Chapter 2:

Oversight of Managed Care Directed Payments

Oversight of Managed Care Directed Payments

Recommendations

2.1 To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should make directed payment approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website.

2.2 To inform assessments of whether managed care payments are reasonable and appropriate, the Secretary of the U.S. Department of Health and Human Services should make provider-level data on directed payment amounts publicly available in a standard format that enables analysis.

2.3 To provide additional clarity about the goals and uses of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to quantify how directed payment amounts compare to prior supplemental payments and clarify whether these payments are necessary for health plans to meet network adequacy requirements and other existing access standards.

2.4 To allow for more meaningful assessments of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to develop rigorous, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.

2.5 To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

Key Points

- Managed care directed payments are a large and growing share of Medicaid spending.
  - The Centers for Medicare & Medicaid Services created this new option in 2016 and approved 230 distinct arrangements in 37 states by the end of 2020.
  - Although information on spending under this new option is extremely limited, state projections indicate that total spending exceeded $25 billion in 2020.
- States use directed payment arrangements for a variety of purposes.
  - Many directed payment arrangements set base payment rates for services provided in managed care.
  - Some states use this option to increase the adoption of value-based payment methods.
  - Some states make large additional payments to providers, similar to supplemental payments in fee for service.
- More transparency is needed to understand how much is being spent and the extent to which these payments are advancing quality and access goals.

CHAPTER 2: Oversight of Managed Care Directed Payments

There are two major categories of Medicaid payments: (1) base payments for services and (2) supplemental payments, which are additional payments to providers that are typically made in a lump sum for a fixed period of time. In fee for service (FFS), states set payment levels for both types; in managed care, states pay managed care organizations (MCOs) a per-member per-month capitation rate and historically have had little control over the rates that MCOs pay providers.[1] Because the capitation rate is intended to be sufficient to cover the cost of the services specified in the MCO contract, the Centers for Medicare & Medicaid Services (CMS) does not allow states to make supplemental payments for services provided through managed care.[2]

In 2016, CMS created a new option for states to require MCOs to pay providers according to specified rates and methods, referred to as directed payments. Many states have used directed payments to set parameters for base payment rates (e.g., requiring MCOs to pay no less than the state's FFS payment rate), and some states are using this option to increase the use of value-based payment (VBP) methods in managed care. However, a few states are also using the directed payment option to make large additional payments to providers that do not have a clear link to quality or access goals, similar to supplemental payments in FFS.

Since 2016, the use of directed payments has grown substantially. As of August 2018, CMS had approved 65 distinct directed payment arrangements in 23 states (Pettersson et al. 2018).[3] By December 2020, based on MACPAC's review of directed payment approval documents (which are not publicly available), this had grown to 230 distinct arrangements in 37 states.[4] Some states are using directed payments to preserve prior payment arrangements, and some are using directed payments to make new payments to providers.

Available information on directed payment spending is extremely limited, but according to state projections, total spending was more than $25 billion in 2020.[5] This amount is greater than fiscal year (FY) 2020 spending on each of the two largest types of FFS supplemental payments—disproportionate share hospital (DSH) and upper payment limit (UPL) payments.[6] Moreover, this estimate is an undercount given that spending information was not available for more than half of approved directed payment arrangements that we reviewed.[7]

Because directed payments are such a large and growing share of Medicaid spending, policymakers and the public have an interest in knowing more about where this money is being spent and the extent to which these payment arrangements are advancing quality and access goals for Medicaid beneficiaries. The Commission has long been concerned about the transparency and oversight of FFS supplemental payments, and so we are particularly concerned that directed payments have even less transparency.

In the Commission's view, assessment of Medicaid payment policy requires information on all types of Medicaid payments that providers receive. Because directed payments appear to account for more than half of Medicaid managed care payments to some hospitals, physicians, and other providers, lack of information about these payments severely limits our ability to understand whether Medicaid payments are consistent with statutory principles (MACPAC 2015a).

The Commission is also concerned about the potential of some directed payment arrangements to undermine the integrity of the managed care rate setting process. In general, managed care capitation rates are required to be actuarially sound, meaning that they are sufficient to cover all reasonable, appropriate, and obtainable costs under the contract, including the costs of

complying with managed care access standards. As a result, it is not always clear what additional value is obtained when states use directed payments to substantially increase payments above rates that were previously certified as actuarially sound. In interviews with state officials, CMS, and actuaries, we heard conflicting views about the extent to which actuaries should be involved in the review of directed payment arrangements, suggesting that more guidance and clarity about roles and responsibilities are needed to help ensure that actuarial soundness requirements are being met.

As a first step toward improving the transparency and oversight of directed payments, the Commission makes five recommendations, which are discussed further in this chapter:

- To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should make directed payment approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website.
- To inform assessments of whether managed care payments are reasonable and appropriate, the Secretary of the U.S. Department of Health and Human Services should make provider-level data on directed payment amounts publicly available in a standard format that enables analysis.
- To provide additional clarity about the goals and uses of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to quantify how directed payment amounts compare to prior supplemental payments and clarify whether these payments are necessary for health plans to meet network adequacy requirements and other existing access standards.
- To allow for more meaningful assessments of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to develop rigorous, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.
- To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

Improved transparency about directed payments can also help inform future policy development. In particular, more information about directed payment spending would help inform discussion of whether there should be any upper limits on directed payments, similar to the limits on other types of Medicaid spending. This chapter concludes with a discussion of this issue and potential areas for future work.

Background

The new directed payment option has roots in the history of supplemental payments and managed care as well as state efforts to promote quality and access in managed care.

Supplemental payments and managed care

In FFS, supplemental payments account for a large share of Medicaid payments for some providers. In FY 2020, states made $57 billion in supplemental payments to hospitals, mental health facilities, nursing facilities, and physicians, which was 36 percent of total FFS payments to these providers (MACPAC 2021a).[8]

MACPAC's prior research has found that states often use supplemental payments to offset low base payment rates in circumstances in which states have difficulty financing the non-federal share of Medicaid payments with state general funds. Medicaid is jointly financed by states and the federal government, and states have flexibility to finance the non-federal share of Medicaid payments from multiple sources, including state general funds, provider taxes, and intergovernmental transfers (IGTs) from publicly owned providers and other local government sources. In the absence of state general funds to increase base payment rates, states often collaborate with providers to increase provider contributions toward the non-federal share to implement new Medicaid supplemental payments (Marks et al. 2018).[9]

Federal rules do not allow states to make supplemental payments for services provided in managed care.[10] This limitation was historically a barrier to the expansion of comprehensive managed care in some states because providers that relied on large FFS supplemental payments could lose substantial revenue when a state transitioned from FFS to managed care. For this reason, some states excluded certain services or populations from managed care or sought demonstration waiver authority under Section 1115 of the Social Security Act to continue making supplemental payments in managed care.[11] Other states indirectly made additional payments to providers in managed care by increasing capitation rates paid to MCOs and then requiring MCOs to direct these additional funds to particular providers. These payments, known as pass-through payments, were typically not tied to the use of Medicaid services or performance on measures of quality or access.

