Executive summary: Medical practice and quality

Rising health care costs, responsible use of resources, and concerns about the quality, safety, and appropriateness of medical care delivery are some of the factors accelerating efforts in clinical quality measurement. Physicians, policymakers, payers and various health care-related organizations are all involved in measurement efforts. Collaboration on efforts to address the problems of misaligned measure requirements, e.g., the adoption of core quality measure sets, and the harmonization of measures across both commercial and government payers has begun. Several U.S. organizations are involved with the development, collection, analysis, endorsement, and implementation of performance measures.

Findings on outcomes of alternative care delivery models are mixed. While evidence on the effects of ACO contracts on cost savings is limited, the effects on quality have been more impressive, such as increased adherence to appropriate process and outcome domains. Medicare beneficiaries also reported improved access to care and, for those with multiple chronic conditions, substantially higher subjective rating of the overall quality of care. Importantly, there is some evidence that integrated medical groups led by physicians have achieved greater savings than those in health systems. Findings show that the medical home model drives reduction in health care costs and/or unnecessary utilization, and various approaches to payment show potential, particularly those of multi-payer collaboratives with specific incentives or performance measures linked to quality, utilization, patient engagement, or cost savings. Further improvements to both models are expected going forward.

For more than a decade, pay for performance (P4P) has been a tool used for profiling and rating performance of physicians and other health care providers. These fields are rapidly evolving and many programs now address overall value by incorporating quality, cost, narrow networks, and other factors as major design elements. Additionally, value-based programs have become popular among policymakers, and private and public payers. However, physicians’ criticisms of current profiling activities stem from potentially adverse effects of pressures to restrict services on quality of care; burdens created by uncoordinated and redundant requests for data; reports based on variable and often poor quality data; and inadequate case-mix and risk-adjustment methodologies.

The measurement of and incentives linked to patient satisfaction and patient experience are increasing. Studies have demonstrated that patient-physician communication is a key factor. As payers increasingly tie reimbursement to patient feedback, physicians and academics are expressing concerns about unresolved methodological issues related to survey content, and the measurement and interpretation of patient satisfaction and patient experience survey results.

According to a Gallup survey, 53% of Americans rate the quality of health care as “excellent” or “good,” which is similar to the rating prior to the insurance exchanges of the Patient Protection and Affordable Care Act (ACA), and down from the more positive ratings of 2008-2012. Gallup found that health care coverage in the United States is viewed less favorably than quality. Additionally, Americans who are insured through Medicare or Medicaid are more satisfied than those who have private insurance.
Physician professionalism is grounded in the obligations to society and individual patients to achieve optimal health outcomes, and to self-regulate the responsible use of health care resources. The profession and society are confronted by the related challenges of escalating health care costs, increasingly complex and expensive medical innovations, pervasive consumer demand for interventions, increasing difficulties with access to care, and concerns about the quality, safety, and appropriateness of medical care delivery. As a result, new performance measurement initiatives have arisen that significantly affect the relationship between patients and their physicians as greater public reporting influences patient decisions.

Trends: Clinical quality and performance measurement

There is growing recognition that clinical quality measures being used in various programs (e.g., at the federal, state, and community levels) are often not well-aligned with each other—different programs will frequently use very similar measures, intending to address the same fundamental quality issue, but will use slightly different or modified versions of the same measure, and variation exists among program requirements of payers. This leads to a number of challenges, including confusion for stakeholders and a high burden of data collection for physicians and other health care providers, who may need to report on multiple measures and satisfy differing payer requirements for program participation. In addition, the use of multiple measures and differing payer requirements create difficulties when trying to compare clinical performance. Therefore, measures need to be harmonized across data platforms such as administrative claims, electronic health records (EHRs), and patient registries, and across sites of care and among different providers at regional, health system, facility and practice group levels so that patients receive evidence-based care regardless of the provider or the care setting. Most critically, physicians must be involved in the development of clinical performance measures to ensure that valid, reliable measures are developed and implemented.¹
Performance measurement is in demand today and the trend is accelerating. Payers want information on clinical performance to make contract decisions, as well as to track return on payments to physicians, and other health care professionals and providers. In turn, physicians and other health care professionals need reliable information about performance to improve “value” of care for their patients. Researchers and regulatory agencies need valid information from clinical performance measures to develop and implement policy. The increased demand for clinical performance measurement reinforces the need for physicians to be knowledgeable about the measurement systems currently in place, the limitations of performance measurement—sometimes due to statistical factors—and how clinical practice is affected.

A 2015 report from the Institute of Medicine (IOM), Vital Signs: Core Metrics for Health and Health Care Progress, addresses the major opportunities and current problems in the health care measurement enterprise. The document identifies a set of standardized measures required at national, state, local, and institutional levels and recommends the steps necessary to implement and refine those measures.

- Life expectancy—measure for a validated basic health concept that reflects overall system performance with respect to a wide range of factors influencing health.
- Well-being—measure of self-reported health status, as a general indicator of elements shaping quality of life.
- Overweight and obesity—measured by Body Mass Index (BMI) and largely the product of diet and physical activity patterns, together representing leading sources of preventable early deaths.
- Addictive behavior—measure of dependence on tobacco, alcohol, or other drugs, which, together, impose high social and economic burdens on individuals and their families.
- Unintended pregnancy—measure with generational implications that reflects a combination of behavioral, social, and cultural dynamics.
- Healthy communities—index of a community’s profile on health-related social and environmental dimensions, e.g., education, housing, income, parks, and air and water quality.
- Preventive services—index of receipt of immunization, screening, counseling, and chemoprophylaxis services recommended by the U.S. Preventive Services Task Force.
- Care access—measure of ability of individuals to receive the care they need in a timely fashion.
- Patient safety—index of system priority and performance in avoidance of harm to patients in the course of care.
- Evidence-based care—index of system priority and performance in the delivery of care best supported by scientific evidence as to appropriateness and effectiveness.
- Care match with patient goals—measure of the extent to which patient and family goals have been ascertained, discussed, and embedded in care process.
- Personal spending burden—measure of personal expenditures for health care relative to income.
- Population spending burden—measure of aggregate health care expenditures for a population relative to that population’s income.
- Individual engagement—index of personal involvement in health-related behaviors, self-care, caregiving, and social activities that reflect a personal health orientation.
- Community engagement—index of community priority and relative social and economic initiative, investment, and opportunities that reflect a health-oriented culture.

