

The Future of the Safety Net: Federal Legislation and Behavioral Health Financing

By Dan Mistak, General Counsel, Community Oriented Correctional Health Services

Introduction

The Substance Abuse and Mental Health Services Agency estimates that 89.6 percent of people with substance use disorder never receive treatment.ⁱ Around two-thirds of people with diagnosable mental disorders do not receive treatment.ⁱⁱ

The costs for failing to meet the needs of these individuals are high, and many find themselves in jails, emergency departments, or high-cost treatment programs that react to crises instead of managing health. Creating an integrated health care system that can deliver high-quality care at sustainable costs has proved elusive. However, some sectors of the health care system are moving toward value-based purchasing. Generally, value-based purchasing encompasses a broad set of performance-based payment strategies that link financial incentives to a provider's performance on a set of defined measures of quality, cost, and resource use. These programs are intended to improve quality and slow the growth of health care spending.

Shifting from business as usual to a value-based future will not happen without careful planning. It will require policymakers to deploy data, research, and technological tools to rationalize health care delivery and incentivize better outcomes.

It is clear, however, that value-based purchasing is becoming an expectation throughout the health care system. The Affordable Care Act (ACA) accelerated the adoption of new incentives that align with value-based purchasing. New kinds of delivery models, like Accountable Care Organizations (ACOs), which manage care and share risk among providers, and health homes, which coordinate care for Medicaid recipients with chronic needs, support a re-ordering of the health care system to target high-needs populations. The ACA has also included new metrics for measuring, rewarding, and penalizing hospital systems for their performance.ⁱⁱⁱ

Because of disparities in financial and data resources, progress toward value-based purchasing is slower in the behavioral health sector than in the physical health sector, but it is happening. Federal legislation like the Mental Health Parity and Addictions Equity Act of 2008 and the ACA mandate commensurate coverage between behavioral and physical health. This is particularly important because one of the most effective ways to reduce costs and improve outcomes is to integrate behavioral health care into physical health care. Unfortunately, behavioral health programs lack the reliable funding streams and data collection mechanisms to allow this approach to mature.

In addition, within behavioral health, many payers have focused on creating robust commercial markets, to the detriment of public behavioral health systems. The result is that public behavioral health systems are both under-resourced and understaffed, and many of society's most vulnerable members are left with no place to go for behavioral health services.

There is hope, however, that new resources will allow Medicaid's behavioral health system to prepare for a value-based purchasing future. Section 223 of the Protecting Access to Medicare Act (colloquially known as the "Excellence Act") provides the key to unlocking value-based purchasing for behavioral health care and integrating behavioral and physical health. The Excellence Act provides funding and resources to lay the groundwork for researching which modalities of treatment and payment structures are most appropriate for behavioral health conditions—holding out the possibility of consistent funding for the behavioral health sector as well as an integrated future with the physical health sector.

To understand these new possibilities, it is important to recognize that health care financing exists on a continuum of increasingly shared risk shared among providers. Value-based purchasing is essentially the next step in that evolutionary process. Skipping over one stage of financing will leave a system less prepared to adapt to savings-and-quality-based financing mechanisms.

This issue paper begins by discussing the evolution of financing systems and describes the current state of the behavioral health system. It then moves on to describe how the Excellence Act supports the evolution toward value-based purchasing. In particular, we report on the opportunity established under the Excellence Act for states to participate in a new demonstration, the Certified Community Behavioral Health Clinics program, which will help prepare them for value-based purchasing in an integrated health care system.

The Evolution of Payment Structures

Most readers will be familiar with the three fundamental models of health care financing and payment: fee-for-service, bundled payment, and population-based payment. Here, we provide a quick review of these models and describe how each lays the foundation for the next.

Fee For Service

Fee-for-service (FFS) financing models are the basic method of health care financing. This model closely represents a transactional method of payment, except that, in this case, the vendor (i.e., the doctor) helps the consumer (patient) select the item to be purchased and is then paid by a third party.

The danger here is obvious: Giving the vendor so much power creates the potential for “supplier-side demand induction.” Because of the direct correlation between the amount of services rendered and the amount of reimbursement that a provider receives, the incentive is to provide more, not better or more effective, services.

