

Supplemental Safeguards: Rules, Monitoring, and Accountability

Background

As discussed in preceding sections, a distinct feature of shared savings programs as compared to some other total cost of care payment methods (e.g. earlier forms of pure capitation) is the use of a balanced mix of incentives for providers. This mix includes continued use of fee-for-service payments and strong incentives to improve quality, along with incentives to manage total cost of care. Still, despite the balancing incentives inherent in these contracts, and even with the payment design safeguards recommended in this report above, Connecticut believes that supplemental safeguards are essential to ensure that these new contracting methods broadly benefit consumers and do not adversely affect at-risk groups.

While shared savings contracts have been rapidly adopted over the last three years, they are still relatively new. There is not yet a well-defined set of safeguards against under-service or patient selection that are considered to be best practice. However, payers and ACOs have adopted a number of approaches that provide relevant examples of safeguards that might be useful for the Equity and Access Council to consider. Any set of safeguards will contain three key elements:

- I. **Rules:** The guidelines that govern participation in a contract for all participants (e.g. payers, providers, ACOs)
- II. **Monitoring:** Methods for evaluating performance and/or identifying unwanted behaviors through the use of data and observation (i.e. claims data, clinical data, and patient feedback)
- III. **Accountability:** Methods through which results, including prevalence of non-compliance with rules, are made known to appropriate audiences; and an appropriate response occurs when undesired outcomes are identified

A framework for instituting safeguards along these lines requires some articulation of which entities will perform what functions. By way of background, a number of entities have historically played key roles in the delivery, financing, and oversight of high-quality healthcare in Connecticut:

- **Healthcare consumers, consumer advocates, researchers, and other members of the public** play a role in assessing the way that healthcare is delivered, highlighting barriers to access and high-quality care, and evaluating the impact on services due to changes in financing or regulatory methods.
- **Individual providers** are responsible for delivering the best patient care by following standards for the practice of medicine and their own clinical judgment.
- **Provider groups** create standards for member providers and measure and reward performance.
- **Health systems, hospitals, and other service delivery organizations** have an array of responsibilities under federal and state statute to maintain, monitor, and report on quality and other standards.
- **ACOs** establish governance and performance evaluation structures to drive high performance among their participating organizations and providers.
- **Payers** utilize contracts with providers and ACOs to establish rules for distribution of incentive payments, rules for obtaining reimbursement for valid services, and processes for handling disputes that may arise.

- **Employers** that use payers to administer self-insured plans play a role in determining features of payer-provider and payer-ACO contracts.
- **The State of Connecticut** plays several relevant roles:
 - **The Department of Health (DPH)** licenses providers, hospitals, and other organizations that deliver healthcare services. It also establishes and enforces rules about these entities' performance, and collects and publishes information for public consumption.
 - **The Connecticut Insurance Department (CID)** regulates several aspects of health insurance policies that are issued for sale in the state. It also licenses and sets rules related to companies that issue those policies.
 - **The Office of the Healthcare Advocate (OHA)** is an independent agency that helps commercially insured consumers access medically necessary services and educates consumers about their rights and responsibilities under health plans.
 - **Access Health CT** is Connecticut's health insurance marketplace. It approves insurance plans for participation on the exchange and engages consumers to encourage enrollment.
 - **The Connecticut All-Payer Claims Database (APCD)** is intended to be a consolidated repository of health insurance claims data that will allow for analysis in the interest of improving the way healthcare is delivered, utilized, and financed. It is established by law and overseen by Access Health CT. It is not operational as of this report's writing.
 - **The Department of Social Services (DSS)** is the single state agency for Medicaid in Connecticut. It contracts with **Community Health Network of Connecticut, Inc. (CHNCT)**, a not-for-profit corporation, to provide administrative services for the Medicaid program. In this section of the report, the term "payers" is meant to include DSS and CHNCT acting on behalf of DSS

