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June 28, 2022

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
The Honorable Cathy McMorris Rodgers
Republican Leader
Committee on Energy & Commerce
House of Representatives
The Honorable James Comer
Ranking Member
Committee on Oversight and Reform
House of Representatives

Medicaid: State Directed Payments in Managed Care

Medicaid—a joint, federal-state program that finances health care coverage for certain low-income and medically needy populations—covered an estimated 78 million individuals at an estimated cost of \$709 billion in fiscal year 2021.¹ Federal matching funds are available to states for different types of Medicaid payments that states make according to each state’s federal medical assistance percentage.² States finance their share of Medicaid payments—called the nonfederal share—with state general funds and, within limits, other sources of funding, such as taxes on health care providers and funds from local governments.

States may provide Medicaid services under a managed care model, a fee-for-service model, or both.³ Under managed care, states pay managed care plans capitation payments, which are fixed periodic payments typically paid on a per enrolled Medicaid beneficiary basis.⁴ In turn, the managed care plans are responsible for paying providers for the services delivered to enrolled beneficiaries.

¹See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *2018 Actuarial Report on the Financial Outlook on Medicaid* (Baltimore, Md.).

²The federal medical assistance percentage is based on a formula established by law. The formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. Under the Families First Coronavirus Response Act, states received a temporary additional 6.2 percentage point increase in federal matching funds. See Pub. L. No. 116-127, div. F, § 6008, 134 Stat. 178, 208 (2020).

³Under fee-for-service, states make payments directly to providers for services provided.

⁴For purposes of this report, we use the term managed care plans to refer to managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans.

In general, states are not permitted to direct a managed care plan's payments to its providers.⁵ However, in 2016, the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services that oversees Medicaid, issued regulations establishing certain circumstances under which states may direct managed care plan payments to providers, referred to as state directed payments.⁶ Within federal parameters, states determine the criteria for providers to receive directed payments; for example, directing a payment to providers that improve performance in providing timely access to care.

The regulations generally require annual CMS approval in advance of implementing state directed payments, which were permitted beginning in July 2017. The regulations also required states to phase out payments states had been directing managed care plans to make, but that CMS no longer considered allowable, referred to as pass-through payments.⁷ In January 2021, CMS issued additional guidance and revised its review process, in part, to enhance program integrity around state directed payments.⁸

We performed our work under the authority of the Comptroller General to conduct evaluations on the Medicaid program to assist Congress with its oversight responsibilities. In this report, we describe (1) the use of state directed payments in Medicaid, and (2) CMS's changes to guidance and oversight of state directed payments.

To address our objectives, we analyzed the following CMS information:

- the number of approved state directed payments each year from 2017 through 2021 (the most recent year for which complete information on approvals was available) by state; and
- documentation for approved state proposals for payments taking effect on July 1, 2021, or later (a total of 79 as of February 2022).⁹

We also reviewed federal regulations and CMS guidance, and interviewed CMS officials about recent and planned changes to oversight.

⁵There are limited circumstances in which a state may direct a managed care plan's payments to providers, such as in the case of payments for graduate medical education or Medicaid disproportionate share hospital payments. See 42 C.F.R. § 438.60 (2021).

⁶See 81 Fed. Reg. 27,498 (May 6, 2016) (amending 42 C.F.R. § 438.6(c)). These state directed payments must be based on delivery and utilization of services to Medicaid beneficiaries covered under the contract, outcomes, and quality of delivered services. See 42 C.F.R. § 438.6(c)(1) (2021).

⁷According to CMS, pass-through payments were commonly made in states that had moved from a fee-for-service payment model, under which states make base payments to providers for services provided, as well as supplemental payments, to a managed care model of capitated payments. CMS has noted that pass-through payments have been made to ensure a consistent payment stream for certain critical safety-net hospitals and providers. In 2016, CMS provided states with up to 10 years to phase-out pass-through payments, and simultaneously authorized states to begin making state-directed payments. See 81 Fed. Reg. 27,498 (May 6, 2016) (amending 42 C.F.R. § 438.6(d) (pass-through payments)).

