

Special Delivery

*How Coordinated Care
Programs Can Improve
Quality and Save Costs*

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Jessica Curtis and Renée Markus Hodin, Community Catalyst

*Robert W. Seifert, Center for Health Law and Economics,
University of Massachusetts Medical School*

COMMUNITY CATALYST



Community Catalyst, Inc.
30 Winter St. 10th Floor
Boston, MA 02108

Phone: 617.338.6035
Fax: 617.451.5838

www.communitycatalyst.org

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Special Delivery: How Coordinated Care Programs Can Improve Quality and Save Costs is the fourth in a series of Community Catalyst publications on consumer-friendly options to improve quality and contain costs. The other papers in the series are:

- More for Our Health Care Dollar: Improving Quality to Cut Costs (October 2008)
- Getting What We Pay For: Reducing Wasteful Medical Spending (December 2008)
- Saving Money by Improving Medicaid (January 2009)

They are available on the Community Catalyst website at <http://www.communitycatalyst.org/resources/>

About Community Catalyst

Community Catalyst is a national nonprofit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

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Executive Summary

The delivery of health care in the United States is fragmented and uncoordinated. This adds unnecessary risks and costs to people's health care experience.

- Lack of coordination can be *unsafe*, even fatal, when abnormal test results are not communicated correctly, prescriptions from multiple doctors conflict with each other or primary care physicians do not receive hospital discharge plans for their patients.
- Uncoordinated care is also *costly* because of duplicated services, preventable hospital readmissions and the overuse of more intensive procedures.

Models of care coordination—including a number of chronic care and medical home partnerships in the states; mission-driven health plans, including some Medicare Advantage Special Needs Plans (SNPs); and integrated health care delivery systems—are demonstrating how health care can be delivered more smoothly and efficiently, particularly for people with chronic illnesses and complex needs. Though details differ, the best of these models share some common characteristics:

- Individuals and families at the center of care planning and delivery.
- Care continuity across medical and non-medical services and from acute to long-term settings.
- Strong clinical and organizational support for effectively coordinating care.
- Appropriate payment incentives for coordinating care and integrating benefits.
- Systems for including the consumer voice in care design and plan governance.

Consumer advocates have a critical role to play in ensuring that coordinated care models are devised and implemented with patients and families at their center and that the resulting programs produce better care and reduced costs. Actions for advocates include:

- Promoting coordinated care projects in their own states by identifying people who have benefited from receiving coordinated services and educating policy makers about these benefits.
- Working to strengthen SNPs.
- Supporting coordinated care models as part of national health reform.
- Building alliances among consumer groups, including senior and disability advocates such as AARP, ARC Health, Family Voices and other activist groups.
- Partnering with a broad range of stakeholders, including providers, public and private payers, mission-driven health plans and delivery systems and business groups.

Background: The Hazards and Costs of Uncoordinated Health Care

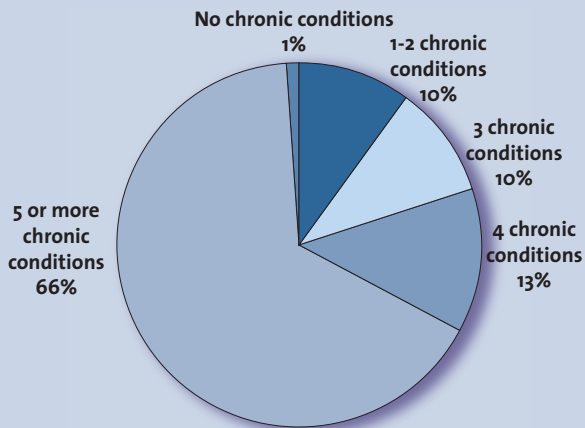
Our country's health care delivery system is disorganized and broken. Patients are often treated by a variety of primary care physicians and specialists who do not routinely communicate. This is especially the case for people with one or more chronic illnesses such as diabetes, asthma or heart failure, and for elderly people with multiple health care needs. The average elderly Medicare beneficiary interacts with seven physicians in four different

practices over a year.¹ That number rises for beneficiaries with chronic conditions.

