

American Academy of Pediatrics (AAP)
Comments
Federal Trade Commission (FTC)
Health Care Workshop, Project No. P131207

The American Academy of Pediatrics (AAP) welcomes the opportunity to comment on the Federal Trade Commission's (FTC) effort to better understand the competitive dynamics of evolving health care product and service markets. The Academy's comments are based on the February 24, 2014 *Federal Register* notice announcing a public workshop to be held the following month to gather information from the health care field on developments related to: (1) professional regulations, (2) innovations in health care delivery, (3) advancements in health care technology, (4) price transparency for health care services, and (5) measuring and assessing health care quality. The Academy comments on these five areas are delineated below.

Professional Regulations

The Academy appreciates the FTC's interest in examining the effect professional regulations (eg, certification, licensure, scope of practice, etc.) have on the competitive structure of the health care marketplace. As will be addressed below, the Academy supports limitations on the scope of practice of non-physician clinicians and opposes legislation that expands their scope of practice, including independent practice, hospital admitting privileges, and independent prescriptive authority. Furthermore, the pediatrician should serve as the leader of the pediatric health care team (<http://pediatrics.aappublications.org/content/131/6/1211.full.pdf+html?sid=096eb533-9802-439d-b43e-faea91548564>).

Recent FTC activities demonstrate its interest in opening up the market to a broader range of clinicians by easing up on professional regulations that restrict market entry. In fact, in recent years the FTC has frequently commented on state efforts to either expand, or restrict competition faced by doctors from advanced practice registered nurses ("APRNs"). The FTC's initiatives are part of its competition advocacy function; the FTC recognizes that harm to competition can result as effectively from legal restrictions as from private actions. The FTC has consistently argued against restrictions that exclude less costly consumer alternatives to doctors, lawyers, or other higher-priced professionals. In many instances, the FTC acknowledged that patient safety is the foremost concern, but cautioned that efforts to restrict services should be no stricter than needed to ensure patient safety.

The Academy seriously questions the FTC's stand that competition and patient safety are on equal planes. Patient safety is clearly primary. The concept of the medical home was first introduced to the health care field by the Academy in the 1960s. By its very nature, its design and function is to promote a systems approach to care that is benchmarked by quality and safety. The Academy believes that optimal pediatric health care depends on a team-based approach with supervision by a physician leader, preferably a pediatrician. Indeed, the Academy recognizes the valuable contributions of non-physician clinicians,

including nurse practitioners and physician assistants, in delivering optimal pediatric care and views them as integral members of the health care team.

In its policy statement “Scope of Practice Issues in the Delivery of Pediatric Health Care” (<http://pediatrics.aappublications.org/content/131/6/1211.full.pdf+html?sid=096eb533-9802-439d-b43e-faea91548564>), the Academy stresses its support for safe, quality care for all children and their families and believes that any health care professional who wishes to actively participate in the care of children must demonstrate appropriate education, training, skills, and ongoing competencies in pediatric health care within his or her scope of practice to ensure the highest standards of care. More importantly, as a direct result of their extensive training and experience, pediatricians possess the broad range of competencies required to best assess and manage health issues in children. Pediatric illness runs the gamut from basic to complex, from common behavioral disorders to rare metabolic and genetic diseases. In addition, diseases that present initially as a common condition, such as a cold, may sometimes progress to a severe and complex illness such as pneumonia or respiratory failure. The pediatrician is the clinician most extensively educated in pediatric health care and has the depth and breadth of knowledge, skills, and experience to deliver optimal care to children.

In terms of scope of practice and attempts to legislate changes to ease entry by non-physician clinicians, the Academy endorses the 2005 recommendations of the Federation of State Medical Boards (FSMB) regarding the approach to scope of practice legislation. A portion of the Federation of State Medical Boards statement follows:

“Changing or creating a new scope of practice for a health profession necessitates establishment of a legitimate need for the change, along with a systematic review of the impact of the proposed change on public health, safety, and welfare. Patient safety and public protection must be the primary objectives in making decisions on scope of practice. It is important for boards and legislatures to recognize that there are often significant differences in the prerequisites, the scope, and the duration of education provided to other health care practitioners when compared with that provided to physicians. Policy makers must ensure that all practitioners are prepared, by virtue of education and training, to provide the services authorized in their scope of practice in a safe, effective, and economical manner.”¹

The FSMB guidelines were designed to assist policy makers in assuring that all clinicians are prepared by virtue of education, training, and ongoing evaluation of competency to provide services authorized in their scopes of practice in a safe, effective, and cost-efficient manner.

