Department of Health

Medicaid Program: Maximizing Drug Rebates Under the Federal Medicaid Drug Rebate Program

Report 2021-S-11 | April 2023

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health (Department) took appropriate steps to collect all available drug rebates under the federal Medicaid Drug Rebate Program (MDRP). The audit covered the period from April 2018 through March 2022 and certain claims going back to January 2017.

About the Program

In 1990, Congress created the MDRP to reduce state and federal expenditures for Medicaid prescription drugs. The program was later expanded to require rebate collection for certain physician-administered drugs and drugs dispensed to individuals enrolled in Medicaid managed care plans. The MDRP requires drug manufacturers to enter into a national rebate agreement with the Centers for Medicare & Medicaid Services in exchange for Medicaid coverage of most of the manufacturer's drugs. On a quarterly basis, states are required to send rebate invoices to each manufacturer for any rebate-eligible drugs the states paid for. Since April 1, 2018, the Department's rebate contractor, Magellan Medicaid Administration Inc. (Magellan), has been responsible for submitting rebate invoices to manufacturers and collecting payments. Prior to April 1, 2018, the Department was solely responsible for administering the MDRP and sending rebate invoices to manufacturers. On a weekly basis, the Department extracts fee-for-service and managed care claims from the Medicaid Data Warehouse and provides them to Magellan for rebate invoicing. Magellan then determines which claims will be invoiced to drug manufacturers.

Key Findings

During the audit period, the Department made significant process improvements and system enhancements in the rebate collection process. However, certain improvements are still needed. We identified uncollected drug rebates totaling $183.7 million, as follows:

- $119 million in rebates missed due to errors in Department claim extraction procedures. The Department updated its extraction procedures in 2020 to fix these issues going forward.
- $44.5 million in rebates missed primarily due to inaccurate or incomplete claim information submitted by managed care organizations and providers.
- $12.8 million in rebates missed because Program of All-Inclusive Care for the Elderly managed care claims were excluded from the rebate process.
- $7.4 million in rebates missed due to processing errors by the Department and the rebate contractor.

Key Recommendations

- We made 12 recommendations to the Department to invoice manufacturers for missed rebates, improve claims processing controls, and formally review certain rebate procedures.

Office of the New York State Comptroller
Division of State Government Accountability

April 5, 2023

James V. McDonald, M.D., M.P.H.
Acting Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Maximizing Drug Rebates Under the Federal Medicaid Drug Rebate Program*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
Department	Department of Health	*Auditee*
ACA	Affordable Care Act	*Law*
CMS	Centers for Medicare & Medicaid Services	*Federal Agency*
EIS	Encounter Intake System	*System*
eMedNY	Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-service	*Key Term*
Magellan	Magellan Medicaid Administration Inc.	*Contractor*
MCO	Managed care organization	*Key Term*
MDRP	Medicaid Drug Rebate Program	*Program*
MDW	Medicaid Data Warehouse	*System*
NDC	National Drug Code	*Key Term*
PACE	Program of All-Inclusive Care for the Elderly	*Key Term*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (Department). For the State fiscal year ended March 31, 2022, New York State's Medicaid program had approximately 7.8 million recipients and Medicaid claim costs totaled about $74.6 billion. The federal government funded about 57.1% of New York State's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 42.9%.

The Department pays health care providers through the fee-for-service (FFS) method or through managed care. Under FFS, the Department, through its Medicaid claims processing and payment system (eMedNY), makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients. Under managed care, the Department pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid recipient and the MCOs arrange for the provision of health care services and reimburse providers for those services. MCOs are also required to submit encounter claims to the Encounter Intake System (EIS) to inform the Department of each medical service provided.

In 1990, Congress created the Medicaid Drug Rebate Program (MDRP) to reduce state and federal expenditures for Medicaid prescription drugs. The MDRP requires drug manufacturers to enter into a national rebate agreement with the Centers for Medicare & Medicaid Services (CMS) in exchange for Medicaid coverage of most of the manufacturer's drugs. Manufacturers are then responsible for paying a rebate on those drugs for which states made a payment. The Deficit Reduction Act of 2005 further enhanced the MDRP, requiring states to collect rebates for certain physician-administered drugs. These drugs are usually injectable or intravenous drugs administered by a medical professional in a physician's office or other outpatient clinical setting. The Affordable Care Act (ACA), enacted in 2010, extended state rebate collection requirements to drugs dispensed to individuals enrolled with Medicaid MCOs. Additionally, the ACA requires MCOs to report to states detailed information on each covered outpatient drug dispensed to Medicaid MCO enrollees.

