MACPAC

Directed Payments in Managed Care

Decisions on Recommendations for the June Report to Congress

Medicaid and CHIP Payment and Access Commission

Robert Nelb

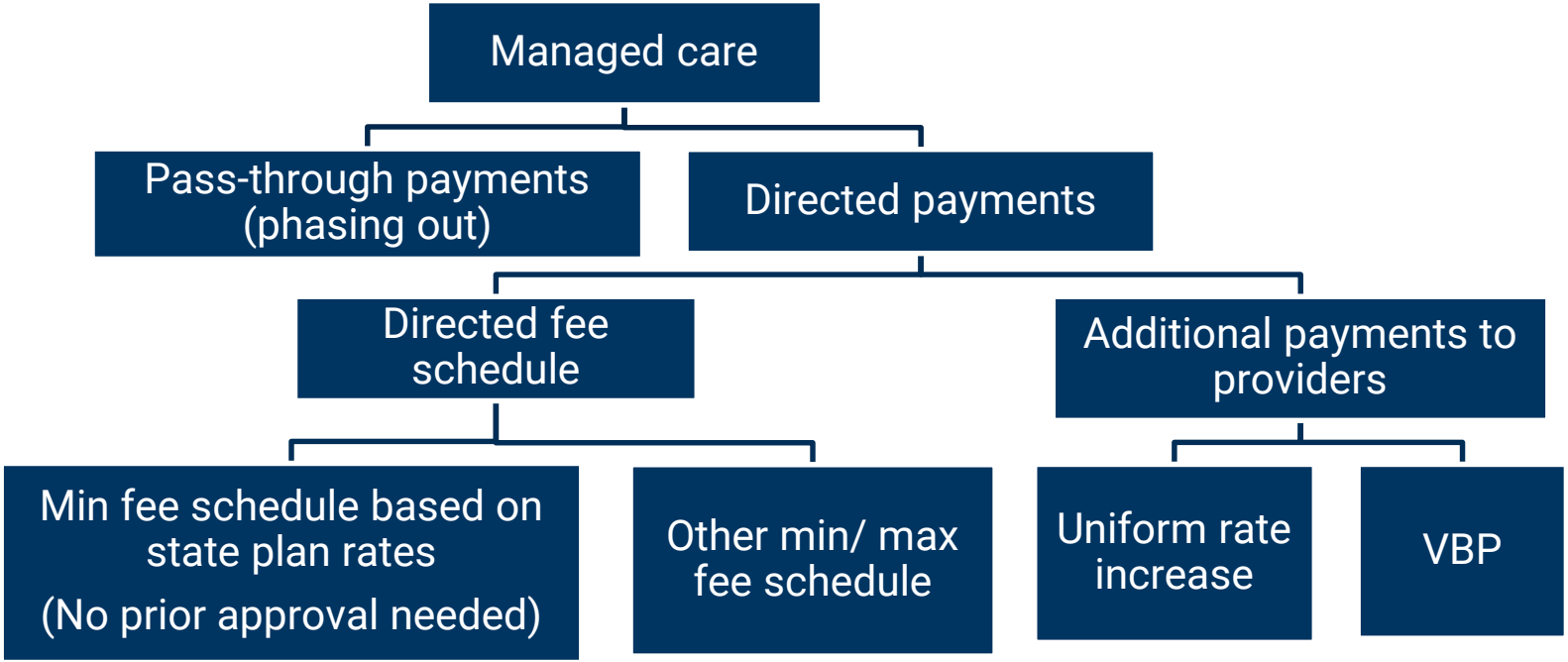
Overview

- Background
- Discussion of potential recommendations and rationale
  - Better transparency of existing directed payment information
  - New, provider-level data on directed payment spending
  - Clarifying directed payment goals and their relationship to network adequacy requirements
  - Guidance for directed payment evaluations
  - Coordinating reviews of directed payments and managed care rates
- Next steps
  - Considerations for setting an upper limit on directed payments

