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. These directed payment arrangements can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment (VBP) arrangements, or to make uniform payment rate increases. Several 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] In 2024, CMS released a managed care rule that made additional updates intended to improve the oversight and transparency of directed payments (CMS 2024).

This issue brief discusses the history of directed payment policy, highlights changes made in the 2024 managed care rule, and examines the use of directed payments based on MACPAC's review of directed payments approved as of August 1, 2024. 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) 2022, about 36 percent ($56 billion) of FFS payments to hospitals, mental health facilities, nursing facilities, and physicians were supplemental payments (MACPAC 2023). More information about supplemental payments is included in MACPAC's issue brief *Base and Supplemental Payments to Hospitals* (MACPAC 2024a).

Federal rules do not allow states to make supplemental payments for services provided in managed care.[2] 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.[3] 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.[4]

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 2023). 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 reviewed all standard application forms (referred to as a preprint) for directed payments approved between February 1, 2023 and August 1, 2024. We did not include directed payments that set minimum fee schedules at state plan approved rates in our analysis because they are exempt from prior CMS written approval. This analysis updates MACPAC's prior review of directed payments approved between July 1, 2021 and February 1, 2023. All directed payment preprints approved on or after February 1, 2023 are publicly available on the Medicaid.gov website.

Types of directed payments

Our review classified directed payment arrangements into three categories, based on the distinctions CMS uses in its preprint.

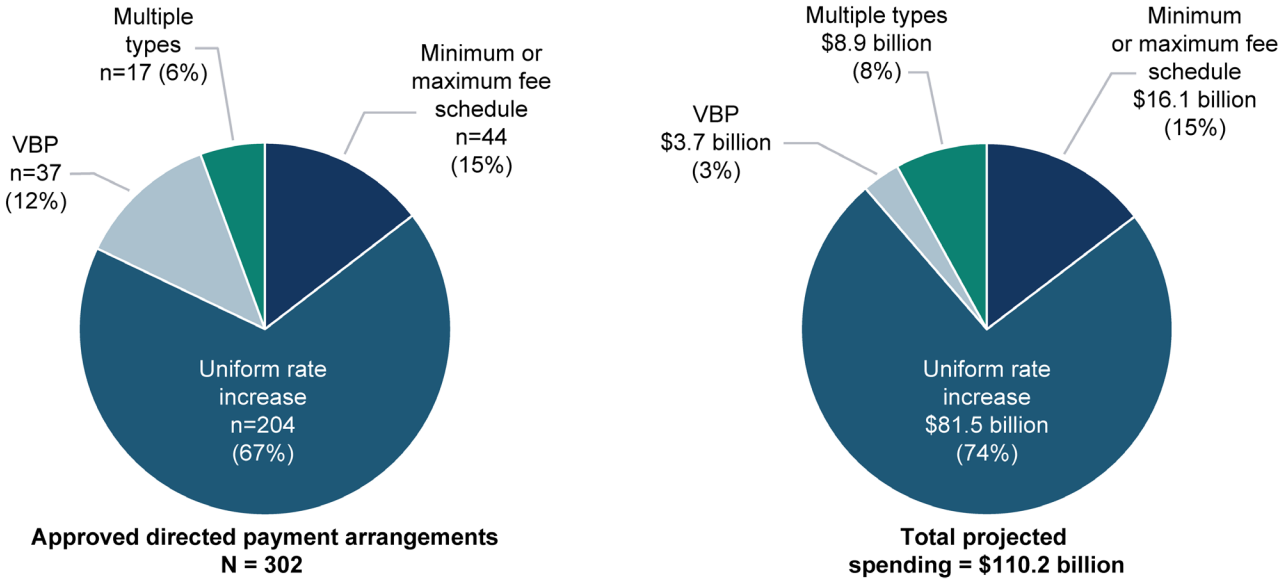
- **Minimum or maximum fee schedule:** a type of directed payment that sets parameters for the base payment rates that managed care plans pay for specified services. MACPAC's prior review of directed payments approved before December 31, 2020 found that most directed fee schedules required MCOs to pay providers no less than the FFS rate approved in the Medicaid state plan. Effective December 2020, CMS no longer requires states to submit preprints for fee schedules that require MCOs to pay providers no less than the state plan approved FFS rate, so these arrangements are not included in this analysis (CMS 2020). In the 2024 managed care rule, CMS also exempts states from submitting preprints for fee schedules set at 100 percent of Medicare rates, which is effective July 9, 2024 (CMS 2024). States are still required to submit directed payment preprints for minimum or maximum fee schedules based on fee schedules other than state plan or Medicare approved rates, such as rates that are at 90 percent of Medicare or at average commercial rates.
- **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, of the three types of directed payments.
- **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 multi-payer 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

Between February 1, 2023 and August 1, 2024, CMS has approved 302 distinct directed payment arrangements in 40 states and Puerto Rico.[5] Most of these directed payments were uniform rate increases and these types of arrangements also accounted for the majority of directed payment spending (Figure 1).