In the drug rebate process, the Department uses certain information submitted on claims by providers and MCOs to obtain rebates. In particular, pharmacy and physician-administered drug claims should contain a drug's National Drug Code (NDC). The NDC is a unique number that serves as a universal product identifier for each medication and is the basis for the Department's manufacturer rebate requests. The NDC information on claims is used to calculate rebates for each drug and to submit rebate invoices to drug manufacturers.

The Department contracted with Magellan Medicaid Administration Inc. (Magellan) to administer the MDRP in New York State, and transitioned the rebate process to Magellan beginning April 1, 2018. Prior to April 1, 2018, the Department was solely responsible for administering the MDRP and sending rebate invoices to manufacturers. Magellan is responsible for creating and sending rebate invoices to manufacturers in accordance with CMS and Department guidelines. CMS guidelines

require the State to send rebate invoices to each manufacturer for any rebate-eligible drugs the State paid for each quarter. Magellan uses its eRebate system for invoicing, payment collection, and allocation of payments received against invoices.

On a weekly basis, the Department extracts FFS and encounter claims from the Medicaid Data Warehouse (MDW) and provides them to Magellan for rebate invoicing. Magellan then applies certain system logic to determine which claims will be invoiced. It also flags invoiced claims as well as claims that are not invoiced, such as voided claims and other excluded claims not eligible for rebates. Once complete, the results of Magellan's invoicing processes are reported to the Department and the related claim detail information is loaded into the MDW. Scenarios that result in claims being excluded from rebate invoices are clearly outlined by Magellan. For example, claims submitted with a 340B drug indicator are excluded from invoices, as these claims are not rebate-eligible. Between April 1, 2018 and March 31, 2022, Magellan invoiced a total of almost $13 billion in rebates to manufacturers for managed care and FFS pharmacy and physician-administered drug claims.

Audit Findings and Recommendations

During the audit period, the Department made significant process improvements and system enhancements in the rebate collection process. However, certain improvements are still needed. Several errors and control weaknesses, regarding both Department policy and procedures, resulted in $183.7 million in Medicaid drug rebates that were not invoiced. Specifically, errors in the Department's claim extraction procedures caused claims to be excluded from invoices or invoiced using incorrect data. Additional rebates were missed due to incomplete or incorrect drug information submitted on claims. We also determined the Department's policy to exclude from the rebate process all managed care claims related to the Program of All-Inclusive Care for the Elderly (PACE) was incorrect. We further identified rebates that may have been missed during the transition of invoicing from the Department to Magellan in April 2018 and certain claims that were not processed by the rebate contractor. Furthermore, we identified claims that were incorrectly assumed to be non-drug items not eligible for rebates. In some cases, the Department had made improvements or corrected the errors that caused the missed rebates.

Department Procedure Errors

To meet its obligation to provide claims to Magellan for rebate invoicing, the Department developed procedures to extract drug claims from the MDW. However, certain rebates went uncollected due to the Department reporting incorrect payment amounts and drug unit amounts to the rebate contractor. Errors in the Department's claim extraction procedures resulted in missed rebates of about $119 million on 634,870 claims for the period from April 2018 through October 2020. The Department updated its extraction procedures in 2020 to fix these issues going forward.

Zero Dollar Paid Error

Magellan's eRebate system has logic to exclude claims from invoices if the FFS paid amount is equal to zero. The Department missed rebates totaling about $109.4 million on 490,875 claims because an error in the Department's extraction procedures caused claims to incorrectly show a zero dollar Medicaid payment in the data sent to Magellan. Medicaid actually paid nearly $91.1 million for these claims. For example, we found the Department could have collected a rebate of $16,149 on a drug claim where Medicaid paid $25,553. However, because the claim sent to Magellan erroneously contained a zero dollar Medicaid payment, the claim was excluded from invoicing. The Department updated its claim extraction procedures in September 2020 to fix the issue going forward. The Department plans to set up a process to invoice these missed rebates retroactively; however, the rebates missed as a result of this issue have not yet been invoiced.

Incorrect Units

Rebates collected by the State are based on NDC unit rebate amounts, which are determined quarterly and provided to states in CMS' Quarterly Drug Rebate Files. Therefore, it is essential that the Department accurately report drug units to Magellan. Rebates totaling nearly $9.6 million on 143,995 claims were missed due to

an error in the Department's claim extraction procedures that resulted in lower than actual drug unit amounts and sometimes zero units on claims reported to Magellan.

