

Key Attributes of High-Performing Integrated Health Plans for Medicare-Medicaid Enrollees

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FOREWORD

States and the federal government are partnering to better integrate medical, behavioral, and long-term services and supports (LTSS) for individuals dually eligible for Medicare and Medicaid. The success of both the financial alignment demonstrations that serve Medicare-Medicaid enrollees through managed care delivery systems and the efforts to align Medicare and Medicaid services via Dual Eligible Special Needs Plans (D-SNPs) depends on having high-performing health plans with expertise serving the unique and diverse needs of this population.

Recognizing this need, The Commonwealth Fund supported the creation of PRIDE (PRomoting Integrated Care for Dual Eligibles) to identify strategies used by integrated health plans that provide high-quality and cost-effective care to Medicare-Medicaid enrollees. Launched in 2012 by the VNSNY Research Center, PRIDE is now managed by the Center for Health Care Strategies.

This brief by Penny Hollander Feldman of the VNSNY Research Center introduces a framework of key attributes necessary for high-performing health plans to support integrated care. While the framework is intended as a *guide* rather than a set of formal criteria for evaluating plans, it is a valuable tool for thinking about health plan capacity. We are indebted to VNSNY's early work in shaping the project and developing the framework.

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Over 10 million people in the United States are dually eligible for Medicare and Medicaid (also known as Medicare-Medicaid enrollees or "dual eligibles").¹ These individuals are more likely to have multiple chronic conditions and disabilities requiring complex care than those covered by Medicare alone.² Frailty, mental illness, and homelessness may compound their health challenges. Because they are served by two separate programs covering different benefits and services, dual eligibles are more likely to experience fragmented, inefficient care.

The Centers for Medicare & Medicaid Services (CMS), through its Medicare-Medicaid Coordination Office (MMCO) is working with states to test innovative models that integrate Medicare and Medicaid to improve care and reduce costs for the high-need, dual eligible population.³ One of the pathways to integration supported by MMCO is a capitated model in which health plans provide comprehensive, integrated Medicare and Medicaid services.^{4,5} This model relies on health plans that have the commitment and capacity to serve this high-need population.

To increase the number of high-performing health plans, The Commonwealth Fund supported the creation of PRIDE (PRomoting Integrated Care for Dual Eligibles). PRIDE is a consortium of seven integrated health care organizations brought together to advance strategies for providing high-quality and cost-effective care for dual eligibles. This brief describes a framework outlining the attributes of

high-performing health plans developed through the PRIDE project. The framework can help guide states and health plans in defining essential elements for high-performing integrated health plans that serve Medicare-Medicaid enrollees.

The PRIDE Project

Through Commonwealth Fund support, PRIDE was launched in 2012 by the VNSNY Research Center. One of the first project tasks was to define the characteristics of a high-performing health plan. When a search of the literature turned up scant information, the project staff developed their own framework, drawing on available literature, the input of experts and advocates, and advice from a National Advisory Group convened for one year to develop and launch the PRIDE initiative (Exhibit 1).⁶

The available literature and expert opinion emphasized that a cornerstone of high-quality integrated care for people with medical, behavioral, and long-term services and supports (LTSS) needs is a *dynamic person/family-centered plan of care built on significant individual/caregiver involvement and comprehensive assessments and reassessments over time to capture changes in people’s circumstances and preferences.*⁷⁻¹⁰ Other key ingredients consistently identified were:

1. *A multi-disciplinary care team* with one accountable care coordinator;
2. *A comprehensive provider network* with a strong primary care base and a range of other providers and services that can accommodate diverse needs throughout a lifetime;
3. *Robust LTSS options*, with a bias toward home- and community-based services (HCBS);
4. *Effective information exchange* across organizational silos, multiple providers, and diverse individuals and their caregivers;
5. *Clear performance metrics* with rigorous monitoring and quality improvement; and
6. *Financial incentives* aligned across service providers that reward high performance consistent with the “Triple Aim”¹¹ – improving population care, improving the patient experience, and reducing cost.