In concluding its comments on this element of the FTC’s framework, the Academy would like to point out its opposition to the Institute of Medicine’s (IOM) “Future of Nursing”²

¹ Federation of State Medical Boards. Assessing scope of practice health care delivery: critical questions in assuring public access and safety. Available at: www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf Accessed April 26, 2014.

² The Institute of Medicine’s report, *The Future of Nursing: Leading Change, Advancing Health*, is available at www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx.

report which parallels FTC's questioning of current scope of practice laws and their effect on health care competition. The IOM report calls for removal of "scope of practice barriers" but fails to consider the safety implications of this. The authors of the IOM report wrongly infer that these barriers primarily exist to curb competition from non-physician clinicians and dismiss the foremost concern of pediatricians - the safety and well-being of their patients. Patient safety and quality of care should always be the system's primary considerations, followed closely by patient satisfaction and fiscal responsibility. Safety and quality should never fall victim to turf battles between members of the health care team.³ The Academy would like to stress that all health care, whether provided by pediatricians or other health care personnel and whether provided in pediatric medical homes or in other venue, should meet the same standards of quality and safety.

Innovations in Health Care Delivery

Why is innovation critical to the American Academy of Pediatrics? Although the future of pediatrics is uncertain, the organizations that lead pediatrics, and the professionals who practice within it, have embraced the notion that the pediatric community must anticipate and lead change to ultimately improve the health of children and adolescents. In an attempt to proactively prepare for a variety of conceivable futures, the American Academy of Pediatrics Board of Directors established the Vision of Pediatrics 2020 Task Force in 2008. This group was charged to think broadly about the future of pediatrics, to gather input on key trends that are influencing the future, to create likely scenarios of the future, and to recommend strategies to best prepare pediatric clinicians and pediatric organizations for a range of potential futures. <http://www2.aap.org/visionofped/> This idea flows through the Academy's responses to the FTC's perspective on innovations in health care delivery.

First and foremost, the Academy supports the growth and ongoing development of the patient-centered medical home. Within pediatrics, as in other primary care settings, community care has increasingly evolved into health care teams, often including staff who help coordinate care for children and youth with chronic conditions, co-located mental health providers, staff who can aid in identifying family service needs and connect them with community clinicians, and enhancing early childhood through home visiting and helping families develop strong skills in nurturing young children. The patient-centered medical home is a powerful idea capable of transforming the health care system and serving as the hub for continuous and realistic innovations in care delivery. These innovations particularly address important needs of children and families and the Academy urges the FTC to develop a deeper understanding and demonstrate its unconditional support of this transformation in health care delivery.

In the *Federal Register* notice, the FTC aptly points out that several new models of health care delivery, including retail clinics, have emerged in recent years, spurring additional

³ Pletcher BA, Rimsza, MA. Commentary. Academy voices concerns with IOM report on future of nursing. *AAP News* Published online December 8, 2010.

competition. The FTC believes that these models may offer significant cost savings while maintaining, or even improving, quality of care. In addition, FTC postulates that these models may increase the supply of health care services, which may expand access to care.

The AAP strongly disagrees with the FTC's assumption that retail based clinics may both result in savings to the health care system and advance quality of care. In its 2014 policy statement "AAP Principles Concerning Retail-Based Clinics" (<http://pediatrics.aappublications.org/content/133/3/e794.full.pdf+html?sid=e1ee2ff4-21e3-4aa6-8deb-2e104d621d57>) AAP stipulated that retail-based clinics (RBCs) are an inappropriate source of primary care for pediatric patients, as they fragment medical care and are detrimental to the medical home concept of longitudinal and coordinated care.

A commentary published in *Pediatrics* in 2007 stressed that the emergence of RBCs has created a conflict between relative priorities of continuity of care and those of convenience and cost.⁴ Continuity of care embraces 3 primary dimensions: time, accessibility, and setting. Fostering a setting in which a pediatrician cares for a patient over many years (time) with knowledge of not only the medical but developmental and emotional needs of a patient and family significantly affect care and outcomes in a positive manner. Accessibility refers to ensuring care by a pediatrician and team with 24/7 availability for prompt and expert care in an appropriate medical setting. The setting is the pediatric medical home, which involves effective coordination of care throughout various medical settings, including office, hospital, home, school, and specialty referrals.

