



Gauging Payment Reform Progress in Medicare Advantage: Current State and Opportunities for Improvement

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KEY THEMES

- Medicare Advantage plans are already implementing a range of payment and benefit reforms, making over 40 percent of their payments through Alternative Payment Models, and are well positioned to lead new initiatives.
- However, there is less known about which Medicare Advantage payment reforms are working well and why. CMS has begun to remedy this by releasing some encounter data, and should also make available existing summary data about current payment reform efforts and support multipayer models that build an evidence base without identifying individual payers.
- Medicare Advantage plans report several challenges in expanding their payment reforms, which CMS should address by encouraging the use of common measures and components to reduce provider burden, implementing new flexibility through CMS Innovation Center pilots, and leveraging the MACRA All-Payer Combination Option.

Introduction

Across the health care system, public and private payers are transitioning from fee-for-service (FFS) to alternative payment models (APMs) that focus on value. The Department of Health and Human Services has taken a leading role with its commitment to value-based payment in Medicaid and Medicare.¹ As part of that commitment, the Medicare Advantage (MA) program presents an important opportunity for advancing payment reform given its reach and flexibility.

Medicare Advantage plans are well positioned to lead payment reform adoption for four key reasons. First, the financing of MA plans provides an incentive to innovate; plans are able to keep savings, enhance benefits, or lower beneficiary cost-sharing if they reduce costs while maintaining or improving quality (as measured through the Star Ratings

program). Second, MA plans represent a growing part of the Medicare program, covering more than one-third of Medicare beneficiaries in 2018. Third, MA plans are already engaged in payment reform, reporting over 40 percent of their payments through APMs in 2016 (the last year data are available).² Finally, CMS leadership under the current administration has emphasized the importance of the private sector in developing and testing new payment reforms.³

However, a number of challenges impede the implementation of payment reforms in MA. Plans report regulatory or market factors that limit their ability to expand payment reform efforts broadly. Providers may be less likely to participate or may be less successful in payment reforms if they feel pulled in multiple directions. Each payment model can have different performance measures, incentivized outcomes, care processes, or targeted patient populations. Finally, few plans release detailed results or assessments, so we know relatively little about how well specific payment reforms work and what we can learn from early results. An improved payment reform environment in MA would show more clearly what is working—and why—while continuing to provide plans the flexibility that is a hallmark of the program.

This brief surveys the landscape of payment reform in MA, examining the state of the evidence about MA payment reform, identifying challenges that limit spread, and describing recommendations that could overcome these barriers. The brief was developed from interviews with MA leaders, health plans leaders, and national experts, along with a review of published articles and reports about MA payment initiatives.

Why is Medicare Advantage Well Positioned to Drive Payment Reform?

MA plans now cover over one-third of all Medicare enrollees, up from 13 percent in 2004 and 25 percent in 2010. (These enrollment trends are illustrated in Figure 1.) Enrollment rose 7.7 percent in 2017 alone, and is growing faster than traditional Medicare.⁴⁻⁶ If these trends continue, MA will cover approximately 31 million people by 2028, or almost half of all Medicare recipients. Though most new Medicare-eligible individuals still enroll initially in traditional Medicare, many shift quickly to MA.⁷ Reasons for rising consumer interest in MA go beyond payment reform: MA plans resemble the ones enrollees had with employers; Medicare payment rules and plan care management activities enable plans to offer more comprehensive coverage—some plans include dental and vision benefits—without requiring purchase of supplemental plans; and plan design flexibility allows MA plans to offer zero-premium coverage, which 52 percent of MA enrollees choose.⁵

In many parts of the country, MA plans cover a substantial share of the total health insurance market (including traditional Medicare, MA, Medicaid, and commercial insurance). Figure 2 shows MA market share by county for 2016, and Table 1 highlights illustrative counties.^{9,10} Over 400 counties had MA market shares greater than 10 percent; in some counties, MA comprises almost one-quarter of the county's total insured population. These geographic regions are where MA plans have the greatest ability to engage providers about value-based care. MA's effective market power may be even higher for popular payment reform targets like joint replacements and cardiac procedures where older Americans utilize a disproportionate amount of the care.

