HHS Office of Inspector General

REPORT HIGHLIGHTS

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Medicaid Managed Care: States Do Not Consistently Define or Validate Paid Amount Data for Drug Claims

Why OIG Did This Review

- In Medicaid managed care, consistent and accurate data on the amount pharmacies were reimbursed for filling prescriptions are critical for CMS and States to administer the program and oversee drug spending. Such data are particularly important in light of concerns that pharmacy benefit managers' (PBMs') use of spread pricing could inflate Medicaid drug costs.
- In the Transformed Medicaid Statistical Information System (T-MSIS), the Medicaid Paid Amount data elements that States report for managed care drug claims could—in practice—represent (1) the amount that the plan or its PBM reimbursed to the pharmacy or (2) the amount that the plan paid to its PBM, which may include PBM administrative fees, such as spread.
- If these paid amount data do not consistently and accurately reflect pharmacy reimbursement, this could undermine States' use of these data to determine actual Medicaid drug spending; to develop plans' capitation rates; and to combat fraud, waste, and abuse in Medicaid managed care. Also, CMS has emphasized the importance of these data for Federal oversight, including financial management of Medicaid managed care.

What OIG Found

State requirements varied for how plans should report the paid amount for drug claims. Of the 36 States that covered outpatient prescription drugs for Medicaid through managed care in January 2022, 28 States required Medicaid managed care plans to report the paid amount for drug claims as the amount the plan or its PBM reimbursed to the pharmacy; 2 States required plans to report the amount the plan paid to its PBM; and 6 States had no reporting requirements.

For 37 of 252 managed care drug claims in our review, the T-MSIS paid amount did not equal pharmacy-reported reimbursement, raising concerns about the accuracy or consistency of the paid amounts on these claims. Twenty-two non-matching claims in our sample were from States where the T-MSIS paid amounts should have equaled pharmacy-reported reimbursement amounts for all claims according to States' requirements and practices.

Although all States relied on drug claim paid amounts to safeguard and administer the Medicaid program, many States did not conduct certain activities to validate these data. Most States relied on these data to develop capitation rates and identify fraud, waste, and abuse. Ten States did not validate these data by comparing them to another data source—a recommended, but not required, activity.

What OIG Recommends

CMS should (1) revise the T-MSIS Data Dictionary to instruct States to report the paid amount as the amount paid to the pharmacy for all Medicaid managed care drug claims; (2) provide additional technical assistance to States to clarify what to include or exclude from the reported paid amounts to providers for Medicaid managed care drug claims; and (3) follow up with States that did not verify that paid amounts for managed care drug claims were complete. CMS concurred with all three recommendations.