

MACRA & Medicaid Value-based Purchasing

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is changing the way that many Medicare providers are paid under Medicare Part B. This law, which received wide bipartisan support, eliminated Medicare's sustainable growth rate (SGR) formula and replaced it with two new payment pathways for providers in Medicare, which are collectively called the Quality Payment Program. Participation in this program began on Jan. 1, 2017 and providers will start being paid under it in 2019. Although the Quality Payment Program affects Medicare payment, it has indirect implications for the widespread state Medicaid efforts to transform the health care delivery system from volume to value.

This resource, which was developed with support from The Commonwealth Fund, provides state Medicaid leaders with an overview of the intersection of Medicare's Quality Payment Program with Medicaid. It offers an at-a-glance look at the Quality Payment Program, its multi-payer components, and highlights potential opportunities for Medicaid and Medicare alignment around the Quality Payment Program's Advanced Alternative Payment Model (APM) component. Finally, it provides additional resources that may be helpful for state Medicaid leaders who are interested in potential alignment opportunities.

Broad Medicare & Medicaid Alignment: Why it Matters

Recent studies show that Medicaid programs are broadly transforming the health care delivery system to improve health outcomes and contain costs through value-based purchasing initiatives.¹ But Medicaid agencies are not the only payers that are actively engaged in getting more value out of their health care purchase. Medicare, commercial payers, and employers are leading simultaneous transformation efforts. Further, Medicare, as a single national program, is likely to have significant influence on the landscape of payment reform.

Broad alignment of payment reform efforts across payers reduces the burden on providers and beneficiaries, and helps payment reforms achieve the maximum effect at improving health, improving care and lowering costs. In particular, there may be significant opportunities for Medicare and state Medicaid programs, which collectively cover more than one-third of all Americans,² to broadly align successful value-based purchasing efforts. Because MACRA's Quality Payment Program is a primary lever for Medicare to drive payment reform, this program presents potential opportunities for such alignment.

¹ [The Role of State Medicaid Programs in Improving the Value of the Health Care System](#). National Association of Medicaid Directors & Bailit Health Purchasing (with support from The Commonwealth Fund). March 2016.

² [Health Insurance Coverage of the Total Population](#). Kaiser Family Foundation. State Health Facts. 2015.

MACRA’s Quality Payment Program At-A-Glance

Medicare’s Quality Payment Program creates two paths for provider payment in Medicare Part B: the Merit-Based Incentive Payment System (MIPS) program or the Advanced APM program. Most Medicare Part B providers are expected to participate in the less-advanced MIPS program – at least in the early years of the program – and only a few of the most advanced providers and provider systems are expected to be eligible for the Advanced APM program. Nevertheless, many providers are interested in the Advanced APM program because of the sizable financial incentive available to those who participate in it. The two components of MACRA’s Quality Payment Program are outlined below.

	MIPS	ADVANCED APM PROGRAM
Participation	MIPS is the default program through which eligible Medicare providers will be paid. Eligible providers initially include physicians, PAs, nurse anesthetists, NPs, & clinical nurse specialists.	These providers may participate in the Advanced Alternative Payment Model (APM) program, <i>instead of MIPS</i> , if they have a certain percent of their patients or payments in APMs that are considered “advanced.”
Program Components	<p>Providers participating in MIPS will have a percentage of their Part B payment tied to performance across four areas:</p> <ul style="list-style-type: none"> • Quality; • Interoperability and information exchange; • Participation in clinical practice improvement activities, such as medical homes and APMs; and • Costs. <p>Providers’ performance in these four areas will be calculated and compared to the average performance score of all eligible providers at the beginning of the performance year. This will determine their payment adjustment.</p>	<p>Unlike MIPS, the Advanced APM program does not require providers to demonstrate performance in various areas. Instead, providers must just be eligible for the Advanced APM program. All providers eligible for it receive a bonus payment.</p> <p>Providers are eligible for the Advanced APM program if a certain percentage of their Medicare payments are received through Advanced APMs or a set threshold of their Medicare patients are in Advanced APMs. This percentage increases over time. Advanced APMs³ must:</p> <ul style="list-style-type: none"> • Require participants to use certified EHR technology. • Base payment on quality measures comparable to those under MIPS. • Require participants to bear more than nominal financial risk or be a medical home model expanded under CMMI authority.⁴

³ A list of the Medicare APMs that are Advanced APMs for performance year 2017 is on [CMS’s website](#).

⁴ Note: no medical home models have been expanded under CMMI authority to date. As such, models can only meet this criteria by requiring providers to bear more than nominal financial risk.

	MIPS	ADVANCED APM PROGRAM
Payment	Depending on their MIPS score, providers may receive a penalty or bonus of plus or minus 4 percent in payment year 2019. This increases to a penalty or bonus of plus or minus 9 percent in 2022 and beyond.	Providers eligible for the Advanced APM program receive a 5 percent Medicare bonus payment in payment years 2019-2024 and higher fee schedule updates starting in 2026. There is no downside risk inherent in the Advanced APM program. In other words, providers who qualify for the program receive the 5 percent Medicare bonus regardless of their performance in the underlying APMs.
Explicit multi-payer component?	No.	Yes. Starting in performance year 2019 (payment year 2021), participation in Other Payer Advanced APMs, including qualifying Medicaid APMs, can help Medicare providers achieve the threshold needed to qualify for the program and ultimately receive the 5 percent Medicare bonus. Under this all-payer option, a set percentage of payments or patients must still be in Medicare Advanced APMs, with other payer APMs accounting for the remaining share. ⁵

Potential State Medicaid Opportunities for Alignment in MACRA

Given providers’ interest in the Advanced APM program – and the explicit multi-payer component of it – the most immediate alignment opportunities for state Medicaid leaders may be around this component of the Quality Payment Program. Some of these potential opportunities are outlined below, along with the likely benefits and challenges of each opportunity, which state Medicaid leaders may wish to consider.

