American Academy of Actuaries

Issue Brief

Medicaid Managed Care State-Directed Payments—A Primer

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Key Points

- This issue brief provides an overview of Medicaid managed care state-directed payments, including how they have evolved from supplemental and pass-through payments; recent changes to federal guidance governing them; and recommendations from the Medicaid and CHIP Payment and Access Commission (MACPAC), a nonpartisan congressional advisory body, on how state-directed payments should be further evaluated by policymakers going forward.
- State-directed payments are a special type of payment arrangement regulated by the Centers for Medicare and Medicaid Services (CMS), which allows a state to direct expenditures to providers under the managed care organization (MCO) contracts in certain situations.
- As the number of state-directed payments increases, so does the potential for higher Medicaid expenditures that flow through them. Their increasing size over time has attracted the attention of CMS and the Government Accountability Office.
- Depending on the state, actuaries might be involved in the development, review, and CMS approval process for a state-directed payment preprint. However, once a state-directed payment is included under an MCO contract, it must be reflected in the capitation rates per actuarial soundness requirements.

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This issue brief provides an overview of Medicaid managed care state-directed payments, including how they have evolved from supplemental and pass-through payments; recent changes to federal guidance governing them; and recommendations from the Medicaid and CHIP Payment and Access Commission (MACPAC), a nonpartisan congressional advisory body, on how state-directed payments should be further evaluated by policymakers going forward.

State-directed payments are a special type of payment arrangement regulated by the Centers for Medicare and Medicaid Services (CMS), which allows a state to direct expenditures to providers under the managed care organization (MCO) contracts in certain situations.[1] CMS authorized state-directed payments in the May 6, 2016, Medicaid Managed Care Rule (2016 Rule) under 42 CFR § 438.6, *Special contract provisions related to payment*.[2] The following federal activity related to state-directed payments has occurred within the past two years:

- On November 13, 2020, CMS published the 2020 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule (2020 Rule),[3] which updated regulations from the 2016 Rule.
- A few months after issuing its 2020 Rule, CMS sent State Medicaid Director Letter (SMDL) #21-001.[4] The letter clarified items related to directed payments in previous guidance[5] and introduced a more

1 https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html
2 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6
3 https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care
4 https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf
5 https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery; https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf

comprehensive preprint form[6] required for review and approval. Due to this guidance, states and actuaries must provide more detailed documentation to support CMS' review and approval of these payments.

In June 2022, MACPAC released its *Report to Congress on Medicaid and CHIP*[7] and recommended that state-directed payment information be made publicly available and more rigorously evaluated to assess whether these payment arrangements are meeting state goals, including network adequacy and other access standards. As such, state-directed payment documentation may be subject to additional detailed reporting and increased public exposure.

Readers of this issue brief are assumed to have a general understanding of Medicaid, fee-for-service (FFS) and managed care delivery systems, and the various funding sources that support the financing of the Medicaid program.

1. Evolution of State-Directed Payments

The use of state-directed payments in managed care evolved from an older form of payment to Medicaid providers called FFS supplemental payments. FFS supplemental payments are not specifically defined in federal regulation and became a common state plan[8] reimbursement strategy to increase Medicaid funding to providers like hospitals or nursing homes. These payments might be intertwined with state provider taxes or intergovernmental transfer (IGT) programs. Although providers might supply the funding for some or all of the state portion in certain situations, the increased federal matching funds made FFS supplemental payments a valuable provider reimbursement arrangement.

In 2001, CMS revised upper payment limits (UPL) regulations[9] to address growth in supplemental payment programs and required states to demonstrate compliance. Many states have since moved their Medicaid delivery system from predominantly FFS to a predominantly managed care system. Managed care represented 15% of nationwide

6 https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf
7 https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf
8 See for a description of state plans: https://www.macpac.gov/subtopic/state-plan/
9 https://www.federalregister.gov/documents/2001/01/12/01-635/medicaid-program-revision-to-medicaid-upper-payment-limit-requirements-for-hospital-services-nursing

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Medicaid enrollment in 1995, and had steadily grown to 69% by 2019.[10] As FFS delivery systems shrank in volume of dollars directly reimbursed from states to providers, so did the size of state FFS supplemental payment programs. Some states then leveraged the managed care program by including supplemental payments in the MCOs' capitation rates and directing the MCOs to pay the included funds to providers as states did with FFS supplemental payments. Sometimes, the payments were excluded from the capitation payments and were implemented through managed care contract requirements. These MCO payments to providers became known as pass-through payments.