As part of its comprehensive update to Medicaid managed care regulations in 2016, CMS required states to phase out the use of pass-through payments because of concerns that pass-through payments were too similar to supplemental payments and thus not consistent with the requirement that managed care rates be actuarially sound. Specifically, CMS noted that "because the capitation payment that states make to a managed care plan is expected to cover all reasonable, appropriate, and attainable costs associated with providing the services under the contract, the statutory provision for managed care payment does not anticipate a supplemental payment mechanism" (CMS 2016). However, because pass-through payments accounted for a large share of Medicaid payments for some providers, CMS allowed states to gradually phase out the use of pass-through payments over 10 years for hospitals and 5 years for physicians and nursing facilities (CMS 2017a).

In place of pass-through payments, the 2016 managed care rule created a new option for states to direct payments to providers under certain circumstances. To limit lump sum payments to providers based on how the payment was financed, CMS required that directed payments be based on the delivery of services covered under the managed care contract, be distributed equally to a class of providers, and not be conditioned on provider participation in IGT agreements. In addition, to address concerns that pass-through payments were not tied to quality and access goals, CMS required directed payments to advance at least one goal of the state's quality strategy and required states to measure the degree to which the payment arrangement achieves these goals. To enforce these requirements, CMS required states to seek prior approval of directed payment arrangements each year.[12]

Promoting quality and access in managed care

CMS's stated goal when creating the directed payment option was to "assist states in achieving their overall objectives for delivery system and payment reform" (CMS 2016). These include efforts to ensure access to an adequate provider network and to increase the use of VBP methods. Although MCOs generally have the flexibility to negotiate payments with providers that advance these goals, the directed payment option provides states with more control over the rates and methods used by MCOs when paying providers.

First, directed payments allow states to require MCOs to increase payment rates to providers, which may help improve provider participation. For example, MACPAC's review of the National Ambulatory Medical Care Survey found that higher Medicaid payment rates were associated with higher rates of physician acceptance of new Medicaid patients (Holgash and Heberlein 2019).

MCOs are already required to provide timely access to care, including access to an adequate network of providers, and actuaries must certify that the capitation rate is sufficient to meet this requirement.[13] In practice, we have found that MCOs often pay providers base payment rates that are similar to FFS, in part because managed care capitation rates are often initially developed based on FFS rates (Marks et al. 2018). FFS base rates are also required to meet federal access requirements (§1902(a)(30)(A) of the Social Security Act), but in many states, base FFS payment rates to hospitals and physicians are below the rate that Medicare would pay for the same service (MACPAC 2017; Zuckerman et al. 2017).

Second, directed payments allow states to require MCOs to increase the use of VBP models, including pay-for-performance incentives, shared savings arrangements, and other alternative payment models. Although a growing share of Medicaid beneficiaries is enrolled in managed care, most Medicaid payments to providers are still made using FFS payment methods that are based on the volume of care provided (HCP-LAN 2021). In contrast, VBP models reward providers for achieving quality goals and, in some cases, cost savings.

MCOs can negotiate VBP arrangements with providers without a directed payment arrangement, but requiring plans to adopt a particular model can help ensure consistency across multiple Medicaid MCOs in a state. States can also set broad VBP targets for the share of Medicaid MCO payments that should be based on value without using a directed payment arrangement (Bailit 2020; Hinton et al. 2022).

Uses of Directed Payments

Our review of approved directed payment arrangements found that states are using directed payments for a variety of purposes. Consistent with CMS's stated goals, many directed payments set parameters on base payments to providers to advance access goals, and some arrangements are intended to increase the use of VBP models in managed care. However, CMS has also approved some arrangements that appear to make large additional payments to providers that are similar to supplemental payments in FFS.

To analyze the uses of directed payments, MACPAC contracted with Mathematica to review directed payment approval documents for all states. This information is not publicly available, but CMS provided it to us for this analysis. Overall, of the 490 state directed payment arrangements that had been approved, renewed, or amended as of December 31, 2020, we identified 230 distinct arrangements that targeted the same providers using a similar payment method for one or more rating periods. Twenty-nine of these arrangements were temporary changes approved through an expedited approval pathway created during the COVID-19 pandemic; these arrangements are excluded from our analyses. The approval documents that we reviewed included the CMS standard application form (referred to as a preprint) as well as state responses to CMS questions about payment amounts, financing, and other information that is not included on the preprint.

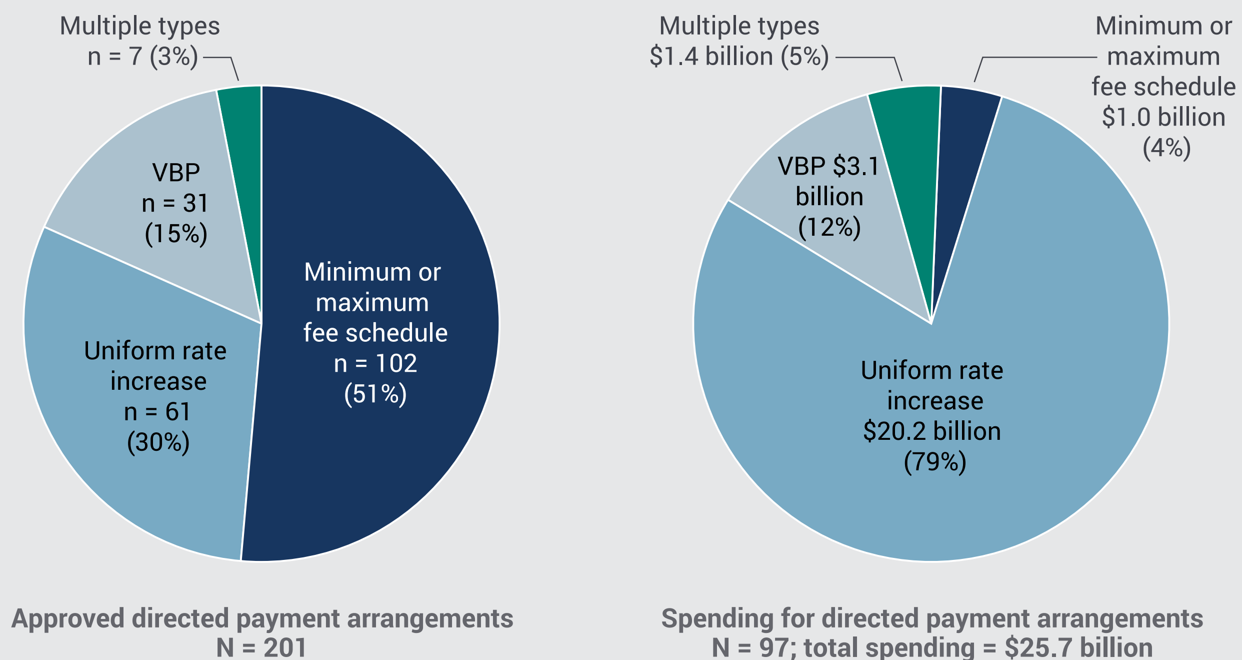
Mathematica also interviewed state officials and stakeholders in five states (California, Florida, Massachusetts, Ohio, and Utah) to learn more about why states are using directed payments and how states are assessing the effects of directed payments on quality and access goals. In addition, the project team interviewed CMS officials and actuaries who work with multiple states.

