§ 438.3(c)(1)(ii) to the populations covered under the contract.

(f) *Adjustments.* Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting, address appropriate programmatic changes, reflect the health status of the enrolled population, or reflect non-benefit costs, and be developed in accordance with generally accepted actuarial principles and practices.

(g) *Risk adjustment.* Prospective or retrospective risk adjustment methodologies must be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices.

[81 FR 27853, May 6, 2016, as amended at 85 FR 72837, Nov. 13, 2020]

§ 438.6 Special contract provisions related to payment.

(a) *Definitions.* As used in this part, the following terms have the indicated meanings:

Base amount is the starting amount, calculated according to paragraph (d)(2) of this section, available for pass-through payments to hospitals in a given contract year subject to the schedule in paragraph (d)(3) of this section.

Incentive arrangement means any payment mechanism under which a MCO, PIHP, or PAHP may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

Pass-through payment is any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of this section for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments.

Risk corridor means a risk sharing mechanism in which States and MCOs, PIHPs, or PAHPs may share in profits and losses under the contract outside of a predetermined threshold amount.

State plan approved rates means amounts calculated for specific services identifiable as having been provided to an individual beneficiary described under CMS approved rate methodologies in the Medicaid State plan. Supplemental payments contained in a State plan are not, and do not constitute, State plan approved rates.

Supplemental payments means amounts paid by the State in its FFS Medicaid delivery system to providers that are described and approved in the State plan or under a demonstration or waiver thereof and are in addition to State plan approved rates. Disproportionate share hospital (DSH) and graduate medical education (GME) payments are not, and do not constitute, supplemental payments.

Withhold arrangement means any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

(b) *Basic requirements.* (1) If used in the payment arrangement between the State and the MCO, PIHP, or PAHP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.

(2) Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved

capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound. For all incentive arrangements, the contract must provide that the arrangement is—

(i) For a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Does not condition MCO, PIHP, or PAHP participation in the incentive arrangement on the MCO, PIHP, or PAHP entering into or adhering to intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy at § 438.340.

(3) Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, PIHP's or PAHP's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under § 438.7(b)(6). For all withhold arrangements, the contract must provide that the arrangement is—

(i) For a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Does not condition MCO, PIHP, or PAHP participation in the withhold arrangement on the MCO, PIHP, or PAHP entering into or adhering to intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under § 438.340.

(c) *Delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts*—(1) *General rule.* Except as specified in this paragraph (c), in paragraph (d) of this section, in a specific provision of Title XIX, or in another regulation implementing a Title XIX provision related to payments to providers, that is applicable to managed care programs, the State may not direct the MCO's, PIHP's or PAHP's expenditures under the contract.

(i) The State may require the MCO, PIHP or PAHP to implement 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.

(ii) The State may require MCOs, PIHPs, or PAHPs to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

(iii) The State may require the MCO, PIHP, or PAHP to:

(A) Adopt a minimum fee schedule for network providers that provide a particular service under the contract using State plan approved rates as defined in paragraph (a) of this section.

(B) Adopt a minimum fee schedule for network providers that provide a particular service under the contract using rates other than the State plan approved rates defined in paragraph (a) of this section.

(C) Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract.

(D) Adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the MCO, PIHP, or PAHP retains the ability to reasonably manage

risk and has discretion in accomplishing the goals of the contract.

(2) *Process for approval.* (i) All contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) of this section must be developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

(ii) Contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) and (ii) and (c)(1)(iii)(B) through (D) of this section must have written approval prior to implementation. Contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraph (c)(1)(iii)(A) of this section do not require written approval prior to implementation but are required to meet the criteria in paragraphs (c)(2)(ii)(A) through (F) of this section. To obtain written approval, a State must demonstrate, in writing, that the arrangement—

(A) Is based on the utilization and delivery of services;

(B) Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;

(C) Expects to advance at least one of the goals and objectives in the quality strategy in §438.340;

(D) Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in §438.340;

(E) Does not condition provider participation in contract arrangements under paragraphs (c)(1)(i) through (iii) of this section on the provider entering into or adhering to intergovernmental transfer agreements; and

(F) May not be renewed automatically.

