

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-13)
Delivery of Care and Financing Reform for Medicare and Medicaid Dually Eligible Beneficiaries
(Reference Committee A)

EXECUTIVE SUMMARY

The Council on Medical Service presents this report to address the delivery of care and financing reform for dually eligible beneficiaries, consistent with the American Medical Association (AMA) strategic focus on delivery reform. Dually eligible beneficiaries are the sickest, most costly population in the health care system. While this group represents 21 percent of Medicare beneficiaries, it accounts for 36 percent of Medicare spending. Comparatively, this population comprises 15 percent of Medicaid enrollees, and 39 percent of total Medicaid spending.

The provision of health care to individuals receiving both Medicare and Medicaid often results in fragmented care for many beneficiaries due to misaligned incentives between the two programs. Streamlining the coverage provided by Medicare and Medicaid so that the programs work more effectively and efficiently together is a key goal in health care reform efforts-both to provide higher quality care and to reduce health care costs.

There are two nationwide state demonstration programs for dually eligible beneficiaries: 1) State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees; and 2) The Financial Alignment Initiative. Through the first demonstration, 14 states have been awarded up to \$1 million each to design new approaches to better coordinate and integrate care for dually eligible beneficiaries. These states are awaiting federal approval of their proposed designs. Through the second demonstration, Massachusetts, Washington, Ohio, Illinois and California have signed contracts with the Centers for Medicare & Medicaid Services (CMS) to align Medicare and Medicaid funding under either a capitated or managed fee-for-service model and to integrate services and supports for dually eligible beneficiaries.

The Council believes that final outcomes of the demonstrations could vary from the initial intent since the details of each state's demonstration will be the result of a negotiation between the state, health insurance plans and CMS. Accordingly, this report addresses planned aspects of the demonstrations that may impact delivery and financing of care.

This report provides background on the dually eligible population, outlines state demonstrations, highlights quality measures, summarizes AMA policy and advocacy, and presents policy recommendations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-13

Subject: Delivery of Care and Financing Reform for Medicare and Medicaid Dually Eligible Beneficiaries

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee A
(Jerry L. Halverson, MD, Chair)

1 The dually eligible population consists of a diverse group of 10.2 million beneficiaries covered by
2 both the Medicare and Medicaid programs. Individuals under the age of 65 with a disability
3 account for 41 percent of the dually eligible population, while those over the age of 65 account for
4 59 percent.¹ The majority of individuals in this population suffer from serious chronic health
5 conditions, while 31.9 percent do not. Furthermore, 17 percent live in institutions, while almost 80
6 percent live in the community.²

7
8 The Council on Medical Service presents this report to address the delivery of care and financing
9 reform for dually eligible beneficiaries, consistent with the American Medical Association (AMA)
10 strategic focus on delivery reform. The report provides background on the dually eligible
11 population, outlines state demonstrations, highlights quality measures, summarizes AMA policy
12 and advocacy, and presents policy recommendations.

13 14 BACKGROUND

15
16 Dually eligible beneficiaries are the sickest, most costly population in the health care system.
17 While this group represents 21 percent of Medicare beneficiaries, it accounts for 36 percent of
18 Medicare spending. Comparatively, this population comprises 15 percent of Medicaid enrollees,
19 and 39 percent of total Medicaid spending.³ In 2011, approximately \$300 billion was spent
20 collectively by states and the federal government for individuals who qualify for both Medicare
21 and Medicaid.⁴ Dually eligible individuals consume an average of \$30,000 per capita in health care
22 services annually.⁵

23
24 The provision of health care to individuals receiving both Medicare and Medicaid often results in
25 fragmented care for many beneficiaries due to misaligned incentives between the two programs.
26 For example, nursing homes receive higher payments from Medicare when their patients are
27 admitted to the hospital and then return to the nursing home. Very strong financial incentives exist
28 for a nursing home to periodically transfer a patient to the hospital since Medicare covers up to 100
29 days of skilled nursing facility (SNF) care per period of illness after a medically necessary inpatient
30 hospital stay of at least three days. For the first 20 days of SNF care after a hospital stay, Medicare
31 pays 100 percent of payment rates. For the next 80 days, beneficiaries are responsible for
32 copayments and Medicare pays the rest of a qualified SNF stay. Medicaid or the nursing home
33 resident then resumes payment of care if still needed. If a beneficiary has a lapse in SNF care that
34 lasts more than 60 days, a new three day stay in the hospital is needed to qualify for another 100
35 days of SNF care covered by Medicare.