As the health care system moves towards value-based reimbursement models, there is a great demand for accurate, useful information on health care quality that can inform the decisions of consumers, employers, physicians and other clinicians, and policymakers. To address the problem of misaligned measure requirements among payers, the Centers for Medicare & Medicaid Services (CMS), commercial plans, purchasers, physician and other care provider organizations, and consumers...
worked together through the Core Quality Measures Collaborative to identify core sets of quality measures that payers have committed to using for reporting as soon as feasible. The guiding principles used by the Collaborative in developing the core measure sets are that they be meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost. The goal is to establish broadly agreed upon core measure sets that could be harmonized across both commercial and government payers.

- In February 2016, CMS and Americas Health Insurance Plans, as part of a broad collaborative of health care system participants, including physician organizations and medical specialty societies, released seven sets of clinical quality measures that support multi-payer alignment on core measures for physician quality programs. The core measure sets are intended to promote alignment of quality measures for the physician or group practice level accountability in the following areas: Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH) and Primary Care; Cardiology; Gastroenterology; HIV and Hepatitis C; Medical Oncology; Obstetrics and Gynecology; and Orthopedics.

- CMS has aligned quality measures across acute care hospital programs, such as the Inpatient Quality Reporting Program, Hospital Value Based Purchasing, and the Hospital-Acquired Condition Reduction Program. Hospitals report quality measures once, which are used for these multiple programs.

- The National Quality Forum (NQF) initiated a project focused on variation in measure specifications. Through this project, NQF sought to identify how, where, and why variation is occurring across current measures; create a framework for understanding and interpreting the different types of variation across measures and the implications of this variation; and develop a common understanding around key terms, concepts, and measure components to help standardize measurement efforts and minimize unnecessary variation. In December 2016, NQF released a final report on the project that also identifies future opportunities to pilot test and operationalize ways to reduce the incidence and impact of variation in measure specifications.

- Since 2003, the Agency for Healthcare Research and Quality (AHRQ) has produced annual reports on progress and opportunities for improving health care quality and reducing health care disparities. As mandated by the U.S. Congress, the National Healthcare Quality and Disparities Report (QDR) measures trends in several dimensions of quality on prevailing disparities in health care delivery as it relates to racial and socioeconomic factors, including effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care. The report, based on more than 250 measures of quality and disparities, covers an array of health care services and settings. Key findings of the 2015 QDR include the following:

- Access to health care has improved dramatically, led by sustained reductions in the number of Americans without health insurance and increases in the number of Americans with a usual source of medical care.
- Quality of health care continues to improve, but wide variation exists across the National Quality Strategy priorities:
  - Effective treatment measures indicate success at both improving overall performance and reducing disparities.
  - Care coordination measures lagged behind other priorities in overall performance.
  - Patient safety, person-centered care, and healthy living measures have improved overall; however, few disparities have been reduced.
  - Care affordability measures are limited for summarizing performance and disparities.
Disparities, related to race and socioeconomic status, persist among measures of access and all National Quality Strategy priorities, but progress is being made in some areas. Disparities in quality of care and disparities in access to care typically follow the same pattern, although disparities in access tend to be more common than disparities in quality.5

Several U.S. organizations are involved with the development, endorsement, and implementation of performance measures for collecting, analyzing, and reporting outcomes.

- NQF and a number of medical specialty societies have initiatives that promote the use of patient-reported outcomes measures (PROMs) as a basis for performance measurement.
- The National Committee for Quality Assurance (NCQA) is working with the U.S. Office of the National Coordinator for CMS to identify PROM strategies supported by EHRs.
- A number of medical specialty societies (e.g., the American Society of Clinical Oncology, the Society of Thoracic Surgeons, and the American College of Cardiology) are working on the development of PROMs and/or registries, including the assessment of these measures.
- The Physician Consortium for Performance Improvement® convened a technical expert panel to identify best practices for developing PROMs.6

Trends: Outcomes of alternative care delivery models

PCMHs and ACOs are two practice models that seek to move beyond a strictly fee-for-service (FFS) payment model. Each holds the potential of driving higher-quality care and lower costs, largely by improving care coordination among different types of health care providers that often operate independently.

Patient-centered medical homes

The PCMH, sometimes referred to as the medical home, or advanced primary care, is an innovation in health care delivery designed to improve patient experience, improve population health, and reduce the cost of care. Although its origins date back to 1967 (in pediatrics), the medical home concept has grown over the past decade, with nearly 500 public and private sector PCMH initiatives being tracked across the United States.7 A number of nationwide PCMH recognition and accreditation programs exist. Although some practices are required to complete a recognition program (e.g., for participation in an ACO or a PCMH incentive program), PCMH recognition for many practices is voluntary.8

In 2007, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association developed the Joint Principles of the Patient-Centered Medical Home.