CMS has created a basic framework for monitoring for under-service and patient selection in the MSSP, and holding ACOs accountable. An ACO that wants to participate in CMS MSSP agrees to follow the guidelines set forth in the final rule. Though the rule does not require ACOs to be certified or accredited to participate, it does establish limited guidelines for governance and legal structure that require ACOs to exercise oversight over its participating providers. The ACO governing body must have the "...authority to execute the functions of the ACO as defined in this final rule, including but not limited to, the definition of processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinating care" (CMS, CMS Shared Savings Program Final Rule, 2011). MSSP ACOs are required to report on quality, but not on other measures.

While MSSP does not require ACO accreditation, other CMS innovation demonstrations (e.g. CMS FQHC Advanced Primary Care Practice Demonstration, which required Level 3 Patient Centered Medical Home accreditation) do (CMS, Innovation Models, 2015). Accreditation standards often include detailed guidelines about reporting capabilities. In addition, accreditation for ACOs does exist. The National Council on Quality Assurance (NCQA) and URAC (formerly known as the Utilization Review Accreditation Commission) confer ACO accreditation that requires numerous capabilities that promote quality of care, of which several directly or indirectly support equitable and accessible care for patients. Among others, the requirements include: conducting performance monitoring geared toward population health management, requiring technology capabilities to report on performance results, enforcing clinical guidelines and protocols, and implementing advanced population management strategies. In addition,

the accreditation standards require ACOs to establish mechanisms to monitor for utilization – though, notably, they do not prescribe a specific method for doing so (NCQA, 2015; URAC, 2013).

Several concurrent (i.e. monitoring that is meant to identify the problem when it happens) and retrospective (i.e. monitoring that uses data to identify a behavior after it has occurred) methods used to monitor performance within the healthcare delivery system today – both within and outside the confines of shared savings programs – could be relevant for monitoring under-service and patient selection. A common method used to identify problems with the care experience or the provision of care is patient feedback, as demonstrated by the reliance on survey-generated measures such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for hospitals and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for healthcare providers more broadly (CMS, HCAHPS: Patients' Perspectives of Care Survey, 2015; AHRQ, 2015). Another manner of capturing patient feedback is through the use of patient advocacy services. CMS has done this through the creation of an Ombudsman Center. This center is responsible for assisting beneficiaries with grievances, taking ownership of the related casework, and conducting robust analyses on the complaints received in order to pinpoint systemic problems and recommend solutions (Ombudsman, 2013). In Connecticut, the Office of the Healthcare Advocate (OHA) serves a similar function as the CMS Ombudsman office.

When CMS began the MSSP initiative, resources within the Ombudsman office were dedicated specifically to respond to the needs of beneficiaries enrolled in an MSSP- ACO (CMS, CMS Shared Savings Program Final Rule, 2011). Mystery shopping is another method of evaluating service that is commonly used in healthcare and could help to identify instances of patient selection. Mystery shopping is when the shopper, in this case a patient, is secretly evaluating the entity from which they are receiving services, in this case the provider. In healthcare mystery shopping is often conducted at the point of entry to healthcare system. An individual posing as a patient will call to make an appointment and take notes about their experience and/or ask specific questions to obtain specific information. DSS runs a mystery shopper program study annually that assesses access to care by visit type (i.e., urgent visit, routine care, etc.) and the impact of insurance type on access to appointments.

Retrospective monitoring methods for under-service and patient selection predominately rely on analysis of claims data. The CMS MSSP final rule states that monitoring for potential instances of stinting on care or avoidance of at risk beneficiaries will be conducted and flagged for further investigation (CMS, CMS Shared Savings Program Final Rule, 2011). CMS has not publicized the methods used to monitor under-service or patient selection nor the outcomes to date, but the final rule suggests that changes in utilization could serve to identify stinting on care and the risk profile of an ACO over time could suggest avoidance of at risk beneficiaries. Even though to date there is very little outcomes data on whether or not monitoring utilization is in fact the best way to detect under-service, other providers and payers use utilization variation to detect both under and over service (Maheras & Cooper, 2015; Kelly, 2014; Hines, 2013).