1 Medicare is responsible for acute care provided by physicians and hospitals, diagnostic tests, and
2 prescription drugs. Medicaid covers some long-term supports and services and in some states
3 assists with paying for Medicare premiums and cost-sharing. Although each program is
4 accountable for providing specific health care services, care is often poorly coordinated, which can
5 result in unnecessary and costly care, or alternately, inadequate care. Streamlining the coverage
6 provided by Medicare and Medicaid so that the programs work more effectively and efficiently
7 together is a key goal in health system reform efforts-both to provide higher quality care and to
8 reduce health care costs.

9 10 STATE DEMONSTRATIONS

11
12 There are two nationwide state demonstration programs for dually eligible beneficiaries: 1) State
13 Demonstrations to Integrate Care for Medicare-Medicaid Enrollees; and 2) The Financial
14 Alignment Initiative.

15 16 *State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees*

17
18 The Patient Protection and Affordable Care Act of 2010 established the Federal Coordinated
19 Health Care Office, or also known as the Medicare-Medicaid Coordination Office, to improve
20 quality, reduce costs, and improve the experience for dually eligible beneficiaries. Through the
21 solicitation of proposals for the “State Demonstrations to Integrate Care for Medicare-Medicaid
22 Enrollees” initiative, this office is working within the Centers for Medicare & Medicaid Services’
23 (CMS) Center for Medicaid and Medicare Innovation on state demonstrations to integrate care for
24 dually eligible enrollees.

25
26 In 2011, 15 states (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New
27 York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and
28 Wisconsin) were awarded up to \$1 million each to design new approaches to better coordinate and
29 integrate care for dually eligible beneficiaries (also called “design contracts”).⁶ Since then,
30 Tennessee decided to withdraw from the program due to concerns about adequate payment from
31 the demonstration plans. According to CMS, the primary goal of a design contract is the
32 development of a detailed demonstration model describing how each state would structure and
33 implement its proposed integrated program. States were instructed to work with beneficiaries,
34 beneficiaries’ families, and other stakeholders to develop their demonstration proposals. After
35 federal review of the proposals, CMS will work with states to implement the plans that hold the
36 most promise. Selection for a design contract does not ensure federal approval or endorsement for
37 any implementation activities associated with these plans.⁷

38 39 *Financial Alignment Demonstrations*

40
41 The “Financial Alignment Initiative” provides states an opportunity to align Medicare and
42 Medicaid funding under either a capitated model or managed fee-for-service model and to integrate
43 primary, acute, behavioral health, and long-term care services and supports for dually eligible
44 beneficiaries. This demonstration also allows states to share in the overall cost savings. Through
45 this demonstration, CMS will assess the effectiveness of these two delivery and payment models
46 for the dually eligible population.

47
48 Massachusetts was the first state to finalize a memorandum of understanding (MOU) with CMS to
49 implement its demonstration of the capitated financial alignment model, beginning on
50 April 1, 2013. Since then, the state of Washington finalized a contract with CMS to provide care
51 under the managed fee-for-service payment model and Ohio, Illinois and California have secured

1 contracts to demonstrate the capitated model. CMS continues to work with more than 20 other
2 states that have submitted proposals for a financial alignment demonstration.⁸

3 4 QUALITY MEASURES

5
6 To develop a national measurement strategy for the dually eligible population, the Department of
7 Health and Human Services (HHS) engaged the Measure Applications Partnership (MAP), a multi-
8 stakeholder group of public and private organizations, including the AMA, and experts convened
9 by the National Quality Forum (NQF). MAP seeks to address the fragmented, episodic nature of
10 care that many dually eligible beneficiaries currently receive. MAP has identified an evolving core
11 measure set that is sensitive to the unique needs of dually eligible beneficiaries and has outlined
12 suggestions for improving and broadening many existing measures to make them more applicable
13 to this population.