CMS addressed this increase in pass-through payments by including 42 CFR § 438.6 *Special contract provisions related to payment* regulation in the 2016 Rule.[11] Now, states may only direct MCOs' expenditures per 42 CFR §§ 438.6(c)[12] and 438.6(d).[13] The 2016 Rule also defined pass-through payments, forbade new ones, and introduced a phase-out for existing ones. CMS also recognized that states needed some flexibility in directing provider payments, particularly when implementing value-based purchasing or delivery system reform strategies. Thus, CMS created and defined state-directed payments. The 2016 Rule allows states to direct some MCOs' payments to providers under specific situations and subject to CMS review and approval. State-directed payments' key features include:

- Tying provider payments to service utilization;
- Linking payments to a state's quality strategy;
- Requiring funding for state-directed payments to be included in the capitation rates;
- Equal participation and terms of performance to provider classes in alternative payment arrangement state-directed payments; and
- CMS approval of all state-directed payments submitted for review using a CMS-defined preprint for each payment.

The preprint referenced in the last bullet above is a CMS template that collects information to check that the proposed payment meets regulations. The 2020 Rule and subsequent preprint increase how much documentation states and actuaries must put into the preprint. CMS also reflects this increased detail in their rate development guide (Guide, starting with the July 2021–June 2022 Guide, subsequent Guides,[14] and the 2022 State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval[15]).

10 https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/; https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf
11 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6
12 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(c)
13 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(d)
14 https://www.medicaid.gov/medicaid/managed-care/downloads/2022-2023-medicaid-rate-guide-03282022.pdf
15 https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf

2. 2020 Rule Updates to State-Directed Payments

The 2020 Rule[16] included several updates to the regulations for state-directed payments as outlined below.

Arrangements Based on State Plan-Approved Reimbursement Levels

Under the 2016 Rule, all state-directed payments required CMS approval. In the 2020 Rule, state-directed payments based on state plan-approved reimbursement rates no longer require CMS approval before implementation under 42 CFR § 438.6(c)(2)(ii).[17] CMS, however, still requires that these payments follow the criteria of other directed payments: based on utilization, consistent provider treatment, tied to the state managed care quality strategy, and required evaluation of the effectiveness of the state-directed payment in meeting state quality strategy goals and objectives identified in the preprint.

Multiyear Arrangements

According to 42 CFR § 438.6(c)(3)(i), states now have the option for a multiyear approval on a preprint, under certain conditions.[18] First, the contract must identify and describe the arrangement as a multi-year payment arrangement, including a description by year if it varies by year. The state must also include its plan to implement, evaluate, and tie the multiyear arrangement to its quality strategy. CMS prior approval is required for any changes once the multiyear arrangement begins.

New Pass-Through Payment Arrangements

Effective for contracts starting on or after July 1, 2021, the 2020 Rule allowed states to create new pass-through payments in their managed care programs on a temporary basis under 42 CFR § 438.6(d)(6)[19] when states are transitioning from FFS to managed care for the first time, when new services are carved into managed care (such as managed longterm services and supports), or when new populations are added into managed care. To do so, states must have existing FFS supplemental payments in their approved state plan for the services or populations moving to managed care. The pass-through is capped at the historic FFS supplemental payment amount, prorated by the proportion of hospitals, nursing facilities, and physician services transitioning to managed care.

The allowance for a new temporary pass-through payment could help states that are seeking to transition a Medicaid population or service to managed care, but for which the loss of supplemental payments made it financially or operationally difficult to do so.

Provision of Additional Guidance

CMS will guide rate development standards and documentation requirements annually under 42 CFR § 438.7(e).[20] The Guide started with the implementation of the new Adult

16 https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care
17 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(c)(2)(ii)
18 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(c)(3)(i)
19 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(d)(6)
20 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7#p-438.7(e)

Expansion group under the 2014 Affordable Care Act and was codified in the 2020 Rule to clarify that CMS must issue this guidance annually. The Guide contains CMS documentation criteria that a state's actuaries must include as part of the rate certification document. CMS typically clarifies and modifies the Guide's requirements with each annual version.