- Physician-led practice—patients have access to a personal physician who leads the care team within a medical practice.
- Whole-person orientation—the care team provides comprehensive care, including acute care, chronic care, preventive services, and end-of-life care, at all stages of life.
- Integrated and coordinated care—practices take steps to ensure that patients receive the care and services they need from the medical neighborhood, in a culturally and linguistically appropriate manner.
- Focus on quality and safety—practices use the quality improvement process and evidence-based medicine to continually improve patient outcomes.
- Access—practices commit to enhancing patients’ access to care.9

While most PCMH primary care practices strive to incorporate all of the attributes, the medical home is not a “one size fits all” framework. Each practice implements the attributes based on its own unique
characteristics, such as the size of the practice, the location (i.e. urban versus rural setting); the composition (solo/small practice, mid-size primary care practice, large multi-specialty practice, academic-affiliated practice, etc.), the patient population it serves (health status, other social & economic characteristics), whether financial or performance incentives are provided, etc.10

- Five safety-net clinics in four U.S. Gulf Coast states (Louisiana, Mississippi, Alabama, and Florida) are participating in the Community-Centered Health Home Demonstration Project, directed by the Louisiana Public Health Institute, to expand from a PCMH to a Community-Centered Health Home (CCHH). The CCHH model provides a framework for primary care practices and health care organizations to address individual health needs, while systematically addressing community conditions that affect individual health. Depending on skill sets, team member involvement in the CCHH structure falls into one or more of the following categories: advocacy, information sharing, or coordination with community partners. Although the CCHH model is still in a demonstration phase, the growing emphasis on pay for value and expanding health care’s role in population health may generate interest nationwide.11

- The PCMH model had a positive impact on controlling costs and improving quality of care, according to a recent Patient-Centered Primary Care Collaborative report, The Medical Home’s Impact on Cost and Quality: Annual Review of Evidence 2014-2015. Findings from studies on the PCMH model (17 peer-reviewed studies, 4 state government evaluations, 6 industry reports, and 3 independent evaluations of federal initiatives) show that the medical home drives reductions in health care costs and/or unnecessary utilization, such as emergency department visits, inpatient hospitalizations, and hospital readmissions. Additionally, various approaches to PCMH payment show potential, particularly those of multi-payer collaboratives with specific incentives or performance measures linked to quality, utilizations, patient engagement, or cost savings.12

- Under Section 3024 of the Patient Protection and Affordable Care Act (ACA), the U.S. Congress mandated that the CMS conduct a demonstration designed to test the ability of a home-based, primary care delivery model to reduce health care costs and improve health outcomes of high-need Medicare beneficiaries.
  - The practices chosen to participate in the Independence at Home Demonstration designed and implemented coordinated care plans tailored to individual beneficiaries’ chronic conditions, made in-home primary care visits to these patients, and were available 24 hours per day to meet their health needs.
  - In the second performance year of the demonstration, there were more than 10,000 beneficiaries and 15 practices participating in the program, which saved CMS more than $10 million.
  - CMS will provide seven of the participating practices that met three or more of the quality measures—four practices met all six quality measures—with a total of $5.7 million in incentive payments.13

- Intermountain Healthcare conducted an observational study to evaluate the association of receiving primary care in integrated team-based care practices (TBC) versus traditional practice management (TPM) practices with patient outcomes, health care utilization, and costs. Results demonstrated that receipts of primary care at TBC practices compared with TPM practices was associated with higher rates of some measures of quality of care, lower rates for some measures of acute care utilization, and lower actual payments received by the delivery system. The study highlights the challenge of transforming physician practices to function as a team and manage the complexities of population health.14
ACOs emerged as a prominent alternative to traditional FFS payment and were the cornerstone of the novel payment strategies for Medicare reform under the ACA. As of January 2016, Leavitt Partners has identified 838 active ACOs with service areas in all 50 states and the District of Columbia that cover more than 28 million Americans, of whom 60% are under commercial ACO contracts. Approximately, 477 Medicare ACOs cover 22% of Medicare beneficiaries.15

ACO leaders face many challenges in redesigning care, including achieving organizational buy-in, using technology to manage a population, and aligning intra-organizational incentives—all while making measurable progress on quality and cost. Organizational change is hard in any industry, but shifting an infrastructure from volume to value requires a significant amount of structural change. More importantly, it requires individual providers to change how they practice medicine. Changing the fundamental practice of medicine takes buy-in, effort, and significant time to accomplish. For example, a successful ACO must first understand their population, which requires developing and using health information technology (HIT) in new ways. Selecting, implementing, and maintaining connected electronic data to support population health platforms remains a challenge, with both providers and vendors creating new products, and refining data-sharing and analytic technologies. Additionally, ACOs that bear risk at the organizational-level for the financial outcomes of populations must grapple with how to calculate that risk and share it with individual providers or practices.

In 2015, Medicare ACOs had combined total program savings of $466 million, which includes all ACOs’ experiences, for 392 Medicare Shared Savings Program (MSSP) participants and 12 Pioneer ACO Model participants. More ACOs shared savings in 2015 compared to 2014 and those with more experience tend to perform better over time. Collectively, Medicare ACOs have generated more than $1.29 billion in total Medicare savings since 2012.16 Evidence on spending suggests modest savings overall. The first cohort of ACOs in the MSSP, for example, realized savings of 1.4% in year 1, whereas the second cohort did not experience significant savings.17 Medicare Pioneer ACOs, which comprise larger organizations that bear risk, experienced at least 1.2% savings in year 1 with smaller savings in year 2.18,19 In both Medicare programs, performance on spending demonstrated significant variation; about half of ACOs achieved any savings and only a quarter received bonuses. Importantly, ACOs led by primary care groups achieved greater savings than those integrated with hospitals.20
All 12 participants in the Pioneer ACO Model improved their quality scores from 2012 to 2015 by more than 21-percentage points. Overall quality scores for nine out of 12 participants were more than 90% in 2015.