⁸See Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services, *RE: Additional Guidance on State Directed Payments in Medicaid Managed Care*, State Medicaid Director Letter (Baltimore, Md.: Jan. 8, 2021).

⁹State proposals for directed payments beginning on or after July 1, 2021, include the estimated amount of total payments, as well as the estimated federal and nonfederal share of payments. For purposes of this report, states include the District of Columbia and Puerto Rico.

We conducted this performance audit from January 2022 to June 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Managed Care Payments

Under managed care, states make capitation payments to managed care plans that contract with the state to provide or arrange for services to enrolled Medicaid beneficiaries. Capitated payments must be actuarially sound, covering the reasonable, appropriate and attainable costs associated with providing the services under the contract. In general, states may not make additional payments for services covered under the contracts nor direct managed care plans' payments to providers.¹⁰ However, beginning with contract rating periods starting on or after July 1, 2017, CMS allows states to direct how managed care plans pay providers under certain circumstances.¹¹ Within those parameters, states establish the criteria for providers to receive these directed payments. For example, CMS approved a state directed payment for providers that achieve a 5 percentage point improvement in enrolled beneficiaries receiving timely access to care from one year to the next. There is no aggregate limit on the amount of directed payments a state may request.

Federal matching funds are available for state directed payments. States can incorporate directed payments into capitation rates in different ways. As shown in figure 1, a directed payment can be established as

- a separate payment term; for example, a dollar amount separate from the existing capitation rate;¹² or
- an adjustment to the base capitation rate; for example, a percentage or dollar amount increase in the rate.¹³

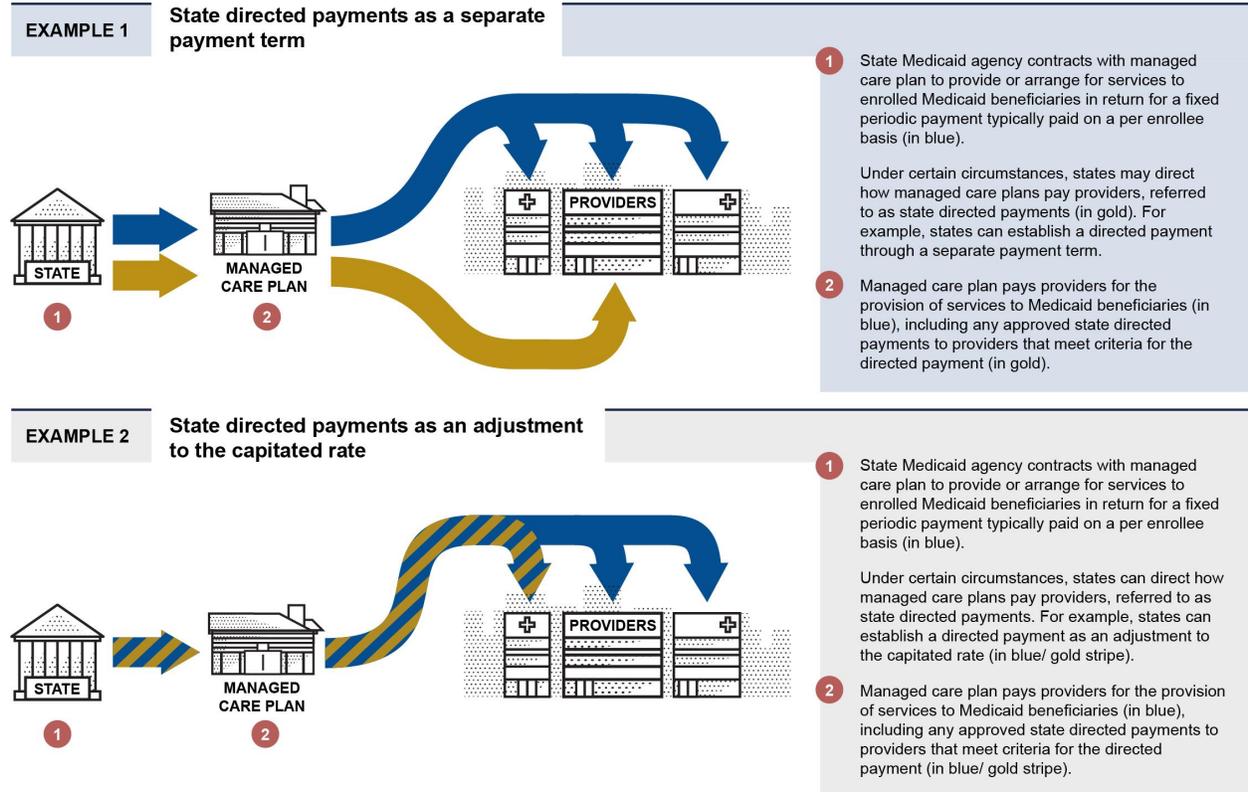
¹⁰Exceptions apply. See 42 C.F.R. §§ 438.60, 438.6 (2021).