For example, the 2021–2022 Guide requests more details around state-directed payments than past Guides. Prior to CMS approval of rate certification, CMS requires approval of any state directed payments arrangement preprints.

3. State-Directed Payments SMDL #21-001

The 2016 Rule gave states some flexibility to direct MCOs' payments to providers. The rule introduced state-directed payments and pass-through payments per 42 CFR §§ 438.6(c)[21] and 438.6(d),[22] respectively. After the 2016 Rule was published, CMS issued a November 2017 informational bulletin clarifying what qualified as state-directed payments. CMS stated that *general contracting requirements* for increasing provider payments that did not specify rates for specific providers were *not* considered state-directed payments or pass-through payments. Therefore, general contracting requirements did not require CMS approval.

For example, a state implementing a general requirement for MCOs to increase provider reimbursement to a provider class, but not a mandate for a specific provider reimbursement methodology, would not be considered a state-directed payment. Under this example, an MCO maintains the ability to negotiate provider contracts to implement the provider reimbursement increases. This payment strategy was flexible enough that CMS did not consider it a state-directed payment, and if tied to utilization, it would not be classified as a pass-through payment.

Shortly after finalizing the 2020 Rule, however, CMS revised its guidance from 2017. In the SMDL #21-001,[23] CMS shared its concerns that this general contracting circumvented the accountability of having funds in the capitation rates "not clearly and directly tied specifically to the utilization and delivery of a specific service or benefit provided to a specific enrollee under the contract."[24] CMS required states with these general contracting requirements to convert them into state directed payments, or CMS would "consider such contract requirements out of compliance with federal regulations."[25]

States were expected to implement this guidance for contracts starting on or after July 1, 2021. However, CMS granted several states one-year extensions, likely due to the

21 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(c)
22 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(d)
23 Centers for Medicare & Medicaid Services (CMS), Additional Guidance on State Directed Payments in Medicaid Managed Care, SMD# 21-001, smd21001.pdf (medicaid.gov)
24 Ibid., p. 4.
25 Ibid.

complexity of converting such contract requirements into state-directed payments. This conversion necessitates submission of a state-directed payment preprint that addresses the key features outlined above. During that submission, states may need to re-engineer how the payment makes its way to providers and usually requires stakeholder involvement. As one example, this re-engineering might involve converting a payment arrangement from a unilaterally determined payment allocation to an allocation by provider that is tied to service utilization. CMS has offered technical assistance to states going through this process. Depending on the structure of the state-directed payment arrangement, actuaries working on behalf of states may be involved in this process to perform the analytics that may be required by the preprint.

Basing Payment on the Utilization and Delivery of Services

CMS reemphasized that state-directed payments must be based on the utilization of existing services under the contract. State-directed payments made to providers must also be based on utilization data from the rating period. Historical data is still acceptable for capitation rate-setting.

Prior Approval of State-Directed Payments

Effective for contracts starting on or after December 14, 2020, state-directed payments need CMS approval before implementation, with the exception of a minimum fee schedule using state plan-approved rates. This approval is a CMS prerequisite before it approves the corresponding managed care contracts and rate certification.

State-Directed Payment Levels

CMS requires states to show that state-directed payments result in reasonable, appropriate, and attainable provider rates. The guidance indicates that states are required to document the average payment rate paid by MCOs to providers before and after state-directed payments and pass-through payments. A standardized measure can be used like payment rates as a percentage of Medicare or Medicaid state plan rates. If a state-directed payment or a combination of state-directed payments to a class of providers results in payment levels that exceed 100% of Medicare payment levels for the service, states must provide a comparison to the average commercial rate. CMS has required states to provide state-specific analyses for all providers affected by the state's directed payments. This type of analysis is required for every combination of class of providers and service type within a state-directed payment. CMS reserves the right to also examine the data at the unique provider level.

CMS also updated the state-directed payment preprint templates to include a table for these analyses.