ACOs in the MSSP also continued to show improvement, with overall improvement of 84% on the quality measures reported in both years. Average quality performance improved by more than 15% on key preventive care measures.

These efforts support CMS’ goal to have 50% of traditional Medicare payments flowing through alternative payment models by 2018—currently, 30% of Medicare payments go through alternative models.

Under the proposed Quality Payment Program, established by the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), health care providers who sufficiently participate in advanced tracks of Medicare ACOs may qualify for exemption from payment adjustments under the Merit-based Incentive Payment System, as well as the additional incentive payments beginning in 2019 for participation in Advanced Alternative Payment Models.21

- Among private payers, the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)—a global budget model in which ACOs bear risk—was associated with an initial modest slowing of spending (1.9% in year 1) that increased to 6.8% after 4 years.22 Changes in referral patterns toward lower-priced physicians and hospitals explained most of the savings in the initial years, while reductions in utilization played a larger role over time.

- Quality improved for both process and outcome domains in the AQC. For example, process measures included adherence with guidelines for screening for colorectal or breast cancer and follow-up testing for patients with diabetes or coronary artery disease; outcome measures included the proportion of patients with diabetes achieving target blood pressure, lipid levels, or hemoglobin A1c levels.23,24

- In December 2015, Leavitt Partners released a whitepaper, Projected Growth of Accountable Care Organizations, which details ACO growth projections under four possible future scenarios. By comparing the projections in the different scenarios, valuable insights may be gained about how different factors influence growth of accountable care. Though the projections ranged widely, the number of ACO-covered lives increased in each scenario, providing confidence that accountable care will continue to play an important role in the health care industry. The Medicare Access and Chip Reauthorization Act of 2015 (MACRA) has had a substantial impact on the growth of accountable care.25

- On October 14, 2016, the Department of Health and Human Services (HHS) issued its final rule with comment period implementing the Quality Payment Program that is part of MACRA, which also eliminated the Sustainable Growth Rate (SGR) formula that threatened physicians participating in Medicare with potential payment cliffs. The Quality Payment Program’s purpose is to provide physicians and other health care professionals with new tools and resources for providing patients with high-value care. The Quality Payment Program has two tracks for physicians that are based on practice size, specialty, location or patient population: Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).26

- In May 2016, the National Association of ACOs, the largest association of Medicare ACOs, released a white paper, ACOs at Crossroads: Costs, Risk, and MACRA, that identifies significant obstacles to
improving ACOs, including overwhelming risk models, high cost of investments, exclusion from MACRA’s advanced payment models, and the overlap of other CMS programs. The whitepaper incorporates findings of the Association’s *ACO Cost and MACRA Implementation Survey*, which 144 unique Medicare Shared Savings Program ACOs in 40 different states completed this year.\(^{27,28}\)

In 2015, Premier Inc. and eHealth Initiative surveyed 68 ACOs of which 79% provide care to Medicare patients; 44% to commercially insured patients; 35% to Medicare Advantage patients; 35% to employer-based patients, and 24% to Medicaid patients. Nearly 75% of respondents have EHRs in their institutions, with 84% using analytics software. Ninety-six percent of respondents use these data for adjudicating claims, 76% for EHRs or other quality measurement systems, and another 84% to find gaps in care. Results from the survey include:

- Around 70% of ACOs reported integrating data from out-of-network providers is the biggest HIT challenge they face.
- Respondents said the more care settings and providers visited by a patient, the less likely the initial provider would receive patient data from those appointments.
- About half of the ACO respondents have not been able to integrate data from long-term and post-acute care providers, and more than half have yet to integrate any data from behavioral health providers. Further, 46% said there was no integration with palliative and hospice facilities.
- While integration is challenging, ACOs are having an impact on improving various cost and quality metrics, even with limited data.\(^{29}\)

*Trends: Profiling and rating performance*

Major changes in the health care delivery system have increased public awareness of quality and cost of care issues. Responses include intense efforts to measure the performance of physicians and health care organizations, and use of the results to improve the quality of care, lower health care costs, provide input to accreditation processes, form narrow networks, and to inform the public. Physician profiling efforts to date have been limited in scope and focused primarily on controlling overuse of health care services and reducing costs. This emphasis has been driven by competition among payers, and employers’ demands for control of health care premiums. Physicians’ criticisms of current profiling activities stem from potentially adverse effects of pressures to restrict services on the quality of care; burdens created by uncoordinated and redundant requests for data; reports based on variable and often poor quality data; and inadequate case-mix and risk-adjustment methodologies.

*Pay for performance*

Pay for performance (P4P) is not a new concept as some payers have been using this type of initiative with physicians and other providers for more than a decade. Most early P4P experiments narrowly focused on quality with very little, if any, consideration of cost. However, the P4P concept has been evolving and most programs now address overall value by incorporating quality, cost, patient satisfaction/experience, and other factors into measures of performance and contract design. These arrangements may provide financial incentives to hospitals, physicians and other health care providers to carry out such improvements, and achieve optimal outcomes for patients.

Additionally, P4P has become popular among policymakers. However, researchers say, experimentation with P4P programs should include thoughtful monitoring and evaluation to identify design elements that positively influence outcomes. Evaluation of these programs should take into account variations in health care markets, such as in the supply of providers, and should include control or comparison groups so that the effects of P4P can be isolated from other factors. Evaluations should be conducted over sufficiently
long periods to identify any unintended consequences, such as long-term effects on vulnerable populations.  

