Department of Health and Human Services
Office of Inspector General
Office of Audit Services

November 2025 | A-03-24-00206

Pennsylvania Correctly Invoiced Rebates to Manufacturers for Most Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations

REPORT HIGHLIGHTS

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Pennsylvania Correctly Invoiced Rebates to Manufacturers for Most Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations

Why OIG Did This Audit

- 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.
- Prior OIG audits found that States did not always invoice and collect all rebates due for drugs administered to Medicaid managed-care organization (MCO) enrollees.
- This audit, one of a series, determined whether Pennsylvania complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees.

What OIG Found

- Pennsylvania generally complied with applicable Federal Medicaid requirements but did not invoice all rebate eligible physician-administered drugs dispensed to MCO enrollees.
- Specifically, Pennsylvania did not invoice for rebates totaling $488,051 ($284,617 Federal share):

Drug Category	Amount Not Invoiced for Rebate	Federal Share
Single-source (brand name) drugs	$478,406	$278,965
Top-20 (by dollar volume) multiple-source drugs	$9,645	$5,652
Totals	**$488,051**	**$284,617**

What OIG Recommends

We made three recommendations to Pennsylvania, including that Pennsylvania invoice for and collect from manufacturers rebates totaling $488,051 ($284,617 Federal share) for single-source and top-20 multiple-source physician-administered drugs and refund the Federal share of rebates collected. The full recommendations are in the report.

Pennsylvania agreed with all three recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

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. States generally offset the Federal share of these rebates against their Medicaid expenditures. States invoice the manufacturers for rebates to reduce the cost of drugs to the program. However, prior Office of Inspector General (OIG) audits found that States did not always invoice and collect all rebates due for drugs administered to Medicaid managed-care organization (MCO) enrollees.[1] For this audit, we reviewed the Pennsylvania Department of Human Services' (State agency's) invoicing for rebates for physician-administered drugs dispensed to MCO enrollees for the period January 1, 2021, through December 31, 2023 (audit period).[2]

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees.

BACKGROUND

Medicaid Drug Rebate Program

The Medicaid drug rebate program became effective in 1991 (the Social Security Act (the Act) § 1927). For a covered outpatient drug to be eligible for Federal reimbursement under the program, the drug's manufacturer must enter into a rebate agreement that is administered by the Centers for Medicare & Medicaid Services (CMS) and pay quarterly rebates to the States. CMS, the States, and drug manufacturers each have specific functions under the program.

Manufacturers are required to submit a list to CMS of all covered outpatient drugs and to report each drug's average manufacturer price and, where applicable, best price.[3] On the basis of this information, CMS calculates a unit rebate amount for each drug and provides the information to the States each quarter. Covered outpatient drugs reported by participating drug manufacturers are listed in the CMS Medicaid Drug File, which identifies drugs with such fields as National Drug Code (NDC), unit type, units per package size, and product name.

[1] OIG performed similar audits for rebates due to the States for drugs administered by physicians to fee-for-service and MCO enrollees. https://oig.hhs.gov/reports/report-series/states-collection-of-medicaid-rebates-from-drug-manufacturers/.

[2] The audit period reflects the most recent available data at the start of our audit.

[3] Section 1927(b) of the Act and section II of the Medicaid rebate agreement.

Section 1903(i)(10) of the Act prohibits Federal reimbursement for States that do not capture the information necessary for invoicing manufacturers for rebates as described in section 1927(a)(7) of the Act.[4] To invoice for rebates, States capture drug utilization data that identifies, by NDC, the number of units of each drug for which the States reimbursed Medicaid providers and report the information to the manufacturers (the Act § 1927(b)(2)(A)). The number of units is multiplied by the unit rebate amount to determine the actual rebate amount due from each manufacturer.