Types of directed payments

In our review, we classified directed payments into three categories based on the distinctions that CMS uses in its current directed payment preprint form:

- **Minimum or maximum fee schedule:** a type of directed payment that sets parameters for the base payment rates that managed care plans pay for specified services. Most of these fee schedules require MCOs to pay providers no less than the FFS rate approved in the Medicaid state plan. Some states also use the Medicare fee schedule or another fee schedule established by the state to set minimum or maximum payment rates for providers.
- **Uniform rate increase:** a type of directed payment that requires MCOs to pay a uniform dollar or percentage increase in payment above negotiated base payment rates. These types of arrangements are the most similar to supplemental payments in FFS.
- **VBP:** a type of directed payment that requires MCOs to implement VBP models, such as pay-for-performance incentives, shared savings arrangements, or other alternative payment models. This category also includes arrangements that require MCOs to participate in multipayer or Medicaid-specific delivery system reforms.

FIGURE 2-1. Directed Payment Types and Projected Payment Amounts, 2020



Notes: VBP is value-based payment. This analysis is based on a review of unique directed payment arrangements approved through December 31, 2020, and excludes temporary directed payments approved under the expedited COVID-19 pathway (n = 29). Prior versions of directed payment arrangements that were subsequently renewed or amended are also excluded (n = 260). Projected payment amounts are for the most recent rating period, which may differ from calendar year or fiscal year 2020. In addition, projected spending reported in directed payment approval documents may differ from actual spending. Percentages may not sum to 100 due to rounding.

Source: Mathematica, 2021, analysis for MACPAC of directed payment preprints approved through December 31, 2020.

Within each of these categories, there is wide variation in the size and scope of arrangements. For example, some uniform rate increases make incremental adjustments to base payment rates (e.g., a 10 percent increase), while others make large additional payments that are greater than the original base payment rate. Similarly, some VBP arrangements require participation in arrangements that do not increase spending, while others provide large additional pay-for-performance incentives to providers, similar to delivery system reform incentive payments (DSRIP) authorized under Section 1115 demonstrations (MACPAC 2020).

Number of directed payments and projected spending amounts

Of the 201 directed payment arrangements not related to COVID-19, approximately half were minimum or maximum fee schedules, and about one-third were uniform rate increases (Figure 2-1). However, uniform rate increases accounted for the vast majority of projected directed payment spending that was available for our review. Thirty-five states, the District of Columbia, and Puerto Rico had at least one approved directed payment arrangement, and five states (Arizona, California, Massachusetts, New York, and Washington) had 10 or more distinct arrangements.

The spending data in the approval documents we reviewed was extremely limited. Less than half of directed payment approval documents included information about projected spending amounts, and those that did so did not always present it in a consistent format.[14] Moreover, during our interviews with states, we learned that actual spending on directed payments was sometimes higher or lower than the amount projected in approval documents.

Based on the information that was available for our review, a small number of directed payments account for the vast majority of projected spending. Specifically, about 90 percent of all directed payment spending that we identified was attributable to the 35 directed payment arrangements that were projected to increase payments to providers by more than $100 million a year. Most of these arrangements were uniform rate increases, but some were large pay-for-performance incentive payments, similar to DSRIP. The majority of these arrangements (20 of the 35 we identified) increased provider payments above the Medicare payment rate, which is generally used as the basis for setting an upper limit on FFS payments (MACPAC 2021c).

Currently, no upper limit exists on the amount of directed payments that states can make. In general, it appears that CMS has often permitted states to pay providers as high as the average rate that providers negotiate with private payers (referred to as the average commercial rate), which is often much higher than the amount Medicare would have paid for the same service. For example, in some cases, we found examples of directed payments that paid almost three times the Medicare rate for hospitals inpatient and outpatient services.

Targeting and financing of payments

The targeting and financing of directed payments varied based on the directed payment type (Table 2-1). Minimum or maximum fee schedules were often targeted to behavioral health providers; uniform rate increases were most often targeted to hospitals; and VBP arrangements were most often targeted to physicians, including those employed by academic medical centers or public hospital systems. Minimum or maximum fee schedules and VBP arrangements were often financed with state general funds, but most uniform rate increases were financed by providers through provider taxes or IGTs.

The largest directed payment arrangements are typically targeted to hospitals and financed by them. Of the 35 directed payment arrangements projected to increase payments to providers by more than $100 million a year, 30 were targeted to hospital systems and at least 27 were financed by provider taxes or IGTs.[15] During our interviews,

TABLE 2-1. Directed Payment Programs by Payment Type, Provider Type, and Funding Source, 2020

Directed payment characteristics	Minimum or maximum fee schedule		Uniform rate increase		VBP		Total	
	Number	Share	Number	Share	Number	Share	Number	Share
Total	**103**	**100%**	**68**	**100%**	**37**	**100%**	**201**	**100%**
Provider type								
Hospitals	19	18	30	44	9	24	58	29
Professional services at AMCs or public hospital systems	6	6	23	34	11	30	36	18
Physicians and other professional service providers	13	13	6	9	10	27	29	14
Behavioral health and substance abuse providers	39	38	8	12	9	24	56	28
Nursing facilities	14	14	7	10	3	8	21	10
Dental providers	7	7	3	4	1	3	11	5
HCBS providers	9	9	2	3	–	–	11	5
Transportation services	6	6	1	1	–	–	7	3
Other	15	15	3	4	5	14	23	11
Funding source								
State general fund	38	37	29	43	20	54	86	43
IGT or CPE	5	5	28	41	14	38	42	21
Health care-related tax	5	5	20	29	4	11	28	14
Other non-state general fund	–	–	2	3	1	3	3	1
Not specified	58	56	2	3	1	3	61	30

Notes: VBP is value-based payment. AMCs are academic medical centers. HCBS is home- and community-based services. IGT is intergovernmental transfer. CPE is certified public expenditure. This analysis is based on a review of unique directed payment arrangements approved through December 31, 2020, and excludes temporary directed payments approved under the expedited COVID-19 pathway (n = 29). Prior versions of directed payment arrangements that were subsequently renewed or amended are also excluded (n = 260). Totals do not sum because a single directed payment arrangement can target multiple provider types or have multiple funding sources.

– Dash indicates zero.

Source: Mathematica, 2021, analysis for MACPAC of directed payment arrangements approved through December 31, 2020.

stakeholders noted that the amount of available IGTs or provider taxes often determined the total amount of spending for these types of arrangements. Once this available pool of funding was determined, states then worked backward to calculate the percentage increase in provider rates.

Goals of directed payments

The stated goal of most directed payment arrangements (60 percent) was improving access to care. However, the level of detail about access goals provided in directed payment approval documents varied widely. In some cases, the goal was to ensure that providers remain in the MCO network, and in other cases, the goal was more specifically related to beneficiaries' ability to obtain care in a timely manner.

VBP directed payment arrangements were more likely to address other goals, such as increasing receipt of preventive screenings and reducing avoidable hospital use. During our interviews, several of the stakeholders expressed interest in aligning the measures used to monitor directed payment performance with those used to monitor MCO performance, but they also noted the many operational challenges involved in adjusting MCO contracts to align these measures.

In addition to quality and access goals, stakeholders noted that directed payments were a useful tool for making FFS and managed care payment policies consistent. For example, in Massachusetts, which uses multiple delivery system models, the state has implemented several minimum fee schedules that are intended to ensure parity between managed care and FFS rates. For states transitioning new services or populations from FFS to managed care, directed payments were meant to ensure continuity of payment for providers. For example, when Florida expanded managed care to cover long-term services and supports, the state required MCOs to pay nursing facilities no less than FFS rates.