While at first glance P4P may seem like the panacea that will improve quality and affordability, several factors pose threats to the effectiveness of P4P, including the following:

- Serious concerns have been raised about the impact of P4P approaches on poorer and disadvantaged populations. In particular, there are fears that these programs may exacerbate racial and ethnic disparities in health if providers avoid patients that are likely to lower their performance. Additionally, providers may avoid treating disadvantaged populations for fear that they are less likely to comply with treatment plans. Exacerbating this issue is the fact that safety-net hospitals and physician groups often have low or zero profit margins, so financial penalties for poor performance could ruin their business, thereby further reducing access to care for these populations.

- Providers that care for disproportionate numbers of disadvantaged patients tend to perform less well on quality measures commonly used in P4P programs. This can lead to the undesired effect of redistributing resources away from providers that most need them to improve care. Researchers from RAND Health developed an alternative incentive payment approach that started with a standard incentive payment allocation, then “post-adjusted” provider payments using predefined patient or provider characteristics. Their findings suggest that post-adjustment provider categories could be a useful supplement to paying for improvement as a means of broadening P4P incentives while also aligning the goals of disparity reduction and quality improvement.

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Public sector programs

The CMS launched its first P4P pilot program in 2003, the Premier Hospital Quality Incentive program, and since then has participated in many demonstration projects that have tested a range of P4P methods for different types of providers. The ACA and MACRA expanded Medicare value-based programs and encouraged experimentation to evaluate program effectiveness. The following are some of the most influential programs to date:

- CMS’ value-based programs may reward physicians and other health care providers with incentive payments for the quality of care they provide to people with Medicare. These programs are part of the agency’s larger quality strategy to reform how health care is delivered and paid for. Value-based programs also support its three-part aim: better care for individuals, better health for populations and lower cost.
The value-based programs are important because they assist CMS with moving toward payment that is based on the quality, rather than the quantity of care provided to patients.\textsuperscript{36}

There are four original value-based programs: Hospital Value-Based Purchasing (HVBP) Program, Hospital Readmission Reduction (HRR) Program, Value Modifier (VM) Program (also called the Physician Value-Based Modifier or PVBM) and Hospital Acquired Conditions (HAC) Program.\textsuperscript{37}

There are several other value-based programs: End-Stage Renal Disease (ESRD) Quality Initiative Program, Skilled Nursing Facility Value-Based Program (SNFVBP) and Home Health Value Based Program (HHVBP).\textsuperscript{38}

The CY 2016 Medicare Physician Fee Schedule (MPFS) final rule with comment period was placed on display at the Federal Register on October 30, 2015. In addition to policies affecting the calculation of payment rates, this final rule identified potentially misvalued codes, added procedures to the telehealth list, and finalized a number of new policies, including several that were a result of recently enacted legislation. The rule also finalized changes to several of the quality reporting initiatives that are associated with MPFS payments, including the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (Value Modifier), and the Medicare Electronic Health Record (EHR) Incentive Program, as well as changes to the Physician Compare website on Medicare.gov. This is the first MPFS final rule since the repeal of the SGR formula by MACRA. The calendar year 2016 MPFS final rule is one of several final rules reflecting a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people.\textsuperscript{39}

In January 2016, CMS proposed rules expanded access to analyses and data that may help providers, employers, and others to make more informed decisions about care delivery. The new rules, as required by MACRA, allow organizations approved as qualified entities (QEs) to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers, and other groups who can use these data to support improved care.\textsuperscript{40}

The CMS Qualified Entity Program (also known as the Medicare Data Sharing for Performance Measurement Program) enables organizations to receive Medicare claims data under Parts A, B, and D for use in evaluating provider performance. Organizations approved as QEs are required to use the Medicare data to produce and publicly disseminate CMS-approved reports on provider performance. QEs are also permitted to create non-public analyses and provide or sell such analyses to authorized users. In addition, QEs may provide or sell combined data, or provide Medicare claims data alone at no cost, to certain authorized users. Under the Qualified Entity Certification Program (QECP), CMS certifies QEs to receive these data and monitors certified QEs. As of November 3, 2016, there were 16 certified entities listed on the CMS QE Program’s website.\textsuperscript{41}

The ACA required CMS to establish the Physician Compare website, launched in December 2010, to provide information for beneficiaries to encourage informed health care decisions.

- Physician Compare includes information about physicians and other health care professionals who voluntarily participate in CMS quality programs.
- If a group practice or individual health care professional reports any of the measures designated as “available for public reporting” in the Physician Fee Schedule rule, then the measure may be included on the Physician Compare website. Only those measures deemed statistically comparable, valid and reliable, and that meet public reporting standards, including the minimum 20-patient threshold, will be considered for inclusion on the website. If the minimum threshold is not met for a particular measure, or the measure is otherwise deemed not to be suitable for public
reporting, the group or individual’s performance rate on that measure will not be publicly reported. Additionally, during the preview period, physicians have the ability to contest incorrect performance information.