(iii) Any contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraph (c)(1)(i) or (ii) of this section must also demonstrate, in writing, that the arrangement—

(A) Must make participation in the value-based purchasing initiative, delivery system reform or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the reform or improvement initiative;

(B) Must use a common set of performance measures across all of the payers and providers;

(C) May not set the amount or frequency of the expenditures; and

(D) Does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

(3) *Approval timeframes.* (i) Approval of a payment arrangement under paragraphs (c)(1)(i) and (ii) of this section is for one rating period unless a multi-year approval is requested and meets all of the following criteria:

(A) The State has explicitly identified and described the payment arrangement in the contract as a multi-year payment arrangement, including a description of the payment arrangement by year, if the payment arrangement varies by year.

(B) The State has developed and described its plan for implementing a multi-year payment arrangement, including the State's plan for multi-year evaluation, and the impact of a multi-year payment arrangement on the State's goals and objectives in the State's quality strategy in §438.340.

(C) The State has affirmed that it will not make any changes to the payment methodology, or magnitude of the payment, described in the contract for all years of the multi-year payment arrangement without CMS prior approval. If the State determines that changes to the payment methodology, or magnitude of the payment, are necessary, the State must obtain prior approval of such changes under paragraph (c)(2) of this section.

(ii) Approval of a payment arrangement under paragraph (c)(1)(iii) of this section is for one rating period.

(d) *Pass-through payments under MCO, PIHP, and PAHP contracts*—(1) *General rule.* States may continue to require MCOs, PIHPs, and PAHPs to make pass-through payments (as defined in paragraph (a) of this section) to network providers that are hospitals, physicians, or nursing facilities under the contract, provided the requirements of this paragraph (d) are met. States may

not require MCOs, PIHPs, and PAHPs to make pass-through payments other than those permitted under this paragraph (d).

(i) In order to use a transition period described in this paragraph (d), a State must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities in:

(A) Managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or

(B) If the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.

(ii) CMS will not approve a retroactive adjustment or amendment, notwithstanding the adjustments to the base amount permitted in paragraph (d)(2) of this section, to managed care contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments defined in paragraph (a) of this section.

(2) *Calculation of the base amount.* The base amount of pass-through payments is the sum of the results of paragraphs (d)(2)(i) and (ii) of this section.

(i) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the State must determine reasonable estimates of the aggregate difference between:

(A) The amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

(B) The amount the MCOs, PIHPs, or PAHPs paid (not including pass through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(ii) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the State must determine reasonable estimates of the aggregate difference between:

(A) The amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

(B) The amount the State paid under Medicaid FFS (not including pass through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(iii) The base amount must be calculated on an annual basis and is recalculated annually.

(iv) States may calculate reasonable estimates of the aggregate differences in paragraphs (d)(2)(i) and (ii) of this section in accordance with the upper payment limit requirements in 42 CFR part 447.

(3) *Schedule for the reduction of the base amount of pass-through payments for hospitals under the MCO, PIHP, or PAHP contract and maximum amount of permitted pass-through payments for each year of the transition period.* For States that meet the requirement in paragraph (d)(1)(i) of this section, pass-through payments for hospitals may continue to be required under the contract but must be phased out no longer than on the 10-year schedule, beginning with rating periods for contract(s) that start on or after July 1, 2017. For rating periods for contract(s) beginning on or

after July 1, 2027, the State cannot require pass-through payments for hospitals under a MCO, PIHP, or PAHP contract. Until July 1, 2027, the total dollar amount of pass-through payments to hospitals may not exceed the lesser of:

(i) A percentage of the base amount, beginning with 100 percent for rating periods for contract(s) beginning on or after July 1, 2017, and decreasing by 10 percentage points each successive year; or

(ii) The total dollar amount of pass-through payments to hospitals identified in the managed care contract(s) and rate certification(s) used to meet the requirement of paragraph (d)(1)(i) of this section.

(4) *Documentation of the base amount for pass-through payments to hospitals.* All contract arrangements that direct pass-through payments under the MCO's, PIHP's or PAHP's contract for hospitals must document the calculation of the base amount in the rate certification required in §438.7. The documentation must include the following:

(i) The data, methodologies, and assumptions used to calculate the base amount;

(ii) The aggregate amounts calculated for paragraphs (d)(2)(i)(A), (d)(2)(i)(B), (d)(2)(ii)(A), (d)(2)(ii)(B) of this section; and

(iii) The calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in paragraph (d)(3) of this section.