EXHIBIT 1: PRIDE National Advisory Group Membership

MEMBER NAME	ORGANIZATION
Sophia Chang	California HealthCare Foundation
Tim Engelhardt	CMS Medicare and Medicaid Coordination Office
Richard G. Frank	Harvard Medical School, Department of Health Care Policy
Mary Kennedy	Association for Community Affiliated Plans
Mary Jane Koren	The Commonwealth Fund*
Alice Lind	Center for Health Care Strategies*
Barbara Lyons	Kaiser Commission on Medicaid and the Uninsured
Renee Markus Hodin	Community Catalyst
Sandy Markwood	National Association of Area Agencies on Aging
Kevin Prindiville	National Senior Citizens Law Center
Lisa R. Shugarman	The SCAN Foundation
James Toews	Administration for Community Living (HHS)
Alan Weil	National Academy for State Health Policy*

*Organizational affiliation has changed since the National Advisory Group was convened.

Attributes Framework

Based on the key ingredients identified, the project team developed a framework defining the attributes of high-performing integrated plans. The tool was refined with input from PRIDE's National Advisory Group, along with state and federal policy experts, providers, and public advocates. The resulting framework describes attributes of health plan performance across five broad domains, each with multiple dimensions (Exhibit 2). Following are some of attributes of high-performing plans in the five domains (see the Appendix, page 7, for the complete framework listing all attributes).

Domain I: Leadership and Organizational Culture. The culture of the health plan should reflect a commitment to integrated care. This starts with the senior managers who should be champions of integrated care providing the resources necessary to support high-quality, person- and family-centered care. The front-line clinical staff and direct care workers should be engaged as contributors to and ambassadors of organizational mission and goals. The health plan should be committed to integrating medical services, mental and behavioral health services, and LTSS. Importantly, there should be clear accountability and emphasis on continuous quality improvement.

Domain II: Infrastructure to “Scale Up” and “Stretch Out While Maintaining Quality and Value. To provide integrated care on a larger scale, a health plan should have sufficient capacity. Starting at the top, the senior management should have the requisite knowledge and experience to envision and implement both scaling up operations and expanding services, networks, and/or geographical range. The plan should be able to manage financial risk and have access to capital to make investments in necessary infrastructure. Quality management should keep ahead of organizational change to ensure that performance does not lag during expansion. The plan should have quality improvement mechanisms and staff development resources to sustain and spread best practices. Additionally, there needs to be robust information technology to support risk management, care coordination, and quality and performance improvement. Finally, the plan should have effective procedures to develop and sustain positive relationships with consumers and members, network providers, government entities, and local communities.

Domain III: Financial and Nonfinancial Incentives and Related Mechanisms that Align Plan, Provider, and Member Interests. The plan's payments and related financial incentives should be structured to improve key performance indicators, integrate services, and manage costs within and across network providers. For example, the plan could use alternative payment arrangements such as global capitation that crosses service silos and allows/requires reinvestment of savings in new benefits or new services for members. Similarly, the plan should use non-financial incentives, for example, communications and information feedback strategies to improve alignment of plan, provider, and member interests to pursue fully integrated care. The plan should use both data metrics and monitoring to inform its contracting and incentive systems. Provider contracting should reflect the needs of the plan's population.

Domain IV: Coordinated Care Provided through Comprehensive, Accessible Networks and Person/Family-Centered Care Planning. Depending on the type of plan, the network should cover the spectrum from primary, preventive and acute services through transitional care; chronic illness management; LTSS; mental and behavioral health services; palliative care; and end of life/hospice care.

EXHIBIT 2: Overview of High-Performing Integrated Health Plan Domains

DOMAIN	DIMENSIONS
Leadership and Organizational Culture	<ul style="list-style-type: none"> • Visible, dynamic, stable leadership and widely shared mission and goals • Commitment to integration • Accountability and emphasis on continuous improvement
Infrastructure to “Scale Up” and “Stretch Out” while Maintaining Quality and Value	<ul style="list-style-type: none"> • Management depth and breadth • Quality apparatus and staff development resources to sustain and spread best practices • Information technology to support communications, analytics, and ready data access • Financial resources to support growth • Capacity to develop and sustain positive relationships with consumers and members, network providers, government entities and local communities
Financial and Nonfinancial Incentives and Related Mechanisms to Align Plan, Provider, and Member Interests	<ul style="list-style-type: none"> • Payment and related financial incentives to improve key performance indicators (including quality of care and quality of life), integrate services, and manage costs • Non-financial incentives to improve alignment of plan, provider and member interests to pursue fully integrated care • Experience in network and provider selection
Coordinated Care Provided through Comprehensive, Accessible Networks and Person/Family Centered Care Planning and Coordination	<ul style="list-style-type: none"> • Network comprehensiveness and accessibility • Network cohesiveness • Effective care coordination • Commitment to reducing health disparities
Capacity to Attract and Retain Members, Expand Enrollment, and Increase Retention	<ul style="list-style-type: none"> • Strong member outreach mechanisms, consumer friendly member services (e.g., call systems), and availability of patient navigators, advocates, ombudsmen • Record of low disenrollment and high member retention • Regular, reliable surveys (through CAHPS or other surveys) to assess members’ experiences with programs, services and providers and robust mechanisms for understanding and acting on the results of those surveys to improve members’ reported experiences • Record of successful strategic growth • Capacity to successfully engage in and manage relations/relationships among multiple consumer/member advocacy groups, including members and families • Meaningful consumer role in governance and oversight