Relationship to supplemental payments

Although many directed payments are intended to adjust base payment rates, some are intended to preserve prior supplemental payments or make new additional payments to providers that are similar to FFS supplemental payments (Box 2-1).

BOX 2-1. Examples of Directed Payments with Different Relationships to Supplemental Payments

Although many states use directed payments to adjust the base payment rate that providers receive, some states have begun using this authority to make additional payments to providers that are similar to supplemental payments in fee for service (FFS). During interviews with state officials and stakeholders involved in the development of directed payments, we learned that some directed payments are intended to replace prior supplemental payments, while others are intended to make new payments to providers. Illustrative examples of these different types of arrangements are described below:

Adjusting base payment rates

- **Florida minimum payment rate for nursing facility services.** Florida requires managed care plans to pay nursing facilities no less than the Medicaid state plan rate. The state first enacted this policy in 2013 to minimize the effects of managed care expansion on nursing facilities.

BOX 2-1. continued

- **Massachusetts COVID-related rate increases.** During the COVID-19 pandemic, Massachusetts used directed payment authority to enact a number of temporary rate increases for a variety of provider types. For example, the state increased payments to personal care attendants by 10 percent, mirroring an increase that the state made in FFS.

Preserving prior supplemental payments

- **Utah uniform increase for private hospitals.** Before 2016, Utah made a pass-through payment to private hospitals financed by a provider tax. In 2018, the state transitioned this pass-through payment to a directed payment to preserve a similar level of funding for providers. In state fiscal year (SFY) 2021, total spending on this arrangement was $182 million; the state estimated that this arrangement increased payments for participating hospitals from approximately 86 percent to 156 percent of the Medicare payment rate.

- **California quality incentive program (QIP).** In 2018, California transitioned a prior pass-through payment to designated public hospitals into a $640 million pay-for-performance incentive program financed by intergovernmental transfers (IGTs) from participating public hospitals. The hospitals participating in this program also participated in the state's Public Hospital Redesign Incentives in Medi-Cal (PRIME) program, a type of delivery system reform incentive payment program authorized under the state's Section 1115 demonstration. In 2019, the state ended its PRIME program and increased total funding for QIP to $1.6 billion for the July 2019 through December 2020 rating year. The performance measures used in QIP are similar to those used in PRIME.

Making new additional payments to providers

- **Florida hospital directed payment program.** In 2021, Florida established a new directed payment arrangement to supplement Medicaid base payment rates for hospitals. These payments are financed by IGTs from local governments, many of which have authorized new local provider taxes to claim more federal funding through this program. Payment increases for participating hospitals ranged from 45 to 70 percent of base payment rates, and in total, the state made $1.8 billion in payments through this arrangement in SFY 2021.

- **Ohio Care Innovation and Community Improvement Program.** In 2018, Ohio created a new enhanced payment for physician services, 10 percent of which is tied to achievement of quality goals related to substance use, mental health, and infant mortality. The program is limited to physicians affiliated with public hospitals or the state university. Participating hospitals finance the payment through IGTs. In SFY 2021, the four participating hospital systems received $254 million from the directed payment and $36 million from a corresponding upper payment limit supplemental payment. This payment amount is equal to the difference between their Medicaid payment rate for physician services and the average commercial rate, which is approximately three times as high as the state's base payment rate and 158 percent of the Medicare payment rate, according to state estimates.

Preserving prior supplemental payments. All five states we interviewed developed one or more directed payments that were intended to preserve prior pass-through payments or supplemental payments authorized under Section 1115 demonstration authority. States were concerned that ending these prior payments would disrupt access to care because they accounted for such a large share of Medicaid payments to providers (in some cases almost half of their Medicaid managed care payments).

When transitioning prior supplemental payments to directed payments, states were able to preserve the total amount of funding, but some states reported changes in how the payments were distributed among providers. Because directed payments must be tied to Medicaid utilization, states often could not maintain the same distribution of payments when prior supplemental payments were made based on other factors, such as care provided to uninsured individuals.

New additional payments to providers. Four of the five states we studied also created new directed payment arrangements that substantially increased payments for some providers, similar to supplemental payments in FFS. In general, interviewees indicated that these directed payment arrangements were intended to improve access or quality above existing levels. However, stakeholders noted that the initial impetus for many of these arrangements came from providers who identified new sources of non-federal financing, rather than from state officials who had identified a particular quality or access problem.

For states that have maximized other types of supplemental payments to hospitals, directed payments are a tool to increase payments further. For example, in Florida, the state's new directed payment to hospitals ($1.8 billion in state fiscal year (SFY) 2021) is larger than the amount of state and federal DSH funding in the state ($383 million in FY 2021) and the limit on the hospital uncompensated care pool authorized in the state's Section 1115 demonstration ($1.5 billion).[16]

Current Oversight Process

To obtain approval for a directed payment arrangement, states must first submit a preprint to CMS for review. After the preprint is approved, states must incorporate the directed payment into their managed care contracts and rate certifications. At the time of approval, states are also required to submit a directed payment evaluation plan; at renewal, states are expected to submit their evaluation results.[17]

CMS officials with whom we spoke acknowledged that the rapid growth of directed payments in recent years has presented several oversight challenges for CMS as well as challenges for states seeking quick review and approval of their directed payment requests. As a result, CMS has made some changes to its process to better manage the volume of directed payment requests.

Preprint approval

The approval process begins with CMS review of directed payment preprint applications for compliance with regulatory requirements using a process similar to the one used to review Medicaid state plan amendments. The preprint form includes information about who is eligible for the payment, how the payment amounts are determined, and how the payment relates to the state's managed care quality strategy. CMS often follows up to request additional information before a directed payment is approved. Directed payment preprints are not automatically renewed, and in general, states must submit a new preprint every year for review.

In 2020, CMS made regulatory changes to the approval process and no longer requires states to submit a preprint for minimum fee schedules based on state plan rates, which were the most common type of directed payment arrangement in our review (accounting for about half of all directed payment arrangements). These regulations also allowed states to obtain multiyear approval of VBP directed payment arrangements (CMS 2020).[18]

In 2021, CMS revised its preprint form to request additional information to help in its review of directed payments (CMS 2021a). Most notably, the new preprint asks for projected spending information relative to an external benchmark such as costs, Medicare payments, or the average commercial rate. In addition, the preprint asks for more information about the sources of non-federal share used to finance the directed payment arrangement. Stakeholders we interviewed expressed hope that this new preprint would help streamline the review process and limit the need for CMS to request additional information during its review. These changes took effect for contract rating periods beginning on or after July 1, 2021, and thus were not available for MACPAC's review.

Capitation rate development

After a preprint is approved, states must incorporate the directed payment arrangement into their managed care contracts and rate certifications. Managed care rate certifications are reviewed by CMS and include information about the portion of the capitation rate that is attributable to directed payments.[19] In some cases, directed payments are included as an adjustment to the base capitation rate, and in other cases, the directed payment is made separately from the base capitation rate that the MCO receives (which is referred to as a separate payment term).

Overall, actuaries must certify that managed care rates are sufficient to cover the reasonable, appropriate, and attainable costs of the services provided under the contract, a standard known as actuarial soundness (42 CFR 438.4(a)). Actuarial soundness has long been the basis for federal oversight of Medicaid managed care spending, and the 2016 revisions to the Medicaid managed care rule added several new requirements for how states should document compliance with this standard (MAPAC 2022b; CMS 2016).

