

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INDIANA DID NOT ENSURE THAT
MEDICAID PAYMENTS WERE MADE
PROPERLY FOR SOME CLAIMS
IDENTIFIED AS HAVING THIRD-PARTY
COVERAGE**

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Office of Inspector General

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Report in Brief

Date: September 2020
Report No. A-05-18-00046

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Prior Office of Inspector General and other reports indicated substantial improvements in States' third-party liability (TPL) identification and recovery efforts. However, the reports also indicated longstanding challenges States had in their TPL efforts. We conducted an audit of Indiana's efforts to determine whether Medicaid is paying too much for claims in which members were identified as having TPL.

Our objective was to determine whether Indiana ensured that Medicaid payments were made properly for claims identified as having third-party coverage.

How OIG Did This Audit

Our audit covered 79,920 non-pharmacy claims, totaling \$7.4 million, that had service dates during our audit period and that indicated third-party payment, or the members' Medicaid eligibility files indicated that they had other insurance.

We selected 120 non-pharmacy claims, totaling \$49,666, to determine whether Medicaid paid appropriately after the third-party paid to the extent of its liability. Using the results of our sample, we estimated the total value and Federal share of unallowable Medicaid payments that Indiana did not recover.

Indiana Did Not Ensure That Medicaid Payments Were Made Properly for Some Claims Identified as Having Third-Party Coverage

What OIG Found

Indiana ensured that Medicaid payments were made properly for claims for which the members had been identified as having third-party coverage for 54 of the 120 sampled claims. However, for 9 of the 120 claims, Indiana should not have paid some or all of the Medicaid payments totaling \$5,082. For the remaining 57 claims, as well as 6 of the 9 overpayments, we found that Indiana; its contractor, DXC Technology (DXC); or DXC's subcontractor, HMS, did not (1) maintain accurate or complete information, or both, to avoid or recover Medicaid payments when there was TPL; (2) verify that members had other Medicaid expenditures to which excess payments received from third-party carriers could be applied; or (3) did not bill the third-party carrier in a timely manner or did not pursue recovery when there was TPL.

On the basis of our sample results, we estimated that Indiana made Medicaid overpayments totaling at least \$54,965 (\$36,573 Federal share) for service dates during our audit period. These issues occurred for a variety of reasons which are detailed in the body of the report.

What OIG Recommends and Indiana Comments

We recommend that Indiana refund \$36,573 to the Federal Government. In addition, we made procedural recommendations to the State in the body of the report.

In written comments on our draft report, the State agency disagreed with one finding, parts of two findings, and agreed with or acknowledged the validity of the remaining two findings. The State agency did not indicate concurrence or nonconcurrence with our recommendations but described corrective actions that it has implemented or planned or that it is considering.

After reviewing the State agency's comments, we maintain that our findings, recommendations and estimate are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

Generally, Medicaid is intended to be the payer of last resort. If Medicaid members have another source of health care coverage, that source should pay, to the extent of its liability, before Medicaid pays. Federal regulation refers to this requirement as third-party liability (TPL).¹ Prior Office of Inspector General (OIG) and other reports² indicated substantial improvements in States' TPL identification and recovery efforts. However, these reports also indicated longstanding challenges States had in their TPL efforts. The findings in prior reports and congressional interest led us to conduct an audit of the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning's (State agency's) TPL efforts to determine whether Medicaid is paying too much on claims for which the members have been identified as having third-party coverage.

OBJECTIVE

Our objective was to determine whether the State agency ensured that Medicaid payments were made properly for claims identified as having third-party coverage.

BACKGROUND

The Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States report Medicaid payments claimed by providers on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10). During the

¹ See 42 CFR §§ 433.135 through 433.139.

² For example, *Medicaid Third-Party Liability Savings Increased, But Challenges Remain*, report number OEI-05-11-000130, issued January 2013.

period January 1, 2015, through December 31, 2016 (audit period) the FMAP in Indiana ranged from 66.52 percent to 66.74 percent.³

Medicaid Third-Party Liability

CMS requires States to (1) identify Medicaid members' third-party health coverage, (2) determine the TPL for services, (3) avoid payment for services in most circumstances in which the State believes that a third party is liable, and (4) recover reimbursement from liable third parties after Medicaid payment if the State can reasonably expect to recover more than it paid to seek reimbursement (42 CFR §§ 433.137 through 433.139). A Medicaid payment is termed "avoided" under two scenarios. The first scenario occurs when a provider submits a claim to the State agency first, then the State agency returns the claim as denied to the provider, which must submit this claim to the liable third party. The second scenario occurs when a provider bills the liable third party first.⁴ Third-party coverage includes health insurance; self-insured plans; group health plans; Government-sponsored health insurance, such as Medicare and TRICARE; service benefit plans; managed care organizations; pharmacy benefit managers; and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.⁵

Indiana Medicaid Third-Party Liability

In Indiana, the State agency is responsible for administering the Medicaid program. The State agency contracts with DXC Technology (DXC), formerly known as HP Enterprise Services, to provide operations and maintenance services for Indiana's Medicaid Management Information System (MMIS). DXC serves as the State agency's fiscal agent by performing claim processing functions for all Medicaid nonpharmacy, fee-for-service billing.

Indiana Medicaid is provided under the Indiana Health Coverage Programs (IHCP). IHCP's TPL program has five primary sources of information for identifying members who have other health insurance. Those sources are:

- *Caseworkers with the Family and Social Services Administration Division of Family Resources* – During the IHCP application process, and upon recertification of members, applicants are asked if they have other insurance coverage. If so, all available information is obtained and updated in the member's file in the Indiana Client Eligibility

³ The audit period encompassed the most current data available at the time we initiated our audit.

⁴ (CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3901).

⁵ (the Act § 1902(a)(25) and 42 U.S.C. § 1396a(a)(25)).

System (ICES). ICES electronically transfers this information to the member eligibility file in *CoreMMIS*.⁶

- *Provider* – During the IHCP member’s medical appointment, providers must ask if there is another resource available for payment. If so, providers must obtain information about the other policy and send this information to the IHCP by written notice, telephone call, notification through the IHCP Provider Healthcare Portal, or inclusion on a claim form.
- *Data matches* – DXC subcontracts with a private vendor, HMS, to perform regular data matches between IHCP members and commercial insurance eligibility files. HMS performs data matches with all major insurers. Also, HMS obtains full information about any identified coverage and transmits this information electronically to DXC.
- *Managed care entities (MCEs)* – MCEs submit information to DXC about members enrolled in the MCEs’ networks. Health analysts at DXC verify this information before updating a member’s file in the State’s database (*CoreMMIS*).
- *Medicaid Third-Party Liability Questionnaire* – Providers and members use this questionnaire to update an IHCP member’s file. DXC verifies this information before updating *CoreMMIS*.

DXC updates and verifies third-party carrier information received from members, providers, and caseworkers. Regardless of the source, all third-party health coverage information is stored in *CoreMMIS* and available to providers through the Eligibility Verification System (EVS), except for indemnity policies that pay only the member. Before providing a service, providers should use the EVS to verify the member’s eligibility. Additionally, the EVS should be used to verify third-party coverage information to determine whether another insurer is liable for all or part of the claim amount. The EVS has the member’s most current third-party coverage information on file, including the health insurance carrier, policy numbers, and coverage type. When a provider determines that a member has third-party coverage, the provider is required to bill that third-party before billing Medicaid.⁷ If the EVS indicates that a member has TPL, and the provider submits the claim to Medicaid without documenting that the third-party carrier was billed, the claim is denied. If the third-party carrier denies payment or pays less than the IHCP would have paid, the provider may rebill the claim to Medicaid but must document that the service was submitted to the third-party carrier. DXC reviews the documentation to

⁶ *CoreMMIS* is Indiana’s MMIS, which began processing claims in February 2017. Prior to *CoreMMIS*, the State agency processed claims using *IndianaAIM*.