Having an entire health care sector that is solely based on FFS would produce massive inefficiencies. However, the FFS model plays an important role by ensuring payment for new and comparatively underused treatments. In that way, it helps ensure access to needed treatment while providing base-level data to support the future use of such treatment.

FFS is not the optimum financing mechanism for a value-based purchasing future, yet much of the current health care system remains under FFS. This is especially true of the behavioral health sector, which accounts for about 5.6 percent of the total U.S. health care budget.^{iv}

The predominance of FFS in behavioral health, while understandable, contributes to serious problems. For behavioral health, FFS means that providers will be incentivized to provide more units of service in order to increase their reimbursements. Although this incentive provides for an influx of cash into the behavioral health system, it does not incentivize best practices and outcomes. It would be impossible, however, to expect behavioral health providers, chronically starved for cash, to have developed robust systems of care, to have the Medicaid claims data to create bundled payments, and to be responsive to quality payments. Early, immature markets, especially where the best treatment modalities have yet to be worked out, require broad fee-based reimbursement that is agnostic to outcomes. By creating provider capacity and gathering claims data, payers can gain an understanding of what services cost and be prepared to move forward to the next step on the continuum: bundled payment.

Bundled Payment

Bundled payment models come in many flavors, but they all require markets that have matured beyond FFS dependency. Bundled payment depends upon sources of historical data that help identify the link

between payment and outcomes. In these models, providers are paid a fixed-dollar amount based on the expected costs of a clinically defined episode or a bundle of related health care services needed by a particular individual for a particular treatment. Thus the provider assumes the risk of providing an agreed-upon scope of services for a set price. Bundled payment can help reduce overuse of unnecessary services, support better coordination of care across providers, and prevent costly complications.

However, this incentive structure may also lead a provider to provide a low level of care or fail to diagnose complications before the end of the bundled payment date. A bundled payment methodology does not incentivize providers to reduce the number of care episodes per patient. Under bundled payment, providers may exert more autonomy over treatment, without having to focus on the relationship between treatment and billing.

One of the most important forms of bundled payment is prospective payment (PPS), where a provider is paid based on a predetermined, fixed amount for a particular service or encounter. A PPS rate is used in many acute inpatient hospitals, home health agencies, hospital outpatient settings, and federally qualified health centers.

Bundled payment rates cannot be set without an understanding of the costs of services and adequate historical data to identify what works. Many programs that use bundled payment can rely on historical claims data that have been collected in a fee-for-service environment. These historical data are then employed to prospectively define rates to cover the bundled payment. When a system integrates episodic payments into a budget for maintaining an individual's health over time, it is ready for population-based payment.

Population-based Payment

Population-based payment is the gold standard for value-based purchasing. It prospectively pays providers a set amount for all health care services rendered to a specific population for a fixed period of time, regardless of whether the members of that population actually seek care during that time. This differs from bundled payment, where payment is rendered only if an individual seeks care.

There are several forms of population-based payment. Traditional capitation determines the amount paid per individual across the entire population, regardless of the person's health status or how often he or she seeks services. Condition-adjusted capitation (also called risk-adjusted global fees) determines the amount paid per individual and adjusts that rate based on the relative health and other characteristics of individuals within that group. A partial capitation payment gives a provider a fixed-dollar amount to cover the costs of a pre-defined set of services. Partial capitation payment is typically used for carve-outs for high-cost items and services that a specified group may receive in a given time period, while other payments continue on FFS or other methods.

Population-based payment ensures that providers consider the costs of treatments and do not provide more services simply to increase revenues. This, in turn, gives providers more flexibility in deciding how services may be delivered to a patient and how to properly allocate resources for a particular patient. Providers here have an interest in providing the most effective care possible and ensure a patient's overall health over time. If a provider cannot provide quality care for a client, the practice is sure to suffer because costs will outpace service. In this model, preventive care is a gold standard, because illness prevention tends to be less expensive than illness treatment.

Establishing rates for population-based payment is a complex process. In certain circumstances, the amount of payment will need to be adjusted based upon severity of conditions and other factors associated with a person's treatment. This requires data to understand and properly establish rates that respond to the nuances and interplay of individual needs. A robust understanding of the most appropriate practices is essential to establishing accurate rates.

