payment rates does not prohibit a state from (implementing value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; such alternate payment models should be developed using actuarially sound principles to the extent applicable.

(b) A State may establish higher rates than permitted under paragraph (a) of this section if such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

(c) The rates must be designed to reasonably achieve a medical loss ratio standard, calculated in accordance with the provisions of §438.8 of this chapter, that—

(1) Is equal to at least 85 percent for the rate year; and

(2) Provides for reasonable administrative costs.

(d) The State must provide to CMS, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (a), (b), or (c) of this section.

(e) The state must comply with the requirements related to medical loss ratios in accordance with the terms of §438.74 of this chapter, except that the description of the reports received from the MCOs PIHPs and PAHPs under to §438.8(k) of this chapter will be submitted independently, and not with the actuarial certification described in §438.7 of this chapter.

(f) The state must ensure, through its contracts, that each MCO, PIHP, and PAHP complies with the requirements §438.8 of this chapter.

§457.1206 Non-emergency medical transportation PAHPs.

(a) For purposes of this section Non-Emergency Medical Transportation (NEMT) Prepaid Ambulatory Health Plan (PAHP) means an entity that provides only NEMT services to enrollees under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

(b) The following requirements and options apply to NEMT PAHPs, NEMT PAHP contracts, and States in connection with NEMT PAHPs, to the same extent that they apply to PAHPs, PAHP contracts, and States in connection with PAHPs.

(1) All contract provisions in §457.1201 except those set forth in §457.1201(h) (related to physician incentive plans) §457.1201(l) (related to mental health parity).

(2) The information requirements in §457.1207.

(3) The provision against provider discrimination in §457.1208.

(4) The State responsibility provisions in §§457.1212 and 457.1214, and §438.62(a) of this chapter, as cross-referenced in §457.1216.

(5) The provisions on enrollee rights and protections in §§457.1220, 457.1222, 457.1224, and 457.1226.

(6) The PAHP standards in §438.206(b)(1) of this chapter, as cross-referenced by §§457.1230(a), 457.1230(d), and 457.1233(a), (b) and (d).

(7) An enrollee's right to a State review under subpart K of this part.

(8) Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in §438.610 of this chapter, as cross referenced by §457.1285.

(9) Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in §457.1209.

§457.1207 Information requirements.

The State must provide, or ensure its contracted MCO, PAHP, PIHP, PCCM and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of §438.10 of this chapter.

§457.1208 Provider discrimination prohibited.

The state must ensure through its contracts that each MCO, PIHP, and PAHP follow the requirements related to the prohibition on provider discrimination in §438.12 of this chapter.