achieve tight glycemic control with diet and lifestyle modifications alone should be encouraged to do so, he added.

Yet Leffert fears that physicians and patients will settle for less based on the new recommendations. "What will happen is that we'll get this lack of intensification in patients who already have poor control over diabetes," he said. "My sense is that when the patients get to 8.5 or 8.3 or 8.2 and we have this target of between 7 and 8, then the physician and the patient will stop there."

To Schneider, however, the ACP's guidance doesn't feel like a major shift from the ADA's advice, which says less intensive therapy may be appropriate in some patients, such as those with a history of severe hypoglycemia, extensive comorbidities, or limited life expectancy. All of the available clinical guidance statements, he points out, recommend individualized HbA_{1c} goals.

Experts agree that the best HbA_{1c} target for a patient with diabetes is a personalized one.

"What we're really arguing about is a small change in the approach," Schneider said. "Having arguments about it between different specialty societies is hard on patients and hard on physicians that are having these conversations on a daily basis."

Lipska sees some benefit to the debate: "Perhaps the fact that these guidelines disagree is actually good for the discourse and for clinicians to realize there is no one right answer." ■

Note: Source references are available through embedded hyperlinks in the article text online.

The JAMA Forum

The Need to Simplify Measuring Quality in Health Care

Gail Wilensky, PhD

The leadership of US health care institutions as well as practicing clinicians have raised concerns about the burdens being placed on them by the many quality and performance metrics required by various payers and regulators. Although the total number of health care measures in use in unknown, some 1700 reportedly are used by the Centers for Medicare & Medicaid (CMS) alone. The multiplicity of metrics is not a new problem, but resolving this issue is proving difficult.

Part of the challenge is the continuing debate regarding the validity and accuracy of the measures themselves, leading to concerns about how best to promote the continuing improvement of health care quality and performance. Although various types of process-of-care metrics (such as administering vaccinations or ordering a screening colonoscopy, as recommended by guidelines) have been in use for several decades, the increasing interest in focusing on outcomes in health care has meant that better ways to measure outcomes are also needed.

The nature of a multipayer environment, including the many public and private payers in the United States, complicates the development of a uniform or parsimonious set of metrics, although it's certainly achievable. Even the federal and state governments' growing roles as payers in health care—accounting for 45% of total health expenditures in 2016 and expected to grow as more baby boomers age into Medicare—has had only a limited effect on resolving the multiplicity of metrics affecting institutions and clinicians.

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Recognizing the Problem

There seems to be an increasing recognition of the problem, however. Led by the American Health Insurance Plans, CMS, commercial plans, Medicare and Medicaid managed care plans, purchasers, physician groups, other care provider organizations, and consumers have worked in a Core Quality Measures Collaborative to reach a consensus on a set of core measures. The collaborative has developed measures that rely on medical claims records in several areas thus far, including metrics for accountable care organizations (ACOs) and patient-centered medical homes, cardiology, gastroenterology, HIV and hepatitis C, medical oncology, orthopedics, obstetrics and gynecology, and pediatrics.

Both commercial plans and the CMS are adopting the measures during 2018, representing an important first effort in harmonization. It will be important to assess whether medical claims data used for billing can provide an adequate array of performance measures, which should be possible to do after the next year or two.

The Medicare Payment Advisory Commission (MedPAC) also recently recommended using medical claims data as a way to reduce the burden on physicians in fee-for-service practices that would result from the Merit-based Incentive Payment System (MIPS), as it is currently designed under provisions of legislation passed in 2015 (the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA). According to these provisions, physicians who work for organizations participating in advanced alternative payment models (AAPMs) are scheduled to receive a 5% bonus for each of the next 5 years; the physicians can experience gains or losses, depending on whether the organization does or does not meet its spending and quality goals. In contrast, most physicians who participate in ACOs may share gains with the government but are not at risk for losses. Other physicians—those in fee-for-service practices or simple ACOs who see more than 200 Medicare patients a year or receive more than $90 000 a year from Medicare Part B payments—can earn a bonus based on their MIPS scores. MIPS represents a consolidation of 3 previous quality programs and was intended to reduce the burdens on clinicians associated with reporting metrics.

However, according to MedPAC, the problem with MIPS is that it is a very burdensome system, would cost about $1.3 billion to implement, and it wouldn't help patients choose more appropriate physicians or help physicians improve their clinical practices. Instead MedPAC recommends the use of a "Voluntary Value Program," where physicians would agree to have 2% of their Medicare fee payments withheld. The withheld payments can be earned back on the basis of population-level measures (such as mortality or hospital readmission rates) for their group, which can be either a real physician group or a virtual group (such as physicians who practice at the same hospital or belong to a local medical society). The measures would be based on Medicare claims data, which means the administrative burden would be on CMS rather than on the physician. Nonparticipating physicians would lose the 2% withheld payment.

MedPAC's recommendation is intriguing and should be implemented as a pilot project by the Center for Medicare and Medicaid Innovations—as quickly as possible, because MIPS is scheduled to go into effect in 2019. Congress will need to consider legislation slowing down the implementation of MIPS if it wishes to pursue this alternative strategy.

Developing a Uniform Set of Metrics

Given the proliferation of quality metrics currently being collected, it is time for CMS to reconvene the various stakeholders—including patients—to extend the agency's efforts on developing a uniform set of metrics to be collected from clinicians and institutions. These should include metrics of importance to patients and not just those regarded as relevant by the clinicians and payers. Payers could also continue to use information from medical claims records because that doesn't add any additional burdens on clinicians.

Although the move to a single set of quality metrics would ease some of the reporting burdens being placed on clinicians and institutions, the quality metrics in use are primarily "micro" in their orientation and are frequently more focused on complications or errors associated with an event such as an episode of illness or a treatment. In contrast, a more fully outcomes-focused assessment would include whether a selected treatment was the most appropriate intervention, given the patient's condition; whether a diagnosis was clinically accurate; or whether a treatment actually improved the patient's health, particularly in ways that are important to the patient.

Addressing these broader issues in health will require advances in several areas, including the availability of better clinical guidelines that are easily and readily accessible to clinicians, the broader adoption of truly interoperable medical records, and the development of better ways to foster shared decision making between clinicians and patients. But developing strategies that can reduce the current burdens on clinicians related to reporting metrics is not a bad place to start. ■

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Published Online: May 2, 2018, at https://newsatjama.jama.com/category/the-jama-forum/.

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