

Medicaid Managed Care Capitation Rate Setting

Over the last 30 years, states have increasingly turned to managed care to deliver Medicaid services. The share of Medicaid beneficiaries enrolled in a comprehensive risk-based managed care organization (MCO) grew from about 15 percent in 1995 to about 50 percent by 2011 and about 70 percent by 2019 (MACPAC 2014, MACPAC 2021a). Comprehensive managed care is now the primary Medicaid delivery system in nearly three-quarters of the states, accounting for over half of federal and state Medicaid spending in fiscal year 2020 (MACPAC 2021b). In addition, states are increasingly using managed care to serve people over the age of 65 and those with disabilities who, on average, have higher costs, and to cover long-term services and supports (LTSS), which were previously excluded from managed care. These trends are likely to continue.

State Medicaid programs pay MCOs to cover a defined package of benefits for an enrolled population through fixed periodic payments, also referred to as capitation payments. Capitation payment rates are typically established prospectively and remain in effect for the duration of the 12-month rating period (42 CFR 438.2), regardless of changes in health care costs or use of services. The rates are based on actuarial estimates of the amounts necessary to cover the anticipated health care costs of covered enrollees as well as plan administration, reserves, and profit.

Capitation payment rates influence many aspects of a managed care program including MCO willingness to contract with a state, the solvency of participating MCOs, MCOs' ability to pay providers sufficiently, the potential to save costs relative to fee for service (FFS), enrollee access to care, and quality of care delivered. States seek to develop payment rates that are adequate but also efficient. From a state perspective, these should approximate actual contract costs, as the state does not want to overpay and risk excessive MCO profits or underpay and risk an MCO being unable to provide services to enrollees. From the MCO perspective, rates are adequate if they are anticipated to cover costs under the contract and there is a reasonable expectation of profit or surplus to balance the financial risk assumed by the plan. MCOs have a financial incentive to manage benefit and administrative spending to stay under the total capitation, which keeps state spending close to anticipated population health costs and slows the rate of cost growth.

The federal standard for payment adequacy in managed care is the actuarial soundness rule, a standard established in statute and defined in regulations that require a qualified actuary to certify that the capitation rates should cover anticipated costs and appropriately balance profit and risk. Detailed specifications for the process of demonstrating and enforcing actuarial soundness were not provided in regulation until 2016 when, in response to concerns about inconsistent oversight and application of the statute, the Centers for Medicare & Medicaid Services (CMS) updated the federal managed care rule. States, MCOs, and CMS have now implemented an extensive annual rate development and certification process and continue to develop tools to ensure that managed care payments support access, quality, and efficiency. Under the current rule, states have some flexibility on whether or how to apply various



techniques to apportion and manage risk between the state and MCOs, and whether to focus more on cost savings or health system investment.

This issue brief begins with a brief history of federal regulation of Medicaid capitation payments, followed by a description of current federal rate setting standards and processes. It then describes the tools available to states to manage various risks. The brief concludes with a discussion of several policy issues relevant to developing Medicaid capitation rates. Note that while this brief discusses the requirements for Medicaid managed care, the same requirements apply to the State Children's Health Insurance Program (CHIP) managed care entities for contracts and rating periods that begin on or after July 1, 2018 (42 CFR §457.1203).

Background

Beginning in the 1970s, a small number of states began enrolling Medicaid beneficiaries into managed care on a capitated basis, making fixed periodic payments to MCOs for a defined package of benefits for a group of enrollees. The contracted MCOs in turn negotiated with providers to provide services on a fee-for-service or subcapitated basis. These initial managed care programs operated under various waivers of the Act and capitation payment standards were addressed in the waiver terms and conditions for each program.

In 1981, federal Medicaid law was amended to require all managed care capitation rates to be set on an actuarially sound basis (§1903(m)(2)(A)(iii) of the Act). Between 1981 and 2002, federal regulations provided little guidance on actuarial soundness other than limiting capitation payments to an upper payment limit equal to the cost of providing the same services in FFS Medicaid to an actuarially equivalent population (42 CFR Part 447.361 [subsequently repealed]). Thus, while the statute required the rates to be actuarially sound, the rules in effect between 1981 and 2002 emphasized setting a ceiling rather than establishing a floor. This raised concerns among providers and beneficiaries that states could use managed care to excessively cut costs. In addition, as states operated managed care programs for longer periods of time, it became more difficult to establish an appropriate upper payment limit using FFS data.