Providers should be geographically and physically accessible to a diverse membership with different needs. The plan should provide effective care coordination based on ongoing assessments of member/family needs and preferences. The care managers should use appropriate collaborative mechanisms and communication strategies based on members' risk levels and individual needs. In addition, the care managers should have well-defined competencies and appropriate training in techniques for patient engagement, coaching, and self-management support. The plan's information system should accommodate real time access to care plan information and allow for communication among various providers.

Domain V: Capacity to Attract and Retain Members, Expand Enrollment, and Increase Retention. The plan should have strong member outreach mechanisms, consumer-friendly member services (e.g., call systems), and sufficient numbers of patient navigators, advocates, and ombudsmen to assist members. There should be a high member retention rate, and the plan should use regular, reliable surveys (e.g., CAHPS) to assess members' experiences with programs, services, and providers. The plan should have developed mechanisms to engage and manage relationships with multiple stakeholder groups. Consumers should have a role in plan governance and oversight.

Because very few plans have accumulated experience or achieved excellence in all five framework domains, the attributes listed above should be viewed as *aspirational* rather than as defining characteristics of currently operating plans. Moreover, uniform national measures and data are lacking for most domains. Thus the framework is intended as a *guide* rather than a set of formal criteria for judging plans that are seeking to scale capacity to offer patient/family-centered integrated care for dually eligible beneficiaries.

The PRIDE Consortium

The Attributes Framework described above is being “put to the test” by the PRIDE consortium, first as a tool to support plan recruitment and now, as PRIDE consortium members are identifying innovative approaches to advance quality and cost-effective care for dual eligibles while serving more members. To select organizations to participate in PRIDE, the PRIDE project team focused on community- and provider-based health plans in states seeking to integrate care for dual eligible beneficiaries. The project team specifically sought plans with strengths in the attribute framework domains. Ultimately, seven organizations were selected:

- [CareSource](#) (Ohio)
- [Commonwealth Care Alliance](#) (Massachusetts)
- [Health Plan of San Mateo](#) (California)
- [iCare](#) (Wisconsin)
- [Together4Health](#) (Illinois)
- [UCare](#) (Minnesota)
- [VNSNY CHOICE](#) (New York)

Through PRIDE, these organizations are: (1) sharing their key challenges and success factors; (2) further defining the characteristics of high-performing plans; and (3) testing new approaches to better serve Medicare-Medicaid enrollees. PRIDE consortium members are exploring key issues for achieving high-functioning integrated models such as fostering person-centered care; building provider networks; and scaling-up models while maintaining high-touch care.

Potential Challenges

Though the PRIDE consortium members are organizationally and geographically diverse, they have identified many common challenges that may be a barrier to achieving the vision outlined in the attributes framework. For example, plans with expertise serving one segment of the dually eligible population (e.g., the frail elderly) will need to develop the capacity to serve other populations (e.g., individuals with mental health or substance use disorder treatment needs). Similarly, health plans will need to develop mechanisms to promote communication and coordination across different types of providers in their networks (e.g., medical, behavioral health, LTSS).

The PRIDE consortium members have found that information systems are vital – both for care management and for quality/performance measurement. Shared data is the lynchpin that holds the parts of truly integrated care systems together; yet information exchange is perhaps one of the most difficult hurdles for plans to surmount. While several PRIDE members have shared innovative strategies for securing data from local hospitals, all face obstacles to obtaining timely information from health information technology-poor LTSS providers – a challenge they are working on both individually and collectively.

