Provider Networks in the Medicare Advantage Program

by

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I. Introduction

Chairman Blumenthal and members of the committee, I am Stephanie Kanwit, principal at Kanwit Healthcare Consulting, and I am testifying today on behalf of America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. I previously served as Special Counsel to AHIP from 2004 until 2010, and prior to that was a partner in a Washington, D.C. firm specializing in health care law and head of Aetna's litigation department, based in Hartford. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

We appreciate this opportunity to testify on issues surrounding provider networks in the Medicare Advantage (MA) program, and strategies our members are employing in this area to hold down costs and improve value for their enrollees. In the MA program, health plans have a strong track record of offering high quality coverage options, with innovative programs and services to serve seniors and individuals with disabilities. One strategy that plans are pioneering involves the use of high-value provider networks. In recent years, health plans – initially in the commercial marketplace and more recently in MA – have implemented programs that encourage enrollees to obtain care from high-value providers that have demonstrated, based on performance metrics, their ability to deliver high-quality, cost-effective care. We appreciate the committee's interest in learning more about these innovative programs and other opportunities for improving patient care for MA enrollees.

Our testimony focuses on the following:

- Background information about the MA program, including its role as a safety net for over 14.5 million seniors and individuals with disabilities, the value MA plans deliver to beneficiaries, and the deep funding cuts that have been imposed on the MA program through recent legislative and regulatory changes that may negatively impact beneficiaries.

- The opportunity for high-value provider networks to preserve benefits and mitigate the cost impact on beneficiaries as the MA program faces a future of severe underfunding.

- The leadership role health plans are playing in advancing delivery system reforms.

II. Background on the Medicare Advantage Program

More than 14.5 million seniors and people with disabilities currently are enrolled in MA plans because they value the care coordination and disease management activities, improved quality of care, and innovative services and benefits that are available through these plans. These MA enrollees account for approximately 28 percent of the Medicare population.

MA Plans Provide Value to Beneficiaries

MA plans offer a different approach to health care delivery than beneficiaries experience under the Medicare fee-for-service (FFS) program. MA plans have developed systems of coordinated care for ensuring that beneficiaries receive health care services on a timely basis, while also emphasizing prevention and providing access to disease management services for their chronic conditions. These coordinated care systems provide for the seamless delivery of health care services across the continuum of care. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, manage chronic conditions, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious stage. MA plans also help to reduce emergency room visits for routine care, ensure prompt access to primary care physicians and specialists when care is needed, and promote communication among treating physicians about the various treatments and medications a patient needs.

The success of these strategies is evidenced by survey findings which show that MA enrollees are highly satisfied with the care they receive through their health plans. A February 2013 North Star Opinion Research survey found that 90 percent of beneficiaries are satisfied with their MA plans, 94 percent are satisfied with the quality of care they receive, and 90 percent are satisfied with the benefits they receive.[1]

Furthermore, a broad range of research findings consistently demonstrate that the innovative strategies adopted by MA plans translate into better health outcomes for enrollees:

[1] North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."

- A 2013 study published in *Health Affairs* found that MA plans' performance measures for breast cancer screening, diabetes care, and cholesterol testing were consistently better when compared to FFS Medicare. For example, in 2009 mammography screening rates were over 13 percent higher, eye tests for individuals with diabetes were 17 percent higher, and cholesterol screening rates for individuals with diabetes and cardiovascular disease were 7-9 percent higher in MA plans compared to FFS.[2]

- Data published in February 2012 in the *American Journal of Managed Care* indicated that the hospital readmission rate for MA enrollees was about 13 percent to 20 percent lower than for Medicare FFS enrollees.[3]

- A study published in the January 2012 edition of *Health Affairs* found that beneficiaries with diabetes in a MA special needs plan (SNP) had "seven percent more primary care physician office visits; nine percent lower hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare."[4]

- Research published in November 2010 in the *American Journal of Managed Care*, co-authored by researchers affiliated with The Brookings Institution and Harvard University Department of Economics, concluded that MA plans outperformed the Medicare FFS program in 9 out of 11 clinical quality measures.[5]

The value that MA enrollees receive through their plans also can be seen in the additional services and benefits that are offered by MA plans – but are not available in the Medicare FFS program. While these extra features vary from plan to plan, the following are specific examples of the additional services and benefits that many MA plans offer to improve enrollees' coverage

[2] Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. all. "Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare." *Health Affairs* 32. no. 1228-1235. July 2013.