Population-based payment relies on the conditions created by both FFS and bundled payment. As mentioned, FFS is essential in the early stages of market development. FFS allows providers and payers

to learn how to identify costs for effective treatments and services over time through rate-settings and readjustments. This awareness of costs and treatments allows for payers to begin bundling treatments and sharing risk with treatment providers. This, however, is not full-scale value-based purchasing because of the episodic nature of payment. A fully capitated program, where the overall health of individuals in a population is managed, allows for providers to share risk, be incentivized to promote the wellness of individuals absent illness, and identify the most cost-effective treatments.

As health care systems move toward a population health approach, new statutory and regulatory incentives and structures are being created. The ACA incentivized the creation of health homes that manage the care of individuals with two or more comorbidities. The ACA also incentivized creating Accountable Care Organizations that allow providers to integrate and share savings and risk. The ACA also tied penalties to hospital readmission rates.

Many states are experimenting with managed care structures that allow for flexibility in behavioral health management. New York is employing many of these population-based programs to manage the health care of high-need clients. Through its Medicaid Managed Care waiver, New York has created Health and Recovery Plans (HARPs) that integrate physical and behavioral health by creating sub-capitation rates for managing the care of individuals with behavioral health needs. HARPs are example of the power of the creativity that providers can bring to their work in order to effectively meet the health needs of their clients.

As described, health care financing exists on a continuum from FFS to population health. These structural steps are essential to facilitate a movement from bundled payments to population health payments. However, the behavioral health system remains in a state of moving from FFS to bundled payment. The Excellence Act provides the booster shot that the behavioral health system needs in order to catch up and move into value-based purchasing.

Filling the Gaps: The Excellence Act

To recapitulate, value-based purchasing exists at the end of an evolutionary continuum that relies upon precedent financing mechanisms and quality of care sensitivity. True, population-based value-based purchasing requires integrating systems of care across the behavioral health and physical health systems and allowing for providers to share risk. But these system reforms are dependent upon having a clear understanding of both the modalities of care and the costs for care. While physical health is beginning to tackle these challenges, behavioral health is starting at a disadvantage.

The key to meeting these shortcomings comes from a nascent demonstration project passed with bipartisan support as part of the Protecting Access to Medicare Act of 2014 (PAMA). Section 223 of the PAMA, colloquially called the Excellence Act, contains the statutory authority for states to participate in a demonstration project that creates certified community behavioral health clinics (CCBHCs), which will integrate primary and physical health care under a cost-based prospective payment system. Each state in the demonstration project has great latitude to create its CCBHC program as it sees fit. This demonstration provides an opportunity for behavioral health centers move from FFS to bundled-payment and establish many of the building blocks for value-based purchasing. At present, twenty-four states are competing for eight slots to become CCBHCs, but even if a state is not selected to participate in the program, the planning phase will be invaluable for the coming VBP future.

The skills that behavioral health providers will gain as they prepare to become CCBHCs are the same skills that will allow them to succeed under value-based purchasing. In order to participate, providers will need to understand cost accounting, including cost per unit or case; to manage an episodic rate of service; to have a functional electronic health record and health information exchange capabilities; to use clinical decision support tools; to be prepared for instant consumer access; and to measure systemic qualities. These are the same building blocks of a successful value-based purchasing program.

Broadly, the CCBHC program moves the behavioral health system to a bundled-payment system that will, in turn, move toward integration with physical health and value-based purchasing. Each CCBHC will be paid a set PPS rate for a scope of services to manage each client's care. In the process, the CCBHC

program will standardize data within the state in order to inform population health financing mechanisms.

The CCBHC is distinct from any other safety-net program to date. On the surface, a CCBHC may look a lot like a Federally Qualified Health Center (FQHC) because of the PPS and encounter rate. The similarities between these two programs largely end there. The table below demonstrates some of the key differences. Very importantly, the service components that define a CCBHC will largely be set by the state, not the federal government. This means that, within the nine required essential service areas, each state has great latitude to define how these services are constituted.