14
15 MAP's intention is to inform constituents that are critical to the successful implementation of an
16 aligned measurement strategy for dually eligible beneficiaries, such as the National Committee for
17 Quality Assurance (NCQA). The NCQA, with support from the SCAN Foundation, has developed
18 a framework for evaluating integrated care for the dually eligible population and a draft set of
19 structures and processes that could be a roadmap to developing an integrated care system. At the
20 time this report was written, the NCQA was testing the feasibility and utility of the draft structure
21 and process measures for integrated care entities serving the dually eligible population.

22 23 AMA POLICY AND ADVOCACY

24 25 *AMA Policy*

26
27 The AMA strongly supports efforts to better coordinate the care of individuals who are dually
28 eligible for Medicare and Medicaid, and who often face barriers to obtaining the correct care in the
29 appropriate setting (Policy H-290.968). However, the AMA advocates limiting the size and
30 expansion of the dually eligible managed care pilot process until it demonstrates improved
31 accessibility, quality and cost efficiencies (Policy D-290.978[2]). Importantly, the AMA
32 encourages adequate and timely public disclosure of pending implementation of managed care
33 under a state program, so as to allow meaningful public comment and advocates for a phased
34 implementation to ensure availability of an adequate, sufficiently capitalized managed care
35 infrastructure and an orderly transition for beneficiaries and providers (Policy H-290.985[1,2]).

36
37 The AMA promotes demonstration projects that preserve and protect the freedom of patients to
38 choose their providers (Policies H-415.988, H-330.988, H-373.998[2] and H-165.985[2]) and
39 maintain their current treatment or drug regimen (Policies H-125.991[4,c], H-125.983 and
40 D-290.980[2]). The AMA advocates that CMS encourage states to empower dually eligible
41 beneficiaries with understandable information about their options including covered benefits,
42 deductibles, co-payments, prescription drug formulary, prior authorization requirements, and the
43 provider network (Policies H-285.998[5] and D-390.999).

44
45 State demonstration projects should allow dually eligible beneficiaries the ability to "opt-in" to a
46 given plan (Policies H-290.984, H-373.998[2] and H-165.985) rather than passively enrolling
47 individuals (Policy D-290.980[4]). The AMA advocates that CMS require all states to develop
48 forms and related processes to facilitate "opting out" of managed care programs by dually eligible
49 individuals, and that those forms and directives be available no less than 120 days before the
50 implementation date of a state's dually eligible managed care program (Policy D-290.978[1]). The

1 demonstration projects should include policies that allow beneficiaries to disenroll at any time from
2 a plan if it does not meet their health care needs (Policies H-290.985[9] and H-165.985).

3
4 The AMA advocates that CMS's financial alignment demonstration should operate as a true
5 demonstration program and should not enroll a majority of dually eligible beneficiaries in any state.
6 In addition, there must be a rigorous evaluation plan that can provide useful information to
7 policymakers. This demonstration should uncover potential ways of achieving efficiencies in
8 organizing the care of dually eligible beneficiaries and any savings from coordination of care
9 should arise from better health outcomes and efficiencies gained by reducing duplicative,
10 unnecessary, or inappropriate care (Policy D-290.980[3,5]).

11
12 The AMA advocates that care coordination be led by a physician and involve a robust partnership
13 among the physician, patient, the patient's family, and other health care providers (Policy
14 H-290.985[10]). Provider networks should include a sufficient number of primary care physicians
15 and specialists within the geographic region to meet the complex medical needs of this population
16 (Policies H-285.973 and H-285.911). To help maintain an adequate network, the AMA encourages
17 states to continue providing full payment of deductibles and co-payments for all dually eligible
18 beneficiaries (Policies H-290.978 and D-290.998).