- In December 2016, CMS expanded the number of quality measures publicly reported on the Physician Compare website. Approximately 175,000 individual clinicians now have performance scores available on Physician Compare profile pages. This includes 90 individual clinician-level Physician Quality Reporting System (PQRS) measures collected via claims and registry.
- A Qualified Clinical Data Registry (QCDR) is a reporting mechanism that was introduced for the Physician Quality Reporting System (PQRS) beginning in 2014. A QCDR can complete the collection and submission of PQRS quality measures data on behalf of individual eligible professionals (EPs). Starting in 2016, individual-level QCDR measures, which include PQRS and non-PQRS data, will be available for public reporting on Physician Compare. In 2017, both individual and group-level QCDR measures will be available for public reporting. Publicly reporting QCDR data on Physician Compare expands the quality measure data available for EPs and group practices regardless of specialty and provides more quality data to consumers to help them make informed decisions.42

Private sector programs

- In 2016, the Health Care Transformation Task Force, a coalition of private insurers and provider organizations, announced that its members are committing to move 75% of their contracts into alternative payment models by 2020. The task force aims to reach an accord on the most effective payment models for hospitals, private insurance companies, and public payers to accelerate change in health care delivery.43
- The Value Based Pay for Performance (VBP4P) (formerly the California P4P Program) is managed by the Integrated Health Association (IHA), a nonprofit, multi-stakeholder group that promotes quality improvement, accountability, and affordability in health care. The VBP4P recommended incentive design is a shared savings model that relies on quality, cost, and resource use. While the design recommends payment based on high quality, managed cost, and appropriate resource use, each health plan determines its own budget and methodology for calculating and distributing payments to physician organizations.44
- Developed by IHA in partnership with the California Health Care Foundation and California Health and Human Services Agency, the California Regional Cost & Health Care Quality Atlas includes information about care provided to nearly two-thirds of the state’s total population, or 24 million people. Spanning commercial insurance, Medicare Advantage and FFS, and Medi-Cal managed care and FFS, the Atlas brings together data on clinical quality, hospital utilization, and total cost of care to assess geographic and insurance product-type performance variation.

- Key findings of Atlas data include: 1) If care for all commercially insured Californians represented by the Atlas were provided at the same quality as top-performing regions, nearly 200,000 more people would have been screened for colorectal cancer and 50,000 more women would have been screened for breast cancer in 2013; and 2) If care for all commercially insured Californians represented by the Atlas were provided at the same cost as observed in San Diego—a relatively high-quality, low-cost region—overall cost of care would decrease by an estimated $4.4 billion annually, or about 10% of the $44 billion total cost of care for the commercially insured people represented in the Atlas in 2013.45

- The report, Rising to the Challenge: The Commonwealth Fund Scorecard on Local Health System Performance, 2016 Edition,” displays rankings of more than 300 U.S. communities based on 36
indicators of access, quality, avoidable hospital use, costs, and outcomes measures. The scorecard shows that between 2011 and 2014 many communities experienced improvements such as fewer uninsured residents, better quality of care in physicians’ offices and hospitals, and fewer deaths from treatable cancers, among other gains. However, the persistence of widespread differences in areas is a reminder that many local health systems have yet to reach the potential attained elsewhere in the country.

- About half of local areas (155 of 306) saw meaningful reductions in 30-day readmissions—areas making the most progress averaged a nearly 30% reduction.
- In general, ambulatory care quality did not improve to the same degree as did care provided in hospitals and other institutional settings.
- Infant mortality varied more than threefold across regions, ranging from less than three deaths per 1,000 live births in San Mateo and Santa Barbara to more than 10 deaths per 1,000 live births in parts of Mississippi, South Carolina, and Georgia.
- Wide variation exists within many large states. In Texas, the share of adults who reported going without needed care because of the cost varied from 12% in Temple to 31% in McAllen. In Florida, hospital admission rates for younger Medicare beneficiaries for potentially avoidable causes ranged from 14 admissions per 1,000 in Sarasota to 46 per 1,000 in Lakeland.
- The cost of health care varies widely between, and even within, local areas. Per-enrollee spending among Medicare beneficiaries in Miami, Florida, the highest-spending region, is more than double that in Honolulu, Hawaii, the lowest-spending region ($13,189 versus $5,593). In the working-age population with employer-sponsored insurance, per-enrollee spending differences are even greater, ranging from $2,720 (Columbus, Georgia) to $9,362 (Wilkes-Barre, Pennsylvania).
- Local areas with a disproportionate share of low-income residents tend to exhibit worse health system performance than areas with relatively fewer low-income residents. However, many economically disadvantaged regions were among the most improved on certain indicators. Leaders in Pueblo, Colorado are collaborating to improve health system performance; Jonesboro, Arkansas experienced the largest decline in uninsured rates; and McAllen, Texas saw the largest reduction of readmissions in all lower-income areas, with 17 fewer per 1,000 beneficiaries.46

Narrow Networks
The use of narrow networks in health insurance plans is a cost containment strategy that has proliferated on the marketplaces established by the ACA. They have also become more common in Medicare Advantage and commercial plans. Increasingly, health plans are incented to narrow their networks. Exchanges and other comparison tools encourage consumers to shop based on premium, and narrow networks may hold down costs. Emerging value-based payment models are premised on health plans driving their members to “high-value” providers that deliver targeted outcomes—ACOs are grounded on highly cooperative providers with tight referral patterns. These trends incent narrow networks and disincent “any willing provider,” open-access, and other broad networks. As the research on provider networks matures, so will the debate. Health plans will have the chance to help regulators consider emerging measures of network quality while complying with measures of network adequacy.

