MACPAC

Transparency and Oversight of Directed Payments in Medicaid Managed Care

Medicaid and CHIP Payment and Access Commission

Michelle Millerick and Rob Nelb

Overview

- Background
- Use and characteristics of directed payments
- Themes from interviews
  - Many directed payment arrangements are similar to fee-for-service (FFS) supplemental payments
  - Directed payments are a large share of Medicaid payments for some providers
  - Directed payment spending is growing substantially with no upper limit
  - The effects of directed payments on quality and access are unclear
  - The rapid growth of directed payments has created oversight challenges
- Policy approaches and next steps

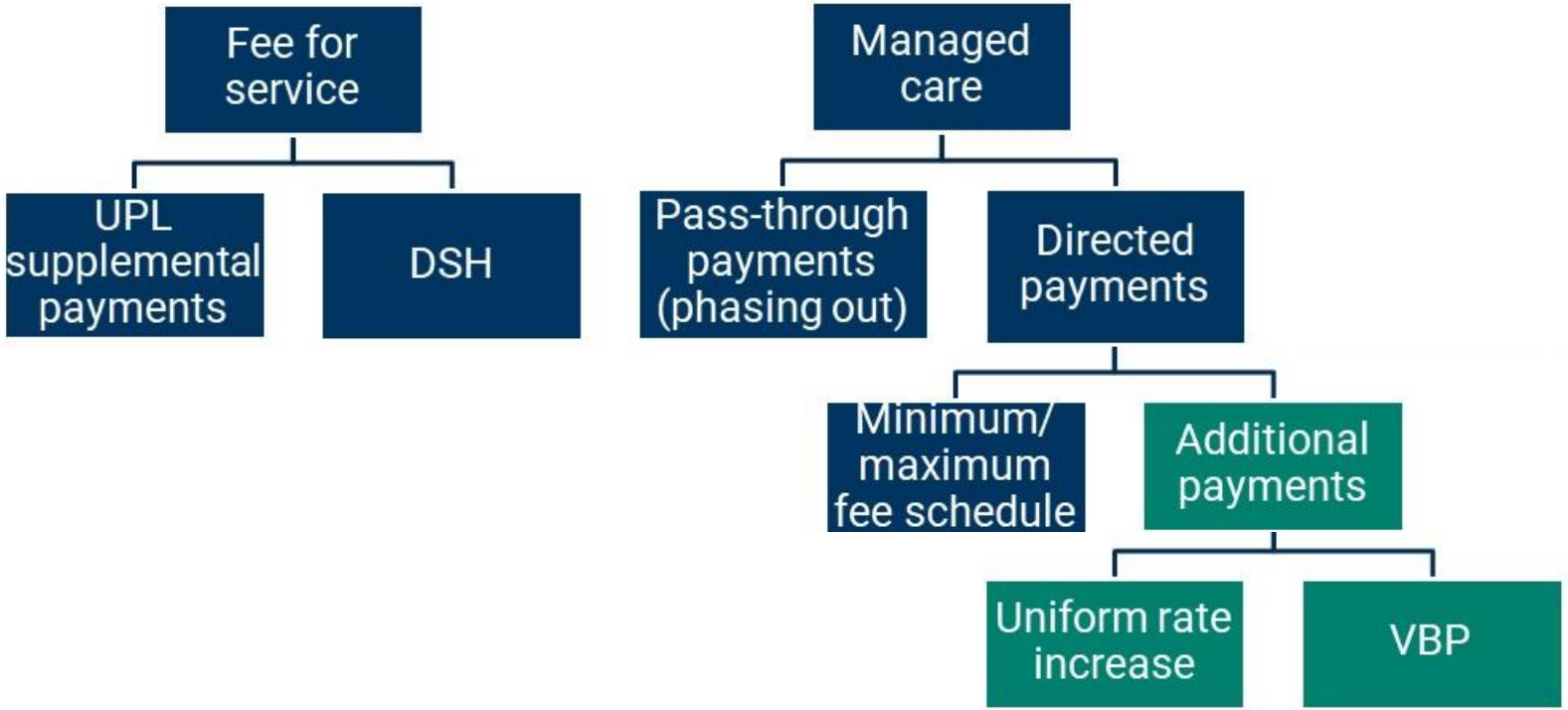
Supplemental Payments and Managed Care

- In FFS, states can make supplemental payments up to the upper payment limit (UPL)
  - For hospitals and other institutional providers, UPL is a reasonable estimate of what Medicare would pay
  - For physicians, UPL is the average commercial rate (ACR)
- Prior to 2016, states were not allowed to make supplemental payments for services provided in managed care
  - Some states required MCOs to make additional payments to providers, known as pass-through payments
  - 2016 managed care rule phased out the use of pass-through payments over 10 years and created a new option for directed payments

Directed Payment Option

- States can direct managed care payments to providers if they meet certain criteria:
  - Tied to services provided under the managed care contract
  - Advance at least one of the goals of the state's quality strategy
  - Are not conditioned on provider participation in intergovernmental transfer (IGT) funding agreements
- States must submit a pre-print application to CMS for review prior to implementing a directed payment arrangement
- Directed payment arrangements are typically approved for one year and are not renewed automatically