CMS holds MSSP ACOs accountable for unwanted behaviors, which includes stinting on care and avoidance of at-risk beneficiaries. Violation of guidelines are addressed primarily through the use of a corrective action plan (CAP) and/or termination if the unwanted behaviors are not resolved or violations continue (CMS, CMS Shared Savings Program Final Rule, 2011). The Vermont Medicaid ACO program responds to the discovery of unwanted behaviors by engaging the ACO in a collaborative learning

process with other high-performing ACOs (Maheras & Cooper, 2015). Another way to promote accountability is through transparency. While CMS has not made metrics related to under-service or patient selection available publicly, quality performance and financial performance are made public. Transparency concerning quality in healthcare has played a large role in the movement to hold providers accountable for outcomes.

Discussion

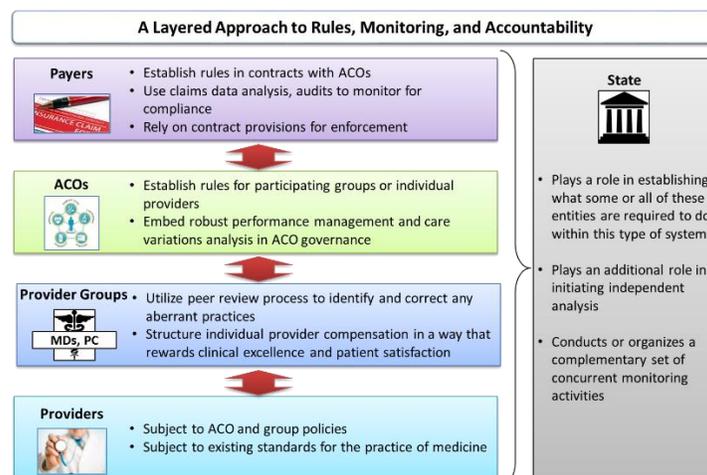
The Equity and Access Council’s charter includes three charges that motivate the recommendations contained in this report:

- I. Recommend “retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care”
- II. “...recommend a response to demonstrated patient selection and under-service”; and
- III. “...define the state’s plan to ensure that that at-risk and underserved populations benefit from the proposed reforms”

This report focuses in particular on items (I) and (II), and on safeguards other than analytic methods that might similarly limit patient selection and under-service. The recommendations above concerning shared savings payment design will enhance the extent to which Connecticut’s under-served populations benefit from payment reforms, but alone they are not sufficient to safeguard against under-service and patient selection. Recommendations for monitoring and accountability will complement the recommendations concerning payment design.

At this early stage in the adoption of shared savings contracts, their full impact – positive or negative – on under-service and patient selection is unknown. Accordingly, to ensure that the residents of Connecticut benefit from payment reform it will be imperative that new payment models are monitored for unwanted effects, and that the results of this monitoring are used in a way that holds ACOs and providers accountable if systemic or repeated under-service and/or patient selection are identified.

The EAC recommends a multi-layered approach to supplemental safeguards in which ACOs, payers, and state agencies each play a role in promoting continuous performance improvement and accountability for delivering high-quality care to Connecticut’s most at-risk and historically underserved groups.



The first layer of safeguards should be established at the ACO level. These safeguards can be initiated and memorialized via ACO agreements with participating groups and individual providers, and/or via ACO contracts with payers.

Recommendation #1: ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under-service and patient selection.

Recommendation #2: Over time, payers and/or the state should consider requiring that ACOs obtain accreditation (e.g. URAC or NCQA ACO accreditation). This might apply to all ACOs or only to ACOs that do not demonstrate capabilities via consistent performance on quality and other outcomes.

