



November 10, 2022

Agency for Healthcare Research & Quality
(AHRQ), HHS

Submitted electronically via:

MCC@ahrq.hhs.gov

Re: AHRQ Request for Information on Person-Centered Care Planning for Multiple
Chronic Conditions (MCC)

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- Document Number: 2022-20027

Dear AHRQ:

Thank you for the opportunity to respond to the above-referenced request for information. The [GTMRx Institute](#) (Get the Medications Right) is a non-profit organization focused on ensuring optimal use of medication and gene therapies through interprofessional and team-based care. This is done through a scientific, evidence-based, and cost-effective decision-making processes which we refer to as comprehensive medication management (CMM).¹

GTMRx fully supports AHRQ's efforts to advance comprehensive, longitudinal, person-centered care planning for people with Multiple Chronic Conditions (MCC). We believe that CMM, implemented based on a standard, evidence-based process², should be a central component of care planning *especially* for people with MCC.³ The opportunity for improvement is tremendous. Approximately 68.7% of clinician visits involve drug therapies⁴, 275,000 people die each year due to non-optimized medications contributing to \$528B in annual costs (16% of 2016 U.S. health care spend).⁵ The evidence shows that CMM improves quality of care and has an average return-on-investment (ROI) of 3:1⁶ to 12:1⁷ when applied to patients with chronic conditions. This is because CMM goes beyond medication adherence by establishing an optimal patient-centered regimen in addition to optimal use. Assessing these unique, personal issues through CMM are critically important for people with MCC and are not typical elements of traditional medication therapy management (MTM).

We believe that optimizing medication is best achieved through CMM services delivered as part of interprofessional teams in collaboration with primary care clinicians. GTMRx has published multiple use cases that highlight the benefits of CMM.⁸ A recent Centers for Medicare and

¹ <https://gtmr.org/resources/10-steps-to-achieve-cmm/>

² <https://gtmr.org/what-is-the-comprehensive-medication-management-process/>

³ <https://gtmr.org/what-we-believe/>

⁴ <https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm>

⁵ <https://pubmed.ncbi.nlm.nih.gov/29577766/>

⁶ <https://pubmed.ncbi.nlm.nih.gov/25329409/>

⁷ <https://pubmed.ncbi.nlm.nih.gov/18359733/>

⁸ <https://gtmr.org/use-cases/>

Medicaid Innovation Center (CMMI) funded hypertension improvement project at the University of Southern California School of Pharmacy demonstrated⁹, the collaborative process between clinicians and clinical pharmacists that is central to the CMM model, can generate remarkable results. 87% of enrolled patients achieved blood pressure targets within 45 days; over 67,000 medication-related problems were identified among 5,775 patients, and all involved (clinicians, patients) reported high degrees of satisfaction. Notably, medication adherence represented only 20% of the medication-related issues. 33% of the interventions related to appropriateness/effectiveness, 20% were safety-related, and 12% involved improving patient self-management.

When team-based care is supported through professional training, collaboration, infrastructure, and reimbursement models, people receive better, individualized care. This more personal, collaborative approach facilitates collection and use of appropriate information related to social risks, social needs, barriers to care, etc. which can lead to higher quality, more equitable care, especially for people with chronic conditions.¹⁰

We appreciate your leadership and the opportunity to comment on these important issues.

The remainder of our comments are organized according to select questions from the RFI.

What terms, strategies, and models of care are used to describe and deliver care planning for the whole person (not just for individual health conditions) that records: (1) roles and tasks among care team members, including the individual, their family and caregivers; (2) plans for coordinating care within and across organizations and settings; (3) strategies for supporting and empowering patients to manage their own health; (4) plans for engaging in shared decision making?

What key components are necessary to fully deliver on the promise of person-centered care planning?

What are examples of innovative models of care, approaches, promising strategies, and solutions that could support clinicians and practices in routinely engaging in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC?

The necessary components to successfully advance care for people with MCC have been described/implemented by a variety of organizations and delivery systems and can therefore, form the basis for advances that leverage new concepts and technology to advance care for people with multiple chronic conditions.

