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CENTERS FOR MEDICARE & MEDICAID SERVICES
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CMCS Informational Bulletin

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SUBJECT: State Directed Payment Quality Evaluations

State directed payments (SDPs) permit states to implement contractual Medicaid managed care arrangements that direct a managed care organization (MCO), prepaid ambulatory health plan (PAHP), or prepaid inpatient health plan (PIHP)'s expenditures under 42 CFR § 438.6(c). The use of SDPs has grown substantially since they were first introduced in 2016; in 2024, CMS received more than 330 SDP preprint submissions from 39 states and territories. For FFY 2024, CMS's Office of the Actuary (OACT) projected annual SDP spending exceeded $97.8 billion (total computable) and projected that spending would increase to approximately $124.3 billion (total computable) for FFY 2025 and $144.6 billion (total computable) for FFY 2026, representing a significant proportion of Medicaid managed care expenditures. To demonstrate the impact of SDP spending on quality of care, health outcomes, or access to care within their Medicaid managed care programs, states must select appropriate quality metrics and implement effective evaluations.[1]

Ultimately, CMS believes that all funds used for SDPs should drive access and higher quality of care resulting in tangible, sustainable improvements in health outcomes and health for Medicaid beneficiaries. At the same time, CMS also wants to address concerns regarding Medicaid program integrity, including fraud, waste, and abuse in Medicaid managed care delivery systems. By better understanding the quantifiable impact of SDPs on quality, this will help ensure that the total payment rate for each service and provider class included in the SDP is reasonable, appropriate, and attainable.[2] This Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) details CMS expectations and existing regulatory requirements for state design and submission of SDP quality evaluation plans and findings.

On May 6, 2016, CMS finalized the *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*[3] rule which established SDP regulatory requirements under 42 CFR § 438.6(c). As part of the regulatory parameters for SDPs, CMS established the standard that all SDPs must be expected to advance at least one of the goals and objectives in the state's managed care quality strategy required under 42 CFR § 438.340 and have an evaluation plan that measures the degree to which the SDP has advanced those goals and objectives.[4] Those regulatory requirements remain in place as of this CIB publication.

[1] 42 CFR § 438.6(c)(2)(ii)(C) and (D)
[2] 42 CFR § 438.6(c)(2)(ii)(I)
[3] 81 FR 27498
[4] 42 CFR § 438.6(c)(2)(i)(C) and (D) found at: "https://www.govinfo.gov/content/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-part438.pdf"

CMS has clarified requirements and best practices for SDP quality evaluations in several publications over the years, including the *Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts* CIB published November 2, 2017 and State Medicaid Director Letter 21-001 *Additional Guidance on State Directed Payments in Medicaid Managed Care* published on January 8, 2021. CMS has also provided technical assistance to states to improve compliance with SDP quality requirements and best practices. In the fall of 2021, CMS hosted group technical assistance sessions to help states improve their responses to the quality-related elements of the SDP preprint. The sessions focused on aligning SDPs with quality strategy goals and objectives, designing evaluations, and reporting evaluation findings. In 2024, CMS began making available technical assistance resources to states with a recently approved SDP to further support their evaluation work.

Despite regulatory requirements and technical assistance, many states initially submit incomplete SDP evaluation plans or do not include SDP evaluation findings at the time of SDP preprint renewal submission which raises concerns for CMS that the total payment rate for the SDP may not be reasonable, appropriate and attainable.[5] In CMS' review of a subset of SDPs that we ultimately approved between January and September 2024[6]:

- Almost all (97 percent) of the preprints identified at least one quality strategy goal and objective, however a lower proportion (83 percent) had evaluation plans that aligned with best practices in evaluation.[7]
- All renewal preprints included information about the state's evaluation methodology, but a lower proportion (65 percent) of all renewals included evaluation findings.
- Over half of states did not submit evaluation findings for all their renewal preprints in their state.