A second layer of safeguards should be established by payers in the form of monitoring claims data. As is the case with the CMS MSSP and Vermont's Medicaid ACOs, the payer can play a central role in monitoring for under-service and patient selection as it would monitor for over-service and fraud and abuse. Some monitoring methods can be employed by all payers across all populations. In other cases, understanding variations in utilization that are disease specific for diagnoses that raise particular under-service concerns will also be necessary.

Recommendation #3: Each payer that enters into shared savings contracts should monitor for under-service and patient selection on an annual basis using a set of analytic methods that it establishes. At a minimum, the standard under-service and patient selection monitoring performed by payers should include:

- a. Under-service should be monitored through utilization comparisons over time and between groups (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to assess total cost of care variations.
- b. Patient selection should be monitored by evaluating the change in risk adjustment of a population assigned to an ACO over time.
- c. For both under-service and patient selection, payers should identify populations that may be at particular risk (i.e. characterized by particular clinical conditions and/or socioeconomic attributes), and conduct population-specific analysis. For example, under-service should also be monitored by evaluating variations in utilization (i.e. of different interventions) by diagnosis where there is a specific under-service concern and well-established intervention guidelines. To be a more effective deterrent of under-service payers should not necessarily disclose to providers which diagnoses will be monitored.
- d. Claims data analysis should only be used as a first cut to flag potential under-service or patient selection. When potential under-service or patient selection are flagged, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or patient selection is likely to have occurred.

The use of concurrent monitoring will also serve an important role in detecting potential instances of under-service and patient selection. The SIM model test grant award explicitly describes and allocates

funding for a “nurse consultant” to play a key role in Connecticut’s concurrent monitoring framework (Administrators, 2014). Connecticut currently employs ombudsmen (nurse consultants) in the Office of the Healthcare Advocate (OHA) to respond to patient complaints and requests for assistance related to health insurance coverage. The work OHA does today to field complaints is not specific to patients enrolled in shared savings programs nor does it have a focus on detecting under-service or patient selection. While gathering and responding to patient concerns is undoubtedly beneficial, using this type of approach to detect under-service and patient selection will likely be difficult. Specifically, patients who have experienced under-service or patient selection will likely not be able to identify what they experienced as such, and without specific training a nurse consultant may not be able to recognize under-service or patient selection either.

For a nurse consultant role to contribute effectively to monitoring for under-service and patient selection, the role will require training and education and should be dedicated to fielding, responding, and analyzing concerns arising from patients who are receiving care through an ACO that is participating in a shared savings program as well as providing patients with education about what under-service and patient selection is.

Recommendation #4: A nurse consultant (i.e. ombudsman) will play a key role as a “hub” of information related to under-service and patient selection and act as a one-stop source of information for consumers. The nurse consultant should be dedicated to addressing under-service and patient selection concerns arising from shared savings and related value-based contracting programs. This role will be funded by the SIM initiative and be overseen by the Office of the Healthcare Advocate (OHA).

A set of recommended elements of the nurse consultant’s job description is contained in Appendix A.

Mystery shopping can serve as a more proactive approach to identifying instances of patient selection. Conducting mystery shopping in a similar manner to what CHNCT does on behalf of DSS today, assessing access to care by visit type and the impact of insurance type on appointment availability, would bring to light variations in access that are due to insurance, particular diagnoses, or socioeconomic factors. This activity has the potential to identify instances in which patient selection might be occurring at the point of entry into a medical practice and expanding it more broadly across payers will support the identification of patient selection.

Recommendation #5: Mystery shopping programs should be implemented by all payers to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to each payer population.

When instances of under-service or patient selection are detected and verified – via payer analysis, an ACO’s own analysis, consumer reporting to the State, or a combination of the above – a thorough, fair, and constructive process should be undertaken to correct the problems identified.

