply with the CAP and mitigate risk for improper payment in the future. The key categories of overpayment errors addressed in Indiana's 2024 cycle CAP were: 1) incomplete documentation or no documentation provided; 2) errors with provider information and enrollment; and 3) eligibility.

1. Incomplete Documentation or No Documentation Provided
    - These errors accounted for 119 (46%) of the overpayment errors. In general, this type of improper payment occurs when a provider does not include complete and appropriate documentation to audit the claim. In some cases, providers fail to provide any documentation necessary to substantiate a claim of payment. Indiana Medicaid makes up to three outreach attempts based on each error and conducted outreach on 110 errors. Upon this outreach, documentation was provided for 60 errors. If documentation is not provided, the claim is automatically considered a finding of overpayment and included as an error in the state's improper payment rate.
    - Corrective Actions: A combination of recoupment, further audit, and education is being utilized to address this category of errors. Additionally, Indiana Medicaid is changing the provider agreement such that providers that do not respond to CMS, the State or our audit partners may be subject to payment suspension and/or disenrollment as an Indiana Medicaid provider for up to three years – this is a new measure which will place tighter controls on Medicaid dollars.

2. Provider Information and Enrollment Errors
    - These errors accounted for 71 (27%) of the overpayment errors. CMS's PERM Review Contractor assesses sampled claims from states and is responsible for requesting the medical record documentation needed to verify a claim directly from providers. Providers must submit the information within 75 days from receipt of request. Improper payment errors occur when the information submitted by the provider does not support a claim of payment. These errors also occur when enrollment information does not verify the claim and payment provided. In general, the root cause of these errors is attributable to lack of, or insufficient, administrative practices in health facilities.
    - The majority of these identified claims were claims for therapy services from the Indiana Department of Education and Indiana's First Steps program. CMS updated the Medicaid Provider Enrollment Compendium (MPEC) in December 2023 clarifying that school-based services require the National Provider Identifier (NPI) of an ordering/referring individual provider to be included on the claim. Claims from these two sources routinely did not include an ordering provider. Therefore, because the claims processing system did not require the NPI of an ordering provider, the claims were paid. The Indiana Health Coverage Programs (IHCP)

published *BT202486* in June 2024 reminding school corporations and the First Steps program of the ordering provider requirement. Additionally, the IHCP announced in *BT2024162* a claims system correction in which a claim submitted without an ordering provider would be denied. Finally, the IHCP reminded providers in *BT2024170* that institutional claims (inpatient, outpatient, ambulatory surgical center, and long-term care) require the NPI of an attending provider. These were not fraudulent billing claims as they were administrative errors. Additionally, the automated claims processing system was corrected to identify any institutional claims that have been improperly submitted without the NPI of an attending provider.

- Corrective Actions: A claims edit was put in place to prevent payment for (1) facility claims that were filed without a Type 1 (Individual) NPI of an attending provider; and (2) any claims filed for services requiring an order or referral that lacked a Type 1 (Individual) NPI of an ordering or referring provider on the claim. Education through published provider bulletins was sent to all providers.

3. Eligibility
    - These errors accounted for 34 (13%) of the overall errors. The majority of errors cited were human-made errors by the Division of Family Resources (DFR) staff, which resulted in the failure to request proper documentations or verifications to support eligibility determination. These errors caused an inability to accurately determine member eligibility. Some errors, however, were the result of previous functionality within the auto renewal process. The previous functionality was not compliant with CMS requirements for renewal processes. Taking quick action under Governor Braun's leadership, Indiana came into compliance by requiring must-return mailers to verify member eligibility as of March 2025.
    - Corrective actions: The DFR Learning and Development (L&D) team developed trainings which targeted errors cited during the PERM review. Staff have been trained in the correct procedures for identifying, requesting, and verifying the documentation necessary to make accurate eligibility determinations. These trainings provide both practical guidance and case-based examples to ensure staff understand not only what is required, but also how to apply the agency's requirements/policies effectively in daily practice. Indiana updated the renewal process to require must-return mailers to verify member eligibility—ensuring that more Medicaid members complete a full eligibility review rather than being automatically renewed without reporting changes.

Of the total 257 errors identified by CMS, 33 were not directly attributable to one of these categories.

The OMPP Program Integrity Team coordinated the development of the CAP for all errors identified in the PERM Audit by working with DFR on their eligibility errors and errors attributable to the state's FFS claims payment and provider enrollment vendor, Gainwell Technologies. Each claim identified as having an improper payment was reviewed and a corrective plan was developed.