To address these issues, in 2002 CMS replaced the upper payment limit with new regulations defining actuarial soundness as capitation rates developed in accordance with generally accepted actuarial principles and practices, appropriate for the covered population and services, and certified by a qualified actuary (42 CFR 438). In revising the regulation, CMS considered but chose not to adopt other approaches, such as making the determination of actuarial soundness itself rather than relying on each state's actuary (CMS 2002). These regulations were updated in 2016, adding to the existing standard, defining actuarially sound capitation rates as those projected to provide for all reasonable, appropriate, and attainable costs required under the terms of the contract and for the operation of the MCO for the time period and the population covered under the terms of the contract (42 CFR 438.4). The rules were further updated in 2020 with additional procedures and clarifications.

The 2016 update also requires capitation rates to be developed and documented in accordance with certain regulatory requirements in order to be considered actuarially sound (42 CFR 438.3-438.8). For



example, state actuaries must develop and apply trend factors to base data using actual Medicaid experience (42 CFR 438.5(b)(2)). States are also prohibited from certain practices, such as cross-subsidizing payments across rate cells or modifying risk-sharing mechanisms after the start of the contract period ((42 CFR 438.4(b)(5), 438.6(b)(1)). To support CMS review of capitation rates, states must provide documentation in a specific format and timeline ((42 CFR 438.4(b)(8)). As appropriate, states must also provide CMS the underlying data to support rate review.

In addition to providing more specificity regarding development of the rates and standards for actuarial soundness, federal rules now include requirements regarding the adequacy of the capitation rates. States must ensure that capitation rates are adequate to meet MCO contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care ((42 CFR 438.4(b)(3)). States are also required to develop capitation rates in such a way that MCOs could reasonably achieve a medical loss ratio (MLR) of at least 85 percent for the rate year ((42 CFR 438.4(b)(9)). That is, in addition to being actuarially sound, capitation rates should be sufficient to allow MCOs to spend at least 85 percent of total capitation revenue on covered services and no more than 15 percent on other activities such as plan administration, and profit.

Capitation Rate Development Process

States and MCOs sign contracts that outline the populations that will be enrolled in the managed care program, the services that will be the responsibility of the MCO, and the capitation rates that the state will pay the MCO.¹ Capitation rates are developed for a prospective 12-month rating period and must be submitted 90 days prior to the new contract effective date in order to be approved by CMS before they will go into effect.²

To develop capitation rates, state Medicaid agencies apply generally accepted actuarial methods and follow federal rules, which require (at a minimum) that they identify and develop base utilization and price data; develop and apply trend factors based on actual Medicaid or similar experience; make appropriate and reasonable adjustments; take into account past and projected medical loss ratio (MLR) data; develop the non-benefit component of the rate to account for reasonable expenses; and apply risk adjustment in a budget neutral manner (42 CFR 438.5).

- Baseline costs.** The first step is to establish a baseline of the costs and utilization of the services that will be covered by the capitation rate for the populations enrolled. States can use validated encounter data (information relating to items or services by received MCO enrollees), FFS data (as appropriate), and audited MCO financial reports to establish baseline costs and utilization. The baseline data must be from the three most recent and complete years prior to the rating period unless CMS approves an exception. States then adjust the baseline to account for incurred but not reported claims, missing data, non-claims payments or recoupments such as pharmacy rebates, and the effects of differences between the baseline data and the expected covered population or services. These types of adjustments must reflect reasonable, appropriate, and attainable costs in the actuary's judgment and must be documented in the rate certification (CMS 2021). States may also decide at this point to take some costs out of the baseline (e.g., certain high-cost services that



are difficult to predict, such as neonatal intensive care for high-cost newborns, or highly predictable service costs, such as maternity costs) and pay these as supplemental payments (also known as kick payments), instead of including them in the capitation rates. These kick payments are made per event (e.g., delivery).