Provider Class Definition

In its May 2020 Information Bulletin,[26] CMS confirmed that states have flexibility in defining the *class of providers* eligible for a state-directed payment. Moreover, 42 CFR § 438.6(c)(2)(ii)(B)[27] requires that a payment "[d]irects expenditures equally, and using the same terms of performance, for a class of providers." CMS clarified that this does not mean every provider in that class earns the same amount. Each provider is responsible for its performance.

When calculating the payment rate analysis, states must base the analysis on the specific class of providers impacted. CMS gives this example:[28] Suppose the class of providers is primary care physicians. Then the analysis should be only for *primary* care physicians and exclude *specialty* physicians.

Incorporating State-Directed Payments into Capitation Rates

In the recent Guides,[29] CMS outlines two ways in which state-directed payments can be incorporated into capitation rates:

- Adjustment applied in the development of base capitation rates.
- Separate payment term.

CMS has indicated that the incorporation of state-directed payments as an adjustment in base capitation rate development is "consistent with the nature of risk-based managed care."[30] Therefore, given the nature of at-risk managed care, it is unlikely that a state-directed payment incorporated as an adjustment in the capitation rate development will be linked to a fixed amount of funding.

Separate payment terms identify funding that is included as part of the composite capitation rate; however, unlike state-directed payments that are incorporated as capitation rate adjustments, those that are under separate payment terms are generally paid separately from the monthly capitation rates paid to MCOs, and payments could be made at a different frequency from the monthly capitation rate payment. CMS noted that separate payment terms are popular with states but is concerned that MCOs bear little risk in such arrangements.[31] If a state implements a state-directed payment under a separate payment term, CMS will require additional state justification for that decision and documentation of the total capitation rates by rate cell inclusive of separate payment term funding once the rating period is complete. When implementing separate payment terms, it is important for states and actuaries to consider interactions with medical loss ratios, risk corridor arrangements, and premium taxes.

26 https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf
27 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(c)(2)(ii)(B)
28 https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf, p. 7.
29 https://www.medicaid.gov/medicaid/managed-care/downloads/2022-2023-medicaid-rate-guide-03282022.pdf
30 https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-template.pdf, p. 13.
31 https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf, p. 7.

Financing of State-Directed Payments

States continue to have flexibility in funding their non-federal share of state-directed payments. However, CMS' preprint released after the 2020 Rule had detailed questions on funding if the state-directed payment used IGTs or provider taxes to finance the non-federal share. If states use IGTs, they must identify all transferring entities and amounts transferred. In the SMDL #21-001, CMS writes, "However, approval of a state directed payment does not constitute approval of the financing mechanism for the non-federal share."[32] CMS also reiterated that states could not require providers to use IGTs as a condition for participating in a state-directed payment. States also cannot define a class of providers by the providers' ability to supply IGTs.

Quality and Accountability

In the SMDL #21-001, CMS requires that state-directed payments be linked to a state's managed care quality strategy and have evaluation plans. In its 2017 Center for Medicaid and Chip Services (CMCS) Informational Bulletin (CIB), CMS gave guidance on what preprints should also include:

- Performance criteria to assess specific goals and objections.
- Baseline data for performance measures.
- Improvement targets for performance measures.[33]

CMS encouraged states to use measures already being collected or easily available, including the Medicaid and CHIP Adult and Child Core Sets. In June 2021, CMS also released its Managed Care Quality Strategy Toolkit,[34] which names state-directed payments as a tool for achieving quality strategy objectives.

States must use this guidance for all quality strategy updates submitted after July 1, 2021.

Preprint Template and Technical Assistance

As mentioned previously, CMS updated the preprint template to include a section for a provider payment-level analysis. Other formatting changes were made to make the template more streamlined. CMS encourages states to submit preprints for approval at least 90 days before the rating period starts but does not provide a timeline for CMS review and approval. CMS indicates that preprint and technical assistance questions should be sent to StateDirectedPayment@cms.hhs.gov.

