NCPA Member Summary of CMS Medicaid & Children's Health Insurance Program (CHIP) Managed Care Final Rule

On November 9, 2020, CMS announced the Medicaid & CHIP Managed Care final rule, which finalizes policies from a proposed rule that had been issued in 2018. Below is NCPA's interpretation of those provisions addressing state oversight of Medicaid managed care programs that may have the most significant impact on community pharmacy.

State-Directed Payments

Under the final rule, states are no longer required to obtain CMS approval to require managed care organizations to reimburse providers at the same rates established in the fee-for-service program. A number of states (e.g., Iowa, Kansas, Louisiana, Michigan, and Mississippi) have increased transparency in their Medicaid prescription drug benefit programs by requiring MCOs and their PBMs to reimburse pharmacies using the evidence-based fee-for-service reimbursement methodologies. The new rule makes it easier for states to implement this transparent reimbursement model in their Medicaid programs.

Enrollee Encounter Data

The final rule updates requirements regarding enrollee encounter data that must be reported to the Transformed Medicaid Statistical Information System (T-MSIS). The data released through T-MSIS "provides timely and accurate information on utilization and spending under Medicaid and CHIP, and are needed to enable research and analysis to improve quality of care, assess beneficiary care costs and enrollment, improve program integrity and monitor performance."[1] The final rules requires contracts between a state and an MCO to provide for the submission of certain data, including the paid amount of claims. In response to NCPA's requests, CMS clarified that this data submission requirement applies to PBMs, as well.

Network Adequacy Standards

Over NCPA's objection, the final rule modifies network adequacy standards by replacing existing time/distance network requirements with state-established quantitative standards. NCPA is concerned that this change will allow states to adopt network adequacy standards that minimize the importance of patient access to community pharmacy services.

Quality Rating System

The final rule makes several revisions to the Quality Rating System (QRS) that states will use to rate MCOs. Specifically, the CMS-developed QRS will align with other CMS quality rating approaches, including the Medicare Advantage 5-Star Rating System. CMS will also engage with stakeholders to develop guidance for states that choose to use a state-specific QRS instead of the CMS-developed system.

[1] https://www.cms.gov/newsroom/press-releases/cms-releases-updates-medicaid-and-chip-transformed-medicaid-statistical-information-system-t-msis.

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