STATES MUST IMPLEMENT NEW LIMITS ON STATE-DIRECTED PAYMENT SCHEMES

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Key Findings

1. STATE-DIRECTED PAYMENTS **ARE ON THE RISE.**

2. THE BIDEN ADMINISTRATION SET THE STANDARD FOR STATES TO USE STATE-DIRECTED PAYMENT PROGRAMS TO PAY PROVIDERS AT MUCH HIGHER RATES. **AS A RESULT, FEDERAL MEDICAID SPENDING INCREASED AND STATES POCKETED THE EXCESS REVENUE, EVEN FOR NON-MEDICAID PURPOSES.**

3. LEGALIZED MEDICAID MONEY LAUNDERING ALLOWS STATES TO **SHIFT MEDICAID SPENDING AWAY FROM THEIR BUDGETS AND ONTO FEDERAL TAXPAYERS.**

4. CONGRESS PASSED AND PRESIDENT TRUMP SIGNED INTO LAW **MUCH-NEEDED LIMITS ON STATE-DIRECTED PAYMENTS.**

THE BOTTOM LINE:

STATES SHOULD IMMEDIATELY IMPLEMENT THE FEDERALLY IMPOSED LIMITATIONS ON MEDICAID STATE-DIRECTED PAYMENTS.

Overview

Medicaid costs and enrollment are skyrocketing, busting budgets at both the state and federal levels.[1] The program's combined cost totaled nearly $919 billion in 2023, roughly doubling the cost from a decade prior.[2] Federal costs have surged, with federal taxpayers covering nearly 80 percent of the program's increase over the last decade.[3]

Medicaid was designed as a joint federal-state program. But with an open-ended financing structure, states tap into an essentially limitless supply from the federal tax base.[4] The federal government covers a share of a state's Medicaid program costs according to the federal medical assistance percentage (FMAP) formula.[5] The FMAP is generally determined annually and is designed to provide more federal funding to states with lower per capita incomes.[6]

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Unfortunately, states use schemes to maximize and generate even more federal funding.[7] They can do this without making legitimate expenditures.[8] **The result is essentially legalized money laundering.** Medicaid payments to providers often far exceed the true cost of services. Worse, these gimmicks do nothing to benefit those with a true need.

One way this is happening is through managed care organizations' (MCOs) state-directed payments. MCOs are health plans contracted by the state to provide Medicaid benefits to enrollees. MCOs represented 75 percent of all Medicaid enrollees in 2022.[9]

Similar to supplemental payments in the fee-for-service model, though subject to fewer rules, state-directed payments in MCOs allow additional payments to providers in some states. State-directed payments, as they are used today, ultimately allow states to increase Medicaid spending and squeeze more money from the federal taxpayer. By shifting the burden to federal taxpayers, state-directed payments lead to rising inflation and higher interest rates for hardworking Americans.

State-directed payments are on the rise.

Driven by changes from the Centers for Medicare & Medicaid Services (CMS), state-directed payments are on the rise. State-directed payments, through which states direct insurers to pay providers, are a relatively new option for MCOs.[10] In the fee-for-service model, states traditionally have had more flexibility and can make lump sum payments, called supplemental payments.[11] States are not permitted to make supplemental payments for services in managed care since, in general, capitated payments are sufficient to cover costs.[12] **Providers reliant on supplemental payments argue that this makes transitioning from a fee-for-service model to a managed care option difficult.**[13] In response, more than a dozen states applied for and received Section 1115 waivers to work around this rule, allowing them to essentially make supplemental payments in managed care.[14-15]

In 2016, CMS changed the regulations for MCOs, making an exception for additional payments in managed care.[16] CMS gave options for states, allowing them to direct MCOs to pay providers directly under certain circumstances.[17] But the guardrails imposed on these payments fall short of providing clear standards. CMS requires states to demonstrate that state-directed payments are based on utilization and the delivery of high-quality services.[18] In the approval process, states are required to describe why their payment request is reasonable, appropriate, and attainable.[19] CMS also requires states to demonstrate that all providers of the service are being treated equally, including both public and private providers, and that states seek prior approval for direct payment arrangements each year.[20]