⁷ Certain medical services are exempt from States’ requirements to avoid payment before the third-party carrier has paid. For the scope of our audit, Indiana exempted services related to prenatal care and preventive pediatric care, including Early and Periodic Screening, Diagnosis, and Treatment. Providers that render any of these exempted services are still permitted, but are not required, to bill available third-party resources. Claims for these services bypass the claim system’s edit for avoiding payment when there is third-party coverage.

determine whether Medicaid should pay based on the denial reason from the third-party carrier.

When providers submit claims for services for which another carrier was billed, the total amount paid by the third-party must be entered in the appropriate field on the Medicaid claim, even if the payment amount is zero. *CoreMMIS* automatically deducts the third-party payment amount from the total Medicaid payment allowed under the approved State agency payment schedule. If *CoreMMIS* does not have a record of third-party coverage reported on a claim, an inquiry letter is automatically generated to the provider to obtain additional information on the third-party coverage.

If HMS identifies third-party coverage for a member after Medicaid paid on a claim, it pursues recovery of Medicaid payments. HMS receives Indiana Medicaid fee-for-service paid claim files on a monthly basis from Enterprise Data Warehouse (EDW). EDW combines MMIS data for paid non-pharmacy claims from DXC and pharmacy claims from OptumRx, another State contractor. These paid claims files are matched against HMS's insurance eligibility database to identify coverage for the member on the date of service. Claims identified through this process to be covered by a third-party carrier are billed to those carriers by HMS on a monthly basis. HMS also performs disallowance projects for claims that should have been covered by Medicare. HMS identifies claims with Medicare coverage, and the providers are instructed to bill Medicare for payment within 60 days. After 60 days, HMS sends these Medicaid claims to DXC to adjust and recoup the payments.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 79,920 non-pharmacy claims, totaling \$7,355,692,⁸ that had service dates during our audit period and that indicated third-party payment, or for which the members' Medicaid eligibility files indicated that the members had other insurance. We selected 120 non-pharmacy claims, totaling \$49,666, to determine whether Medicaid paid appropriately after the third-party paid to the extent of its liability. Stratum 1 consisted of 5 judgmentally selected Medicaid claims with third-party payment amounts of \$0.01 or \$0.02. For strata 2 through 4, we selected the remaining 115 claims using a stratified random sample. Using the results of our sample, we estimated the total value and Federal share of Medicaid overpayments that the State agency did not recover.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁸ All dollar totals include both the State and Federal share.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains the Federal and State requirements.

FINDINGS

The State agency ensured that Medicaid payments were made properly for claims for which the members had been identified as having third-party coverage for 54 of the 120 sampled claims. However, for 9 of the 120 claims, the State agency should not have paid some or all of the Medicaid payment, totaling \$5,082. For the remaining 57 claims, as well as 6 of the 9 overpayments,⁹ the State agency, DXC, or HMS did not (1) maintain accurate or complete information, or both, to always avoid or recover Medicaid payments when there is TPL; (2) verify that members had other Medicaid expenditures to which excess payments received from third-party carriers could be applied; or (3) did not bill the third-party carrier in a timely manner or did not pursue recovery when there was TPL. Specifically, for 27 claims, *CoreMMIS* did not contain accurate and complete third-party coverage information. For 46 claims, HMS did not have accurate and complete information necessary to recover all Medicaid payments when there could have been TPL. For two claims, the State agency did not verify that members had other Medicaid expenditures to which excess payments received from third-party carriers could have been applied. For two claims, HMS did not bill the third-party carrier in a timely manner or did not pursue recovery when there was TPL. On the basis of our sample results, we estimated that the State agency made Medicaid overpayments totaling at least \$54,965 (\$36,573 Federal share) for service dates during our audit period.

These issues occurred because (1) providers did not bill Medicaid properly; (2) *CoreMMIS* and HMS had inaccurate or incomplete coverage information from third-party carriers, providers, or members to avoid or recover Medicaid payments; (3) the Medicaid claim was priced incorrectly; (4) the third-party carrier incorrectly coded the denial of a claim for an out-of-network provider; (5) HMS did not always receive accurate and complete Medicaid paid claims information and had an incorrect system edit preventing billing to recover Medicaid payments; (6) HMS recovered from third-party carriers payments that exceeded the total Medicaid payment on a claim without determining whether the member had other Medicaid expenditures for which the excess payments could have been applied; and (7) HMS did not bill third-party carriers for a few months when DXC updated its claim processing system and when it did not receive denials or payments from third-party carriers.

THE STATE AGENCY DID NOT ENSURE THAT MEDICAID PAID CLAIMS CORRECTLY

If the State agency has established the probable existence of third-party liability when a claim is filed, the State agency must reject the claim and return it to the provider to determine the

⁹ These 63 claims relate to 77 errors because some claims had more than one finding as described later in this paragraph.

amount of liability. The establishment of third-party liability takes place when the State agency receives confirmation from the provider or a third-party resource indicating the extent of third-party liability. When the amount of liability is determined, the State agency must then pay the claim to the extent that payment allowed under the State agency's payment schedule exceeds the amount of the third-party's payment (42 CFR § 433.139(b)(1)).

A provider of services to a member must not submit a claim for reimbursement by Medicaid until the provider has first ascertained whether any third party may be liable for all or part of the cost of the services and has sought reimbursement from that resource (405 IAC 1-1-3(f)(1)). The provider may not develop or bill Medicaid for charges that are in excess of the usual and customary charges billed for similar services to non-Medicaid payers (405 IAC 1-11.5-3(a)). Notwithstanding any prior authorization by the State agency, the provision of all services and supplies must comply with the provider agreement, the appropriate provider manual applicable at the time such services or supplies are provided, all other Medicaid policy documents issued to providers, and any applicable State or Federal statute or regulation (405 IAC 5-3-8(c)). The State agency requires members to follow the rules of his or her primary insurance carrier. If the primary insurance carrier requires the member to be seen by in-network providers or it will deny payment, the State agency will not reimburse for claims denied by the primary carrier because the member received out-of-network services.¹⁰

For 9 of the 120 claims in our sample, the State agency made Medicaid overpayments totaling \$5,082 as follows¹¹:

- For four claims, the providers incorrectly reported the third-party payment amounts on the Medicaid claims. On two of these claims, the provider understated the third-party payment amount on the Medicaid claims, resulting in a higher Medicaid payment amount. For the remaining two claims, the provider submitted Medicaid claims indicating that Medicare and another third-party carrier each paid \$0.01 even though both carriers denied the claims because Medicare had denied them as medically unnecessary. By indicating third-party payments of \$0.01 for each of the carriers, the provider bypassed *CoreMMIS*'s edits that would have denied these claims and required the provider to resubmit the claim with additional documentation to receive Medicaid payment. Without a submission and review of additional documentation to support the Medicaid claim, the provider should not have been paid.
- For two claims, the provider did not bill the third-party carrier even though it was liable,

¹⁰ (Indiana Provider Reference Module, *Third Party Liability, Services Rendered by Out-of-Network Providers*).