The Academy urges the FTC to temper its perspective that retail-based clinics are an innovative pathway to improvements in quality care and increasing the supply of health care services, which may expand consumer access to care. : Demographic data to date do not indicate that expansion of RBCs has improved access to care in areas shown to have a shortage of primary care physicians.⁵ Also, RBCs caring for children challenge the medical home concept by offering care that is arguably more convenient and less expensive but also fragmented, episodic, and not coordinated: traits that pose a serious risk to quality care. Convenience is desirable but subtle changes in the clinical and social trajectory of childhood development requires the child be seen regularly with a continuous medical record so that early intervention can be implemented.

The Academy also would like to point out that treatment of children in urgent care facilities has become common in pediatric care. In its 2014 policy statement "Pediatric Care Recommendations for Freestanding Urgent Care Facilities" (<http://pediatrics.aappublications.org/content/early/2014/04/22/peds.2014-0569.full.pdf+html?sid=a2578dcf-21b1-4cc8-a920-c60ae991aa76>), the Academy states that well-managed freestanding urgent care facilities can improve the health of the children in their communities, integrate into the medical community, and provide a safe, effective adjunct to, but not a replacement for, the medical home or the emergency department.

⁴ Berman S. Continuity, the medical home, and retail-based clinics. *Pediatrics* 2007;120(5): 1123-25.

⁵ Pollack CE, Armstrong K. The geographic accessibility of retail clinics for underserved populations. *Archives of Internal Medicine* 2009;169(10): 945-949. Discussion 950-953

Second, the growing use of telemedicine provides opportunities and challenges. Telemedicine has the potential to expand access to the healthcare market. The AAP recognizes that the FTC could play a bigger role in advocating for a broader use of telemedicine by deeming interstate licensure restrictions as anti-competitive. To date, power has resided with states to bar out-of-state physicians from consulting patients through telemedicine, which uses telecommunications to connect patients with clinicians distances apart. However, telemedicine has the potential to bring more sophisticated care to underserved communities and rural and frontier regions of the country. There has been some research that demonstrates the utility of telemedicine in improving children's access to care in those communities where there is a recognized dearth of pediatric subspecialty care. The Academy urges caution in the widespread promotion of telemedicine; particularly given that competition for this service will be at the tertiary level of care where careful scrutiny of marketing of these services needs to occur – truth in advertising guidelines versus what could amount to inappropriate patient solicitation.

Advancements in Health Care Technology

The Academy is dedicated to ensuring that advancements in health care technology do not overlook the needs of children and families. There is a strong need to harness the potential of health care technology to improve child and adolescent health. The AAP launched the Child Health Informatics Center (CHIC) in 2009 to support and prepare pediatricians for the many changes that will be occurring over the next few years in regard to health information technology.

Recent advances in health care technology, particularly involving electronic health records (EHRs), can have competitive implications. In addition to EHRs, the FTC also itemized a need for additional information on health data exchanges and technology platforms for health care payers and providers, including the state of competition among hardware and software platforms.

Interoperability concerns are counteracting many of the potential benefits EHRs can bring in health care delivery. The silo nature of the vendor community works against the creation of a health care information environment that is designed to improve patient care and reduce costs. Presently, more than 700 vendors produce approximately 1,750 distinct certified EHR products. In a recent newsletter focusing on health care information technology, experts pointed out the following:

“Federal oversight of EHR vendors is largely unregulated. Notwithstanding industry growth, a small number of companies controlling much of the market have frustrated interoperability goals contemplated by Stage 2 meaningful use criteria. Providers argue that vendors do not have a vested interest to build interoperability into their systems. Many EHR vendors do not meet Stage 2 meaningful use criteria as written and are not motivated to do so. Vendor architectural requirements hamper and constrain their products. To the extent

that vendors offer solutions for data sharing, they offer and require all users to be on the same platform or they charge significant fees to interface nonconforming entities. Vendors often refuse to communicate solutions devised for other clients to common problems. Commercial contracts between providers and vendors often prohibit frank discussion about problems with a given system, even in published medical literature. Concern exists that public discussion of problems with EHR may lead to malpractice lawsuits against the healthcare provider and/or product liability lawsuits against vendors. Communications in this regard are not protected against use by the legal community at this time.”⁶

The Academy previously pointed out that the sharing of data needs to be incentivized. Providers are currently creating discharge documents or transition of care documents that are faxed or mailed and have been proven to be of little use. Providing hospitals and providers with payments for sharing data will create the incentive for health information exchange (HIE.)