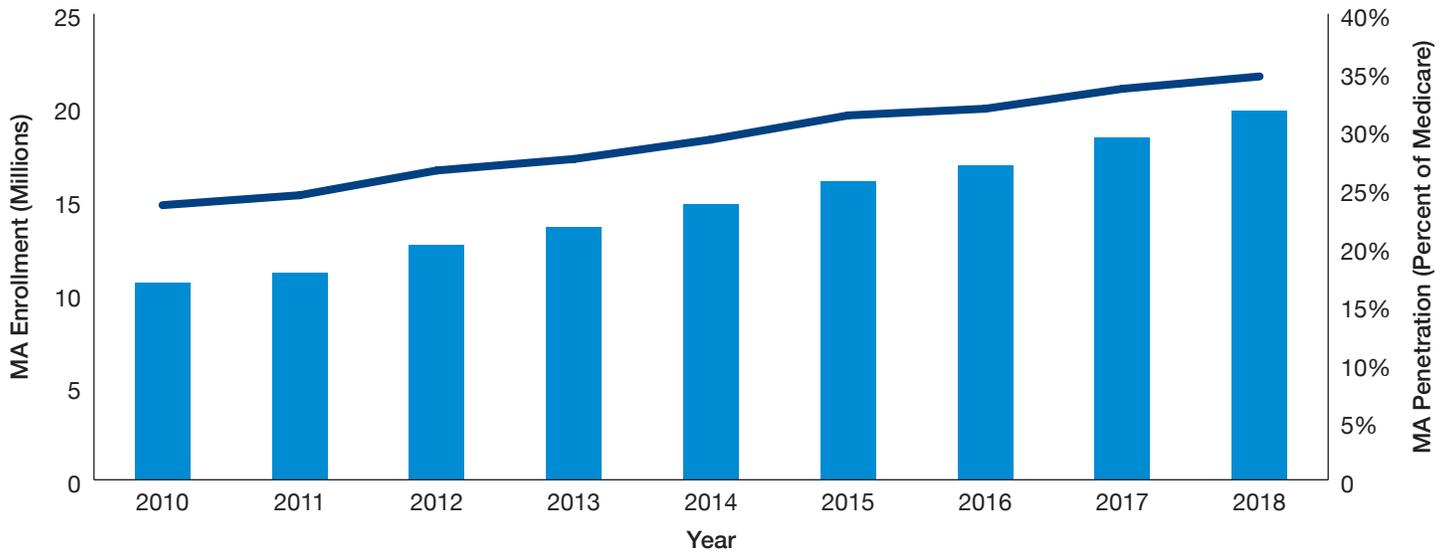
Medicare Advantage is already a major hub for developing and implementing new payment models. Figure 3 illustrates the results of a 2016 survey by the Healthcare Payment Learning and Action Network (LAN), in which plans reported that 41 percent of MA dollars were in APMs in 2016, the most of any market sector.¹¹

The financing of MA helps drive this innovation. Plans are paid through monthly, capitated payments based on an enrollee's age, location, and health status. Plans are able to keep savings, receive bonuses, and enroll beneficiaries continuously if they reduce costs while maintaining or improving quality, which CMS measures through the Star Ratings program. Furthermore, plans that demonstrate high quality through Star Ratings measures (achieving four or more stars) receive substantial additional payments. In 2017, those bonuses added 3 percent to plan payments.¹²

Payment reforms can also help improve coverage for MA populations with multiple chronic conditions and complex health needs. The key services needed for management of those conditions, such as care coordination and expanded primary care access, are poorly reimbursed under traditional fee-for-service payment and could be more feasible to provide through new payment models.