[3] Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care*. February 2012. Vol. 18, no. 2, p. 96-104. This study was preceded by a series of working papers and reports published by AHIP's Center for Policy and Research. One earlier study based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27 percent lower in Medicare Advantage than in Medicare FFS among patients with at least one admission.

[4] Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients." *Health Affairs*. January 2012. Vol. 31, no. 1, p. 110-119.

[5] Brennan, Niall MPP & Shepard, Mark BA. "Comparing Quality of Care in the Medicare Program." *American Journal of Managed Care*, November 2010.Vol. 16 No. 11, p. 841-848.

and manage their overall health and well-being on an ongoing basis:

- Case management services;
- Disease management programs;
- Wellness and prevention programs;
- Coordinated care programs;
- Prescription drug management tools integrated with medical benefits;
- Tools and data collection to address disparities in care for minorities;
- Nurse help hotlines;
- Enhanced coverage of home infusion, personal care and durable medical equipment;
- Personal health records to offer beneficiaries greater control over their health information and to coordinate information better; and
- Vision, hearing, and dental benefits coordinated with medical services.

MA plans also protect beneficiaries from high out-of-pocket costs. In 2014, all MA plans offer an out-of-pocket maximum for beneficiary costs, and almost 60 percent of enrollees are in plans that have annual out-of-pocket maximums of $5,000 or less. These out-of-pocket maximums – which are not offered by the Medicare FFS program – help protect Medicare beneficiaries from catastrophic health care expenses that otherwise might pose a serious threat to their financial security. MA plans also help reduce out-of-pocket costs for enrollees by reducing premiums for Part B and Part D, and by limiting cost-sharing for Medicare-covered services, including primary care physician visits and inpatient hospital stays.

MA Has Strong Consumer Protections, Including Network Adequacy Standards

Another important feature of the MA program is that enrollees have strong consumer protections. This includes extensive network adequacy standards, established by the Centers for Medicare & Medicaid Services (CMS), which ensure that enrollees in MA plans have access to all provider types, including primary care physicians and specialists, within a reasonable time and distance. The agency works with MA plans when network changes are made to ensure that beneficiaries continue to have access to the benefits and services they need.

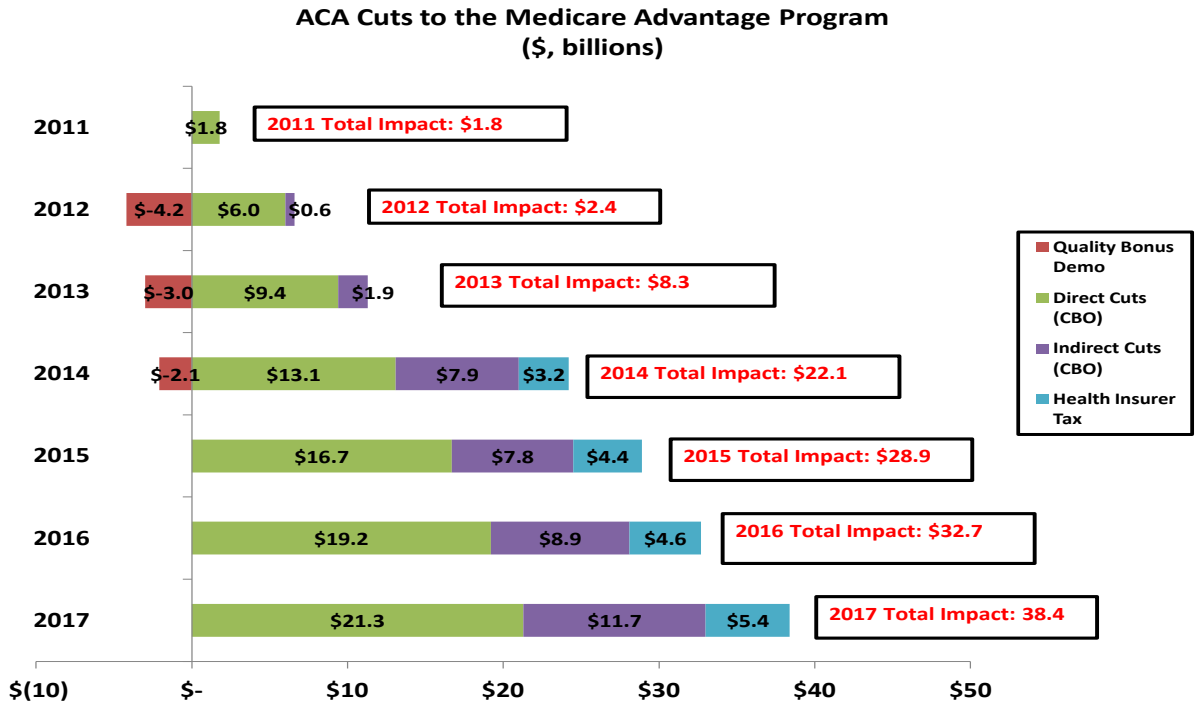
Additionally, coverage is "guaranteed issue" and MA plans offer coverage to all beneficiaries regardless of their age or health status, although Special Needs Plans (SNPs) enroll only vulnerable beneficiaries who meet certain criteria. All beneficiaries who choose an MA plan pay the same premium as all other plan enrollees. CMS performs annual reviews of MA plan benefit packages to ensure that they are appropriate to beneficiaries with all health conditions. In addition, nearly 90 percent of all MA enrollees are enrolled in MA plans that offer Part D prescription drug benefits, which allows beneficiaries to receive medical and prescription drug coverage from the same health plan – similar to how people receive coverage in the commercial market. MA plans typically re-design and reduce the cost sharing that applies under the Medicare FFS program. They may offer lower cost sharing as an additional benefit and typically eliminate deductibles and establish copayments rather than coinsurance.