However, CMS intended state-directed payments to be exceptions to the general rules in managed care.[21] Notably, CMS did not set any limits on total state-directed spending.[22] **In 2022, state-directed payments snowballed to more than 10 percent of total managed care spending, with no signs of slowing.**[23] The Government Accountability Office (GAO) found the state-directed payment process lacked sufficient guardrails.[24] For example, the guardrails imposed by CMS fail to consider payment outcomes and have significant gaps in transparency and oversight.[25] As a result, state-directed payments have grown rapidly, presenting challenges for CMS.[26] Between the 2016 final rule and October 2023, CMS reviewed 1,400 state-directed plan proposals and approved roughly 90 percent of them.[27]

What was once intended to be an exception to managed care payments is now a growing proportion of managed care spending. States are abusing these payments, using them to enhance provider payment rates.[28] Moreover, Medicaid's state-directed payments are a driver of the nation's growing federal deficit, and, until recent action from Congress, the payments were projected to continue growing, taking up an even larger percentage of Medicaid outlays.[29]

What was once intended to be an exception to managed care payments **is now a growing proportion of managed care spending.** States are abusing these payments, using them to enhance provider payment rates.[28]

The Biden administration set the standard for states to use state-directed payment programs to pay providers at much higher rates. As a result, federal Medicaid spending increased and states pocketed the excess revenue, even for non-Medicaid purposes.

Taking the abuse a step further, President Biden's Department of Health and Human Services finalized a rule in 2024 that authorized states to use state-directed payment programs to pay providers at much higher rates for Medicaid services.[30] In particular, CMS effectively made the

average commercial rate the new standard for state-directed payments.[31] Average commercial rates are calculated by taking the mean payment for the same service as determined by the state's leading commercial insurers.[32]

Notably, the average commercial rate is much higher than what Medicare would have paid for the same service.[33] This is important as supplemental payments in states' fee-for-service programs are generally limited to Medicare rates. Average commercial rates, however, are more than 2.5 times as high as the typical Medicare rates.[34] This rule would have incentivized providers to favor Medicaid recipients over Medicare recipients.

Use of state-directed payments continues to grow, and the Biden administration's rule made the financial burden of such payments even more staggering. Already, between 2020 and 2024, state-directed payments have more than quadrupled.[35] State-directed payments must generally be approved in writing before implementation through preprinted documentation.[36] Even before the Biden-era rule, between 2017 and early 2022, CMS approved 145 preprint actions that were expected to yield state-directed payments equal to the average commercial rate.[37]

Allowing state-directed payments to pay up to average commercial rates also incentivizes providers to increase commercial rates. According to the Congressional Budget Office (CBO), commercial hospital payments were 223 percent of Medicare payment rates and commercial physician payment rates were 129 percent of Medicare rates on average.[38] Other analyses found even greater differences.[39] CMS's gimmicks will inflate Medicaid payments far above necessary levels.