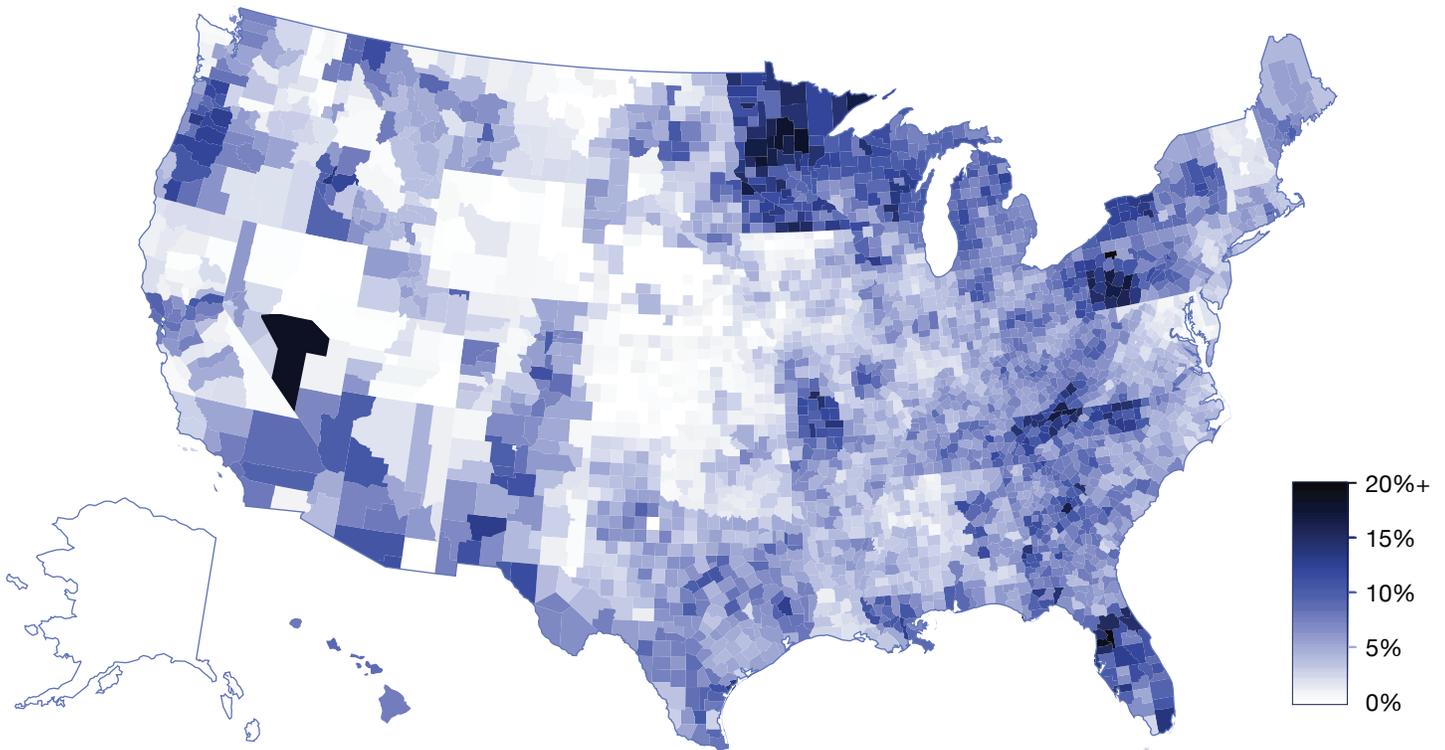
Finally, MA plans are well-positioned in payment reform given the priorities outlined by the current administration. In its recent Request for Information, the CMS Innovation Center highlighted "Market-Based Innovation Models" and "Medicare Advantage Innovation Models" as two key focus areas for the center over the next few years.¹³ CMS has also indicated that it is focused on developing a wider range of payment models.¹⁴ If CMS wants the private sector to take greater leadership in payment reform adoption and innovation, much of that leadership will come through MA.

Figure 1. Growth in Medicare Advantage enrollment between 2010 and 2017, calculated as enrollment on January of that year and excluding Medicare Cost plans, demonstration plans, Medicare-Medicaid plans, and PACE.



(Authors' calculation from publicly available CMS data on MA enrollment and penetration, January 2010 to January 2018.^{6,8})

Figure 2. Market share of MA plans by county in 2016, calculated as a percentage of enrollees divided by the total insured population (traditional Medicare, MA, Medicaid, and commercial insurance).