Types of Supplemental Payments



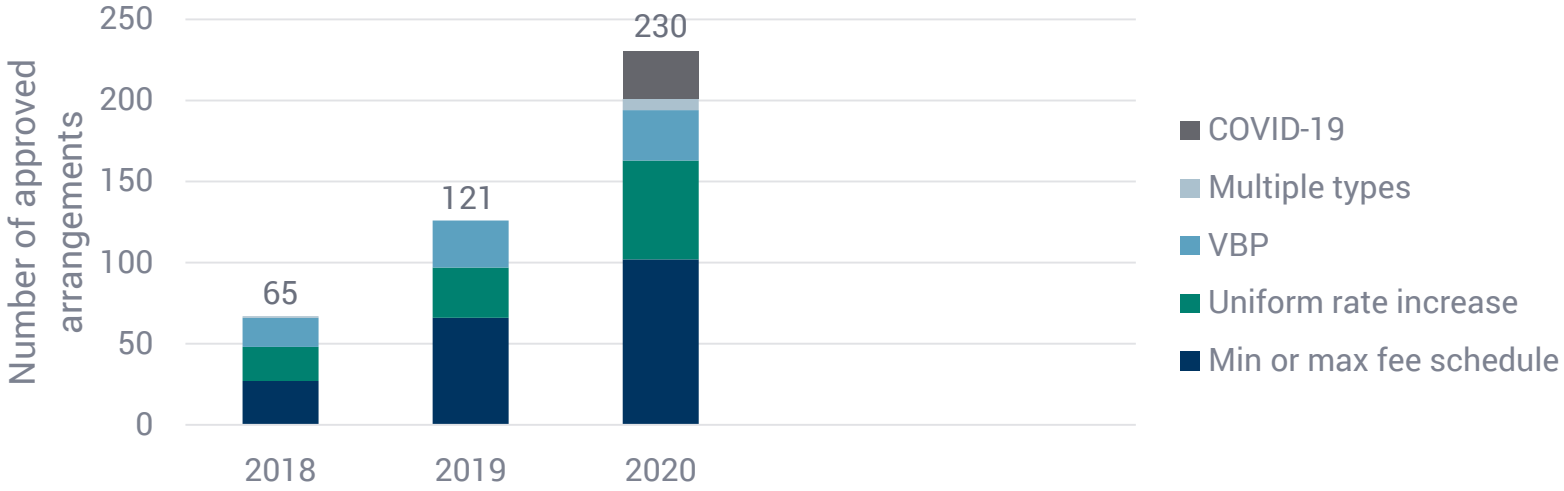
Notes: UPL is upper payment limit. DSH is disproportionate share hospital. VBP is value-based payment.

Methodology

- Review of approval documents:
  - Requested and obtained pre-prints and associated approval documents from CMS
  - Reviewed pre-prints and associated approval documents for all directed payment arrangements approved as of December 31, 2020 (n=230)
- Interviews
  - Conducted structured interviews in five states (California, Florida, Massachusetts, Ohio, and Utah)
  - In each state, we interviewed state officials, providers, and managed care representatives
  - We also interviewed national experts, actuaries, and staff from CMS

Use and Characteristics of Directed Payments

Growth of Approved Directed Payment Arrangements, 2018-2020

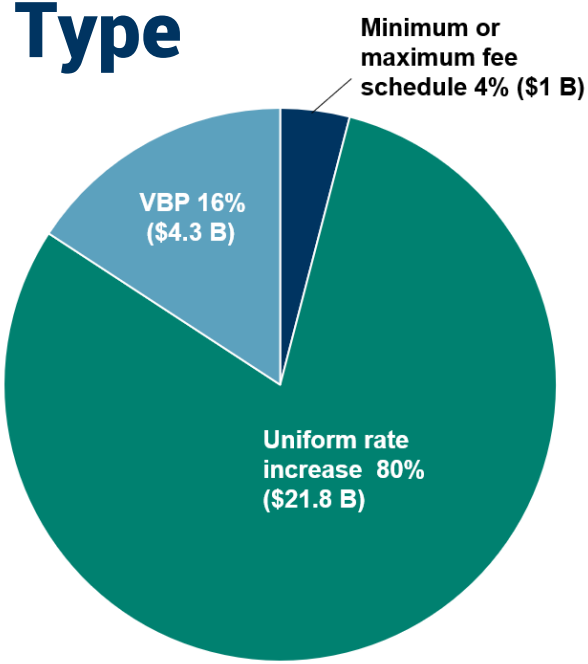


Notes: VBP is value-based payment. Number of approved arrangements excludes prior versions of directed payment arrangements that have been renewed or amended after they were initially approved.
Source: MACPAC, 2020, analysis of directed payments approved as of June 6, 2019; Mathematica, 2021, analysis for MACPAC of directed payment pre-prints approved through December 31, 2020, and Pettersson, J., B. Mori, L. Roth, and J Clarkson. 2018. Approved Medicaid state directed payments: How states are using §438.6(c) preprints to respond to the managed care final rule, Seattle, WA: Milliman, http://www.milliman.com/insight/2018/Approved-Medicaid-state-directed-payments-How-states-are-using-438_6c-Preprints-to-respond-to-the-managed-care-final-rule/.