Additional consumer protections provide that an MA enrollee who is not satisfied with a plan's decision about providing or paying for covered services may exercise appeal rights through an internal plan appeals process, as well as automatic external review if the plan's decision is not wholly in the beneficiary's favor. MA plans also comply with detailed requirements associated with CMS oversight activities that include operational and financial audits, evaluation of quality improvement projects, validation and evaluation of data on a broad spectrum of operational activities (e.g., customer service, resolution of appeals, and provider network adequacy), review and approval of plan marketing materials, and strong standards for the conduct of marketing activities.

The MA Program Faces a Future of Severe Underfunding for Enrollees' Benefits

While it is very clear that the MA program is highly valued by beneficiaries, we are deeply concerned that the program is facing a future of severe underfunding that jeopardizes the stability of these plans for the beneficiaries they serve.

The Affordable Care Act (ACA) imposes more than $200 billion in funding cuts on the Medicare Advantage program over a ten-year period. Through December 2013, only 10 percent of these cuts had gone into effect. Another 35 percent of the ACA funding cuts will be phased in between 2014 and 2016. MA enrollees are further impacted by the new ACA health insurance tax that went into effect on January 1, 2014. An actuarial study[6] by Oliver Wyman found that this will require MA plans to allocate an estimated $16 to $20 per enrollee per month in 2014 and $32 to $42 per enrollee per month by 2023 for the ACA health insurance tax, which is imposed on top of the ACA's significant funding cuts. The average expected increase in the cost of MA coverage as a result of the health insurance tax is estimated to be $3,590 per enrollee over ten years. This number represents a direct reduction in the resources that will be available to support the health care benefits of more than 14.5 million Medicare beneficiaries who value the improved quality of care, additional benefits, and innovative services their MA plans provide.



To further illustrate what these cuts mean for beneficiaries, the table below provides data estimating the combined impact of the ACA's funding cuts and the new health insurance tax on MA enrollees in Connecticut in 2015. These data show, for example, that the combined impact

[6] Oliver Wyman, *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans*, October 31, 2011.

will be an estimated $50 per member per month – or $600 for the entire year – for MA enrollees in five counties (Fairfield, Hartford, New Haven, New London, Windham). In Litchfield and Middlesex Counties, the combined impact is estimated to be $60 per member per month or $720 for the entire year. In Tolland County, the combined impact is estimated to be $70 per member per month or $840 for the entire year.

2015 Medicare Advantage: ACA's Estimated Impact Per Member Per Month

Methodology Notes:
• Enrollment data is based on analysis of December 2013 CMS enrollment data posted at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html?redirect=/MCRAdvPartDEnrolData/01_Overview.asp.
• Payment cut estimates are based on AHIP modeling. Assumes no changes in MA enrollment patterns and enrollment in 4-star and above plans increases to 55% nationwide by 2017. Incorporates growth rate assumptions based off the 2014 May CBO Baseline with growth rates of -.8% in 2015, +2.2% in 2016 and + 2.9% in 2017. Does not account for Regional PPOs. Estimates are rounded to the nearest 10th.
•Health Insurer Tax estimates are based upon findings in Oliver Wyman study, "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans" (October 31, 2011).

