MACPAC

Oversight of Managed Care Directed Payments

Draft Chapter and Recommendations for June Report to Congress

Medicaid and CHIP Payment and Access Commission

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Overview

- Background
- Uses of directed payments
- Current oversight process
- Proposed recommendations
- 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
  - Phased out the use of pass-through payments and clarified that supplemental payments in managed care are not actuarially sound
  - Directed payments were intended to advance quality and access goals
- Use and spending on directed payments has grown rapidly
  - 65 arrangements in August 2018; more than 200 in December 2020
  - For the half of approved arrangements with spending information, projected spending totaled $25.7 billion in 2020
  - There is currently no limit on directed payment amounts

Types of Directed Payments

- We reviewed directed payment arrangements and classified them using the categories used on CMS's application form
  - Most directed payment arrangements establish a minimum fee schedule
  - Most directed payment spending is for uniform rate increases
- Commissioners noted that some directed payments that make large lump sum payments to providers are difficult to categorize
  - 35 directed payment arrangements increasing payments by more than $100 million a year accounted for 90 percent of reported directed payment spending
  - Most of these are uniform rate increases but some are pay-for-performance incentives similar to Delivery System Reform Incentive Payments (DSRIP)
  - Most are targeted to hospitals, financed by hospitals, and pay providers above the corresponding Medicare rate

Directed Payment Examples

- Adjusting base payment rates
  - Florida requiring managed care organizations (MCOs) to pay nursing facilities no less than the fee-for-service (FFS) rate
  - Massachusetts making temporary rate increases during COVID pandemic
- Preserving prior supplemental payments
  - Utah preserving a prior pass through payments to hospitals
  - California transitioning its DSRIP program to a directed payment
- Making new supplemental payments
  - Florida making $1.8 billion in new payments to hospitals not tied to quality
  - Ohio tripling payments to selected hospital-based physicians and tying a portion of the payment to achievement of quality goals

Directed Payment Oversight

- Pre-print approval
  - States submit a standard application form (referred to as a pre-print) for CMS review before implementing directed payments not based on state plan rates
  - CMS recently revised its pre-print to help streamline the review process
- Capitation rate development
  - Once directed payments are approved by CMS, they are incorporated into capitation rates, which must be certified as actuarially sound
  - Actuaries are not involved in reviewing directed payment amounts
- Evaluation
  - States are required to develop evaluation plans for their directed payment arrangements, but few are available and results of evaluations are mixed

Proposed Recommendations

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.

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
- Little administrative effort to make existing information available

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.

Recommendation 2: Rationale

- This recommendation builds off of the Commission's prior recommendations for provider-level supplemental payment data
- Provider level data are available for disproportionate share hospital (DSH) and upper payment limit (UPL) supplemental payments
- Chapter discusses design considerations to limit administrative burden of data collection
  - Smaller directed payments that adjust base payment rates could be collected through the Transformed Medicaid Statistical Information System (T-MSIS)
  - Larger, lump sum payments that are not in T-MSIS could be tracked using the same process used for UPL payments

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.

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
- Benchmarking payment amounts can help clarify payment goals
  - Comparing to prior supplemental payments (if applicable)
  - Comparing to Medicare payment rates or another benchmark
- Distinguishing payments needed to meet existing access standards from payments intended to improve access would help inform how payments are evaluated and incorporated into managed care rates

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 substantially increase provider payments above the rates described in the Medicaid state plan.

Recommendation 4: Rationale

- MACPAC's review of directed payment evaluations raised several concerns:
  - Many directed payments arrangements have no reported evaluation results
  - 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 substantially increase payments merit a more rigorous review

Recommendation 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.

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 about 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

Next Steps

Upper Limits on Directed Payments

- The chapter concludes with a discussion of issues to consider when setting an upper limit on directed payment amounts
- Potential limits
  - External benchmark (e.g., UPL, which is based on Medicare)
  - Historic spending (e.g., DSH allotments)
- Interaction with other limits on managed care spending
  - Section 1115 demonstration budget neutrality
  - Section 1915(b) waiver cost-effectiveness test
- More information about directed payment spending is needed to assess the effects of any new limits

Next Steps

- The Commission will vote tomorrow on these recommendations as a single package
- Chapter will be included in June report to Congress

Proposed Recommendation Summary

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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