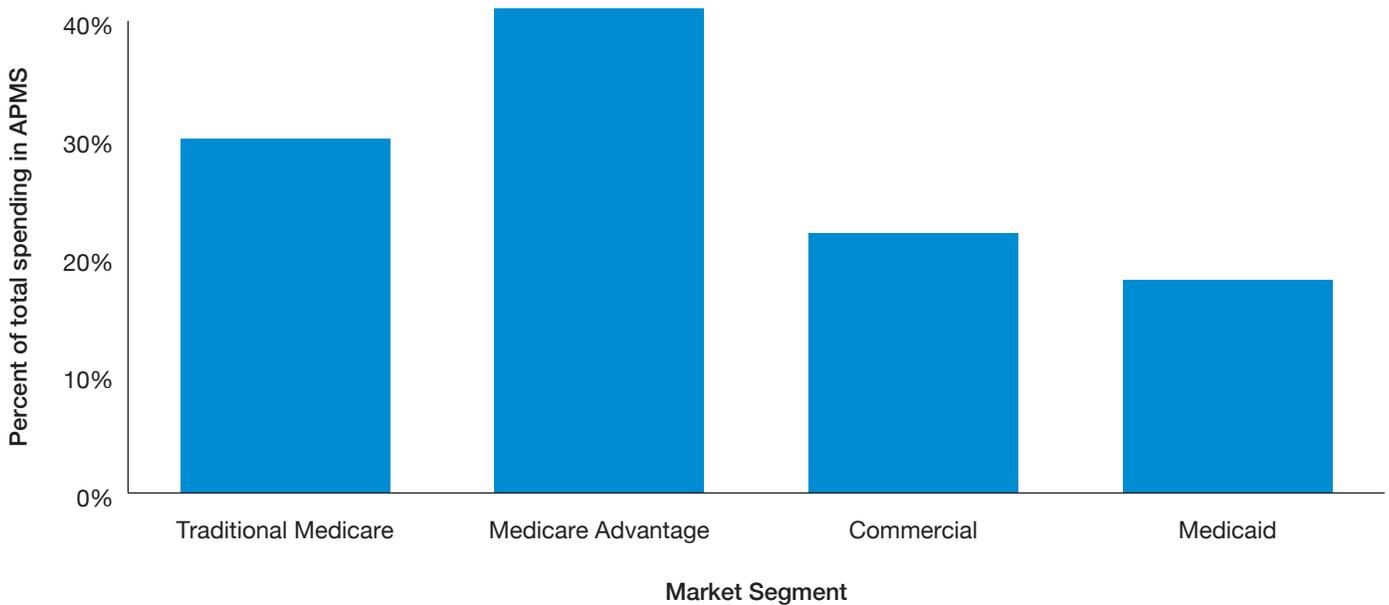
(Authors' calculation from publicly available CMS data on county-level MA enrollment from December 2016,⁸ and from the Census Bureau's 2016 5-year estimates of health insurance coverage.⁹)

Table 1. MA market share for example counties in 2016, calculated as a percentage of the total insured population in that county (traditional Medicare, MA, Medicaid, and commercial insurance). Example counties selected to show variance in market share in both urban and rural areas.

Example Counties	County Population Size (2016)	MA Market Share (of Total Insurance Market)
Sumter County, Florida	104,298	24%
Forest County, Pennsylvania	3,048	20%
Nye County, Nevada	42,783	19%
Aitkin, Minnesota	15,535	19%
Miami-Dade County, Florida	2,637,220	14%
Riverside County, California (LA metro area)	2,301,893	10%
Montgomery County, Maryland (DC metro area)	1,017,915	2%
Washakie County, Wyoming	8,183	0%
Elko County, Nevada	51,382	0%

(Authors' calculation from publicly available CMS data on county-level MA enrollment from December 2016,⁸ and from the Census Bureau's 2016 5-year estimates of health insurance coverage.⁹)

Figure 3. APM adoption in different market segments as measured in percentage of total spending in APMs as of 2016 (Health Care Payment Learning and Action Network Measurement Effort, 2016). This graph counts spending in more advanced payment models like shared savings, population-based payments, and bundled payments.¹¹



Why is Medicare Advantage Well Positioned to Drive Payment Reform?

- **Market Share:** MA plans cover over one-third of Medicare enrollees, with enrollment rising quickly. Plans in many parts of the country enroll a notable share of their state's health insurance market, and are particularly well-situated to drive change for popular payment reform targets like joint replacement and cardiac care.
- **Financing:** Plans can keep savings, receive bonuses, and enroll beneficiaries continuously if they reduce costs while maintaining or improving quality. The highest-quality plans (measured through Star Ratings) receive additional payments.
- **Flexibility:** Plans can offer more comprehensive coverage than traditional Medicare—and now have flexibility in designing benefits that support value-based care and providing services addressing social factors not traditionally included in fee-for-service payment.
- **Policy Support:** The CMS Innovation Center has highlighted “Market-Based Innovation Models” and “Medicare Advantage Innovation Models” as key focus areas, and CMS under the new administration has pushed broadly for the private sector-driven leadership.
- **History:** A 2016 survey by the Healthcare Payment Learning and Action Network (LAN) found that 41% of MA payments were made through alternative payment models, more than any other market sector.