It is important to note that while the major components of the Advanced APM program have been finalized, other details are still in proposed form. CMS recently released a [notice of proposed rulemaking](#), which provides more information on how Medicaid models might be considered under this Medicare program. The additional benefits and/or challenges that these proposals might create are also discussed in the table below.

⁵ Under the patient count threshold, CMS requires at least 20 percent of patients to be in Medicare Advanced APMs and the remaining percent may be from other payer advanced APMs (total of 35 percent of patients in 2021-2022 and 50 percent of patients in 2023 and later). Under the payment threshold, at least 25 percent of payments must be in Medicare Advanced APMs, and the remaining percent may be in other payer advanced APMs (total of 50 percent of payments in 2021-2022 and 75 percent in 2023 and later).

	Benefits	Challenges
<p>Opportunity #1: <i>Medicaid APMs could become certified as Other Payer Advanced APMs</i></p>	<p>This may enhance state Medicaid efforts to recruit providers for its APMs. This is because it will help certain providers achieve the critical mass of patients and/or payments required in qualifying APMs to be eligible for the Advanced APM program. Thus, it will help them become eligible for the Medicare Part B bonus payment in this program.</p>	<p>Few providers are likely to participate in the Advanced APM program initially, given the high bar it sets for participation and the fact that few Medicare models exist today that qualify as Advanced APMs (for example, only a limited number of Medicare APMs require providers to bear the necessary financial risk).</p> <p>The criteria for what Medicaid APMs are considered “advanced” may not reflect the realities of providers serving the Medicaid population, which often have fewer financial reserves and serve a more complex patient population. In particular, state Medicaid leaders may not find the minimum level of financial risk required in Advanced APMs to be appropriate for their models.</p> <p>CMS recently proposed a process for how new or existing Medicaid APMs would be certified as Other Payer Advanced APMs. While the proposal clarifies key state questions, the process could be burdensome for states. State Medicaid programs would voluntarily submit a form every year that provides CMS with the necessary information to certify its APM as an Advanced APM (alternatively, there is a process for providers to submit the request). The state would also have to submit the request for its MCOs to have models certified as Advanced APMs.</p>
<p>Opportunity #2: <i>Align quality measures across MIPS and Medicaid</i></p>	<p>Like many efforts to create alignment across measure sets, this would reduce the reporting burden for providers participating in Medicare and Medicaid APMs and could help providers more effectively target their quality improvement efforts.</p>	<p>The CMS/AHIP Core Measures Collaborative, which informed the MIPS quality measures, appears to minimally align its measure sets with existing Medicaid adult and child core sets. This may make it more difficult for state Medicaid leaders to align with MIPS measures.</p> <p>While a recent proposed rule would add a few more pediatric focused measures to MIPS, it is unclear if there will be greater harmony across these measure sets going forward.</p>

	Benefits	Challenges
Opportunity #3: <i>Medicaid could participate as a payer in new multi-payer Advanced APMs</i>	In the final MACRA rule, CMS notes its intent to offer a growing menu of APMs that are “advanced.” It is possible that these models, if they are multi-payer models, could allow for state Medicaid participation in them.	<p>New federal models may not be well aligned with existing state Medicaid payment models and could inadvertently derail state innovation already underway. States will need to carefully assess this possibility when considering new CMS-led multi-payer models. (Similarly, CMS can mitigate this challenge by partnering with states around new model development).</p> <p>State Medicaid leaders will also want to consider whether their participation in a CMS multi-payer Advanced APM automatically qualifies the Medicaid model as an Advanced APM. Under the recent proposed rule, for example, this would not be the case. Medicaid programs participating in CMS-led multi-payer Advanced APMs (i.e., CPC+) would still need to submit a certification request to CMS each year for their model to be considered an Advanced APM.</p>

Although MACRA’s Quality Payment Program is in the early stages of implementation, state Medicaid leaders may find it valuable to consider the opportunities for alignment now. This may help build a foundation for Medicare and Medicaid to maximize their collective impact in transforming the health care delivery system and support providers in achieving success.

Other Resources

The following resources provide additional information on MACRA’s Quality Payment Program, Medicare and Medicaid alignment around value-based purchasing, and Medicaid payment reform.

- [MACRA Final Rule](#). Centers for Medicare and Medicaid Services. November 2016.
- [CY2018 Updates to the Quality Payment Program](#). Notice of Proposed Rulemaking. Centers for Medicare and Medicaid Services. June 2017.
- [Medicaid and the Quality Payment Program](#). Centers for Medicare and Medicaid Services. December 2016.
- [Value-based Purchasing in Medicare and Medicaid: Areas of Intersection and Opportunities for Future Alignment](#). National Association of Medicaid Directors (supported by The Commonwealth Fund). June 2016.

- [The Role of State Medicaid Programs in Improving the Value of the Health Care System](#). National Association of Medicaid Directors, Bailit Health Purchasing (supported by The Commonwealth Fund). March 2016.
- [Draft APM Framework Refresh White Paper](#). HHS Health Care Paying Learning & Action Network. May 2017.
- [Medicaid Value-based Purchasing: What is it & Why Does It Matter?](#) January 2017. National Association of Medicaid Directors (supported by The Commonwealth Fund).
- [Buying Value Measure Selection Tool](#). State Health and Value Strategies and Bailit Health Purchasing.