Specifically, because the drug units reported to Magellan were lower than actual units reported on certain claims, manufacturers were invoiced just $912,587 in rebates for 143,332 claims that were actually eligible for approximately $10.3 million in rebates, resulting in missed rebates of about $9.4 million. The remaining $202,750 (of the $9.6 million) in missed rebates related to 663 claims that were excluded from invoices because the units were erroneously reported as zero. The Department updated its claim extraction procedures in October 2020 to fix these issues going forward. The Department also plans to set up a process to invoice these missed rebates retroactively; however, the rebates missed as a result of this issue have not yet been invoiced.

Recommendation

1. Review the $119 million in missed rebates and invoice manufacturers, as appropriate.

Procedure Code and NDC Issues

In order for Magellan to process rebate invoices for physician-administered drug claims, both a procedure code and an NDC are needed. A physician-administered drug procedure code represents a specific drug (e.g., procedure code Q0165 is an anti-nausea drug). However, some physician-administered drug procedure codes have more than one corresponding NDC because a drug may come in different strengths and package sizes or from multiple manufacturers. For example, a drug may be provided by two manufacturers and, therefore, the procedure code may have two corresponding NDCs; or a drug may be provided by only one manufacturer but be provided in three different strengths and thus have three different corresponding NDCs. Physician-administered drug procedure codes with more than one corresponding NDC are referred to as "one-to-many" drugs and those with only one corresponding NDC are referred to as "one-to-one."

To validate procedure code and NDC combinations on physician-administered drug claims during the invoicing process, Magellan uses a procedure code to NDC crosswalk that is based on information maintained by CMS. If NDCs are missing from claims, or the crosswalk does not yet contain the procedure code and NDC combinations listed on the claims, then the claims might be excluded from invoices. We determined the Department missed more than $44.5 million in rebates on 753,456 claims as a result of these procedure code and NDC issues.

Missing NDCs

The ACA requires MCOs to provide states with the NDC and drug units necessary for states to access Medicaid drug rebates. However, for the period January 2017 to March 2022, we found that approximately $26.1 million in rebates went uncollected because MCOs submitted 463,197 physician-administered drug encounter claims

to the Department without an NDC. To help address the issue, the Department updated its policies in January 2019 to append an NDC onto claims for "one-to-one" physician-administered drugs with missing NDCs. Further, the Department updated an EIS edit in September 2021 to reject MCO-submitted physician-administered drug encounter claims without NDCs. We found this edit update has resulted in significantly fewer encounter claims with missing NDCs getting accepted by the EIS. However, some MCO drug encounter claims that are eligible for rebates continue to be accepted when submitted without an NDC.

Invalid NDC/Procedure Code Combination

Physician-administered drug claims containing procedure code and NDC combinations that are not listed on the crosswalk are excluded from rebate invoices. However, claims containing valid procedure code and NDC combinations might be excluded from invoices in certain cases. According to Department officials, this occurs because there is sometimes a lag between when new procedure code and NDC combinations are used by providers on claims and when these new combinations are updated to the crosswalk. The crosswalk is maintained by CMS and the Department relies on it to contain the most up-to-date information. We estimate these issues resulted in missed rebates totaling about $16.7 million for 188,132 encounter and FFS claims for the period April 2018 through March 2022.

The Department updated eMedNY system controls in September 2018 to help ensure FFS physician-administered drug claims include a valid procedure code and NDC combination (e.g., the codes are both for the same drug). However, these controls did not apply to encounter claims.

Unclassified Drugs

Physician-administered drugs that have not been assigned a procedure code are submitted with generic procedure codes described as "unclassified" along with a corresponding NDC. Claims with unclassified drug procedure codes are excluded from invoices. We estimated the Department missed over $1.7 million in rebates for 102,127 encounter and FFS claims for the period April 2018 through March 2022 due to this exclusion. For some of these claims, we found the NDC on the claim was on the crosswalk with an assigned procedure code. According to Department officials, it is possible that in some cases NDCs had been assigned procedure codes, but the claims were submitted incorrectly with an unclassified procedure code by providers.