19
20 In order to protect access to care for dually eligible beneficiaries, the AMA advocates that CMS
21 ensure the state demonstration projects maintain adequate payment rates for physicians (Policy
22 H-290.980). Specifically, the AMA supports physician payment for treating dually eligible
23 beneficiaries to be at least as high as Medicare fee for service payment rates (Policy H-290.976[2]).
24 The initiative should not be employed as a policy lever simply to reduce provider payment rates,
25 which could significantly harm beneficiary access (D-290.980[5]).

26
27 *AMA Advocacy*

28
29 The Council has previously addressed the dually eligible population. Council on Medical Service
30 Report 6-A-06 described the characteristics of the dually eligible population, explained the
31 difficulty that the population has navigating the health care system, reviewed costs related to their
32 care and described the tradeoffs associated with policy options for the care of this extremely
33 vulnerable group.⁹ In Council on Medical Service Report 1-A-12, which focused on Medicaid
34 financing reform, the Council expressed optimism about the state demonstrations and indicated it
35 would monitor the new program.¹⁰

36
37 Since the adoption of recommendations contained in Council on Medical Service Report 1-A-12
38 (Policy H-165.855), many stakeholders, including the AMA, have issued letters of concern to HHS
39 about the details of the demonstration program. In July 2012, the AMA sent a letter to CMS
40 requesting delayed implementation of the dually eligible demonstration program to allow
41 beneficiaries and providers time to understand the initiative (Policy D-290.980[1]). The letter also
42 recommended the following: demonstration projects should be reasonable in size, scope, and speed
43 of implementation, beneficiaries' freedom to choose their providers should be preserved and
44 protected, care coordination should be led by a physician, demonstration projects should include an
45 adequate network of providers, physician payment should be at least as high as current Medicare
46 fee-for-service rates, program savings should come from improved care coordination and quality,
47 not from reduced provider rates and the demonstration projects should be simple and easy to
48 navigate for patients and providers.¹¹

49
50 In addition, the AMA Advocacy Resource Center developed an issue brief highlighting key issues
51 that states should consider in reviewing proposed demonstrations for dually eligible beneficiaries.¹²

1 DISCUSSION

2
3 At the time this report was written, only five states had signed contracts with CMS to implement a
4 state demonstration for dually eligible beneficiaries. Each of these demonstrations is scheduled for
5 three years, after which an evaluation will take place. At this early stage, the Council is unable to
6 comprehensively assess a demonstration's consistency with AMA policy since implementation is
7 barely underway. The Council believes that final outcomes of the demonstrations could vary from
8 the initial intent since the details of each state's demonstration will be the result of a negotiation
9 between the state, health insurance plans and CMS. Accordingly, this report has addressed planned
10 aspects of the demonstrations that may impact delivery and financing of care.

11
12 Given the diversity of medical needs within the dually eligible population, it is unlikely that one
13 approach to integrated delivery of care will address all of this population's health care needs.¹³
14 As stated previously, the dually eligible population consists of two subpopulations-disabled
15 individuals under the age of 65 and individuals over the age of 65. Both of these groups include
16 individuals who are mentally ill, developmentally disabled, diagnosed with dementia, and
17 diagnosed with having a range of chronic conditions. The Council believes that this population
18 needs customized benefits and services from health plans according to each beneficiary's specific
19 medical needs. Various approaches to integrated delivery of care should be promoted under the
20 state demonstrations, including primary care medical homes with adequate payment to physicians,
21 provision of care management, and mental health resources.

22
23 Because dually eligible beneficiaries often have complex medical and social needs, the AMA
24 advocates that established patient-provider relationships and current treatment plans not be
25 disrupted by the state demonstrations so as to preserve robust, patient-centered continuity of care.
26 The AMA opposes automatically enrolling this population in a coordinated care program or
27 managed care plan without their prior approval or consent (D-290.980[2,4] and H-290.984).
28 However, CMS has provided guidance to the states that it will allow a passive enrollment process
29 as long as beneficiaries are given the ability to enroll or disenroll on a month-to-month basis at any
30 time in the year throughout the entire duration of the initiative

31
32 The Council believes it is imperative that this population have the option to continue receiving
33 health care services from their current physicians in order to maintain continuity of care. Opting
34 out of a state demonstration needs to be as easy as possible since more than half of dually eligible
35 beneficiaries have a cognitive or mental impairment that may make it difficult for them to navigate
36 the health care system.¹⁴ Also, the ability to opt out of a state demonstration should be as efficient
37 as possible so as not to interrupt necessary care that is currently being managed.