During our interviews, we heard conflicting views about whether current actuarial soundness requirements have any practical effect on directed payment spending. Although actuaries certify that capitation rates are reasonable and appropriate to cover the services in the contract, they are not typically involved in assessing whether directed payment amounts are reasonable and appropriate. In practice, the actuaries with whom we spoke noted that if CMS approves a directed payment arrangement, then it is often incorporated into the managed care rate certification without changes. Moreover, because CMS has not established an upper limit on directed payment spending, no federal standard exists for actuaries to apply in their review.

Actuarial soundness requirements are also supposed to help ensure that rates are sufficient for MCOs to meet network adequacy and other access requirements in the contract. However, CMS's managed care rate development guide does not currently provide explicit guidance on how actuaries should evaluate access (CMS 2022b). In practice, actuaries noted that they typically assume that historical payment rates are adequate to ensure access to care in the absence of any evidence of penalties levied on plans for insufficient network adequacy or availability of services.

Evaluation

States are required to develop evaluation plans for directed payments at the time of their preprint submission and are generally expected to report evaluation results when the directed payment is renewed. However, in our review of the information provided by CMS, we were able to find directed payment evaluations for only 48 of the 215 directed payment arrangements that had been renewed at least once and operating for at least a year.

In interviews, state officials noted that many directed payment evaluations were not available because of various delays. Most notably, lags in data collection prevented states from reporting results in time for the one-year renewal time frame used for most directed payment arrangements.

In addition, the COVID-19 pandemic caused disruptions in care and sustained drops in use of services, complicating the task of quality measurement and delaying evaluation results for many states.

States with directed payments that built on prior VBP efforts were better positioned to report evaluation results. For example, California's quality incentive pool for public hospitals was built off the state's prior DSRIP program, and so hospitals were already prepared to report on the specified quality measures. Similarly, Utah noted that it was able to provide evaluation results for its hospital directed payment program because it used similar metrics as an existing accountable care organization initiative in the state.

States reporting evaluation results described year-over-year improvements of varying magnitude. Although many states reported modest improvements in quality, some states reported negative outcomes; even so, their directed payment arrangements were approved without changes. For example, after implementing a directed payment that more than doubled Medicaid payments to hospital-based physicians to improve access, one state reported that the Medicaid payer mix for participating providers declined and that the time to appointment for Medicaid beneficiaries increased. These results should be interpreted with caution, however. Although they may indicate that the arrangement is not meeting its access goals, the results may also indicate that the measures used may not adequately capture access.

Commission Recommendations

As a first step toward improving the transparency and oversight of directed payments, the Commission makes five recommendations in this chapter. The rationale and implications of these recommendations are described in the following sections:

Recommendation 2.1

To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should make directed payment approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website.

Rationale

Directed payments are a large and growing portion of Medicaid spending. Consequently, it is important for the public and policymakers to have timely access to information on what payment arrangements have been approved and the effects of these arrangements on quality and access to care for Medicaid enrollees. Making this information available is an important first step toward improving the transparency of these payments and would complement any future efforts to make more information about directed payments publicly available.

CMS already makes approval documents for many other similar types of payments publicly available on its website. For example, CMS currently posts approval documents for Medicaid state plan amendments, which describe FFS supplemental payments, and approval documents for Section 1115 demonstrations, which describe DSRIP and other supplemental payments. However, when states transition FFS supplemental payments and DSRIP into directed payments, information about these payment arrangements is no longer publicly available.

Managed care rate certifications are an important complement to directed payment approval documents because they provide information on how the directed payment arrangement is incorporated into managed care rates. Such information is also useful for informing oversight of managed care rate setting more generally. Although actuaries may use some proprietary data from health plans when developing capitation rates, the final rate certification document is intended to be a public document and is already

publicly available in some states. Prior CMS regulations have clarified that managed care spending data should be publicly available even though some stakeholders viewed this information as proprietary, and so CMS could apply a similar standard to justify making rate certification information available (CMS 2020).

Evaluation plans and results are important for understanding the objectives of the directed payment arrangement and the extent to which it is meeting its goals. Although the Commission identified weaknesses in current directed payment evaluations, making these public would still allow stakeholders to learn from state experience and provide input on how to improve the rigor of evaluations. CMS makes Section 1115 demonstration evaluation plans and results publicly available on Medicaid.gov; a similar process could be used for directed payment evaluations.

Currently, information about directed payment approvals, managed care rate certifications, and evaluation plans are only available to the public through a Freedom of Information Act request, which can be complicated and time consuming to pursue. Moreover, because states do not need to provide public notice about directed payment arrangements, some stakeholders may not even know whether there are directed payments for which they can request information. CMS already uses the Medicaid.gov website to make information about various payments available to a wide range of stakeholders in a timely manner, and so it could also use this website to make information on directed payments publicly available as soon as they are approved.

Implications

Federal spending. The Congressional Budget Office (CBO) assumes that this policy would not affect federal spending. There may be some additional administrative effort to make existing reports available in a timely manner, but this activity is not expected to increase federal spending.

States. This policy should have a limited effect on states because they are already required to provide this information to CMS.

Enrollees. This policy would not directly affect Medicaid enrollees. Over time, greater transparency of directed payment arrangements could lead to additional public input on the design of these arrangements and whether they are meeting their intended goals of improving access and quality of care for enrollees.

Plans and providers. This policy would not directly affect payments to providers or health plans, but it would make information on their payment arrangements publicly available. Over time, greater transparency could lead to modifications in state directed payment methodologies.

Recommendation 2.2

To inform assessments of whether managed care payments are reasonable and appropriate, the Secretary of the U.S. Department of Health and Human Services should make provider-level data on directed payment amounts publicly available in a standard format that enables analysis.

Rationale

Complete data on Medicaid payments is important to understanding whether payment amounts are consistent with federal requirements, including the federal requirement that managed care rates be reasonable and appropriate (42 CFR 438.4). This is a large and rapidly growing form of Medicaid payments to providers, but we do not have provider-level data on how billions of dollars in directed payments are being spent. The projected spending information available on directed payment preprints may not match actual spending; the aggregate information on directed payment amounts in managed care rate certifications does not provide sufficient detail needed to examine how MCOs pay particular providers.

Directed payments are now larger than DSH and UPL supplemental payments, but we have much less data on who is receiving them. Providers have long been required to submit hospital-level audits for DSH payments, and beginning in FY 2022, states will be required to submit provider-level UPL supplemental payment data. Because many states use directed payments to make additional payments to providers that are similar to supplemental payments in FFS, it is equally important to collect provider-level data on these payments.

CMS currently collects information on projected directed payment amounts in the aggregate but does not monitor the actual amount of payments made, either in the aggregate or to particular providers. Collecting data on actual spending would help CMS ensure that spending is consistent with what was approved. In addition, provider-level data would help CMS and other stakeholders understand how payments are being targeted.

This recommendation builds on the Commission's prior recommendations that the Secretary of U.S. Department of Health and Human Services collect and report data on all Medicaid payments to hospitals for all hospitals that receive them, as well as data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level (MACPAC 2016). In some circumstances, directed payments appear to account for more than half of Medicaid managed care payments to hospitals, physicians, and other providers, and so it is particularly important to collect provider-level data on these payments.

