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Report to Congressional Addressees

December 2023

MEDICAID MANAGED CARE

Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency

Accessible Version

GAO-24-106202

GAO Highlights

Highlights of GAO-24-106202, a report to congressional addressees

December 2023

MEDICAID MANAGED CARE

Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency

Why GAO Did This Study

In 2022, spending for managed care represented more than half of the $800 billion spent on Medicaid. The percentage is expected to continue growing in the next decade. With few exceptions, states may not direct managed care plans' payments to providers. However, CMS began allowing a new exception in 2017: state directed payments. Since then, states have made widespread use of directed payments; for example, to increase payments to safety net providers to ensure beneficiary access.

Among other issues, this report describes estimated spending for, and state financing of, state directed payments, and examines CMS's policies and procedures for approving these payments.

GAO analyzed information on approved state directed payments in effect in 2022, and interviewed CMS and Medicaid officials from five states. These states were selected, in part, based on having a directed payment estimated at $1 billion or more in 2022. GAO assessed CMS's policies and procedures against agency guidance and federal internal controls.

What GAO Recommends

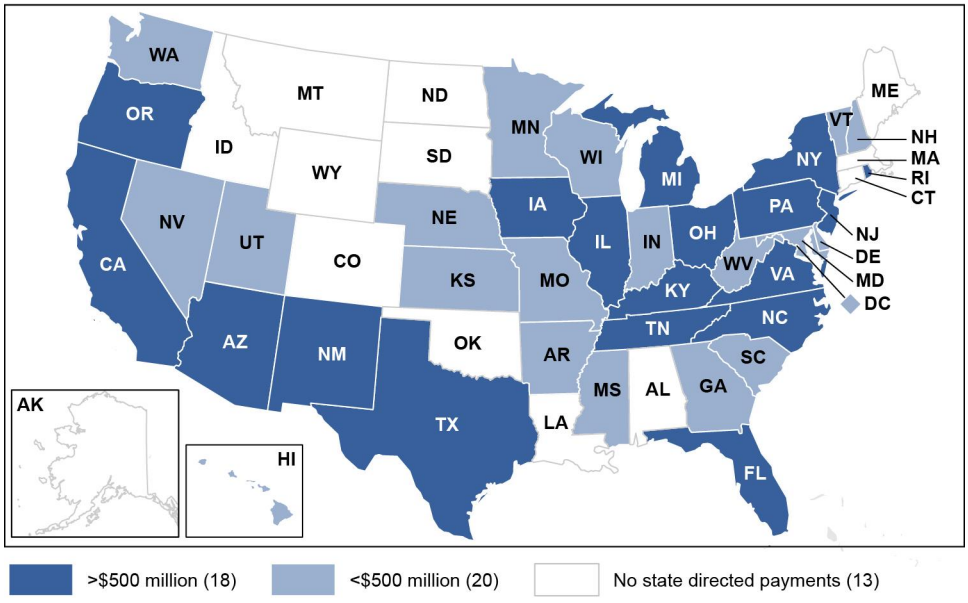
GAO is making four recommendations to CMS, including to enhance the agency's fiscal guardrails for approving state directed payments, review outcome information at renewal, and make publicly available additional approval documents. The Department of Health and Human Services agreed with two recommendations. It neither agreed nor disagreed with the other two recommendations, but noted CMS actions underway to address them.

View GAO-24-106202. For more information, contact Catina B. Latham at (202) 512-7114 or lathamc@gao.gov.

What GAO Found

Using state directed payments, states can direct how Medicaid managed care plans pay providers in certain circumstances. This includes requiring payments in addition to the base payment rates negotiated between plans and providers. State directed payment spending has grown to at least $38.5 billion in 2022, the sixth year of state use, and further growth is expected.

Estimated 2022 Spending for State Directed Payments, by State



Source: GAO analysis of Centers for Medicare & Medicaid Services data (data); MapResources (map). | GAO-24-106202

Note: For more details, see figure 3 in GAO-24-106202.

States often relied on taxes on providers, instead of state general funds, to finance the nonfederal share of state directed payments. States' limited stake in the cost of state directed payments raises concerns for GAO given the weaknesses GAO identified in the Centers for Medicare & Medicaid Services' (CMS) policies and procedures for approving such payments.

- **Weak fiscal guardrails.** CMS has indicated that payments must be reasonable and appropriate, but has not established and communicated a definition of, or standards for, assessing that. CMS has set no other limits on spending under directed payments.
- **No consideration of payment outcomes when renewing.** CMS does not appear to consider state evaluation results or any other outcome information when deciding whether to approve a renewal of a directed payment.
- **Gaps in transparency.** CMS recently made payment applications publicly available, but does not post other information, such as attachments including important financing information, evaluation plans, and evaluation results.

These weaknesses leave the agency at risk of approving ineffective payments.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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Washington, DC 20548

December 14, 2023

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Cathy McMorris Rodgers
Chair
Committee on Energy and Commerce
House of Representatives

The Honorable James Comer
Chairman
Committee on Oversight and Accountability
House of Representatives

In 2022, spending for managed care represented more than half of the $800 billion spent on Medicaid—the joint, federal-state program that finances health care coverage for certain low-income and medically needy populations. Managed care costs are expected to continue growing as a percentage of Medicaid in the next decade. Under managed care, states pay managed care plans capitation payments, which are fixed periodic payments typically paid on a per enrolled Medicaid beneficiary basis.[1] Those payments must be actuarially sound—meaning reasonable, appropriate, and attainable—to fulfill the requirements of the contract, including ensuring network adequacy and access to care for the services covered under the contract. Managed care plans are incentivized to set efficient payment rates for the providers delivering the care, and to effectively coordinate and manage beneficiary utilization of care.

In general, states may not direct managed care plans' payments to providers, because this type of state direction reduces plans' ability to effectively manage program costs. However, in 2016, the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, issued regulations establishing certain circumstances under which states may

[1]For 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.

direct managed care plan payments to providers, referred to as state directed payments, or directed payments.[2] According to CMS, a state may decide to implement a directed payment to further the state's overall Medicaid program goals and objectives; for example, directing plans to increase payment rates to safety net providers to ensure or enhance access to care. States must generally seek CMS approval prior to implementing a directed payment. Approvals are typically for a year, and states can seek renewal. States are required to have a plan for evaluating the effect of the directed payment on meeting quality objectives.[3]

Since 2017, the first year of use, states have made widespread use of state directed payments in their managed care programs. Our prior work found that 35 states had received CMS approval for one or more directed payments in 2021.[4] Unlike with some supplemental payments to providers outside of managed care, there are no statutory or regulatory limits on the amounts of directed payments states can make. States also have flexibility within limits in how they finance their share of directed payments—called the nonfederal share—including using state general funds and other sources of funding, such as taxes on health care providers.

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

1. describe estimated spending for, and state financing of, state directed payments in Medicaid managed care;

2. describe selected states' design and oversight of certain state directed payments; and

[2]See 81 Fed. Reg. 27,498 (May 6, 2016). 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) (2022).

[3]Specifically, states are required to have an evaluation plan to assess the effect of the state directed payment on meeting a related goal and objective in the state's managed care quality strategy. All states are required to have a quality strategy for their managed care programs.

[4]See GAO, *Medicaid: State Directed Payments in Managed Care*, GAO-22-105731 (Washington, D.C.: June 28, 2022).

3. examine CMS's policies and procedures for reviewing and approving state directed payments.

To describe estimated spending for, and state financing of, state directed payments in Medicaid managed care, we analyzed information on approved state directed payments in effect in 2022.[5] Specifically, we reviewed state estimates and financing information from 169 approved directed payment applications for payments in effect in 2022.[6] Our analysis included only applications approved as of August 2022.[7] We determined the estimated total amount of the state directed payment, as well as the federal and nonfederal share of the payment, for each state and nationally. We also determined the number of new and renewed state directed payments in 2022 and the services for which payments were made.

We reviewed CMS's estimate of state directed payments in 2022 and projections of directed payment spending in 2023 and beyond. In addition, we estimated the effect of states' decisions on how to finance the nonfederal share of Medicaid directed payments on the net directed payments providers receive and the federal share of the net directed payments.[8] (See app. I for more information about the scope and methodology of this estimate.)

To describe selected states' design and oversight of certain state directed payments, we reviewed state documentation and interviewed Medicaid officials from five states: Arizona, Michigan, Rhode Island, Tennessee, and Texas. Each selected state had at least one directed payment the state estimated to be $1 billion or more in 2022. Selected states varied geographically and by the proportion of the state's managed care spending that directed payments represented.[9] We reviewed state

[5]For purposes of our report, states includes the District of Columbia.

[6]CMS refers to applications for state directed payments as "preprints."

[7]Our analysis did not include state directed payments in effect in 2022 that were approved after August 26, 2022. Directed payments that do not require CMS approval prior to implementation and directed payment applications that did not include state spending estimates are also not included.

[8]Net Medicaid directed payments are the total directed payments received by all providers minus the amount of funds the providers contributed to finance the nonfederal share of the directed payments they receive.

[9]The state directed payments we reviewed from our selected states ranged from being 9 percent to 65 percent of total state Medicaid managed care spending.

directed payment applications, evaluation plans, and evaluation reports for directed payments that were in effect from July 2020 to July 2023 for those states' payments that were estimated to be $1 billion or higher.[10] We also reviewed documentation on state monitoring efforts, and interviewed state Medicaid officials about their reasons for implementing the directed payments and any challenges in designing or overseeing them.

To examine CMS's policies and procedures for reviewing and approving state directed payments, we reviewed CMS documentation and interviewed officials. We reviewed CMS guidance to states, technical assistance documents, and procedures for reviewing and approving state directed payment applications. We also reviewed approval and evaluation documents submitted to CMS for our selected states' 2022 payments that the states estimated were $1 billion or more in their state directed payment applications, including state directed payment applications, written correspondence between the states and CMS, and evaluation reports available from January 2020 to June 2023. Additionally, we interviewed CMS officials about the agency's state directed payment approval policies and procedures, including any planned changes. We compared CMS's policies and procedures for reviewing and approving state directed payments to CMS guidance, the *CMS Health Equity Framework 2022-2032*, and federal standards for internal control related to information and communication and monitoring.[11]

We conducted this performance audit from August 2022 to December 2023 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

[10]Two selected states (Tennessee and Texas) had more than one state directed payment arrangement that the state estimated was $1 billion or more. The directed payments reviewed in these two states for our report went to hospitals for inpatient and outpatient services.

[11]See GAO, S*tandards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. Applicable underlying principles for information and communication and monitoring are that management should use quality information to achieve the entity's objectives, externally communicate the necessary quality information to achieve the entity's objectives, and establish and operate monitoring activities to monitor the internal control system and evaluate the results.

that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

State Directed Payments

With limited exceptions, states are not permitted to make supplemental payments to providers for services under the managed care contract or direct a managed care plan's payments to its providers for such services, as doing so reduces plans' ability to effectively manage program costs under their contracts.[12] However, when CMS clarified this general prohibition in regulation in 2016, it also created a new exception to that general rule, allowing states to direct how managed care plans pay providers under certain circumstances, beginning in 2017.[13] State directed payments must meet several requirements, including that they be (1) based on utilization and delivery of services, (2) directed equally across a class of providers, (3) advance at least one goal in a state's quality strategy, and (4) have an evaluation plan to measure whether the payment is meeting such goals.[14]

States have flexibility, within federal parameters, in designing state directed payments. States can direct payments by requiring managed care plans to pay providers based on performance; for example, an incentive payment that is conditioned upon a specified percentage point improvement in enrolled beneficiaries receiving timely access to care from one year to the next. States can also direct payments by requiring managed care plans to pay providers at prescribed payment rates; for example, by setting minimum payment rates for a particular service or

[12]States may directly supplement Medicaid managed care provider payments or direct a managed care plan's payments to providers in limited circumstances, such as for graduate medical education. See, e.g., 42 C.F.R. § 438.60 (2022).

[13]In 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) (2022).

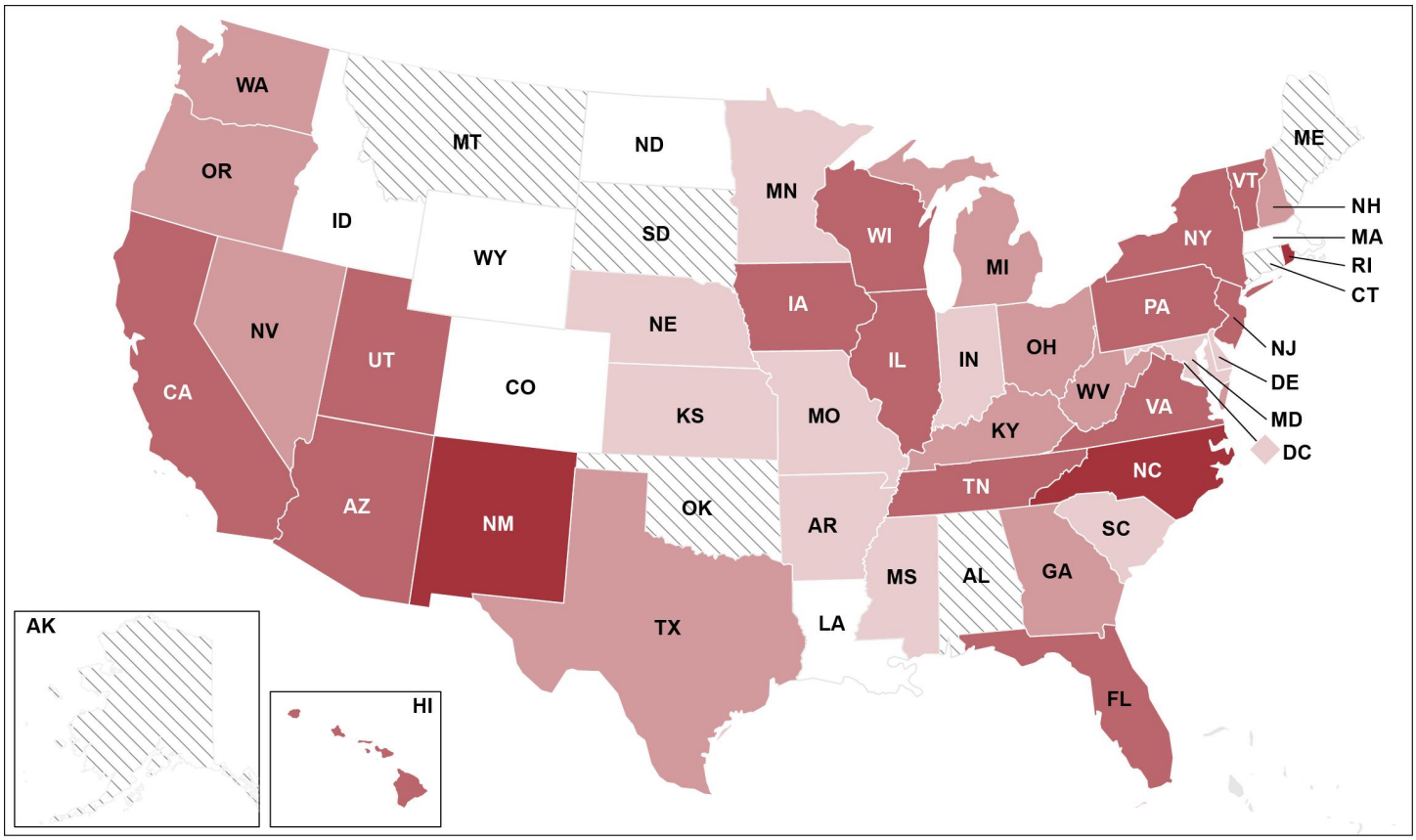
[14]See 42 C.F.R. § 438.6(c)(2) (2022).

requiring that plans pay providers an additional set percentage above the base rates the plan negotiates with the provider.

State use of state directed payments has become widespread since CMS began approving them in 2017. CMS approved 169 directed payment applications—more than half of which were to renew payments approved in previous years—from 38 states in 2022, an increase from the 10 states with approved applications in 2017.[15] (See fig. 1.)

[15]Of the 13 states that did not have an approved directed payment application in 2022, seven states did not have managed care programs under which the state could implement a state directed payment in 2022.

Figure 1: Number of State Directed Payments in Effect in 2022, as of August 2022



10 or more state directed payments (3 states)
5-9 state directed payments (14 states)
2-4 state directed payments (10 states)
1 state directed payment (11 states)
No state directed payments (6 states)
Did not have managed care in 2022 (7 states)

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data (data); MapResources (map). | GAO-24-106202

Notes: Seven states did not have managed care programs under which the state could implement a state directed payment in 2022. The number of state directed payments does not include directed payments in effect in 2022 that were approved after August 26, 2022, or directed payments that do not require CMS approval prior to implementation. Of the six states with no state directed payments in 2022 at the time of our analysis, at least one of these states (Massachusetts) later received CMS approval to implement a directed payment effective in 2022.

State Directed Payments and Actuarial Soundness

State payments to managed care plans, inclusive of any state directed payments, must be actuarially sound, by law.[16] CMS has defined actuarially sound rates as sufficient for covering the reasonable, appropriate, and attainable costs associated with plans providing the services under the managed care contract with the state for the population covered.[17] As part of ensuring that a state's final capitation rates paid to a managed care plan cover reasonable and appropriate costs, CMS requires that state directed payments result in provider payment rates that are reasonable and appropriate, among other things.[18]

State Directed Payment Financing

As with other types of Medicaid payments, states have significant flexibility to determine which sources of funds to use to finance the nonfederal share of state directed payments, within certain limits.[19] States can finance the nonfederal share with state funds, particularly state general funds appropriated directly to the state Medicaid program. In addition, states can use the following sources of funds, within limits, to finance state directed payments:

- **Health care provider taxes.** A state may levy certain taxes on health care providers (provider taxes) to generate revenues to finance the

[16]42 U.S.C. § 1396b(m)(2)(A)(iii).

[17]42 C.F.R. § 438.4(a) (2022).

[18]CMS refers to this standard for provider payment rates as "reasonable and appropriate" in its state directed payment application, and that is how we refer to the standard in this report. See 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).

[19]For the purposes of this report, sources of funds are the means (e.g., taxes) by which funds are supplied by entities (e.g., providers) to the state to be used to finance the nonfederal share of Medicaid; we do not use the term to refer to the entities themselves. In July 2020, we issued a primer with information on Medicaid financing, identifying and illustrating examples of the most common types of permissible arrangements states have used to fund their Medicaid programs. See GAO, *Medicaid: Primer on Financing Arrangements*, GAO-20-571R (Washington, D.C.: July 14, 2020).

nonfederal share of Medicaid payments.[20] Provider taxes are typically imposed on private health care providers.[21] States may tax a wide range of services, and health care providers may be subject to more than one tax during a year.[22]

- **Intergovernmental transfers.** A state may obtain funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state that can be used to finance the nonfederal share of Medicaid payments.[23]

Federal law requires that states finance at least 40 percent of the nonfederal share of total Medicaid expenditures, including state directed payments, through state funds. State funds can include appropriations from state general funds and permissible health care provider taxes levied by the state. The remaining 60 percent of the nonfederal share for total annual Medicaid expenditures can be derived from local governments; for example, via intergovernmental transfers.[24] The limit on the percentage of the nonfederal share that may be financed by local governments is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments. Similar to

[20]Under federal requirements, such taxes must be broad-based (i.e., imposed on all nonfederal, nonpublic providers within a category of services in the state), uniformly imposed (e.g., the tax is the same amount for all providers furnishing the services within the same category), and not hold providers harmless (e.g., must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back). 42 U.S.C. § 1396b(w)(1)(A); 42 C.F.R. § 433.68 (2022).

[21]Provider 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, such that at least 85 percent of the burden of the tax falls on health care providers. See 42 U.S.C. § 1396b(w)(3); 42 C.F.R. § 433.55 (2022).

[22]Under federal regulations, there are 18 defined categories of services on which provider taxes may be imposed, which include inpatient and outpatient hospital services, nursing facility services, physician services, and services provided through managed care organizations. 42 C.F.R. § 433.56(a) (2022).

[23]See 42 U.S.C. § 1396b(w)(6); 42 C.F.R. § 433.51 (2022). Under agency policy, CMS requires that intergovernmental transfers occur before the state makes a Medicaid payment to the provider and that the amount of the transfer cannot be greater than the nonfederal share of the Medicaid payment amount.

[24]Local governments may also impose health care provider taxes or receive provider donations that may be used for the nonfederal share if they are in compliance with federal requirements. Revenue from these sources is generally transferred from the local government to the state through an intergovernmental transfer.

other types of Medicaid payments, states' nonfederal share funds for state directed payments are matched with federal funds according to each state's federal medical assistance percentage.[25]

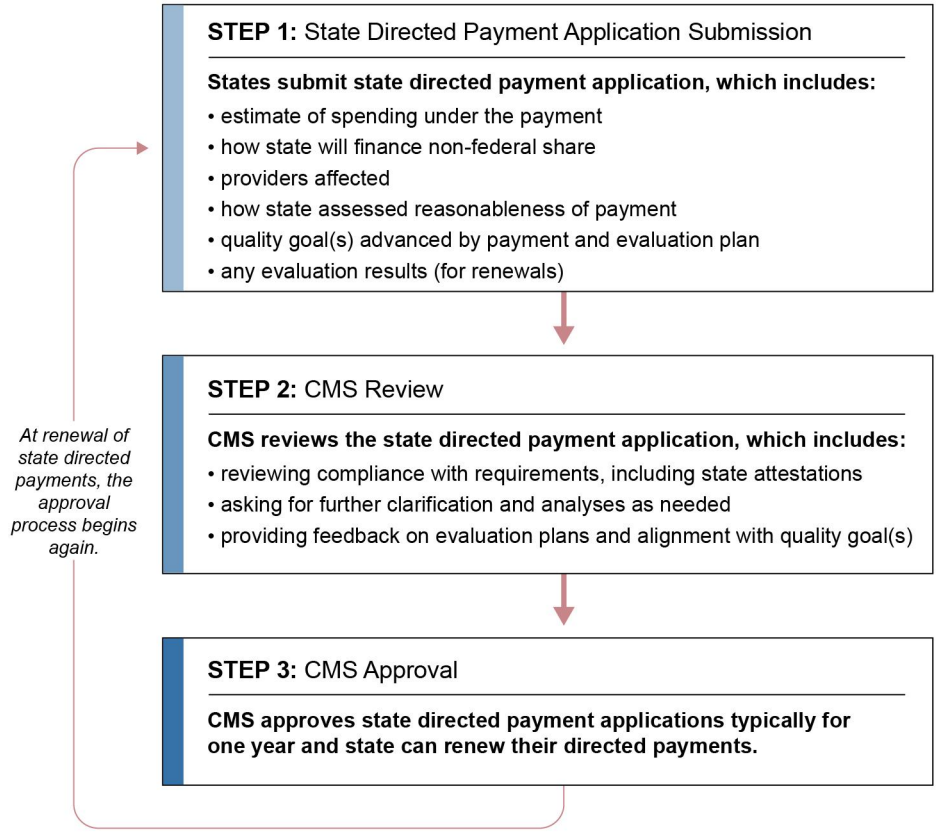
Federal Approval Process for State Directed Payments

States generally must receive CMS approval in writing in advance of implementing a new state directed payment or renewing an existing directed payment.[26] Before approval, CMS officials review state directed payment applications, which ask states to provide a standard set of descriptions of the payment and related quality goals. (See fig. 2.)

[25]The percentage match is based on a formula established by law.

[26]In November 2020, CMS clarified that certain state directed payments setting a minimum fee schedule using state plan approved rates would no longer require prior CMS approval.

Figure 2: CMS State Directed Payment Review and Approval Process



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation and guidelines. | GAO-24-106202

Note: CMS refers to applications for state directed payments as "preprints."

As part of the application, states indicate whether the state directed payment has been included in the terms of the related managed care contract and incorporated into the state's certification of its capitation payment rates for its managed care plans.[27] The rate certification is developed by an actuary and certifies that the managed care capitation rates are actuarially sound. CMS is responsible for reviewing contracts and rate certifications, and ensuring that states have reflected directed payments consistent with what was approved in the directed payment application. The directed payment application, contract, and actuarial

[27]Based on the state's indications, CMS may require the state to provide additional information about where the information is included in the managed care contract and state's rate certification or when it will be available.

certification reviews are three separate processes that can occur simultaneously.

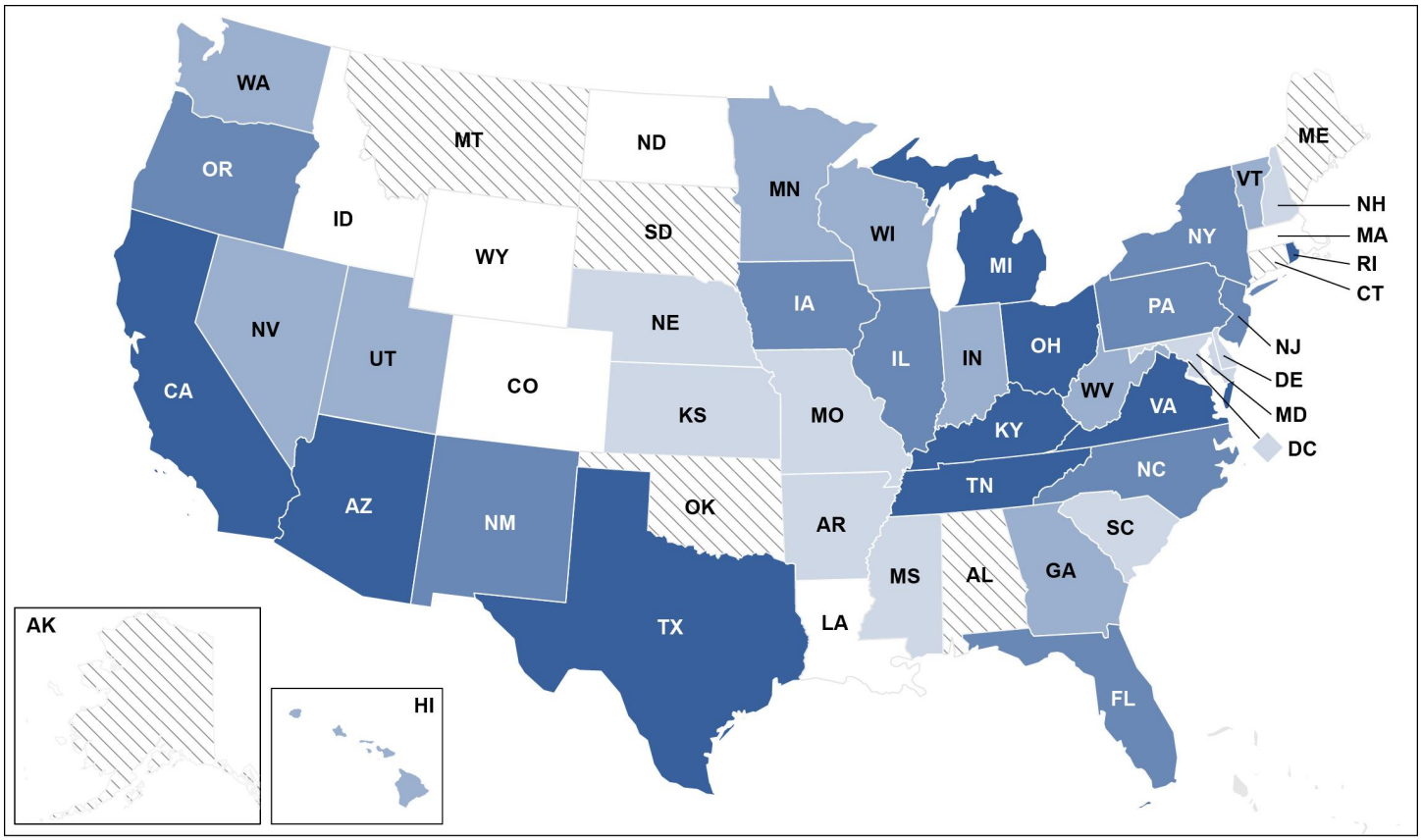
State Estimates of Directed Payment Spending Exceeded $38 Billion in 2022 with Limited State Financing

State-Estimated Spending in 2022 Was Over $38 Billion, with Total Spending Likely Higher and Projected to Increase; Hospitals Received Majority of Funds

State estimates of state directed payments totaled $38.5 billion in 2022, according to our analysis of CMS-approved directed payments through August 2022. Total estimated spending for directed payments effective in 2022 was likely higher; a recent CMS estimate indicates that, after August 2022, the agency approved billions of dollars in additional directed payments effective in 2022.[28] Of the $38.5 billion, nine states estimated spending $1 billion or more on directed payments, and those states' combined payments accounted for over $28 billion—about 74 percent—of total spending. (See fig. 3.)

[28]CMS approved state directed payments effective in 2022 as late as July 2023. Applications for directed payments in 2022 could have been approved in 2023, for example, because the state submitted the application to CMS in late 2022 and required revisions before CMS approved it. Our analysis excludes state directed payments requested using an older version of the directed payment application that did not require a spending estimate and directed payments that do not require CMS prior approval. 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.

Figure 3: Estimated Total Spending in 2022 for State Directed Payments, approved by August 2022, by State



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data (data); MapResources (map). | GAO-24-106202

Notes: Seven states did not have managed care programs under which the state could implement a state directed payment in 2022. Amounts of directed payments are based on the estimates states included in their directed payment applications to CMS approved as of August 26, 2022. Of the six states with no state directed payments in 2022 at the time of our analysis, at least one of these states (Massachusetts) later received CMS approval to implement a directed payment effective in 2022. State directed payments that do not require CMS approval prior to implementation and directed payment applications that did not include state spending estimates are not included. CMS refers to applications for state directed payments as “preprints.”

Inpatient and outpatient hospitals were the most common recipients of state directed payments in effect in 2022. States can request and be

approved to make directed payments for one or multiple types of services. In 2022, of the 169 approved directed payments, 56 were at least in part for inpatient hospital services and 46 were at least in part for outpatient hospital services.[29] States estimated payments for inpatient hospital services were at least $2.2 billion and as much as $26.0 billion, and payments for outpatient hospital services were at least $150 million and as much as $23.7 billion in 2022.[30] Other types of services receiving directed payments in 2022 included home-and community-based services and personal care services (27 directed payments), and behavioral health outpatient services (21 directed payments).[31] (See app. II for more information about the number of payments for each type of service.)

State directed payments have been a significant factor in Medicaid expenditure growth in recent years. Estimates by CMS and the Medicaid and CHIP Payment and Access Commission suggest spending could have averaged less than $10 billion per year in the first few years of directed payment use.[32] Directed payment growth has come from various sources. For example:

- **New Medicaid spending.** CMS reported that most state directed payment spending in recent years reflects new Medicaid program expenditures. Prior to that, directed payments often replaced supplemental payments made outside of managed care as states transitioned more of their Medicaid programs into managed care.[33] State directed payments also replaced what are commonly referred to as pass-through payments, which are payments states make within

[29]Inpatient hospital services were the sole service for which a payment was directed for 16 payments and one of multiple services for 40 payments. Outpatient hospital services were the sole service for which a payment was directed for eight payments and one of multiple services for 38 payments.

[30]When states request to make a state directed payment for multiple types of services, they are not required to estimate the amount of spending for each type of service.

[31]According to CMS officials, many of these state directed payments were approved as part of one-time initiatives during the COVID-19 pandemic.

[32]CMS and the Medicaid and CHIP Payment and Access Commission estimates were based on incomplete information, because prior to a January 2021 CMS change, state directed payment applications did not require total payment estimates.

[33]CMS officials said the agency has not estimated the net effect of directed payments on Medicaid program expenditures, but noted that states reported small decreases in supplemental payments made outside of managed care since 2016, while state directed payment growth has far exceeded this reduction.

managed care to increase payments for certain safety-net hospitals and providers.[34]

- **New state directed payments.** Our analysis shows that most state directed payment spending in 2022 was for directed payments that have been in effect for more than one year; however, almost 16 percent of spending was for new directed payments. Specifically, about $32 billion of total estimated state directed payments were for renewals of payments first implemented prior to 2022, while the remaining $6 billion was for new directed payments implemented in 2022.[35]
- **New states implementing state directed payments.** New directed payments were implemented in 2022 in states that both had and had not previously used them. Our analysis shows that of the 27 states with new directed payments approved in 2022, 21 states also renewed a directed payment from 2021 and six states did not.

State directed payment growth is likely to continue. Of the six states with no directed payments in 2022 at the time of our analysis, at least one of these states later implemented a directed payment effective in 2022 and at least one other state implemented a directed payment in 2023. Recently, the Medicaid and CHIP Payment and Access Commission projected directed payment spending in 2023 to exceed $69 billion per year.[36] CMS estimates directed payments could exceed $125 billion in 2033.

State Financing Decisions Effectively Shifted More Responsibility for Funding Directed Payments to the Federal Government

Of the $38.5 billion in state directed payments in 2022, the state-estimated federal share of directed payments was about $26.2 billion (68 percent) and the nonfederal share was the remaining $12.3 billion (32

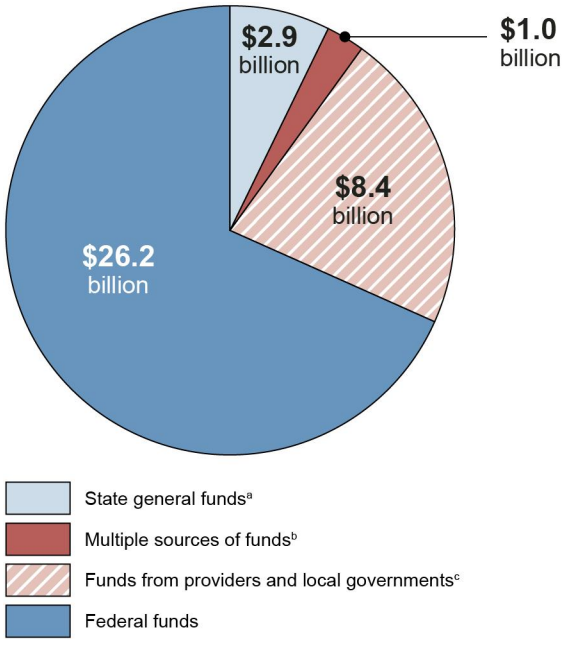
[34]In 2016, CMS provided states with up to 10 years to phase-out pass-through payments, which are not tied to utilization and delivery of services. See 81 Fed. Reg. 27,498 (May 6, 2016) (amending 42 C.F.R. § 438.6(d) (pass-through payments)).

[35]We are unable to calculate estimated spending in 2021 for these renewed state directed payments to determine how much they grew from 2021 to 2022, because of data limitations, among other things.

[36]See Medicaid and CHIP Payment and Access Commission, *Issue Brief, Directed Payments in Medicaid Managed Care* (Washington, D.C.: June 2023). This estimate was for directed payments in effect, or planned, as of February 1, 2023.

percent). As shown in figure 4, states estimated using funds from providers and local governments—using provider taxes and intergovernmental transfers, respectively—to finance at least $8.4 billion of the nonfederal share of directed payments.[37]

Figure 4: Federal Share and Nonfederal Share Sources of Medicaid Managed Care State Directed Payments in Effect in 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106202

Notes: Amounts of state directed payments are based on the estimates states included in their directed payment applications to the Centers for Medicare & Medicaid Services (CMS) approved as of August 26, 2022. Directed payments approved later in 2022, directed payments that do not require CMS approval prior to implementation, and directed payment applications that did not include state spending estimates are not included. CMS refers to applications for state directed payments as "preprints."

[a]State general funds include about $900 million in other sources of funds; for example, tobacco settlement funds.

[b]There were 25 state directed payments financed, in part, with funds from providers or local governments, with the remaining funds from state general funds or other sources of funds.

[37]Of the 169 payments in our analysis, 25 were financed, in part, with funds from providers or local governments, with the remaining funds from state general funds or other sources of funds. For purposes of our analysis, we considered all of the nonfederal share funds to be state general funds for these 25 payments, since states do not provide information on the amount of funds from each source of the nonfederal share. As such, the total amount of the nonfederal share from providers and local governments is undercounted.

[c]Total funds from providers and local governments only include the amounts for state directed payments when provider taxes and intergovernmental transfers are the only sources of the nonfederal share.

Net Directed Payment

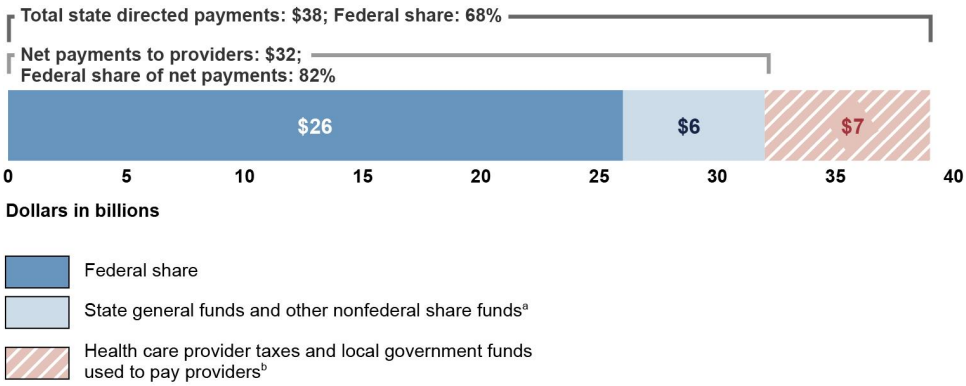
The net directed payment is the total payment to a group of providers minus the amount contributed by those providers to finance the nonfederal share of the payment.

Total payment – provider contribution = net directed payment

Source: GAO analysis. | GAO-24-106202

According to our estimates, states' reliance on funds from providers and local governments—through provider taxes and intergovernmental transfers—to finance the nonfederal share of state directed payments effectively increased the federal government's share of the net directed payments made to providers in 2022. This occurs because net payments to providers are smaller than total payments, after the provider taxes and intergovernmental transfers are taken into account, but the federal government's contribution does not change. Specifically, we estimated that states' reliance on those sources of funds resulted in net directed payments to providers of $32.0 billion, which is $6.5 billion less than total directed payments. As a result, while the federal government's contribution in 2022 remained $26.2 billion, that amount represented 82 percent of net directed payments (a 14 percentage point increase).[38] (See fig. 5 and app. III for more information.)

Figure 5: Estimated Cost Shifting for State Directed Payments in Effect in 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106202

Notes: Percentages rounded to the nearest whole number, and dollar amounts rounded to the nearest billion. Total state directed payments does not equal the sum of the sources of the payments due to rounding. Amounts of state directed payments are based on the estimates states included in their directed payment applications to CMS approved as of August 26, 2022. Directed payments approved later in 2022, directed payments that do not require CMS approval prior to implementation, and directed payment applications that did not include state spending estimates are not included. CMS refers to applications for state directed payments as "preprints."

[38]We previously estimated that states' reliance on funds from providers and local governments effectively increased the federal government's share of net Medicaid managed care payments made to providers by 5 percentage points in 2018. 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).

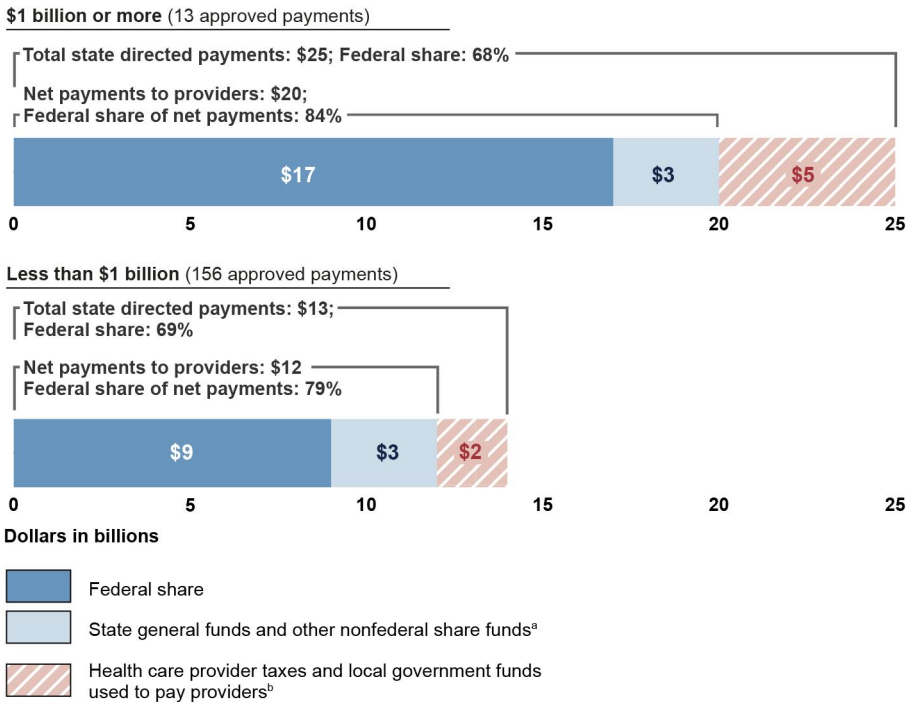
Provider taxes are funds generated from taxes levied by the state primarily on health care providers. Intergovernmental transfers are fund transfers to the state from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments. Our estimates assume that 80 percent of funds from provider taxes were returned to the same providers and 75 percent of funds from local governments were returned to local government providers. Those assumptions were developed based on information from states, the Medicaid and CHIP Payment and Access Commission, and CMS.

[a]State general funds and other nonfederal share funds include nonfederal share funds that were not used to make total Medicaid state directed payments to providers contributing these funds. These funds include state general funds, and provider taxes and intergovernmental transfers not used to make total Medicaid payments to providers contributing these funds.

[b]The amount of provider taxes and intergovernmental transfers used to make total Medicaid state directed payments to providers contributing these funds is subtracted from total Medicaid directed payments to calculate net Medicaid directed payments.

The effective increase in the federal government's share of the net directed payments was higher for directed payments over $1 billion than for payments under $1 billion, according to our estimates. This is because the nonfederal share of those larger directed payments was more often financed with funds from providers and local governments, as shown in figure 6.

Figure 6: Estimated Cost Shifting for State Directed Payments in Effect in 2022, by Size of Directed Payment



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106202

Notes: Percentages rounded to the nearest whole number, and dollar amounts rounded to the nearest billion. For state directed payments less than $1 billion, total state directed payments does

not equal the sum of the sources of the payments due to rounding. Amounts of state directed payments are based on the estimates states included in their directed payment applications to CMS approved as of August 26, 2022. Directed payments approved later in 2022, directed payments that do not require CMS approval prior to implementation, and directed payment applications that did not include state spending estimates are not included. CMS refers to applications for state directed payments as "preprints."

Provider taxes are funds generated from taxes levied by the state primarily on health care providers. Intergovernmental transfers are fund transfers to the state from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments. Our estimates assume that 80 percent of funds from provider taxes were returned to the same providers and 75 percent of funds from local governments were returned to local government providers. Those assumptions were developed based on information from states, the Medicaid and CHIP Payment and Access Commission, and CMS.

[a]State general funds and other nonfederal share funds include nonfederal share funds that were not used to make total Medicaid state directed payments to providers contributing these funds. These funds include state general funds, and provider taxes and intergovernmental transfers not used to make total Medicaid payments to providers contributing these funds.

[b]The amount of provider taxes and intergovernmental transfers used to make total Medicaid state directed payments to providers contributing these funds is subtracted from total Medicaid directed payments to calculate net Medicaid directed payments.

States' use of provider taxes and intergovernmental transfers to finance the entire nonfederal share of state directed payments was common. For example:

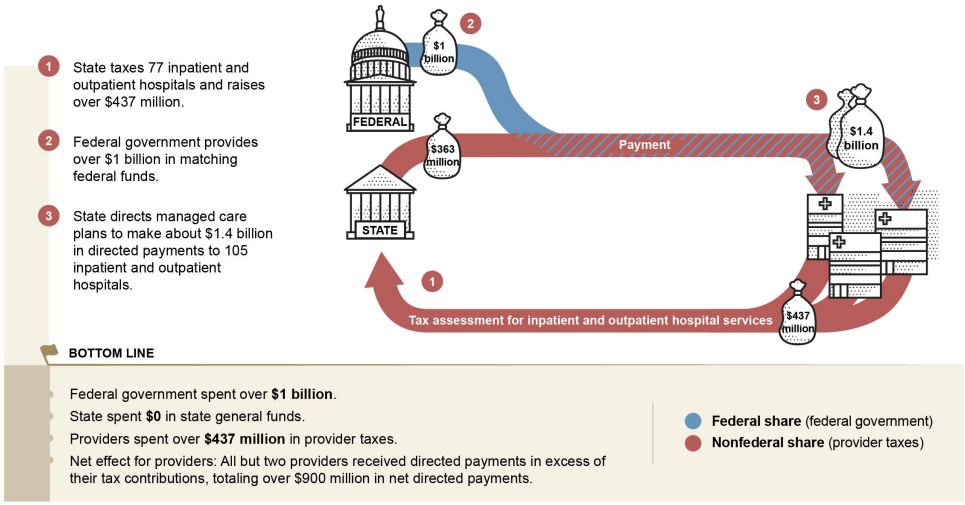
- According to our analysis, 40 percent of state directed payments (68 out of 169) in effect in 2022 were financed entirely with funds from providers, local governments, and the federal government, with no contributions from state general funds.
- Officials in one of our selected states (Michigan) said a state directed payment financed with a provider tax was an effective strategy to increase payments to providers and had been used in the past to finance other Medicaid payments. In reviewing the state's 2021 through 2023 directed payment applications, we found that the Medicaid base rate managed care plans were paying providers—financed through state general funds—decreased.[39] Specifically, when looking at base rates paid as a percentage of what Medicare would have paid for the same service, the state indicated that the rates decreased from 57 percent to 52 percent for inpatient services. Our prior work found that while providers would prefer not to be subject to a provider tax, recognition that revenue from the taxes

[39]The Medicaid base rates are the rates before considering the effects of other payments, such as state directed payments.

would be used for making Medicaid payments to contributing providers made the tax acceptable.[40]

As an illustration of this nonfederal share financing, providers in another one of our selected states (Arizona) contributed, via provider taxes, over $437 million to finance nearly $1.4 billion in state directed payments.[41] The state projected that 103 of 105 providers would receive directed payments in excess of their tax contributions, totaling over $900 million in net directed payments. (See fig. 7.)

Figure 7: Example of State Directed Payment in Arizona Financed Using State Provider Tax Revenue and Federal Funds



Source: GAO analysis of Centers for Medicare & Medicaid Services data (data); GAO (illustrations). | GAO-24-106202

Note: Over $363 million of the $437 million in taxes is used for state directed payments. The remaining $74.8 million is used as the nonfederal share of other payments and state administration of the payments.

States' reliance on funds from providers and local governments to finance the nonfederal share raises questions about Medicaid's federal-state partnership, particularly when those sources are used in lieu of state general funds. That partnership is designed to provide states with an interest in operating and monitoring their Medicaid programs in the best interest of beneficiaries and in a manner that results in receiving the best

[40]See GAO, *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).

[41]The state indicated that over $363 million of the tax is to be used for state directed payments. The remaining $74.8 million is used as the nonfederal share of other payments and state administration of the payments.

value for taxpayers for funds expended. We have previously raised concerns about states' increased reliance on funds from providers and local governments to finance the nonfederal share overall, and particularly for Medicaid payments over which states have more flexibility, such as Medicaid supplemental payments.[42]

Selected States' Directed Payments Design Met Different Needs and Their Oversight of Progress on Quality Goals Was Limited

Selected states designed their $1 billion or more state directed payments to meet different quality and financial goals, such as addressing financial shortfalls experienced by providers. While CMS requires states to develop evaluation plans that measured progress toward quality goals, selected states faced challenges using evaluation results in their oversight. Selected states employed different strategies to oversee the accuracy and timeliness of directed payments.

Selected States Designed Directed Payments to Meet Quality and Financial Goals

Selected states designed their $1 billion or more state directed payments to meet different needs, including to improve quality of care and address financial shortfalls of their providers. Of our five selected states, one state (Rhode Island) implemented its directed payment to help it better link payments to quality and lower costs. Officials from the other selected states told us they designed directed payments to transition certain existing Medicaid payments to become directed payments and support providers' financial needs. For example:

- Officials from two of our selected states (Tennessee and Texas) said they transitioned other Medicaid payments that were previously in

[42]See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed,* GAO-13-48 (Washington, D.C.: Nov. 26, 2012); *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, GAO-15-322 (Washington, D.C.: Apr. 10, 2015); and *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, GAO-16-108 (Washington, D.C.: Feb. 5, 2016); GAO-14-627, and GAO-21-98.

place to state directed payments because CMS indicated they should. Officials from Tennessee said their payment design, which was also a payment under managed care, did not change during the transition. In contrast, Texas officials said CMS encouraged the state to use directed payments to help it redesign a Medicaid payment that the state had to end.[43] The original supplemental payment made outside of managed care aimed to incentivize hospitals and other providers to improve access and quality of care. The redesign led to the directed payment's actual costs being twice as much as the original payment, from about $3 billion to $6.2 billion, according to state officials.

- Officials from three of our selected states (Arizona, Michigan, and Texas) said they implemented state directed payments to support the financial needs of their providers. Arizona officials said they implemented their $1 billion directed payment because their providers were experiencing financial shortfalls. Michigan officials told us they implemented state directed payments to replace a managed care payment stream that was expiring and ensure hospitals were adequately paid by managed care plans for their services.

Quality Expectations for State Directed Payments

The Centers for Medicare & Medicaid Services (CMS) expects state directed payments to be directly linked to quality improvement. It requires states to

1. use state directed payments to advance at least one of the goals or objectives from the state's Medicaid managed care quality strategy, and
2. develop an evaluation plan that measures the state's progress toward the quality strategy goal.

Source: GAO summary of CMS documentation. | GAO-24-106202

All of our selected states' directed payment applications to CMS also included information on the quality goals the payment would advance, as required by CMS.[44] These quality goals were generally broad and included improving the health of the states' Medicaid managed care beneficiaries or addressing the root causes of adverse health outcomes, though some were more specific. For example, Tennessee had a $1.4 billion payment that was expected to advance one goal: to provide high-quality cost-effective care and improve the overall health of its members by reducing certain hospital readmissions and ambulatory care visits. The state planned to measure progress toward this goal by tracking hospital readmission and ambulatory care rates.[45] (See table 1 for examples of quality goals and payment designs for selected states.)

[43]CMS did not renew the specific supplemental payment Texas had previously used, so it ended.

[44]CMS requires states to use state directed payments to advance at least one of the goals or objectives from the state's Medicaid managed care quality strategy. Goals and objectives are synonymous for the purposes of our report.

[45]Ambulatory care refers to health care that is provided in an outpatient setting such as a medical office or clinic.

Table 1: Examples of Quality Goals and Payment Design for State Directed Payments in Selected States

State	Total estimated cost in 2022 (in billions)	Example of quality goal	Description of payment design
Arizona	$1.4	Improve beneficiaries' experience of care, including quality and satisfaction.	**Increased payments to providers.** Managed care plans pay providers an estimated 15 percent to 96 percent more than the negotiated base rate for certain hospital services. Payment increases vary based on the type of hospital. For example, rural hospitals' payments were estimated to increase by 72 percent, while specialty hospitals' payments were estimated to increase by 15 percent.
Michigan	$1.9	Ensure high quality and high levels of access to care.	**Increased payments to providers.** Managed care plans must pay providers 70 percent more for inpatient hospital services and 87 percent more for outpatient hospital services than the negotiated base rate.
Rhode Island	$1.2	Improve perinatal outcomes.	**Payments based on performance.** Managed care plans must pay providers based on the quality of care and total cost of care through value-based payments, and the state sets performance targets for quality and spending. If spending is below the capitated rate, high performing managed care plans receive a portion of the savings.
Tennessee	$1.4	Provide high-quality cost-effective care and improve overall health of beneficiaries.	**Payments based on established payment range.** Managed care plans must pay providers an amount that falls within a defined payment range for certain hospital services. State law defines the minimum and maximum amounts for this range.
Texas	$4.7	Attract and retain high-performing providers.	**Increased payments to providers.** Managed care plans pay providers, on average, 20 percent to 169 percent more per claim for certain hospital services. Payments vary based on the type of hospital and service. For example, rural hospitals received, on average, 20 percent more per claim for inpatient hospital services. Urban hospitals received, on average, 121 percent more per claim for outpatient hospital services.

Source: GAO summary of state Medicaid documentation. | GAO-24-106202

Note: The Centers for Medicare & Medicaid Services requires states to use state directed payments to advance at least one of the goals or objectives from the state's Medicaid managed care quality strategy.

Selected States Had Challenges Using Evaluations to Oversee Quality

Selected states used evaluations required by CMS as part of their oversight of their $1 billion or more state directed payments; however, the evaluations did not always include useful information to measure progress toward quality goals. According to our analysis of selected state evaluation plans and results for directed payments, all five selected states developed evaluations, but none consistently included elements CMS

identified as best practices for evaluations.[46] These elements include performance targets and baselines, which CMS has indicated allow for clear measurement of progress toward states' quality goals.[47] CMS found similar limitations in reviewing state evaluation plans and results; for example, in 2022, CMS found that 21 percent of directed payment evaluation plans did not include measurable performance targets.[48] Medicaid officials from three of our selected states (Arizona, Rhode Island, and Texas) said the evaluation plans were initially difficult to develop and implement due to challenges with obtaining timely and accurate data from providers and resource constraints.

Three selected states (Arizona, Rhode Island, and Texas) are working to address some limitations in their evaluation plans and results; for example, states have begun selecting evaluation measures that better reflect quality goals. However, it is too early to determine whether these changes will improve their usefulness. (See fig. 8.) According to CMS officials, states have improved evaluations since 2020. For example, the percentage of evaluations that included an evaluation measure increased from 60 percent in 2020 to 98 percent in 2023.

[46]CMS identified elements, such as performance targets, that are best practices for states to include in their evaluation plans and results, but has not formally required these elements.

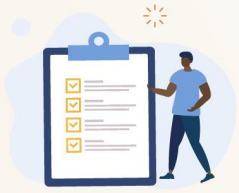
[47]Depending on how the evaluation is designed, the evaluation may help states monitor trends for different quality of care outcomes, but not determine how effective the state directed payment was in causing any desired outcomes.

[48]CMS reviewed 136 directed payment evaluation plans and 97 state directed payment renewal results for directed payments approved from April 1, 2021, through April 30, 2022.

Figure 8: Selected States' Evaluation Limitations and Improvement Efforts, as of July 2023

Evaluation Measures

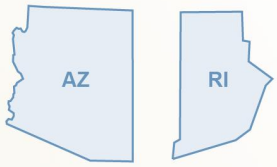
Choose measures that (1) reflect the quality strategy goals and objectives, (2) are related to the providers participating in the program, and (3) quantify health care and outcomes.



Reason for best practice

Allows states to better measure progress towards their stated goals.

States with limitation in meeting best practice:
Arizona and Rhode Island



Example of limitation and improvement effort

Arizona's state directed payment targets hospitals, including multiple long-term care hospitals, but it did not include any measures related to these providers in its evaluation plans for October 2020 through September 2023. Arizona is planning to track measures specific to long-term care hospitals as part of its pay-for-performance efforts.

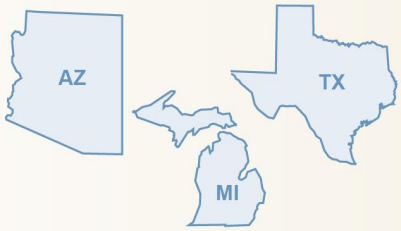
Performance Targets

Include a measurable performance target for each measure in the evaluation.

Reason for best practice

Helps determine if states are meeting their quality goals.

States with limitation in meeting best practice:
Arizona, Michigan, and Texas



Example of limitation

Michigan did not include measurable performance targets for 11 of its 13 quality measures in its evaluation plan for October 2022 through September 2023, the sixth year of its state directed payment. Instead, the state noted it would monitor the measures for fluctuations.

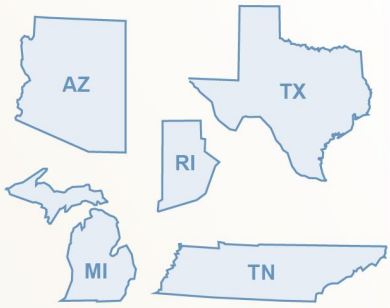
Baselines

Include a baseline for each measure in the evaluation that is set before the start date of the state directed payment.

Reason for best practice

Allows states to track quality outcomes before and after implementation of the state directed payment.

States with limitation in meeting best practice:
Arizona, Michigan, Rhode Island, Tennessee, and Texas

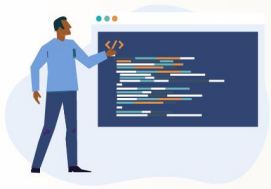


Example of limitation

Tennessee included baselines in its evaluation plan for January 2023 through December 2023 that were based on quality outcomes after the start date of the state directed payment.

Data Sources

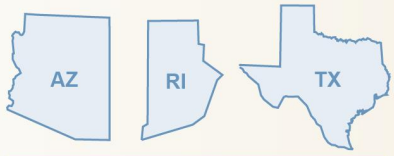
Restrict data to providers receiving state directed payments and Medicaid managed care beneficiaries.



Reason for best practice

Helps ensure results reflect the state directed payment and participating providers and beneficiaries.

States with limitation in meeting best practice:
Arizona, Rhode Island, and Texas



Example of limitation and improvement effort

Texas's evaluation results for September 2021 to August 2022, the first year of its state directed payment, were not limited to Medicaid managed care beneficiaries.Texas initially had difficulties in obtaining Medicaid managed care specific data from its providers due to their previous data systems. After working with providers to resolve the issues, Texas officials said providers would be able to give Medicaid managed care specific data for future evaluations.

Source: GAO analysis of state Medicaid information and Centers for Medicare & Medicaid Services (CMS) guidelines (information), MapResources (states), Julien Eichinger/stock.adobe.com (illustrations) . | GAO-24-106202

Notes: Best practices reflect CMS guidance to states provided during national webinars. Information on state limitations are based on evaluation plans, evaluation results, and other documentation that

selected state Medicaid agencies from Arizona (AZ), Michigan (MI), Rhode Island (RI), Tennessee (TN), and Texas (TX) sent to CMS for $1 billion or more state directed payments in effect between July 2020 and July 2023. For Tennessee and Texas, directed payments we analyzed were made to inpatient and outpatient hospitals.

Selected states reported challenges when using evaluation results to monitor progress toward state directed payment quality goals. For example:

- **Limited results.** Officials from two selected states (Arizona and Texas) said the results they had were not sufficient to determine areas needed for improvement. For example, officials from Texas said they needed results from at least 3 to 4 years from the start of the state directed payment before they could meaningfully rely on any trends in the data. As of July 2023, less than 2 months from the start of the third year of the payment, the state only had data available from the first year of its directed payment to analyze, according to the officials.[49] Officials from Arizona said their initial results did not use Medicaid-specific data, and they were working with providers to ensure future results were specific to the directed payment before making any changes to improve the effectiveness of the directed payment.
- **Challenges in interpreting results.** Officials from four selected states (Michigan, Rhode Island, Tennessee, and Texas) said using the evaluations to determine the effects of the payments on quality of care is difficult due to the influence of other factors, such as the COVID-19 pandemic or other types of Medicaid payments. As a result, it is not always clear what caused changes in evaluation measures; for example, the state directed payment, another factor, or both, according to the officials.[50]

Instead of relying on evaluation results, four selected states used other measurement approaches to ensure the state directed payments helped meet states' goals. For example:

- **Michigan.** Officials from Michigan said the quality of care measures they included in the evaluation plan are part of a wider quality

[49]Texas officials attributed this, in part, to the length of time it took to get CMS approval for the state directed payment. CMS did not approve Texas's directed payment for its first year until March 2022, 7 months into the directed payment due to ongoing discussions between the state and CMS on the design of the directed payment.

[50]GAO has previously identified best practices for developing evaluations. These include how to account for external factors that may affect the evaluation results. See GAO, *Designing Evaluations: 2012 Revision*, GAO-12-208G (Washington, D.C.: Jan. 31, 2012).

improvement strategy for the state. As a result, they are able to monitor several of these quality of care outcomes using alternative tools such as quarterly performance reports that the managed care plans share with the state. If there are concerning trends, the Michigan officials told us they work with the managed care plans to improve performance.

- **Tennessee.** Tennessee officials told us they use the state directed payment to help maintain or improve access to care. As a result, the state tracks compliance with network accessibility standards. If a managed care plan did not meet the standards, the state requires it to implement a corrective action plan, according to officials.

Selected States Used Payment Data, Provider Feedback, and Other Information to Ensure Payments are Accurate and Timely

Selected states' oversight of their $1 billion or more state directed payments included different strategies to monitor directed payment accuracy and timeliness. Officials in some selected states told us they used a combination of strategies for monitoring, including the following:

- **Payment data.** Officials from two selected states (Michigan and Texas) used payment data to monitor state directed payments and ensure providers received the correct amounts. For example, Michigan officials said they provide payments after a service is provided, and subsequently conduct monthly analyses and calculations using encounter data to ensure payments are accurate. For example, if a record for a health care service was voided after it was paid, then the state would ensure the payment for that service would be deducted from future payments.
- **Managed care plan reports.** Officials from two selected states (Tennessee and Texas) said they used reports from managed care plans to monitor the accuracy or timeliness of state directed payments. For example, Tennessee officials said they have a quarterly auditing process where they review managed care plan reports on provider payments to ensure the payments are accurate and timely.
- **Provider feedback.** Officials from four selected states (Arizona, Michigan, Rhode Island, and Texas) said they used provider feedback as part of their monitoring of the accuracy or timeliness of state directed payments. For example, Arizona officials said they monitor

the outflow of funds to the managed care plans and inform providers how much they should receive from the plans. If any problems arise with the accuracy of the payment amount, then providers can report these issues to the state.

Federal Approval Process Has Insufficient Fiscal Guardrails, Limited Consideration of Outcomes, and Gaps in Transparency

While CMS has taken steps to enhance its process for approving state directed payments, the process lacks sufficient fiscal guardrails. Additionally, CMS does not take payment outcome information into consideration when deciding whether to renew directed payments. Finally, CMS does not make all directed payment application documents publicly available, resulting in gaps in transparency.

CMS Has Taken Steps to Enhance State Directed Payment Approval Process, but Process Lacks Sufficient Fiscal Guardrails

CMS has taken steps to enhance the approval process for new and renewed state directed payments since 2021. Agency officials indicated that these changes have often resulted from CMS's ad hoc requests for additional information from states becoming more standard and formal. For example:

- We found that selected states were typically providing additional information CMS was requesting as part of its review. In 2021, CMS implemented an expanded application, which requests more information on states' directed payments; for example, the application requests the basis for state determination of reasonableness and appropriateness, and payment financing.
- CMS officials told us that in recent years they began asking for more information from states that were proposing state directed payments that would result in the managed care plans paying a class of providers above Medicare payment rates. For example, CMS will ask the state to provide documentation demonstrating that the resulting rate inclusive of the directed payment is below the average commercial rate, which is the average rate that commercial insurers in the private market pay for the same services. In February 2023, CMS

further formalized this process by incorporating it into its standard operating procedures.

- CMS has continued to clarify how states are to incorporate state directed payments in their managed care rate certifications and managed care contracts. For example, CMS updated annual rate setting guidance in 2023 to include some clarity to states on what to include from all of the related directed payment application documents.[51]

While CMS has taken recent steps to enhance its approval process, we found the process lacks sufficient fiscal guardrails to ensure state directed payments result in provider payment rates that are reasonable and appropriate as is required under CMS guidance. Moreover, these weaknesses are inconsistent with federal internal control standards that require federal agencies to obtain quality and relevant information and use it to conduct oversight and monitor changes over time.[52] We found the following three weaknesses in CMS's fiscal guardrails:

No definition of or standards for what is reasonable and appropriate. CMS requires states to describe why their proposed state directed payments are reasonable and appropriate when seeking approval.[53] However, CMS has not established and communicated a definition of reasonable and appropriate for state directed payments, which would serve to limit directed payments. CMS has also not established and communicated standards for how states are to assess what is reasonable and appropriate, such as around the data and assumptions that can be used in that assessment.[54] CMS also does not require state actuaries be

[51]Since 2017, CMS has included requirements in its annual rate setting guidance for how states are to account for state directed payments in their rate certifications. In 2023, CMS updated this guidance to clarify that all state directed payments must be documented in rate certifications, and that states' actuaries must confirm alignment between the state directed payment application and the rate certification.

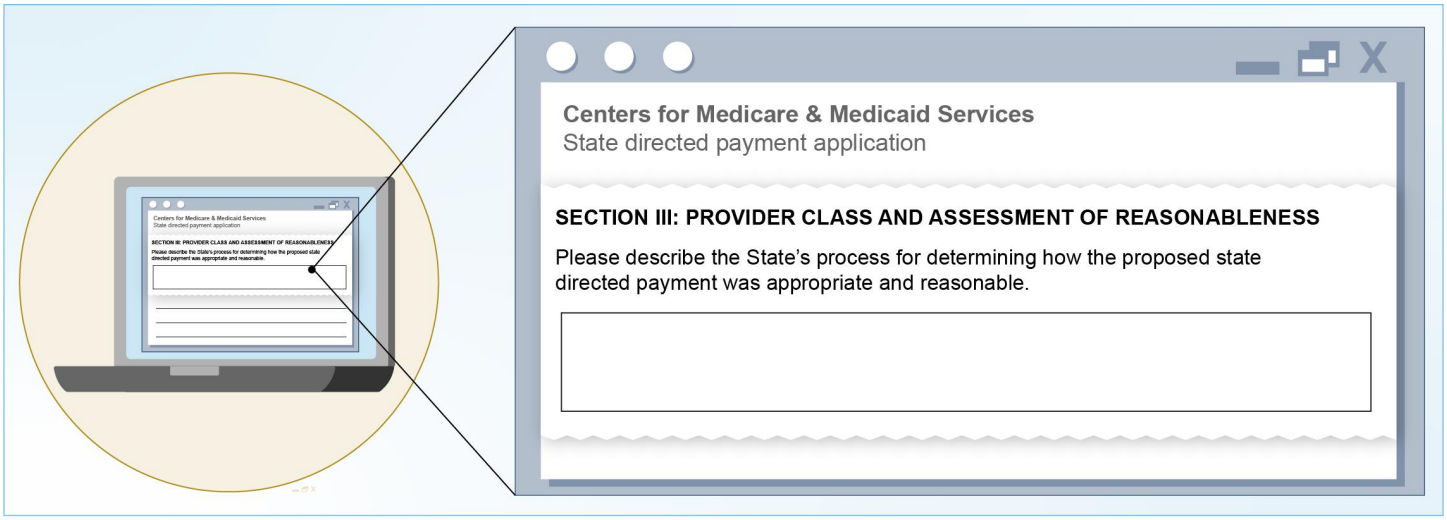
[52]See GAO-14-704G.

[53]See 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).

[54]There is precedent for CMS establishing such standards. CMS rules establish standards for how states are to assess that capitation rates are actuarially sound.

involved in that assessment.[55] In the application, states are asked to describe their process for determining that the state directed payment is reasonable and appropriate without any further direction. (See fig. 9.)

Figure 9: Excerpt from Centers for Medicare & Medicaid Services' State Directed Payment Application



Source: GAO analysis of Centers for Medicare & Medicaid Services website. | GAO-24-106202

CMS also requires states to describe the effect of the state directed payment on provider payment rates for some types of payments. In these cases, states are asked to identify the benchmark they are using as a comparison, such as Medicare payment rates or average commercial rates. However, for other types of state directed payments, such as value-based payments, which represent about 10 percent of approved payments in 2022, CMS does not require states to describe the effects of the directed payments on provider payment rates.[56] For example, the value-based directed payment CMS approved for one of our selected

[55]CMS also does not require state actuaries to be involved in developing state directed payments. In certifying the reasonableness and appropriateness of managed care capitation rates, state actuaries are to treat directed payments as a required cost under the managed care contract.

[56]Any states proposing state directed payments that do not represent a payment made in addition to negotiated rates between providers and the plan do not have to provide an analysis of the effect of the directed payment on provider reimbursement rates. In addition to some value-based payments, these could include some minimum or maximum fee schedule payments.

states (Rhode Island) did not include any analysis of the effect on payments to targeted providers.

Absent a definition or standards, CMS has allowed a wide range of state determinations of what is reasonable and appropriate. For example, our selected states determined reasonableness for the approved payments we reviewed by comparing their proposed provider payment rates to Medicare payment rates, average commercial rates, or a combination, and used different methodologies in making those comparisons.[57] Two of our selected states determined that state directed payments resulting in provider rates well above what Medicare pays were reasonable and appropriate.[58] (See table 2.)

Table 2: Examples of the Effects of State Directed Payments on Provider Payment Rates in Selected States Approved by CMS

State	Provider class	Comparison payment rate state used	Base rate as percentage of comparison rate	Total rate with directed payment as percentage of comparison rate[a]
Arizona	Inpatient hospital	Medicare payment	40 to 73[b]	47 to 102[b]
	Outpatient hospital	Medicare payment	69 to 85[c]	88 to 150[c]
Michigan	Inpatient hospital	Medicare payment	52	93
	Outpatient hospital	Medicare payment	49	92
Tennessee	Inpatient hospital	Medicare payment	70	119
	Outpatient hospital	Medicare payment	88	142
Texas	Inpatient hospital	Average commercial	26 to 167[d]	41 to 209[d]
	Outpatient hospital	Average commercial	12 to 76[e]	80 to 145[e]

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation. | GAO-24-106202

Notes: This table reflects examples from four of five selected states with approved state directed payments in 2022 that were estimated at $1 billion or more, and required plans to pay an amount above their negotiated rates with the relevant provider class.

[57]The Medicaid and CHIP Payment and Access Commission recently noted that unlike Medicare payment rates, which are publicly available and are generally consistent for all providers, the rates that private insurers pay are not readily available and can vary widely based on providers' ability to negotiate their payment rate. Additionally, the Congressional Budget Office found commercial hospital payments were 223 percent of Medicare payment rates and commercial physician payment rates were 129 percent of Medicare rates on average.

[58]CMS's review focuses on the aggregate payment rate for a class of providers, and does not consider rates for individual providers. This could result in individual providers receiving payment rates above 100 percent of the comparison rate.

[a]The total rate can include other state directed payments affecting the same class of providers or lump-sum payments states have required managed care plans to make to those providers, referred to as pass-through payments.

[b]Arizona had six inpatient hospital sub-classes: freestanding children's, private urban acute, public urban acute, rural acute, rural reservation-adjacent, and specialty hospitals.

[c]Arizona had six outpatient hospital sub-classes: freestanding children's, private urban acute, public urban acute, rural acute, rural reservation-adjacent, and specialty hospitals.

[d]Texas had 49 inpatient hospital sub-classes participating in the program. For example, hospital sub-classes included rural, urban, children's and state, and non-state-owned institutions for mental disease. According to state officials, in the cases where an inpatient hospital sub-class was paid above the average commercial rate, it was still below the Medicare payment rate because Texas does not pay providers at a rate that exceeds the Medicare payment rate.

[e]Texas had 36 outpatient hospital sub-classes participating in the program. For example, hospital sub-classes included rural, urban, children's and state, and non-state-owned institutions for mental disease. According to state officials, in the cases where an outpatient hospital sub-class was paid above the average commercial rate, it was still below the Medicare payment rate because Texas does not pay providers at a rate that exceeds the Medicare payment rate.

No other limits on state directed payment spending. In addition to the lack of a definition or standard for determining what is reasonable and appropriate, CMS does not set any other limits on state directed payment spending. States' estimates of the total dollar amount of the directed payment in their applications are not binding. This can result in actual state directed payments that far exceed CMS approved state estimates. For example, in one of its approved applications, Texas estimated $4.7 billion for a directed payment in effect from September 2021 through August 2022. According to state officials, actual spending exceeded the $4.7 billion estimate by about $1.5 billion. Texas officials told us that this difference was due to the state's assumption that the COVID-19 pandemic public health emergency would end during the payment year and therefore, service utilization would decrease; that did not happen. In addition to Texas, two of the other selected states (Michigan and Tennessee) had actual spending that exceeded estimates, which both states also attributed to the COVID-19 pandemic public health emergency.[59]

CMS also has not set any limits on states' total state directed payment spending or directed payment spending as a proportion of their total managed care spending, despite indicating that these payments are intended to be exceptions in managed care. In each of three of our selected states, we found that one directed payment's estimated spending represented about 20 percent of the state's total managed care

[59]We excluded Rhode Island because the state implemented a value-based state directed payment, under which providers received a portion of shared savings.

spending.[60] Overall, CMS estimated directed payments have grown to over 10 percent of total managed care spending in 2022 and will reach 15 percent in a few years.[61]

No actual spending amounts available at renewal. CMS does not require states to provide historical data on actual state directed payment amounts overall, or to individual providers, when applying to renew a state directed payment. Further, CMS does not have any other source of state directed payment data to consider during renewal. For example, states are not required to report actual directed payment information in any of CMS's expenditure reporting systems.[62] In December 2020, we recommended CMS collect and document complete and consistent provider-specific information about Medicaid payments to providers, including state directed payments.[63] CMS officials indicated that the agency does not consider actual spending data at renewal because the approval process is primarily prospective.[64]

In its rationale for proposed changes to its state directed payment regulations released in May 2023, CMS acknowledged some of the fiscal

[60]Each of the three states had other directed payments, so overall state directed payment spending as a proportion of total managed care spending is higher.

[61]In its May 2023 proposed rule, CMS sought public input on a proposal to limit total state directed payment expenditures to a percentage of each Medicaid managed care program within a state.

[62]These expenditure reporting systems include the Transformed Medicaid Statistical Information System and the CMS-64. The Transformed Medicaid Statistical Information System is CMS's national data repository to support Medicaid program management, including oversight activities. On a monthly basis, states are to submit over 1,400 data elements to the eight data files that comprise the system. The data elements include information touching upon most aspects of Medicaid and the Children's Health Insurance Program, including beneficiary eligibility, service use, and payments. States are required to submit aggregate total quarterly Medicaid expenditures on the form CMS-64 no later than 30 days after the end of each quarter. 42 C.F.R. § 430.30(c) (2022).

[63]See 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 October 2023, this recommendation remains unimplemented.

[64]CMS officials told us the agency has taken some efforts to conduct back-end auditing of state directed payment expenditures in selected state through financial management reviews. Such reviews were underway in three states as of June 2023.

guardrail weaknesses we identified.[65] Officials indicated that some of the provisions in the May 2023 proposed rule were designed to enhance fiscal oversight of state directed payments. As of October 2023, the rule has not been finalized. CMS's weak fiscal guardrails in its approval process have contributed to state directed payments' growth as a portion of overall managed care spending and leave the agency at risk of approving payments that result in provider payment rates that are not reasonable and appropriate.

CMS Does Not Consider Directed Payment Outcomes when Approving Renewals and Evaluation Requirements Do Not Reflect Health Equity Priorities

CMS has gaps in its policies and procedures for ensuring that state directed payments improve the quality of care for Medicaid beneficiaries. First, it is unclear whether CMS considers evaluation results or any other payment outcome information when reviewing a directed payment for renewal. Second, the agency has not aligned evaluation requirements with health equity priorities.

No Consideration of Payment Outcomes at Renewal of State Directed Payments

Though CMS requires that state directed payments be directly linked to quality improvement, the agency does not consistently collect or consider evaluation results or other payment outcome information at renewal to ensure that link. Specifically, CMS does not always receive timely evaluation information from states, did not always appear to be considering results when available, and does not consider any other information on payment outcomes when determining whether to approve renewals.

- **States do not always provide timely evaluation information.** CMS requests the state's evaluation results for the previous year with a state directed payment renewal application. Not all states, however, provide results. In CMS's review of 228 renewal applications submitted by 33 states between April 2018 and February 2021, the

[65]For example, in the preamble to its proposed rule, CMS indicated that definitions of reasonable and appropriate state directed payments currently do not exist, and proposed several regulatory standards in response. See 88 Fed. Reg. 28,092, 28,119 (proposed May 3, 2023).

agency found that less than half (43 percent) of the renewal applications included any evaluation results.[66] We found that one selected state (Rhode Island) did not provide any evaluation results as part of the state's directed payment renewal application in its third year of the payment, even after CMS requested them.

- **Unclear whether CMS considers available evaluation results at renewal.** We also found instances in which states did provide evaluation results, but CMS did not appear to consider them during the agency's approval process. For example, CMS approved two selected states' directed payments (Michigan and Texas) despite early evaluation results indicating declines in quality for some evaluation measures they were targeting for improvement.[67] In the results provided to CMS, Michigan did not indicate how it would address and improve performance on measures that did not meet the state's targets or show improvement over time. CMS also did not ask the state about any planned mitigation efforts or the reason for the decline. CMS officials told us that the state attributed the decline in performance to the COVID-19 pandemic.[68]
- **CMS does not consider any other performance information.** CMS did not ask any of our selected states for other types of performance information outside of the limited evaluation results we noted previously for their $1 billion or more state directed payments. Further, the agency's renewal procedures do not include asking for that type of information. States may have such information readily available. For example, CMS may be able to leverage data states are collecting on certain CMS Adult and Child Core Set quality measures, which are

[66]According to CMS officials, the percentage of renewal applications with evaluation results has increased since 2021.

[67]For Texas, we reviewed the state directed payment that was $1 billion or more for inpatient and outpatient hospital services. CMS officials said that the agency addressed issues related to renewing directed payments with declines in quality for a nursing facility services directed payment. The Department of Health and Human Services Office of Inspector General reported on this directed payment. See Department of Health and Human Services, Office of Inspector General, *Aspects of Texas' Quality Incentive Payment Program Raise Questions About its Ability to Promote Economy and Efficiency in the Medicaid Program*, A-06-18-07001 (Washington, D.C.: December 2020).

[68]The performance decline was for deliveries that resulted in c-sections, hospital readmissions, and inpatient hospital utilizations.

scheduled to become mandatory in 2024.[69] CMS recommended that at least two of our selected states use these measures to evaluate their directed payments.[70]

CMS has acknowledged that the agency needs evaluation results to further its policy goals in the areas of evaluation and quality improvement.[71] However, according to CMS officials, the agency's current regulations do not allow the agency to use evaluation results to determine whether to approve a state directed payment renewal application. For example, according to CMS officials, current regulations do not allow the agency to deny a directed payment application if the state does not provide any evaluation results or if evaluation plan performance targets are not met. CMS officials said that they have proposed changes to their regulations that would allow them to deny state directed payment applications in those cases.

Without considering timely information on state directed payment outcomes, either in the form of evaluation results or other sources, CMS may approve renewals of directed payments without considering whether quality goals are being met. Further, CMS may be renewing ineffective payments, including payments where there is a decline in quality performance.

No Alignment of Evaluation Requirements with CMS Health Equity Priorities

CMS has not aligned state directed payment evaluation requirements with the agency's priorities to better assess health equities. In 2022, CMS published these priorities in its *Framework for Health Equity*.[72] CMS's framework priorities include gathering better data on demographics and

[69]Beginning with the state reports for 2024, states generally must report all measures included in the Child Core Set and all behavioral health measures included in the Adult Core Set. See 42 U.S.C. §§ 1320b-9a(a)(4)(B) (mandatory reporting of child health quality measures), 1320b-9b(b)(3)(B) (mandatory reporting of adult behavioral health quality measures).

[70]Adult and Child Core Set measures are reported at the state level, but CMS suggested that our two selected states restrict the measures to providers receiving the state directed payment for the purposes of evaluation.

[71]See 88 Fed. Reg. at 28,138.

[72]See Centers for Medicare & Medicaid Services, *CMS Framework for Health Equity 2022-2032,* (Baltimore, Md.: April 2022).

key social factors to better assess health inequities and drive quality improvement.

However, CMS has not required states to incorporate framework priorities into state directed payment evaluations. Of the five selected states we reviewed, CMS did not request any to analyze health inequities, which are differences in health status between people related to demographic and social factors, such as race, or income.[73] None of our selected states separately reported their results by different demographics or social factors, despite four states (Michigan, Rhode Island, Tennessee, and Texas) having specific objectives in their Medicaid managed care quality strategy to reduce health inequities. Officials in two selected states (Arizona and Rhode Island) said they did not separately report their results because of data challenges.

CMS officials told us they would like states to include an analysis of health inequities when possible and that they believe states can utilize state directed payments to advance health equity initiatives. CMS officials also said they are working with states to address barriers with reporting demographic data through technical assistance and some planned trainings when states have relevant health equity goals and objectives.[74] However, it is unclear whether these efforts will be effective in aligning state evaluations with the framework. As such, state evaluations will continue to lack information that would allow states and CMS to assess health inequities, which is necessary for improving quality of care.

CMS Has Taken Steps to Publicly Post Approval Documents, but Transparency Gaps Remain

CMS has begun making approved state directed payment applications available publicly. In July 2023, CMS began posting on its web site approved state directed payment applications dating back to February 2023. This is a positive step forward toward transparency and is consistent with other types of Medicaid payment approvals CMS includes on its web site.

[73]CMS officials told us that some states have voluntarily opted to stratify their state directed payment evaluation data to better understand health inequities.

[74]CMS officials said there are both existing ways and provisions in the proposed rule to collect demographic data on the Medicaid population enrolled in managed care, which can help states phase health equity analysis into state directed payment evaluations.

However, CMS is not making other state directed payment application documents publicly available; for example, CMS does not include approved application attachments, evaluation plans, and evaluation results on its web site. State directed payment application attachments are common and include payment analysis and financing information that is important for fully understanding what CMS has approved. All five of our selected states included attachments as part of their directed payment applications for their payments estimated at over $1 billion in 2022. For example, Texas's directed payment application—for its payment to hospitals estimated at $4.7 billion—included attachments that described the payment arrangement, rate increases, and payment levels for 418 hospitals; the state's assessment of reasonableness and appropriateness of the payment; and information about participating providers. CMS officials told us they have considered making approved application attachments publicly available, but as of September 2023 had no plans for doing so.

CMS also does not make evaluation plans or results publicly available and does not require states to do so. Of our selected states, only one (Texas) voluntarily made evaluation results publicly available.

CMS has acknowledged that greater transparency around state directed payments is warranted as managed care payments have grown significantly as a share of total Medicaid payments. Officials said they have proposed to increase transparency of evaluations in the May 2023 proposed rule. The lack of publicly available information about state directed payments is inconsistent with federal internal control standards that require federal agencies to obtain quality and relevant information and ensure it is accessible.[75] Without full transparency around approved state directed payments—including application attachments, evaluation plans, and evaluation results—states and other policymakers will not have all the information needed to inform future decisions about directed payments.

Conclusions

State directed payments were intended to be exceptions to how managed care payments are made, but now represent a significant and growing proportion of managed care spending. Widespread state use of directed

[75]See GAO-14-704G.

payments indicates that states find them a useful strategy for enhancing provider payment rates in managed care. However, directed payments also reduce managed care plans' ability to control program costs, limiting the potential benefit of managed care. Despite that, CMS has not developed fiscal guardrails sufficient to ensure that state directed payments result in provider payment rates that are reasonable and appropriate.

Further, CMS has gaps in its policies and procedures for ensuring that state directed payments are increasing quality of care for Medicaid beneficiaries as intended. As a result, the agency risks renewing approval for state directed payments that are ineffective in meeting quality goals. CMS recently took steps to enhance transparency around directed payments through public posting of approved applications. However, by stopping short of posting important information on, for example, how directed payments are being financed and directed payments' effects on quality of care, states and other policymakers will not have the details needed to inform future policy decisions.

In its rationale for its May 2023 proposed rule, CMS acknowledged many of these weaknesses and proposed some changes to the rules around state directed payments to address them. However, it is unclear what changes will be finalized or how they will be implemented. Without stronger guardrails and better accountability, CMS is at risk of approving billions of dollars in federal funds for ineffective state directed payments.

Recommendations for Executive Action

We are making the following four recommendations to CMS:

The Administrator of CMS should enhance the agency's fiscal guardrails for approving state directed payments by establishing a definition of, and standards for, assessing whether directed payments result in payment rates that are reasonable and appropriate, and communicating those to states; determining whether additional limits are needed; and requiring states to submit data on actual spending amounts at renewal. (Recommendation 1)

The Administrator of CMS should consider interim evaluation results or other performance information from states at renewal to gain more timely information on whether state directed payments are advancing quality goals. (Recommendation 2)

The Administrator of CMS should require states to consider health equity priorities in designing evaluations of state directed payments. (Recommendation 3)

The Administrator of CMS should make publicly available all approval documents related to new and renewed state directed payments, including application attachments, state evaluation plans, and evaluation results. (Recommendation 4)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment, and its comments are reprinted in appendix IV. HHS also provided us with technical comments, which we incorporated in the report as appropriate.

With regard to our first recommendation—that CMS enhance fiscal guardrails for approving state directed payments—HHS indicated that the agency appreciated the recommendation and that, if finalized, provisions in its May 2023 proposed rule should address the recommendation. As an example, HHS noted proposed provisions related to ensuring that state directed payments are reasonable and appropriate. In addition to calling for CMS to establish a definition of, and standards for, assessing whether directed payments result in payment rates that are reasonable and appropriate, our recommendation also calls for CMS to determine whether additional limits are needed and to require states to submit data on actual spending amounts at renewal.

With regard to our second recommendation—that CMS consider interim evaluation results or other performance information at renewal—HHS also indicated appreciation for the recommendation and that provisions of the proposed rule should address it if finalized. HHS acknowledged that meaningful evaluation results are critical and asserted that the proposed rule, if finalized, would enhance CMS's ability to collect evaluations from states and increase the level of detail in evaluations. However, it remains unclear whether CMS will consider those evaluation results or other performance information as part of the renewal process.

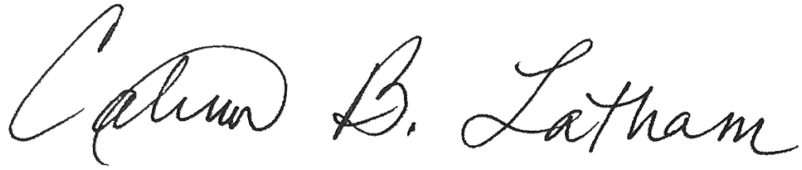
With regard to our third recommendation—that CMS require states to consider health equity priorities in designing evaluations of state directed payments—HHS concurred, stating the agency fully supports states considering health equity priorities in designing evaluations of state directed payments and is working to improve the measurement of health

disparities. For example, HHS said as stratification of state-level reporting on certain data to improve the measurement of health disparities becomes more prevalent, the agency expects to encourage it more often as part of state directed payment evaluations. HHS said it also intends to develop additional guidance on this topic.

With regard to our fourth recommendation—that CMS make publicly available all approval documents related to new and renewed state directed payments—HHS concurred, stating the agency is actively working to make publicly available the attachments states submit with their directed payment applications. Regarding making evaluation plans and results publicly available, HHS did not indicate plans for posting those documents. However, HHS said the proposed rule included provisions that would require states to post their evaluation reports on their public facing website.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or lathamc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.



Catina B. Latham
Director, Health Care

Appendix I: Scope and Methodology of Estimated Effects of States' Reliance on Funds from Health Care Providers and Local Governments

To describe estimated spending for, and state financing of, state directed payments in Medicaid managed care, we analyzed the estimated effect of states' decisions on how to finance the nonfederal share of Medicaid directed payments on the net directed payments providers receive and the federal share of the net directed payments.[1] To do so, we took the following steps:

- **We calculated the federal share and nonfederal share percentages of total state directed payments.** To do this, we calculated each state's total amount of directed payments, as well as the total amount of the federal share and nonfederal share, using the estimates states provided in their directed payment applications for payments in 2022.[2] We limited our review to the revised version of the directed payment applications the Centers for Medicare & Medicaid Services (CMS) implemented in 2021 and to applications in effect in 2022 that CMS had approved by August 26, 2022.[3] We also

[1]For purposes of our report, states includes the District of Columbia.

[2]For state directed payments approved for more than 12 months, we assumed equal payments each month and reduced the total payment amount in the directed payment application to reflect a year's worth of payment.

[3]Most managed care contract rate years last 12 months. Since state managed care contract rate years differ, we considered state directed payments in effect during the following dates to be in effect in 2022: (1) April 1, 2021, through March 31, 2022; (2) July 1, 2021, through June 30, 2022; (3) September 1, 2021, through August 31, 2022; (4) October 1, 2021, through September 30, 2022; or (5) January 1, 2022, through December 31, 2022. For managed care contract rate years that were less than or longer than 12 months, we considered directed payments with the following begin dates or end dates to be in effect in 2022: (1) begin dates of April 1, 2021; July 1, 2021; September 1, 2021; October 1, 2021; or January 1, 2022; or (2) end dates of March 31, 2022; June 30, 2022; August 31, 2022; September 30, 2022; or December 31, 2022.

calculated the federal share and nonfederal share percentages for each state and nationally.

- **We calculated states' net directed payments: the total state directed payments received by all providers minus the amount of funds the providers contributed to finance the nonfederal share of the state directed payments they receive.** To do this, we used states' directed payment application responses regarding nonfederal share financing, our calculations of the amount of the federal share and total directed payments, and an assumption about the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers. Our assumptions replicated those used in a prior GAO report.[4] In that report, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission that estimated these percentages as follows:
  - 80 percent of the funds providers contributed from provider taxes and donations were returned to the same providers as part of a Medicaid payment; and
  - 75 percent of the funds local governments contributed from intergovernmental transfers were returned to local government providers as part of a Medicaid payment.[5]

  We determined that these percentages remained appropriate, in part, by confirming them with CMS officials. Based on this assumption, we estimated the amount of funds the providers did not contribute to finance the nonfederal share of the state directed payments they receive.[6] We added this amount to the federal share we calculated earlier to calculate net directed payments.

- **We calculated the share of net Medicaid payments financed by the federal government.** To do this, we divided the federal share of state directed payments by net directed payments.

[4]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).

[5]See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017).

[6]When a state used multiple sources of funds to finance the nonfederal share of a state directed payment, we assumed that all of the funds came from the source of the nonfederal share that resulted in the smallest difference between the total directed payment and the net directed payment.

We did not independently verify the accuracy of the approved state directed payment applications data; however, we took steps to assess the reliability of the data, such as comparing our analysis to CMS's directed payment analysis. We determined 169 approved state directed payment applications in effect in 2022 were reliable for the purposes of describing estimated spending for, and state financing of, directed payments in Medicaid managed care. We accounted for any limitation or discrepancy in the application data during our analyses. For example, directed payment applications that did not include state spending estimates are not included in our analysis.

Appendix II: Provider Services Receiving State Directed Payments

States can instruct managed care plans to make state directed payments for one or multiple types of provider services, subject to Centers for Medicare & Medicaid Services approval. We reviewed the targeted provider services identified by states in approved directed payment applications for 169 payments in effect in 2022. See table 3 for the number of directed payments directed to one or multiple provider services.

Table 3: Number of State Directed Payments in 2022, approved by August 2022, by Type of Provider Service

Provider service	Only service	One of multiple services	Overall
Inpatient hospital service	16	40	56
Outpatient hospital service	8	38	46
Other	26	20	46
Home- and community-based services /personal care services	16	11	27
Behavioral health outpatient services	6	15	21
Nursing facility services	13	8	21
Professional services at an academic medical center	11	10	21
Primary care services	4	15	19
Specialty physician services	0	15	15
Behavioral health inpatient services	2	10	12
Dental services	2	2	4

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106202

Notes: Numbers of state directed payments are based on directed payment applications to CMS approved as of August 26, 2022. Directed payments approved later in 2022, directed payments that do not require CMS approval prior to implementation, and directed payment applications that did not include state spending estimates are not included. States can instruct managed care plans to make directed payments for one or multiple types of provider services. In 2022, 104 approved directed payment applications were for payments for one provider service and 65 approved directed payment applications were for payments for more than one provider service.

Appendix III: Estimated Cost Shifts Resulting from States' Reliance on Funds from Providers and Local Governments

State estimates of state directed payments totaled $38.5 billion in 2022, according to our analysis of directed payments the Centers for Medicare & Medicaid Services (CMS) approved through August 2022.[1] The federal share of these payments was about $26.2 billion and the nonfederal share was the remaining $12.3 billion. States used funds from providers and local governments—using provider taxes and intergovernmental transfers, respectively—to finance at least $8.4 billion of the nonfederal share of directed payments.[2] States' use of provider taxes and intergovernmental transfers effectively increased the federal government's share of the net directed payments made to providers by between 1 percentage point and 26 percentage points across states, according to our estimates of directed payments in effect in 2022. (See table 4.)

[1]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. Our analysis did not include any of these directed payments.

[2]Of the 169 payments in our analysis, 25 were financed, in part, with funds from providers or local governments, with the remaining funds from state general funds or other sources of funds. For purposes of our analysis, we considered all of the nonfederal share funds to be state general funds for these 25 payments, since states do not provide information on the amount of funds from each source of the nonfederal share. As such, the total amount of the nonfederal share from providers and local governments is undercounted.

Table 4: Total Estimated Amounts of State Directed Payments and Effect of Funds from Providers and Local Governments to Finance the Nonfederal Share of Payments, by State

State	Total number of directed payments	Total amount of directed payments	Nonfederal share from all sources	Nonfederal share from providers and local governments[a]	Net payment	Federal share	Federal share of total directed payments (pct)	Federal share of net directed payments (pct)
AR	1	$52,283,631	$14,874,693	$0	$52,283,631	$37,408,938	72%	72%
AZ	5	1,807,840,000	486,890,000	360,969,000	1,446,871,000	1,320,950,000	73	91
CA	5	6,877,489,000	2,407,121,150	1,531,477,640	5,346,011,360	4,470,367,850	65	84
DC	1	11,938,836	3,581,651	0	11,938,836	8,357,185	70	70
DE	1	6,440,000	2,323,552	0	6,440,000	4,116,448	64	64
FL	5	991,419,190	343,713,081	61,655,988	929,763,202	647,706,109	65	70
GA	2	304,223,045	91,282,125	68,461,594	235,761,451	212,940,920	70	90
HI	6	222,731,827	69,073,393	0	222,731,827	153,400,699	69	69
IA	5	607,658,204	169,389,728	109,500,000	498,158,204	438,268,476	72	88
IL	5	635,770,000	265,310,000	13,485,000	622,285,000	370,470,000	58	60
IN	1	407,900,000	65,300,000	52,240,000	355,660,000	342,600,000	84	96
KS	1	30,000,000	11,250,000	0	30,000,000	18,750,000	63	63
KY	3	1,194,524,634	238,140,386	188,618,749	1,005,905,885	956,384,248	80	95
MD	1	10,066,667	3,566,667	2,675,000	7,391,667	6,500,000	65	88
MI	4	2,510,616,407	605,489,471	478,404,380	2,032,212,027	1,905,126,937	76	94
MN	1	220,546,300	74,412,100	55,809,075	164,737,225	146,134,200	66	89
MO	1	42,026,933	14,284,955	10,713,716	31,313,217	27,741,979	66	89
MS	1	38,783,002	7,309,626	5,482,220	33,300,783	31,473,376	81	95
NC	10	747,867,661	214,014,644	67,517,411	680,350,250	533,853,017	71	78
NE	1	4,100,000	1,680,876	1,260,657	2,839,343	2,419,124	59	85
NH	4	90,116,817	32,193,431	0	90,116,817	57,923,386	64	64
NJ	8	696,889,804	265,314,126	196,285,595	500,604,210	431,575,678	62	86
NM	12	684,000,000	148,590,000	56,620,000	627,380,000	535,510,000	78	85
NV	3	132,648,563	48,319,153	35,857,120	96,791,443	84,329,410	64	87
NY	7	803,567,323	326,957,080	0	803,567,323	476,620,241	59	59
OH	3	1,577,529,333	435,785,467	332,850,000	1,244,679,333	1,141,743,867	72	92
OR	3	737,741,880	189,505,212	151,359,469	586,382,411	548,236,668	74	93
PA	9	831,700,000	224,698,000	32,240,000	799,460,000	607,002,000	73	76
RI	13	1,236,114,771	379,147,394	0	1,236,114,771	856,967,377	69	69
SC	1	48,000,000	14,054,400	0	48,000,000	33,945,600	71	71
TN	9	4,249,548,302	1,402,385,888	267,576,268	3,981,972,034	2,843,829,081	67	71

State	Total number of directed payments	Total amount of directed payments	Nonfederal share from all sources	Nonfederal share from providers and local governments[a]	Net payment	Federal share	Federal share of total directed payments (pct)	Federal share of net directed payments (pct)
TX	4	6,595,742,001	2,456,142,411	1,842,106,808	4,753,635,193	4,139,599,590	63	87
UT	7	328,346,169	103,844,159	78,865,146	249,481,023	224,502,234	68	90
VA	5	2,400,440,561	715,830,081	511,300,000	1,889,140,561	1,683,610,481	70	89
VT	8	478,079,012	200,274,073	0	478,079,012	277,804,939	58	58
WA	4	195,847,000	56,943,000	18,750,000	177,097,000	138,904,000	71	78
WI	7	281,180,000	112,028,816	0	281,180,000	169,151,185	60	60
WV	2	401,304,086	66,492,445	4,804,039	396,500,047	334,811,641	83	84
Total	**169**	**$38,493,020,959**	**$12,267,513,234**	**$6,536,884,876**	**$31,956,136,083**	**$26,221,036,884**	**68%**	**82%**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106202

Notes: Percentages rounded to the nearest whole number. Amounts of state directed payments are based on the estimates states included in their directed payment applications to CMS approved as of August 26, 2022. Directed payments that do not require CMS approval prior to implementation and directed payment applications that did not include state spending estimates are not included. In some cases, states' estimates of the nonfederal share from all sources and the federal share did not equal states' estimates for the total amount of directed payments. Since these were estimates, we did not resolve all discrepancies. For example, the total amount of directed payments do not always equal the sum of the nonfederal share from all sources and the federal share.

[a]Nonfederal share from providers and local governments include provider taxes and intergovernmental transfers.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

November 17, 2023

Catina B. Latham
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Latham:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"Medicaid Managed Care: Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency" (GAO-24-106202).**

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID MANAGED CARE: RAPID SPENDING GROWTH IN STATE DIRECTED PAYMENTS NEEDS ENHANCED OVERSIGHT AND TRANSPARENCY (GAO-24-106202)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS is committed to partnering with states to help strengthen the monitoring and oversight of Medicaid managed care programs.

Under risk-based managed care arrangements, Medicaid managed care plans have the responsibility to negotiate payment rates with providers to ensure access and meet contractual requirements.[1] Generally, states are not permitted to direct the expenditures of a Medicaid managed care plan, or to make payments to providers for services covered under the contract between the state and the managed care plan, as this type of state direction may reduce the plan's ability to effectively manage risk and costs in the delivery of contractually required Medicaid services.[2] However, there are circumstances in which states may believe that requiring managed care plans to make specified payments to health care providers could further the state's overall Medicaid program goals and objectives. For example, states may want to require that certain minimum payments be made to safety net providers to ensure access to care or provide funding for payments that could be used to ensure providers are appropriately rewarded for meeting certain program quality goals. The 2016 Medicaid and CHIP Managed Care Final Rule established the regulations at 42 CFR 438.6(c), which specify the parameters for how and when states may direct the expenditures of their Medicaid managed care plans, as well as the associated requirements and prohibitions on such arrangements.[3] These types of payment arrangements, known as State Directed Payments (SDPs), can assist states in achieving their overall objectives for access to services, delivery system and payment reform, and performance improvement as well as other priorities such as advancing health equity and improving quality of care.

Examples of the requirements specified in 42 CFR 438.6(c) include requirements that SDPs must be based on the utilization and delivery of services under the managed care contract, and that they be expected to advance at least one of the objectives in the state's managed care quality strategy with an appropriate evaluation plan. In addition, 42 CFR 438.6(c) and 438.7(b)(6) require that SDPs be included in all applicable managed care contract(s) and rate certification(s), and that they be developed in accordance with 42 CFR 438.4 and the standards specified in 42 CFR 438.5. Further, 42 CFR 438.6(c)(2)(ii)(B) requires that states direct expenditures equally, using the same terms of performance, for a class of providers providing the service under the contract. Historically, HHS has deferred to states in defining the provider class for purposes of SDPs, as long as the provider class is reasonable and identifiable, such as the provider class being defined in the state's Medicaid State Plan. This flexibility has proven important for states to target their efforts to achieve their stated policy goals tied to their managed care quality

[1] "Managed care plan" refers to risk-based managed care organizations (MCOs), prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs)
[2] 42 CFR 438.6 and 438.60
[3] *Federal Register*: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule (81 FR 27497) (May 6, 2016)

strategy. For example, HHS has approved SDPs with provider classes defined by criteria such as participation in learning collaboratives which were focused on health equity or social determinants of health.

As described in 42 CFR 438.6(c)(2)(ii), most types of SDPs must be approved in writing prior to implementation. Currently, one type of SDPs, SDPs that set a minimum fee schedule using Medicaid State Plan approved rates for a particular service, do not currently require prior written approval. To obtain written prior approval, states must submit a "preprint" form to HHS that documents how the SDP complies with federal requirements. Following the publication of the 2016 Medicaid and CHIP Managed Care Final Rule, HHS published an initial preprint form for states to use, along with guidance on the use of SDPs.[4] Subsequently, in January 2021, HHS published additional guidance for states, and issued a revised preprint form that states were required to use for rating periods that began on or after July 1, 2021.[5, 6] The revised preprint form is more comprehensive than the initial form and is designed to systematically collect the information necessary to ensure the SDPs are in compliance with the federal regulatory requirements. For example, the revised preprint form requires that states identify the estimated total dollar amount for the SDP and requires the submission of an analysis of provider reimbursement rates for the class(es) of providers that the SDP is targeting.

In the years since the requirements at 42 CFR 438.6(c) were first established, the scope, size, and complexity of the SDP arrangements submitted by states for HHS approval has grown steadily and quickly. For example, in calendar year 2022, HHS received 307 preprint forms for review and approval, compared to just 36 preprint forms received in calendar year 2017. As noted in the GAO's draft report, SDPs also represent a notable amount of Medicaid spending. Using the total spending captured for each SDP through the end of fiscal year 2022, HHS has calculated that SDP payments in 2022 were at least $52.2 billion. At least half of this estimate is for dollars that states are requiring to be paid in addition to the rates already negotiated between the plans and providers.[7] As the volume of SDPs and total dollars flowing through them continues to increase, HHS recognizes the importance of ensuring that these payment arrangements are both contributing to Medicaid quality goals and objectives, as well as ensuring that they are being developed and implemented with the appropriate fiscal and program integrity guardrails. To that end, HHS proposed a rule in May 2023 which included numerous proposals intended to enhance HHS and state oversight of SDPs.[8] HHS appreciates the information shared in the GAO's draft

[4] CMS, Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts. 2017. Accessed at: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib11022017.pdf

[5] CMS, Additional Guidance on State Directed Payments in Medicaid Managed Care. 2021. Accessed at: https://www.medicaid.gov/sites/default/files/2021-12/smd21001.pdf

[6] CMS, Section 438.6(c) Preprint. 2022. Accessed at: https://www.medicaid.gov/sites/default/files/2022-12/sdp-4386c-preprint-template-12192022.pdf

[7] As part of the revised preprint form, states are asked to identify if the payment arrangement requires plans to pay an amount in addition to negotiated rates vs. limiting or replacing negotiated rates. Approximately half of the total dollars identified for the SDP actions included were identified by States for payment arrangements that required plans to pay an amount in addition to the rates negotiated between the plan and provider(s) rates

[8] *Federal Register* Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality; Proposed Rule (88 FR 28092) (May 3, 2023)

report and notes that several of the proposals in the May 2023 proposed rule, if finalized, would address the concerns raised by the GAO.

GAO's recommendations and HHS's responses are below.

Recommendation 1
The Administrator of CMS should enhance the agency's fiscal guardrails for approving state directed payments by: establishing a definition of, and standards for, assessing whether directed payments result in payment rates that are reasonable and appropriate, and communicating those to states; determining whether additional limits are needed; and requiring states to submit data on actual spending amounts at renewal.

HHS Response
HHS/CMS appreciates the GAO's recommendation. As noted above, HHS proposed a rule in May 2023 which included numerous proposals that are intended to enhance HHS and state oversight of SDPs. If finalized, HHS believes those proposals would address the GAO's recommendation.

For example, HHS recognizes that additional regulatory requirements about the totality of provider payment rates under SDPs may be needed to ensure proper fiscal and programmatic oversight as SDP spending continues to increase. Through guidance and individual technical assistance, states were previously informed that they must demonstrate that SDPs result in provider payment rates that are reasonable, appropriate, and attainable as part of the preprint form review process. The May 2023 proposed rule included provisions that, if finalized, would codify a standard regarding the provider payment rates for each SDP more clearly in regulation. Specifically, the proposal would require that the total payment rate for each service and provider class included in the SDP be reasonable, appropriate, and attainable and that states would be required to provide documentation demonstrating the total payment rate for each service and provider class. The proposed rule also included a proposed definition of "total payment rate" which would provide clearer, more consistent, guidance for states on how to assess whether SDPs result in payment rates that are reasonable, appropriate, and attainable.

Recommendation 2
The Administrator of CMS should consider interim evaluation results or other performance information from states at renewal to gain more timely information on whether directed payments are advancing quality goals.

HHS Response
HHS/CMS appreciates the GAO's recommendation. As noted above, HHS proposed a rule in May 2023 which included numerous proposals that are intended to enhance HHS and state oversight of SDPs. If finalized, HHS believes those proposals would address the GAO's recommendation.

HHS recognizes the importance of ensuring that SDPs are contributing to Medicaid quality goals and objectives and acknowledges that meaningful evaluation results are critical for ensuring that SDPs further improvements in quality of care. The May 2023 proposed rule, if finalized, would

enhance HHS's ability to collect evaluations of SDPs and increase the level of detail described in the evaluation.

Recommendation 3
The Administrator of CMS should require states to consider health equity priorities in designing evaluations of state directed payments.

HHS Response
HHS/CMS concurs with this recommendation, but notes that HHS currently lacks the authority to require states to consider health equity priorities in designing evaluations of SDPs. In order to require states to consider health equity priorities in designing evaluations of SDPs, HHS would have to consider additional rulemaking. HHS fully supports states considering health equity priorities in designing evaluations of SDPs and already encourages states to incorporate health equity into their SDP evaluations when appropriate. As noted above, SDPs are expected to advance at least one goal or objective from a state's quality strategy, and 42 CFR 438.340 requires that states include their plan to address health disparities in their quality strategy. When providing individual technical assistance on SDP evaluations, HHS has begun asking states to connect their quality goals and objectives related to health equity to evaluation metrics when possible.

Another key way in which HHS is working to improve the measurement of health disparities is through the stratification of state-level reporting on certain data. For example, in an August 2023 final rule, HHS recently finalized requirements for state-level stratification of certain Child, Adult, and Health Home Core Set measures.[9] Through the issuance of annual reporting guidance, HHS will phase-in over 5 years, a requirement to stratify specific measures in the Child Core Set, the behavioral health measures on the Adult Core Set, and the Health Home Core Sets that must be stratified by certain categories (which will also be phased-in as data is available), such as race, ethnicity, sex, age, rural/urban status, disability, and language. Additionally, HHS has required the stratification of data appropriate for the goals and design features of certain Section 1115 Demonstrations. Stratification will allow for the identification of potential differences in access, quality, and outcomes based on demographic factors like race, ethnicity, age, rural/urban status, disability, language, sex, sexual orientation, and gender identity, as well as social determinants of health. As the stratification of data becomes more prevalent, HHS expects to encourage this more often as part of SDP evaluations and intends to develop additional sub-regulatory guidance on this topic.

Recommendation 4
The Administrator of CMS should make publicly available all approval documents related to new and renewed state directed payments, including application attachments, state evaluation plans, and evaluation results.

HHS Response
HHS/CMS Concurs with GAO's recommendation.

[9] *Federal Register* Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting; Final Rule (88 FR 60278) (August 31, 2023).

HHS/CMS has already taken steps to increase transparency into how states are directing managed care plan expenditures under their managed care contracts by publishing all SDP preprint forms that were approved on or after February 1, 2023.[10] HHS plans to continue publishing this information and is actively working to make publicly available the attachments states submit with their preprints. Further, the May 2023 proposed a rule, if finalized, would require states to post their evaluation reports on their public facing website.

[10] CMS, Approved State Directed Payment Preprints. Accessed at: https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints

Accessible Text for Appendix IV: Comments from the Department of Health and Human Services

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Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Catina B. Latham, (202) 512-7114 or lathamc@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Peter Mangano (Assistant Director), Drew Long, Dhara Patel, Emily Quick-Cole, Jennifer Rudisill, Kendra Sippel-Theodore, Roxanna Sun, and Carolyn L. Yocom made key contributions to this report.

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