In addition, health plans must ensure that the payments they receive are allocated to fully cover the amount and quality of care needed by dually eligible members who are among the sickest and neediest beneficiaries. Plans must find incentives that will encourage the provision of coordinated care in the least restrictive setting.

Finally, questions abound regarding how quality of care for dual eligibles will be defined, measured, and rewarded. Health plans, along with other healthcare sectors (e.g. hospitals, nursing homes, home health agencies) are already subject to federal and state standards and quality measures – measures that do not align with one another now. Moreover, many of the existing, validated measures are not sensitive to the unique needs of dual eligibles and must be modified, amplified, and/or better targeted to make them more applicable.¹² The PRIDE consortium members are working together to address these and other challenges that arise to ensure quality, patient-centered care for dual eligible enrollees.

Conclusion

In 2012, only about 160,000 dual eligibles were enrolled in integrated and coordinated systems,¹³ but through the federal Financial Alignment Initiative this number will grow. Regional, not-for-profit plans will need to become larger players in their marketplaces to support increased enrollment of dual eligibles, while maintaining fidelity to their core missions as community-based organizations providing person/family-centered quality care.

As health plans enter (or contemplate entering) the dual eligible market, they can use the Attributes Framework to assess their readiness to build capacity; identify their strengths and weaknesses; and develop action plans. The experiences of the PRIDE consortium members will be instructive to states and plans entering this arena, developers of quality measures, and CMS as it progresses in its financial alignment efforts.

APPENDIX: Framework of High-Performing Integrated Health Plan Attributes

Domain I: Leadership and Organizational Culture

Visible, dynamic, stable leadership and widely shared mission and goals

- CEO, backed by the organization’s Board of Directors, is the most prominent champion of dual integration initiative.
- CEO has marshaled the necessary resources to support his/her commitment to high quality, person- and family-centered integrated services.
- Other vocal champions include senior management and empowered leaders in medical, mental, behavioral and long-term support services across the organization.
- Front-line clinical staff and direct care workers are engaged as contributors to and ambassadors of organizational mission and goals.

Commitment to integration

- Medicare Advantage Plans, broad Medicaid plans and specialized plans (e.g., for people with disabilities) show commitment to integrating LTSS into routine medical services as evidenced by service delivery model, coordination mechanisms and related resource allocation.
- Managed long-term care plans show commitment to integrating medical services into LTSS as evidenced by service delivery model, coordination mechanisms and related resource allocation.
- All types have concrete plans to provide ready access to mental and behavioral health services and supports to meet population and individual needs.

Accountability and emphasis on continuous improvement

- Organizational strategy (programmatic and individual objectives, targets, strategies and milestones) embodies key elements of person- and family-centered integrated care.
- Clear metrics track progress toward targets and milestones, and are reinforced by incentive systems (e.g., bonuses, “holdbacks” etc.).
- Work processes, tools and continuous improvement mechanisms support achievement of goals, strategies and milestones.
- History of successful clinical and programmatic performance and innovation demonstrates capacity to expand scope and achieve excellence.

Domain II: Infrastructure to “Scale Up” and “Stretch Out” while Maintaining Quality and Value

Management depth and breadth

- Senior leaders (e.g., CFO or COO) have insurance industry or substantial risk-based payment experience and access to appropriate outside expertise.
- Throughout the enterprise managers and responsible staff have appropriate experience – or mechanisms to tap appropriate experience – with member populations (e.g., older persons, people with mental or behavior health problems, people with disabilities, ethnic/cultural subgroups), services and supports.
- Plan has an established mechanism for identifying and contracting with outside experts to complement the skills and experience of internal management.
- Plan has demonstrated successful experience with managing change to expand services, networks and/or geographical range.

Quality apparatus and staff development resources to sustain and spread best practices

- Commitment to implementing and disseminating best practices throughout the plan and the network/s is demonstrated by formal staff development, education and training programs, and/or regular use of outside experts with focus on building plan-wide competencies and best practices.
- Plan demonstrates high performance in key quality indicators applicable to specialized member populations/services – both publicly reported and plan-specific indicators, including member-reported quality of life, quality of service, and quality of care.
- Plan has robust mechanisms – and requires network/s to have such mechanisms – for acting on results of quality studies, including formal measures and complaints/grievances.

Information technology supports communications, analytics, and ready data access

- Plan demonstrates commitment to and experience with health information exchange (preferably electronic) to facilitate coordination and quality.
- Strong informatics function exists to analyze and feedback data for program planning, performance improvement and individual care planning.
- Plan uses data for provider accountability and motivation (e.g., targets, “report cards,” etc.).
- Plan provides or shows intent to provide member access to provider performance measures, members’ personal records, and care plans.