Projected Directed Payment Spending

- Projected spending estimates were available for less than half of the approved arrangements
- Of the 96 arrangements with estimates, states projected potential spending of $27.1 billion
  - This is larger than spending on disproportionate share hospital (DSH) ($19.7 billion) or upper payment limit (UPL) supplemental payments ($19.1 billion) in FY 2019.
- Amounts are often missing and there are significant inconsistencies
  - Projected spending for 105 of the approved arrangements is unknown
  - Spending is projected; not actual expenditures
  - Unclear in some cases whether spending is for renewal year or entire arrangement
  - Some arrangements use more than one type of payment method making it difficult to allocate estimated payment amounts for each payment and provider type

Projected Directed Payment Spending by Arrangement Type



- Additional payments to providers account for approximately $26 of the $27 billion in projected spending

Notes: DSH is disproportionate share hospital. UPL is upper payment limit supplemental payments. Projected spending amounts include the estimated amount from the most recently approved arrangement between 2017 and 2020. Total estimated spending amounts where available are projected by states at the time of pre-print submission and are not reconciled with actual spending.
Source: Mathematica, 2021, analysis for MACPAC of directed payment pre-prints approved through December 31, 2020.

Use of Additional Payments to Providers

- Targeting
  - Most are targeted to hospitals and hospital-affiliated physicians
- Financing
  - Most are financed by provider taxes and IGTs
  - Targeting appears related to the financing of the non-federal share
- Quality goals
  - Stated intent of most uniform rate increases is to improve access
  - Unclear whether there have been meaningful improvements above what is already required under managed care network adequacy requirements

Perspectives on the Use of Directed Payments

Relationship to Supplemental Payments

- States have used directed payments to preserve the ability to make supplemental payments to providers in managed care
  - Preserving prior pass-through payments
  - Continuing expiring Section 1115 demonstration waiver supplemental payments (e.g., Delivery System Reform Incentive Payments, DSRIP) that will expire
- Utilization requirement for directed payments is different from other authorities and may affect distribution of payments
- States are increasingly using directed payments to make new supplemental payments that do not replace prior payments

Directed Payments Represent a Large Share of Medicaid Payments to Some Providers

- Providers noted that directed payments were often important for their financial viability
- In some states, directed payments can be larger than DSH or UPL supplemental payments to providers
  - One of Ohio's new directed payments is 4 times greater than what the eligible hospitals received in UPL payments and 6.5 times greater than what they received in DSH payments in 2017
  - In Michigan, directed payments accounted for 40 percent of managed care payments to hospitals in the state in 2016
- Source of non-federal share often influenced state decisions to use directed payments rather than base payment rate increases

Lack of Upper Limits

- No statutory or regulatory upper limit on directed payments
  - Actuarial soundness rules do not provide a clear upper limit
- Most additional payments to providers used benchmarks similar to the UPL
  - Many arrangements make payments up to the ACR for hospital-based physicians
  - ACR is higher than Medicare would have paid
- We identified seven directed payments for hospital services that exceeded FFS UPL limits
  - Actuaries noted that state interest in making payments above the UPL is growing
- CMS asks states about how directed payments compare to the UPL but does not appear to have the authority to limit them

Relationship to Quality and Access Goals

- Most directed payment arrangements do not have evaluations, even after being renewed and operating for multiple years
  - Evaluation results are often not publicly available
  - It is not clear how CMS uses evaluation results in its review
- Results so far are mixed
  - Some have shown incremental improvements
  - Some reported worse outcomes and were still renewed
- Challenges with evaluation include:
  - Data lags and short time frame
  - Lack of alignment between access measures and payment goals
  - Disruptions caused by the COVID-19 pandemic
- New, multi-year approval option for value-based payment directed payments may allow more time to measure and evaluate effects

CMS Oversight

- CMS did not anticipate the rapid growth in the use of directed payments
  - The large volume of arrangements has been challenging to review
  - State officials expressed frustration with the time required for CMS review and the need for more clear guidance
- CMS issued new pre-print template and guidance in January 2021 to address some of these issues
- CMS does not track spending on directed payments after approval

Policy Approaches

Potential Policy Approaches

- Make directed payment information publicly available
  - Approval documents
  - Payment amounts
  - Evaluation results
- Establish an upper limit on directed payments similar to the UPL in FFS
- Be more explicit on how directed payments should relate to quality and access goals

Next Steps

- Staff would appreciate Commissioner feedback on the issues raised in this presentation as well as the potential policy options
  - Right set of policy options? Any that are missing? Others that should be removed?
  - What additional information might you need to support your decision-making?
- Staff can flesh out policy options further to present at an upcoming meeting, potentially for inclusion in a June chapter

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