- **Rate cells.** States develop Medicaid capitation rates for subgroups of the enrolled population who have similar cost characteristics. These subgroups, or rate cells, are defined using characteristics such as age, gender, geographic residence, eligibility category, and other factors. Baseline costs typically are divided into the specified rate cells before making any adjustments for future costs, such as price or utilization trends. The number of different rate cells depends on the program design, availability of demographic and health status information, and state preferences. The actuary may also establish a rate range for each cell, with the value within that range being certified as actuarially sound (i.e., the state can choose to pay any amount from the low to high end of the range).³
- **Future costs and other adjustments.** The next step is to project the baseline costs to the future contract period, accounting for factors such as inflation, changes in utilization patterns, and Medicaid program changes (i.e., eligibility, benefits, or cost sharing). States must develop trend assumptions using the actual experience of the Medicaid population or a similar population, to the extent possible. States must take prior medical loss ratio experience, if available, into account. States can also make adjustments to account for expected savings through managed care efficiency (e.g., assumptions regarding potential lower use of emergency room services due to improved provision of timely preventive care). Such adjustments must be made in accordance with generally accepted actuarial principles and practices and must be documented in the rate certification (CMS 2021).
- **Non-benefit costs.** The non-benefit component of the rate is calculated separately from health costs and includes expenses related to administration, taxes, licensing and regulatory fees, contributions to reserves, risk margin, and cost of capital. These costs are usually applied across all populations and can be calculated as a percentage of premiums, as a fixed amount, or different approaches can be taken for different categories of costs. Non-benefit costs are added to each rate cell to determine the total capitation payment for each rate cell.
- **Special contract provisions.** States can include a variety of contract arrangements that further adjust the payments made to MCOs (42 CFR 438.6). These arrangements may include incentives, withholds, risk-sharing mechanisms, state directed payments, and pass-through payments, each of which are subject to specific regulatory requirements. Total payments under the incentive arrangement (i.e., capitation rate plus incentive payment) cannot exceed 105 percent of the approved capitation payments (42 CFR 438.6(b)(2)). The other arrangements are discussed in more detail in the following sections.

CMS reviews state rate-setting methods to ensure compliance with federal requirements as part of the annual contract review process, and CMS approval of capitation rates is necessary before states can claim federal match for payments made to MCOs (42 CFR 438.3). CMS provides states with guidance, originally



a checklist developed in 2003 that was updated to an annual rate development guide in 2014, to support the review of state-submitted actuarial certifications and associated data and documentation (CMS 2021). States must submit an attestation from the state's actuary that certifies that the capitation rates are actuarially sound and provide supporting documentation for the elements described in the rate certification (e.g., adjustments to baseline data, projections of future costs) in sufficient detail that CMS can determine whether the regulatory standards are met. CMS often asks states and their actuaries for additional information or documentation before approving the rates. The federal review process for each rate certification or subsequent change to the rates can take several months.

After a 2010 U.S. Government Accountability Office (GAO) report found inconsistent review of state rate certifications by CMS regional offices, CMS strengthened its oversight (GAO 2010). For example, in 2013, CMS began developing new tools to collect standardized information regarding state rate-setting methods, data sources and practices, and to identify payment practices that constitute high risk, either to actuarial soundness or program integrity. It also developed additional training and other strategies to standardize CMS regional office review of rate setting documentation and began collaborating with CMS actuaries in the Office of the Actuary (OACT).

CMS review of each state capitation rate certification now includes three components:

- a compliance check to ensure that the benefits, populations, and program factors incorporated into the rates are consistent with the MCO contract and with the state's waiver terms and conditions (if applicable);
- an actuarial review to ensure that the actuarial components of the rate development process result in capitation rates that meet the actuarial soundness standard (e.g., reasonableness of the trend for the enrolled population, and the cost assumptions underlying each non-benefit expense); and
- a policy review to ensure compliance with federal rules (e.g., limits on in lieu of services).

Tools to Manage Uncertainty

A core component of managed care is the transfer of risk for health care use and cost from the state to MCOs through prospectively set capitation rates. However, states and MCOs face challenges in projecting and managing spending, including the high variability of health care needs among Medicaid beneficiaries and lack of historical claims experience when new population groups are added. States use many tools to mitigate the risk of setting rates too high or too low, which can affect program stability and sustainability; they can adjust individual rate cells or overall health plan payments to account for variation in enrollee risk, uncertainty in the rate setting process, and health plan performance unknowns. States are not generally required to use these techniques, but when they do, they are subject to rules that ensure that MCO payments remain actuarially sound. Further, any risk mitigation methods must be documented in the rate setting certification reviewed by CMS and cannot be changed during the contract period or added retrospectively after the start of the contract (42 CFR 438.6(b)(1)).