State	County	MA Enrollment	MA Penetration	Estimated 2015 PMPM Impact: ACA Payment Cuts	Estimated 2015 PMPM Impact: Health Insurer Tax Cuts	Estimated 2015 Total PMPM Impact (Payment Cuts + Health Insurer Tax Cuts)	Estimated Annual Impact (Payment Cuts + Health Insurer Tax Cuts)
Connecticut	Fairfield	30,901	22%	$20.00	$30.00	$50.00	$17 million
Connecticut	Hartford	41,742	26%	$20.00	$30.00	$50.00	$25 million
Connecticut	Litchfield	6,655	18%	$30.00	$30.00	$60.00	$4 million
Connecticut	Middlesex	7,059	22%	$30.00	$30.00	$60.00	$5 million
Connecticut	New Haven	40,415	27%	$20.00	$30.00	$50.00	$23 million
Connecticut	New London	8,005	16%	$20.00	$30.00	$50.00	$5 million
Connecticut	Tolland	5,616	24%	$40.00	$30.00	$70.00	$5 million
Connecticut	Windham	4,282	21%	$20.00	$30.00	$50.00	$3 million
State Total		144,675	24%				$87 million

In the face of these funding cuts, MA plans are working hard to maintain access to high-value benefits and services for their enrollees. However, in 2014, beneficiaries across the nation are beginning to experience the impact of these cuts in the form of higher out-of-pocket costs, fewer choices, and reduced benefits. Beneficiaries in over 2,000 counties across the country in which more than 60 percent of all MA enrollees live have fewer plan options today compared to 2013, and many enrollees are experiencing higher premiums and out-of-pocket costs.

Looking forward, we have serious concerns about the underfunding of the MA program and how this will harm beneficiaries – particularly vulnerable enrollees with complex needs and low incomes – as the ACA's cuts are phased in at an increasingly faster rate over the next several years. These concerns underscore the importance of maintaining the future viability of the MA program and avoiding any additional funding cuts through either the legislative or regulatory

process. We urge the committee and the entire Congress to focus instead on providing relief, before even deeper cuts begin to take effect in 2015, to avoid further disruptions in the choices and benefits of MA enrollees.

III. The Role of High-Value Provider Networks

As a direct result of the serious funding challenges facing the MA program, the need is greater today than ever before for innovations that deliver increased value to beneficiaries with the increasingly limited resources that are available to support the MA program. In response to this challenge, MA plans are working to preserve benefits and improve quality for enrollees by developing high-value provider networks at a time when the nation is transitioning toward a 21st century health care system and away from FFS payment systems. We urge the committee to view these efforts through this prism as you focus on these innovations.

Improving Quality and Efficiency Through High-Value Provider Networks

In the effort to advance delivery system reforms, one of the many areas in which health plans, including sponsors of MA plans, are making great strides is in the development of high-value provider networks. Health plans typically develop these networks using performance metrics – with a strong emphasis on quality criteria – to select high-performing, cost-effective providers. Using widely recognized, evidence-based measures of provider performance, such as those endorsed by the National Quality Forum (NQF), health plans can create select or tiered networks of providers comprised of clinicians and facilities that score well on measures of efficiency and quality.

A recent survey of health plans examined performance measures used by private payers and found that the performance measures used in high-value network and tiering programs most often focus on cardiovascular conditions, diabetes, preventive services, and patient safety. This study[7], authored by AHIP researchers and published by *Health Affairs* in August 2013, focused on data from 23 health plans and identified 546 distinct performance measures that plans are using in various payment and delivery models. Process, outcome, and utilization measures accounted for 80 percent of these performance measures. The study concluded that

[7] A. Higgins, "Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate," *Health Affairs* 32, no. 8 (2013).

policymakers and stakeholders who seek less variability in the use of performance measures to increase consistency should balance this goal with the need for flexibility to meet the needs of specific populations and promote innovation.

A central goal of high-value provider networks – including those offered by MA plans – is to improve both health care quality and efficiency through ongoing evaluation of provider performance, assessment of resource use, referrals to other high-performing providers, and the exchange of health information with the plan and other providers caring for the same patient. Private sector high-value networks also discourage enrollees from using poor quality providers and services that have been shown by evidence to be ineffective. Additionally, these strategies to move towards greater reliance on high-value networks may also be used by health plans to offer technical assistance to providers in organizing care, and provide physicians with other decision support tools and ongoing feedback on performance compared to peer groups.

Another key advantage of high-value provider networks is that they create strong incentives for providers to offer competitive prices, in response to the increased number of patients they gain as a member of the network. This, in turn, enables health plans to deliver substantial savings to their enrollees, in addition to connecting them to high-quality providers.