These findings suggest a systemic compliance issue in ensuring that there are accountable goals from state directed payments. Effective immediately, CMS will no longer consider an SDP preprint complete and eligible to begin federal review unless it includes the minimum elements listed below in the SDP preprint itself or in an attachment submitted with the preprint in accordance with federal requirements. For preprints submitted after the date of this guidance, CMS will require the following elements for SDP preprints to be considered eligible for review:

1. A description of how the SDP explicitly ties to goals and objectives in the state's managed care program quality strategy required under 42 CFR § 438.340.[8]
2. An evaluation plan with specific evaluation measures and for each of those measures, baseline statistics, the baseline year, and a measurable performance target for improvement or attainment against the baseline measure.[9]
3. If the state is requesting renewal of an SDP that has been in place for at least two rating

[5] 42 CFR § 438.6(c)(2)(ii)(I)
[6] Based on a subset of 103 SDPs out of 233 total SDPs approved during this time period.
[7] Evaluation plan best practices include identifying metrics, baseline year, baseline statistics, and performance improvement targets. Per 42 CFR 438.6(c)(2)(iv), these elements will be required with rating periods beginning on or after July 9, 2027.
[8] Table 7 in the preprint template published on December 20, 2022.
[9] Table 8 in the preprint template published on December 20, 2022.

periods, CMS expects the state to provide complete evaluation results based on the evaluation plan provided in the prior preprint submission(s).[10] States are sometimes unable to provide complete annual evaluation results at the time of preprint submission due to claims lag or measure reporting specifications; in those instances, the state is expected to submit interim annual evaluation results. States may choose to utilize an optional template to report evaluation findings to CMS. This optional template is available here: https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments.

We also take this opportunity to remind states of best practices (some of which will be required in future rating periods per the 2024 *"Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality"* rulemaking[11]) for SDP evaluation plans and reporting evaluation findings:

- CMS recommends that states select validated quality measures that are relevant to the services and populations covered under the SDP, such as those from the Medicaid and CHIP Adult and Child Core Sets[12] and the Medicaid and CHIP Quality Rating System measure set.[13] CMS is available to provide technical assistance to states on evaluation, measure selection, stratification, and design.
- CMS is available to provide technical assistance to states on stratification of measures collected through state directed payments. CMS is particularly interested in stratification by eligibility group such as those beneficiaries covered under the adult expansion group.
- SDPs are specific to Medicaid managed care and must be tied to the delivery of services and utilization incurred by Medicaid managed care enrollees.[14] To the extent feasible, CMS strongly recommends that states limit their evaluation data to the Medicaid managed care population and the specific services covered under the SDP. States that fail to do so risk disapproval of their SDP.
- States are strongly encouraged to identify evaluation measure performance targets that represent attainment or improvement relative to the identified baseline statistics.
- When an SDP evaluation report indicates declining quality relative to the baseline statistic, the state should clearly acknowledge this and identify next steps for remediation, including potential SDP redesign. SDPs with declining quality over a two year period may not be approved.
- States should consider partnering with their external quality review organization (EQRO) for technical support and to maximize efficiencies associated with SDP evaluation.

On May 10, 2024, CMS finalized the *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality* rule,[15] which specified the requirements for SDP evaluations and established guardrails to ensure that SDPs are having a positive impact on health outcomes within the Medicaid program. CMS is

[10] 42 CFR § 438.6(c)(2)(ii)(I)
[11] 89 FR 41002
[12] Found at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures
[13] Found at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/quality-rating-system#one
[14] 42 CFR § 438.6(c)(2)(ii)(A)
[15] 89 FR 41002

currently reviewing the 2024 final rule for potential revisions to the regulatory requirements.

CMS is committed to working with states to help identify strategies to improve quality and health outcomes in their Medicaid and CHIP programs. If you have questions regarding this CIB or SDPs generally, please email StateDirectedPayment@cms.hhs.gov.