The two primary methods that CMS could use to collect provider-level data on directed payments are the Transformed Medicaid Statistical Information System (T-MSIS) and the Medicaid Budget and Expenditure System (MBES). T-MSIS is used to report Medicaid claims and encounters, but according to CMS's review of preliminary 2020 data, 10 states are missing more than 10 percent of Medicaid spending for managed care encounters (CMS 2022c). MBES is the system that CMS uses to track overall Medicaid spending and collect provider-level data on UPL payments (CMS 2021b). However, the current provider-level UPL reporting process requires manual data entry from states, which is administratively burdensome.

In the Commission's view, the administrative burden of the data collection should be reduced where possible and should be commensurate with the size of the payment. For many smaller directed payment arrangements that adjust base payment rates, this spending may already be captured in T-MSIS, and it may not be worthwhile to distinguish the amount of funding attributable to the directed payment from the base payment rate negotiated by the MCO. However, for large directed payments that are similar to FFS supplemental payments and are not currently being reported in T-MSIS, it may be necessary to use the same process used for tracking UPL payments, even though it may be more administratively burdensome.

The Commission continues to support better collection of data related to the non-federal share of Medicaid payments, which are necessary to calculate net Medicaid payments at the provider level. However, doing so would be most effective through a broader data collection effort that is not limited to directed payments, since provider taxes and IGTs can be used to finance a wide range of Medicaid payments.

Implications

Federal spending. CBO assumes that this policy would not affect federal spending. There may be administrative effort to develop reporting standards, make required changes to information technology systems, and make the data publicly available, but these activities are not expected to result in increased spending.

States. Reporting provider-specific Medicaid payments would likely require some increased administrative effort by states to the extent that payment information would need to be compiled from different data systems. In our interviews, state officials noted that they already track actual spending on uniform rate increases at the provider level, but there may still be effort involved in providing these data to CMS in a prescribed format.

Enrollees. This policy would not have a direct effect on Medicaid enrollees.

Health plans. Depending on the approach that states and CMS use to collect data on provider-level directed payments, health plans may need to submit additional information, increasing administrative effort.

Providers. State reporting of provider-level payments would not have a direct effect on Medicaid payments to providers. Over time, however, increased transparency could lead to modifications in state payment methodologies.

Recommendation 2.3

To provide additional clarity about the goals and uses of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to quantify how directed payment amounts compare to prior supplemental payments and clarify whether these payments are necessary for health plans to meet network adequacy requirements and other existing access standards.

Rationale

Understanding the goals of any payment is an important first step for assessing whether it is meeting its objectives. Although CMS requires states to describe how directed payments advance at least one goal of the state's managed care quality strategy, the link between directed payments and quality and access goals is often unclear.

Most of the directed payment preprints we reviewed described improving access as the primary goal of the directed payment. However, managed care rates are already required to be sufficient to ensure access to services in a timely manner, including access to an adequate network of providers. Thus, it is not clear what improvements to access states are buying when they use directed payments to make additional payments above rates that were previously certified as actuarially sound.

Distinguishing payments needed to meet existing access standards from those intended to improve access above this level would help inform how directed payments are evaluated and incorporated into managed care rates. In particular, making this distinction would help evaluators understand what additional improvements should be expected from the directed payment and would help the state's actuaries determine what the capitation rate would be if the directed payment were discontinued in the future.

Quantifying how the directed payment compares to prior supplemental payments, including prior pass-through payments that are similar to FFS supplemental payments, is a first step toward clarifying the payment goals. For example, if the directed payment is intended to replace pass-through payments that were previously part of the actuarially sound capitation payment, then it may be reasonable for the state to attest that this payment is necessary to meet existing access standards. However, if the directed payment substantially increases payment rates above levels that actuaries previously certified as sufficient, then it may be reasonable to expect the payment to result in improvements in access and quality above existing levels. Because spending on prior pass-through payments is not publicly available, quantifying the amount of these payments in the directed payment preprint would be particularly helpful.[20]

Information on how total Medicaid payments to providers compare to external benchmarks, such as Medicare payment rates, would also be useful for understanding the goals of the directed payment. CMS's new directed payment preprint includes questions for states to describe how total payments to providers compare to Medicare after accounting for directed payments, and so we are hopeful that these data can be used in CMS's review of directed payment goals.

Requiring states to more explicitly describe the goals of their directed payment arrangements could also help inform future policy development.

For example, CMS may want to encourage states to incorporate payments needed to comply with access standards into base payment rates so that any remaining additional payments to providers can be tied to more ambitious quality and access goals, similar to the approach it has used for some DSRIP demonstrations (MACPAC 2015b).

Implications

Federal spending. CBO assumes that this policy would not affect federal spending as it would only require that CMS modify existing guidance on this topic.

States. States are already required to provide information about program goals through the current directed payment approval process. New guidance would require only that they elaborate on these goals further.

Enrollees. We do not have enough information to assess how this policy would affect Medicaid enrollees. Directed payment policies affect enrollees' access to quality care, but it is not clear how states might change their directed payment methodologies in response to federal requirements to clarify their payment goals.

Health plans. This policy would not have a direct effect on health plans. However, over time, clarifying the relationship between directed payments and network adequacy requirements may affect the extent to which health plans are involved in the development of directed payment arrangements.

Providers. This policy would not have a direct effect on providers. However, over time, distinguishing new directed payment funding from prior supplemental payment funding could lead to changes in state directed payment methodologies.

Recommendation 2.4

To allow for more meaningful assessments of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to develop rigorous, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.

Rationale

MACPAC's review of directed payment evaluations raised several concerns about how directed payments are being evaluated and how evaluation results are being used. Although some states have reported improvements in quality and access measures after the implementation of directed payments, information on the results of many directed payment arrangements is unknown even after multiple renewals. In addition, we identified some circumstances in which performance on quality measures declined but the payment arrangement was renewed without changes.

To make evaluations more useful for policymakers, CMS should clarify its expectations for directed payment evaluation plans. For example, CMS could provide written guidance on the types of measures that states should monitor and the timing for submitting results. It would also be helpful for CMS to clarify how evaluations will be used to inform decisions about whether directed payments are renewed and the type of information needed to support this decision making.

Allowing states to develop multiyear evaluation plans would also help improve states' ability to conduct meaningful assessments of performance. For example, given the data lag with many of the sources of data that states are using, it often takes at least a year to collect baseline information on some quality measures and another year or two to measure changes in performance. Although CMS only permits multiyear approval for VBP directed payments, we have found that many uniform rate increases have been approved for multiple years in a row, and so it is reasonable to expect multiyear evaluations of these payment arrangements as well.

Even though states are required to develop evaluation plans for all directed payments, it would be most helpful for CMS to develop evaluation

guidance for the subset of directed payments that make substantial additional payments to providers. In the Commission's view, the rigor of the evaluation should be commensurate with the level of new federal spending associated with these arrangements.

Implications

Federal spending. CBO assumes that this policy would not affect federal spending. There may be some additional administrative effort for CMS to develop guidance on this topic.

States. This recommendation would increase administrative effort for states that do not currently have rigorous evaluation plans for their directed payments. However, developing multiyear evaluation plans rather than single-year evaluation plans may reduce administrative effort for states over time.

Enrollees. This policy would not have a direct effect on enrollees. However, over time, better evaluations of directed payment arrangements may help ensure that these payments promote better access to quality care for Medicaid enrollees.