Research Findings on the Benefits of High-Value Provider Networks

A number of studies and research findings indicate that high-value provider networks are successful in encouraging consumers to take advantage of better-performing providers and facilities while helping to reduce spending. For example:

- One plan's program assesses providers across 21 specialties based on quality of care and cost efficiency, with the best-performing providers receiving a "Premium Two-Star" designation. This program yields an estimated average savings of 14 percent, with savings ranging from 7 percent to 19 percent depending on physician specialty.[8]

- Another plan's tiered provider network uses clinical performance and cost efficiency criteria to assess providers in 12 specialties and enables employers to set the level of incentives to

[8] UnitedHealthcare Insurance Company, UnitedHealth Premium Designation Program: FAQ for Employers (2011).

reward employee behavior. The plan reports that its high-value providers are 1 percent to 8 percent more cost-efficient relative to other providers within the network.[9]

- Recognizing in-network hospitals and selected specialties (general surgery, ob-gyn, cardiology, orthopedics, and gastroenterology) on quality, cost efficiency, and accessibility performance generated savings for one plan of up to 10 percent.[10]

- A study of a high-value network in California found that the use of provider tiers resulted in 20 percent lower health care costs and 20 percent higher quality.[11]

- In California, some of the largest employers – including the state employee program (CALPERS) – have offered a high-value plans option with premium savings of up to 25 percent over traditional broader network plans.[12]

- Health plans are also incorporating high-value and tiered networks as part of new innovations in care delivery and payment – including adoption of patient-centered medical homes and value-based insurance design. By combining multiple payment and benefit design strategies, these innovations are assuring greater value and efficiency in care delivery while promoting affordable coverage.[13]

IV. Other Health Plan Innovations in Delivery System Reform

In addition to advancing high-value provider networks, health plans – in both the commercial market and in public programs – have demonstrated leadership in implementing a broad range of delivery system reforms and new payment models.

[9] Institute of Medicine, *U.S. Roundtable on Evidence-Based Medicine* (Washington: National Academies Press, 2010).
[10] BlueCross BlueShield of North Carolina, *New BCBSNC Products Offer Cost Savings for Individuals and Employers* (Chapel Hill, NC: BlueCross BlueShield of North Carolina, December 12, 2012).
[11] R. Steinbrook, "The Cost of Admission – Tiered Copayments for Hospital Use," *New England Journal of Medicine* 350, no.25 (2004): 2,539-2,542.
[12] Duke Helfand. "A shift toward smaller health networks." *Los Angeles Times*; April 3, 2011.
[13] Joseph Burns. "Narrow Networks Found to Yield Substantial Savings." *Managed Care*; February 2012.

Partnering With Providers to Address Both Quality and Efficiency

Health plans are redesigning payment mechanisms to move away from the practice of rewarding volume through FFS payments and toward encouraging better outcomes and improved efficiency through accountable care organizations (ACOs), patient-centered medical homes, and bundled payments. In moving away from retroactive payment to a prospective design, these new models are built on accountability, shared risk, and population-based care.

AHIP has convened three invitational summits over the past two years bringing together health plans and their provider partners to discuss how they have restructured their payment contracts, key features of their programs, and the results they are seeing. While these initiatives are at various stages of development and implementation, we have observed two distinct features that are fundamental to the new models being launched across the country: (1) collaboration between health plans and their provider partners; and (2) both quality performance and cost reduction goals are being negotiated. This approach allows health plans to engage in meaningful population-based measurement and gives providers confidence that performance metrics are transparent and fair.

Another major development is that health plans are redesigning benefit structures at the same time they are changing payment mechanisms. These changes are designed to work synergistically to reward providers for achieving results, while also rewarding patients for making choices to use higher-performing hospitals and physicians and regularly obtaining services that are crucial for chronic care management. Strategies advancing either payment restructuring or benefit design cannot work optimally if they are working alone. To maximize results, they need to be aligned and coordinated, and health plans are in a unique position to make that happen.

In building new payment models, health plans are offering their provider partners more data, as well as decision-support tools. These data help physicians recognize gaps in care, such as which patients need comprehensive case management, which patients are most at risk of developing serious conditions, and which are in need of immunizations and preventive care.

From our research, we have noted several characteristics that are present in today's plan-provider collaborative models that are yielding promising results. Buy-in for these new arrangements must start with leadership. Clinical integration, a culture of initiating change, a robust health information technology infrastructure, and acceptance of new payment arrangements are all key

criteria.[14] In addition, a relationship of three or more years is critical to achieving efficiencies among all partners.

