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 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. In 2024, CMS released a managed care rule that made additional updates intended to improve the oversight and transparency of directed payments.

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. Between February 1, 2023 and August 1, 2024, the number of distinct directed payment arrangements continued to grow for all directed payment types. 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.

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*](https://www.macpac.gov/publication/june-2022-report-to-congress-on-medicaid-and-chip/) (MACPAC 2022a).