⁹ https://16bvl028dn7zhgp35k7rzh5c-wpengine.netdna-ssl.com/wp-content/uploads/2022/03/Hochman_Chén_GTMRx-Issue-Brief.pdf

¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8275864/>

The Chronic Care Model (CCM) developed by Dr. Ed Wagner and team at the MacColl Center for Health Care Innovation (now the ACT Center)¹¹ called for a prepared proactive practice team and an informed, activated patient. The Joint Principles of the Patient-Centered Medical Home (PCMH)¹² built upon the CCM and called team-based care led by a physician. This was followed by Joint Principles for the Medical Education of Physicians as Preparation for Practice in the PCMH (2010)¹³, an American College of Physicians paper on Dynamic Care Teams¹⁴, and subsequent position papers and policy statements by the Primary Care Collaborative¹⁵, Primary Care for America¹⁶, and GTMRx Institute¹⁷. Consistent across these documents is the importance of well-organized teams that function at a high level with defined roles, responsibilities, and communication approaches to facilitate seamless, person-centered care.

Team-based care can reduce the load on busy clinicians while enabling more patient-specific services. A recent JGIM study calculated the mean time for primary care clinicians to provide guideline-concordant care for a hypothetical adult population of 2500 people.¹⁸ The result was 26.7 hours/day. With team-based care, that was reduced to 9.3 hours/day – still unreasonable, but an improvement.

The National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home recognition program¹⁹ includes multiple criteria that address the roles/tasks of members on the team, expectations about coordinating care as well as supporting/empowering patients to manage their own health and engage in shared decision making

Here are some of the competencies assessed by the program which align with the RFI questions:

- TC 02 Structure and Staff Responsibilities
- TC 04 Patient/Family/Caregiver Involvement in Governance
- CM 04 Person-Centered Care Plans
- CM 06 Patient Preferences and Goals
- CM 07 Patient Barriers to Goals
- CM 08 Self-Management Plans
- CC 07 Performance Information for Specialist Referrals
- CC 20 Care Plan Collaboration for Practice Transitions

The Interprofessional Education Collaborative, an organization that represents 21 national health professions associations, developed Core Competencies for Interprofessional Collaborative

¹¹ <https://act-center.org/>

¹² https://www.acponline.org/system/files/documents/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinciples_05_17.pdf

¹³ https://www.acponline.org/system/files/documents/running_practice/delivery_and_payment_models/pcmh/understanding/education-joint-principles.pdf

¹⁴ <https://www.acpjournals.org/doi/10.7326/0003-4819-159-9-201311050-00710>

¹⁵ <https://www.pcpcc.org/about/shared-principles>

¹⁶ <https://www.primarycareforamerica.org/our-mandate/>

¹⁷ <https://gtmr.org/what-we-believe/>

¹⁸ <https://link.springer.com/article/10.1007/s11606-022-07707-x>

¹⁹ <https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/>

Practice (2016 update).²⁰ The document provides a definitional framework for “Competency-Based Interprofessional Education” that addresses some of the key issues identified in this RFI including communication about roles, responsibilities, collaboration, and team-based care, including patients/families and the community.

Comprehensive Medication Management (CMM) starts with the person, not the pill and it is a very important distinction between the current medication use process which starts with the therapeutic area (i.e., diabetes mellitus) and then is often siloed in the prescribing, management and follow up of patients. The unique value proposition of CMM is that the diagnosis is the trigger, but the assessment, evaluation, and management is based on whole-person needs as identified by the process of care (CMM) that is used to manage the long-term, longitudinal needs of the patient. This creates an opportunity for meaningful engagement with patients, their families, and caregivers. Unlike Medicare Part D, which is performed outside the patient care team, and largely without the patient, the patient-centered CMM process facilitates shared decision making *with* the patient). It is important to emphasize the distinction between CMM and Medication Therapy Management (MTM).^{21,22}

Integration of a clinical pharmacist into primary care settings has been shown to reduce clinician burnout. At least 87% of provider respondents in a recent study strongly agreed or somewhat agreed that the integrated clinical pharmacist reduced their workload, improved overall medication use, helped patients meet health goals and quality measures, and overall helped them to effectively manage their panel of patients.²³ Another program at Stanford University (“Primary Care 2.0”), demonstrated that close collaboration between clinicians, nurses, pharmacists, and dietitians proved beneficial for patients and for primary care physicians, but only if the model is sustained.²⁴