Preliminary data suggest that new private sector ACO models are off to a strong start, with initial quality improvements of approximately 10 percent, a 15 percent decrease in hospital readmissions and total inpatient days, and an initial annual savings of $336 per patient.[15]

Plans also are moving to budget-based methodologies in their provider contracts.[16,17] This approach combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments tied to nationally accepted measures of quality, effectiveness, and patient experience. Other developments in the market today involve the creation and implementation of non-financial infrastructure and support systems. Plans have introduced an array of programs designed to support physicians with patient-centered medical homes, providing access to skilled care coordinators, improved data sharing, and reporting among participating practices.[18,19]

Patient engagement and consumer transparency tools are important complements to enhanced provider partnerships. Health plans are working closely with patients on an array of programs that help increase medication compliance, promote rewards for seeking health appraisals and meeting personal goals, and provide low-cost or no-cost coverage for certain preventive and other high-value benefits. Health plans also are making information about premiums, cost-sharing, and deductibles available in readily understood, web-based formats.

Innovations in value-based insurance design (VBID) have been developed to help improve health – encouraging individuals who are healthy to stay healthy, and encouraging individuals with certain risk factors, and/or those with chronic conditions, to seek treatment. A key component of these strategies is a health-risk assessment (HRA) tool, along with administrative data to help

[14] Ellis P, Sandy LG, Larson AJ, Stevens SL. Wide variation in episode costs within a commercially insured population highlights potential to improve the efficiency of care. *Health Affairs* (Millwood). 2012;31(9): 2084-2093.
[15] Higgins A, Stewart K, Dawson K, Bocchino C. Early lessons from accountable care models in the private sector: partnerships between health plans and providers. *Health Affairs* (Millwood). 2011;30(9):1718-1727.
[16] Song Z, Safran DG, Landon BE, et al. The 'Alternative Quality Contract,' based on a global budget, lowered medical spending and improved quality. *Health Affairs* (Millwood). 2012;31(8):1885-1894.
[17] Markovich P. A global budget pilot project among provider partners and Blue Shield of California led to savings in first two years. *Health Affairs* (Millwood). 2012;31(9):1969-1976.
[18] Patel UB, Rathjen C, Rubin E. Horizon's patient-centered medical home program shows practices need much more than payment changes to transform. *Health Affairs* (Millwood). 2012;31(9):2018-2027.
[19] Raskas RS, Latts LM, Hummel JR, Wenners D, Levine H, Nussbaum SR. Early results show WellPoint's patient-centered medical home pilots have met some goals for costs, utilization, and quality. *Health Affairs* (Millwood). 2012;31(9):2002-2009.

plans identify individuals at risk and provide customized action plans. Indeed, data from a number of sources show that these programs are helping to increase drug therapy compliance among chronically ill patients[20] and producing non-medical benefits, including increased productivity among the working-age population, and reduced absenteeism.[21] Another important step has been the development of culturally competent care plans that bring together the patient, the patient's family and/or caregivers, and a team of providers and experts to coordinate medical care and necessary home and community-based services.[22,23]

V. Conclusion

Thank you for considering our views on these critically important issues. We look forward to continuing to work with committee members to strengthen and preserve high quality, affordable health plan choices through the MA program, while ensuring – as essential steps toward achieving this goal – that funding for the MA program is stabilized and that MA plans have the flexibility to advance high-value provider networks and other innovations that promote quality and efficiency for Medicare beneficiaries.

Additionally, our members are fully committed to continuing to play a leadership role in advancing delivery system reforms that improve health care quality and efficiency for Medicare beneficiaries and the broader U.S. population.

[20] Chernew ME, Juster IA, Shah M, et al. Evidence that value-based insurance can be effective. *Health Affairs* (Millwood). 2010;29(3):530-536.
[21] Fendrick AM. Value-based Insurance Design Landscape Digest. National Pharmaceutical Council. July 2009.
[22] Gazmararian J, Carreón R, Olson N, Lardy B. Exploring health plan perspectives in collecting and using data on race, ethnicity, and language. *American Journal of Managed Care*. 2012;18(7):e254-e261.
[23] Claffey TF, Agostini JV, Collet EN, Reisman L, Krakauer R. Payer provider collaboration in accountable care reduced use and improved quality in Maine Medicare Advantage plan. *Health Affairs* (Millwood). 2012;31(9):2074-2083.