Lack of coordination, even within one hospital system, can be dangerous and even fatal. In 2004, a patient died because a teaching hospital failed to tell him and his caregivers that he had tuberculosis (TB). The man walked into an outpatient clinic complaining of weight loss and a cough. Although test results showed he had TB, he received no notice or appropriate care, and doctors treating him in subsequent visits to the same hospital did not know of the diagnosis. He was hospitalized for several weeks, then transferred to a nursing home and died after suffering a series of heart attacks.²

Uncoordinated care is also costly. People in areas of the country with higher numbers of physicians and hospital beds receive more duplicated, unnecessary services.³ A study of Medicare patients found that nearly one in five hospitalizations resulted in a readmission within 30 days of discharge and that three-quarters of these could have been prevented by better coordinated care.⁴ The price tag to Medicare alone for these readmissions was \$15 billion.⁵

Two-Thirds of Medicare Spending is for People with Five or More Chronic Conditions



Source: The Commonwealth Fund; Data from G. Anderson and J. Horvath, *Chronic Conditions: Making the Case for Ongoing Care* (Baltimore, Md.: Partnership for Solutions, Dec. 2002)

Uncoordinated care leads to inferior quality and excessive costs, and is a common problem in many hospitals. Various studies report:

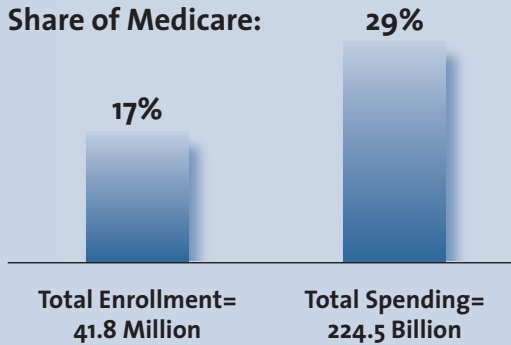
- 25 percent of referring physicians do not receive consultation reports from a specialist four weeks after the consultation visit.
- Fewer than half of primary care doctors are given information about the discharge plans and medications of their recently hospitalized patients.
- 33 percent of physicians do not consistently notify patients about abnormal test results.⁶

The shortcomings of the U.S. health system are amplified through the experiences of people with chronic illness, who tend to use more health care from more sources. Americans with chronic illness—about 133 million people—are more likely to report forgoing care, experiencing medical errors, paying high out-of-pocket costs and being unnecessarily placed in hospitals and nursing homes compared with people in other countries.⁷ Extra costs associated with lack of coordination are particularly problematic for public programs, which serve the highest concentration of people living with chronic illness: 98 percent of Medicare spending and 83 percent of Medicaid spending goes to caring for people with chronic illness.⁸

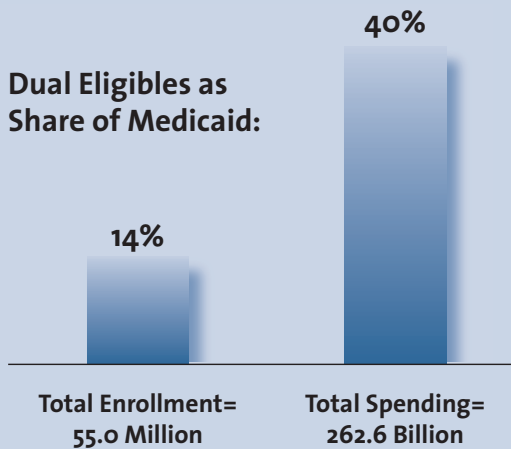
A special category of people with chronic illness are those eligible for both Medicare and Medicaid (“dual eligibles”). Poorer, sicker and frailer than most, they also have an additional challenge: negotiating two separate systems of care—Medicare and Medicaid—that do not coordinate care delivery.