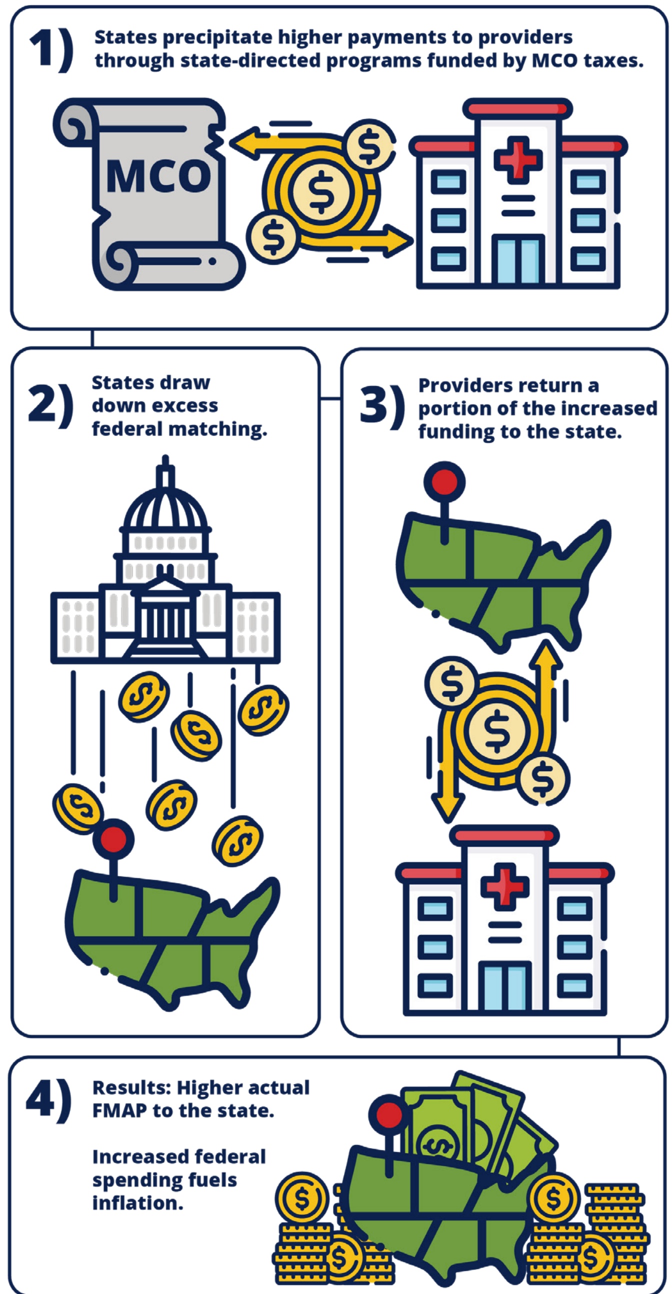
Permitting state-directed payments to pay up to average commercial rates could have increased Medicaid spending by up to $220 billion over the next decade.[40] CBO estimated that Medicaid outlays would increase by $116 billion over 10 years due to the new state-directed payment arrangement.[41] The Biden administration's rule allowed for additional unnecessary overpayments for Medicaid services, further undermining program efficiency.

Ultimately, the rule discouraged fiscal sanity at the state level as states draw down more federal funds. States pocket the surplus from state-directed payments, often for non-Medicaid purposes. For example, the Biden administration approved North Carolina's state-directed payment plan to increase provider rates to average commercial rates if providers agreed to relieve medical debt.[42] State-directed plans do not require transparency and are easily abused under the guise of flexibility. CMS has approved state-directed plans based on a provider's participation in so-called learning collaboratives that focused on health equity and social determinants of health.[43-44] In the same way, excess supplemental payments in the fee-for-service model have been used to fund general hospital operations, maintenance, and even a new helicopter.[45]

Legalized Medicaid money laundering allows states to shift Medicaid spending away from their budgets and onto federal taxpayers.

The federal government contributes to state Medicaid programs according to the FMAP formula, which is designed to provide more federal support to states with lower per capita incomes. The most recent FMAP for states ranges from a statutory minimum of 50 percent in states like Massachusetts and California to nearly 77 percent in Mississippi.[46] **However, Medicaid financing schemes cause the actual federal match to be much higher as states draw down even more money from the federal government.** State-directed payments are just one way

states draw down more federal money. In fact, for state-directed payments, 21 states achieved an effective FMAP of 80 percent or higher.[47] **States often finance these payments using funds from provider taxes, shifting the cost to the federal government.** More than 80 percent of recently approved state-directed payments were financed either in full or in part by provider taxes.[48]