GTMRx previously submitted comments to CMS regarding Medicare Advantage and team-based interprofessional care with an emphasis on the need to include Comprehensive Medication Management.²⁵ Many of the recommendations are appropriate to this RFI including the suggestions to:

- **Support team-based, interprofessional care through programs, policies, and new reimbursement models.** This will advance health equity by better ensuring that all MA enrollees receive the care they need.
- **Implement GTMRx payment and policy recommendations.**²⁶ These include compensating interprofessional care teams for delivering CMM services.
- **Address inequities in access to high-quality medication therapy through a National Pharmaco-equity Initiative.** This initiative would include regulatory changes that

²⁰ <https://www.ipecollaborative.org/assets/2016-Update.pdf>

²¹ <https://gtmr.org/blog-cmm-vs-mtm-patient-focused-process-vs-medication-focused-activity/>

²² <https://www.ahdonline.com/issues/2021/september-2021-vol-14-no-3/3174-medication-optimization-integration-of-comprehensive-medication-management-into-practice>

²³ <https://www.jabfm.org/content/jabfp/34/3/553.full.pdf>

²⁴ <https://med.stanford.edu/news/all-news/2021/12/team-based-care-physician-burnout.html>

²⁵ https://gtmr.wpenginepowered.com/wp-content/uploads/2022/08/GTMRx_CMS-RFI-on-MA_CMS-4203-NC_8.31.22.pdf

²⁶ https://16bv1028dn7zhgp35k7rzh5c-wpengine.netdna-ssl.com/wp-content/uploads/2022/05/GTMRx-Payment-Policy-Recommendations-Discussion-Documents_5.11.22.pdf

promote pharmacoequity through value-based care payment models that support person-centered interprofessional teams and CMM.

- **Broaden access to standardized CMM services through telehealth.** This could be part of a broader pharmacoequity initiative to address the issue of pharmacy deserts and lack of access to medication management.
- **Support value-based payment models that encourage team-based, interprofessional care across all CMS programs.** Team-based care is considered the optimal approach to care delivery, but current payment models neither recognize its value nor provide sufficient incentives to support implementation.

In addition, the experience of the Covid-19 pandemic demonstrated that there are very few, if any technological barriers to widespread implementation and use of telehealth, remote physiologic monitoring, and other patient-facing technologies other than internet accessibility and bandwidth issues. Care for people with MCC should focus on optimizing medication use and avoidance of emergency department and hospitals – which means providing services and support in the home and community. To do this effectively, payment and policy changes should consider the \$528 billion dollars wasted each year associated with non-optimized medication use, and support technology enabled team-based, interprofessional care to encourage the practice models and uses of the technology described above.²⁷ CMM, like other important elements of care, depends on timely access to the right information at the right time by all members of the clinical team – including the person receiving care. GTMRx advances “Four Formative Pillars” for health information technology to support/improve CMM²⁸:

1. Clinical Decision Support Tools
2. Population Health & Risk Stratification
3. Patient Engagement & Care Coordination
4. Outcomes: Economic, Clinical, and Humanistic Outcomes

How is comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC currently being done in health systems, primary care, and other ambulatory practices?²⁹

Which organizations are successfully engaged in person-centered care planning for people at risk for or living with MCC?

Who are the thought leaders in this area and/or where would leaders go to seek information about how to begin this work?

Here are several examples of CMM in action, aligned with the goals of this RFI to identify thought leaders, organizations, and implementation of innovations to address people with chronic conditions. While the use cases below are focused on hypertension and diabetes mellitus, it is important to note that CMM is not a condition-focused process – it is a comprehensive assessment to optimize medications, which is especially relevant for people with

²⁷ <https://escholarship.org/uc/item/3n76n4z6>

²⁸ <https://gtmr.wpenginepowered.com/wp-content/uploads/2020/11/The-Four-Formative-Pillars-Top-Health-IT-Capabilities-That-Will-Improve-CMM-11252020.pdf>