Hospitals and organizations must be incentivized to share data. For example, providing “your” data for free to another organization could create a negative incentive, depending on the type of data and organization. A data-sending hospital will incur the cost for extracting, sending, and providing data to a data-receiving hospital, while the receiving hospital may save costs associated with labs/imaging that do not need to be repeated unnecessarily. Setting up a system where organizations can provide pertinent data and get paid for the effort is critical. The Academy recommends the FTC consult and work with other federal agencies, such as the Centers for Medicare and Medicaid Services (CMS) to identify an incentive model that covers the cost for both the sending and receiving hospital to use the data. It is important to acknowledge that the receipt of and storing of data - for example images - is not without cost and should also be incentivized. In addition to changing payment policy, a more standardized EHR data design is essential. A design that would provide standard vendor exchange tools that match up with existing EHR data elements and do not require customized reports is **essential** to facilitate exchange. Finally, It is also important for CMS and the ONC to consider the term interoperability as it relates to the transfer of the entire patient record (patient mobility). The federal government must search out more effective approaches to move interoperability and HIE beyond its current state since the transfer of limited data, or loss of data in transfer, or loss of data search-ability after transfer, are all critical aspects to the use of patient data for clinical and outcomes use and ultimately improving health care.

The FTC also expressed interest in learning more about various impediments that serve to bar useful flow of patient health information to improve health care coordination and quality. HIE currently has a fundamentally flawed incentive model. The Academy recognizes that financial incentives are essential in assuring the success of HIEs as we

⁶ Rupp S. The case for federal oversight of EHR vendors to promote interoperability and usability. Electronic Health Reporter. February 2014 Accessed April 2014: <http://electronichealthreporter.com/the-case-for-federal-oversight-of-ehr-vendors-to-promote-interoperability-and-usability/>

have seen a number of them fail in models where incentives were lacking. The reality is that data providers incur costs when providing information. Providers who could receive information may be dis-incentivized because it will cut down on testing and associated utilization of their ancillary services. Receiving data also requires processes and systems to accept, validate and review data which incur un-reimbursable costs. Unless data providers are incentivized to provide data and data recipients are incentivized to query for such data HIE will remain underutilized. To improve HIE, the FTC should work with other federal agencies to create policies on acceptable patient identification algorithms (what identifier combination is considered standard of care to match a patient to existing health data?) and work to promote data standards and exchange protocols. To address the burden of data correctness falling on clinicians, institutions, and the HIE, the federal government should consider policies and congress should sponsor legislation that provide hold harmless clauses for HIE participants.

Before offering its thoughts on the growing use of new technologies in managing patient care (eg, smart phones, tablets, and other wireless methods of acquiring patient data), the Academy urges the FTC to examine competitive approaches that would encourage EHR vendors to agree on common data sources and mechanisms of storage. This often results in fragmentation of data, frustrating the goals of the Health Information Technology for Economic and Clinical Health Act (“HITECH” Act). There are no standards for “big data” or enforcement of standardization that would improve the ability to manage patient populations.

One of the most pressing concerns the Academy would like to share with the FTC is the growing and potential misuse of the value of telehealth care by “virtual health care providers” that have the potential to harm the medical home. These virtual health care providers may be linked to RBCs, entrepreneurs, or health plans. Their business model is to provide health care services to patients via smart phone, laptop, or video consult kiosk without a prior physician-patient relationship, no prior medical history, no hands-on physical exam (other than what can be viewed and assessed via the technology). It appeals to consumers because it is faster, more convenient and more affordable than an office visit.