According to an Academy Health research brief, *Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice*, the adequacy of plan networks is a key consideration when narrow network strategies are employed. However, researchers raised other considerations such as the impact of narrow networks on health outcomes, access to care, health care costs, appropriate measurement standards, consumer awareness, consideration of quality into network design strategies, and the potential for narrow network approaches to succeed.47
According to an analysis of the 2015 health insurance exchange plans by McKinsey & Company, nearly 50% of networks were narrow; median premiums were lower for narrow-network plans; plans co-branded by an insurer and provider had lower median premiums than plans offered solely by providers; and consumers who purchased narrow-network plans reported less satisfaction with their payers.\(^4\)

Greater transparency about health plans’ provider networks is needed to help patients understand which doctors and hospitals they can go to without incurring very high out-of-pocket costs. To help address this issue, the Leonard Davis Institute of Health Economics created a standardized and integrated data set of providers in networks. The public dataset provides policymakers, developers, and other interested parties with detailed information on network size overall and by specialty for every silver plan offered on the AMA marketplace, which will enhance transparency for patients.\(^4\)

**Trends: Patient satisfaction and patient experience**

The measurement of and incentives linked to patient satisfaction and patient experience are increasing. The IOM’s *Triple Aim* describes the patient experience of care as including both care quality and patient satisfaction, suggesting that these features are interrelated. In the Annals of Internal Medicine publication, *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider*, Drs. Bodenheimer and Sinsky propose adding a fourth dimension to the triple aim: “the goal of improving the work life of health care providers, including clinicians and staff.” The added workload related to performance measurement, EHR use, greater documentation requirements, and increased access (expanded hours, email, etc.) have had detrimental effects on the satisfaction and morale of members of the health care team.\(^5\)

Patient experience surveys sometimes are mistaken for customer satisfaction surveys. Patient experience surveys focus on how patients experienced or perceived key aspects of their care, not how satisfied they were with their care. Patient experience surveys focus on asking patients whether or how often they experienced critical aspects of health care, including communication with their physicians, understanding their medication instructions, and the coordination of their health care needs. They do not focus on amenities. The absence of a solid conceptual basis and consistent measurement tool for patient satisfaction and patient experience has led to a proliferation of surveys, which have their roots in consumer marketing, and are measures of how services or products meet or exceed the anticipated expectations of the customer, e.g., waiting times and the quality of basic amenities.

As payers increasingly tie reimbursement to patient feedback, ethical tensions related to physicians’ objections of the use of these surveys are rising. There are unresolved methodological issues related to the measurement and interpretation of patient satisfaction and patient experience, such as survey content and risk adjustment. If scientifically grounded metrics were developed that measure patients’ overall assessment of care, cross-study comparisons could be made, which might reduce confusion and skepticism concerning measurement.\(^5\) In the future, measures of patient satisfaction and patient experience, intended to capture the responsiveness of the health system—the manner and environment in which patients are treated when they seek health care—are likely to receive even greater attention as physicians and other health care providers come under growing pressure to improve the quality of care, enhance patient safety, and lower the cost of services.

The CMS develop, implement and administer several different patient experience surveys. These surveys ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, physicians, and
health and drug plans, among others. CMS publicly reports the results of its patient experience surveys, and some survey results affect payments to CMS providers.

- Many of the CMS patient experience surveys are in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) family of surveys. Others are developed following CAHPS principles and used by CMS, but are not CAHPS surveys. All surveys officially designated as CAHPS surveys have been approved by the CAHPS Consortium, which is overseen by the Agency for Healthcare Research and Quality (AHRQ).
- CAHPS surveys follow scientific principles in survey design and development to assess the experiences of a large sample of patients. They use standardized questions and data collection protocols to ensure that information can be compared across health care settings. CAHPS surveys are developed with broad stakeholder input, including a public solicitation of measures and a technical expert panel, and the opportunity for anyone to comment on the survey through multiple public comment periods via the Federal Register. Many CAHPS measures are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes. CAHPS surveys are an integral part of CMS’ efforts to improve U.S. health care.  

The Institute for Healthcare Communication, in its article, Impact of Communication in Healthcare, outlined nine core elements that contribute to improved patient satisfaction and patient experience:

- Expectations—providing an opportunity for the patient to tell his story.
- Communication—patient satisfaction increases when providers take the problem seriously, explain information clearly, attempt to understand the patient’s experience, and provide viable options.
- Control—patient satisfaction improves when patients are encouraged to express their ideas, concerns, and expectations.
- Decision-making—patient satisfaction increases when the importance of their social and mental functioning is acknowledged as much as their physical functioning.
- Time spent—patient satisfaction rates improve as the length of the healthcare visit increases.
- Clinical team—although it is clear that the patient’s first concern is his clinician, he also values the team with whom the clinician works.
- Referrals—patient satisfaction increases when the health care team initiates referrals, relieving the patient of the responsibility.
- Continuity of care—patient satisfaction increases when they receive continuing care from the same health care provider(s).
- Dignity—patients who are treated with respect and who are invited to partner in their health care decisions report greater satisfaction.

Studies have demonstrated that patient-physician communication is a key factor in improving the patient experience. Although, patient-physician communication can be challenging, it presents a tremendous opportunity for improvement. Researchers from Mayo Clinic College of Medicine conducted a study on the effects of improving the patient experience through provider communication skills building. Results demonstrated that organizations enhance the patient experience by understanding patients’ expectations, listening to their preferences, developing programs to improve provider communication and interpersonal skills, measuring service quality, and providing feedback and tools for continuous improvement.