Patients with Both Medicaid and Medicare: A Disproportionate Share of Public Spending

Dual Eligibles as Share of Medicare:



Dual Eligibles as Share of Medicaid:



Source: Kaiser Family Foundation, *Medicare Chartbook 2005*. Medicare data are from Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File. Medicaid data are from KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2001 MSIS data applied to CMS-64 FY2003 data.

Public program spending on care for dually eligible beneficiaries is disproportionately high. While only 14 percent of Medicaid beneficiaries and 17 percent of Medicare beneficiaries are eligible for both programs, they account for 40 percent of spending in Medicaid and 29 percent in Medicare, respectively.⁹ Despite this tremendous outlay of funds, dually eligible beneficiaries suffer from poorer health.¹⁰

Fortunately, the changes needed to make the health care system work more smoothly and efficiently, especially for these groups, are already being demonstrated in a variety of models that formally incorporate care coordination:¹¹

- A number of mission-driven Medicare Advantage Special Needs Plans and integrated health care delivery systems that effectively coordinate care currently operate at a small scale around the country.
- Several states—including Pennsylvania, North Carolina, New York, and Texas—have made changes to their Medicaid financing structures to incorporate the chronic care model or medical home model for certain high-risk, high-cost beneficiaries within their Medicaid programs.¹²
- Public-private initiatives are developing effective coordinated care models, such as Vermont’s Blueprint for Health.¹³
- Private initiatives are integrating health care and other services, such as Geisinger Health System’s “ProvenCare” and AXIS Healthcare, a Minnesota-based care coordination system for people with disabilities.

As these initiatives become more common, it’s important that consumer advocates are equipped to separate fact from fiction, and understand the key concepts of effective care coordination. The rest of this issue brief defines consumer-friendly care coordination, outlines the key features advocates and others should use to identify effective systems of care coordination around the country, and offers examples of such systems. It concludes by suggesting what consumer advocates can do to promote coordinated care in their communities.

What Is Coordinated Care, and Why Does It Matter?

The concept of “care coordination” is gaining traction as a means of addressing gaps in care that many people with chronic illnesses routinely experience. Care coordination models have relevance for states seeking to reduce program costs while improving the quality of care they offer to people enrolled in their public programs. Assessing the effectiveness of coordinated care programs in improving patient health and reducing costs is difficult, however, because there is no standard definition for what constitutes “coordinated care.”¹⁴ Conflicting results from recent studies also raise questions about whether care coordination really works for patients and families, or simply adds another layer of bureaucracy within an already-complicated health care system.¹⁵ These results turn on how coordinated care is defined and also on how a particular program is implemented. Advocates should be aware of both factors as they assess and promote coordinated care models.

Spotlight on: AXIS HEALTHCARE

AXIS Healthcare is a care coordination organization in Minnesota for people with disabilities.

“Ellen” joined AXIS early in 2005 through a referral from the director of her assisted-living program. During the previous year, Ellen had gone to the emergency room or been hospitalized 47 times, frequently for treatment of pneumonia or mental illness. Ellen’s multiple diagnoses affected both her physical and mental health, and her opportunity to live independently was in jeopardy.

AXIS care coordinators built community supports around Ellen. They established in-home services, including extended personal care assistance, weekly visits from a nurse, and training in independent living skills. They connected Ellen to mental health rehabilitation services to help organize her apartment and reconnect her with the community, implemented a more consistent medication regime, and ensured that someone was around to help Ellen follow through. These services allowed Ellen to reconnect with activities she enjoyed, such as art and writing, and brought her back to playing a more positive role within the community. Her care coordinators also connected Ellen to a primary care physician and attended regular visits and check-ups with her.

With this consistent care and involvement, Ellen came to trust her AXIS team and began to notify them sooner if she started to feel unwell. During Ellen’s second year as an AXIS member, she went for 10 months without a single visit to the ER. For Ellen, her community, and the AXIS team, this was a huge accomplishment.