Background

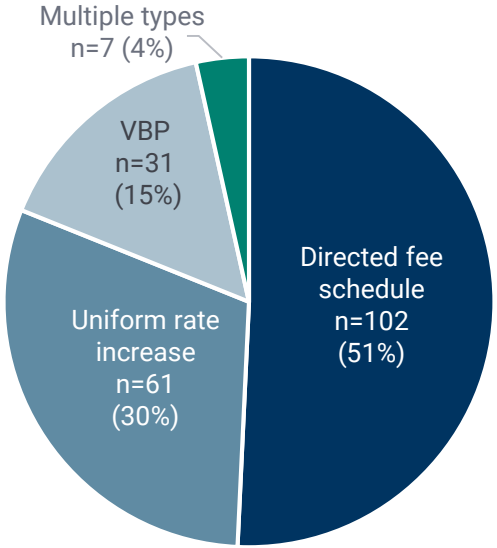
- The 2016 managed care rule created a new option for states to direct managed care payments to providers
- MACPAC's recent review found that the use of and spending on directed payments has grown significantly in recent years
  - 65 arrangements in August 2018; more than 200 in December 2020
  - For the half of approved arrangements with spending information, projected spending totaled $25.6 billion in 2020
  - Projected spending is larger than disproportionate share hospital (DSH) and upper payment limit (UPL) supplemental payments
  - There is currently no upper limit on directed payment amounts

Types of Directed Payments

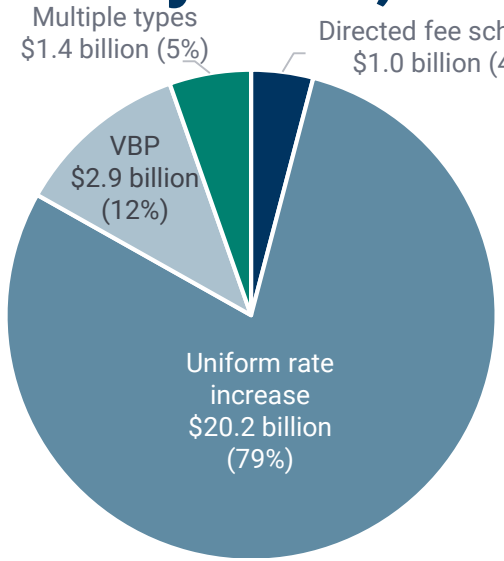


Notes: VBP is value-based payment. Min/max fee schedule is minimum or maximum fee schedule. Since 2020, states no longer need to receive prior approval for minimum fee schedules based on fee-for-service rates approved in their Medicaid state plan.

Number of Arrangements and Projected Spending, by Type of Directed Payment, 2020



Approved directed payment arrangements (N = 201)



Spending for directed payment arrangements N = 96; Total = $25.6 billion

Notes: VBP is value-based payment. Based on analysis of directed payment programs approved through December 31, 2020 and excludes prior versions of directed payment arrangements that have been renewed or amended after they were initially approved (n=260) and COVID-19 expedited review directed payment programs (n=29) approved between March 20, 2020 and December 31, 2020.
Source: Mathematica, 2021, analysis of directed payment pre-prints approved through December 31, 2020.

Interview Findings

- We spoke with state officials, CMS, providers, actuaries, and health plans about their experience with directed payments
- Key themes:
  - Many directed payment arrangements are similar to supplemental payments in fee for service (FFS) and do not have a clear link to quality or access goals
  - Because the goals of these payments are unclear, it is difficult to assess whether they are meeting their objectives
  - It is also unclear how directed payments intended to promote access should relate to existing managed care access standards, such as network adequacy

Proposed Recommendations

Proposed Recommendation 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.

Proposed Recommendation 1: Rationale

- Directed payments are a large and growing portion of Medicaid spending
- CMS already makes approval documents for similar types of arrangements available on its website
- Managed care rate certifications complement approval documents by providing additional information about payment amounts
- Evaluation plans and results are important for understanding directed payment objectives and whether they are being met

Proposed Recommendation 1: Implications

- Federal spending
  - No effect on federal spending, but there may be some administrative effort to make existing information available
- States
  - No effect because states are already required to submit this information
- Health plans and providers
  - No direct effect; greater transparency may result in changes to directed payment methodologies over time
- Enrollees
  - No direct effect; over time, greater transparency could lead to greater public input about whether directed payments are meeting their intended goals of improving access and quality of care for enrollees

Proposed Recommendation 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 payments amounts publicly available in a standard format that enables analysis.

Proposed Recommendation 2: Rationale

- Directed payments are now larger than DSH and UPL supplemental payments, but we have much less data on which providers receive directed payments
  - States have long been required to submit hospital-level DSH audits each year
  - Beginning in fiscal year 2022, states are required to submit provider-level information on UPL supplemental payments
- Collecting data on actual spending would help CMS ensure that spending is consistent with what was approved
- This recommendation builds off of the Commission's prior recommendations for provider-level supplemental payment data

Proposed Recommendation 2: Implications

- Federal spending
  - No effect on federal spending, but some administrative effort likely required (e.g., developing reporting standards, information technology system changes)
- States
  - May require some increase in administrative effort by states to compile information, but many state officials we interviewed noted that they already collect this information
- Health plans
  - May need to submit additional information, depending on data collection approach
- Providers
  - No direct effect
- Enrollees
  - No direct effect

Proposed Recommendation 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.