Recommendations

2. Review the $44.5 million in missed rebates and invoice manufacturers, as appropriate. Where rebates cannot be sought due to missing NDCs or invalid procedure code and NDC combinations on physician-administered drug claims paid by MCOs, follow up with MCOs for proper drug information or seek recovery directly from MCOs for the missed rebates.

3. Ensure the EIS edit is working properly and requires a valid NDC on physician-administered drug encounter claims.
4. Add or enhance system edits to ensure all claims include a valid procedure code and NDC combination, where applicable.
5. Add or enhance system edits to prevent the use of unclassified drug codes on claims when a procedure code has been assigned.
6. Formally determine whether rebates can be sought on physician-administered drug claims where the procedure code and NDC combination is not yet on the crosswalk or the procedure code is an unclassified drug code, either by invoicing claims in a subsequent quarter or by using NDC information on the claims.

PACE Claims

PACE managed care plans provide a comprehensive range of health care services, including prescription drugs, for certain Medicaid recipients age 55 and older. Department officials have historically excluded PACE encounter claims from the rebate process due to concerns about whether Medicaid or Medicare has the liability for the drugs. Upon further review as a result of our audit, Department officials have concluded that drugs provided to PACE recipients who are Medicaid-only recipients (i.e., not enrolled in Medicare) are in fact eligible for rebates. For the period April 2017 to March 2022, we determined that 263,522 PACE claims for Medicaid-only recipients were eligible for rebates totaling about $12.8 million. The Department is planning to update its policies to include PACE encounter claims in the rebate process and will seek the missed rebates retroactively as well.

Recommendations

7. Review the $12.8 million in missed rebates and invoice the manufacturers, as appropriate.
8. Ensure all rebate-eligible PACE encounter claims are included in the rebate process and invoiced appropriately.

Other Claims Not Processed

For the period April 2018 through March 2022, the Department may have missed rebates totaling nearly $6.4 million for 114,435 claims that were not reported to the rebate contractor or were rejected upon loading to the eRebate system. About $6.1 million of the $6.4 million (95%) we identified occurred during the transition of the rebate process to Magellan in the second quarter of 2018. The remaining $276,806 in missed rebates are likely due to the eRebate system incorrectly rejecting claims that are eligible for rebates.

Recommendations

9. Review the $6.4 million in missed rebates and invoice the manufacturers, as appropriate.
10. Take corrective actions to ensure rebate-eligible claims are not incorrectly rejected by the rebate contractor's system.

Contractor Processing Errors

We identified claims that were processed by Magellan but were not listed as invoiced, voided, or excluded when reported back to the Department. Department and Magellan officials stated that claims not flagged as invoiced, voided, or excluded should be for non-drug items that are not eligible for rebates. We provided the identified claims to the Department for review, and officials later clarified that another scenario exists that would cause this. If claims submitted by providers or MCOs are subsequently reversed within the same quarter, then the claims are ignored during the invoicing process and reported by Magellan to the Department with no indicators on the claims. After adjusting for reversed claims, we identified missed rebates totaling $993,207 on 4,102 drug claims for the period April 2018 through March 2022 that appear to have been incorrectly ignored during the invoicing process.

Recommendations

11. Review the $993,207 in missed rebates and invoice the manufacturers, as appropriate.
12. Periodically review Magellan's data after it processes claims to ensure drug claims eligible for rebates are not ignored during the invoicing process.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department took appropriate steps to collect all available drug rebates under the federal MDRP. The audit covered the period from April 2018 through March 2022 and certain claims going back to January 2017.

To accomplish our audit objective and assess related internal controls, we met with Department and Magellan officials and reviewed applicable sections of federal and State laws. We examined relevant federal guidance and Department and Magellan procedures. We reviewed data from the MDW, eMedNY, and CMS Quarterly Drug Rebate Files, and determined the data was sufficiently reliable for the purposes of this audit.

We obtained MDRP rebate invoice data from the Department and the MDW and extracted FFS and MCO pharmacy drug and physician-administered drug claims from the MDW to identify rebate-eligible claims that were not invoiced. We then calculated missed rebate amounts for these claims using various methodologies, including (but not limited to) using actual unit rebate amounts, unit conversion factors, and drug units or using the median rebate amount invoiced for a given procedure code and quarter.