Recommendation #6: When a payer, via monitoring and follow up investigation, determines that an ACO or its member provider(s) have engaged in repeated or systematic under-service and/or patient selection, it should provide the ACO with a written finding of relevant facts. The ACO should have an opportunity to appeal any such finding. If the finding is verified, the payer should place the ACO on a corrective action plan (CAP) for a period of time during which

the ACO will not be eligible for receiving shared savings. If after the CAP period is complete, performance concerns are not addressed, the ACO may face termination from the shared savings program. The same process should apply if ACOs do not abide by required rules for participation in a shared savings program. A CAP should not be punitive, but rather supportive through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern.

The rules and monitoring recommended above are intended for implementation within a relatively short timeframe. However, in light of the relative paucity of accumulated experience to date with respect to outcomes of shared savings programs, in particular among certain patient populations, additional monitoring and evaluation should occur in the long-term. A more in depth assessment of shared savings programs after several years of experience will help to identify the extent to which these programs are ameliorating or aggravating equity and access problems, including under-service and patient selection.

Recommendation #7: After Connecticut gains more experience with shared savings contracting, an independent third party (non-payer, non-provider) should conduct a retrospective, multi-payer analysis of how value-based contracting is impacting service delivery. This analysis may rely on the all-payer claims database (APCD) and/or other sources of data. This analysis should be overseen by a committee of clinical and analytic experts who will use available data (i.e. claims data, patient feedback, clinical data) to evaluate the impact of shared savings contracts on healthcare delivery practices and outcomes. This will include patterns of under-service and patient selection. The analysis will seek to understand root causes and recommend adjustments to contracting methods and supplemental safeguards going forward. The goal of this more comprehensive analysis will be to identify and address any programmatic elements or unwanted ACO/provider behaviors not captured by initial recommended monitoring that are contributing to equity and access problems, in particular under-service and patient selection.

For the framework of safeguards above to be effective, a degree of transparency must be embedded at the appropriate places in the system. At a minimum, the public should have access to information about the rules under which shared savings contracts are being implemented, the monitoring for under-service and patient selection that is taking place, and the results of that monitoring. This will promote public confidence that contracting methods of this type are broadly benefiting Connecticut's residents and are not having undesired effects.

Recommendation #8: Entities involved in the use of shared savings contracts in Connecticut should report information in order to inform the public and allow for the effect of these contracts to be evaluated using an array of relevant data points. At a minimum, this should include:

- a. **Payers should publicly report on an annual basis: the names of the ACOs with which it has shared savings contracts, the number of lives attributed to each, a description of methods that it used during the prior year to monitor for under-service and patient selection, and a summary of the results of that monitoring which includes a statement describing any instances in which shared savings were withheld from an ACO.**

- b. OHA should publicly report on an annual basis a summary of the activities it undertook related to under-service and patient selection including: patient complaints received by the nurse consultant, cases referred to payers, ACOs, provider groups, and/or licensing authorities for further evaluation, and actions taken to initiate corrective actions.

Summary of Recommendations:

Recommendation #1: ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under-service and patient selection.

Recommendation #2: Over time, payers and/or the state should consider requiring that ACOs obtain accreditation (e.g. URAC or NCQA ACO accreditation). This might apply to all ACOs or only to ACOs that do not demonstrate capabilities via consistent performance on quality and other outcomes.

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- a. Under-service should be monitored through utilization comparisons over time and between groups (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to assess total cost of care variations.
- b. Patient selection should be monitored by evaluating the change in risk adjustment of a population assigned to an ACO over time.
- c. For both under-service and patient selection, payers should identify populations that may be at particular risk (i.e. characterized by particular clinical conditions and/or socioeconomic attributes), and conduct population-specific analysis. For example, under-service should also be monitored by evaluating variations in utilization (i.e. of different interventions) by diagnosis where there is a specific under-service concern and well-established intervention guidelines. To be a more effective deterrent of under-service payers should not necessarily disclose to providers which diagnoses will be monitored.
- d. Claims data analysis should only be used as a first cut to flag potential under-service or patient selection. When potential under-service or patient selection are flagged, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or patient selection is likely to have occurred.