Defining Coordinated Care

Effective care coordination is a consumer-friendly, system-wide approach to care that seeks to improve patients’ health, increase access to appropriate care, and reduce costs by placing the patient at the center of care.¹⁶

Consumer-friendly programs tend to use an expanded model of health that addresses individuals’ physical and behavioral health care needs within their family and home, as well as non-medical needs, such as food and transportation.¹⁷ The goal of this approach is to allow the program to identify factors that increase the chances of poorer health outcomes; to work with the individual and family caregivers to develop a plan of care to address those issues; and to maneuver around traditional barriers to addressing needs by integrating medical and non-medical services as part of a patient’s routine care.¹⁸

Though the models used to deliver care may differ, the objective of a consumer-friendly care coordination program is to make sure that patients and their families have access to the right care in the right place at the right time. Evidence suggests that coordinated care of this kind can mean higher quality care, better outcomes and reduced reliance on expensive medical interventions. In Massachusetts, a study of the Senior Care Options (SCO) program, which provides a full array of health care and social services for low-income seniors, showed that frail elders enrolled in SCOs were able to remain in their homes for longer periods of time prior to entering nursing homes. They also spent less time in nursing facilities compared with similar populations outside of the program.¹⁹

Implementing Coordinated Care

“Care coordination” is a fluid term that is used to refer to consumer-friendly coordinated care (as defined above), as well as to case management and disease management.²⁰ This is problematic on two fronts. Not only do these approaches have different goals and use different processes, but preliminary studies also suggest that they lead to different outcomes in terms of improving patient health and reducing waste in the health care system.

For example, *disease management programs*, which grew rapidly a decade ago, aim to improve the quality of care delivered to people with chronic conditions, and to reduce the costs associated with their care. While well-intentioned, most of these programs involve only patient education,

appointment-scheduling services or check-in phone calls that have been tacked onto a more traditional, uncoordinated care model.²¹ Disease management programs commonly focus on specific diseases such as diabetes, asthma, and congestive heart failure, rather than on the whole person. Like some care coordination models, health plans implementing a disease management program often contract with outside vendors to provide this benefit to their members. However, numerous studies have found questionable savings and unimpressive health improvements associated with these programs, as well as with care coordination programs that mimic their approach.²²

Similarly, many plans employ *case management strategies* that require providers to obtain authorization prior to ordering a particular service. These strategies require providers within an organization to communicate, but often the sole objective is reducing costs. Little to no consideration is given to the non-medical factors that may be affecting a patient's health, let alone to addressing any health care needs that fall outside the scope of "covered services." The focus of case management is on what is covered by the plan, not what is needed by the patient.

Consumer-friendly care coordination, by contrast, anticipates the needs of the whole person, both medical and non-medical, and provides or arranges for the patient to receive proactive, continuous, appropriate care across settings. In a coordinated care model, providers work with individuals and their family caregivers to develop a plan that meets their medical and social needs and anticipates longer-term needs. A single provider works closely with the patient and family and oversees the delivery of all services across disciplines, organizations, providers and settings. In addition to other benefits, this personalized approach allows providers to flag problems in a patient's care (including non-medical issues, such as missed appointments due to faulty transportation). They can intervene earlier and prevent problems from getting worse, keeping patients healthier and reducing overall costs.

Coordinated care models that work well for consumers tend to share a common set of core principles. They are:

- Placing the **individual and family at the center** of care planning and delivery.
- Coordinating care across a **continuum of medical and non-medical services**, from primary and acute to long-term and home- or community-based care.
- Implementing **appropriate clinical and organizational supports** needed to effectively coordinate care.
- Establishing **appropriate payment incentives** for coordinating care and for integrating Medicare and Medicaid benefits.
- Incorporating the **consumer voice** in plan design and governance.

The next section describes these principles in greater detail.