38
39 Some states plan to enroll most of their dually eligible population in a demonstration. However,
40 Policy D-290.980[3] advocates that demonstrations should not enroll a majority of dually eligible
41 beneficiaries in any state. The Council does not believe that outcomes could adequately be assessed
42 with the majority of a state's population in a demonstration since an equally sized control group
43 would not exist with which to compare the demonstration population.

44
45 The Council believes that delivery and payment reform for dually eligible beneficiaries should
46 involve actively practicing physicians and take into consideration the diverse patient population
47 and local area resource. Actively practicing physicians should be involved in the implementation of
48 state demonstrations to ensure that the patient-physician relationship is preserved and continuity of
49 care is prioritized in this especially vulnerable population. An example is an earlier pilot, the
50 Medicare Physician Group Practice Demonstration (PGPD), in which participating physician
51 groups received bonus payments if they met quality targets and achieved lower cost growth than

1 local controls. The PGPM was a Medicare demonstration that ran from 2005-2010, which included
2 10 physician group practices across the nation. Although evidence indicates the PGPD improved
3 quality, uncertainty remains about its overall effect on costs. However, among the dually eligible
4 beneficiaries in the demonstration, which were 15 percent of participating patients, PGPD
5 physician groups achieved a mean annual per capita savings of \$532 or five percent.¹⁵
6

7 Education and counseling are needed to assist these individuals in making decisions about potential
8 changes in their health benefits. For states with approved financial alignment demonstrations,
9 funding is available through CMS and HHS' Administration for Community Living to
10 provide such counseling to ensure access to unbiased information on options for receiving
11 Medicare and Medicaid benefits. The funding will go to support local state health insurance
12 counseling and assistance programs, and aging and disability resource centers. The Council
13 encourages states to apply to receive this funding as each state should provide education and
14 counseling to beneficiaries on their options for receiving Medicare and Medicaid benefits. In
15 addition, the Council suggests that Policy D-290.978[1] be reaffirmed because it calls for CMS to
16 require that all states develop forms and related processes to facilitate opting out of managed care
17 programs by dually eligible individuals, and that those forms and directives be available no less
18 than 120 days before the implementation date of a state's dually eligible managed care program.
19

20 There are many areas in which the Medicare and Medicaid programs have conflicting requirements
21 or create incentives that prevent dually eligible beneficiaries from receiving coordinated care. As
22 noted earlier, nursing homes receive higher payments from Medicare when their patients are
23 admitted to the hospital and then return to the nursing home. The Council believes that conflicting
24 payment rules between the Medicare and Medicaid programs should be eliminated, that the two
25 program's benefit plans and the delivery of those benefits should be coordinated, and that
26 beneficiary care plans should be streamlined among clinical providers and social service agencies.
27

28 RECOMMENDATIONS

29
30 The Council on Medical Service recommends that the following be adopted and the remainder of
31 the report be filed:
32

- 33 1. That our American Medical Association (AMA) adopt the following principles on the
34 delivery of care and financing reform for Medicare and Medicaid dually eligible
35 beneficiaries:
 - 36 a. Various approaches to integrated delivery of care should be promoted under
37 demonstrations such as physician-led patient-centered medical homes with adequate
38 payment to physicians, provision of care management and mental health resources.
39
 - 40 b. Customized benefits and services from health plans are necessary according to each
41 beneficiary's specific medical needs.
42
 - 43 c. Care coordination demonstrations should not interfere with the established patient-
44 physician relationships in this vulnerable population.
45
 - 46 d. Delivery and payment reform for dually eligible beneficiaries should involve actively
47 practicing physicians and take into consideration the diverse patient population and
48 local area resource.
49