What Do We Actually Know About How Well Payment Reform Is Working? Not Much

While surveys indicate Medicare Advantage plans are adopting new payment models, there is little information available publicly on the specific payment models being implemented or the impact those models have had on care quality and cost. Overall, the quantity and quality of evidence for MA payment reform is substantially lower than that for traditional Medicare payment reform.

Some existing evidence comes from health plans' internal analysis and self-reported data. For example, Humana recently released results on value-based payment programs covering 1.4 million people, including quality bonuses, shared savings, care coordination payments, and capitation.¹⁵ Compared to Humana MA beneficiaries in FFS arrangements, enrollees in MA value-based programs experienced improved outcomes in chronic condition care, screenings, and health outcome assessments.¹⁵ Additionally, physicians had higher-quality measure scores (measured through the HEDIS measure set) in any given year compared to FFS, and also improved quality scores after transitioning into value-based arrangements.¹⁵ Total cost of care decreased by 15 percent compared to traditional Medicare and 4 percent to FFS MA.¹⁵

Publicly reported studies like these are relatively uncommon. Most internal analyses do not necessarily share all the information needed for collective learning or permit independent, replicable analysis.

Independent academic studies of MA reforms are equally rare. Searches of the National Library of Medicine's PubMed database finds few academic research publications on Medicare Advantage and alternative payment models, accountable care organizations, or bundled payments. There were some notable exceptions that have found positive results. One academic research example looked at an MA plan in Portland, Maine, using an ACO-like model with per member, per month primary care payments, and saw lower costs compared to traditional Medicare and received high Star Ratings.¹⁶ Another looked at an accountable care model, organized similarly to the Medicare Shared Savings Program, in an MA plan and an independent physician association and found reductions in hospital admissions and readmissions, lower costs, and positive quality measure results.¹⁷

Building an evidence base for payment reform innovation in MA can help lead to major changes in traditional Medicare and across the health care system. The Hospital At Home (HaH) program provides a clear example of the potential. The program pays for teams of providers to treat elderly patients at home, either because they refuse to go to the hospital or are at risk for adverse events. By participating in pilots across the country and contracting with hospital systems, MA plans—along with Medicaid Managed Care Organizations and the VA—helped build the evidence needed to show the Hospital At Home program works, resulting in lower costs, fewer complications, a 38 percent reduction in the six-month mortality rate for participating patients, and higher patient satisfaction.^{18,19} In 2012, CMS awarded an Innovation Center challenge grant

What Do We Actually Know About How Well Payment Reform is Working?

- **Overall:** The limited amount of publicly available information means we know little about which reforms are working well, despite extensive MA payment reform activity.
- **What Evidence Exists?** Most existing evidence comes from internal plan analyses and independent academic studies. These studies generally show improved quality scores, improved outcomes, and slightly lower costs, but the evidence base is too small to make broad generalizations.
- **How else can we determine success?** Tracking the adoption of programs that have built an evidence base in part through MA pilots—such as the Hospital at Home program—can help show where the program has provided critical incentives for development and expansion.
- **How can we learn more?** Releasing data that CMS already collects, offering further incentives for APM adoption, standardizing and aligning incentives across plans, providing more flexibility on benefit design, and leveraging the MACRA All-Payer Combination option.

to New York's Icahn School of Medicine at Mount Sinai to test a 30-day bundled payment model for Hospital At Home in FFS Medicare.²⁰ Five years later, the Physician-Focused Payment Technical Advisory Committee (PTAC) recommended the program for full implementation in traditional Medicare, largely because of the robust evidence developed around the program.²¹ This model's expansion would not have been possible without the participation of MA plans and their willingness to build and disseminate evidence on the model.

Improving MA Payment Reform: Better Evidence

More evidence is needed to understand what is working best in the MA market.²¹⁻²³ Reforms are still in their early phase, and will differ based on factors like market context, patient population, plan type, and geography. While plans may be generating evidence internally, additional public evidence can help identify successful models for different situations and support the transformation to a value-based payment system.

