DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: **May 14, 2020**

FROM: **Calder Lynch, Deputy Administrator and Director**
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: **Medicaid Managed Care Options in Responding to COVID-19**

The COVID-19 public health emergency is causing dramatic shifts in utilization across the healthcare industry, causing financial uncertainty for both healthcare providers and managed care plans. While some providers are experiencing surges in COVID-19 related utilization, other providers are experiencing dramatic declines in utilization and revenue. The Centers for Medicare & Medicaid Services (CMS) understands that many states are now seeking ways to temporarily modify provider payment methodologies and capitation rates under their Medicaid managed care contracts to address the impacts of the public health emergency while preserving systems of care and access to services for Medicaid beneficiaries. This guidance provides several options that states can consider under their Medicaid managed care contracts, including the following:

1. Adjusting managed care capitation rates exclusively to reflect temporary increases in Medicaid fee-for-service (FFS) provider payment rates where an approved state directed payment requires plans to pay FFS rates;
2. Requiring managed care plans to make certain retainer payments allowable under existing authorities to certain habilitation and personal care providers to maintain provider capacity and access to services; and
3. Utilizing state directed payments to require managed care plans to temporarily enhance provider payment under the contract.

To appropriately respond to COVID-19, we understand that states are interested in a variety of mechanisms to modify their managed care contracts and rates. In this guidance, CMS is announcing temporary flexibilities to help states address the public health emergency. The options in this guidance align with statutory and regulatory requirements, such as the requirements in 42 CFR Part 438, including that managed care capitation rates must be actuarially sound and that state directed payments under managed care contracts must be based on utilization and delivery of services covered under the contract.

In addition to the options described in this guidance, CMS will consider, where appropriate, state requests to retroactively amend or implement risk mitigation strategies only for the purposes of

responding to the COVID-19 pandemic. In the Notice of Proposed Rulemaking (NPRM), Medicaid Program: Medicaid and CHIP Managed Care (CMS-2408-P) published in November 2018,[1] CMS proposed to prohibit states from implementing retroactive risk mitigation strategies. CMS continues to support the identification of all risk mitigation strategies in contracts prospectively. However, given that this NPRM has not been finalized, CMS recognizes that these are unique and unanticipated circumstances under which approving retroactive risk mitigation strategies may be appropriate when other methods for making retroactive adjustments to capitation rates may be extraordinarily difficult for states to implement at this time. Such risk mitigation strategies could include a 2-sided risk corridor on all medical costs. CMS provides an example in the appendix of this guidance that relies on a managed care plan's medical loss ratio (MLR) reporting, outlined in 42 CFR 438.8, and includes a required MLR remittance. This approach would provide prudent financial protections and limit financial risks to both state and federal governments and managed care plans during this period of uncertainty caused by the public health emergency regardless of any other changes the state wishes to consider in responding to the public health emergency.

1. Adjusting Managed Care Capitation Rates Exclusively to Reflect Temporary Increases in Medicaid FFS Provider Payments

Many states have implemented, or are in the process of implementing, temporary increases in Medicaid FFS provider payment rates as part of a disaster state plan amendment (SPA) in response to COVID-19. Such temporary rate increases in FFS fee schedules may have a corresponding impact on a state's managed care capitation rates where states have existing contractual requirements that require managed care plans to adopt the Medicaid FFS provider rates for specific provider types or services.

In order to revise a state's managed care capitation rates to reflect temporary increases in FFS fee schedules where an approved state directed payment requires plans to pay FFS rates, states may have the following options:

- De minimis rate adjustments**:** States currently have the authority to make *de minimis* rate adjustments to their managed care capitation rates under 42 CFR 438.7(c)(3) if these adjustments result in an increase or decrease to the capitation rate per rate cell of less than 1.5 percent. For such *de minimis* rate changes, a revised actuarial rate certification does not need to be submitted; only a contract amendment needs to be submitted to CMS. If the states' actions to implement temporary rate increases result in a less than 1.5 percent adjustment to the capitation rates, states may use this option, and they are not required to submit a new actuarial rate certification to CMS.[2]

- Rate amendment**:** For states that implement capitation rate adjustments that result in an increase or decrease of more than 1.5 percent per rate cell, states will need to submit a

[1] https://www.federalregister.gov/documents/2018/11/14/2018-24626/medicaid-program-medicaid-and-childrens-health-insurance-plan-chip-managed-care.

