Dear Chairman Griffith,

This letter is in response to your July 14, 2023, Question for the Record: "What specific policy solutions should Congress focus on to make doctors accountable to their patients directly rather than imposing an artificial set of federal metrics?" To summarize my personal views on this question, I recommend:

- In the short run, promoting patients' financial autonomy and simplifying quality accountability through:
    - Encouraging Medicare Advantage enrollment and access to savings accounts;
    - Refocusing Medicare's quality programs on basic clinical appropriateness and mistreatment or misdiagnosis metrics that allow simple and meaningful comparisons between providers; and
    - Payment reforms that encourage provider efficiency such as capitation or market-based pricing.
- In the long run, Medicare should encourage private assessment of value outside formal performance-based incentive programs, with the goal of eventually ending them across Medicare.

As I testified before the Subcommittee on June 22, I was critical of Medicare's approach to "value-based care" under the Medicare Access and CHIP Reauthorization Act (MACRA), specifically the Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). These policies have failed to improve the quality of care in Medicare.

Medicare takes an approach similar to MIPS in numerous other quality programs. Their results have likewise been disappointing. In the long run, Congress should eliminate performance-based quality programs like MIPS and give more space for private actors to compete based on value. Enacting new payment incentives based on government-developed metrics will only replicate the same problems. In a forthcoming paper for Paragon Health Institute, I will examine general approaches to reforming Medicare's quality programs.

Two incremental approaches are to give patients more control over their health care dollars and to simplify mechanisms for patients and payers to judge quality.

Financial Autonomy for Patients

Currently, the strongest tool for empowering patients to control their own health care dollars is Medicare Advantage (MA), since it enables seniors to shop for coverage options that best meet their needs (including extra benefits or cost-sharing reductions offered by plans). The success of this model has led beneficiary

participation in MA to grow faster than traditional Medicare, including ACO-focused APMs like the Medicare Shared Savings Program. Congress should avoid policies that inhibit choice in MA and stifle its growth.

Congress could also increase beneficiaries' access to savings accounts and allow individuals to shop for care more directly. This would make providers more responsive to consumers rather than federal agencies. MA provides a platform for this with Medicare medical savings account (MSA) plans. Extending flexibilities to MSA plans, such as expanding the scope of benefits they can cover, could increase their uptake.

Quality Accountability for Providers

Efforts to streamline measures across quality programs like MIPS have been slow and continue to rely on federal officials to micromanage clinical activities. Rather than maintain complex systems of rewards and penalties, Medicare should narrow its focus towards detecting poor outcomes. It is estimated that 5 to 15 percent of health care interactions lead to serious misdiagnosis.[1] Up to 30 percent of overall health care spending is wasteful, costing almost $1 trillion per year.[2] Medicare should use a much smaller inventory of consensus-based clinical appropriateness and mistreatment measures.[3] Reporting a few broadly applicable and meaningful metrics would empower patients and payers to compare quality across providers.

Payment reforms outside of quality programs would also help move away from fee-for-service. MA plans receive fixed, capitated payments, which holds them accountable for the total cost of care and incentivizes them to maximize quality and minimize waste. Some MA policies, such as quality bonuses, distort plan behavior and should be reformed. But expanding similar mechanisms of capitation or market-based pricing (i.e., competitive bidding or reference pricing) can increase value in Medicare without government metrics.

Thank you again for the opportunity to offer my views on this important issue to the Subcommittee.

Sincerely,

Joe Albanese
Senior Policy Analyst
Paragon Health Institute

[1] Robert A. Berenson, "If You Can't Measure Performance, Can You Improve It?," *JAMA Network*, February 16, 2016, https://jamanetwork.com/journals/jama/fullarticle/2491628.
[2] William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," *JAMA Network*, October 15, 2019, https://jamanetwork.com/journals/jama/article-abstract/2752664.
[3] AHIP, "Clinical Appropriateness Measures Collaborative Project: A Data-Driven Collaboration to Promote Evidence-Based Care," December 2021, https://www.ahip.org/documents/AHIP_AppropriatenessMeasures_2022.pdf.