Provider tax schemes, like taxes on Medicaid managed care plans, allow states to increase total Medicaid funding to providers at "no cost" to the state taxpayer.[49] Because state-directed payments are not directly linked to a health care service, states are able to increase provider payments, funded through schemes like provider taxes, without improving the quality of care or increasing the services offered.[50] Worse, state-directed payments are often based on providers' ability to fund the payment, rather than on the Medicaid services provided.[51]

According to GAO, state-directed payments in 2022 totaled $38.5 billion.[52] The federal share covered nearly 70 percent, $26.2 billion, and states paid the remaining $12.3 billion.[53] States used schemes to fund at least $8.4 billion, 68 percent, of the nonfederal share of directed payments.[54]

Twenty-two states now have MCO taxes, up from 12 states in 2018.[55] According to GAO, 40 percent of state-directed payments in 2022 were financed entirely with funds from providers, local governments, and the federal government, without any contributions from state general funds.[56] These taxes essentially finance higher Medicaid payments.

MCO taxes are ripe for abuse. California illustrates the dangers of MCO tax schemes. In the Golden State, MCOs contribute more than 99 percent of the total tax revenue, which they then get back through the federal match.[57] This scheme fully funds the state's Medicaid program for illegal aliens.[58] In Arizona, provider taxes funded $437 million of the nearly $1.4 billion in state-directed payments.[59] **The lack of transparency in state-directed payments discourages fiscal responsibility and ultimately shifts the state's responsibility for its Medicaid programs onto federal taxpayers.**[60]

Thankfully, a new federal law addresses this issue by freezing existing provider taxes, heading off the additional siphoning of federal dollars.[61] The law also phases down the "safe harbor" threshold in expansion states—a federal provision allowing provider taxes set at or below six percent—curbing the

illegitimate funding of Medicaid expansion.[62-63] Moreover, the law tightens the definition of taxes that are "generally distributive," targeting key states that use federal Medicaid dollars to fund unrelated interests, for example, health coverage for illegal aliens.[64]

Congress passed and President Trump signed into law much-needed limits on state-directed payments.

Congress passed and President Trump signed legislation that caps state-directed payments at the equivalent Medicare payment rate in expansion states.[65] For non-expansion states, the law caps state-directed payments at 110 percent of the equivalent Medicare payment amount.[66] Certain existing state-directed payments that already pay the average commercial rate and have received written prior approval will be grandfathered in.[67] However, the total amounts of these payments will be reduced by 10 percent each year until they reach the new rates specified in law.[68]

Capping state-directed payments so that they do not exceed Medicare rates brings parity with the upper payment limits that already exist for supplemental payments in states' fee-for-service Medicaid models. This action is crucial to addressing abuse in the Medicaid program.

The Trump administration is also addressing state-directed payments through rulemaking.[69] CMS proposed a rule that would close a loophole that allows states to use provider taxes to shift more of the financial burden to the federal government in a way that exceeds the parameters set in statute.[70] Problematic exploitation of this loophole has resulted in $23.6 billion per year in state tax collection.[71]

THE BOTTOM LINE: States should immediately implement the federally imposed limitations on Medicaid state-directed payments.

While state-directed payments were meant to be an exception in managed care, they have grown substantially and are often used to fund non-Medicaid goals. **The Biden-era rule to set average commercial rates as the new standard for state-directed payments further inflated Medicaid rates, leaving seniors vulnerable as Medicaid rates outpace that of Medicare.** The rule undermined the intended federal-state nature of the Medicaid program, allowing states to surrender responsibility for their own Medicaid programs and saddle hardworking Americans with the tab for more federal spending.

Congress passed and President Trump signed landmark legislation that limits the use of state-directed payments. States will no longer be permitted to artificially inflate their share of Medicaid expenditures using state-directed payments to garner more federal funds.

States should implement these changes immediately, reassuming responsibility for their Medicaid programs. With this reform, Medicaid can reorient to its proper role as a federal-state partnership providing health care coverage for the truly needy.

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