According to an article published in the AMA Journal of Ethics, measuring patient satisfaction raises a number of concerns over linking financial incentives to patient survey scores. Patient experience measures are based on patients’ expectation of care, as opposed to objective measures of
experience.\textsuperscript{55} Patient perceptions may not be correlated with technical quality.\textsuperscript{56} Voluntary surveys are relatively long and are often answered many weeks after the experience. There may be selection and recall bias in the responses of those with very positive or negative experiences. Limited sample sizes could also affect the validity of the scores across different hospitals and clinics. Moreover, it is not clear whether there is a “crowding-out” effect of patient experience surveys on other potentially more important or valid quality metrics. The article concludes that more research is needed on the consistency with which surveys are implemented.\textsuperscript{57}

\begin{itemize}
  \item According to Gallup survey results, 53\% of Americans rate the quality of health care as “excellent” or “good,” which is similar to the rating prior to the insurance exchanges of the ACA, and down from the more positive ratings of 2008-2012.
  \begin{itemize}
    \item Americans’ overall satisfaction with the total cost they pay for health care has been stable over the past 14 years, with 57\% reporting they are satisfied. This satisfaction with U.S. health care remains stable despite the fact that Gallup also found cost is one of the most urgent health problems.
    \item Gallup found that health care coverage in the United States is viewed less favorably than quality, although it is higher now (33\%) than before President Obama took office (27\%).
    \item Americans who are insured through Medicare or Medicaid are more satisfied with the cost of their insurance than those who have private insurance. Similarly, an earlier survey found that people with government plans are also more satisfied with how the health care system works.\textsuperscript{58}
  \end{itemize}
\end{itemize}

\textbf{Predicted impacts}

\begin{itemize}
  \item Patients will increasingly seek information about quality and cost-of-care options. While more information will become available, some of that information will be inaccurate or contradictory, which will cause confusion and, in the worst cases, may even result in poor health care choices.
  \item Patient-experience surveys, when designed and administered properly, may provide robust measures of health care quality. Efforts to assess the relationship of patient-reported outcomes to clinical outcomes and measurement of both will increase.
  \item Quality improvement professionals and operational team leaders will learn how to add clarity and consistency to their quality improvement work, discover how to identify emotional touchpoints that influence the patient experience, and practice qualitative and quantitative experience-based design methods to guide process improvement. Use of online sources by patients to obtain health-related information and ratings of physicians, hospitals and other health care providers will increase. However, information may be unavailable, incomplete, or inaccurate; consequently, patients will increasingly seek trusted sources—their physicians—for that information. This should be an area of active physician engagement to ensure that the information and ratings are valid and reliable.
  \item Patients who are engaged in their own health care will experience better encounters with their physicians. Further research on the relationship between engaged patients and their physicians, and the impact on health outcomes will be necessary.
  \item Pay-for-performance programs could exacerbate racial and economic health disparities unless case-mix adjustment (which captures variations in patients’ illness severity, complicating coexisting conditions, or relevant socio-economic and demographic differences) is implemented, and an accurate method of attributing health care costs is developed. If these calculations do not control for such factors, physicians could be motivated to avoid caring for sicker, more complicated, or more difficult-to-manage patients.
\end{itemize}
- Effective patient-physician communication will continue to be a key factor in improving patient satisfaction and patient experience.

- Unmet social determinants of health will continue to impede physicians’ ability to control health conditions. Increasingly, physicians will have conversations with their patients about barriers that might be keeping them from leading healthier lives and determine whether they could intervene to overcome those barriers.

- Physicians will face increased pressure to provide evidence of the quality of care they deliver and will spend more time explaining quality indicators to patients. In some cases, physicians will be defending their record related to quality.

- Payers will increasingly use results of quality measurement in negotiations with physicians over payment rates and other contractual terms.

- Physician report cards will continue to affect the image of physicians. There is a risk that without standardization, physicians will become increasingly frustrated in their attempts to stay apprised of the diverse number of metrics and methods employed by various payers in their quality improvement programs and processes.

- Physicians will increasingly adopt computer software programs and systems that improve workflow, provide clinical decision support, collect and analyze data, increase compliance with recommended treatment regimens, and promote communication with patients and other physicians.

- As the focus on population health increases, physicians and payers will escalate collaborative efforts to integrate care, and share information for participation in new payment models with the potential for improved quality and shared savings.

- One of the realities of the evolving health care delivery system is that patients will require improved access to care; therefore, even though the focus is shifting to better value, the use of metrics that are based on resources and cost (e.g., patients seen, revenue generated, work performed) will continue to determine physician payment.

- As outcomes-based methods are developed, physician groups— independent or hospital-owned— these measures will increasingly become key determinants of physician performance.

- Physician control over processes of care will increase as hospitals and other care facilities seek physicians’ expertise in efforts to reduce infections, re-admissions, etc.

- It will be critically important for physicians to gain a better understanding of the issues related to patient satisfaction and patient experience.

- As more patients use the Internet and social media websites to describe and rate their health care experiences, these factors will become important differentiators among health care organizations. Consequently, payers and regulators will consider new ways to incorporate patient feedback into their organizational quality improvement processes. More research will be necessary to better define and improve methods of measuring patient satisfaction and patient experience.

- Without the development of a valid method to measure physicians’ overall value in informing quality-, cost-, and safety-improvement efforts, a policy that holds physicians accountable for the care they provide will prove to be a flawed approach. Increasingly, physicians will opt-out of participation in incentive programs that generate misleading or inaccurate assessments of their value.
- Organizations developing measure specifications to profile physician performance will likely test and refine them before they incorporate them into their physician contracts.

- If designed correctly, physician incentive programs may have a profoundly positive effect on the culture, behavior, and success of health care organizations.

- Neither health policymakers nor physicians should underestimate the influence of physician-rating websites. They already play an important role in providing information to help patients decide on an appropriate physician. Assuming there will be a rising level of public awareness, the influence of their use will increase well into the future. Future studies should assess the impact of physician-rating websites and investigate whether physician-rating websites have the potential to reflect the quality of care offered by physicians and other health care providers.

- Collaboration on efforts to address the problems of misaligned measure requirements (e.g., the adoption of core quality measure sets) and the harmonization of measures across both commercial and government payers will increase.

References


36 Ibid.

37 Ibid.


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