¹¹In general, these circumstances include (1) directing managed care plans to implement provider payment models intended to recognize value or outcomes over volume of services; (2) directing managed care plans to participate in multi-payer or Medicaid-specific delivery system reform, or performance improvement initiatives; and (3) directing managed care plans to adopt certain provider payment parameters (e.g., minimum fee schedules). See 42 C.F.R. § 438.6(c)(1) (2021).

¹²The separate payment term is captured in the applicable actuarial rate certification that the state submits for its capitation rates. However, the directed payment is made separately to the managed care plans from the capitation rates paid to plans. Actuarially sound capitation rates must be certified by an actuary as being appropriate for the populations and services covered, and adequate for managed care plans to meet requirements for ensuring availability and timely access to services.

¹³The adjustment is applied in developing the capitation rates paid to managed care plans.

Figure 1: Overview of How State Directed Payments are Made in Medicaid Managed Care



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-22-105731

Notes: See 42 C.F.R. § 438.6(c) (2021). Managed care plans refers to managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans.

CMS Oversight of State Directed Payments

States generally must receive CMS approval in writing in advance of implementing a state directed payment. Before approval, CMS officials review state directed payment proposals to ensure they meet federal requirements and are appropriately incorporated into managed care contracts and capitation rates. For example, CMS reviews how the state directed payment will be used and how the nonfederal share of the payment will be financed to ensure compliance with federal requirements, which include that the directed payment must:

- not be conditioned upon intergovernmental transfers of funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments;¹⁴
- be based on utilization and delivery of services;

¹⁴Federal law requires that states finance at least 40 percent of their share of total Medicaid expenditures through state funds. Within limits, however, states can use other funding sources to finance the nonfederal share. For example, states can finance their nonfederal share of Medicaid expenditures through intergovernmental transfers, which are transfers of funds from local government entities, including hospitals or other providers that are owned or operated by local governments.

- be directed equally, using the same terms of performance across a class of providers; for example, all rural hospitals would be subject to the same metrics and benchmarks for earning a payment, and the amount each provider would earn would be based on each provider's individual performance;¹⁵ and
- be expected to advance at least one goal in the state's Medicaid managed care quality strategy and have an evaluation plan that measures the degree to which the payment is meeting such goals.¹⁶

After an initial review of the state proposal, CMS may send clarifying questions and request revisions. CMS also checks that the directed payment is linked to a specific service or benefit provided to a specific Medicaid beneficiary covered under the contract; in guidance, the agency noted this is necessary to meet actuarial soundness requirements for capitation rates.¹⁷

State Use of Directed Payments Is Widespread, with Estimated Spending of at least \$20 Billion for Approved Payments on or after July 2021

CMS has approved 660 state directed payment proposals since it began approving them in 2017, according to the agency's information. As shown in figure 2, CMS approved the most state directed payment proposals in 2020, the same year the agency issued guidance on how states could use directed payments to require managed care plans to temporarily enhance provider payments in response to the COVID-19 pandemic.¹⁸