[2] The state could not submit two separate contract amendments to increase rates 1.5 percent per amendment (for a total increase of 3 percent from the original certified rates) without submitting a revised actuarial rate certification.

revised actuarial rate certification and contract amendment to address implementation of these temporary rate increases. To expedite review and approval of such amendments, states and actuaries may develop a revised actuarial rate certification and contract amendment that contains only the information needed to incorporate the temporary payment rate increases. For example, where appropriate, states and actuaries would be permitted to address only the pricing assumptions in the revised actuarial rate certification and rate amendment without having to address the underlying assumptions around utilization. To the extent states and actuaries believe it would be necessary or reasonable to also revise utilization assumptions for a state directed payment at this time, CMS would accept revised actuarial rate certifications and contract amendments to reflect the proposed changes as well.

In addition to these two options, CMS remains committed to reviewing COVID-19 related contract and rate amendments as our top priority related to managed care rates and reiterates our commitment to a more expedited review and approval process.

2. Requiring Managed Care Plans to Make Retainer Payments to Certain Habilitation and Personal Care Providers to Maintain Provider Capacity and Access to Services

As discussed in existing CMS guidance,[3] states are authorized to make retainer payments under section 1915(c)(4)(B) of the Social Security Act to allow certain providers to continue to bill for individuals enrolled in a Medicaid program, and individuals receiving personal care or habilitation services that include personal care specified in their person-centered service plan when circumstances prevent such individuals from receiving these services. Such circumstances could include self-quarantining activities during the COVID-19 public health emergency, which may lead to the temporary closure of a provider or limit a provider's ability to furnish the type of in-person services that are typically included in the service plan. These retainer payments have been used historically in 1915(c) HCBS waivers since 2000. States should review the guidance relevant to when and how retainer payments may be authorized, as having authorization for those payments is necessary before states can direct their managed care plans to make such payments.

Since retainer payments are specifically linked to the delivery of services specified in an individual's person-centered service plan, and are made only when qualifying circumstances prevent an individual from receiving those services identified in the person-centered service plan, these payments meet the requirement in 42 CFR 438.6(c)(2) that state directed payments be based on the utilization and delivery of services. Therefore, we believe that states may implement state directed payments under 42 CFR 438.6(c) that contractually require managed care plans to make these retainer payments to providers where the authorized service is covered under the contract. The state directed retainer payments must meet all requirements and criteria for retainer payments to be permissible, as well as the requirements in § 438.6(c), and this

[3] See, for example Olmstead Update No 3, published July 25, 2000: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd072500b.pdf.

guidance does not address all of those requirements. We strongly recommend that states review the applicable guidance cited above, as well as the COVID-19 FAQs published by CMS for future guidance on retainer payments.

In order for states to seek approval under 42 CFR 438.6(c), the retainer payments must be authorized as part of the 1915(c) HCBS waiver, section 1115(a) demonstration waiver for 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must be submitted to effectuate the state directed retainer payments under a state's contract with its managed care plans. In order to facilitate our expedited review and approval of these payments, CMS is making a prepopulated template available to states for minimum fee schedule requirements tied to approved retainer payments. The next section of this guidance includes applicable requirements related to state directed payments developed in response to COVID-19.

3. State Directed Payments to Temporarily Enhance Provider Payment in Managed Care

Medicaid managed care regulations at 42 CFR 438.6(c) include requirements for how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. These types of payment arrangements permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs, including a state's response to COVID-19.

In November 2017, CMS published guidance, a related appendix with examples, and a preprint for states to obtain approval of state directed payments under 42 CFR 438.6(c).[4] Under § 438.6(c)(2), state directed payments must be developed in accordance with actuarial soundness standards in § 438.4, the rate development standards specified in § 438.5, generally accepted actuarial principles and practices, and have written CMS approval prior to implementation. States must demonstrate in writing that the directed payment arrangement[5]:

(A) Links to utilization and delivery of services under the current contract rating period;
(B) Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;
(C) Advances at least one of the goals and objectives in the state's managed care quality strategy (42 CFR 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;
(E) Does not require or condition provider participation on entering into or adhering to intergovernmental transfer agreements; and
(F) Does not renew automatically.