¹¹ Additionally, for two claims in our sample, Medicaid paid before the third-party carrier paid its full liability. This occurred because Medicaid has different requirements for billing by Federally Qualified Health Centers. Because the State agency recovered the overpayments for these two claims, we did not include the claims in our claim or overpayment totals.

stating it did not know the member had other coverage.¹² In addition, when HMS eventually billed the claims to the third-party carrier, the carrier denied the claims because of inaccurate or missing claim information.

- For one claim, the provider billed different amounts to Medicaid and the third-party carrier for the same services. For 8 of the 12 procedure codes billed, the provider increased the amounts billed to Medicaid to the total payment Medicaid allows for those services.
- For one claim, Medicaid overpaid because DXC incorrectly priced the claim manually at a rate higher than the total payment amount Medicaid allows for that service.
- For one claim, the third-party carrier denied the service because the provider was out-of-network. However, the third-party carrier did not correctly code the denial on the claim as out-of-network. If the third-party carrier had correctly coded the denial, Medicaid would have denied the claim because the Medicaid member received out-of-network services.

For an additional nine claims in our sample, we could not determine whether the State agency overpaid because the third-party carriers would not provide the policy information or the amount of liability. Specifically:

- For six claims, we were unable to obtain third-party policy information to determine whether the third-party policy provided benefits related to the Medicaid claim.
- For four claims,¹³ we were able to verify that the Medicaid members' third-party policy included home health benefits, for which the claims were made. However, the third-party carriers did not provide the amount of their liability.

These issues occurred because (1) providers did not bill Medicaid properly; (2) *CoreMMIS* and HMS had inaccurate or incomplete coverage information from third-party carriers, providers, or Medicaid members to avoid or recover Medicaid payments; (3) the Medicaid claim was priced incorrectly; or (4) the third-party carrier incorrectly coded the denial of a claim for an out-of-network provider. These issues resulted in Medicaid overpayments totaling \$5,082 for the sampled claims.

¹² *CoreMMIS* included the correct third-party policy but did not reflect the benefits included on the Medicaid claim to avoid payment before the provider billed the third-party carrier.

¹³ The Medicaid member associated with one of these claims had coverage through an additional carrier for which we were unable to obtain the third-party policy information. This claim is also included in the prior bullet.

THE STATE AGENCY’S DATABASE DID NOT HAVE ACCURATE AND COMPLETE INFORMATION TO ENSURE THAT IT AVOIDED OVERPAYMENTS

To identify members with third-party health coverage, States are required to request coverage information from potential Medicaid members at the time of any determination or redetermination of eligibility for Medicaid. States are also required to obtain and use information pertaining to third-party liability, for example by conducting data matches with State wage information agencies, Social Security Administration wage and earning files, State motor vehicle accident report files, or State workers’ compensation files (42 CFR § 433.138). States must incorporate into the third-party database all health insurance information necessary to appropriately avoid payment of claims when there is TPL (42 CFR § 433.138(g) and the CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3903.4). Indiana Code requires third-party insurers to furnish the State with records or information pertaining to coverage, eligibility, and claims data (IC 12-15-29-2).

For 27 claims in our sample, *CoreMMIS* contained inaccurate or incomplete third-party coverage information to ensure that Medicaid payment was avoided when there was TPL. Specifically:

- For 18 claims, *CoreMMIS* did not include the correct third-party carrier policy that provided coverage at the time of service. For 16 of these 18 claims, *CoreMMIS* instead included a third-party carrier that did not provide coverage for the benefits on the claim, or inaccurately reflected benefit coverage at the time of service, and the policy had terminated before the service dates on the claim. For one claim, *CoreMMIS* included the correct third-party carrier, but the policy number still listed as active had terminated a few years before the service dates on the claim. For the remaining claim, *CoreMMIS* did not include any third-party carrier in effect at the time of service.
 - For 10 claims, HMS did not send the third-party policies to DXC because HMS’s system edits prevented it from sending the policies. *CoreMMIS* did not generate inquiry letters to the providers for the claims because *CoreMMIS* listed other third-party policies in effect. Of the 10 claims, 7 were related to dental-only policies.¹⁴ For these dental claims, the third-party policy listed in *CoreMMIS* did not reflect dental benefits.
 - For four claims, HMS did not have the correct third-party carrier or had inaccurate coverage dates, which indicated that the policies were not in effect at the time of service.

¹⁴ In 2019, the State agency took corrective action based on our audit, requiring HMS to send dental-only policies to DXC for incorporation into the *CoreMMIS*.

- For three claims, the Medicare Advantage¹⁵ policies were not entered into the *CoreMMIS* because this database reflected Original Medicare coverage. If both Original Medicare and Medicare Advantage policies were entered into the *CoreMMIS*, the system would consider the policies as two separate sources of third-party coverage, requiring both sources of payment before Medicaid would pay. However, without both policies listed in *CoreMMIS*, the State agency could not avoid payment for services covered by the Medicare Advantage policy that Original Medicare does not cover and vice versa.
- For one claim, HMS stated that it had sent the third-party policy information to DXC. However, DXC could not locate the policy in files received from HMS.
- For five of the 27 claims in our sample, *CoreMMIS* included the correct third-party carrier but not the correct coverage dates in effect at the time of service. DXC stated that it did not always get accurate information from third-party carriers. For one of these claims, DXC stated that *CoreMMIS* had accurate coverage dates when the claim was processed. Afterwards, the Medicaid member notified DXC that the policy had ended. Although DXC was unable to confirm with the third-party carrier when the coverage ended, the coverage end date in *CoreMMIS* was changed to the same date as the coverage start date. We confirmed with the third-party carrier that the coverage ended more than 7 months after the dates in *CoreMMIS* were incorrectly changed.
- For four of the 27 claims in our sample, Medicaid paid before the third-party carrier was billed because the third-party policies in *CoreMMIS* did not reflect home health benefits. However, the third-party carriers told us that the members' policies included home health benefits. For these claims, home health benefits were not reflected as covered under the third-party policy in *CoreMMIS* because the State agency did not always obtain specific benefit-level coverage (e.g., home health benefits).

CoreMMIS had inaccurate or incomplete information from third-party carriers, providers, or Medicaid members. Without accurate and complete information, the State agency could pay Medicaid claims before the providers have billed the correct third-party carrier and the third-party carrier paid to the extent of its liability. For 21 of the 27 claims, the State agency relied on providers being able to determine the correct third-party carrier and bill that carrier before billing Medicaid, which the providers did. For the remaining six claims, the providers did not have the correct third-party carrier, resulting in the State agency paying those claims before the

¹⁵ Medicare Advantage Plans are an alternative to Original Medicare. When people join a Medicare Advantage Plan, they will still have Medicare but will get most of their Medicare Part A and Medicare Part B coverage from the Medicare Advantage Plan, not Original Medicare. Some Medicare Advantage Plans offer extra coverage for vision, hearing, dental, and other health and wellness programs.