Core Principles of Well-Coordinated Care

1. Placing the Individual and Family at the Center of Care

The insurance model of care provides or withholds services and resources based on a narrow definition of "medical necessity" and a rigid approach to "covered benefits." By contrast, a consumer-friendly coordinated care model is oriented to the patient's individualized needs and circumstances. In this context, "care management" is not a justification for gate-keeping. Instead, it implies that the program has worked with the patient and her family to develop an individualized plan of care that starts with an initial assessment of the patient's needs, environment and goals, and continues with

regular reassessments as needed to adjust the original plan. For example, when a new member joins the Santa Clara Family Health Plan, a Medicaid managed care program in California, home health aides interview her in her home. The aides assess both the patient's medical needs and how her living arrangements and limitations affect her well-being. This creates a partnership among providers, patients and their families that helps keep patients healthy and involved in their care.

Ideally, coordinated care is rooted in an interdisciplinary team led by a primary care provider—physician or non-physician—who is paid and held accountable for gauging the member's needs and coordinating care across the full spectrum of services. The goal is to deliver appropriate care, and to engage patients and caregivers in developing their own care plans and managing their health. Thus, the primary care provider plays the role of facilitator by working with patients and their caregivers to maintain the patient's overall well-being and quality of life, reduce suffering and enable independence at home. The facilitator also provides continuity of care, and prevents medical errors and unnecessary cost.

2. Continuity of Medical and Non-Medical Services

Care that is truly coordinated addresses the entire range of medical needs, including mental health, acute care, chronic care, community-based care and self care. Well-coordinated care also facilitates access to non-medical services, such as food stamps and heating assistance, which have a direct effect on a patient's health. It draws together all aspects of the health care system—doctors offices, nursing homes, hospitals—and uses the resources available in the patient's home, family, and community. Most health plans using coordinated care models deliver this kind of care through the use of multi-disciplinary teams (e.g. doctors, nurses, social workers) with a single point of contact.²³

3. Formal Mechanisms for Delivering Services

Effective care coordination requires health plans and systems to develop appropriate clinical and organizational supports that enable providers to work across organizations and care settings.²⁴ A 2008 Commonwealth Fund study of 15 diverse care delivery systems found that better-organized systems are more likely to provide better quality care—and, to a lesser extent, more cost-effective care—in part because they use tools such as electronic medical records that track patient care and remind providers of needed tests. Internally, this means having the structure, leadership and organizational culture that actively seeks to improve care, responds to identified problems or needs by making changes at the systems level and promotes best practices. Externally, hallmarks of well-coordinated care include:

- **Provider networks** that both meet the needs of the patients and support the care coordination model. For example, **Commonwealth Care Alliance** (“CCA”), a Special Needs Plan in Massachusetts, has identified doctors and other health care providers who share its commitment to enabling its members to make decisions, and to keeping members in the home and community for care. CCA has found that a well-designed provider network is a key to ensuring that patients have access to the care they need. Provider support has also proven important to the plan's expansion.²⁵
- **Interdisciplinary care** teams that address the full range of patient needs, integrating health care and non-medical services.
- **Data and communications systems** that simplify patient records and interactions, expand patient access to care, monitor team performance and patient well-being, and facilitate care coordination within and across organizations.

Spotlight on: GEISINGER HEALTH SYSTEM

Geisinger Health System, an integrated health organization in Pennsylvania that serves many people with chronic conditions, coordinates members' care in innovative ways. The system makes broad use of electronic patient records across 10 hospitals and 700 private practices. Members can easily access their own records, and use them to make appointments or order medication refills. The system has also designed a patient-centered medical home initiative (“ProvenHealth Navigator”) built around a nurse care coordinator at each practice site. This care coordinator works with the doctors to follow members' care, help them access specialists and social services, follow them when hospitalized and discharged and be available for inquiries 24 hours a day/7 days a week. This approach has shown results: some of Geisinger's sickest members' hospital admissions have decreased by 25 percent, days in the hospital decreased by 23 percent, and readmissions following discharge decreased by 53 percent.²⁶