[4] https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html.
[5] In addition to these requirements, the regulation specifies additional standards for value-based service payment models and delivery system reform initiatives.

Additionally, state directed payments must be incorporated into both contract(s) and rate certification(s).

In responding to COVID-19, we understand that states may be interested in ways to contractually require their managed care plans to make specific payments to providers to help mitigate the impacts of the public health emergency. To help states comply with 42 CFR 438.6(c) in designing state directed payments in response to the COVID-19 pandemic, we provide the following framework. Using this framework will facilitate CMS' review and approval process.

1. **Connection to Utilization:** The regulations at 42 CFR 438.6(c)(2)(i)(A) require that all state directed payments be based on the utilization and delivery of services under the contract in the current managed care contract rating period. As such, states cannot use a state directed payment to require their plans to make advance payments. However, we note that managed care plans have the discretion to voluntarily implement a number of techniques, which may include advance payments, in order to fulfill their contractual requirements to ensure access to care and network adequacy.

   For states that would like to implement temporary increases in provider payments to address declines in utilization and other impacts due to the public health emergency through their managed care contracts, there are mechanisms states may use to accomplish this goal in a manner consistent with regulatory requirements. For example, states could require plans to provide a uniform (even if temporary) increase in per-service payment amounts for furnishing covered services to enrollees covered under the contract in order to affect total (or overall) payments to providers. States could also consider some combination of different state directed payments to address temporary increases in provider payments.

2. **Quality:** The regulations at 42 CFR 438.6(c)(2)(i)(C) and 42 CFR 438.6(c)(2)(i)(D) require that all state directed payments advance a goal and objective in the state's managed care quality strategy and have an evaluation plan that measures the degree to which the arrangement advances such goal and objective. Ensuring the continued availability and accessibility of covered services for Medicaid managed care enrollees may be a goal of the state's managed care quality strategy, which would be served by the state instituting ways to address temporary increases in provider payments in order to respond to providers who may be experiencing dramatic declines in utilization and revenue or incurring additional costs due to this public health emergency. It is an appropriate goal of the managed care quality strategy for states to use state directed payments to increase payment for actual utilization of services as a method to preserve and retain the availability of services for Medicaid managed care enrollees. It is also an appropriate goal of the managed care quality strategy for states to use state directed payments to address the increased use of telehealth or other approaches to maintain access to care, whether for all beneficiaries or for specific subgroups with specialized needs, during the public health emergency. States may use any of these purposes as quality goals and objectives as part of the managed care quality strategy under §438.340

to comply with the quality strategy requirements in § 438.6(c)(2) during this public health emergency.

If a state would like to continue a state directed payment arrangement in future rating periods after the end of the public health emergency, CMS will work with states to identify expectations for a more detailed approach to specifying goals and objectives in the quality strategy and for ensuring the evaluation plan measures the degree to which the arrangement advances those goals and objectives.

3. **Targeted Providers:** The regulations at 42 CFR 438.6(c)(2) permit states to direct expenditures for a class of providers providing services under the contract. Historically, CMS has deferred to states in defining the provider class for purposes of state directed payment arrangements, as long as the provider class is reasonable and identifiable, such as the provider class being defined in the state's Medicaid State Plan. For purposes of responding to this public health emergency, we have heard from states that are concerned about providers that serve a high proportion of Medicaid beneficiaries. Examples of state directed payments for a target class or classes of providers providing services under the contract could include dental, behavioral health, home health and personal care, pediatric, federally-qualified health centers, and safety-net hospitals. These payments must be directed equally, using the same terms of performance across a class of providers, and provider participation in these state directed payments cannot be conditioned upon the provider entering into or adhering to intergovernmental transfer agreements.

4. **Risk Mitigation:** Under 42 CFR 438.6(c)(2), all state directed payments must be developed in accordance with generally accepted actuarial principles and practices. Since there is significant uncertainty related to costs and utilization due to this public health emergency and state directed payments may limit plans' available capitation revenue to devote to responding to the public health emergency, CMS will carefully evaluate state directed payment proposals to inform review of the actuarial soundness of the capitation rates. CMS will also require implementation of a 2-sided risk mitigation strategy (e.g., risk corridor) when states implement new state directed payments intended to mitigate the impacts of the public health emergency. For example, states could institute a 2-sided risk corridor based on a target MLR. Under such an approach, the state could establish thresholds under which a plan and the state would be required to share in the gains or losses if the plan did not meet the target MLR. An example of this strategy is included in the attached appendix.