third-party carrier had been billed.¹⁶

HMS DID NOT HAVE ACCURATE AND COMPLETE INFORMATION TO ENSURE MEDICAID PAYMENT RECOVERIES ON BEHALF OF THE STATE AGENCY

The State agency must seek recovery of reimbursement unless it determines that recovery would not be cost effective (42 CFR § 433.139(d)(3)). The State plan must specify the threshold amount or other guideline that the State agency uses in determining whether to seek recovery of reimbursement from a liable third party or describe the process by which the State agency determines that seeking recovery of reimbursement would not be cost effective (42 CFR § 433.139(f)(2)). The State agency established no threshold amount in determining whether to seek recovery of reimbursement when DXC is notified that a recipient has insurance coverage for a service for which a paid claim appears on the Medicaid monthly Explanation of Benefits (Indiana State plan attachment 4.22-B). After billing a third-party, States must track the status of payments targeted for recovery and follow up with the third party if a response is not received within a reasonable amount of time.¹⁷

For 46¹⁸ of the claims in our sample, HMS had inaccurate or missing information needed to bill third-party carriers:

- For 29 claims in our sample, HMS stated that its system edits prevented billing or rebilling a third-party carrier because the Medicaid paid claims information incorrectly showed a third party had already paid on the claim.¹⁹
- For 19 of the claims in our sample, HMS had inaccurate information or was missing information needed to recover payments from third-party carriers.
 - For 12 claims, HMS had inaccurate third-party coverage information. Specifically, HMS's system had an incorrect third-party carrier or was missing the third-party carrier, had incorrect coverage dates, or did not reflect benefit coverage on the claim. HMS stated that these errors occurred because it did not always get accurate information from the carriers. HMS also experienced

¹⁶ Two of these six claims were included in the nine claims that Medicaid did not pay correctly because the State agency did not recover the third-party carrier's liability amount. The remaining four claims were included in the claims for which the third-party carrier did not provide policy information or the amount of liability.

¹⁷ (CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3904.3).

¹⁸ Two of these claims relate to both of the following bullets.

¹⁹ When DXC changed claims processing systems, a conversion issue resulted in part of the Medicaid payment amount incorrectly showing as the third-party payment amount. The conversion issue affected home health claims processed in the old system and converted to the new system. DXC stated that the issue did not affect new claims put into in the new system; however, DXC did not provide documentation to support its claim.

challenges obtaining policy information from third-party carriers in a timely manner and that was compatible with its system.²⁰

- Five claims were missing information or had incorrect information that caused the third-party carrier to deny the claim. These errors occurred because the Medicaid claim system did not require the same information from the provider that the third-party carrier required to pay the claim or because HMS received incorrect or missing claim information in the Medicaid paid claims file.
- For one claim, an HMS system edit incorrectly prevented HMS from billing a particular third-party carrier.
- For one claim, HMS did not bill the third-party carrier that covered the benefits included on the Medicaid claim. The claim was for needles provided at a pharmacy. The State agency's system processed the claim as a medical claim. The third-party carrier that paid on the claim was the third-party carrier that provided pharmacy benefits.

HMS had inaccurate and missing information because it did not always receive accurate and complete Medicaid claim information from the State agency or accurate and complete third-party coverage information from third-party carriers. Also, HMS had an incorrect system edit. Because HMS had inaccurate or missing information to bill the correct third-party carrier, the State agency may not be recovering Medicaid payments when there could be TPL.

THE STATE AGENCY DID NOT DETERMINE WHETHER MEMBERS HAD OTHER MEDICAID EXPENDITURES TO WHICH EXCESS PAYMENTS RECEIVED FROM THIRD-PARTY CARRIERS COULD BE APPLIED

States may distribute third-party collections to itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based; the Federal Government for the Federal share of the State Medicaid expenditures; and the Medicaid member for any remaining amount.²¹ States may apply third-party monies to any Medicaid expenditures, even if the additional expenditures were not covered by the third party. The application of the collected monies is not limited to a particular Medicaid service for which

²⁰ HMS stated that it experiences challenges with the electronic interface between HMS and the third-party carriers, software compatibility issues, and issues obtaining agreements with third-party insurers to allow electronic verification of coverage rather than manual verification.

²¹ (CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3907).

insurance was available to the Medicaid member, and States may apply the collected amounts to any medical assistance payments made on behalf of the Medicaid member.²²

For two claims in our sample, the State agency did not verify that members had other Medicaid expenditures to which excess payments received from third-party carriers could be applied. HMS recovered from the third-party carrier Medicaid payments that exceeded the amount Medicaid paid on the claims. However, the State agency, DXC, and HMS did not have procedures in place to determine whether the member had other Medicaid expenditures to which the excess payment could be applied. HMS stated that it applied the Medicaid excess payments to the claim on the accounts receivable system because that is the way HMS's system is set up for Indiana Medicaid. The State agency may owe money to Medicaid members because the State agency, DXC, and HMS did not verify that the members had other Medicaid expenditures to which the excess payments recovered from third-party carriers could be applied.

HMS DID NOT BILL THIRD-PARTY CARRIERS IN A TIMELY MANNER OR DID NOT PURSUE RECOVERY WHEN THERE WAS THIRD-PARTY LIABILITY

If the State agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third-party after a claim is paid, the State agency must seek reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available (42 CFR § 433.139(d)(2)). The State plan must specify the threshold amount or other guideline that the State agency uses in determining whether to seek reimbursement from a liable third party, or describe the process by which the State agency determines that seeking reimbursement would not be cost effective (42 CFR § 433.139(f)(2)). The Indiana State plan established no threshold amount for seeking recovery for which DXC has identified insurance coverage (Indiana State plan attachment 4.22-B). After billing a third-party, States must track the status of payments targeted for recovery and follow up with the third party if a response is not received within a reasonable amount of time (CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3904.3).

For two claims in our sample, HMS did not bill the third-party carrier in a timely manner or did not pursue recovery when there was TPL.²³ For one claim, HMS had the correct third-party policy information in its system when the Medicaid claim was processed. However, HMS billed the third-party carrier more than 15 months after Medicaid paid the claim.²⁴ For the remaining claim, HMS initially billed the third-party carrier in a timely manner in October 2016; however,

²² (*Memorandum of Policy Clarification – Distribution of Third Party Collections*, from the Director of Medicaid, issued in 1995).

²³ For an additional 11 claims in our sample, HMS did not bill or rebill the third-party carrier in a timely manner. However, we determined that no TPL remained for those claims.

²⁴ HMS eventually recovered the full Medicaid payment of \$2,200 from the third-party carrier. Because the State agency recovered this amount, we excluded it from the monetary amount in our recommendations.

HMS never rebilled or followed up on the claim after the carrier sent the claim back without a denial code or payment. The third-party carrier indicated to us that the member's policy included home health benefits, for which the claim was made, but did not provide us the amount of its liability.

HMS stated that it generally bills a third-party carrier within 45 days of the Medicaid claim payment when third-party carrier information is known, but HMS did not bill for a few months after DXC converted its system because there was a change in how HMS receives the paid claims data from the State agency. Also, HMS stated that it sometimes takes months for a third-party carrier to respond, the third-party carrier may respond but not include a denial or payment, or a third-party carrier may not respond to a claim. Furthermore, HMS stated that it does not rebill all outstanding claims to third-party carriers every 90 days because the carriers would not be happy with HMS if it rebilled all claims repeatedly. During our audit, HMS stated that it had an upcoming initiative to address when third-party carriers respond with no denial or payment. Because HMS did not bill in a timely manner or pursue recovery on claims, the State agency did not recover all Medicaid payments in a timely manner when there was TPL.