We shared our methodologies and findings with Department officials during the audit for their review. We took their comments into consideration when performing our analyses.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of rebate collection under the federal MDRP.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials generally concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our response to certain Department comments are included in our State Comptroller's Comments, which are embedded within the Department's response.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

February 16, 2023

Andrea Inman
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report **2021-S-11** entitled, "Maximizing Drug Rebates Under the Federal Medicaid Drug Rebate Program."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Melissa Fiore
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Department of Health Comments to Draft Audit Report 2021-S-11 entitled, "Medicaid Program: Maximizing Drug Rebates Under the Federal Medicaid Drug Rebate Program" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2021-S-11 entitled, "Medicaid Program: Maximizing Drug Rebates Under the Federal Medicaid Drug Rebate Program" by the Office of the State Comptroller (OSC).

General Comments:

The Department issued invoices totaling $16.9 billion (gross) during the six-year audit period in its fee-for-service and managed care program. This audit identified an additional $119 million (gross) in rebates that should have been invoiced during the audit period, findings represent less than one percent over the audit period.

State Comptroller's Comment 1 – The audit identified $183.7 million in Medicaid drug rebates that were not invoiced. The $119 million pertains only to a portion of the audit findings.

The Department recognizes the OSC audit process as an opportunity to improve and strengthen policies and procedures. In November 2017, the Department secured an independent contractor to assume the invoicing process and has recently renewed the contract to continue the work to administer the pharmacy rebate program. As found by the OSC and discussed below, the Department has already addressed certain issues raised in the audit and has mobilized the contractor to handle all concerns raised in this audit. If claims are found to have been missed, the Department will seek to bill where appropriate.

Recommendation #1:

Review the $119 million in missed rebates and invoice the manufacturers, as appropriate.

Response #1:

The Department has reviewed the $119 million and has verified that, as found in the audit, the issues listed under this recommendation have already been addressed. Proof of this work was supplied to OSC for verification. The Department intends to invoice for the drug rebates referenced and will refund the federal share of the collected rebates to the CMS. The total amount of this finding is all related to the period prior to the prospective query update that the Department put into place in 2021. The retroactive correction was deployed in December 2022 for older claims and is in the queue for processing. The Department will continue to monitor and work with its contractor to ensure the claims are properly invoiced.

Recommendation #2:

Review the $44.5 million in missed rebates and invoice manufacturers, as appropriate. Where

rebates cannot be sought due to missing NDCs or invalid procedure code and NDC combinations on physician-administered drug claims paid by MCOs, follow up with MCOs for proper drug information or seek recovery directly from MCOs for the missed rebates.

Response #2:

The Department discovered the findings under this section prior to the audit and implemented steps to resolve.

In 2019 the Department took steps to ensure all claims for covered outpatient physician-administered drugs were invoiced going forward by requiring NDCs on all physician-administered drugs billed on the institutional claim form effective July 1, 2019. The Department published a Medicaid Update reminder in March 2019 entitled *Reporting of the National Drug Code is Required for all Fee-for-Service Physician-Administered Drugs*, which addresses the OSC recommendation. The article can be found in Volume 35 - Number 4: https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-03.htm#ndc

The Department would like to note that steps have already been taken to enhance the edit logic in the EIS. Effective 9/30/2021 the edit was turned to a hard edit to ensure the collection of NDCs on all drug encounters. There was a request for retroactive resubmission of MCO drug claims back to 1/1/2016 to capture missing MCO claims, which was completed on 3/4/2022. MCOs submitted what they could for the missing NDCs. However, due to the length of the audit lookback the claims with missing NDC information proved challenging for the MCOs to either obtain within their systems or through provider outreach. The Department has seen that the stronger edit is working and the errors of missing NDCs on rebate eligible MCO claims have decreased significantly. As discussed below, these enhancements address Recommendation Nos. 3 and 4 and the edit appears to be working with respect to these Recommendations as well.

In response to the invalid procedure code and NDC combinations segment of the report on page 9, the Department would like to clarify that CMS does not provide an exhaustive crosswalk. There is not a single, comprehensive source available. As a result, rebate programs nationwide must assemble and maintain a custom list of valid procedure codes/combinations to accurately invoice for rebates, and the resultant lag in available data is not within the control of the Department

The Department will work with its contractor to invoice for the remaining drug rebates as appropriate and will refund the federal share of the collected rebates to CMS.

State Comptroller's Comment 2 – Despite the Department's efforts, tens of millions of dollars in rebates went uncollected due to missing NDCs and invalid NDC and procedure code combinations. If the Department does not act on this recommendation, tens of millions of dollars in rebates will remain uncollected, including the $26.1 million in rebates that went uncollected because MCOs submitted physician-administered drug encounter claims without an NDC. We urge Department officials to fully implement our recommendation.