Spotlight on: VERMONT'S BLUEPRINT FOR HEALTH

In 2006, Vermont launched a public-private initiative called the “Blueprint for Health” as part of health care reform. This initiative is aimed at improving care for people with chronic conditions by helping primary care providers operate as patient-centered medical homes, coordinating care through multidisciplinary teams that include public health specialists and expanding the use of electronic medical records. In each of three pilot sites, practices operating as medical homes receive extra funds to support their multidisciplinary teams and bonuses for meeting quality standards. All major commercial insurers and Vermont Medicaid have agreed on standards for the bonuses and share in the costs of the support teams.²⁸

4. Coordinated Payment, Integrated Benefits

Each of the previous elements addresses the ways in which coordinated care should be delivered. Coordinating the delivery of care in this way also requires the proper payment incentives. Simply put, the U.S. system for paying doctors and other health care providers does not currently reward care coordination; if anything, the opposite is true.²⁷ To achieve high-quality, well-coordinated care, the following changes are needed:

- Rework the payment system to invest in primary care and when appropriate, in community-based care rather than institutional care.
- Pay providers for care coordination services using methods that account for the complexity and intensity of patients’ needs, and support the interdisciplinary team approach.
- Provide federal grant funding and other economic assistance to states that incorporate effective care coordination models in their public programs.
- Link payment to measures of quality, efficiency, outcomes and patient satisfaction.
- Integrate payments from all sources to allow better coordination of services.

This last point is particularly relevant to dual Medicare/Medicaid enrollees. These programs cover different benefits, and there is an incentive for each to shift costs to the other. Integrated payment can make it easier for patients to get care if there is a single set of coverage rules and administrative processes. When possible, Medicare and Medicaid dollars should be combined, with a single agency responsible for organizing and coordinating all services.

5. Incorporating the Consumer Voice

Successful consumer-friendly care coordination models serve patients better by giving them a role in shaping their health plans. For example, when Wisconsin began its Supplemental Security Income Managed Care Program in order to integrate medical and social services and to coordinate care, it invited consumer representatives and advocates to join a series of advisory committee meetings. These meetings led to changes in the program’s design, including the establishment of an “external advocate”²⁹ who represents individual consumers in complaints.³⁰ Some Medicare Special Needs Plans are using surveys and focus groups to learn about patients’ experiences. Others have included consumers on their boards of directors.³¹ In 2008, consumer advocates at UHCAN Ohio brought together disability advocates with an Ohio-based mission-driven Special Needs Plan to improve care management and develop an effective approach for integrating Medicare and Medicaid benefits for dually eligible enrollees. The advocates are now working with the plan to develop a consumer advisory committee that includes members, families and their advocates. They are also collaborating on developing systems to better incorporate the members and their families in the care management planning.

What Can Consumer Advocates Do To Promote Coordinated Care?

Coordinated care models are multiplying across the country, but they are often developed and implemented without the input of consumer advocates. Advocates have a critical role to play in ensuring that the programs offer patient-and family-centered care.

Promote Coordinated Care Projects in Their Own States

State consumer advocates should learn more about existing efforts in their own state to implement coordinated care models that meet the core principles outlined in this issue brief. In particular, advocates should take a lead role in incorporating the consumer voice in any proposed effort. Advocates have a particularly important role in educating policymakers about the benefits of coordinated care. They can help identify individuals within their own networks, or those of their allies, who suffer under the existing fragmented system, as well as those who have benefited from receiving care coordination services.

Of course, state opportunities depend on state environments. For example, in many states, one fundamental impediment to consumer-friendly coordinated care is the amount of Medicaid funds that are currently being directed to institutional care providers. For a system of coordinated care to work well, these states will need to invest in building a community-based system. To shift the focus away from institutional services and toward home- and community-based care, state advocates in these states could begin by identifying and organizing allies in health centers, primary care practices and state policy roles who would support a Home and Community Based (HCB) Medicaid waiver that integrates the principles of consumer-friendly care coordination articulated above.