While these tools are intended to mitigate the inherent uncertainties associated with a prospective rate-setting process, they do not address all risks, including significant or unanticipated events such as the COVID-19 pandemic. Other unpredictable events that can adversely affect the stability of a managed care program if they occur within the rating period include the introduction of a new high-cost treatment, a localized natural disaster, or a major facility closure or merger. For these reasons, MCOs must hold financial reserves and capitation rates include a risk margin and a component for additional contributions to reserves. MCOs can also limit their risk through reinsurance, participation in high-risk pools, or other mechanisms.⁴

Medical loss ratio and profit caps

Medical loss ratios can protect Medicaid from paying for excessive administrative expenses or profits. States have always been allowed to impose an MLR or similar medical spending target, as long as the targets met federal requirements for actuarial soundness. Since 2019, states have been required to develop managed care capitation rates such that each MCO can reasonably achieve an MLR of at least 85 percent for the rate year. States can choose whether to implement a minimum MLR and whether to require health plans to pay back any excess revenue between the minimum threshold and what the plan spent on health care (in the form of a remittance back to the state and federal government) (42 CFR 438.8(j)). If a state chooses to impose remittance requirements, the state must have an MLR equal to or higher than 85 percent (42 CFR 438.3). For more information on Medicaid MLRs, see *Medical Loss Ratios in Medicaid Managed Care* (MACPAC 2022).

As an alternative to the MLR, states can implement profit caps on health plans. These caps limit only profit, not administrative spending; however, some states may limit the amount of administrative spending that can be counted in the profit cap calculation. They are often structured so that the plan can retain profits up to a certain percentage, then must return a portion of any profit above that up to a higher threshold.

Risk corridors

States can use risk corridors or other forms of risk sharing to mitigate financial risks to both the state and MCOs and help limit the risk of adverse selection. Risk corridors allow the plan and state to share in costs or savings beyond a certain threshold. States often use them for new programs, such as the Financial Alignment Initiative for dually eligible beneficiaries. They may also be used when there is significant variability or uncertainty in the assumptions used to develop the rates, such as when states enroll new population groups into Medicaid plans and actuaries do not have sufficient historical claims experience to set base rates.

Risk corridors allow MCOs and the state to share potential savings—and losses – although there are limits on the amount of savings that can be retained by plans (42 CFR 438.6(a)). For example, as part of a risk sharing agreement, the state can agree to make payments to MCOs with claims above a target threshold (e.g., 105 percent of the capitation rate) and recoup money from those whose claims fall below the threshold (e.g., 95 percent of the capitation rate). While risk corridors are most commonly structured around benefit spending, they can also be used to mitigate the risk associated with certain actuarial



assumptions, such as the mix between institutional and non-institutional LTSS when developing a blended LTSS capitation rate.

Risk adjustment and acuity adjustment

States use risk adjustment to adjust capitation payment rates to better reflect the health status and expected costs of the populations enrolled in each MCO; this mitigates financial risks to MCOs and helps limit the risk of adverse selection. Risk adjustment techniques account for enrollee health status via relative risk factors to reduce the incentive for plans to enroll healthier beneficiaries, avoid enrolling sicker beneficiaries, or limit access to care by beneficiaries with greater than average health care needs.

Based on the relationship between these characteristics and costs, the models calculate a risk score for each individual or for groups with similar characteristics, relative to the average of all enrollees. Whether risk adjustment is applied prospectively or retrospectively, states must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner across all MCOs. That is, increased payments to one MCO must be offset by decreased payments to other MCOs (42 CFR 438.5(g)).

Most states use the Chronic Illness and Disability Payment System (CDPS) model for risk adjustment, in part because it was specifically developed for Medicaid-enrolled adults and children (Courtot et al. 2012). States sometimes use other models instead of, or in addition to CDPS, such as ambulatory care groups (ACGs), clinical risk groups (CRGs) or the Medicaid Rx system, which takes into account prescription drug use. While some risk adjustment tools are better than others in predicting costs, even the most accurate explain less than 30 percent of variation in medical costs across individuals on a prospective basis (Hileman and Steele 2016).⁵ States must also decide how to implement the selected risk adjustment model, such as deciding how often to update the risk factors and how to adjust for new enrollees and new plans.