	FQHC	CCBHC
Medicaid services reimbursable under Title XIX	Defined by the federal government	Defined by the states within federal guidance
Definition of a visit	Defined by the federal government	Defined by the states within federal guidance
Electronic data	No defined requirement; defined by market forces	Mandated
Integrated care	No defined requirement; defined by market forces	Mandate
Uniform reporting	Unified Data System	Defined by the federal government; states can define other metrics
Service setting	Typically only within the four walls of a clinic	Anywhere

The central component of the CCBHC is care coordination. It is not enough to simply offer services, especially in value-based purchasing. Care coordination requires examining and partnering with the entire health landscape, even agencies such as prison or jail, in order to identify ways in which clients can be engaged. This care coordination could be likened to an FQHC's enabling services, but the CCBHCs will have a much broader opportunity to engage with many providers, not simply those that aid in access to health care. This holistic approach to care coordination is a central and important distinction from FQHCs. Care coordination ensures that other agencies surrounding a CCBHC become full partners with the CCBHC, rather than competing to ensure high-quality care to people who may not otherwise have access to services.

As a new provider type, CCBHCs have distinct features that build value-based purchasing into their DNA. They are the first provider type required by statute to collect structured meta-data on their services. This means that state-determined data and metrics are a part of all behavioral health services provided by these facilities. CCBHCs are also required to work with a range of agencies and partners. But, regardless of who provides the service, the CCBHC must collect data on demographics, quality, and other metrics. This creates an integrated database that transcends the work done within the CCBHC.

While the federal government created the FQHC system with a strong, centralized set of guidelines and criteria, the states will determine much of what constitutes a CCBHC, including details related to scope of services and data collection. The federal government created a Unified Data System for FQHCs, but no such central reporting scheme exists for CCBHCs. This means that each state can craft how its demonstration project will fit into the value-based purchasing ecology. This flexibility, while certainly a burden, could be invaluable for states that are circumspect about the state of their behavioral health system and the goals of their value-based purchasing experiments. Synchronizing FQHCs into these value-based purchasing plans has proven to be challenging because of the strong federal role. But with CCBHC, the state can craft a program that aligns with its strategic goals.

To better understand the path ahead for states, we outline key decision points below. Each decision point represents a key moment in crafting CCBHCs to integrate into planning for value-based

purchasing. Naturally, each state will make these decisions differently. Underlying all these decision points are questions regarding what data will be collected and shared. As mentioned, understanding value and costs require collecting and analyzing data in ways that improve care.

Decision Point 1: Evidence-Based Practices and the Scope of Benefits

Each state's CCBHC must provide nine services in order to be certified, and these services and other social services must be coordinated by the CCBHC among multiple providers. Each state will need to decide how each of these services is designed. These nine services are:

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2. Screening, assessment, and diagnosis, including risk assessment.
3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4. Outpatient mental health and substance abuse services.
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6. Targeted case management.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.^v

The distinctive array of services does not currently exist in any provider's repertoire. These services, and the care coordination that will ensure that these services are deployed in a manner that meets the needs of Medicaid recipients, are the essence of value-based purchasing. CCBHCs must have care coordinators on staff who can assess a person's needs and ensure that those needs are met, whether by the CCBHC, a collaborating agency, or an outside agency with whom the CCBHC has a relationship. This single point of consolidation will support holistic, patient-centered treatment planning, including consideration of the patient's family's needs, and connect the patient to many services that will enable the patient to succeed.

Beyond care coordination, the services themselves create an opportunity for value-based purchasing. States have great leeway in describing what constitutes, for example, psychiatric services. By defining these services expansively, each state can integrate the CCBHC program into its value-based purchasing plan. States also must decide which evidence-based practices will be adopted in order to provide high-quality behavioral health care within the nine broad service requirements.

The payment methodology for service mix within the scope of service is fundamentally an all-inclusive bundled payment rate. By statute, the services and care coordination provided under CCBHC are unique and represent a rough outline of the best practices in behavioral health. The costs associated with all these services will be included in the rate that a CCBHC draws down.

