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

February 2026 | A-07-24-06116

West Virginia Did Not Obtain Rebates Associated With Millions of Dollars in Medicaid Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations

February 2026 | A-07-24-06116

West Virginia Did Not Obtain Rebates Associated With Millions of Dollars in Medicaid 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.
- States invoice the manufacturers for rebates to reduce the cost of drugs to the program.
- This audit, one of a series of OIG audits of the Medicaid drug rebate program, sought to determine whether West Virginia complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to Medicaid managed-care organization (MCO) enrollees.

What OIG Found

- West Virginia did not invoice for, and collect from manufacturers, estimated rebates totaling $6.1 million (Federal share) for physician-administered drugs dispensed to MCO enrollees.
- Although West Virginia's policies required the collection of drug utilization data necessary to invoice for rebates on all physician-administered drug claims, West Virginia's internal controls did not always ensure that the collected data were used to invoice manufacturers and collect rebates for physician-administered drugs dispensed to MCO enrollees.

What OIG Recommends

We recommend that West Virginia refund to the Federal Government the $6.1 million (Federal share) (broken out into two recommendations) for physician-administered drugs. The full recommendations are in the report.

West Virginia did not concur with our recommendations but described corrective actions that it had taken and planned to take.

TABLE OF CONTENTS

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 their 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, previous Office of Inspector General (OIG) audits found that States did not always invoice and collect all rebates due for drugs administered by physicians to enrollees of Medicaid managed-care organizations (MCOs).[1] For this audit, we reviewed the West Virginia Bureau for Medical Services's (State agency's) invoicing for rebates for physician-administered drugs dispensed to MCO enrollees for the period January 1, 2019, through December 31, 2022 (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] Physician-administered drug audit reports issued by the OIG are published on the OIG website.

[2] These data were the most recent data available to us at the start of the 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 received services during the relevant time period (42 CFR § 438.2). MCOs use the capitation payments to pay provider claims for these services. Capitation payments may cover outpatient drugs, which include physician-administered drugs.

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 (Form CMS-64). The Form CMS-64 contains a summary of actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. These MCO 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 Form CMS-64. States report drug rebate accounts receivable data to CMS on the Medicaid Drug Rebate Schedule (Form CMS-64.9R), which is part of the Form CMS-64. CMS reimburses States for the Federal share of Medicaid expenditures reported on the Form CMS-64.

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

[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, 79084-85 (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.

drugs. NDCs enable States to identify the drugs and their manufacturers to facilitate the 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 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 publishing annually the list of the top 20 multiple-source drugs by HCPCS codes that had the highest dollar volume dispensed.

Effective March 23, 2010, the Patient Protection and Affordable Care Act of 2010 (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 enactment of the ACA, drugs dispensed by Medicaid MCOs were excluded from the rebate requirements. States typically require MCOs to submit to the State information including NDCs for covered outpatient drugs dispensed to eligible individuals. MCOs also submit to the State 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 contracted with a fiscal agent to handle the claims data. The fiscal agent processed, invoiced, and collected Federal rebates through its rebate administration system. The fiscal agent was also responsible for payment tracking and

[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 published lists of the top-20 multiple-source drugs (with respective HCPCS codes and NDCs) in 2006, 2009, 2010, and 2011 and then not again until 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).

reconciliation as well as resolving disputes related to Federal rebates. The fiscal agent housed historic quarterly rebate data in its rebate administration system.

According to the State agency's *Bureau for Medical Services Provider Manual*, chapter 518A, revised July 20, 2018, and in effect throughout our audit period, providers are required to include the NDC when invoicing the State agency for physician-administered drugs. This requirement has been incorporated into State regulations under West Virginia Code § 9-2-6(20), which "require[s] a provider, subgrantee, or other entity performing services on behalf of the [State agency] to comply with all applicable laws, rules, and written procedures pertaining to the program . . . including, but not limited to, policy manuals, statements of work, program instructions, or other similar agreements."

HOW WE CONDUCTED THIS AUDIT

We reviewed physician-administered drug claims totaling $242.9 million that the State agency's MCOs paid during the 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. For claims submitted without an NDC, we matched the HCPCS code on the drug claim to the HCPCS code on CMS's Medicare Part B crosswalk to identify the drug classification.[10] Additionally, we determined whether the HCPCS codes were published in CMS's top-20 multiple-source drug list.

We removed claims for drugs that either were not eligible for rebates or were invoiced for rebates.

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.