2027 PERM Cycle

Indiana recently began the PERM 2027 cycle, which lasts from 2025-2027. The timeline for the 2027 cycle generally follows:

- July 2025 - June 2026 – CMS Identifies Sample Records for Review
- Fall 2026 - April 2027 – CMS Requests Claims from Providers & Reviews; CMS Requests Member Eligibility Records & Reviews
- April 2027 – December 2027 – CMS Analyzes Results
- December 2027 – CMS Provides the Results to OMPP
- February 2028 – OMPP Corrective Action Plan provided to CMS

During the review period, OMPP will assist CMS to remedy identified deficiencies, including one of the most preventable - a lack of provider response. This will be done, as provided before, through education and publications, actively reaching out to vendors and performing site visits. OMPP is exploring strategies employed by other states to improve provider compliance. OMPP's current policy states that provider non-compliance will result in payment suspension and/or disenrollment from Indiana Medicaid. OMPP is actively working in close coordination with CMS to ensure an accurate and efficient PERM process. OMPP has regular meetings scheduled and ongoing correspondence with CMS and their contractors regarding the PERM process.

Next steps

Under the leadership of Governor Braun, Indiana Medicaid remains committed to payment integrity and responsible stewardship of taxpayer dollars. In alignment with this mission, FSSA has taken decisive steps to improve program accuracy and reduce improper payments. This includes eliminating or revising policies and practices that encourage higher risk for waste, fraud, and abuse, including automatic eligibility renewals. For example, the postpartum continuous eligibility period has been extended from 60 days to 12 months, a change expected to reduce procedural disenrollments and minimize coverage disruptions.

FSSA recognizes that further reducing the Medicaid error rate is essential to protecting both enrollees and taxpayers. To that end, OMPP has issued a new request for proposals to administer a robust Fraud and Abuse Detection System to detect, investigate, measure and deter fraud, waste, and abuse in the Medicaid program. Proposals are due to the state by February 20th. Eliminating waste, fraud, and abuse is not only a strategic priority—it is a legal imperative. Under U.S. Public Law 119-21, beginning in federal fiscal year 2030, states will no longer receive federal financial participation for erroneous excess payments exceeding 3 percent. FSSA is committed to meeting this standard and ensuring that Indiana Medicaid continues to deliver high-quality, accountable care to those who need it most.

Appendix

2024 Cycle - Medicaid Improper Payment Rate – Blended 7.57%

	Claims	Member Eligibility
2021 Cycle	22.95%	19.26%
2024 Target (identified in 2021)	12.97%	3%
2024 Cycle	10.11%	3.07%
2027 Cycle Target (future)	6.55%	3%

2024 Cycle - CHIP Improper Payment Rate – Blended 3.58 %

	Claims	Member Eligibility
2021 Cycle	23.05%	14.67%
2024 Target (identified in 2021)	13.02%	3%
2024 Cycle	10.41%	1.38%
2027 Cycle Target (future)	6.70%	3%

Medicaid Claims – 2024 Cycle - Error Summary

Type of Errors (Error Code)	Number of Errors	Sample Federal Dollars in Error
Policy Violation Error (MR8)	1	$2,244.86
Number of Unit(s) Error (MR6)	24	$63,733.24
No Documentation Error (MR1)	29	$65,334.27
Document(s) Absent from Record Error (MR2)	73	$134,412.55
Provider Information/ Enrollment Error (DP10)	36	$89,518.40
Totals:	**163**	**$355,243.32**

Medicaid Eligibility – 2024 Cycle – Error Summary

Type of Errors (Error Code)	Number of Errors	Sample Federal Dollars in Error
Determination not conducted as required; unable to determine beneficiary eligibility (ER3)	1	$223.59
Not eligible for enrolled program; non-financial issue (ER5)	1	$796.91
Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment (ER7)	1	$160.62
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility (ER1)	11	$36,822.16
Other errors (ER10)	6	$1,955.17
Verification/Documentation not done/ collected at the time of determination (ER2)	6	$17,202.03
Not eligible for enrolled program; financial issue (ER4)	4	$5,642.24
Totals:	**30**	**$62,802.72**

CHIP Claims – 2024 Cycle - Error Summary

Type of Errors (Error Code)	Number of Errors	Sample Federal Dollars in Error
Provider Information/ Enrollment Error (DP10)	35	$3,344.31
Policy Violation Error (MR8)	1	$350.24
Number of Unit(s) Error (MR6)	4	$1,014.36
Improperly Completed Documentation Error (MR9)	1	$124.63
No Documentation Error (MR1)	6	$15,403.27
Document(s) Absent from Record Error (MR2)	11	$2,120.00
Procedure Coding Error (MR3)	2	$240.29
Totals:	**60**	**$22,597.10**

CHIP Eligibility – 2024 Cycle - Error Summary

Type of Errors (Error Code)	Number of Errors	Sample Federal Dollars in Error
Determination not conducted as required; unable to determine beneficiary eligibility (ER3)	1	$156.11
Should have been enrolled in a different program (i.e., Medicaid or CHIP) (ER6)	2	$218.26
Other errors (ER10)	1	$148.92
Totals:	**4**	**$523.29**