The Academy believes that quality telehealth can aid in increasing access to pediatric and pediatric specialty and subspecialty care to patients in underserved urban and rural areas, lessen the hardship on families of traveling to distant hospitals for needed services, diminish the demand for expensive medical transports, curtail unnecessary emergency department and hospital care—all this must be done in support of and in connection to the patient centered medical home—not in place of it. While the parent may find these services to be convenient, quick, and affordable, in reality, the trade-offs are continuity of care, quality of care, and patient safety. The Academy strongly urges the FTC to closely monitor the growth and use of virtual health care providers and the potential risk they pose to children’s health care quality.

It is important to stress that the Academy sees the value in the appropriate use of tested and valid mobile health technologies that provide information and guidance on diet,

exercise, and the management of chronic conditions, for example. However, it has concerns with the proliferation of virtual health providers that engage in patient care without having established a physician-patient relationship.

Furthermore, the Academy believes the FTC can play a role in researching the need for a federal policy framework that protects the privacy and security of information collected by telehealth technologies.

Measuring and Assessing Quality of Health Care

Valid and reliable approaches to measuring and assessing quality of children's health care are hallmarks of the Academy's education, research, and advocacy endeavors. Through its work with public and private organizations in creating and testing quality improvement measures and the establishment of networks of Chapters and practices to test and spread innovations in care, the Academy remains a stalwart in ensuring children are not forgotten in the health care system's drive to improve quality of care.

The FTC is seeking out information related to how quality of care affects competition and informs health care choices by patients, payers, providers, employers, and other health-care decision-makers. The Academy acknowledges that quality information is essential for a competitive marketplace and for consumers to make informed decisions on care. In comments made at the March 2014 FTC workshop where the issue of competition was the primary focus, one panelist stressed that an efficient marketplace provides transparent information on cost and quality, which requires a comprehensive understanding on accessibility of care, quality of service, safety of service and its reliability over time. The Academy concurs with this statement and offers the following set of observations FTC should factor into its thinking when evaluating the relationship between stimulating more aggressive competitive behavior in the health care market and evaluating its effect on advancements in quality care.

First, population health management is becoming increasingly important, particularly, with the advent and growth of accountable care organizations (ACOs). A central core of the ACO movement is a focus on the "Three-Part Aim": better care, healthy people and communities, and reduced cost of care. Evidence-based measures of quality are needed to support the implementation of the Three-Part Aim, and although a great deal of effort is expended to do so in the health care delivery realm, increased recognition of and action on non-clinical factors or conditions that influence health outcomes call for greater attention to measures related to the "healthy people and communities" component of the aim.⁷ To this end, the Academy supports the concept that the design and implementation of risk adjustment factors applied to quality measures should consider socioeconomic status and factors as well as other relevant patient and family characteristics/traits. The Academy offers this perspective given the FTC's question on whether quality metrics need to be risk-adjusted.

⁷ Institute of Medicine. *Toward Quality Measures for Population Health and the Leading Health Indicators*. Washington, DC: 2013

Second, the FTC also is searching for perspectives on how health care quality is measured and evaluated and the effectiveness of current measures. In its policy statement “Principles for the Development and Use of Quality Measures”

(<http://pediatrics.aappublications.org/content/121/2/411.full.pdf+html?sid=ca63920e-98c3-4dc2-a963-7de191d5a4a7>) the Academy recommends the following:

- Measures should be appropriate for children’s health. Any effort to measure quality should take into account the unique features of children’s health and health care and recognize the importance of development, dependency, demographics, and disparities. Measures must reflect the differential epidemiology in children as compared with adults and include patient and family participation.
- Measures should address what can be improved. Quality measures should focus on improvable issues that clinicians and health systems can influence.
- Measures should address important issues for children. Measures should address topics of substantial impact, whether defined by prevalence, severity, and/or functional status, and should be chosen for their potential influence on children’s health by addressing a significant gap between current and ideal practice. In addition, measures should enable an assessment of systematic disparities in the quality of care for vulnerable groups.

In addition, children, adolescents, and families play an important role in providing information about the quality of clinical care. Learning about their experiences of care and engaging in partnerships to improve care are essential for achieving the best outcomes. One way to achieve this engagement is by using measures that address factors important to families. Children’s health and outcomes reflect family and community variables, yet as noted earlier, there has been so little work in developing strong risk adjustment measures for children.⁸ In this context, the Academy supports population health approaches but they desperately need a strong and robust commitment of resources for measure development for child and adolescent health.