Financial resources to support growth

- Systems and capacity exist to manage risk.
- Reserves and/or access to outside capital are present for investments in necessary infrastructure.
- Plan has successful prior experience with internal and/or external financing of significant programmatic or geographical expansion.

Capacity to develop and sustain positive relationships with consumers and members, network providers, government entities and local communities

- Plan has successful experience with: (1) Consumer role in governance/oversight; (2) Engaging local communities, both anticipating and responding to community needs and concerns; (3) Government contracting and compliance; and (4) Network contracting with strong network oversight.
- Plan has effective mechanisms for governmental relations, public/community affairs.

Domain III: Financial and Nonfinancial Incentives and Related Mechanisms Align Plan, Provider, and Member Interests

Payment and related financial incentives to improve key performance indicators (including quality of care and quality of life), integrate services, and manage costs

- Payment that promotes primary care continuity and capacity to coordinate care (e.g., through Medical Homes, Health Homes and other innovative primary care and care management models), effective chronic illness management and preventive services.
- Payment that promotes/rewards effective use and integration of mental and behavioral health and LTSS.
- Alternative payment arrangements such as ACO or global capitation that cross service silos and allow/require reinvestment of savings in new benefits or new services for members.
- Mechanisms that, within budgetary limits, provide discretion by care coordinators or others close to the point of care to offer services, equipment, or other supports that meet member needs and preferences.

Non-financial incentives to improve alignment of plan, provider, and member interests to pursue fully integrated care

- Plan uses explicit criteria for selecting and contracting with individual, organizational, and institutional providers across the spectrum of medical care, mental and behavioral health, and LTSS.
- Metrics and monitoring feed into contracting and incentive systems.
- Uniform training standards exist to improve care delivery for elderly, disabled, and members with mental and/or behavioral health problems.

Experience in network and provider selection

- Experience in selecting networks and providers that have demonstrated successful service provision, care coordination, and positive outcomes for individuals with multiple chronic conditions, mental and behavioral health problems, and/or disabilities.

Domain IV: Coordinated Care Provided through Comprehensive, Accessible Networks and Person/Family Centered Care Planning and Coordination

Network comprehensiveness and accessibility

- Depending on the type of plan, the network/s cover the spectrum from primary, preventive, and acute services through transitional care, chronic illness management, LTSS, mental and behavioral health services, palliative care, and end of life/hospice care.
- Primary care services appropriate for individuals with serious mental illness are readily accessible.
- Managed long-term care plans have shown capacity to manage chronic illness and coordinate medical management with delivery of LTSS and mental and behavioral health services.
- The plan's network/s encompass a range of traditional and nontraditional providers, services and supports, and the network/s extend beyond traditional safety net providers, especially for specialty, secondary, and tertiary care.
- Services and supports are geographically and physically accessible to diverse individual, cultural, and population needs and preferences.
- Network/s of clinicians, direct care workers, support staff, and specialty providers are trained and experienced in delivering services appropriate for people with diverse educational, cultural, physical, and other special needs (e.g., linguistic/cultural subgroups, people with minimal health literacy, cognitive impairment, mental or behavioral health problems, transportation problems, and/or physical disabilities – e.g., in wheelchairs).
- Home visiting is available.

Network cohesiveness

- EITHER there is a highly integrated network of providers with elements of shared risk or shared decision-making and clear performance targets;
- There is a tightly managed network of dispersed providers with explicit criteria for selection and clear performance targets; OR
- There is a totally integrated delivery system on the traditional "staff" HMO model.