   CMS believes 2-sided risk mitigation strategies are necessary to ensure actuarial soundness given the many uncertainties associated with the public health emergency, including issues related to increased costs because of local COVID-19 surges, potential pent-up demand after the public health emergency ends, and other potential solvency or cash flow issues. As noted earlier in this guidance, states could consider a 2-sided risk mitigation strategy on all medical costs absent implementing a new state directed payment intended to mitigate the impacts of the public health emergency.

States should describe the risk mitigation arrangements in their contract(s), and they must be developed in accordance with all applicable requirements in 42 CFR Part 438, including §§ 438.4 and 438.5, and generally accepted actuarial principles and practices. The actuarial rate certification and supporting documentation should also describe any risk mitigation arrangement and how it may affect the rates or the final net payments to the health plan(s) under the applicable contract as part of complying with § 438.7. States submitting new or amended state directed payment proposals to address the public health emergency that do not currently have 2-sided risk mitigation in place or that are seeking to make an existing risk mitigation arrangement comply with these requirements, should submit both a contract amendment and a revised actuarial rate certification. If there are no other material impacts on the capitation rates, the revised actuarial rate certification can be limited to just incorporating the risk mitigation arrangement into the rate certification. States should follow the guidance in the Medicaid Managed Care Rate Development Guide for documentation of risk-sharing mechanisms.

As noted in previously published FAQs and earlier in this CIB, CMS will consider, where appropriate, state requests to retroactively amend or implement risk mitigation strategies for the purposes of responding to the COVID-19 pandemic.

5. **Payment Levels:** The regulations at 42 CFR 438.6(c)(2) require that all state directed payments be developed in accordance with 42 CFR 438.4, the standards at § 438.5, and generally accepted actuarial principles and practices; therefore, as part of CMS' approval process, we require states to demonstrate that the state directed payments result in provider payment rates that are reasonable, appropriate, and attainable. CMS has generally asked states to demonstrate that proposed state directed payments meet these requirements through a comparison of the effective payment level before and after the state directed payment to a benchmark like Medicare or commercial rates. States will be required to document a rationale or justification and provide supporting documentation that demonstrates how the directed payments are appropriate and reasonable compared to the total payments the provider would have received absent the public health emergency. States will also be required to document a rationale or justification and provide supporting documentation that demonstrates the addition of the directed payment does not result in total payments that would exceed what was or would have been assumed in the capitation rate certification absent the public health emergency. If states request approval to maintain these payment arrangements in future rating periods, we will require the comprehensive provider payment rate analysis.

6. **Rating Period:** As part of CMS' review and approval process for state directed payments under 42 CFR 438.6(c), we require that the state's actuarial rate certification for the applicable rating period address how each state directed payment is reflected in the capitation payments to managed care plans. CMS has not permitted states to add new state directed payments for rating periods that have ended. The regulation at § 438.6(c) requires prior approval of state directed payments.

   CMS interprets the prior approval requirement in this part of the regulations in line with practices documented in the State Medicaid Manual for prior approval of MCO contracts.

CMS will permit states to develop and implement these specific state directed payments retrospectively to the start of the current contract rating period. States are required to submit the state directed payment preprint for approval before the end of the rating period; for states operating on a State Fiscal Year basis, this would mean submissions for the SFY 2019-2020 rating period would need to be submitted before July 1, 2020. As noted above, states will be required to document a rationale or justification and provide supporting documentation that demonstrates the directed payments are appropriate and reasonable compared to the total payments the provider would have received absent the public health emergency. States will also be required to document a rationale or justification and provide supporting documentation that demonstrates the addition of the state directed payment arrangement does not result in total payments that would exceed what was or would have been assumed in the capitation rate certification absent the public health emergency. If states request approval to maintain these state directed payments in future rating periods, we will work with states to obtain approval prior to the start of the rating period.