One major impediment to research on MA payment reforms is the lack of publicly available data. CMS took an important step forward on April 26, 2018, announcing it would release preliminary encounter data to researchers,²² 10 months after it canceled initial plans to do so due to concerns about accuracy.^{23,24} Previously, it had only released MA contract and enrollment statistics, plus annual performance measures

(assessed largely through HEDIS quality measures in the Star Ratings program). The new encounter data contains plan-reported utilization of inpatient, skilled nursing facility, home health, outpatient, carrier, and durable medical equipment services by beneficiaries for part of 2015, with plans to release the rest of the 2015 data later this year.²⁵ The new data release also includes information on MA plans' benefit packages, premiums, cost-sharing tiers, service areas, and Special Needs Plans.^{26,27} While this is an important step forward, there are important opportunities to increase the amount of data available similar to traditional Medicare, where publicly available claims and encounter data have been critical for understanding the impact of value-based payments.²⁸⁻³²

Given MA is a taxpayer-funded program, there is a public interest argument for releasing data that could show how well the program works.²³ Ideally, this will be the first of many annual releases of MA data. This information could help improve payment reforms by showing which ones work best, allowing for collective learning and benefiting all plans. However, any transparency initiative should account for potential implementation challenges. Collecting and releasing data may be burdensome to plans, but could be minimized if CMS reports data that plans are already required to submit. Releasing data could also reduce a plan's incentive to invest in care improvement if it is worried that competitors will adopt successful approaches. This challenge could be reduced by removing proprietary details from the reported information.

In addition to encounter data, CMS should also release summary information about the types of payment reforms plans are undertaking, which it already collects.^{33,34} These data show general trends in uptake of different payment models under each category of the Health Care Payment Learning and Action Network framework, and could provide a regular source of information about the quantity and types of APMs MA plans have implemented. This would *not* entail sharing proprietary information like contract details, a concern of many plans. If these payment models are going to be used to determine bonus payments through programs like the MACRA All-Payer Combination Option (described later in this brief), then it would be useful for the field to learn more about the models and their use. Additionally, this data set would allow researchers to evaluate which policy options focused on MA payment reforms work best at encouraging APM adoption.

Further efforts could develop more granular data, especially by linking encounter data to a description of applicable payment reforms. Researchers would then have opportunity to examine how care quality or health outcomes are associated with specific APMs.

Encouraging the adoption and evaluation of multipayer models would allow plans to remain anonymous while still generating rigorous evidence about the effectiveness of a payment reform.³⁵ This would increase the amount of independent research available without singling out a specific plan. Multipayer approaches are also more likely to build the critical mass of payers necessary to leverage their market power and shift provider incentives. CMS' Innovation Center could organize these initiatives, building on their prior efforts.^{36,37} Models should be voluntary, to reduce concerns that collaborative efforts would limit individual plan innovation, and include incentives to participate (and participate in shared evaluation) if evidence suggests the multipayer approach will have a bigger impact.

In addition to preliminary encounter data, CMS should release summary information about the quantity and types of APMs that MA plans have implemented and use multipayer payment reforms to generate better evidence and improve care.

Additional Options to Encourage APM Adoption in MA

Beyond generating better evidence, there are a variety of ways to help create a more favorable environment for APM adoption. In a recent report to Congress,³ CMS outlined several options it could undertake to encourage further APM use, such as: providing financial incentives to MA plans that adopt APMs through various modifications of the benchmark that plans bid on or the quality bonus payment; recognizing APM adoption in calculating Star Ratings; and providing extended enrollment periods for plans that have met a specific APM adoption threshold.

Any new incentive must work within existing regulatory constraints. CMS interprets the statutory "non-interference clause" (42 USC § 1395w-24(a)(6)(B)(iii)) as prohibiting CMS from requiring, or directly setting payments to MA plans based on using a specific value-based provider payment model.³ This constraint affects the range of options that may be used to incentivize APM usage.

Proposals must also interact smoothly with existing incentives for APM adoption within the program. Currently, CMS incentivizes improvement in measured results for Medicare Advantage through the Star Ratings system (for quality) and by holding plans to a bid amount (for cost). Then plans are free to innovate, whether through payment reforms or taking other actions, like providing patient data to providers (helping to flag people with serious illness or high utilization), sharing risk prediction tools, or supporting IT and care management programs.

Since CMS already incentivizes outcomes, which successful APMs should improve, complementary approaches can help reduce barriers for APM adoption and promote collaboration in payment reform. As discussed above, CMS could shepherd multipayer initiatives, which would improve our understanding of what works in payment reform and encourage market-wide improvement. CMS could also use the Star Ratings system to further thoughtful measure alignment, which could reduce provider burden and improve APM adoption among providers, and leverage the All-Payer Combination option to help better determine what private sector-driven payment models are working well. The following sections describe these strategies in greater detail.