Also, only $5.1 million of the $16.7 million we identified in missed rebates due to invalid procedure code and NDC combinations was due to a lag in receipt of CMS data. The majority, about $11.6 million, was due to claims submitted by providers that contained

errors. These claims were paid despite including an invalid procedure code and NDC combination. We encourage the Department to take steps to ensure claims contain valid procedure code and NDC combinations; otherwise, missed rebates will continue. Furthermore, as discussed on page 9 of our report, some rebate-eligible MCO drug encounter claims continue to be accepted by the Department when submitted without an NDC. Specifically, we found missed rebates totaling $225,695 in the 4th quarter of 2021 and 1st quarter of 2022 – after the Department's encounter intake system update was implemented.

Recommendation #3:

Ensure the EIS edit is working properly and requires a valid NDC on physician-administered drug encounter claims.

Response #3:

The edit logic was enhanced in the EIS to ensure NDC collection on all drug encounters effective 9/30/21. There was also a retroactive resubmission of MCO drug claims back to 1/1/2016, which was completed on 3/4/2022. The Department will continue to monitor and work with its contractor to ensure the edit continues to work properly.

See State Comptroller's Comment 2.

Recommendation #4:

Add or enhance system edits to ensure all claims include a valid procedure code and NDC combination, where applicable.

Response #4:

The Department has enhanced system edits and will continue to monitor and work with its contractor to ensure the enhancements continue to work properly.

See State Comptroller's Comment 2.

Recommendation #5:

Add or enhance system edits to prevent the use of unclassified drug codes on claims when a procedure code has been assigned.

Response #5:

The unclassified drug codes are assigned by CMS to new drugs and the Department is dependent on the federal government's timing and updates related to the unclassified drugs. The Department initiated discussions related to this issue prior to the OSC audit and included the unclassified drugs in its pharmacy rebate request for proposal (RFP) as a required task. The RFP was posted in 2021. The final contract effective December 2022 includes this as a topic to handle in the near future. The Department is working with its contractor towards a solution.

Recommendation #6:

Formally determine whether rebates can be sought on physician-administered drug claims where the procedure code and NDC combination is not yet on the crosswalk or the procedure code is an unclassified drug code, either by invoicing claims in a subsequent quarter or by using NDC information on the claims.

Response #6:

The Department has discussed this finding with its contractor and is working with its contractor towards a solution.

Recommendation #7:

Review the $12.8 million in missed rebates and invoice the manufacturers, as appropriate.

Recommendation #8:

Ensure all rebate-eligible PACE encounter claims are included in the rebate process and invoiced appropriately.

Response #7 and #8:

The Department intends to invoice for the drug rebates referenced above and will refund the federal share of the collected rebates to CMS. The Department continues to work with our contractor to ensure all appropriate drugs are invoiced.

Recommendation #9:

Review the $6.4 million in missed rebates and invoice the manufacturers, as appropriate.

Recommendation #10:

Take corrective actions to ensure rebate-eligible claims are not incorrectly rejected by the rebate contractor's system.

Response #9 and #10:

The Department will invoice for the drug rebates referenced above, as appropriate, and will refund the federal share of the collected rebates to CMS. The Department will continue to work with its contractor to ensure all appropriate drugs are invoiced.

Recommendation #11:

Review the $993,207 in missed rebates and invoice the manufacturers, as appropriate.

Recommendation #12:

Periodically review Magellan's data after it processes claims to ensure drug claims eligible for rebates are not ignored during the invoicing process.

Response #11 and #12:

The findings in recommendations 11 and 12 should be clarified, as the claims were not ignored but put through the invoicing process and were excluded because they did not fit the rebate logic. For example, there are claims included in the OSC findings where the labeler was not active when invoicing so it was properly excluded. The Department will continue to work with its contractor to ensure all appropriate drugs are invoiced and create an additional exclusion category for this group of claims so that the reason of exclusion is clear in the future.

State Comptroller's Comment 3 – The audit identified missed rebates totaling $993,207 on 4,102 drug claims for the period April 2018 through March 2022. All of the NDCs listed on these claims were part of the drug rebate invoices for the corresponding quarters. Therefore, the claims appear to have been incorrectly ignored during the invoicing process because the claims were not listed as invoiced, excluded, or voided when the rebate contractor reported the results of its processes to the Department.

Contributors to Report

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