The Academy also would like to stress that there has been tremendous investment made in the creation of pediatric-specific quality measures; specifically, those measures created as part of the Child Health Improvement Program Reauthorization Act (CHIPRA) of 2009. These measures quantitate access to care, utilization of services, effectiveness of care, patient outcomes, and satisfaction of both patients and providers related to preventive, primary, acute, and chronic care for children. It is critical that these measures be tested well for use in both accountability and improvement efforts – a high priority in today’s health care system.

Furthermore, the Academy encourages the FTC to collaborate with other federal agencies and external organizations focusing on the development of quality measures, specifically the Academy, the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, the National Quality Forum, and the CHIPRA Pediatric

⁸ Kuhlthau K, Ferris T, Iezzoni L. Risk adjustment for pediatric quality indicators. *Pediatrics*.2004;113;210

Healthcare Quality Measures Centers of Excellence. These organizations can evaluate current quality and performance measures with a goal of recommending modifications or achieving consensus around new measures that pertain to pediatric patients, including children with special healthcare needs. These measures should align with the recommendations outlined in the AAP policy statement “Principles for the Development and Use of Quality Measures” (previously cited.)

Price Transparency of Health Care Services

Families are taking on greater responsibility for health care purchasing decisions. In this role, they need access to clear, readily accessible information to permit them to make wise and informed decisions.

The FTC postulates that price transparency may be used as a means to control costs while maintaining quality in the provision of health care services. It suggests that price transparency may enhance competition among health care providers or between different, potentially substitutable treatments, thereby leading to reduced prices for health care services and a more efficient allocation of health care resources. The FTC seeks to better understand the competitive implications of price transparency for health care services.

The Academy recognizes the value price transparency plays in helping to manage costs and to inform consumers’ health care decisions as they assume greater financial responsibility. Currently, data are available on physician and hospital costs that give consumers an elementary idea about the cost of a medical procedure. Although the Academy acknowledges that the health care system has made significant strides in publicly reporting data on provider performance and quality, it also stresses that purchasers, health plans, clinicians, and policy makers need to do more to help reliable price information flow freely, both overall and for specific services. However, the Academy echoes other health care experts that stress that converting these data into information patients can use is very difficult. A well-functioning child health system requires well-informed consumers to make rational choices, but many believe that the highly specialized nature of medical decision making, coupled with the profound information asymmetries and uncertainties that characterize these interactions, undermines the ability of market mechanisms to effectively function as expected.⁹ Certainly, urgent situations are not compatible with “careful shopping,” and the emotional distress accompanying acute illness often compromises rational decision making.¹⁰

In its 2014 policy statement “High-Deductible Health Plans” (<http://pediatrics.aappublications.org/content/early/2014/04/22/peds.2014-0555.full.pdf+html?sid=28490472-e4bb-4e46-abc7-8462ca2bf004>) where it itemizes its concerns with high-deductible health plans as a competitive alternative to traditional

⁹ Retchin SM. Overcoming information asymmetry in consumer-directed health care. *American Journal of Managed Care*. 2007;13(4): 173-176.

¹⁰ Loewenstein G Hot-cold empathy gaps and medical decision-making. *Health Psychology* 2005;24(4 suppl): S49-S56.

health insurance products (eg, PPOs, HMOs, etc.), the Academy stipulates that market mechanisms depend critically on price signals for consumers to be able to make market decisions, but few prices from clinicians, laboratories, or specialized and diagnostic services are publicly available online or even by request to the office. Indeed, prices negotiated between practices and health plans are confidential by the terms of the contract. In addition, the price of a visit is uncertain beforehand, because the level of the service rendered by the physician cannot be predicted. As the market continues to witness a proliferation of high-deductible health plans, the Academy strongly cautions that pricing data alone is insufficient to enable meaningful health care decisions.

To ensure consumers have full and unblemished access to health plan information to aid in their search for a quality health plan, the Academy recommends in its policy statement “Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults,” that all public entities should publish uniform data for health plans that offer consumers and purchasers the opportunity to evaluate and compare performance, including relevant financial information, among competing plans. The measures reported by states on a managed care plan’s performance should emphasize quality standards, such as access to care, patient satisfaction, and health outcomes along with price.

<http://pediatrics.aappublications.org/content/132/5/e1452.full>