32 Centers for Medicare & Medicaid Services (CMS), Additional Guidance on State Directed Payments in Medicaid Managed Care, SMD# 21-001, smd21001.pdf (medicaid.gov), p. 8.
33 https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf, p. 2.
34 https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf

4. MACPAC (Report to Congress on Medicaid and CHIP June 2022)

State-directed payments were introduced in the 2016 Rule. In 2018, MACPAC recorded 65 approved payments.[35] By 2020, that number grew to more than 200 arrangements across 37 states with an estimated $25 billion in 2020 for the subset of state-directed payments with available information. MACPAC's June 2022 report[36] discusses the transparency and evaluation of these state-directed payments and how these payments intersect with actuarial soundness.[37] This report has accompanying state-directed payment recommendations to the secretary of the U.S. Department of Health and Human Services, of which CMS is a part. The recommendations include:

- **Improve transparency by making preprint approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website.** MACPAC reports that CMS already makes similar documents publicly available.
- **Make provider-level data on directed payment amounts publicly available in a standard format that enables analysis.** MACPAC highlights the lack of available provider-level data today and the potential benefits of having this data made publicly available to stakeholders.
- **Require states to quantify how directed payment amounts compare to prior supplemental payments and clarify whether these payments are necessary for health plans to meet network adequacy requirements and other existing access standards.** MACPAC states that assessing whether state directed payments are meeting objectives begins with understanding payment goals.
- **Require states to develop rigorous, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.** MACPAC discusses some benefits of multiyear evaluation plans to states, CMS, and policymakers.
- **Clarify the roles and responsibilities of states, actuaries, and divisions of CMS involved in the review of directed payments and the review of managed care capitation rates.** MACPAC reports conflicting views of which party is responsible for assessing state-directed payments' reasonableness and observed confusion around the timing of the process and different CMS divisions involved in overseeing rate certifications, MCO contracts, and state-directed payment preprints.

35 https://www.macpac.gov/wp-content/uploads/2022/03/Directed-Payments-Presentation_March-2022-Meeting.pdf
36 https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf
37 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4#p-438.4(a)

The Role of Actuaries With State-Directed Payments

Depending on the state, actuaries might be involved in the development, review, and CMS approval process for a state-directed payment preprint. However, once a state-directed payment is included under an MCO contract, it must be reflected in the capitation rates per actuarial soundness requirements (see text box).

> **§ 438.4 Actuarial soundness. (a)** ***Actuarially sound capitation rates defined.*** Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs[38] that are required under the terms of the contract and for the operation of the MCO,[39] PIHP,[40] or PAHP[41] for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.[42]

When certifying capitation rates as actuarially sound, the role of actuaries is to ensure that the requirements of 42 CFR § 438.4[43] are followed, in particular 42 CFR § 438.4(b)(7),[44] which ties state-directed payments to actuarial soundness by ensuring that requirements at 42 CFR § 438.6(c)[45] are met. The Guides published by CMS require that capitation rate certifications describe each state-directed payment, document how these payments are incorporated into the capitation rate, and ensure alignment with the preprint submitted to CMS. Actuaries must also follow applicable actuarial standards of practice (ASOPs) when rendering actuarial services. Actuaries engaged with Medicaid capitation rate setting should especially comply with ASOP No. 49, *Medicaid Managed Care Capitation Rate Development and Certification*, in addition to other relevant ASOPs. It is important to note, however, that ASOP No. 49 was adopted in March 2015, prior to the regulatory changes previously described, and is currently under review by the Actuarial Standards Board.

MACPAC's last recommendation in the prior section seeks to clarify the current role and responsibilities of actuaries regarding state-directed payments. Therefore, the role of the actuary, alongside that of state and federal stakeholders, may be further explored as there is more discussion surrounding state-directed payments.

38 https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=9036ee2d772b4f377193f96f2bd1a92e&term_occur=999&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:A:438.4
39 https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=1daf12b5f60f2d316a82cf2b0c33d729&term_occur=999&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:A:438.4
40 https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=04b13365cdf0c37f21582e1c74c6bf02&term_occur=999&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:A:438.4
41 https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=a1510460209634314f9c22ffafc5a413&term_occur=999&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:A:438.4
42 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4#p-438.4(a)
43 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4#p-438
44 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4#p-438.4(b)(7)
45 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(c)

Conclusion

As the number of state-directed payments increases, so does the potential for higher Medicaid expenditures that flow through them. Their increasing size over time has attracted the attention of CMS and the Government Accountability Office. In addition to CMS' reporting requirements, MACPAC also calls for more reporting and transparency to ensure that state-directed payments are used effectively toward states' goals. This extra evaluation and transparency will likely mean more work for states and their actuaries.