ESTIMATE OF UNALLOWABLE MEDICAID PAYMENTS

On the basis of our sample results, we estimated that the State agency made overpayments totaling at least \$54,965 (\$36,573 Federal share) to providers for service dates during our audit period.

RECOMMENDATIONS

We recommend that the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning:

- refund \$36,573 to the Federal Government and
- work with DXC to ensure that:
 - providers submit billed amounts and third-party payment amounts that match the claims billed to the third-party carrier;
 - Medicaid claims are priced correctly;
 - *CoreMMIS* contains accurate and complete information to avoid paying claims when a third party is liable, including (1) all active third-party carriers and policies, (2) all third-party coverage benefits (and the system is allowed to generate provider inquiry letters for Medicaid claims with benefits not included in *CoreMMIS*), and (3) accurate third-party coverage dates;

- HMS (1) has accurate and complete Medicaid claim information to bill third-party carriers, (2) has accurate and complete third-party policy information, and (3) addresses system edits preventing billing to third-party carriers;
- when HMS recovers Medicaid excess payments from third-party carriers that exceed the total Medicaid payment on a claim, HMS determines whether the member has other Medicaid expenditures to which the excess payments recovered could be applied; and
- HMS pursues recovery of Medicaid payments in a timely manner for claims with TPL.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with one finding, parts of two findings, and agreed with or acknowledged the validity of the remaining two findings. The State agency did not indicate concurrence or nonconcurrence with our recommendations but described corrective actions that it has implemented or planned or that it is considering. A summary of the State agency's comments and our responses follow. The State agency's comments are included in their entirety as Appendix E.

We recognize the State agency's significant efforts in saving State and Federal Medicaid dollars through avoidance of payments and recovery from third-party carriers when TPL exists, but challenges still remain in working with third-party carriers. After reviewing the State agency's comments, we maintain that our findings, recommendations and estimate of unallowable Medicaid payments are valid.

THE STATE AGENCY DID NOT ENSURE THAT MEDICAID PAID CLAIMS CORRECTLY

State Agency Comments

The State agency disagreed with our findings for 8 of the 9 claims and acknowledged the validity of our finding for the claim that was manually priced incorrectly by DXC. Specifically, for five claims, the State agency stated that these claims were processed inaccurately due to provider error. It also stated that Medicaid providers have the duty to accurately report the dollar amount received from the third-party carrier; bill their usual and customary rate without regard to the Medicaid rate; and adjust a claim or submit a credit balance when a third-party payment is received after Medicaid processes the claim. However, the State agency said that it would explore adding edits or audits to its claims processing to look for unusually low dollar amounts reported as other insurance payments. The State agency also stated that other possible corrective actions could include a back-end review of claims with a low dollar amount reported in the other insurance field, outreach and education to providers utilizing this practice, and possibly forwarding the names of providers to Surveillance and Utilization Reviews for repeat occurrences.

For two of the 9 claims, the State agency stated that the code required by the third-party carrier is not required by Medicaid and was not available for HMS to include on the Medicaid reclamation claim. For one of the 9 claims, the State agency disputed that the claim was denied by the third-party carrier because the provider was out-of-network; rather, it was denied because the plan did not cover medical equipment for which it was billed. As a quality improvement, the State agency, in conjunction with DXC, has recently developed a TPL workgroup that reviews claim edits related to TPL as well as TPL claim activity.

The State agency also disputed the estimate of unallowable Medicaid payments.

Office of Inspector General Response

Regarding the five claims related to provider errors, we maintain that these claims had Medicaid overpayments as a result of the errors. For the two claims for which the third-party carrier required information not required to process the Medicaid claim, the third-party carrier provided us the amount of TPL it would have paid if the claim had been billed correctly. Therefore, we maintain that the claims were Medicaid overpayments. For the claim for which the State agency disputed the reason for denial by the third-party carrier, we maintain that the third-party carrier denied the claim because the provider was out-of-network, and the member did not have out-of-network benefits. We provided the State agency with a copy of the third-party carrier's explanation of benefits for the claim billing by HMS, which included the denial as out-of-network and the explanation for the initial errors in coding the denial of the claim.

In maintaining the validity of our findings, we also stand by our estimate of unallowable Medicaid payments.

THE STATE AGENCY'S DATABASE DID NOT HAVE ACCURATE AND COMPLETE INFORMATION TO ENSURE THAT IT AVOIDED OVERPAYMENTS

The State agency acknowledged that, for some of the claims, the third-party carrier information in CoreMMIS was incomplete or outdated. The State agency stated that corrective actions would include (1) reviewing all business rules and edits, (2) adding Medicare Advantage policies if those policies provide additional coverage beyond basic Medicare Parts A and B coverage, and (3) providing further staff training to validate specific coverages.

HMS DID NOT HAVE ACCURATE AND COMPLETE INFORMATION TO ENSURE MEDICAID PAYMENT RECOVERIES ON BEHALF OF THE STATE AGENCY

State Agency Comments

The State agency disagreed that HMS was provided with claims that had missing information, stating that the claims had complete information to be processed under applicable Medicaid claims processing rules. The State agency also stated that if a commercial carrier required

additional information that is not contained in the Medicaid claim, that information is not available for the Medicaid reclamation claim billed by HMS.

The State agency stated that for the claim that was billed to Medicaid as a medical claim for needles at a pharmacy, the Medicaid reclamation claim could not be billed by HMS as a pharmacy claim because it was not originally billed as a pharmacy claim. The State agency said that reclamation claims are billed exactly as they are billed to the Medicaid agency.

The State agency acknowledged that HMS did not have complete third-party information for all claims sampled and had system edits in place that prevented the billing of some claims. The State agency stated that it, along with DXC and HMS, would conduct an annual review of all business rule requirements for avoiding payments, commercial insurance billing, provider disallowance, and managed care entity come-behind billings to ensure that the State's TPL rules and requirements are met.

Office of Inspector General Response

Regarding the claims missing information, we maintain that the Medicaid claim system did not require the same information from the provider that the third party required. Without this information, the third party denied the Medicaid reclamation claims. HMS is no longer pursuing recovery for these claims. Regarding the claim for needles at a pharmacy, HMS billed the third-party carrier that did not provide the benefits for which the claim was billed because Medicaid processed it as a medical claim. During the audit, HMS stated that it had the capacity to conduct special projects to convert claims from pharmacy to medical or vice versa with client approval. Therefore, we maintain that our finding is valid.

THE STATE AGENCY DID NOT DETERMINE WHETHER MEMBERS HAD OTHER MEDICAID EXPENDITURES TO WHICH EXCESS PAYMENTS RECEIVED FROM THIRD-PARTY CARRIERS COULD BE APPLIED

The State agency agreed with this finding and stated that it has since verified that both members related to the two claims had other Medicaid claims to which the excess payments received from the third-party carriers could have been applied. The State agency also stated that it will review possible additional processes to determine whether excess payments may be applied to other claim payments during the time period received.

HMS DID NOT BILL THIRD-PARTY CARRIERS IN A TIMELY MANNER OR DID NOT PURSUE RECOVERY WHEN THERE WAS THIRD-PARTY LIABILITY

State Agency Comments

The State agency stated that it generally disagreed with the finding that HMS did not bill in a timely manner or did not pursue recovery when there was TPL. The State agency said that HMS sends out monthly Medicaid reclamation billings on a regular and timely basis and that billings

were delayed only during the implementation of the new Indiana MMIS system. The State agency also stated that HMS generally follows up repeatedly on all claims not responded to by the third-party carriers and continues to pursue recovery of a claim until a final unrecoverable denial is returned from the carrier.

