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

Connecticut Claimed Unallowable Federal Reimbursement for Medicaid Physician-Administered Drugs That Were Not Invoiced to Manufacturers for Rebates

Why OIG Did This Review

For a covered outpatient drug to be eligible for Federal reimbursement under the Medicaid program's drug rebate requirements, manufacturers must pay rebates to the States for the drugs. However, a prior OIG review found that States did not always invoice and collect all rebates due for drugs administered by physicians.

Our objective was to determine whether Connecticut complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

How OIG Did This Review

We reviewed claims for physician-administered drugs paid between January 2012 and December 2016.

We used the Centers for Medicare & Medicaid Services' (CMS's) Medicare Part B crosswalk and the CMS Medicaid Drug File to identify single-source and multiple-source drugs. Additionally, we determined whether the Healthcare Common Procedure Coding System codes were published in CMS's top-20 multiple-source drug listing.

What OIG Found

Connecticut did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs. Connecticut did not invoice manufacturers for rebates associated with $1.1 million (Federal share) in physician-administered drugs. Of this amount, $1.07 million was for single-source drugs, and $46,210 was for top-20 multiple-source drugs. Further, Connecticut did not submit the utilization data necessary to secure rebates for all other physician-administered drug claims totaling $2.8 million (Federal share).

What OIG Recommends and Connecticut Comments

We recommend that Connecticut refund to the Federal Government $1.07 million (Federal share) for claims for single-source physician-administered drugs, and $46,210 for claims for top-20 multiple-source physician-administered drugs, and work with CMS to determine the unallowable portion of the $2.8 million (Federal share) for other claims for outpatient physician-administered drugs that were at issue. We also make procedural recommendations to Connecticut.

Connecticut concurred with our first two recommendations and, for our other recommendations, described corrective actions that it had taken or planned to take.