Supplemental Safeguards: Communications

Background

As shared savings arrangements and other forms of value-based payment become increasingly prevalent in Connecticut, it is important that those who provide and receive care have an understanding of how healthcare financing is changing, and what it means for them. Communicating information directly to patients and providers is foundational to promoting this understanding. Such communications might include information about:

- The objectives of shared savings arrangements and the payment components utilized to achieve those objectives
- The ways in which shared savings arrangements are different than fee-for-service contracts
- The role of patients and providers in achieving the objectives of value-based payment

In addition, such communications might include, separately or in combination with other topics, information about issues the EAC has explicitly sought to address in this report, such as:

- The mix of financial incentives that providers, provider groups, and other ACO member service delivery organizations have under a shared savings arrangement
- The existence in some scenarios of a financial incentive to stint on care or inappropriately restrict patient panels
- How to understand if appropriate medical care has been provided
- What patients should do if they believe they have been denied medically necessary care

A number of entities historically communicate with healthcare consumers in Connecticut. These entities could play various roles in informing consumers about the above topics. For example:

- Payers could provide information at the time of patient enrollment
- Payers could provide information annually or on a standing basis
- Providers could post information at the point of care
- State agencie(s) could provide information annually, on a standing basis, or upon certain qualifying events

For the MSSP, CMS requires providers to post signs in facilities notifying beneficiaries that the provider participates in the MSSP, and to provide written notices upon request. Failure to notify beneficiaries of participation in an ACO constitutes grounds for termination from the MSSP. (CMS, 2014) CMS also publishes a beneficiary Q&A guide entitled “Accountable Care Organizations and You.” These materials focus on data privacy, beneficiary retention of provider choice, and benefits of being served by an ACO; they do not discuss financial incentives associated with providers’ participation in an ACO. (CMS, 2014)

Discussion

Choices about the content and medium employed to inform patients and providers about the nature of shared savings arrangements have implications for equity and access, and also for the success of payment reform more broadly. These choices include:

- Who should determine the content of communications?
- What should be the focus and scope of communications?
- Who should write and distribute communications?

- When should communications be issued, in what venues, and using what media?
- What messages should be consistent across all populations or multiple populations, and which messages should be tailored to specific populations?
- What should be done to ensure that the communications are accessible and understood by all of the intended audiences?

Communicating to consumers about shared savings contracts presents a number of opportunities and challenges. At a foundational level, consumers should have access to accurate, complete, usable information how their healthcare services are paid for. In addition, giving clear information to patients about shared savings contracts creates an opportunity to enlist them as participants in the goals of these contracts – improving the quality and coordination of their care, and utilizing healthcare resources efficiently. It also provides an opportunity to generate understanding among patients about how payment reform is intended to affect the way care is delivered, and about how it could unintentionally affect care delivery decisions in other, unwanted ways.

Armed with this understanding, consumers may be able to advocate for themselves more effectively and discern any instances in which medically appropriate services are not ordered for them, or in which they are excluded from a provider's panel for inappropriate reasons. These latter opportunities are particularly important to the context in which the EAC is evaluating this topic. To the extent that informing consumers about the potential for under-service and patient selection helps both to prevent and identify those activities, it will complement other safeguards that the EAC recommends.

At the same time, the complexity and variety of financial incentives associated with shared savings contracts make it inherently challenging to convey them to consumers in a succinct and universally applicable manner. Within an ACO, individual providers and provider groups may or may not be exposed to financial incentives associated with efficiency or quality. Given that fact, and given the mix of potentially countervailing short- and long-term incentives associated with ordering or not ordering a particular procedure or treatment, it may be difficult to characterize with great specificity the financial incentive associated with a provider's decisions.

And, while informing consumers about the potential incentive to stint on care will make them more alert to any actual instances of under-service, it is also likely to induce false positives – instances in which consumers perceive their care to be inappropriate or insufficient, when it is in fact consistent with standards of care and with the provider's clinical judgment. This concern is heightened by the fact that, even absent any prompting, consumers in some instances may already perceive that they are being under-served if a provider fails to order a commercially publicized treatment, even if that treatment is not indicated. If information provided to consumers about payment reform focuses exclusively or unduly on potentially adverse incentives, it may harm patient-provider relationships – which are fundamental to achieving individual and population-wide health goals. In turn, if providers perceive that communications are likely to adversely affect their relationship with patients – or, more generally, that the communications lack context or balance – they may elect to abstain from new payment arrangements or from accepting certain insurance products altogether.

Given the combination of opportunities and challenges described above, it is important that information communicated to patients on this topic be accurate, complete, balanced, and presented in a manner and context that makes it comprehensible and actionable.

<u>Recommendation #1:</u> Consumers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to efficiently manage the total cost of care and definitions of under-service and patient selection. In the context of value-based care delivery, consumers should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's provider, how to evaluate if one is receiving appropriate care, and what to do if one is concerned about the extent or type of care that has been ordered.

<u>Recommendation #2:</u> The type of information described in Recommendation #1 should be communicated to all consumers via a set of consistent messages. Messages should be written and distributed in a manner that is accessible and comprehensible by all consumers. Information should be made available both in advance of receiving care (i.e. at the time of insurance enrollment) and at the point of care (i.e. in the provider office). While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different insurance products, people with different clinical conditions), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as consumers' insurance or health status changes, and give providers standard guidance about engaging consumers that aligns with what consumers are being told.

<u>Recommendation #3:</u> A work group should be convened to advise state agencies and payers on the content to be contained in the core messages described in Recommendation #2. This work group should recommend specific language to be incorporated in messages. The work group should be composed predominately of consumers, consumer advocates, and providers. It should also include representatives of payers and state government agencies, and individuals with experience and expertise in communications, including communications with populations believed to be at particular risk of under-service or otherwise difficult to engage.

Providers also need to be informed generally about the impact of payment reform, and specifically about the potential for under-service or patient selection to occur. These concepts need to be defined in an explicit, consistent way and within their proper context. Messaging to providers should communicate that incentives for quality improvement and cost efficiency operate within the confines of existing, independently established standards for the provision of medically appropriate and necessary care. To the extent that contracts between payers and ACOs stipulate conditions under which an ACO will forfeit eligibility for some or all shared savings that it generates (i.e. demonstrated under-service or patient selection), these conditions – and the process for finding their existence, including appeals – should be made transparent to providers.

<u>Recommendation #4:</u> Providers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to lower the total cost of care and definitions of under-service and patient selection. This latter information should be communicated in a consistent manner to all providers.

References

CMS. (2011). *MSSP Final Rule § 425.312.*

CMS. (2014). *Accountable Care Organizations & You: Frequently Asked Questions (FAQs) for People with Medicare.*

CMS. (2014). *MSSP Final Rule p72868.*