Federal Reimbursement to States for Payments to Medicaid Managed-Care Organizations

States use two primary models to pay for Medicaid services: fee-for-service and managed care. In the managed-care model, States contract with MCOs to provide specific services to Medicaid enrollees, usually in return for a predetermined periodic payment known as a capitation payment. States pay MCOs for each covered individual regardless of whether the enrollee receives services during the relevant time period (42 CFR § 438.2). MCOs use the capitation payments to pay provider claims for these services. Physician-administered drugs may be covered by the capitation payments. To claim Federal reimbursement, States report capitation payments made to MCOs as MCO expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). These expenditures are not identified by specific type or service (such as physician-administered drugs). When States receive drug rebates from manufacturers, the States must report the rebates as decreasing adjustments on the CMS-64 report. States report drug rebate accounts receivable data on the Medicaid Drug Rebate Schedule (Form CMS-64.9R), which is part of the CMS-64 report. CMS reimburses States for the Federal share of Medicaid expenditures reported on the CMS-64 report.

States' Collection of Rebates for Physician-Administered Drugs

Drugs administered by a physician are typically invoiced to the Medicaid program on a claim form using Healthcare Common Procedure Coding System (HCPCS) codes.[5] To collect rebates for drugs, States submit to the manufacturers the drug utilization data containing NDCs for the drugs. NDCs enable States to identify the drugs and their manufacturers and facilitate the

[4] Additionally, CMS issued a final rule on September 26, 2024, that amended 42 CFR § 447.520 to require States to collect NDC information on all covered outpatient single-source and multiple-source physician-administered drugs. Specifically, to receive Federal reimbursement, States must invoice for rebates for all covered outpatient physician-administered drugs, including those that are not single-source drugs and are not on CMS's list of top-20 multiple-source drugs (89 Fed. Reg. 79020, 79084 (Sept. 26, 2024)).

[5] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies. The HCPCS codes associated with physician-administered drugs generally begin with a "J" and are referred to as J-Codes. These physician-administered drugs include injectable drugs that ordinarily cannot be self-administered, such as chemotherapy drugs, immunosuppressive drugs, and inhalation solutions.

collection of rebates for the drugs. Before the Deficit Reduction Act of 2005 (DRA), many States did not collect rebates on physician-administered drugs if the drug claims did not contain NDCs.

The DRA amended section 1927 of the Act to specifically address the collection of rebates on physician-administered drugs for all single-source physician-administered drugs and for the top 20 multiple-source physician-administered drugs.[6] For purposes of the Medicaid drug rebate program, single-source drugs are those covered outpatient drugs produced or distributed under an original new drug application approved by the Food and Drug Administration (FDA).[7] Multiple-source drugs are defined, in part, as those covered outpatient drugs that have at least one other drug rated as therapeutically equivalent by the FDA.[8] Beginning on January 1, 2007, CMS was responsible for annually publishing the list of the top 20 multiple-source drugs by HCPCS codes that had the highest dollar volume dispensed.

Effective March 23, 2010, the Affordable Care Act (ACA) required manufacturers to pay rebates on covered outpatient drugs dispensed to MCO enrollees if the MCOs are responsible for coverage of such drugs.[9] Before the ACA was enacted, drugs dispensed by Medicaid MCOs were excluded from the rebate requirement. States typically require MCOs to submit to the State agency provider claim information, including claim lines for covered outpatient drugs. This information conveys drug utilization data, which States must include when invoicing manufacturers for rebates.

The State Agency's Medicaid Drug Rebate Program

The State agency is responsible for invoicing and collecting Medicaid drug rebates for physician-administered drugs. The State agency is required to submit drug utilization data to manufacturers, detailing drug usage by Medicaid enrollees, within 60 days of the end of each quarter. During our audit period, the State agency utilized a contractor to manage its drug rebate program.

The MCOs submit claims data, including data for NDCs associated with drug utilization, to the State agency. The State agency then sends rebate files to the contractor. The contractor loads these files into its rebate-processing system to invoice manufacturers for rebates quarterly. Manufacturers pay rebates directly to the State agency; the State agency then forwards the

[6] The term "top-20 multiple-source drugs" is drawn from a CMS classification and describes these drugs in terms of highest dollar volume of physician-administered drugs in Medicaid (the Act § 1927(a)(7)(B)(i)). CMS last published the list of the top-20 multiple-source drugs (with respective HCPCS codes and NDCs) in 2021.