Office of Inspector General Response

Regarding the claim that HMS billed more than 15 months after Medicaid paid the claim, Medicaid paid the claim more than 4 months before the State agency's new system was implemented. CoreMMIS began processing claims in February 2017. Based on information obtained during the audit, HMS billed or rebilled Medicaid claims in our sample to third-party carriers as early as May 2017. Regarding the claim that HMS did not pursue recovery from the third-party carrier, the State agency did not provide any additional information to show that the claim was pursued further. Therefore, we maintain that our finding is correct. Furthermore, as indicated in footnote 23, OIG found 11 additional claims in our sample for which HMS did not bill or rebill the third-party carrier in a timely manner. However, we determined that no TPL remained for those claims.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 79,920 non-pharmacy claims, totaling \$7,355,692, for which the claims indicated third-party payment, or for which the members' Medicaid eligibility files indicated that they had other insurance. We reviewed claims that had service dates during the period January 1, 2015, through December 31, 2016 (audit period), and that were paid between January 1 and December 31, 2016. We selected a stratified random sample of 120 non-pharmacy claims totaling \$49,666 for review.

We did not review the overall internal control structure of the State agency or its Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted fieldwork from October 2018 through April 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- discussed with State agency officials, its contractor, and HMS TPL efforts related to Medicaid claims;
- obtained Indiana MMIS data from the State agency's contractor, EDW;
- judgmentally selected 5 claims and a stratified random sample of 115 non-pharmacy claims with third-party payment amounts indicated on the Medicaid claim for which we:
 - obtained from DXC CoreMMIS claim information, including any documentation submitted by the provider with the claim, and third-party carrier information for each member;
 - contacted providers to confirm Medicaid and third-party payment information, and obtained the third-party carrier information;
 - contacted the third-party carriers to obtain information on whether the benefits included on the Medicaid claim were covered under the member's policy and whether the carrier paid to the full extent of its liability;
 - verified that the Medicaid allowable amounts on the claim were in accordance with the approved reimbursement rates; and

- recalculated the Medicaid payment based on the approved Medicaid reimbursement rate less the third-party payment amount or the amount OIG confirmed was the amount for which the third-party carrier was liable;
- estimated the total value and Federal share of Medicaid overpayments that the State agency did not recover by using OIG, Office of Audit Services (OAS), statistical software; and
- discussed the results of our audit with State agency officials, DXC, and HMS.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 79,920 Medicaid non-pharmacy claims with a service date during the audit period, January 1, 2015, through December 31, 2016, and paid January 1 through December 31, 2016, totaling \$7,355,392.

SAMPLE UNIT

The sample unit was a Medicaid non-pharmacy claim for which a third-party carrier paid on the claim or there was a third-party carrier indicated in the member's eligibility file.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample (Table 1). We divided the sampling frame into four strata: (1) claims reviewed to verify that the source data was valid and reliable, (2) claims for which TPL was more than Medicaid paid, (3) claims for which Medicaid paid the same as or greater than \$0 more than TPL but less than \$200 more than TPL, and (4) claims for which Medicaid paid \$200 or more than TPL.

Table 1: Sample Design Summary

STRATUM DESCRIPTION	STRATUM	Total No. of Claims	Total Medicaid Amount	Sample Size
Survey Sample	1	5	\$7,388	5
TPL > Medicaid Paid	2	60,765	2,186,827	35
Medicaid Paid => \$0 More But < \$200 More Than TPL	3	15,138	1,484,628	30
Medicaid Paid => \$200 More Than TPL	4	4,012	3,676,849	50
Total		79,920	\$7,355,692	120

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units within each stratum. We reviewed all five claims in stratum 1. After generating 35 random numbers for stratum 2, 30 random numbers for stratum 3, and 50 random numbers for stratum 4, we selected the corresponding claims in each stratum.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of any unallowable Medicaid payments made to the provider for which the State agency claimed Federal Medicaid reimbursement. To be conservative, we recommend recovery of unallowable payments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual total of unallowable payments in the sampling frame 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Paid Sample Items	Value of Overpayments in Sample
1	5	\$7,388	5	\$7,388	2	\$2,448
2	60,765	2,186,827	35	1,360	0	0
3	15,138	1,484,628	30	3,666	2	25
4	4,012	3,676,849	50	37,252	5	2,609
Total	79,920	\$7,355,692	120	\$49,666	9	\$5,082

**Table 3: Estimates of Unallowable Payments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)**

	Total Amount	Federal Share
Point estimate	\$222,150	\$148,011
Lower limit	52,517	34,943 ²⁵
Upper limit	391,783	261,079

²⁵ The Federal share of overpayments for the judgmental claims in Stratum 1 was \$1,630, totaling \$36,573 in Federal unallowable payments for the audit period.

APPENDIX D: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

If the State agency has established the probable existence of third-party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third-party liability takes place when the State agency receives confirmation from the provider or a third-party resource indicating the extent of third-party liability. When the amount of liability is determined, the State agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third-party's payment (42 CFR § 433.139(b)(1)).

To identify members with third-party health coverage, States are required to request coverage information from potential Medicaid members at the time of any determination or redetermination of eligibility for Medicaid. States are also required to obtain and use information pertaining to third-party liability, for example by conducting data matches with State wage information agencies, Social Security Administration wage and earning files, State motor vehicle accident report files, or State workers' compensation files (42 CFR § 433.138).

If the State agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the State agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third-party or benefits become available (42 CFR § 433.139(d)(2)). The State agency must seek reimbursement unless it determines that recovery would not be cost effective (42 CFR § 433.139(d)(3)). The State plan must specify the threshold amount or other guideline that the State agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the State agency determines that seeking recovery of reimbursement would not be cost effective (42 CFR § 433.139(f)(2)). After billing a third-party, States must track the status of payments targeted for recovery and follow up with the third party if a response is not received within a reasonable amount of time (CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3904.3).

States must incorporate into the third-party database all health insurance information necessary to appropriately avoid payment of claims when there is TPL (42 CFR § 433.138(g) and the CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3903.4).

States may distribute third-party collections to itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based; the Federal Government for the Federal share of the State Medicaid expenditures; and the Medicaid member for any remaining amount (CMS *State Medicaid Manual*, Pub. No. 45, chapter 3, § 3907). States may apply third-party monies to any Medicaid expenditures, even if the additional expenditures were not covered by the third party. The application of the collected monies is not limited to a particular Medicaid service for which insurance was available to the Medicaid member, and States may apply the collected amounts to any medical assistance

payments made on behalf of the Medicaid member (*Memorandum of Policy Clarification – Distribution of Third Party Collections*, from the Director of Medicaid, issued in 1995).

STATE REQUIREMENTS

The State agency established no threshold amount in determining whether to seek recovery of reimbursement when DXC is notified that a recipient has insurance coverage for a service for which a paid claim appears on the Medicaid monthly Explanation of Benefits (Indiana State plan attachment 4.22-B).

Indiana Code requires third-party insurers to furnish the State with records or information pertaining to the coverage, eligibility, and claims data (IC 12-15-29-2).

Resources from health insurance plans available to the member must apply first to defraying the cost of medical services before any share of the Medicaid claim for payment is approved. A provider of services to a member must not submit a claim for reimbursement by Medicaid until the provider has first ascertained whether any such resource may be liable for all or part of the cost of the services and has sought reimbursement from that resource (405 IAC 1-1-3(f)(1)).