Plans and providers. More rigorous evaluation plans may require health plans and providers to provide additional information about performance on quality and access measures. However, the burden of reporting new quality measures could be minimized if directed payment evaluations are coordinated with existing quality reporting efforts, such as those used in monitoring performance of the state's managed care quality strategy.

Recommendation 2.5

To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

Rationale

The statutory requirement that managed care rates be actuarially sound is the foundation for federal oversight of managed care. However, actuaries cannot appropriately assess whether rates are reasonable without clear guidance from CMS about what they should review.

During our interviews, we heard conflicting views about the extent to which actuaries should be involved in assessing directed payments. Although there is currently no federal upper limit on the amount of directed payments that states can make, CMS officials noted that state actuaries are still responsible for determining whether directed payments are reasonable and appropriate as part of their overall review of managed care capitation rates and certification of actuarial soundness. However, the state actuaries with whom we spoke noted that there is little for them to review because they are required to include directed payments in the capitation rate when these are approved by CMS and included in the managed care contract. In addition, some stakeholders had trouble describing how directed payments should be accounted for when assessing whether rates are sufficient to ensure access to services in a timely manner.

Some of the confusion we observed may be due to the timing of the process and the multiple CMS divisions that are involved in overseeing directed payments, managed care rate certifications, and managed care contracts. Stakeholders have been appreciative of the steps that CMS has taken in recent years to streamline the approval process but still expressed frustration with the length of time it took to get approval from the CMS Division of Managed Care Policy (which is primarily responsible for reviewing the preprint), the CMS Office of the Actuary (which reviews rate certifications), and the CMS Division of Managed Care Operations (which reviews managed care contracts).

Although CMS's recent guidance has helped streamline the administrative processes for incorporating approved directed payment preprints into managed care capitation rates,

additional guidance is needed to address the more fundamental question of who is responsible for overseeing what. In the Commission's view, additional guidance about the roles and responsibilities for directed payment oversight should include:

- clarification about who is responsible for reviewing and approving directed payment amounts;
- guidance about whether managed care capitation rates should be sufficient to comply with existing access standards before or after additional payments to providers are made through directed payment arrangements; and
- instructions for states about what additional federal review is needed after CMS approves a directed payment preprint.

In the process, CMS may also be able to identify additional opportunities to reduce administrative burden and focus resources on the oversight activities that are most meaningful.

Implications

Federal spending. CBO assumes that this policy would not affect federal spending. There may be some initial administrative effort involved for CMS to clarify roles and responsibilities, but over time, better coordination could help to lower administrative effort. In addition, greater clarity about who is responsible for overseeing directed payment amounts may affect the amount of directed payments approved by CMS in the future.

States. Better coordination of federal approval processes could help to reduce administrative burden for states over time.

Enrollees. This policy would not have a direct effect on Medicaid enrollees. However, over time, more clarity about the federal oversight processes for ensuring network adequacy could help improve compliance with these requirements, which are intended to ensure that enrollees can access care in a timely manner.

Plans and providers. The policy would not have a direct effect on health plans and providers. However, over time, a more coordinated federal approval process for directed payments may help expedite directed payment reviews, which would provide greater certainty for plans and providers about future Medicaid payments.

Oversight of Directed Payment Spending

As use of directed payments continues to grow, one important question to consider is whether there should be an upper limit on directed payment spending, similar to the upper limits on other types of Medicaid payments. The rapid growth of DSH payments in the early 1990s demonstrates the potential risk that federal spending could increase dramatically if unchecked. Between 1990 and 1992, after Congress clarified that DSH payments were not subject to the UPL that applies to other FFS spending, the total amount of DSH payments increased from $1.3 billion to $17.7 billion (Holahan et al. 1998).[21]

Two approaches that could be used to set an upper limit on directed payment spending are establishing a limit based on an external benchmark or establishing a limit based on historic spending. In addition, policymakers should consider how any limit on directed payment spending relates to existing limits on spending in some managed care authorities. In the following sections, we discuss policy issues to consider with each of these approaches and areas for future analyses.

Limits based on external benchmarks

Medicaid FFS payments to hospitals, nursing facilities, and other institutional providers are limited based on a reasonable estimate of what would have been paid for the same services under Medicare payment principles. This limit is established in the aggregate for a class of

providers. As a result, some providers can be paid more than what Medicare would have paid as long as total payments to each class of providers are below the UPL (MACPAC 2021b).

In our review, we identified a number of examples of directed payments that resulted in Medicaid payments to hospitals and other institutional providers that exceeded what Medicare would have paid. As a result, establishing a limit on directed payments based on the UPL in FFS would likely result in reductions in payments for some providers.

The upper limit for Medicaid FFS payments for physician services is based on the average commercial rate (ACR), which is substantially higher than the Medicare payment rate.[22] For example, CBO's recent review of studies comparing commercial prices to Medicare estimated that on average, commercial prices for physician services were 129 percent of Medicare, and commercial prices for hospital services were 223 percent of Medicare; CBO also found considerable state variation in the differences between commercial rates and Medicare (CBO 2022). Unlike Medicare payment rates, which are publicly available and are consistent for all providers, the rates that private insurers pay are not readily available and can vary widely based on providers' ability to negotiate their payment rate.

The growing use of ACR-based directed payments for hospital-based physician services also raises additional questions about how payments to hospitals should be evaluated. We learned that some states began making additional payments to hospital-based physicians because the state had already maximized the amount of Medicaid supplemental payments that the state can make for inpatient and outpatient hospital services. Because health systems can choose how they allocate the Medicaid payments they receive, it is not clear whether some of these new directed payments ultimately increase payments to physicians or whether they are being used to support the overall finances of the hospital. In addition, it is not clear what rationale states have for paying hospital-based physicians so much more than office-based physicians for the same service, other than the fact that hospitals are able to finance the non-federal share of the payment.

Limits based on historic spending

Another approach to limit spending for directed payments would be to set a cap on payments based on states' historic spending. Compared with an external benchmark, this approach would limit reductions in payments for providers, but it would also preserve the existing variation in directed payment spending by state. Two potential models that could be considered include (1) setting a fixed limit on total spending, similar to the approach used for DSH allotments; and (2) setting limits on a per capita basis, similar to the approach used in Section 1115 budget neutrality.

In the early 1990s, Congress established state-specific caps on the amount of federal funds that could be used to make DSH payments, which were based on state spending in 1992. Although Congress has made several incremental adjustments to federal DSH allotments since then, the states that spent the most in 1992 still have the largest allotments, and the states that spent the least in 1992 now have the smallest allotments. This approach has resulted in a wide variation in state DSH funding that has no meaningful relationship to levels of uncompensated care or other measures of need for DSH funding (MACPAC 2022c).

Most Section 1115 demonstrations limit spending on a per capita basis so that the state is at risk for the costs of individuals served by the demonstration but is not at risk for the number of individuals enrolled. This limit is determined as part of a budget neutrality calculation that uses state historic spending per person, trended forward based on the lower of the state's historical growth rate or the trend assumed in the president's budget. Over time, this approach has resulted in a wide variation in the budget neutrality limits approved for different states, so CMS has recently revised its policy to require states to rebase their

budget neutrality limits when the demonstration is renewed (MACPAC 2021d).

Relationship to other limits on overall managed care spending

Some authorities that states use to operate their managed care programs have limits on spending that could be considered when setting a limit on managed care directed payments. In 2019, 29 states operated managed care through 1915(b) waivers, which are subject to a cost-effectiveness test, and 24 states operated managed care through Section 1115 demonstration authority, which is subject to a budget neutrality limit (CMS 2022d).[23] Both the cost-effectiveness test and budget neutrality limits are based on historical state spending, trended forward for inflation. However, it appears that in some circumstances CMS allows states to increase their cost-effectiveness or budget neutrality limits to account for payment rate increases, which would undermine the ability of CMS to use cost effectiveness or budget neutrality as a tool to limit directed payment spending from uniform rate increases.[24]

In addition, it is worth noting that other types of Medicaid managed care authorities do not have any statutory or regulatory limits on spending. Because directed payments provide states with an option to make additional payments to providers without a Section 1115 demonstration, it is possible that some states may transition their managed care programs to other authorities in the future, similar to what California did in its most recent Section 1115 demonstration renewal.

Areas for future work

More information about directed payment spending is needed to examine the potential effects of each of these approaches and to consider whether statutory or regulatory actions would be required to make such changes. CMS's recent revisions to the directed payment preprint form should help improve the quality of information about aggregate directed payment spending compared with external benchmarks, and so the Commission plans to examine this new data when it is available. If CMS adopts the Commission's recommendations to collect more provider-level data and further clarify the goals of directed payments, it would help us better understand the effects of any changes on providers and beneficiaries.

Endnotes

[1] In this chapter, we use the term MCO to refer to all types of capitated managed care plans in Medicaid, including prepaid inpatient health plans and prepaid ambulatory health plans.

[2] In general, states are not allowed to make supplemental payments for Medicaid services covered in managed care contracts. However, as discussed in this chapter, states can direct MCOs to make additional payments to providers that are similar to supplemental payments in FFS. In addition, states can make disproportionate share hospital (DSH) and graduate medical education (GME) payments for services provided in managed care.

[3] A directed payment arrangement refers to each state directed payment application, technical amendment, and renewal approved by CMS. Distinct programs are defined as a series of directed payment arrangements in one state that use the same payment and provider type(s) for one or more rating period. Some newly authorized directed payments are continuations of prior arrangements that were authorized before the 2016 revisions to the Medicaid managed care rule.

[4] MACPAC contracted with Mathematica to review the 490 state directed payment arrangements that had been approved, renewed, or amended as of December 31, 2020. We identified 230 distinct arrangements, including 29 temporary COVID-19 arrangements. As of June 30, 2021, CMS has approved 557 directed payment arrangements, which by its count includes 218 new payment arrangements, 311 renewals, and 28 amendments (CMS 2022a).

[5] Projected payment amounts are for the most recent rating period, which may differ from calendar year or fiscal year 2020. In addition, projected spending reported in directed payment approval documents may differ from actual spending. Total spending includes state and federal funds.

[6] In FY 2020, states spent $17.9 billion on DSH payments and $24.4 billion in UPL supplemental payments (MACPAC 2021a).

[7] As discussed in this chapter, not all types of directed payment arrangements are projected to increase spending.

[8] Total supplemental payment spending includes DSH payments ($17.9 billion), UPL supplemental payments ($24.4 billion), and supplemental payments authorized by Section 1115 demonstrations ($14.6 billion) (MACPAC 2021a).

[9] Health care providers cannot be given a direct or indirect guarantee that they will be repaid for all or a portion of the amount of taxes that they contribute. However, if a health care-related tax produces revenue that is less than 6 percent of net patient revenue, then the tax is considered to be below the safe harbor threshold, and 75 percent or more of taxpayers in a class can receive 75 percent or more of their total tax costs back from Medicaid (MACPAC 2021b).

[10] States can make DSH and GME payments for services provided in managed care.

[11] For example, in FY 2020, 9 states reported spending on delivery system reform incentive payment (DSRIP) or DSRIP-like programs, and 8 states reported spending on uncompensated care pools authorized under Section 1115 demonstrations (MACPAC 2022a).

[12] Subsequent revisions to the managed care rule in 2020 eliminated the requirement for prior approval for minimum fee schedules based on state plan rates and allowed for multiyear approval of VBP directed payment arrangements (CMS 2020).

[13] Specifically, 42 CFR 438.4(b)(3) requires actuaries to certify that rates are adequate to meet the requirements of 42 CFR 438.206 (timely access to services), 42 CFR 438.207 (network adequacy), and 42 CFR 438.208 (care coordination). States establish their own access standards to enforce this requirement, including quantitative standards for network adequacy (42 CFR 438.68).

[14] For example, it was often unclear whether payment amounts reported in renewals included amounts from prior submissions or amendments to that arrangement or if the number provided reflected only the amount for the current rating period.

[15] Financing information was not available for all directed payment arrangements.

[16] DSH and uncompensated care pools pay for the costs of care for both Medicaid-enrolled patients and uninsured individuals, while directed payments may pay for services only to Medicaid-enrolled patients. DSH payments to individual hospitals are limited to the hospitals' uncompensated care costs for inpatient and outpatient services, but they are not affected by payments that hospitals receive for services to hospital-based physicians, such as those made by several of the directed payment arrangements that we studied.

[17] Federal regulations do not explicitly require states to submit evaluation results, but CMS noted that it asks for this information during its review of directed payment renewal requests.

[18] CMS's 2017 informational bulletin outlined criteria that the agency will consider when approving directed payment arrangements for multiple years; this policy was codified in regulation in 2020 (CMS 2017b; CMS 2020).

[19] Section I.4.D. of CMS's Medicaid managed care rate development guide describes the documentation that states must provide about how directed payments are incorporated into the managed care capitation rate (CMS 2022b).

[20] The revised directed payment preprint requests information about pass-through payment spending in the rate year under review but not about pass-through payment spending for prior rate years.

[21] The growth in DSH in the early 1990s was also attributable to more flexible rules on the sources of non-federal share that states could use to finance Medicaid payments. Since then, Congress has limited provider donations and most provider taxes to no more than 6 percent of provider revenue (MACPAC 2021b).

[22] Because a federal statute or regulation does not exist to establish a UPL for non-institutional providers, states

are permitted to pay these providers rates greater than Medicare in the aggregate. In sub-regulatory guidance, CMS has indicated that states can use the average payment rate from the top commercial payers as an upper limit on enhanced payments to physicians and other qualified practitioners (MACPAC 2021c).

[23] Some states use both Section 1915(b) waivers and Section 1115 demonstrations to provide managed care for different populations within their state.

[24] For example, Appendix D4 of the Section 1915(b) waiver application allows states to adjust their cost-effectiveness test to account for legislatively mandated fee schedule changes.

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Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 8, 2022.

Oversight of Managed Care Directed Payments

2.1 To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should make directed payment approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website.

2.2 To inform assessments of whether managed care payments are reasonable and appropriate, the Secretary of the U.S. Department of Health and Human Services should make provider-level data on directed payment amounts publicly available in a standard format that enables analysis.

2.3 To provide additional clarity about the goals and uses of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to quantify how directed payment amounts compare to prior supplemental payments and clarify whether these payments are necessary for health plans to meet network adequacy requirements and other existing access standards.

2.4 To allow for more meaningful assessments of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to develop rigorous, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.

2.5 To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

2.1-5 Voting Results	#	Commissioner
Yes	15	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Herrera Scott, Weno
Not Present	1	Scanlon