[7] Section 1927(k)(7) of the Act. Single-source drugs are commonly referred to as "brand-name" drugs.

[8] Section 1927(k)(7) of the Act. According to the definition of "therapeutically equivalent" in the FDA Glossary of Terms, a therapeutically equivalent drug product can be substituted for another product to achieve the same clinical effect as the prescribed drug.

[9] Section 2501 of the Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

payment information to the contractor, which reconciles the payments to the rebates. The contractor maintains accounts receivable information and coordinates with manufacturers to resolve any unpaid rebates.

HOW WE CONDUCTED THIS AUDIT

We reviewed physician-administered drug claims totaling $1.8 billion that the State agency's MCOs paid during our audit period.

We used the quarterly CMS Medicaid Drug Rebate files and the Medicaid Drug Product files to determine whether the NDCs listed on the claims were classified as single-source drugs or multiple-source drugs. Additionally, we determined whether the HCPCS codes were published in CMS's top-20 multiple-source drug list. The HCPCS codes associated with physician-administered drugs generally begin with a "J" and are referred to as J-Codes.

We removed claims for drugs that either were not eligible for rebates or were invoiced for rebates. For the remaining physician-administered drug claims, totaling $115.6 million, we worked with the State agency to calculate the rebate amounts that were not invoiced.

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 A contains the details of our audit scope and methodology.

FINDINGS

Although the State agency generally complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees, it did not invoice all rebate-eligible physician-administered drugs dispensed to MCO enrollees. Specifically, the State agency did not submit invoices for and collect from manufacturers rebates totaling $488,051 ($284,617 Federal share) that were required to be rebated for physician-administered drugs dispensed to MCO enrollees.[10] This amount consisted of $478,406 ($278,965 Federal share) for single-source drugs and $9,645 ($5,652 Federal share) for top-20 multiple-source drugs.

Although the State agency's managed care contracts with its MCOs required the collection of drug utilization data necessary to invoice for rebates on all claims, the State agency did not

[10] Of the $488,051 ($284,617 Federal share) we identified as not submitted for rebate, the State agency said that it had invoiced, or would invoice, $378,824 ($221,060 Federal share) in single-source drugs. The remaining $99,582 ($57,905) will be sent to MCOs to review the HCPC/NDC combinations. We did not verify during our audit that the State agency had completed these actions.

ensure that the data were always used to invoice manufacturers and collect rebates for physician-administered drugs dispensed to enrollees of MCOs. Specifically, the State agency did not take steps to review exclusion reports generated by its rebate-processing contractor to verify that claims eligible for rebate were not erroneously marked as excluded.[11]

FEDERAL REQUIREMENTS AND STATE AGENCY GUIDANCE

The DRA amended section 1927 of the Act to specifically address the collection of rebates on physician-administered drugs. States must capture NDCs for single-source and top-20 multiple-source drugs (the Act § 1927(a)(7)). To secure rebates, States are required to report certain information to manufacturers within 60 days after the end of each rebate period (the Act § 1927(b)(2)(A)). Federal regulations prohibit Federal reimbursement for physician-administered drugs for which a State has not required the submission of claims containing the NDCs (42 CFR § 447.520).[12]

Effective March 23, 2010, the ACA amended section 1927 of the Act to specifically require manufacturers to pay rebates on covered outpatient drugs dispensed to MCO enrollees if the MCOs are responsible for coverage of such drugs. States must include information for drugs dispensed to individuals enrolled in MCOs when invoicing manufacturers for rebates (the Act §§ 1927 (b)(1)(A) and (b)(2)(A)).

The ACA also amended section 1903 of the Act to specifically address the conditions of Federal reimbursement for covered outpatient drugs dispensed to MCO enrollees. Essentially, States must secure rebates for drugs dispensed through MCOs and require MCOs to submit to the State NDCs for drugs dispensed to eligible individuals (the Act § 1903 (m)(2)(A)).