Third-party payment applied to the member's cost of care must be deducted from the total payment allowable from Medicaid, with Medicaid paying only the balance. Reimbursement rates are determined by the State agency and its offices, divisions, or designees, according to the requirements of Federal and State laws governing rate setting for Medicaid services and be accepted as party payor (405 IAC 1-1-3(f)(2)).

The State agency may deny payment to any provider for medical assistance services rendered if the office finds that the amount claimed for such services or material has been or can be paid from other sources (405 IAC 1-1-4(a)(3)).

The provider may not develop or bill Medicaid for charges that are in excess of the usual and customary charges billed for similar services to non-Medicaid payers (405 IAC 1-11.5-3(a)).

Notwithstanding any prior authorization by the State agency, the provision of all services and supplies must comply with the provider agreement, the appropriate provider manual applicable at the time such services or supplies were provided, all other Medicaid policy documents issued to providers, and any applicable State or Federal statute or regulation (405 IAC 5-3-8(c)).

The State agency requires members to follow the rules of his or her primary insurance carrier. If the primary insurance carrier requires the member to be seen by in-network providers or it will deny payment, the State will not reimburse for claims denied by the primary carrier because the member received out-of-network services (*Indiana Provider Reference Module, Third Party Liability, Services Rendered by Out-of-Network Providers*).

All FQHCs are required to submit fee-for-service claims for valid medical encounters to the IHCP

on the professional claims (*CMS-1500* claim form, Portal professional claim, or 837P transaction) using HCPCS encounter code T1015. In addition to the T1015 encounter code, FQHC providers must use all Current Procedural Terminology and HCPCS procedure codes appropriate to the services provided during the visit (*Indiana Provider Reference Module, Federally Qualified Health Centers and Rural Health Clinics, FQHC, and RHC Encounters*).

APPENDIX E: STATE AGENCY COMMENTS



Eric Holcomb, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

July 29, 2020

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
DHHS/OIG/OAS
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Report Number: A-05-18-00046

Dear Ms. Fulcher:

This letter is in response to your letter dated June 29, 2020 regarding OIG draft report *Indiana Did Not Ensure That Medicaid Was the Payer of Last Resort for Claims*, Report number A-05-18-00046.

As an introductory response, the Indiana Family and Social Services Administration (hereinafter FSSA or State agency), would note during the audit time frame, January 1, 2015, through December 31, 2016, Indiana saved a total of \$201,528,164 in State and federal Medicaid dollars through cost avoidance and cost recovery. During the same time period, the OIG draft report notes a total of \$5,082, in Medicaid claim payments that purportedly should not have been paid if third party insurance information had been available. Even if this amount is correct, which the State agency contests, it is a mere .0025 percent of the total cost avoidance and cost recoveries achieved by FSSA during the audit time period. Therefore, the title of the OIG's draft report, *Indiana Did Not Ensure That Medicaid Was the Payer of Last Resort for Claims*, mischaracterizes the status of Medicaid third party liability cost avoidance and recoveries in Indiana during the audit time period. To assert that Indiana did not ensure that Medicaid was the payer of last resort on claims, without even limiting it to "some claims," seems to unfairly and incorrectly report the status of TPL processes in Indiana for the audit time period. The State agency would request that a more accurate report title be used.

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Responses to Individual Findings:

- **Finding: The State Agency did not ensure that Medicaid Paid Claims Correctly.**
- **Response:** For nine (9) of the 120 claims, the OIG found that the State agency should not have paid some or all of the Medicaid payment, totaling \$5,082. The FSSA disagrees with these findings and provides the following response:
 - Five (5) of these claims processed inaccurately, due to provider error, with regard to TPL due to provider errors (sample # J5, 53, 61, 82, and 90).
 - For three (3) of these claims (sample # J5, 53, and 82), providers listed inaccurate other insurance paid amounts on the claims.
 - For one (1) claim (sample #61), a provider billed the private carrier \$7.30 less than the provider billed Indiana Medicaid.
 - For the fifth claim (sample #90), the provider failed to report a subsequent payment received from a third-party carrier after the claim was processed and paid by Indiana Medicaid.
 - All five (5) of these claims involve provider errors. Medicaid providers have the duty to accurately report the dollar amount received from the third-party insurance carrier (sample #J5, 53, 82); bill their usual and customary rate without regard to the Medicaid rate (sample #61); and adjust a claim or submit a credit balance when a third-party payment is received after Medicaid processes the claim (sample 390). These responsibilities are set out in the Provider Agreement, manuals and Indiana Administrative Code.
 - Therefore, the FSSA does not concur with these findings; however, based on the OIG's feedback, the State agency will explore adding edits or audits to its claims processing to look for unusually low dollar amounts reported as other insurance payments. Alternative or additional possible corrective actions could include a back-end review of claims with low dollar amounts (\$1 or under) reported in the other insurance field, followed up with outreach and education to providers utilizing this practice, and possibly forwarding providers to SURs for repeat occurrences.
 - With regard to credit balances, FSSA already conducts audits of its providers looking for unpaid credit balances.
 - Short of requiring providers to provide third party EOBs with all claims, which would cause significant provider abrasion, there is no way for the State agency to confirm the amounts the provider billed to the third-party carrier.
 - For two (2) out of the nine (9) claims (sample #91 and 114), the OIG found that if Medicaid had included additional information on the Medicaid reclamation claim, it may have been paid by the third-party carrier.

- Medicaid reclamation claims contain the exact claim data as the original Medicaid claim.
 - On these two (2) claims, the code required by the third-party carrier, the HHRG code, is not required by Medicaid, and was not available for HMS to include on the Medicaid reclamation claim.
 - For claim sample # J3, the OIG asserts that the third-party carrier did not correctly deny the claim (or code the denial).
 - FSSA disputes that the claim was denied by UHC for the provider being out-of-network. The UHC EOB denial that was provided by the provider with the Medicaid claim, indicated that the UHC claim was denied because the plan did not cover medical equipment.
 - The denial received by DXC showed that the plan did not cover the medical equipment being billed for, and the assumption being made is that it would have been covered if the member purchased the equipment from an in-network provider, has not been established.
 - For the final claim in this grouping (sample #67), the State agency would acknowledge that the claim was manually priced incorrectly. DXC will conduct staff training as appropriate.
 - Finally, this section of the report notes that for six (6) claims, the OIG was unable to obtain third-party information to determine whether the third-party policy provided benefits to the Medicaid claim and for four (4) claims they were not able to determine the extent of liability.
 - These acknowledgments by the OIG serve to illustrate the challenging environment Medicaid TPL programs are operating in. State TPL programs are dependent on the cooperation of commercial health insurance carriers to provide accurate and complete information. For many of our members, their private health insurance is employment based and can be very fluid.
 - Keeping up to date TPL information is a constant challenge for any state Medicaid program and is heavily reliant on the cooperation of commercial carriers. As the OIG indicated, some carriers are more forthcoming than others.
 - As a quality improvement, the State agency, in conjunction with DXC, has recently developed a TPL workgroup that reviews claim edits related to TPL as well as TPL claim activity.
- **Finding: The State Agency’s Database Did Not Have Accurate And Complete Information To Ensure That It Avoided Overpayments.**