Use of managed care for people over the age of 65, those with disabilities, and those who use LTSS, has increased the need to add information on functional status to risk adjustment models. However, it can be challenging for states to obtain data from comprehensive assessments of each enrollee's health and functional status to develop risk adjustment models, risk scores, or algorithms to adjust rates for enrollees of each plan. Some states have instead developed a rate cell structure that accounts for functional status and provide an incentive for MCOs to deliver care through home and community-based services instead of a nursing facility.

States may use an acuity adjustment to account for significant uncertainty about the health status of a population. The primary difference is that an acuity adjustment is applied to the total payments across all MCOs and is not budget neutral. Acuity adjustments are not used frequently and generally only when there is significant uncertainty about the health status or risk of a population such as when a new population group (e.g., new adult group) comes into Medicaid, or when enrollment is voluntary and there is concern about adverse selection. The capitation rates for all plans are generally adjusted by a factor determined by the ratio between the risk score projected during rate development and the actual risk scores of the population.



Withholds

States can use withholds to hedge against performance risks by withholding a portion of the MCO payment until contract results are available. Under a withhold arrangement, the state only pays the MCO this amount if the MCO meets certain performance standards or quality of care targets specified in the contract. There is no percentage limit on the amounts that can be withheld from the capitation, but states must demonstrate to CMS that, if a portion of a capitation rate is withheld because the MCO did not meet the targets, the capitation rate will still be actuarially sound (42 CFR 438.6(b)(3)).

States can choose to return withholds based on various criteria --for example, if MCOs achieve specified benchmarks, show a certain amount of improvement, or demonstrate a high level of performance relative to other MCOs. States cannot tie withholds to noncompliance with general operational requirements. (These can be achieved through contract penalties.) Additionally, some states have used withholds to fund high-cost risk pools to help offset costs should a plan have a disproportionate share of high-cost individuals.

Medicaid-Specific Rate Setting Issues

Many aspects of Medicaid capitation rate setting are based on standard actuarial practices and are similar to the approaches used to develop premiums or rates for other insurers. However, several Medicaid-specific programmatic requirements affect rate setting.

In-lieu-of and value-added services

CMS has long permitted MCOs to provide medically appropriate, cost-effective substitutes in lieu of state plan services included under the contract. For example, an MCO can offer in-home provider visits as an alternative to traditional office visits, or a mobile crisis assessment as an alternative to traditional emergency behavioral health services. In-lieu-of services that address social determinants of health can include in-home therapy services in place of transportation to a provider office, or medically tailored meals that meet the unique dietary needs of an enrollee to prevent hospitalization or a nursing facility placement.

In the 2016 update to the managed care rule, CMS created additional requirements around rate setting and documentation of these services (42 CFR 438.3(e)(2)). Specifically, because an in-lieu-of service is considered a substitute for a covered setting or service, the in-lieu-of service should be treated like a service under the contract. Therefore, the utilization and cost associated with any in-lieu-of services should be included in the MCO encounter data and taken into account in developing the component of the capitation rates that represents covered services.

Also as part of the 2016 rule, CMS created a specific exception for stays in an institution for mental disease (IMD), which allows IMD services to be used as an in-lieu-of service but limits Medicaid payment to 15 days per month (42 CFR 438.6(e)). Further, unlike other in-lieu-of services, the costs of an IMD as an in-lieu-of-service must not be used in rate development. Use of services provided to an enrollee in an IMD can be used in developing the utilization component of projected benefit costs, but the utilization must be



repriced to reflect what the cost would have been if the same services were delivered through providers covered under the state plan.

Value-added or additional services are services that the MCO may provide in addition to covered Medicaid services (42 CFR § 438.3(e)(1)). These can be either medical or non-medical services. They can include wellness incentives such as gift cards or car seats for completing prenatal classes, as well as additional services designed to address the social determinants of health. For example, MCOs can provide enabling services such as case management or transportation services not covered under the state plan; post-discharge meals; homeless lodging; and transitional housing. Value-added services generally are paid for out of an MCO's profit margin and the cost of providing these services is not specifically factored into capitation rate setting.