Appendix C contains Federal requirements and State agency guidance related to physician-administered drugs.

THE STATE AGENCY DID NOT INVOICE MANUFACTURERS FOR SOME REBATES FOR PHYSICIAN-ADMINISTERED DRUGS DISPENSED TO ENROLLEES OF MEDICAID MANAGED-CARE ORGANIZATIONS

The State agency did not invoice and collect from manufacturers rebates totaling $488,051 ($284,617 Federal share) for physician-administered drugs dispensed to MCO enrollees. Of this amount, $478,406 ($278,965 Federal share) was for single-source drugs and $9,645 ($5,652 Federal share) was for top-20 multiple-source drugs.

[11] When the rebate-processing contractor does not include a claim for rebate processing, that claim is placed in an "exclusion report." Exclusion reports are generated based on the exclusion code. Each exclusion code represents a reason for claims to be excluded from rebate.

[12] Additionally, effective November 19, 2024, States are also required to invoice for rebates for multiple-source physician-administered drugs that are covered outpatient drugs and that are not in the top-20 multiple-source physician-administered drug list (89 Fed. Reg. 79020, 79084 (Sept. 26, 2024)).

The State agency did not invoice manufacturers for these rebates because the claims were erroneously marked as excluded from rebate. The State agency's policies and procedures did not include steps to review exclusion reports generated by its rebate-processing contractor to verify that claims eligible for rebate were not erroneously marked as excluded. Since the start of our audit, however, the State agency has initiated steps to review the exclusion reports and, where applicable, invoice for drugs eligible for rebate.

RECOMMENDATIONS

We recommend that the Pennsylvania Department of Human Services:

- invoice for and collect from manufacturers rebates totaling $488,051 ($284,617 Federal share) for single-source and top-20 multiple-source physician-administered drugs and refund the Federal share of rebates collected;

- continue to review exclusion reports and invoice manufacturers for rebate-eligible drugs dispensed after our audit period; and

- update its policies and procedures to require steps to regularly review exclusion reports for rebate eligible NDCs, and invoice for rebate those drugs identified as rebate eligible.

PENNSYLVANIA COMMENTS

In written comments on our draft report, Pennsylvania agreed with all three of our recommendations and described some actions it has undertaken to address them, including invoicing manufacturers for rebates outlined in our first recommendation. Pennsylvania also indicated its willingness to implement our second and third recommendations. Pennsylvania's comments are included as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed physician-administered drug claims that MCOs paid during our audit period. MCOs paid $1,799,281,458 for physician-administered drugs dispensed to MCO enrollees. We removed claims for drugs that either were not eligible for rebates or were invoiced for rebates. For the remaining physician-administered drug claims, totaling $115,628,594, we worked with the State agency to calculate the rebate amounts that were not invoiced.

Our audit objective did not require an understanding or assessment of the complete internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the State agency's processes for and controls over invoicing for Medicaid rebates for physician-administered drugs.

We conducted our audit work, which included contacting the State agency in Harrisburg, Pennsylvania, from March 2023 through August 2025.

METHODOLOGY

To accomplish our objective, we took the following steps:

- We reviewed applicable Federal laws, regulations, and guidance pertaining to the Medicaid drug rebate program and physician-administered drugs.
- We reviewed State agency policies and procedures for rebates for physician-administered drugs.
- We interviewed State agency personnel to gain an understanding of the administration of and controls over the Medicaid rebate invoicing process for physician-administered drugs.
- We obtained lists of the CMS top-20 multiple-source physician-administered drugs, the Medicare Part B crosswalk, the CMS Medicaid Drug Rebate File, and the CMS Medicaid Drug Product File for our audit period.[13]

[13] The Medicare Part B crosswalk is published quarterly by CMS and is based on drug and biological information submitted to CMS by manufacturers. CMS uses this information, along with pricing data submitted by manufacturers, to calculate a volume-weighted sales price for each HCPCS code, which becomes the basis for the reimbursement rate. CMS instructed States that they could use the crosswalk as a reference because HCPCS codes and NDCs are standardized codes used across health care programs (State Medicaid Director Letter No. 06-016 (Jul. 11, 2006)).