- **Response:** The State agency acknowledges for some of these claims that the third-party carrier information was incomplete or outdated. In the current TPL environment, with hundreds of commercial carriers on various platforms, perfect and immediate data is not a realistic option. HMS is regularly recruiting new carriers to add additional commercial insurance information to its database.
 - The State agency's TPL database within the MMIS system contains third party coverage information for Indiana Medicaid members. This information comes from a variety of sources, including from members, upon enrollment and reverification, from providers, and from HMS. HMS has a vast database that consolidates commercial insurance carrier member enrollment data. HMS' data base covers 99% of Indiana insureds and contains data from the majority of private health insurance carriers operating in Indiana. Despite access to this data, Medicaid TPL is complex, with many possible points of failure including incomplete, inaccurate, or delayed information being received throughout the eligibility and claims payment continuums. The state TPL programs are limited by the information provided by the commercial carriers with regard to accuracy, completeness and timeliness of the data.
 - The most significant challenge in maintaining TPL data is maintaining up to date policy coverage dates (effective and termination dates). As members frequently switch TPL carriers, the State is dependent on the carriers to provide updated coverage dates, which are not always available.
 - An additional area of difficulty faced by state TPL programs, is obtaining detailed coverage information from the carriers with regard to specific types of coverage such as home health or behavioral health coverage. This information is not generally included in the coverage information provided to HMS.
 - Corrective action will include:
 - The review of all business rules and edits applicable to third-party commercial insurance data provided to DXC by HMS to ensure business rules and/or system edits are not preventing the most up to date information from being added to the MMIS system.
 - DXC staff have been instructed to add Medicare Advantage policies if those policies provide additional coverages beyond basic Medicare A and B coverage. Those policies will be identified by the additional coverage they provide (vision, dental, etc.).
 - DXC will provide further training for staff to validate specific coverages such as home health and behavioral health where carriers are willing to provide this information.
 - Specific claims impacted were addressed in the prior section.

- **Finding: HMS Did Not Have Accurate and Complete Information to Ensure Medicaid Payment Recoveries on Behalf of the State Agency Commercial Insurance Carrier Landscape in the State of Indiana.**

- **Response:** The State agency would disagree with the finding in this section that HMS was provided with claims that had missing information. The paid Medicaid claims had complete information to be processed under applicable Medicaid claims processing rules. HMS bills Medicaid reclamation claims which contain the exact claim data as the original Medicaid claim. If a commercial carrier requires additional information that is not contained within the Medicaid claim, that information is not available for the reclamation claim.
 - HMS has extensive third-party health insurance information in its consolidated database. This database covers 99% of Indiana members. HMS receives eligibility data from all the major carriers in Indiana. HMS bills Medicaid reclamation claims monthly and generally follows up repeatedly on all claims not responded to by the commercial carriers. If a claim is denied, additional follow-up activities will take place if appropriate. The timing of the recovery will be specific to the denial reason itself, available data, and follow up activity performed to verify validity of the denial. HMS will continue to pursue recovery of a claim until a final unrecoverable denial is returned from the carrier
 - The State agency acknowledges that HMS did not have complete TPL information for all claims sampled and had some system edits in place preventing the billing of some of the sampled claims.
 - As noted, a review of all business rules and edits applicable to the third-party commercial insurance data provided to DXC by HMS will be conducted to ensure that the business rules and/or system edits are not preventing the most up to date information from being added to the MMIS system.
 - Further, a review of business rules and edits applicable to all cost recovery and Medicaid reclamation billing activities will be conducted to ensure there are no business rules and/or system edits are preventing appropriate Medicaid reclamation billing.
 - HMS edits have previously been corrected to bill all carriers accepting reclamation claims.
 - As a best practice, the State agency along with DXC and HMS, going forward, will conduct an annual review of all business rule requirements for Cost Avoidance, Commercial Insurance Billing, Provider Disallowance, and MCE Come-behind Billings to ensure the State's TPL rules and requirements are being met.
 - It should be mentioned that there are a number of factors beyond the State agency's and HMS' control that impacts the receipt of complete, accurate and up

to date information from commercial carriers, including the cooperation of carriers, the compatibility of software and challenges with electronic interfaces.

- The last bullet under this section cites a claim (sample #52) that was billed to Indiana Medicaid as a medical claim for needles and the member had commercial pharmacy coverage. Despite the assertions in this finding, the Medicaid reclamation claim could not be billed as a pharmacy claim as it was not originally billed as a pharmacy claim. Reclamation claims are billed exactly as they were billed to the Medicaid agency.

- **Finding: The State Agency Did Not Verify That Members Had Other Medicaid Expenditures to Which Excess Payments Received From Third-Party Carriers Could Be Applied.**

- **Response:** The State agrees with this finding, and provides further information and corrective actions that will be taken to minimize these type of errors in the future.
 - The State agency agrees that HHS issued guidance on July 28, 1995, in a Memo entitled “Policy Clarification – Distribution of Third Party Collections” which advised State Medicaid agencies that they may keep the excess funds received if a carrier pays more than the Medicaid paid amount on a claim. The memo further provides guidance that the State may choose to disburse those funds to other outstanding claims for the same member. The disbursement of those funds would be at the direction of the State.
 - The State agency acknowledges for the two claims referenced (sample # 15 and 44), that the third-party commercial carriers paid an amount higher than the Medicaid paid amount when billed as reclamation claims by HMS. At the time, it was not verified that these members had other paid claims to which the excess payments could be applied. However, since then it has been verified that both members had other paid claims to which the excess claim payments could be applied.
 - Additionally, based on this feedback, the State agency will review possible additional processes to verify that excess payments can be applied to other claim payments during the time period received.

- **Finding: HMS Did Not Bill Third-Party Carriers In A Timely Manner Or Did Not Pursue Recovery When There Was Third-Party Liability.**

- **Response:** The State would, in general, disagree with this assessment. HMS sends out monthly Medicaid reclamation billings on a regular and timely basis.

- In the draft report, the OIG cites 2 claims out of 120 sampled, one of which was delayed in billing, and the other that was billed timely, but not rebilled after no response was received from the carrier.
- The only time period in which this was delayed was during the implementation of the new Indiana MMIS system. With the implementation, HMS began receiving claims and eligibility data from the EDW in table format, when it had been previously received that data from DXC in file format. HMS had to implement programming to convert to the new data format from the EDW and during this conversion time period the monthly billings were delayed.
- State Medicaid agencies regularly change, update or implement new MMIS systems. These implementations are often lengthy and require significant time and resources to ensure the new system works as intended. The implementation Indiana underwent to transition to the new *Core*MMIS system was no exception
- Since the implementation of *Core*MMIS, HMS has sent out monthly Medicaid reclamation billings on a timely basis.
- Additionally, HMS generally follows up repeatedly on all claims not responded to by the commercial carriers. If a claim is denied, additional follow-up activities will take place if appropriate depending on the denial reason itself, available data, and follow up activity performed to verify validity of the denial. HMS will continue to pursue recovery of a claim until a final unrecoverable denial is returned from the carrier

Comments on Estimate of Unallowable Medicaid Payments. As the State agency disputes the monetary findings, it additionally disputes the estimate of unallowable Medicaid Payments based on these monetary findings.

Comments on Recommendations: As noted in the individual sections above, the State agency will pursue the correction actions listed.

If you require further information, please contact David Nelson at David.Nelson@fssa.in.gov.

Sincerely,

Allison Taylor
Medicaid Director
Office of Medicaid Policy and Planning