Recommendation #4: A nurse consultant (i.e. ombudsman) will play a key role as a “hub” of information related to under-service and patient selection and act as a one-stop source of information for consumers. The nurse consultant should be dedicated to addressing under-service and patient selection concerns arising from shared savings and related value-based

contracting programs. This role will be funded by the SIM initiative and be overseen by the Office of the Healthcare Advocate (OHA).

Recommendation #5: Mystery shopping programs should be implemented by all payers to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to each payer population.

Recommendation #6: When a payer, via monitoring and follow up investigation, determines that an ACO or its member provider(s) have engaged in repeated or systematic under-service and/or patient selection, it should provide the ACO with a written finding of relevant facts. The ACO should have an opportunity to appeal any such finding. If the finding is verified, the payer should place the ACO on a corrective action plan (CAP) for a period of time during which the ACO will not be eligible for receiving shared savings. If after the CAP period is complete, performance concerns are not addressed, the ACO may face termination from the shared savings program. The same process should apply if ACOs do not abide by required rules for participation in a shared savings program. A CAP should not be punitive, but rather supportive through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern.

Recommendation #7: After Connecticut gains more experience with shared savings contracting, an independent third party (non-payer, non-provider) should conduct a retrospective, multi-payer analysis of how value-based contracting is impacting service delivery. This analysis may rely on the all-payer claims database (APCD) and/or other sources of data. This analysis should be overseen by a committee of clinical and analytic experts who will use available data (i.e. claims data, patient feedback, clinical data) to evaluate the impact of shared savings contracts on healthcare delivery practices and outcomes. This will include patterns of under-service and patient selection. The analysis will seek to understand root causes and recommend adjustments to contracting methods and supplemental safeguards going forward. The goal of this more comprehensive analysis will be to identify and address any programmatic elements or unwanted ACO/provider behaviors not captured by initial recommended monitoring that are contributing to equity and access problems, in particular under-service and patient selection.

Recommendation #8: Entities involved in the use of shared savings contracts in Connecticut should report information in order to inform the public and allow for the effect of these contracts to be evaluated using an array of relevant data points. At a minimum, this should include:

- a. Payers should publicly report on an annual basis: the names of the ACOs with which it has shared savings contracts, the number of lives attributed to each, a description of methods that it used during the prior year to monitor for under-service and patient selection, and a summary of the results of that monitoring which includes a statement describing any instances in which shared savings were withheld from an ACO.
- b. OHA should publicly report on an annual basis a summary of the activities it undertook related to under-service and patient selection including: patient complaints received by the nurse consultant, cases referred to payers, ACOs, provider groups,

and/or licensing authorities for further evaluation, and actions taken to initiate corrective actions.

Appendix A

OHA Nurse Consultant Job Description -DRAFT

The individual in this role should:

- Be dedicated to addressing under-service and patient selection.
- Proactively monitor utilization data produced from standard monitoring activities and patient grievances to identify trends that point to equity and access concerns and merit further investigation.
- Play a role as a patient educator, in particular as it relates to under-service, and to promote role as a trusted patient resource. This includes education to help patients understand why a concern that they have may not actually represent inappropriate care.
- Play a role as an educator to community health workers who frequently interact with vulnerable populations, providing them with tools to promote under-service education in their day to day interactions.
- Be responsible for communicating back to providers when patients voice grievances, even when there is no evidence of provider mistreatment. This can provide useful information for a provider about potential communication gaps at the practice level.
- Identify process to respond and further investigate under-service and patient selection concerns as they are flagged.
- Be trained to identify/flag under-service and patient selection from patient grievances.
- Be trained to analyze patterns of grievances in relation to utilization monitoring to identify/flag under-service and patient selection.

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