- We obtained a list of 340B claims from the State agency.[14]

- We obtained from the State agency a detailed list of physician-administered drug claims paid between January 1, 2021, and December 31, 2023, that were excluded from rebate, totaling $505,537,318. For those claims excluded from rebates, we took the following steps:

    - We identified single-source drugs based on the classification of the drugs in the quarterly CMS Medicaid Drug Rebate File.

    - We identified the top-20 multiple-source drugs by matching the HCPCS code on the drug claim to the HCPCS code on CMS's top-20 multiple-source drug listing.

    - We identified other multiple-source drugs eligible for rebate that were not top-20 multiple-source drugs.

    - We verified that all 340B claims were removed from the analysis of excluded claims.

- We followed up with the State agency officials for an explanation of eligible claims, totaling $115,628,594, that had not been invoiced for rebate.

- We worked with the State agency to determine the dollar amount of rebates not collected.

- We discussed the results of our audit with State agency officials.

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.

[14] Under the 340B drug pricing program (set forth in 42 U.S.C. § 256b), a 340B entity may purchase reduced-price covered outpatient drugs from manufacturers; examples of 340B entities are disproportionate share hospitals, which generally serve large numbers of low-income and uninsured patients, and State AIDS drug assistance programs. Drugs subject to discounts under the 340B drug pricing program are not subject to rebates under the Medicaid drug rebate program (the Act § 1927(j) and 42 U.S.C. § 256(a)(5)(A)).

APPENDIX B: FEDERAL REQUIREMENTS AND STATE AGENCY GUIDANCE RELATED TO PHYSICIAN-ADMINISTERED DRUGS

FEDERAL REQUIREMENTS

Under the Medicaid program, States may provide coverage for outpatient drugs as an optional service (the Act § 1905(a)(12)). Section 1903(a) of the Act provides for Federal financial participation (Federal share) in State expenditures for these drugs. The Medicaid drug rebate program, created by the Omnibus Budget Reconciliation Act of 1990 that added section 1927 to the Act, became effective on January 1, 1991. Manufacturers must enter into a rebate agreement with the Secretary of Health and Human Services and pay rebates for States to receive Federal funding for the manufacturer's covered outpatient drugs dispensed to Medicaid patients (the Act § 1927(a)). Responsibility for the drug rebate program is shared among the drug manufacturers, CMS, and the States.

Section 6002 of the DRA added section 1927(a)(7) to the Act to require that States capture information necessary to secure rebates from manufacturers for certain covered outpatient drugs administered by a physician. In addition, section 6002 of the DRA amended section 1903(i)(10) of the Act to prohibit a Medicaid Federal share for covered outpatient drugs administered by a physician unless the States collect the utilization and coding data described in section 1927(a)(7) of the Act.

Section 1927(a)(7) of the Act requires that States must provide for the collection and submission of such utilization data and coding for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug to secure rebates for all single-source physician-administered drugs effective January 1, 2006, and for the top 20 multiple-source drugs effective January 1, 2008.[15] Section 1927(a)(7)(C) of the Act stated that, effective January 1, 2007, the utilization data must be submitted using the NDC. To secure rebates, States are required to report certain information to manufacturers within 60 days after the end of each rebate period (the Act § 1927(b)(2)(A)).

Section 2501 of the ACA amended section 1927(b)(1)(A) of the Act to require that manufacturers pay rebates on covered outpatient drugs dispensed to individuals enrolled in an MCO if the MCO is responsible for coverage of such drugs. Section 2501 of the ACA also amended section 1927(b)(2)(A) to require that States submit information necessary to secure rebates from manufacturers for covered outpatient drugs dispensed through MCOs. In addition, section 2501 amended section 1903(m)(2)(A) to essentially extend the Medicaid rebate obligations to drugs dispensed through MCOs. Under this provision, each MCO contract must require that Medicaid rebates apply to drugs dispensed through the MCO. Section 2501