(5) *Pass-through payments to physicians or nursing facilities.* For States that meet the requirement in paragraph (d)(1)(i) of this section, rating periods for contract(s) beginning on or after July 1, 2017 through rating periods for contract(s) beginning on or after July 1, 2021, may continue to require pass-through payments to physicians or nursing facilities under the MCO, PIHP, or PAHP contract of no more than the total dollar amount of pass-through payments to physicians or nursing facilities, respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirement of paragraph (d)(1)(i) of this section. For rating periods for contract(s) beginning on or after July 1, 2022, the State cannot require pass-through payments for physicians or nursing facilities under a MCO, PIHP, or PAHP contract.

(6) *Pass-through payments for States transitioning services and populations from a fee-for-service delivery system to a managed care delivery system.* Notwithstanding the restrictions on pass-through payments in paragraphs (d)(1), (3), and (5) of this section, a State may require the MCO, PIHP, or PAHP to make pass-through payments to network providers that are hospitals, nursing facilities, or physicians under the contract, for each rating period of the transition period for up to 3 years, when Medicaid populations or services are initially transitioning from a fee-for-service (FFS) delivery system to a managed care delivery system, provided the following requirements are met:

(i) The services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period.

(ii) The State made supplemental payments, as defined in paragraph (a) of this section, to hospitals, nursing facilities, or physicians during the 12-month period immediately 2 years prior to the first year of the transition period.

(iii) The aggregate amount of the pass-through payments that the State requires the MCO, PIHP, or PAHP to make is less than or equal to the amounts calculated in paragraph (d)(6)(iii)(A), (B), or (C) of this section for the relevant provider type for each rating period of the transition period. In determining the amount of each component for the calculations contained in paragraphs (d)(6)(iii)(A) through (C), the State must use the amounts paid for services during the 12-month period immediately 2 years prior to the first rating period of the transition period.

(A) *Hospitals.* For inpatient and outpatient hospital services, calculate the product of the actual supplemental payments paid and the ratio achieved by dividing the amount paid through payment rates for hospital services

that are being transitioned from payment in a FFS delivery system to the managed care contract by the total amount paid through state plan approved rates for hospital services made in the State's FFS delivery system. Both the numerator and denominator of the ratio should exclude any supplemental payments made to the applicable providers.

(B) *Nursing facilities.* For nursing facility services, calculate the product of the actual supplemental payments paid and the ratio achieved by dividing the amount paid through state plan approved rates for nursing facility services that are being transitioned from payment in a FFS delivery system to the managed care contract by the total amount paid through payment rates for nursing facility services made in the State's FFS delivery system. Both the numerator and denominator of the ratio should exclude any supplemental payments made to the applicable providers.

(C) *Physicians.* For physician services, calculate the product of the actual supplemental payments paid and the ratio achieved by dividing the amount paid through state plan approved rates for physician services that are being transitioned from payment in a FFS delivery system to the managed care contract by the total amount paid through payment rates for physician services made in the State's FFS delivery system. Both the numerator and denominator of the ratio should exclude any supplemental payments made to the applicable providers.

(iv) The State may require the MCO, PIHP, or PAHP to make pass-through payments for Medicaid populations or services that are initially transitioning from a FFS delivery system to a managed care delivery system for up to 3 years from the beginning of the first rating period in which the services were transitioned from payment in a FFS delivery system to a managed care contract, provided that during the 3 years, the services continue to be provided under a managed care contract with an MCO, PIHP, or PAHP.

(e) *Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease.* The State may make a monthly capitation payment to an MCO or PIHP for an enrollee aged 21–64 receiving inpatient treatment in an Institution for Mental Diseases, as defined in § 435.1010 of this chapter, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services at § 438.3(e)(2)(i) through (iii). For purposes of rate setting, the state may use the utilization of services provided to an enrollee under this section when developing the inpatient psychiatric or substance use disorder component of the capitation rate, but must price utilization at the cost of the same services through providers included under the State plan.

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§ 438.7 Rate certification submission.

(a) *CMS review and approval of the rate certification.* States must submit to CMS for review and approval, all MCO, PIHP, and PAHP rate certifications concurrent with the review and approval process for contracts as specified in § 438.3(a).

(b) *Documentation.* The rate certification must contain the following information:

(1) *Base data.* A description of the base data used in the rate setting process (including the base data requested by the actuary, the base data that was provided by the State, and an explanation of why any base data requested was not provided by the State) and of how the actuary determined which base data set was appropriate to use for the rating period.

(2) *Trend.* Each trend factor, including trend factors for changes in the utilization and price of services, applied to develop the capitation rates must be adequately described with enough detail so CMS or an actuary applying generally accepted actuarial principles