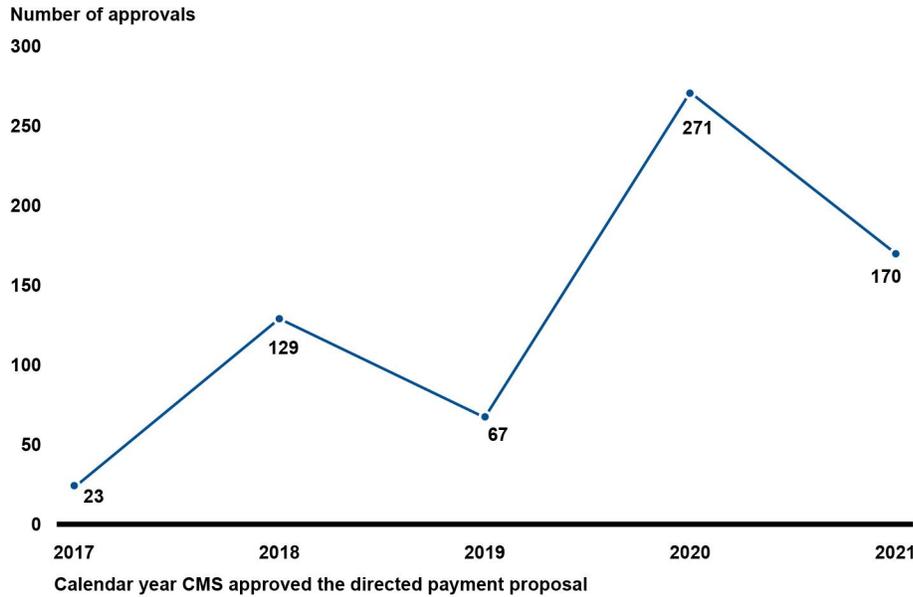
¹⁵According to CMS, the agency has deferred to states in defining the provider class for purposes of state directed payment arrangements, as long as the provider class is reasonable and identifiable, such as the provider class being defined in the state's Medicaid plan.

¹⁶The state's Medicaid managed care quality strategy is a public document required by CMS that includes goals and a process for reviewing managed care plan performance.

¹⁷See Centers for Medicaid & CHIP Services, *RE: Additional Guidance on State Directed Payments in Medicaid Managed Care*.

¹⁸See Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services, *Medicaid Managed Care Options in Responding to COVID-19*, Informational Bulletin (Baltimore, Md.: May 14, 2020). Contract rating periods differ across states and may not correspond with the year in which the state directed payment proposal was approved.

Figure 2: State Directed Payments CMS Approved in 2017-2021



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-22-105731.