- 1 e. States with approved financial alignment demonstration models should provide
2 education and counseling to beneficiaries on options for receiving Medicare and
3 Medicaid benefits.
4
- 5 f. Conflicting payment rules between the Medicare and Medicaid programs should be
6 eliminated.
7
- 8 g. Medicare and Medicaid benefit plans and the delivery of benefits should be
9 coordinated.
10
- 11 h. Care plans for beneficiaries should be streamlined among all clinical providers and
12 social service agencies. (New HOD Policy)
13
- 14 2. That our AMA reaffirm Policy D-290.978, which calls for the Centers for Medicare &
15 Medicaid Services to require all states to develop forms and related processes to facilitate
16 “opting out” of managed care programs by dually eligible individuals, and that those forms
17 and directives be available no less than 120 days before the implementation date of a
18 state’s dually eligible managed care program. (Reaffirm HOD Policy)
19

Fiscal Note: Less than \$500.

References

- ¹ Data Analysis Brief. Medicare-Medicaid Dual Enrollment from 2006-2011. Medicare-Medicaid Coordination Office. February 2013.
Available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf
- ² The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare. Kaiser Commission on Medicaid and the Uninsured. April 2012.
Available at: <http://www.kff.org/medicaid/upload/7895-02.pdf>
- ³ Ibid.
- ⁴ Feder, J, Clemens-Cope, L, Coughlin, T, Holahan, J, and Waidmann, T. Refocusing Responsibility For Dual Eligibles: Why Medicare Should Take The Lead. October 2011.
Available at: <http://www.urban.org/UploadedPDF/412418-Refocusing-Responsibility-For-Dual-Eligibles.pdf>
- ⁵ Report prepared for MedPAC: Medicaid and Medicare Spending on Dual-Eligible Beneficiaries. Mathematica Policy Research. 2010.
- ⁶ New Flexibility for States to Improve Medicaid and Implement Innovative Practices. HHS News. US Department of Health and Human Services. April 2011.
Available at: <http://www.hhs.gov/news/press/2011pres/04/20110414a.html>
- ⁷ State Demonstrations to Integrate Care for Dual Eligible Individuals – Design Contracts. Center for Medicare and Medicaid Services.
Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html>

- ⁸ Financial Alignment Initiative. Center for Medicare and Medicaid Services.
Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>
- ⁹ Medicare/Medicaid Dual Eligibles. Council on Medical Service. American Medical Association. 2006.
Available at: <http://www.ama-assn.org/resources/doc/cms/a-06cmsreport6.pdf>
- ¹⁰ Medicaid Financing Reform. Council on Medical Service. American Medical Association. 2012.
Available at: <http://www.ama-assn.org/resources/doc/cms/a12-cms-report1.pdf>
- ¹¹ AMA Letter to the Centers for Medicare and Medicaid Services on Dual Eligibles. July 2012.
<http://www.ama-assn.org/resources/doc/washington/medicaid-dual-eligible-sign-on-letter-05july2012.pdf>
- ¹² Issue Brief: State Demonstration Projects for Dual Eligible Individuals. Advocacy Resource Center. American Medical Association. 2012.
Available at: <http://www.ama-assn.org/resources/doc/arc/x-ama/dual-eligible-demonstration-projects-issue-brief.pdf>
- ¹³ Report to the Congress: Aligning Incentives in Medicare. Chapter 5: Coordinating the Care of Dual-Eligible Beneficiaries. Medicare Payment Advisory Commission. June 2010.
Available at: www.medpac.gov/chapters/Jun10_Ch05.pdf
- ¹⁴ Brown, R, and Mann, D. Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence. Mathematica Policy Research. Kaiser Family Foundation Medicare Policy.
Available at: <http://www.kff.org/medicare/8353.cfm>
- ¹⁵ Colla, C, Wennberg, D, Meara, E, Skinner, J, Gottlieb, D, Lewis, V, Snyder, C, and Fisher, E. Spending Differences Associated With the Medicare Physician Group Practice Demonstration. Journal of the American Medical Association. 2012; 308(10):1015-1023.
Available at: <http://jama.jamanetwork.com/article.aspx?articleid=1357260>