Pass-through payments

When states implement managed care, hospitals and other institutional providers that have received supplemental payments capped at the federal upper payment limit may see a significant reduction in these payments, as federal rules require that these payments be calculated using only FFS utilization. Further, under actuarial soundness rules, states may not make supplemental payments for services covered under the managed care contract (42 CFR 438.60).⁶ This is because if rates are sufficient to cover the reasonable, appropriate, and attainable costs of providing services covered under the managed care contract, then plans and providers would not need additional payments for these services.

Prior to 2016, a small number of states offset the loss of FFS supplemental payments by increasing capitation rates paid to MCOs and required MCOs to direct these additional funds to particular providers. These pass-through payments were typically not tied to use of services and were often financed by providers through intergovernmental transfers or provider taxes. As part of the 2016 regulatory update, CMS required states to phase out the use of pass-through payments while also creating a new option for states to direct payments to providers under certain conditions. In recognition that the move to managed care can lead to a loss of supplemental payment funding for some providers, in 2020 CMS further amended the managed care rule to allow states that are newly transitioning to managed care to make new pass-through payments for up to three years (42 CFR 438.6(d)(6)). States must include details on any pass-through payments in the rate certification and supporting documentation.

Directed payments

Under the directed payment option, states can require MCOs to pay providers according to specific rates or methods. Typically, states use directed payments to establish minimum payment rates for certain types of providers, to implement uniform rate increases for certain provider types, or to require participation in value-based payment arrangements that advance the state's quality and access goals.

In 2017, CMS issued guidance and a pre-print form for states to use when applying for approval of directed payment arrangements (CMS 2017). CMS reviews directed payment pre-prints using a process similar to that used to review Medicaid state plan amendments. After approval, states must incorporate the directed payment arrangement into their managed care contracts and capitation rates. The portion of the capitation



rate that is attributable to directed payments is then included in the actuarial rate certification that CMS reviews. For more information, see *Directed Payments in Medicaid Managed Care* (MACPAC 2020).

Rate cell cross-subsidization

Most Medicaid capitation payments are matched at the state's regular federal matching assistance percentage (from 50 to 83 percent depending on the state). However, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires the federal government to pay 90 percent of state Medicaid costs for certain newly eligible individuals.

To ensure that states do not increase federal expenditures by shifting costs to the rate cells eligible for higher federal match, states must certify that payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell. Federal rules require that any differences in the assumptions, methodologies, or factors used to develop capitation rates among different eligibility groups or covered populations must represent the actual cost differences in providing covered services and cannot vary with the rate of federal match in a manner that increases federal costs (42 CFR 438.4(b)(1)). CMS may require states to document or demonstrate how the differences in assumptions, methodologies, or factors for different populations represent the actual cost differences.

Endnotes

¹ Any contract amendments during a contract period that affect the covered populations or services (e.g., expansion of Medicaid to include low-income adults, moving dental benefits from FFS to managed care) can require a change to the capitation rates and re-review by CMS.

² Rate development generally takes actuaries three to six months to complete. Actuaries must use data from a prior contract period to develop rates for the subsequent contract period.

³ The upper bound of the rate range may not be more than 5 percent higher than the lower bound of the rate range (42 CFR 438.4(c)(1)(iii)). The state must document the criteria for paying managed care plans at different points within the rate range.

⁴ Reinsurance is a mechanism that protects MCOs from excessive or high-cost, low-frequency claims. States can require MCOs to either purchase reinsurance on the open market or participate in a state-sponsored reinsurance program.

⁵ Prospective risk adjustment uses historical experience to calculate risk scores for the rating period (e.g., diagnoses from calendar year (CY) 2019 are used to calculate risk scores for a CY 2020 rating period). Concurrent risk adjustment uses experience from the same period as the rating period (e.g., diagnoses from CY 2020 are used to calculate risk scores for at the end of a CY 2020 rating period). Concurrent models have been found to have higher predictive power than prospective models and can explain around 50 percent of the variation in medical costs (Hileman and Steele 2016).

⁶ States are permitted to make pass-through or wrap-around payments in certain circumstances, including graduate medical education (GME) payments, federally qualified health center (FQHC), and rural health center (RHC) wraparound payments.



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