²⁹ <https://www.thejournalofprecisionmedicine.com/wp-content/uploads/improving-patient-outcomes-integration-pharmacogenomic-testing.pdf>

MCC:

- Incorporation of ambulatory care clinical pharmacists in interdisciplinary healthcare teams has helped to address healthcare disparities in the Native Hawaiian population.³⁰
- Use of clinical pharmacy services by American Indians and Alaska Native adults with cardiovascular disease³¹ was associated with a 29% lower likelihood of having an elevated systolic blood pressure.
- Federally Qualified Urban Health Network (coalition of 8 FQHCs) under an ACO contract with the Minnesota Department of Human Services demonstrated an average Hemoglobin A1c reduction of 2.4% and estimated cost savings \$950 - \$1,169 per patient for those whose HbA1c decreased $\geq 1\%$.³²
- Department of Veterans Affairs use of Clinical Pharmacist Practitioners (CPP) practicing CMM as part of the Patient-Aligned Care Teams (PACTs) initiative^{33, 34}:
 - In 2019, there were nearly 2.6M CMM interventions captured across 1.2M CPP face-to-face and virtual visits.
 - 27% of return appointments to primary care were avoided due to CMM interventions by the CPP which opened access for Primary Care to other veterans.
 - Patient satisfaction was $>90\%$.
- Kaiser Permanente, focused on people with poorly controlled diabetes mellitus.³⁵
 - Intervention group had lower treatment costs (\$35,740 versus \$44,529), and more quality adjusted life years (5.51 versus 5.02 years) over a 10-year horizon using a Markov Model Analysis.
 - LDL-C, Hemoglobin A1c, and systolic blood pressure decreases were significantly greater at all time points over 12 months.
- University of Southern California School of Pharmacy: CMMI-funded pilot evaluated the impact of integration of clinical pharmacy teams into primary care clinics.³⁶
 - Within 45 days, the program achieved target blood pressure in 87% of patients.
 - $>67,000$ medication-related problems identified among 5,775 patients including issues with appropriateness/effectiveness (33%), safety (20%), medication non-adherence (21%), and insufficient patient self-management (12%).
 - Patient satisfaction as 9.6 (out of 10).
 - Expansion of the program in Sept 2020 demonstrated positive benefits with blood pressure control, hemoglobin A1c reductions, and statin use.

In addition, more than 300 therapeutic products recognized by the United States Food and Drug Administration (FDA) include pharmacogenomic information in their drug labeling. Integration

³⁰ <https://accpjournals.onlinelibrary.wiley.com/doi/10.1002/jac5.1681>

³¹ <https://accpjournals.onlinelibrary.wiley.com/doi/full/10.1002/jac5.1651>

³² <https://gtmr.org/resources/federally-qualified-urban-health-network-fuhn-use-case/>

³³ <https://gtmr.org/resources/department-of-veterans-affairs-va-primary-care-clinical-pharmacy-specialist-cps-practice/>

³⁴ <https://academic.oup.com/ajhp/article-abstract/75/12/844/5101946>

³⁵ <https://gtmr.org/resources/medication-optimization-use-case-kaiser-permanente-north-california-kpnc/>

³⁶ https://16bv1028dn7zhgp35k7rzh5c-wpengine.netdna-ssl.com/wp-content/uploads/2022/03/Hochman_Chén_GTMRx-Issue-Brief.pdf

of pharmacogenomic testing into CMM by an interprofessional team can mitigate risk and optimize the therapy people receive – again, especially relevant for people with MCC.³⁷ More details about these and other use cases are available on the GTMRx website³⁸ categorized by Accountable Care Organizations, Federally Qualified Health Centers, Free Clinic, Health Plan/Managed Care, Integrated Health System, Private Practice, Veterans Administration.

What are suggested strategies for effective implementation of person-centered care planning at multiple levels (e.g., policy, system, practice, clinical team, people with MCC)?

