State Directed Payments

Background

State Directed Payments (SDP) are a funding mechanism used by states to directly influence how Medicaid managed care organizations (MCO) reimburse health care providers for services. SDPs allow states flexibility to design and direct payments to achieve specific health care goals such as improving care quality or addressing health disparities.

Why do we have SDPs?

SDPs are the mechanism available to fulfill a legislative mandate to provide a population or condition-based rate increase. States are typically restricted from directing how MCOs contract and reimburse health care providers except in rare circumstances, such as an SDP. These payments help ensure Medicaid dollars are spent in ways that align with state-specific needs, support the viability of provider networks, and can drive innovation in health care delivery. This helps drive improvement of care quality and efficiency in Medicaid programs.

Progression of SDPs

Since the introduction of the Medicaid Managed Care Rule published in 2016, use of SDPs in Washington State has significantly increased. Some of these rate increases require annual pre-approval by the Centers for Medicare and Medicaid (CMS) in the form of a preprint to ensure they align with specific quality improvement goals:

- **CY2018**: 4 SDPs, all requiring preprints
- **CY2019**: 5 SDPs, all requiring preprints
- **CY2020**: 7 SDPs, all requiring preprints
- **CY2021**: 11 SDPs, all requiring preprints
- **CY2022**: 12 SDPs, 9 requiring preprints
- **CY2023**: 22 SDPs, 10 requiring preprints
- **CY2024**: 22 SDPs, 9 requiring preprints
- **CY2025**: 23 SDPs, 9 requiring preprints

Final Rules implications

The 2024 CMS Managed Care Final Rule aims to improve quality standards and strengthen fiscal and program integrity for SDPs. Given the rising demand for such rate increases, there is greater concern about their effectiveness in supporting care outcomes. To address this, the new regulations mandate increased oversight, leading to the implementation of quality initiatives designed to evaluate and improve these efforts for all SDPs, even if a preprint is not required. Additionally, there are increased reporting requirements for larger state directed payments that exceed 1.5 percent of total capitation payments.

SDPs present both challenges and opportunities for providers. While they can incentivize improvements in access and quality of care, the Final Rule establishes a mechanism for CMS to withhold approval of an SDP if selected measures do not demonstrate progress.

Quality initiative

All SDPs require an annual evaluation plan that identifies measures used to assess the effectiveness of the SDP to advance goals and objectives of Washington's Managed Care Quality Strategy. The measure selection process uses multiple criteria, including CMS guidelines, state priorities for care, and data collection burden, prioritizing metrics that are already collected. Evaluation plans require that selected measures demonstrate maintenance or improvement over baseline statistics. To comply with the CMS Final Rule, all SDPs must have an established quality evaluation plan and be able to submit an evaluation report by the first rating period starting on or after July 9, 2027.

Summary

The way legislative language is drafted will determine how rate increases are operationalized (e.g., minimum fee schedule, uniform increase). Contact HCA for technical assistance on language to support your understanding of implications. Aligning rate increases with Medicaid or Medicare fee schedules does not require CMS approval or an SDP mechanism.

Contact

Email HCA Managed Care Programs with questions.