[10] 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 that States pays to health care providers for the following quarter. 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 (July 11, 2006)). If the claim did not include the NDC, we used the Part B crosswalk to identify drug classifications for all of the NDCs that map to the HCPCS code from the claim. Then we used the most conservative drug classification. For example, if a HCPCS code had NDCs with drug classifications of single-source and multiple-source, we categorized the claim as multiple-source.

FINDING

During our audit period, the State agency did not comply with Federal Medicaid requirements for invoicing manufacturers for some rebates for physician-administered drugs dispensed to MCO enrollees. Specifically, the State agency did not invoice for, and collect from manufacturers, estimated rebates totaling $8.2 million ($6.1 million Federal share) for physician-administered drugs dispensed to MCO enrollees.[11]

Although its policies required the collection of drug utilization data necessary to invoice for rebates on all physician-administered drug claims, the State agency's internal controls did not always ensure that the collected data were used to invoice manufacturers and collect rebates for physician-administered drugs dispensed to MCO enrollees.

FEDERAL AND STATE REQUIREMENTS

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)(C)). 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 NDCs (42 CFR § 447.520).

The ACA amended section 1927 of the Act, effective March 23, 2010, 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. To invoice for rebates, 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)).

According to the State agency's *Bureau for Medical Services Provider Manual*, chapter 518A, revised July 20, 2018, and in effect throughout our audit period, providers are required to include the NDC when invoicing the State agency for physician-administered drugs. This requirement has been incorporated into State regulations under West Virginia Code § 9-2-6(20), which "require[s] a provider, subgrantee, or other entity performing services on behalf of the [State agency] to comply with all applicable laws, rules, and written procedures

[11] Specifically, the State agency did not invoice manufacturers for rebates that totaled $8,166,268 ($6,078,504 Federal share).

pertaining to the program . . . including, but not limited to, policy manuals, statements of work, program instructions, or other similar agreements."

Appendix B contains Federal and State requirements 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 for, and collect from manufacturers, estimated rebates totaling $8.2 million ($6.1 million Federal share) for drugs that were required to be rebated (footnote 11). Specifically, $8,135,741 ($6,055,786 Federal share) was for single-source drugs and $30,527 ($22,718 Federal share) was for top-20 multiple-source drugs.

Although its policies required the collection of drug utilization data necessary to invoice for rebates on all physician-administered drug claims, the State agency's internal controls did not always ensure that the collected data were used to invoice manufacturers and collect rebates for physician-administered drugs dispensed to MCO enrollees. Specifically, in 2019, the State agency's fiscal agent updated its rebate administration system. However, during our audit period the State agency did not receive all of the necessary information to invoice and collect rebates from the drug manufacturers. State agency officials stated that once they had identified this problem, the vulnerabilities in the rebate administration system were addressed, such that the State agency is now generally obtaining rebates for all the eligible drugs.

RECOMMENDATIONS

We recommend that the West Virginia Bureau for Medical Services:

- refund to the Federal Government $6,055,786 (Federal share) for claims for single-source physician-administered drugs that were ineligible for Federal reimbursement and

- refund to the Federal Government $22,718 (Federal share) for claims for top-20 multiple-source physician-administered drugs that were ineligible for Federal reimbursement.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our recommendations but described corrective actions that it had taken or planned to take. The State agency said that it re-processed the claims we identified and submitted them for manufacturer rebate reimbursement during the second quarter of 2025. The State agency added that it would submit the Federal share of the rebates as directed by CMS.

Additionally, the State agency stated that it implemented a system improvement by instructing its fiscal agent to add an expanded file of rebate-eligible HCPCS codes, which allowed the State agency "to rebill the claims for both findings in the rebate billing process for the second quarter of 2025" and would "prevent the omission of eligible HCPCS codes in subsequent quarters."

The State agency's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that both of our recommendations remain valid. We commend the State agency for the corrective actions it described in its written comments on our draft report.

We acknowledge the State agency's statement that it has taken corrective action by re-processing the claims identified in our findings and submitting them for rebate invoicing during the second quarter of 2025. We also acknowledge the State agency's description of its implemented system improvement to expand the universe of rebate-eligible HCPCS codes which, we agree, may help prevent similar issues in the future.

The State agency's actions to re-process the claims we identified and submit them for rebate reimbursement occurred after we had provided the State agency with our analysis of the claims for its review. Therefore, we have retained all of these claims in our findings and recommendations. We will consider these recommendations implemented when we are notified that the funds have been refunded to the Federal Government.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed physician-administered drug claims that the State agency's MCOs paid during the audit period. During the audit period, the MCOs paid $242.9 million associated with physician-administered drugs dispensed to MCO enrollees.