7. **Rate Certification Documentation:** The regulation at 42 CFR 438.7(b)(6) requires that state rate certifications document all special contract payment arrangements in § 438.6, including documentation of state directed payments. While CMS would generally require states to submit an amendment to their rate certifications to include these specific state directed payments, in light of the public health emergency, CMS is using our enforcement discretion as to these documentation requirements. Therefore, CMS will not require rate certification amendments for new state directed payments if the amounts are within the +/- 1.5 percent per rate cell *de minimis* amount in accordance with 42 CFR 438.7(c)(3). As noted above, states will be required to document a rationale or justification and provide supporting documentation that demonstrates the directed payments are appropriate and reasonable compared to the total payments the provider would have received absent the public health emergency. States will also be required to document a rationale or justification and provide supporting documentation that demonstrates the addition of the state directed payment arrangement does not result in total provider payments that would exceed what was or would have been assumed in the original capitation rate certification absent the public health emergency. For a state that plans to maintain these payment arrangements in future rating periods, we will require the rate certification to document all state directed payments of all sizes, whether the arrangement is within the *de minimis* range or not.

8. **Preprint Template:** The regulation at 42 CFR 438.6(c)(2) requires that states have written approval from CMS prior to implementation of the state directed payments. CMS currently utilizes a preprint to implement the prior approval process that states must complete and submit to CMS for approval of the state directed payments. For states seeking to implement state directed payments to respond to this public health emergency, we are publishing a prepopulated version of this preprint to facilitate a more streamlined submission and review process.

In addition to these guiding principles and publication of the prepopulated template, CMS is also publishing an appendix of example state directed payment arrangements that would be

approvable for this public health emergency. If states incorporate all of these guiding principles into their state directed payment arrangements, or choose to implement one of the example state directed payment arrangements from the published appendix, we can commit to an expedited review and approval process. If states include additional elements not contemplated as part of this guidance, our review and approval process may take more time.

Technical Assistance

CMS is continuing to prioritize and expedite reviews of COVID-19 related managed care actions. All managed care actions (contract amendments, rate amendments, state directed payment preprints) needed to respond to COVID-19 should be submitted as soon as possible to CMCSManagedCareCOVID19@cms.hhs.gov. If states have questions about this informational bulletin or need technical assistance regarding this guidance, please contact John Giles, Director of the Division of Managed Care Policy, at john.giles1@cms.hhs.gov.

Appendix A: Example State Proposals

	State Proposal A	State Proposal B
Proposal Overview	The state is directing and contractually requiring their managed care plans to pay an enhanced minimum fee schedule for pediatric primary care providers.	The state is directing and contractually requiring their managed care plans to pay a uniform dollar or percentage increase per service rendered by behavioral health providers. The uniform dollar or percentage increase would be determined by dividing a portion of the total dollars the state has dedicated to this payment arrangement by the number of outpatient behavioral health visits rendered during the quarter based on encounter or claims data and then directing plans to pay $x or x% per service rendered during that quarter in addition to negotiated rates.
Effective Date	May 1, 2020	July 1, 2019
Rating Period	Jan 1, 2020 – Dec 31, 2020	July 1, 2019 – June 30, 2020
Preprint Submission Date[6]	May 15, 2020	May 15, 2020
Tie to Utilization and Outcomes	The payment arrangement requires plans to pay an enhanced fee per service rendered during the contract period.	The payment arrangement requires plans to pay a uniform dollar or percentage increase per service rendered during the contract period. The amount the state directs the plan to pay per service could vary quarter to quarter based on the utilization rendered (e.g. Q1 could be $110 per service while Q2 could be $100 per service if utilization increased).
Targeted Provider Class	Pediatric Primary Care Providers	Behavioral Health Providers

[6] Preprints must be submitted before the end of the rating period that they would be applicable to. For example, states operating on a SFY rating period must submit preprints prior to July 1, 2020 to implement during the SFY 2019-2020 rating period.