Proposed Recommendation 3: Rationale

- The link between directed payments and access goals is unclear
  - Managed care rates are already required to be sufficient to ensure access
  - It is not clear what improvements to access states are buying when they use directed payments to make additional payments to providers above rates that were previously certified as actuarially sound
- Distinguishing payments needed to meet existing access standards from payments intended to improve access above this level would help inform how directed payments are evaluated and incorporated into managed care rates
  - Quantifying how directed payment amounts compare to prior supplemental payments is a first step towards clarifying payment goals
  - This distinction could also help inform future policy development

Proposed Recommendation 3: Implications

- Federal spending
  - No effect on federal spending and relatively little administrative effort
- States
  - Little additional administrative effort for states because they already provide information on goals for directed payments as part of the approval process
- Health plans and providers
  - No direct effect; over time, greater transparency may lead to changes in directed payment methodologies
- Enrollees
  - No direct effect; not enough information to assess how states might change their directed payment methodologies in response to federal requirements to clarify their payment goals

Proposed Recommendation 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, multi-year evaluation plans for directed payment arrangements that increase provider payment rates above the rates described in the Medicaid state plan.

Proposed Recommendation 4: Rationale

- MACPAC's review of directed payment evaluations raised several concerns
  - Many directed payment arrangements did not report any evaluation results, even after multiple renewals
  - In some instances, performance on quality measures declined but the payment arrangement was renewed without changes
- Multi-year evaluation plans would help improve states' ability to conduct meaningful assessments of performance
- The subset of arrangements that make additional payments to providers account for most directed payment spending and merit a more rigorous review

Proposed Recommendation 4: Implications

- Federal spending
  - No effect on federal spending, but some administrative effort likely required to develop guidance
- States
  - May increase administrative efforts for states that currently do not have rigorous evaluation plans, but multi-year evaluation plans rather than single-year evaluation plans would reduce effort over time
- Health plans and providers
  - Plans and providers may be required to report additional information about performance on quality and access measures, but the burden could be reduced if it is coordinated with existing quality reporting efforts
- Enrollees
  - No direct effect on enrollees; over time, better evaluations may help ensure that directed payments promote better access to quality care

Proposed Recommendation 5

To promote more meaningful oversight of directed payments, the Secretary of Health and Human Services should coordinate the review of directed payments and review of managed care capitation rates by clarifying roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services.

Proposed Recommendation 5: Rationale

- During our interviews, we heard conflicting views about the extent to which actuaries should be involved in assessing directed payments
  - Actuaries must assess whether rates are reasonable and appropriate
  - However, if CMS approves a directed payment amount, there is little for the actuary to review
- Additional guidance about roles and responsibilities should include:
  - Clarification of who is responsible for reviewing directed payment amounts
  - Guidance about whether capitation rates should be sufficient to comply with access standards before or after accounting for directed payments
  - Instructions about what additional federal review is needed after CMS approves a directed payment pre-print

Proposed Recommendation 5: Implications

- Federal spending
  - No effect on federal spending; additional administrative effort to clarify roles may result in better coordination that lowers administrative effort over time
  - 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 reduce burden for states over time
- Health plans and providers
  - No direct effect; over time, a more coordinated approval process may help expedite reviews, proving more certainty about future Medicaid payments
- Enrollees
  - No direct effect on enrollees; over time, clarity about oversight processes could help improve compliance with existing access standards

Next Steps

Upper Limits on Directed Payments

- The draft chapter will also discuss issues to consider when setting an upper limit on directed payment amounts, but will not include a recommendation
- Potential limits
  - External benchmark (e.g., UPL, which is based on Medicare)
  - Historic spending (e.g., DSH allotments)
- Data for future analysis
  - We hope to have more aggregate spending data in the future as a result of CMS's new directed payment pre-print form
  - Adoption of transparency recommendations could also help inform analyses of the effects of an upper limit on directed payment amounts

Next Steps

- Plan to discuss a draft chapter and vote on final recommendations at the April meeting
- Anticipate that the Commission will vote on these recommendations as a single package

Proposed Recommendations

- 1. Better transparency of existing directed payment information
- 2. New, provider-level data on directed payment spending
- 3. Clarifying directed payment goals and their relationship to network adequacy requirements
- 4. Guidance for directed payment evaluations
- 5. Coordinating reviews of directed payments and managed care rates

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