Each state will need to choose between two PPS methodologies (described below). Regardless of which methodology is chosen, this broad mix of services will all be bundled into a single rate that will be drawn down during a daily or monthly encounter. It will be up to each CCBHC to decide how best to apply the services to a particular client. This episodic repayment method will provide CCBHCs with clinical decision-making autonomy to fill in many of the existing blanks in the behavioral health world. And because states have so much flexibility in defining the details of these services, states can thoughtfully mold these services to fit their needs.

Service definition is also essential to understanding what data a CCBHC or state must collect. The outcomes from these practices must be maintained by the CCBHC in a manner that can then be accessed by auditors. By building in appropriate evidence-based practices that meet the needs of the

communities in a CCBHC service area for a particular state, the state will ensure that it only pays for practices that match the community's needs.

Data collection leads to many decisions with respect to relationships with other providers and agencies. CCBHCs must coordinate with other providers (called Designating Collaborating Organizations, or DCOs) and agencies in order to provide all of the required services, while collecting structured data and measuring outcomes. It is worth emphasizing that no single clinic will be able to provide all services to all clients—this means that behavioral health providers will have to work together to meet the needs of their clients. This integration at the very core of the CCBHC program is a central tenet of value-based purchasing. This new provider type means that, for the first time, the federal government will be able to collect information on how various states are implementing behavioral health programs. This will allow the behavioral health system to move a step closer to integrating behavioral health into value-based purchasing.

Because of the data reporting requirement, the CCBHC will be better able to identify which providers are good partners for which types of services. In other systems, where typically there is little follow-up on referrals, many referring providers have no idea what care a client received, or to what effect. Since a CCBHC must maintain data for its services, it will be able to track whether a DCO is providing adequate care, or whether one DCO's outcomes are significantly different from those of other providers. This type of central tracking allows a CCBHC to make informed decisions about where to send clients in order to ensure good care and verify that a DCO is a worthy service provider.

In addition to DCOs, CCBHCs must coordinate care with many other agencies and departments in the community. By statute, the CCBHC must reach out to Indian Health Services, inpatient psychiatric facilities, Federally Qualified Health Centers, schools, child welfare agencies, criminal justice agencies, inpatient hospitals, and Veterans Affairs medical centers. The CCBHC program integrates these different actors and tears down siloes that have prevented continuity of care among safety net systems. Coordinating across these agencies and entities means that there are few places that a CCBHC client would go that would be outside the shared agreements to provide care. It would also ensure data collection and coordination from all of these sites.

The state needs to decide how the relationships between the CCBHC, partner entities, and designated collaborating agencies will be managed. CCBHCs and DCOs can structure their relationships to move away from transactional payment and toward bundled-payment. For example, a state could encourage CCBHCs to pay a DCO a global budget for the services it provides to the CCBHC, with bonuses for treating above a certain volume of clients. In this way, the DCO will be responsible for ensuring quality of care and outreach, instead of simply incentivizing billing units. Of course, since providers may exist in different places along the FFS to value-based purchasing continuum, some DCOs might be best served by sticking with FFS. Each service must be evaluated in a way that ties together the current understanding of the data with the value-based purchasing goals of the state.

Decision Point 2: Selecting PPS-1 or PPS-2

As mentioned, behavioral health in the CCBHC demonstrations will be financed via PPS. States have a choice, however, of two PPS development methodologies. The first option, PPS-1, will repay a clinic a single rate per day for an eligible encounter with a client. This single rate will be calculated based on the costs accrued by the clinic divided by the number of encounters, as defined by the state. This bundled payment methodology will give CCBHCs great flexibility in selecting the most appropriate services for clients in their facilities while collecting data and resources that will help states better address behavioral health needs.

The second option, PPS-2, creates a monthly case mix rate with separate reimbursement rates for specific diagnoses. At first glance, the PPS-2 methodology could look like an adjusted capitation population-health model, but, in practice, PPS-2 is just another way of providing bundled payment. States that select PPS-2 will face many challenges in adequately identifying and defining the diagnostic groups to receive the separate payments, as well as matching proper treatments and costs with diagnoses. This will be a reach in the current behavioral health environment. As mentioned, health care

financing is an evolutionary process, and by hurrying the behavioral health system into a proto-population-health approach, PPS-2 might force many behavioral health providers to move beyond their readiness.