Improving MA Payment Reform: The Need for Thoughtful Alignment

Implementing new payment reforms is a complex task, requiring new care workflows and modified data infrastructure to capture and report the necessary data and measures. Providers often struggle if payment reforms from different payers have different reporting requirements and incentives.

Recognizing this challenge, many payers have undertaken initiatives to reduce provider burden. CMS' recent Meaningful Measures Initiative seeks to address quality reporting challenges, aiming to streamline reporting and eliminate unnecessary and redundant measures.³⁸ Its work will build off prior measure alignment efforts, such as CMS and America's Health Insurance Plans' Core Quality Measures Collaborative, the Health Care Payment Learning and Action Network, and the Institute of Medicine's Vital Signs report.³⁹⁻⁴¹ As the Meaningful Measures Initiative matures, it will have a greater impact if it also considers opportunities for alignment for MA.

Common measures across Medicare and MA will help providers in APMs better understand how they are being evaluated and how they can succeed. Some plans have already unified their measures across all lines of business, making it easier for providers to see common areas of quality, cost gaps, or other specific areas of improvement. While alignment by an individual plan is important, collective alignment is a much more significant way to reduce burden.

The Star Ratings measures can also help encourage alignment, since many MA plans use payment reforms to improve in these specific measured areas. For example, CMS could harmonize the measures used in payment models for traditional Medicare with Star Ratings measures, allowing providers to report the same or similar measures for both programs. CMS could also consider how to align patient-reported outcome measures and other patient-focused measures across Star Ratings and payment reforms in traditional Medicare to advance their use.

While aligning measures is important, it is not the only opportunity to reduce provider burden. Other components of APMs could also be aligned, including setting the financial benchmark, risk adjustment, or patient attribution.

The challenge is getting stakeholders to agree on the particular elements, since there is rarely strong evidence that one particular measure (or another payment model component) is superior to all others, with each plan invested in particular approaches.

Alignment takes time, and could slow individual efforts to improve outcomes and lower costs. A practical approach would begin in areas where there is general agreement or on areas that are developing (such as patient-reported outcome measures or PROMs).

Aligning APM components where the current burdens on providers exceed the benefits of plan-level variation can accelerate payment model adoption—and continue to enable plan innovation.

Improving MA Payment Reform: Incentives for APM Participation

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides additional financial incentives for providers to adopt payment reforms. The most significant allows clinicians to waive the reporting requirements of the new Merit-based Incentive Payment System (MIPS) and receive a 5 percent payment bonus if a substantial portion of their care was paid through an advanced APM. The initial version of this bonus only counted advanced APMs sponsored by traditional Medicare, but the law also established an "All-Payer Combination Option" that will count advanced APM participation across all payers (including MA).^{7,42}

In recent regulations, CMS was fairly permissive on what constitutes an advanced APM for the purposes of the "All-Payer Combination Option." Payment reforms have to meet similar criteria as an advanced APM in traditional Medicare: using certified EHRs, using comparable quality measures to those used in the MIPS program, and requiring providers to take on at least nominal financial risk, except in medical home models.^{43,44} To operationalize the all-payer combination option, CMS is establishing a process for payers to submit their APMs in 2018 to determine whether they meet the above criteria. (Providers can also submit additional APMs in the latter half of 2019 if CMS has not previously cleared them.) Despite uncertainty about how this process will work in practice, it should provide needed clarity on the type and amount of APMs that MA plans can offer and that will count towards MACRA all-payer threshold.

As part of the payment model submission process for the All-Payer Combination Option, CMS should require plans and providers to submit key data elements in a standardized format. This could include the type of payment reform categorized

against the Health Care Payment Learning and Action Network framework, the quality measures used, and the types of providers expected to be involved. Publicly releasing this information (after possibly de-identifying) would help provide another data source that could allow greater knowledge about MA payment reform.

The All-Payer Combination Option could also help encourage alignment in measures and payment reform components, both in MA and across the Medicare program. CMS could identify key measures that APMs have to incorporate in order to be eligible for the bonus. This would simplify provider reporting requirements, facilitate comparing the impact of payment reforms (as payers would collect similar data from providers), and could reinforce the adoption of more meaningful performance measures as part of the Stars system.