- ***What kinds of information, tools, resources, or support are most needed to address barriers and challenges to implementation?***
- ***Which payment models might enable and sustain person-centered care planning?***

Provision of effective person-centered care planning requires access to information about the person that goes beyond what is typically collected by any single clinical team, system, or hospital – and not just medically related data. The shortcomings of our current data infrastructure, interoperability and incompleteness are particularly limiting with respect to the care of people with MCC who likely encounter multiple clinicians, across several locations, and live in communities that may or may not have appropriate social support and other services. Whereas policy advancements (e.g., 21st Century Cures Act³⁹, TEFCA⁴⁰) and standards (i.e., NCPDP eCare Plan⁴¹) are advancing the foundation for better information sharing and data quality, payment models need to adjust to support the implementation of practice changes that encourage the type of interprofessional team-based care proven to generate better outcomes especially for people with MCC.⁴²

In a paper entitled, “The Patient Care Process for Delivering Comprehensive Medication Management (CMM),” authors from the UNC Eshelman School of Pharmacy, University of Minnesota College of Pharmacy, AAFP National Research Network, Alliance for Integrated Medication Management, and National Implementation Research Network, developed a thorough implementation guide for CMM in primary care.⁴³ The GTMRx Learning Center has over 380 tools and guidance documents to support employers as well as for health plan sponsors as they work with their health plans/ PBMs, and accountable care organizations as they manage people with multiple chronic conditions, on multiple medications, seeing multiple clinicians.⁴⁴ Accurate information about medications is particularly important given the prevalence of polypharmacy among people with MCC.⁴⁵ As Tinetti et al write in the Annals of Internal Medicine: “...the clinician and patient should consider the probable prognosis and health trajectory, balance of benefit versus harm, and outcomes (which are often functional) that matter

³⁷ <https://www.thejournalofprecisionmedicine.com/wp-content/uploads/improving-patient-outcomes-integration-pharmacogenomic-testing.pdf>

³⁸ <https://gtmr.org/use-cases/>

³⁹ <https://www.congress.gov/bill/114th-congress/house-bill/34>

⁴⁰ <https://www.healthit.gov/topic/interoperability/policy/trusted-exchange-framework-and-common-agreement-tefca>

⁴¹ http://www.hl7.org/documentcenter/public/wg/structure/CDAR2_IG_CCDA_MTM_CAREPLAN_R1_O1_2017SEP_Introductory_Material.pdf

⁴² <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01580>

⁴³ https://gtmr.wpenginepowered.com/wp-content/uploads/2019/06/CMM_Care_Process.pdf

⁴⁴ <https://gtmr.org/learning-center/>

⁴⁵ <https://www.acpjournals.org/doi/full/10.7326/M18-3269>

most to the patient when deciding whether to start, continue, or stop therapy with any medication. Is the potential benefit of the medication worth the potential harm and burden, and is the medication likely to benefit the outcomes that matter to the patient?” These are challenging conversations to have in the context of a traditional office encounter – which is why CMM services provided by clinical pharmacists in collaboration with the treating clinician is such an essential component of improving care for people with MCC. This also highlights the need for payment models to support the actions of the interprofessional team rather than be based on the actions of any one individual (MD/DO, NP, PA).^{46,47}

A recent Health Affairs Forefront post by Drs. Pham, Berenson, and Cavanaugh entitled, “Using the Medicare Shared Savings Program to Innovate Primary Care Payment” proposed a hybrid, population-based and fee-for-service payment model to support integration of a broader set of services necessary to deliver high-quality, high-performing primary care.⁴⁸ We believe that the approaches suggested are aligned with, and would support, the integration of CMM services.

Research indicates that MCC is associated with race/ethnicity and education, as well as potentially social support, psychological stress due to perceived discrimination, mental health, etc.^{49,50} These are all factors associated with health inequities and harm. This is another opportunity for clinical pharmacists and CMM to improve care and equity for people with MCC. The Journal of the American College of Clinical Pharmacy (JACCP) recently published a special issue on health equity and clinical pharmacy.⁵¹ An editorial in the issue points out that, “Pharmacotherapy is a major component of contemporary health care. Some estimates note that nearly 131 million Americans, or 70% of adults, are on at least one chronic medication and \$370 billion are spent on prescription medications annually. Given the importance of pharmacotherapy in healthcare, equitable medication use is paramount to eliminating health disparities. However, high-quality medication use is not available to all.”⁵²