Both PPS-1 and PPS-2 could be structured in a way that will allow a CCBHC to prepare for value-based purchasing. But in selecting a PPS rate, states should not think that they would receive a capitated rate. Instead, the respective rate is only drawn down if a patient enters the CCBHC for the state-defined enumerated visit—leading to very different ways of thinking about how CCBHC will fit into value-based purchasing.

Decision Point 2.1: Creating a PPS-2 Case Mix

For states that choose PPS-2, the complexity is just beginning. Because PPS-2 requires states to create case mix rates for sub-populations, the state must now decide which sub-populations will be reimbursed through a case-mix methodology. Selecting appropriate target populations is essential. Because PPS-2 is an unduplicated monthly encounter rate, failing to create appropriate case rates could have drastic consequences on a CCBHC's ability to cover its costs. Many of the case-mix rates will be created for high-needs populations, making case-mix strategies risky propositions. Even if an individual with acute needs enters a CCBHC fifteen times a month, the CCBHC will receive only one payment. If that same client never returned for the rest of the year, the CCBHC would find it impossible to cover the costs that particular client accrued. For small providers, a few of these events a year could be disastrous.

Decision Point 3: Defining an Enumerated Visit

States also must decide what activities constitute an enumerated visit. Unlike the FQHC, where all services are typically provided behind the doors of a licensed clinic, the CCBHC is fundamentally a non-four-walls approach to service delivery. A CCBHC and a DCO do not have to provide the certified services inside a licensed building at all.

This makes deciding what and how services are administered extremely important. For example, each state must decide how new technologies that are changing patient experience, such as virtual engagement, will be reimbursed.

Again, PPS-2 involves more complicated decision-making. Each case mix, and thus each DCO, will be best managed through different engagement protocols tailored to the client. Strategic thinking here is essential.

Decision Point 4: Defining Quality

Quality bonuses are built into CCBHCs. Because value-based purchasing has a goal of improving outcomes, it makes sense to tie payments to beneficial outcomes. PPS-2 states will have a set of quality metrics for which data must be collected from CCBHCs and DCOs, but each state will have the option to select unique quality bonuses and metrics. Identifying and capturing the appropriate data will be essential to lay the ground for any value-based purchasing system. Understanding what constitutes quality payment requires knowledge and experience. The CCBHC program has significant flexibility regarding how these metrics are determined, while leaving room to experiment with different treatment mixes. CCBHCs will be able to administer care in a way that promotes better outcomes, rather than being concerned with drawing down the fee.

These decision points describe how a CCBHC can be aligned with value-based purchasing. By carefully considering each of these points, states will be poised to propel their behavioral health system into value-based purchasing while meeting the needs of many vulnerable individuals who, for too long, have found themselves in a system that was under-resourced to provide them with adequate care.

Conclusion

Value-based payment is just beginning to roll out across the health care system. Value-based purchasing has long been the Holy Grail in the commercial market, but public health systems have been left behind. The Excellence Act provides the behavioral health system with a much-needed boost to prepare to integrate with physical health. By participating in the Excellence Act, providers will gain many of the necessary skills to prepare for value-based purchasing. The Excellence Act will help providers understand cost accounting, including cost per unit or case; manage an episodic rate of service; have a functional electronic health record and health information exchange capabilities; use clinical decision support tools; be prepared for instant consumer access; and measure systemic qualities. Each of these accomplishments would be laudable in themselves, but together they may fundamentally change the way our behavioral health system orients itself to society's most vulnerable members.

States must think through carefully how they may use this opportunity to transform the entire health care system into one that is ready for value-based purchasing.

ⁱ http://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Briefing_Substance_Use_Treatment.pdf

ⁱⁱ National AFacts About Stigma and Mental Illness in Diverse Communities,
<http://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=5148>

ⁱⁱⁱ <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>

^{iv} Tami L. Mark, Katharine R. Levit, Rita Vandivort-Warren, Jeffrey A. Buck and Rosanna M. Coffey, "Changes in US Pending n Mental Health and Substance Abuse Treatment, 1986-2005, and Implications for Policy, Health Affairs, 30, no.2 (2011):284-292.

^v The Protecting Access to Medicare Act § 223(2)(D)(i-ix).