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 procedures for and controls over invoicing for Medicaid rebates for physician-administered drugs.

We conducted our audit work, which included contacting the State agency in Charleston, West Virginia, from June 2023 to September 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 the State agency requirements, 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 (footnote 10), the CMS Medicaid Drug Rebate File, and the CMS Medicaid Drug Product File for our audit period.

- We removed claims for 340B entities.[12]

- We obtained from the State agency a detailed list of physician-administered drug claims paid between January 1, 2019, and December 31, 2022. In response to this request, the

[12] 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/or 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. Section 1927(j) of the Act and 42 U.S.C. § 256(a)(5)(A).

State agency provided data associated with claims totaling $242.9 million. To analyze these claims data, we took the following steps:

  - We identified single-source drugs based on the classification of the drugs in the quarterly CMS Medicaid Drug Rebate files and the CMS Medicaid Drug Product files. If the claims data did not include an NDC, we matched the HCPCS code on the drug claim to the HCPCS code on CMS's Medicare Part B crosswalk (footnote 10) to identify all of the NDCs associated with each HCPCS code. Because in each of these cases the NDC was unknown, we used the most conservative drug classification for the NDCs associated with the HCPCS code.

  - 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 list.

- We removed claims for drugs that either were not eligible for rebates or were invoiced for rebates.

- We followed up with State agency officials for an explanation of eligible claims that had not been invoiced for rebate.

- 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.

APPENDIX B: FEDERAL AND STATE REQUIREMENTS 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 shall 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 in order 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.[13] 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

[13] 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 REQUIREMENTS

According to the State agency's *Bureau for Medical Services Provider Manual*, chapter 518A, revised July 20, 2018, and in effect throughout our audit period, providers are required to include the NDC when invoicing the State agency for physician-administered drugs. This requirement has been incorporated into State regulations under West Virginia Code § 9-2-6(20), which "require[s] a provider, subgrantee, or other entity performing services on behalf of the [State agency] to comply with all applicable laws, rules, and written procedures pertaining to the program . . . including, but not limited to, policy manuals, statements of work, program instructions, or other similar agreements."

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Alex J. Mayer
Cabinet Secretary

Cynthia Beane, MSW, LCSW
Commissioner

October 15, 2025

James I. Korn, Regional Inspector General
Office of Inspector General
Office of Audit Services, Region VII
1201 Walnut Street, Suite 1309
Kansas City, MO 64106

RE: Report Number A-07-24-06116
West Virginia Managed-Care Rebates
Associated with Physician-Administered Drugs

Dear Mr. Korn:

The West Virginia (WV) Department of Human Services, Bureau for Medical Services (BMS) has received your audit report, A-07-24-06116, West Virginia Did Not Obtain Rebates Associated with Millions of Dollars in Medicaid Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations. As requested, we are responding to the action of each of the recommendations below.

Recommendation for single-Source physician administered drugs that were ineligible for Federal reimbursement; West Virginia Medicaid should submit $6,055,786 (Federal share) for drugs not submitted for reimbursement.

WV Medicaid response: We do not concur. We re-processed the claims and submitted them to the manufacturers for rebate reimbursement with the second quarter 2025 rebate invoicing process. The Federal share of the rebate will be submitted as directed by CMS.

Recommendation for top-20 multiple source drugs that were ineligible for Federal reimbursement: West Virginia Medicaid should submit $22,718 (Federal share) for drugs not submitted for reimbursement.

West Virginia Medicaid response: We do not concur.. We re-processed the claims and submitted them to the manufacturers for rebate reimbursement with the second quarter 2025 rebate invoicing process. The Federal share of the rebate will be submitted as directed by CMS.

West Virginia Medicaid has requested that [redacted][14], our claims processor and rebate contractor, add an additional file of HCPCS codes eligible for rebate and this has been

[14] Office of Inspector General Note—The deleted text has been redacted because it is third-party information.

implemented. This addition has expanded our universe of rebate eligible HCPCS codes and allowed us to rebill the claims for both findings in the rebate billing process for the second quarter of 2025. The additional file will prevent the omission of eligible HCPCS codes in subsequent quarters. With submission of the claims found in the audit, West Virginia Medicaid will submit the Federal share of these additional rebates as directed by CMS.

Regards,

/s/Cynthia Beane

Cynthia Beane, MSW, LCSW
Commissioner

Cc: Dan Bittner, Auditor, Office of the Inspector General (via email)
Gary Knight, Deputy Commissioner, Plans Management & Integrity
Vicki Cunningham, Director, Pharmacy Services
Gail Goodnight, Director, Drug-Rebate Division

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov