

Directed Payments in Medicaid Managed Care

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated the regulations for Medicaid managed care and created a new option for states, allowing them to direct managed care organizations (MCOs) to pay providers according to specific rates or methods. Typically, these directed payment arrangements are used to establish minimum payment rates for certain types of providers or to require participation in value-based payment (VBP) arrangements. However, a few states use the directed payment option to require MCOs to make large additional payments to providers similar to supplemental payments in fee for service (FFS).¹

This issue brief discusses the history of directed payment policy and examines the use of directed payments based on MACPAC's review of directed payments approved as of December 31, 2020. Further discussion of this issue, including MACPAC's recommendations for improving the transparency and oversight of directed payments, is included in Chapter 2 of MACPAC's June 2022 *Report to Congress on Medicaid and CHIP* (MACPAC 2022a).

Background

The 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

Under the Medicaid statute, states have broad flexibility to design their own FFS payment methods. The two broad categories of FFS payments are: (1) base payments for services, which are payments for services provided to individual beneficiaries, and (2) supplemental payments, which are typically made in a lump sum for a fixed period. In fiscal year (FY) 2020, about 36 percent (\$57 billion) of FFS payments to hospitals, mental health facilities, nursing facilities, and physicians were supplemental payments (MACPAC 2021 a).² More information about supplemental payments is included in MACPAC's issue brief *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2022b).

Federal rules do not allow states to make supplemental payments for services provided in managed care.³ 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.⁴ 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 (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 tied to utilization and delivery of services under the managed care contract, be distributed equally to specified providers under the managed care contract, advance at least one goal in the state's managed care quality strategy, and not be conditioned on provider participation in intergovernmental transfer (IGT) agreements (42 CFR §438.6(c)). To enforce these requirements, CMS required states to seek prior approval of directed payment arrangements each year.⁵

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. MCOs are required by federal rules to provide timely access to care, including access to an adequate network of providers, and actuaries must certify that the capitation rates are sufficient to meet this requirement. Although MCOs generally have the flexibility to negotiate payments with providers, the directed payment option provides states with more control over the rates and methods used by MCOs to pay network providers and can direct MCOs to use methods that advance specific state goals.

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).

In addition, 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

To analyze the uses of directed payments, MACPAC contracted with Mathematica to review all state directed payment documents approved from the time the option was made available through December 31, 2020.⁶ This document review was supplemented by interviews with CMS, actuaries, and state officials in five states.

Types of directed payments

Our review classified directed payment arrangements into three categories, based on the distinctions CMS uses in its standard application form (referred to as a preprint).

- **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.

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).

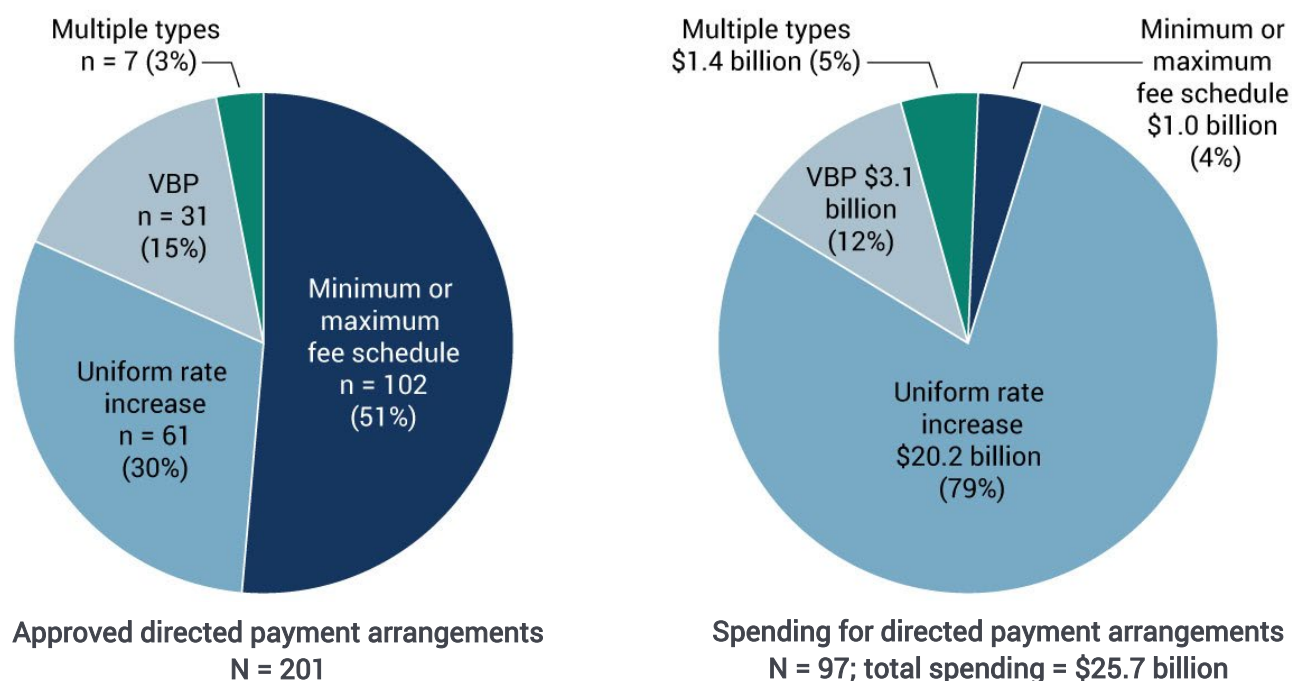
Number of directed payments and projected spending amounts

As of December 31, 2020, CMS had approved 201 distinct directed payment arrangements (excluding those related to COVID-19) in 37 states.⁷ This was a substantial increase over the 65 distinct arrangements approved in 23 states as of August 2018 (Pettersson et al 2018). More than half of these directed



payments were minimum or maximum fee schedules and roughly one-third were uniform rate increases (Figure 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.

FIGURE 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 of directed payment preprints approved through December 31, 2020.

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.⁸ Moreover, during our interviews with state officials, we learned that actual spending on directed payments was sometimes higher or lower than the amount projected in approval documents. However, actual spending amounts on directed payments are not separately reported to CMS and thus were not available for our review.

Based on the information that was available for our review, a small number of directed payment arrangements account for the vast majority of projected spending. Specifically, about 90 percent of all directed payment spending that we identified was attributable to 35 directed payment arrangements that were projected to increase payments to providers by greater 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 upper limit on FFS payments (MACPAC 2021b).

Federal rules do not put an upper limit on the amount of directed payments that states can make to providers. 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. Some directed payment approval documents we reviewed described arrangements that would pay providers almost three times the Medicare rate for hospital inpatient and outpatient services.

Targeting and financing of directed payments

The targeting and financing of directed payments varied based on the directed payment type (Table 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.

TABLE 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



Directed payment characteristics	Minimum or maximum fee schedule		Uniform rate increase		VBP		Total	
	Number	Share	Number	Share	Number	Share	Number	Share
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.

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.⁹

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, states indicated the goal of the directed payment arrangement was to ensure that providers remained in the MCO network; in other cases, the stated 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 stakeholders expressed interest in aligning the measures used to monitor directed payment performance with those used to monitor MCO performance, but they also noted potential operational challenges in adjusting MCO contracts to align these measures.

Although many directed payments are intended to adjust base payment rates, some are meant to preserve prior supplemental payments or make new additional payments to providers that are similar to FFS



supplemental payments. Chapter 2 of MACPAC's June 2022 *Report to Congress on Medicaid and CHIP* includes illustrative examples of the different types of directed payments identified during our interviews with state officials and other stakeholders (MACPAC 2022a).

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 the managed care contract and rate certification. 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.¹⁰

Preprint approval

CMS reviews 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 which providers are 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 requests additional information from the state 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. CMS also permitted states to obtain multiyear approval of VBP directed payment arrangements (CMS 2020).¹¹

Capitation rate development

After a preprint is approved, states must incorporate the directed payment arrangement into their managed care contract and rate certification. An actuary must certify that the capitation 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)). Managed care rate certifications are reviewed by CMS and include information about the portion of the capitation rate that is attributable to directed payments.

More information about the rate setting process is described in MACPAC's issue brief *Medicaid Managed Care Capitation Rate Setting* (MACPAC 2022c).

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.¹² However, in MACPAC's review of the information provided by CMS, we found 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 slowing down evaluation results for many states.

Policy Issues

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. For example, in 2021, CMS revised its preprint form to request additional information to help facilitate the review of directed payments and reduce the number of follow-up requests (CMS 2021).

MACPAC's June 2022 *Report to Congress on Medicaid and CHIP* includes five recommendations for CMS to further improve the transparency and oversight of directed payments. The recommendations relate to:

- making existing directed payment approval documents, rate certifications, and evaluations publicly available;
- collecting new, provider-level data on directed payment spending;
- clarifying directed payment goals and their relationship to network adequacy requirements;
- providing guidance for more meaningful, multi-year assessments of directed payments; and
- improving the coordination of reviews of directed payments and managed care rate setting (MACPAC 2022a).

As use of directed payments continues to grow, one important policy issue 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. However, more information about current directed payment spending is needed to fully examine the potential effects of any new limits.

Endnotes

¹ In this issue brief, we use the term MCO to refer to both fully and partially capitated Medicaid managed care plans, including prepaid inpatient health plans and prepaid ambulatory health plans.

² 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 2021 a).

³ States can make DSH and GME payments for services provided in managed care.



⁴ 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 2022b).

⁵ 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).

⁶ The approval documents 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. This information is not publicly available, but CMS provided it to MACPAC for this analysis.

⁷ This analysis is based on a review of distinct directed payment arrangements approved through December 31, 2020, and excludes temporary directed payments approved under the expedited COVID-19 pathway (n = 29). Distinct arrangements 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. Prior versions of directed payment arrangements that were subsequently renewed or amended are also excluded (n = 260). Some newly authorized directed payments are continuations of prior arrangements that were authorized before the 2016 revisions to the Medicaid managed care rule.

⁸ 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.

⁹ Financing information was not available for all directed payment arrangements.

¹⁰ 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.

¹¹ 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).

¹² 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.

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