Effective care coordination

- Comprehensive, objective, and ongoing assessment of member/family needs and preferences is the cornerstone of care coordination.
- Care plans are adjusted over time to meet changing member needs/preferences.
- Coordination standards and processes (e.g., member/manager ratios, service/support options) are geared to variations in member populations and subpopulations and reflect stratification based on regular, periodic assessment.
- Care coordinator/manager case load, expertise, and resource targets reflect member risk stratification.
- Coordination uses appropriate collaborative mechanisms and communication strategies (e.g., face-to-face, telephonic, virtual) based on member/family needs and preferences, as well as on the best available evidence about what types of collaboration and communication are most appropriate/effective in varying circumstances.
- Members/families can access 24/7 care management consultation by phone, as well as regular telephonic and periodic face-to-face contact with care coordinator/manager.
- Care planning fully engages and builds on the strengths of members, families, and community resources.
- Behavioral health services employ a “recovery oriented” framework that moves beyond symptom reduction; shifts the focus from illness to wellness and from custodial care to community integration; and seeks meaningful outcomes such as health, home, purpose, and community (taken from Massachusetts MOU, 2012).
- Care managers have well defined competencies and appropriate training in provider techniques for patient engagement, coaching, self-management support, and the like.
- A comprehensive, shared patient care plan:
 - Encompasses full range of appropriate services, supports, disciplines, and settings;
 - Routinely provides opportunity for members and families to contribute to the plan and access care plan documentation; and
 - Provides discretion within defined standards and budgets to allow for individual/family needs and preferences.
- An information system accommodates real time access to care plan information and allows for updating and communication among various providers.

Commitment to reducing health disparities

- Plan has a vehicle for identifying health disparities within and across member populations and subgroups.
- Plan has mechanisms for addressing disparities in use of services and supports, quality of care provided, and health and quality of life outcomes.

Domain V: Capacity to Attract and Retain Members, Expand Enrollment, and Increase Retention

- Plan has strong member outreach mechanisms, consumer-friendly member services (e.g., call systems), and availability of patient navigators, advocates, ombudsmen, or the like.
- Plan has record of low disenrollment and high member retention.
- Plan employs regular, reliable surveys (through CAHPS or other surveys) to assess members’ experiences with programs, services, and providers and robust mechanisms for understanding and acting on the results of those surveys to improve members’ reported experiences.
- Plan has record of successful strategic growth.
- Plan has demonstrated capacity to successfully engage in and manage relations/relationships among multiple consumer/member advocacy groups, including members and families.
- There is a meaningful consumer role in governance and oversight of plan activities.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

- ¹ Medicare-Medicaid Coordination Office. *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011*, February 2013.
- ² Hilltop Institute -- MedPac, June 2008; based on data from the 2005 MCBS Cost and Use file
- *Data from 2003 MCBS. Available at: http://www.cms.hhs.gov/MCBS/Downloads/CNP_2003_dhsec8.pdf.
- ³ About the Medicare-Medicaid Coordination Office. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>.
- ⁴ Under the managed fee-for-service model, states sign an agreement with CMS to manage an enhanced fee-for-service program that integrates primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees and may incorporate other care coordination models introduced in the Affordable Care Act, such as health homes or accountable care organizations.
- ⁵ Kaiser Commission on Medicaid and the Uninsured. *Financial Alignment Models for Dual Eligibles: An Update*. November, 2011. Available at: <http://www.kff.org/medicaid/upload/8260.pdf>.
- ⁶ A useful starting point was the "Bridges to Health Model." See J. Lynn, B Straube, K. Bell, KM, S. Jencks, and R. Kambic. *Using Population Segmentation to Provide Better Health Care for All: The "Bridges to Health" Model*. The Milbank Quarterly, 2007, 85(2): 185-208.
- ⁷ D. Shaller. "Patient-Centered Care: What does it take?" The Commonwealth Fund, October 2007. Available at: <http://www.commonwealthfund.org/publications/fund-reports/2007/oct/patient-centered-care--what-does-it-take>.
- ⁸ C. Craig, D. Eby, J. Whittington. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. Available at: <http://healthtransformation.ohio.gov/LinkClick.aspx?fileticket=hvymeMjFI-E%3d&tabid=70>.
- ⁹ National Coalition on Care Coordination and Eldercare Workforce Alliance. *Care Coordination: Issue Brief* (undated). Available at: http://www.nyam.org/social-work-leadership-institute-v2/care-coordination/n3c/EWA_and_N3C_Care_Coordination_Issue_Brief_-_FINAL.pdf.
- ¹⁰ National Committee for Quality Assurance. *Integrated Care for People with Dual Eligibility*. Draft White Paper. June 25, 2012. (Final report issued in March 2013).
- ¹¹ See <http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx>.
- ¹² National Quality Forum. *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*. Washington, DC: National Quality Forum, June 2012.
- ¹³ Estimates derived from data downloaded from State Medicaid Agency Websites, February 2012, and from the Medicare Special Needs Plans enrollment file, March 2013.