The JACCP issue also includes articles describing the “...ongoing transition of pharmacy from MTM [Medication Therapy Management] to more expansive patient centered CMM responding to SDOH,”⁵³ and a description of a program for Native Hawaiians that incorporated clinical pharmacists into interdisciplinary healthcare teams to address healthcare disparities associated with type 2 diabetes mellitus and remote glucose monitoring.⁵⁴ An additional example of clinical pharmacists’ potential role in an expanded effort to address health inequities include a telepharmacy program that addressed social determinants of health during the COVID-19 pandemic.⁵⁵

⁴⁶ <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/issue-brief-payment-physician-led-team-based-care.pdf>

⁴⁷ <https://www.acponline.org/practice-resources/patient-and-interprofessional-education/team-based-care-toolkit>

⁴⁸ <https://www.healthaffairs.org/content/forefront/using-medicare-shared-savings-program-innovate-primary-care-payment>

⁴⁹ <https://www.ajmc.com/view/management-of-individuals-with-multiple-chronic-conditions-a-continuing-challenge>

⁵⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5769041/>

⁵¹ <https://accpjournals.onlinelibrary.wiley.com/toc/25749870/2022/5/8>

⁵² <https://accpjournals.onlinelibrary.wiley.com/doi/10.1002/jac5.1680>

⁵³ <https://accpjournals.onlinelibrary.wiley.com/doi/10.1002/jac5.1679>

⁵⁴ <https://accpjournals.onlinelibrary.wiley.com/doi/10.1002/jac5.1681>

⁵⁵ <https://www.sciencedirect.com/science/article/pii/S2667276621000329?via%3Dihub>

Conclusion

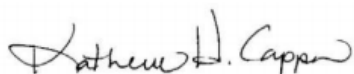
GTMRx supports the goal to improve the quality of and access to optimal therapeutic care. Comprehensive medication management services provide value in advanced primary care through an interprofessional, team-based activity that recognizes clinical pharmacists as the medication experts. CMM includes an intentional, sequential patient assessment (i.e., indication, effectiveness, safety, adherence, or IESA)⁵⁶ designed to identify and help people optimize their medication regimens. Unlike MTM, CMM is a coordinated, holistic approach applicable to any patient.⁵⁷ “Pharmacy deserts” can be created by the physical absence of access to pharmaceuticals, but also adding to these care gaps is limited accessibility to the important services that clinical pharmacists are trained to address through in-person and virtual methods (i.e., telehealth).^{58,59}

Team-based care is widely recognized as the optimal approach to delivery of healthcare. It can help reduce clinician burnout, improve patient experiences⁶⁰ and quality of care.⁶¹ The concept is hardly new – yet despite the research and literature supporting positive experiences for clinical teams and patients, the current payment models do not recognize its value or provide sufficient incentives to support its broad implementation. The important role of clinical pharmacists^{62,63} on interprofessional teams is also widely acknowledged yet poorly supported by current payment models.⁶⁴

In summary, CMM is part of a team-based approach in which all members of the team acknowledge and respect each other’s role and unique ability to contribute to the benefits of the people who place their trust in the team. GTMRx believes that clinical pharmacists providing CMM services, in collaboration with primary care clinicians and other team members can significantly contribute improving care for people with MCC.

We appreciate your leadership and the opportunity to comment on these important issues. The GTMRx Institute stands ready to share evidence, thought leadership, support for and guidance to AHRQ as they advance this important work.

Sincerely,



Katherine Herring Capps
Co-Founder & Executive Director
GTMRx Institute

⁵⁶ http://16bvl028dn7zhgp35k7rzh5c-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/CMM_Care_Process.pdf

⁵⁷ <https://www.sciencedirect.com/science/article/abs/pii/S0002934320311736>

⁵⁸ <https://gtmr.org/resources/the-integration-of-telehealth-delivery-within-a-comprehensive-medication-management-practice/>

⁵⁹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8426730/>

⁶⁰ <https://nam.edu/implementing-optimal-team-based-care-to-reduce-clinician-burnout/>

⁶¹ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0931>

⁶² <https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0209>

⁶³ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.0201>

⁶⁴ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.1225>