FIGURE 1. Directed Payment Types and Projected Payment Amounts, 2024



Notes: VBP is value-based payment. This analysis is based on a review of unique directed payment arrangements approved between February 1, 2023 and August 1, 2024. Minimum fee schedules based on state plan rates are not included because states no longer need to obtain prior approval for these arrangements. Analysis excludes prior versions of directed payment arrangements that were subsequently renewed or amended (n = 198) and directed payments approved after February 1, 2023 that did not use CMS's new template (n = 6). Projected payment amounts represent annualized amounts for the most recent rating period, which may differ from calendar year or fiscal year 2024. In addition, projected spending reported in directed payment approval documents may differ from actual spending.

Source: MACPAC, 2024, analysis of directed payment preprints approved through August 1, 2024.

Between February 1, 2023 and August 1, 2024, the number of distinct directed payment arrangements continued to grow for all directed payment types. Compared to 250 unique directed payment arrangements approved between July 1, 2021 and February 1, 2023, CMS approved 302 unique directed payment arrangements between February 1, 2023 and August 1, 2024, a 21 percent increase from the review period in our last analysis.

Overall, the directed payment arrangements approved as of August 1, 2024 are projected to spend a total of $110.2 billion a year, which is nearly a 60 percent increase over the $69.3 billion in projected spending identified in our review of arrangements approved as of February 2023. Because preprints are based on state-reported spending estimates, there are certain data limitations. We found that projected spending amounts were not always reported in a consistent format.[6] Furthermore, the actual spending amounts may be higher or lower than the amount projected in approval documents. Preprints are not resubmitted to reconcile to the actual payment amounts. Despite these limitations, directed payment preprints are still the most reliable source of directed payment amounts publicly available because there is no centralized reporting system for final directed payment spending as of our analysis.[7]

A small number of directed payment arrangements account for the vast majority of projected spending. Specifically, about 72 percent of all directed payment spending that we identified was attributable to 29 directed payment arrangements that were each projected to increase payments to providers by greater than $1 billion 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 increased provider payments above

the Medicare payment rate, which is generally used as the upper limit on FFS payments (MACPAC 2021). Eleven of the 29 directed payments we identified increased provider payments up to at least 90 percent of the average commercial rate, or the average rate that providers negotiate with private payers.

In the 2024 managed care rule, CMS formalized the average commercial rate as the regulatory upper payment limit on the amount of directed payment spending that states can make for hospital services, professional services at academic medical centers, and nursing facility services (CMS 2024). The average commercial rate is often much higher than the amount Medicare would have paid for the same service. For example, according to the Congressional Budget Office's review of recent studies, commercial hospital payments were 223 percent of Medicare payment rates and commercial physician payment rates were 129 percent of Medicare rates on average (CBO 2022). While there is not a regulatory upper payment limit on directed payment spending for other services, CMS has indicated that they will apply the average commercial rate as a standard when evaluating directed payment arrangements for those other services (CMS 2024).

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, and uniform rate increases and VBP arrangements were most often targeted to hospitals. Minimum or maximum fee schedules and VBP arrangements were mainly financed with state general funds, but most uniform rate increases were financed by providers through provider taxes or IGTs. Most minimum or maximum fee schedules were incorporated as adjustments to base capitation rates, while most uniform rate increases and VBP arrangements were incorporated through separate payment terms.

TABLE 1. Directed Payment Programs by Payment Type, Provider Type, and Funding Source, 2024

Directed payment characteristics	Minimum or maximum fee schedule		Uniform rate increase		VBP		Total	
	Number	Share	Number	Share	Number	Share	Number	Share
Total	**46**	**100%**	**220**	**100%**	**53**	**100%**	**302**	**100%**
Provider type								
Hospitals	10	22	101	46	24	45	128	42
Professional services at AMCs or public hospital systems	3	7	28	13	8	15	34	11
Physicians and other professional service providers	11	24	16	7	9	17	33	11
Mental health and substance abuse providers	16	35	35	16	8	15	58	19
Nursing facilities	4	9	19	9	8	15	27	9
Dental providers	5	11	5	2	0	0	10	3
HCBS providers	3	7	23	10	4	8	29	10
Other	17	37	48	22	10	19	73	24
Funding source								
State general fund	43	93	85	39	27	51	148	49
Intergovernmental transfer	6	13	84	38	15	28	96	32

Directed payment characteristics	Minimum or maximum fee schedule		Uniform rate increase		VBP		Total	
	Number	Share	Number	Share	Number	Share	Number	Share
Health care-related tax	10	22	80	36	13	25	97	32
Other non-state general fund	7	15	26	12	6	11	38	13
Payment Method								
Separate payment term	2	4	149	68	33	62	176	58
Capitation rate adjustment	42	91	67	30	16	30	120	40
Other	2	4	4	2	4	8	6	2