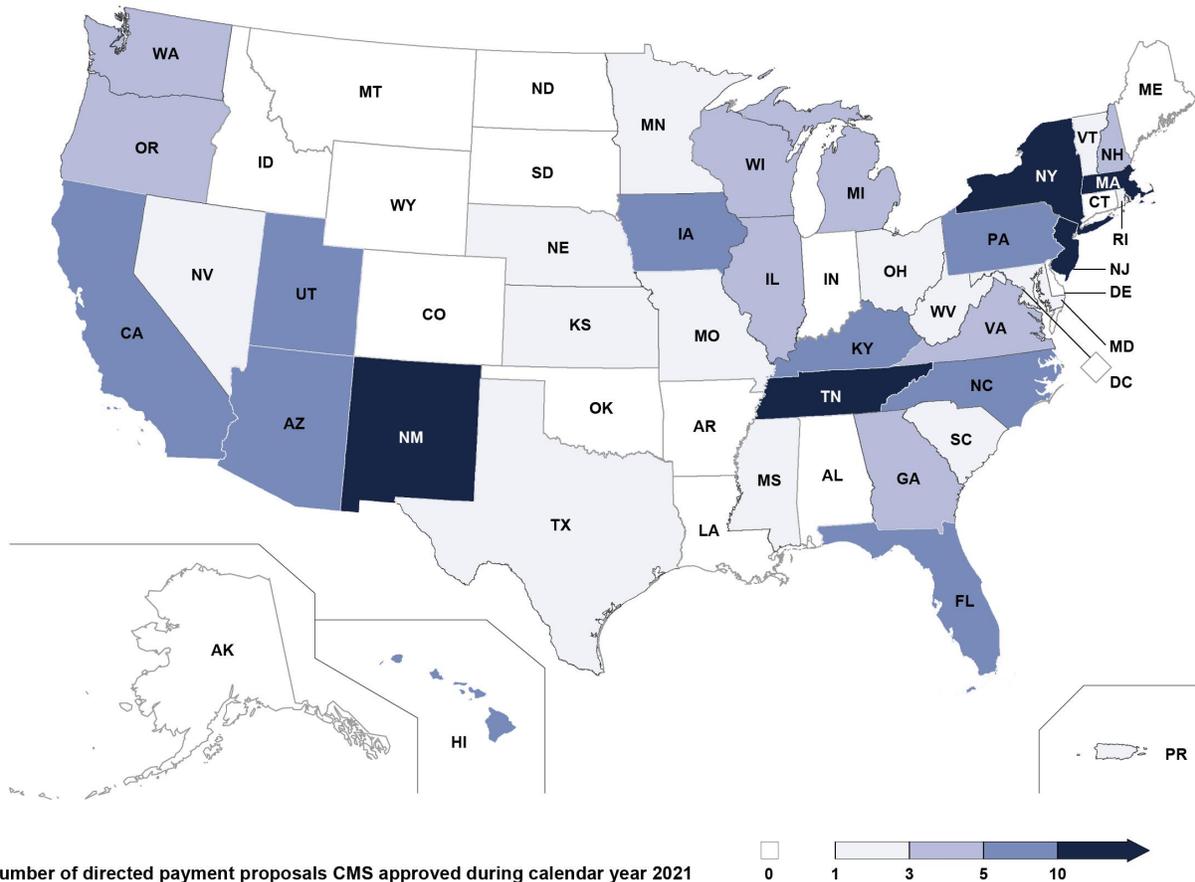
Accessible Data Table for Figure 2

	2017	2018	2019	2020	2021
Number of approvals	23	129	67	271	170

Notes: CMS began permitting state directed payments for Medicaid managed care contract rating periods beginning on or after July 1, 2017. Contract rating periods differ across states and may not correspond with the year in which the state directed payment proposal was approved. In May 2020, CMS issued guidance on how states could use directed payments to require certain managed care plans to temporarily enhance provider payment in response to the COVID-19 pandemic. In November 2020, CMS clarified that certain state directed payments setting a minimum fee schedule using state plan approved rates would no longer require CMS approval. In January 2021, CMS issued guidance clarifying the appropriate use of state directed payments. For the purpose of this figure, states include the District of Columbia and Puerto Rico.

Our analysis of CMS information also found that 36 states received CMS approval of one or more directed payments in 2021, the most recent year for which complete information on the number of approvals was available. This is an increase from the 10 states with approved proposals in 2017—the first year state directed payments were in effect. In 2021, the number of approved directed payments ranged from seven states each making one payment to 17 payments in New York. (See fig. 3.)

Figure 3: State Directed Payments Approved in 2021



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-22-105731

Note: Medicaid managed care contract rating periods differ across states and may not correspond with the year in which the state directed payment proposal was approved.

For the 79 approved proposals for state directed payments beginning on or after July 1, 2021, our analysis found that 28 states had \$20.0 billion in estimated total payments.¹⁹ Of the \$20.0 billion, states estimated about \$14.2 billion in federal share and \$5.8 billion in state share of the cost for those payments.²⁰ Of the 28 states with approved proposals, seven states estimated making total payments over \$1 billion each.

¹⁹State proposals for directed payments beginning on or after July 1, 2021, include the estimated amount of total payments, as well as the estimated federal and nonfederal share of payments. CMS had approved 79 proposals with this information as of February 7, 2022. The managed care contract rating period for 76 of the approved state directed payments was 12 months, with one contract rating period each of 6 months, 18 months, and 24 months.

²⁰These estimates are for contract years during which a temporary additional 6.2 percentage point increase in federal matching funds was available under the Families First Coronavirus Response Act. See Pub. L. No. 116-127, div. F, § 6008, 134 Stat. 178, 208 (2020).

