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Submitter Information

Name: Anonymous Anonymous

General Comment

Increased reporting requirements for pharmacy benefit managers (PBMs) significantly benefits Medicaid managed care oversight. While § 438.3(s)(8) requires PBMs to report amounts to managed care plans related to incurred claims described in § 438.8(e)(2) to ensure more accurate and transparent medical loss ratio (MLR) reporting by managed care plans, CMS should consider that the four data elements described may be subject to interpretation and allow PBMs loopholes in reporting since the four data elements are not clearly defined. Additionally, there may be inconsistencies in reporting across states and managed care plans that can further hinder the effectiveness of the proposed data collection in enhancing Medicaid managed care oversight. The following are questions and considerations that CMS should evaluate based on the proposed collection and review of the data.

1. Reimbursement of Covered Outpatient Drugs (CODs):

- How should PBMs report amounts for reductions to incurred claims related to rebates, incentive payments, and pharmacy rate guarantees such as the examples included (but not limited to) in the CIB (excerpt included below)?
- Typically, other PBM reimbursement or recoupments with pharmacies occur outside of the initial adjudicated pharmacy claim payments (e.g., rebates, pharmacy rate guarantees). Pharmacy rate guarantee amounts have traditionally not been reflected or netted from incurred claims reporting by PBMs and managed care plans on the MLR. For greater transparency, it would be beneficial to have amounts related to when “a managed care plan receives something of value” (excerpt included below) identified and reported separately from the claim payment

amount to the pharmacy.

- Additionally, where should the separate managed care plan's contracted pharmacy rate guarantee amount with the PBM be reported? Based on the CMCS Informational Bulletin (CIB) SUBJECT: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors, dated May 15, 2019 – “CMS interprets this regulation to require that any time a managed care plan receives something of value for the provision of a Medicaid covered outpatient drug (e.g., manufacturer rebates, incentive payments, direct or indirect remuneration, goods in kind, etc.), regardless from whom the item of value is received (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, etc.), the value of that rebate must be deducted from the amount of incurred claims used for calculating and reporting the MLR.”

2. Payments for Other Patient Services:

- What examples would be reflected in the “payments for other patient services” reported value?

3. Dispensing or Administering Provider Fees:

- Dispensing fees are included as part of the drug expense within incurred claims for MLR reporting purposes, whereas “administering provider fees” should be a reduction to incurred claims (transmission/transaction fees applied at the claim level). Typically, these claim transmission fees have not been reflected or netted by managed care plans and PBMs from incurred claims reporting on the MLR. For greater transparency, it would be beneficial to have dispensing and administering provider fee amounts reported separately.

4. Subcontractor Administrative Fees Reporting to the Managed Care Plan:

- Should the “subcontractor administrative fees” reflect administrative services contracted and performed by the PBM for the managed care plan, or other administrative fees assessed to the pharmacies?
- Should other reimbursement/recoupment arrangements between the PBM and the pharmacy, that should be netted against the managed care plan's incurred claims (such as transmission fees, rebates retained by the PBM, and pharmacy rate guarantees), be reported as non-claims costs for MLR reporting purposes?