Notes: VBP is value-based payment. AMCs are academic medical centers. HCBS is home- and community-based services. This analysis is based on a review of unique directed payment arrangements approved between February 1, 2023 and August 1, 2024. Minimum fee schedules based on state plan rates are not included because states no longer need to obtain prior approval for these arrangements. Analysis excludes prior versions of directed payment arrangements that were subsequently renewed or amended (n = 198) and directed payments approved after February 1, 2023 that did not use CMS's new template (n = 6). Totals do not sum because a single directed payment arrangement can target multiple provider types or have multiple funding sources.

Source: MACPAC, 2024, analysis of directed payment arrangements approved through August 1, 2024.

The largest directed payment arrangements are typically targeted to hospitals and financed by provider taxes or IGTs paid by these providers. Of the 29 directed payment arrangements projected to increase payments to providers by more than $1 billion a year, 24 were targeted to hospital systems and 26 were financed by provider taxes or IGTs.

Separate payment terms

Separate payment terms are a type of payment method that provides a fixed amount of directed payment funding outside of the base capitation rate. States often use separate payment terms to make large uniform rate increases. Out of the $81.5 billion of annual spending on uniform rate increases, $70.6 billion, or 87 percent, were delivered through separate payment terms.[8] Many of these directed payment arrangements incorporated through separate payment terms raised hospital payment rates up to the average commercial rate. Furthermore, states tend to use provider contributions to finance uniform rate increases incorporated as separate payment terms. Provider taxes and IGTs financed the majority (78 percent) of these directed payments, as opposed to 34 percent of uniform rate increases incorporated via base rate adjustments.

Under the 2024 managed care rule, separate payment terms will be eliminated effective for the first rating period beginning on or after July 9, 2027, and all directed payment arrangements will henceforth be required to be incorporated through capitation rate adjustments (CMS 2024). CMS eliminated separate payment terms due to concerns that payment streams separate from capitation rates undermine the risk-based nature of managed care and are often driven by the underlying financing of the non-federal share. The transition from separate payment terms to base rate adjustments will have implications for a significant share of directed payments, particularly large uniform rate increases that have been historically paid out as separate pools of funding.

Goals of directed payments

Improving access to care was the most common goal stated in directed payment arrangements approved as of August 1, 2024. 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.

States focused on promoting access to care for specific services or populations based on a range of criteria. For example, one state offered directed payments for hospitals in low-income counties, and another state increased payment for hospitals that provided services for a high percentage of Medicaid beneficiaries. States also administered directed payments for increasing access to specific provider types, such as critical access hospitals, rural health clinics, children's hospitals, and community mental health centers, as well as for specific services, such as behavioral and maternal health services.

VBP directed payment arrangements were more likely to address goals tied to quality of care and patient outcomes. For example, reducing avoidable hospital use and increasing receipt of preventive screenings were commonly identified VBP objectives. VBP directed payment arrangements were also more likely to advance goals related to cost-effectiveness. During interviews from our prior research, 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. The 2024 managed care final rule added more specific evaluation plan requirements (CMS 2024).

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 it approves directed payments. Directed payment preprints are not automatically renewed and, in general, states must submit a new preprint every year for review.[9]

Capitation rate development

After CMS approves a preprint, 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 2022b).

Evaluation

States are required to develop evaluation plans for directed payments at the time of their preprint submission and should report evaluation results when the directed payment is renewed.[10] States reported a variety of evaluation measures in preprints approved as of August 1, 2024, such as hospitalization and readmission rates, utilization and timeliness of preventive and specialty care services, and outcome measures for common chronic conditions.

In MACPAC's prior review of the information provided by CMS for directed payments approved as of December 31, 2020, 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. CMS similarly found that the majority of evaluation plans submitted between April 2018 and February 2021 were incomplete and did not report evaluation results (CMS 2024).

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.

To improve oversight and compliance with evaluation plan requirements, CMS implemented additional standards for evaluation plans in the 2024 managed care final rule (CMS 2024). Effective for the first rating period beginning on or after July 9, 2027, evaluation plans will be required to include at least two metrics, one of which much be a performance metric, as well as baseline statistics and performance targets. Directed payment arrangements that exceed 1.5 percent of total managed care costs will also be required to submit evaluation reports every three years.