Strengthen Special Needs Plans

In 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), which included provisions that strengthened the requirements for Special Needs Plans (SNPs). SNPs were created in the Medicare Modernization Act of 2003 as private Medicare plans to coordinate care to high-risk Medicare beneficiaries, including people who are eligible for both Medicare and Medicaid and people living with certain chronic illnesses. The 2008 law requires all SNPs to deliver effective care with appropriate networks of providers and specialists. The model of care must include several key elements of coordinated care: conducting initial and ongoing assessments, developing a care plan with patient consultation that includes measurable goals and specific services, and using an interdisciplinary team.

Furthermore, SNPs that serve beneficiaries eligible for both Medicare and Medicaid must have contracts with state Medicaid agencies to provide or arrange for the provision of Medicaid benefits, which may include long term care benefits. Advocates can improve the delivery of care by helping to facilitate these contracts between states and SNPs and incorporating additional standards that go beyond what MIPPA requires.

Build Alliances among Consumer Groups

Senior and disability organizations are critical partners in any effort to develop and implement coordinated care programs. These organizations represent broad, powerful and highly motivated constituencies that can inform policymaking and strengthen the consumers' position at the table. Possible partners are activist senior organizations that organize low-income seniors for policy change, and the AARP in states where its chapters have a specific focus on chronic care issues. Organizations serving people with disabilities on the state and local levels include ARC Health, the Cerebral Palsy Association, the National Alliance on Mental Illness and HIV/AIDS groups. In addition, consumer advocates can seek to engage state chapters of Family Voices, a national network of organizations that advocate for families of children with special health care needs.

Partner with Other Stakeholders

Building alliances with a broad range of stakeholders will strengthen advocates' position and improve the chances of achieving policy change that will benefit vulnerable populations. These stakeholders may include:

- Providers, particularly primary care physicians and nurse practitioners.
- Public and private insurers, such as Medicaid and Blue Cross/Blue Shield plans.
- Mission-driven health plans and health delivery systems, such as Commonwealth Care Alliance in Massachusetts and AXIS Healthcare in Minnesota, and similar managed care systems for people with disabilities.
- Labor organizations, such as AFSCME and SEIU.
- Business groups, such as the state Business Roundtable.

Promote Coordinated Care Models as Part of National Health Reform

Advocates should keep their eyes on the national health reform efforts that are now gathering steam.³² There will be opportunities to promote the development of coordinated care programs, and advocates should be ready to contact their congressional delegations with examples of coordinated care models that work and consumer stories that demonstrate the need for reform.

Conclusion

Health care reform will not be sustainable if it is simply about expanding access to a system that is not working properly. It should also include efforts to improve quality and decrease costs. Achieving this type of reform will require changing the way care is delivered, particularly to those with complex health care needs, such as those with chronic conditions and dual Medicare/Medicaid beneficiaries. A cornerstone of this delivery system change is coordination of care. To ensure that policymakers adopt consumer-friendly models, consumer advocates must join the debates in their states and in Washington, D. C. This will help promote change that provides better care, reduces costs and addresses patient and family needs.

Appendix A: Resource List

General Information on Cost and Quality

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²⁷ See, e.g., Shih (2008).

²⁸ Vermont Department of Health. (2009, January). Vermont Blueprint for Health: 2008 Annual Report. Retrieved on May 6, 2009 from <http://healthvermont.gov/admin/legislature/documents/BlueprintAnnualReport0109.pdf>.

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³¹ In the SNP world, CCA contracts with HCFA, the leading consumer advocacy agency in Massachusetts, to facilitate regular meetings with its members to get feedback on the care they receive. Affinity Health Plan of New York's reliance on focus groups during its planning phases resulted in its instituting a single point of contact for its SNP. Members play a meaningful role in the governance of both the Community Living Alliance and CCA: at CLA, members serve on focus groups, the grievance advisory and ethics committee, and the Board of Directors. CCA was founded by consumer organizations, the Boston Center for Independent Living and Health Care For All. See Community Catalyst (2008), Medicare Special Needs, 30-32.

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