Prior to July 1, 2021, CMS did not require states to provide estimates in directed payment proposals, so states did not consistently provide them.²¹ However, according to a Medicaid and CHIP Payment and Access Commission analysis, the projected potential spending for 96 proposed state directed payments that included estimates—approved through December 31, 2020—was over \$27 billion.²²

CMS Has Recent and Planned Actions to Enhance Oversight of State Directed Payments; the Effectiveness of these Actions Is Unknown

In January 2021, CMS issued guidance to enhance program integrity and remind states of the quality requirements associated with state directed payments, among other things. For example, CMS reconsidered part of its November 2017 guidance that had created what CMS referred to as an unintentional loophole.²³ Specifically, CMS described an example of a state including a general contract requirement for an additional amount to be added to the contracted payment rates for certain providers, but without clearly and directly tying the increase to a specific service or benefit for a specific beneficiary under the contract. The January 2021 guidance clarified that such proposals would be out of compliance with federal regulations unless they were modified.

In 2021, CMS also released an updated form for state directed payment proposals that required additional information. CMS officials said that in the early years of reviewing state proposals, they frequently sought information from states that was not required to be included in the proposal. For example, CMS officials said they commonly asked for additional detail on how states planned to finance the nonfederal share of the payment and asked for the estimated amounts of payments through a separate question and answer process after the state submitted a proposal. In its January 2021 guidance, CMS indicated that by including more information in the revised proposal form, the agency hopes to reduce the quantity of follow-up questions during its review, among other things.

States began using the revised form for all state directed payments sought for contracting periods of July 1, 2021, or later. Among the changes to the form were requirements that states provide

- the estimated total dollar amount of the state directed payment, as well as the estimated federal and nonfederal share;
- attestation that the state incorporated the state directed payment into the managed care contracts and capitation rate certifications; and

²¹The Section 438.6(c) Preprint is the form CMS requires states to submit for approval before any state directed payments may be implemented.

²²See Medicaid and CHIP Payment and Access Commission, *Transparency and Oversight of Directed Payments in Medicaid Managed Care* (Washington, D.C.: Dec. 9, 2021). The Medicaid and CHIP Payment and Access Commission reviewed 230 approved proposals approved as of December 31, 2020.

²³For the November 2017 guidance, see Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts*, Informational Bulletin (Baltimore, Md.: Nov. 2, 2017).

- the sources of the funds used to finance the nonfederal share of the state directed payment; for example, whether provider taxes were a source.²⁴

In addition, CMS officials described several other planned efforts to enhance the agency's oversight of state directed payments.

- **Consolidating information on approved state directed payments.** CMS officials said that the agency has tasked a contractor with consolidating more detailed data from approved proposals and expects to have data on approvals for 2021 by summer 2022. CMS officials confirmed that as of February 2022, the agency does not have consolidated information on all of the state directed payments CMS has approved for use in oversight.²⁵ CMS officials have previously said this limitation could make it difficult to perform in-depth national analysis.
- **Making information on approvals publicly available.** In February 2022, CMS officials said they were considering ways to make approved proposals public, which would increase transparency.
- **Supporting state directed payment evaluations.** In April 2022, CMS officials said the level of detail and quality of states' directed payment evaluations varied widely and efforts were underway to provide states with technical assistance. CMS officials said the agency has received evaluation results from approximately half of states that have directed payments that have been approved for at least 2 years. According to CMS officials, technical assistance is intended to improve the quality of both evaluations already submitted to CMS and those in development.

Although CMS has made recent and planned efforts to enhance oversight of state directed payments, information gaps remain. For example, CMS requires states to provide estimated—but not actual—total payments. Some of these information gaps are similar to those for certain supplemental payments made in addition to fee-for-service Medicaid payments.²⁶ We have raised concerns in past work about information gaps leaving federal funds at risk for impermissible or inappropriate payment.²⁷ (See table 1.)

²⁴Provider taxes are defined as a licensing fee, assessment, or some other mandatory payment that is related to a health care service, the provision of or authority to provide the service, or the payment for the service. Provider taxes are typically imposed on private health care providers. States may tax a wide range of services, and health care providers may be subject to more than one tax during a year.

²⁵We previously reported that while CMS maintains information on state directed managed care payments, officials said this information was not compiled in a consolidated manner for oversight. See GAO, *Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight*, [GAO-21-98](#) (Washington, D.C.: Dec. 7, 2020).

²⁶In December 2021, CMS issued guidance on new supplemental payment reporting requirements beginning with information about payments made on or after October 1, 2021. CMS anticipated reports developed based on state reporting of supplemental payments will be made publicly available annually. CMS officials believe the state-reported information will provide CMS with additional information that can be used to validate the accuracy of provider-specific payment data; however, the new state reporting will not include information on the sources of funds used to finance the nonfederal share of Medicaid payments at this time. For additional information on supplemental payments, see GAO, *Medicaid: Primer on Financing Arrangements*, [GAO-20-571R](#) (Washington, D.C.: Jul. 14, 2020).

²⁷See [GAO-20-571R](#) and [GAO-21-98](#).

Table 1: Reporting Requirements for Certain Types of Medicaid Payments, as of April 2022

State reporting requirement	Disproportionate Share Hospital payments ^a	Upper Payment Limit ^b	State directed payments ^c
Total amount of payments made	Yes	No ^d	No ^e
Payment amounts made to individual providers	Yes	Partial ^d	No
Amount of funds contributed by or on behalf of individual providers to finance the nonfederal share	No	No	Partial ^f

Source: GAO. | GAO-22-105731

Note: Disproportionate Share Hospital and Upper Payment Limit supplemental payments are made in addition to fee-for-service Medicaid payments.

^aBy federal law, states are required to make Disproportionate Share Hospital payments to hospitals that serve large numbers of Medicaid and uninsured low-income individuals.

^bUpper Payment Limit payments generally do not have a specified statutory or regulatory purpose. They must be made for allowable Medicaid expenditures, and the limit is applied to payments to all providers rendering specific services within an ownership class and benefit category, such as state government-owned or -operated facilities that provide inpatient services.

^cUnder managed care, states pay managed care plans actuarially sound capitation payments, which are fixed periodic payments. In limited circumstances, states may direct managed care plan payments to providers, referred to as state directed payments. States can only direct how plans pay providers for Medicaid covered services delivered to Medicaid covered beneficiaries that are a part of the contract between the state and the managed care plan.

^dStates must annually report Upper Payment Limit payments for certain types of providers at the provider-specific level, but these may represent estimated payments instead of actual payments.

^eThe Centers for Medicare & Medicaid Services requires states to submit estimated payment amounts when seeking approval, but states are not required to report actual payments.

^fThe Centers for Medicare & Medicaid Services requires states to submit estimated provider-specific amounts of intergovernmental transfers used to finance state directed payments, but not other sources of the nonfederal share, such as provider taxes.

In December 2020, we made a recommendation that if implemented would address some of the information gaps CMS faces. Specifically, we recommended CMS collect and document complete and consistent provider-specific information about Medicaid payments to providers, including state directed payments, and states’ sources of funding for the nonfederal share of these payments.²⁸ Doing so would likely improve CMS’s ability to effectively oversee state directed payments and identify potentially impermissible financing and payments for additional review. Moreover, further GAO review is necessary to determine whether the previous concerns we have raised regarding Medicaid supplemental payments—such as transparency of reporting and assurance of their use to support Medicaid beneficiaries—apply to state directed payments.²⁹ Given these considerations, we plan to continue examining CMS’s oversight of these payments.

²⁸See [GAO-21-98](#). CMS neither agreed nor disagreed with our recommendation, but acknowledged the need for additional financing and payment data for Medicaid oversight. As of June 2022, this recommendation remains unimplemented.

²⁹For example, see GAO, *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, [GAO-16-108](#) (Washington, D.C.: Feb. 5, 2016); *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, [GAO-15-322](#) (Washington, D.C.: Apr. 10, 2015); *Medicaid Financing: States’ Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection [Reissued on March 13, 2015]*, [GAO-14-627](#) (Washington, D.C.: July 29, 2014); *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012); *Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted*, [GAO-10-69](#) (Washington, D.C.: Nov. 20, 2009); and *Medicaid: CMS Needs More*

Agency comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The Department of Health and Human Services provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees and the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at <https://www.gao.gov>.

If you and your staff have any questions, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Other key contributors to this correspondence included Susan Barnidge (Assistant Director), Peter Mangano (Analyst-in-Charge), and Jasleen Modi. Additional assistance was provided by Drew Long, Jennifer Rudisill, and Ethiene Salgado-Rodriguez.



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