	State Proposal A	State Proposal B
Quality Goals and Objectives and Evaluation	The state is directing this payment arrangement to ensure access to care for Medicaid managed care enrollees in light of the COVID-19 emergency. The state is contractually requiring the plans to pay providers in this manner to ensure access to care for Medicaid managed care enrollees in light of the COVID-19 emergency; the state will ensure routine monitoring of access to care as required under 42 CFR 438.66, 438.206, and 438.207. If the state requests approval to maintain these payment arrangement(s) in future rating periods after the end of the public health emergency, CMS will work with states to identify expectations for a more detailed approach to setting goals and objectives defined in the quality strategy and for ensuring the evaluation plan measures the degree to which the arrangement advances those goals and objectives.	
Payment Levels	Document a rationale or justification and provide supporting documentation that demonstrates the payments are appropriate and reasonable compared to the total payments the provider would have received absent the public health emergency. Document a rationale or justification and provide supporting documentation that demonstrates the addition of the state directed payment arrangement does not result in total payments that would exceed what was or would have been assumed in the capitation rate certification absent the public health emergency. If states request approval to maintain these payment levels in future rating periods after the end of the public health emergency, CMS will require the comprehensive provider reimbursement rate analysis in order to provide a subsequent approval and include this as a condition in the approval letter.	
Rate Certification Documentation For New State Directed Payments to Address COVID-19	**If the effect on the approved capitation rates is expected to be a de minimis amount (+/- 1.5% per rate cell)*:** A contract amendment will be required; states will not be required to revise their approved rate certification to account for the directed payment arrangement for the active rating period under the authority of § 438.7(c)(3). **If the effect on the approved capitation rates is expected to be more than a de minimis amount*:** States will need to submit both a contract and rate certification amendment to account for the effect of the directed payment. * Note that as part of the preprint review, states will be required to document a rationale or justification and provide supporting documentation that demonstrates the directed payments are appropriate and reasonable compared to the total payments the provider would have received absent the public health emergency. States will also be asked as part of the preprint review to document a rationale or justification and provide supporting documentation that demonstrates the addition of the state directed payment arrangement does not result in total payments that would exceed what was or would have been assumed in the capitation rate certification absent the public health emergency.	

<table>
<tr><th></th><th><u>State Proposal A</u></th><th><u>State Proposal B</u></th></tr>
<tr><td>Risk Mitigation</td><td colspan="2">
CMS requires that states implementing state directed payments intended to mitigate the impacts of the COVID-19 public health emergency under this guidance must also implement a 2-sided risk mitigation strategy (such as a 2-sided risk corridor across all medical expenses) to provide protection for state and federal governments, as well as managed care plans.

For example, the state could set a target MLR of 85% or greater consistent with definitions outlined in 42 CFR 438.8 and related policy guidance. CMS recommends the state consider setting this target MLR consistent with initial rate development assumptions for the MLR standards as outlined in 42 CFR 438.8 and related policy guidance. The state would then limit MCO gains and losses if the actual MLR is different than the target MLR within a specified margin, such as those laid out below:
<table>
<tr><th>Medical Loss Ratio Corridor</th><th>MCO Share of Gain/Loss in the Corridor</th><th>State/Federal Government Share of Gain/Loss in the Corridor</th></tr>
<tr><td>Less than Target MLR - 2.5%</td><td>0%</td><td>100%</td></tr>
<tr><td>Target MLR - 2.5% to Target MLR - 1%</td><td>50%</td><td>50%</td></tr>
<tr><td>Target MLR - 1% to Target MLR + 1%</td><td>100%</td><td>0%</td></tr>
<tr><td>Target MLR + 1% to Target MLR + 2.5%</td><td>50%</td><td>50%</td></tr>
<tr><td>Greater than or equal to Target MLR + 2.5%</td><td>0%</td><td>100%</td></tr>
</table>
As a specific example, if a state and its actuary assumed a target MLR of 88% in initial rate development for SFY 2020, the 2-sided risk corridor would be:
<table>
<tr><th>Medical Loss Ratio Corridor</th><th>MCO Share of Gain/Loss in the Corridor</th><th>State/Federal Government Share of Gain/Loss in the Corridor</th></tr>
<tr><td>MLR of less than 85.5%</td><td>0%</td><td>100%</td></tr>
<tr><td>MLR of 85.5% to less than 87%</td><td>50%</td><td>50%</td></tr>
<tr><td>MLR of 87% to less than 89%</td><td>100%</td><td>0%</td></tr>
<tr><td>MLR of 89% to less than 90.5%</td><td>50%</td><td>50%</td></tr>
<tr><td>MLR greater than or equal to 90.5%</td><td>0%</td><td>100%</td></tr>
</table>
The above example is standard language that CMS would accept. States may wish to consider other 2-sided risk corridor or risk mitigation designs that they believe may better address the risks specific to each state and program. CMS is happy to provide technical assistance to states and evaluate alternative approaches in advance of state implementation.
</td></tr>
</table>