CMS should use the “All-Payer Combination Option” incentive for transparency about the types of payment reforms being used in MA and for encouraging measure alignment in MA payment models.

Improving MA Payment Reform: New Opportunities to Engage Beneficiaries and Align Benefits with Payment Reforms

As noted in its New Direction strategy, the CMS Innovation Center is explicitly interested in Medicare Advantage Innovation Models.¹³ These new models would build on the experience from the Innovation Center’s current MA-focused model, which implements Value-Based Insurance Design (VBID) in MA plans. The VBID model, which began in 2017, is currently being tested in 25 states and will expand to all 50 states in 2020 under the recently passed CHRONIC Care Act.⁴⁵ Under the VBID pilot program, MA plans can offer varied plan design for enrollees diagnosed with a wide variety of chronic conditions,^{46,47} including reduced cost sharing or supplemental benefits to beneficiaries with certain chronic conditions to encourage use of higher-value services.⁴⁷ The VBID model experience highlights the potential for involving MA plans in CMS Innovation Center programs as well as the interest of MA plans in participating.

The pilot underscores how benefit design flexibility can help improve outcomes, such as in cases where health outcomes

are affected by social determinants of health.⁴⁶ In addition to expanding VBID in MA, recent statutory and regulatory changes (including the 2018 budget bill, proposed MA rule for contract year 2019, the draft 2019 call letter, and the 2019 final call letter), CMS expanded its interpretation of “health care benefits” to allow for greater flexibility in benefit design and for including supplemental benefits that are not necessarily health benefits to chronically ill enrollees.^{45,48–50} Current evidence shows these benefits can reduce injuries and prevent avoidable utilization. Under the expanded definition, MA plans could include as part of their bid any supplemental health benefit that will “reasonably and rationally ... diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization”⁵⁰ provided that it is medically appropriate and recommended by a licensed provider and is not used solely to induce enrollment. This could allow MA plans to offer benefits like transportation, meal delivery, or additional services in the home.

Future pilots could explore the potential and feasibility of aligning benefit design with payment reforms. There may be opportunities to engage beneficiaries through lower copays or expanded benefits if a patient voluntarily participates in a chronic disease or adherence program related to an APM.

Recent legislative and regulatory changes offer new opportunities for innovation in benefit and network design, which should be integrated into new payment reform models.

Additional Considerations for Implementing Payment Reform in MA

Plans and stakeholders often stressed that payment reforms cannot be neatly replicated from traditional Medicare or commercial contracts, but instead must be tailored to the unique features and challenges of the MA market. For example, unlike traditional Medicare, MA plans can use network standards for quality and value as well as payment reform to improve care, while traditional Medicare cannot limit provider networks. Unlike commercial plans, MA plans generally pay close to traditional Medicare rates. Overall, MA is just one part of a company’s contract negotiations, and must often fit into a broader vision.⁵¹

Several plans reported that network adequacy regulations make it more difficult to negotiate with providers on APMs. Plans also noted they had less leverage to negotiate payment reforms with specific providers if those providers are needed to meet network adequacy standards. This challenge highlights the opportunity to update network adequacy rules to focus not just on distance from the patient and travel times, which some plans feel is antiquated, but on other mechanisms to provide convenient access, such as telehealth. Recent statutes provide flexibility for telehealth in Medicare Advantage, where a person could originate a telehealth visit from their home.⁴⁵ This could help to improve access in rural and underserved areas, as well as help with access across the country, and could be integrated into the network adequacy definition.

Further, some plans noted limitations around offering a new insurance product focused on specific payment reforms, since one plan must be “meaningfully different” from another. However, with CMS proposing to eliminate the rule for contract year 2019,⁴⁹ this may not be an issue for long.

Conclusion

Medicare Advantage should play a leading role in driving payment reform across the health care system, especially given its flexible structure and rising enrollment. To maximize MA’s potential to do so, we need more evidence about what is happening in payment reform (and what is working), and need to make those results public. CMS can build on existing work by leveraging and releasing the information it already collects, aligning measures and components to reduce burden, providing flexibility on benefit design through CMS Innovation Center pilots, and leveraging the MACRA All-Payer Combination Option as an incentive to encourage APM adoption within strategic areas.

These moves allow CMS to best tailor payment model development to the MA context, utilizing its unique characteristics while simultaneously ensuring that MA can impact payment reform throughout the health care sector.

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