[15] In general terms, multiple-source drugs are covered outpatient drugs for which there are two or more drug products that are rated therapeutically equivalent by the FDA. See, e.g., section 1927(k)(7) of the Act. Multiple-source drugs stand in contrast to single-source drugs, which do not have therapeutic equivalents. Further, the term "top-20 multiple-source drugs" is drawn from a CMS classification and describes these drugs in terms of highest dollar volume of physician-administered drugs in Medicaid (the Act § 1927(a)(7)(B)(i)).

prohibits payment unless the MCO contracts require MCOs to submit to the State NDC drug utilization data for drugs dispensed to eligible individuals.

Federal regulations set conditions for States to obtain a Federal share for covered outpatient drugs administered by a physician and specifically state that no Federal share is available for physician-administered drugs for which a State has not required the submission of claims using codes that identify the drugs sufficiently for the State to bill a manufacturer for rebates (42 CFR § 447.520).

STATE AGENCY GUIDANCE

The State agency's MCO contracts required that MCOs report timely drug utilization data that is necessary to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Social Security Act—or the conditions of any supplemental rebate program that the State agency has entered into with the manufacturers—no later than 45 days after the end of each quarterly rebate period (or however many days required by the agency). The MCO must transmit a file according to the State agency's specifications and must fully cooperate with the State agency and its contractors to ensure file transmissions are complete, accurate, and delivered by the specified deadlines.

In addition, claims for drug products obtained or administered in an office, clinic, or other non-institutional setting and processed through the MCO's medical benefit must contain a valid eleven-digit NDC and other necessary information, such as a HCPCS codes and appropriate billable units for the actual drug and quantity administered. Finally, MCOs should reject any claims with missing or invalid NDCs.

APPENDIX C: PENNSYLVANIA COMMENTS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

October 7, 2025

Ms. Nicole Freda
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
Strawbridge Building
801 Market Street, Suite 8500
Philadelphia, Pennsylvania 19107

Dear Ms. Freda:

This is in response to your letter dated September 4, 2025, which transmitted the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report number A-03-24-00206 titled *Pennsylvania Correctly Invoiced Rebates to Manufacturers for Most Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations*. The objective of this audit was to determine whether the State agency complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees.

The draft report contains three recommendations. Below is each recommendation, followed by the Department of Human Services' (DHS') response.

OIG Recommendation 1: We recommend that the Pennsylvania Department of Human Services invoice for and collect from manufacturers rebates totaling $488,051 ($284,617 Federal share) for single-source and top-20 multiple-source physician-administered drugs and refund the Federal share of rebates collected.

DHS Response: DHS agrees with this recommendation. We have already invoiced manufacturers for the rebates and, when collected, will report on the CMS-64.9R.

OIG Recommendation 2: We recommend that the Pennsylvania Department of Human Services continue to review exclusion reports and invoice manufacturers for rebate-eligible drugs dispensed after our audit period.

Deputy Secretary for Administration
P.O. Box 2675 | Harrisburg, PA 17105 | 717.787.3422 | F 717.772.2490 | www.dhs.pa.gov

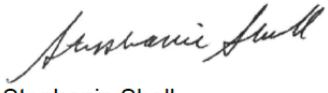
DHS Response: DHS agrees with this recommendation. We will continue to review exclusion reports and invoice manufacturers where appropriate.

OIG Recommendation 3: We recommend that the Pennsylvania Department of Human Services update its policies and procedures to require steps to regularly review exclusion reports for rebate eligible NDCs, and invoice for rebate those drugs identified as rebate eligible.

DHS Response: DHS agrees with this recommendation. We will update our policies and procedures to include the additional steps identified in this recommendation.

Thank you for the opportunity to respond to this draft report. If you have any questions, please contact Mr. David Bryan, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7217 or davbryan@pa.gov.

Sincerely,



Stephanie Shell
Deputy Secretary for Administration

c: Ms. Natalie Edwards, Office of Inspector General
Mr. David Bryan, Bureau of Financial Operations, Audit Resolution Section

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Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov