Medicaid Managed Care Directed Payments

Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services. The Medicaid Managed Care Final Rule published in the Federal Register on May 6, 2016 introduced the possibility for special contract provisions where by states may direct MCOs to make payments to certain Medicaid providers, specifically, to implement value-based purchasing, delivery system reform models, and provider payment initiatives. Pursuant to 42 C.F.R. § 438.6(c)(1), the state may require an MCO to make the following categories of directed payments:

- Value-Based Purchasing. States may specify in their contracts that MCOs reward providers participating in value-based purchasing models. The contract between the state and the MCO would set forth methodologies or approaches to provider reimbursement that prioritize achieving improvements in access, quality, and/or health outcomes rather than merely financing the provision of services.

- Delivery System Reform. States may use MCO payments as a tool to incentivize providers to participate in broad-ranging delivery system reform or performance improvement initiatives. These initiatives can be multi-payer or Medicaid-specific. Examples include patient-centered medical homes, efforts to reduce the number of low birth weight babies, broad-based provider health information exchange projects, and other specific delivery system reform projects to improve access to services. The capitation rates to the managed care plans would reflect an amount for incentive payments to providers for meeting performance targets.

- Minimum or Maximum Fee Schedules and Rate Enhancements. States may require that MCOs support payment initiatives in order to ensure timely access to high-quality, integrated care, specifically (1) minimum (or maximum) fee schedules, (2) uniform percentage increases to contracted rates, or (3) uniform dollar amount increase to certain services.

Among other requirements set forth at 42 C.F.R. § 438.6(c)(2), states seeking approval of one of the above mentioned directed payment arrangements must submit a template written request, known as the Section 438.6(c) Preprint (Preprint), to CMS for review and approval. The Preprint includes fifteen questions that apply to all proposed payment arrangements, as well as three additional questions specific to value-based payment arrangements. The required questions cover many of the requirements set forth in the Medicaid managed care regulations.

As of late 2018, at least twenty-seven states had received CMS approval for at least one directed payment arrangement. Texas, for example, has received CMS approval of a uniform rate increase payment arrangement (Uniform Hospital Rate Increase Program), a value based purchasing directed payment arrangement (Quality Incentive Payment Program), and a minimum fee schedule for nursing facilities. Notably, ten other states have also received CMS approval for value-based purchasing, pay for performance, and/or delivery system reform-based directed payments. These value-based purchasing payment arrangements include enhanced payments for behavioral health services, disability access incentives, patient center medical homes and community health teams, integrated family services, Medicaid accountable care organizations, care innovation and community improvement programs, quality incentives for nursing facilities, dental services incentives, and a women's health initiative.