Policy Issues

The rapid growth of directed payments in recent years has presented several oversight challenges for CMS. As a result, CMS finalized a number of regulatory changes in the 2024 managed care rule intended to align directed payments with the risk-based nature of managed care. As noted above, CMS will eliminate separate payment terms and require states to incorporate directed payments into base capitation rates to have managed care plans bear more risk for directed payment spending. In addition, CMS will prohibit managed care plans from providing payments based on historical utilization and then reconciling to actual service utilization. In rulemaking, CMS expressed concern that payments based on historical utilization reduce risk for managed care plans, and the prohibition of post-payment reconciliations would help ensure that directed payments are tied to actual service utilization. The elimination of separate payment terms and post-payment reconciliation processes will go into effect for the first rating period beginning on or after July 9, 2027.

The final rule included additional requirements to improve the compliance and transparency of directed payments. To enforce federal requirements on permissible funding sources for the non-federal share, the final rule requires states to collect provider attestations indicating that they do not participate in any hold harmless arrangement for a provider tax.[11] In addition, the final rule implemented more stringent requirements for evaluation and reporting. For example, CMS will require states to report provider-level directed payment data via the Transformed Medicaid Statistical Information System (T-MSIS) upon the release of reporting instructions.

MACPAC's June 2022 *Report to Congress on Medicaid and CHIP* included 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).

While the changes in the 2024 managed care rule align with MACPAC's prior recommendations to increase the transparency and oversight of directed payments, further information and clarity on directed payments are still needed to fully understand the goals and uses of directed payments. The 2024 rule does not include information on the sources of non-federal share used to fund directed payments, which is critical for us to examine the effects of any changes to directed payments on access, quality, and value for providers and beneficiaries.

Summary

Overall, our findings show that directed payment arrangements have continued to grow substantially in their usage and spending amounts, often increasing payment rates above Medicare rates and up to average commercial rates. Many directed payment arrangements focus on increasing access to Medicaid services, but the measures of access and quality vary widely across states, and rigorous evaluations of SDP arrangements have been lacking. Additionally, the absence of data on actual directed payment amounts at the provider level limit the ability for stakeholders to assess how these directed payments may relate to specific state policy goals.

Although CMS has taken steps to strengthen transparency and support the fiscal integrity of directed payments under the 2024 managed care rule, it will take time for these provisions to be fully implemented. Furthermore, there are still policy opportunities to ensure that directed payment programs are consistent with the statutory goals of efficiency, economy, quality, and access. For example, the managed care rule does not require reporting on the sources of non-federal share at the provider level that is needed to fully assess how net payments received by providers relate to access, quality, and efficiency. In Chapter 1 of MACPAC's June 2024 *Report to Congress on Medicaid and CHIP*, MACPAC advanced a recommendation to require states to report their Medicaid financing methods, state-level financing amounts, and provider-level costs of financing the non-federal share (MACPAC 2024b).

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] States can make disproportionate share hospital (DSH) and graduate medical education (GME) payments for services provided in managed care.

[3] For example, in FY 2022, seven states reported spending on delivery system reform incentive payment (DSRIP) or DSRIP-like programs, and seven states reported spending on uncompensated care pools authorized under Section 1115 demonstrations (MACPAC 2024a).

[4] 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). The managed care final rule in 2024 subsequently eliminated the requirement for states to obtain prior approval for fee schedules based on Medicare rates (CMS 2024).

[5] This analysis is based on a review of distinct directed payment arrangements approved between February 1, 2023 and August 1, 2024. 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. We excluded prior versions of directed payment arrangements that were subsequently renewed or amended (n = 198) and directed payments approved after February 1, 2023 that did not use CMS's required template (n = 6).

[6] For example, for some directed payment arrangements that involve minimum or maximum fee schedules, some states appear to report total spending for the covered service instead of separately reporting the additional payment attributable to the directed payment arrangement. Similarly, in one state that uses a directed payment to require participation in an accountable care organization (ACOs) program, the state appears to count all spending to the participating ACOs, including payments for services that would have otherwise been covered without the directed payment.

[7] The 2024 managed care rule issued new requirements for states to submit provider-level data on directed payment spending via the Transformed Medicaid Statistical Information System (T-MSIS). This requirement will not go into effect until the date CMS specifies in subsequent T-MSIS reporting instructions.

[8] Our estimate of uniform rate increases through separate payment terms excludes directed payment arrangements that include multiple types of arrangements and arrangements that use a combination of separate payment terms and base rate adjustments.

[9] States can obtain multi-year approval of VBP directed payment arrangements (CMS 2017b).

[10] Federal regulations do not explicitly require states to submit evaluation plan results, but CMS noted that it asks for this information during its review of directed payment renewal requests. Effective July 2027, states will be required to submit evaluation reports with three years of performance results for directed payment arrangements that exceed 1.5 percent of the total capitation payments (CMS 2024).

[11] Current federal regulations prohibit hold harmless arrangements, which constitute arrangements where a state or other unit of government imposing a health care-related tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount ((§ 1903(w)(4) of the Act; 42 CFR 433.68(f)).

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