Connecticut Health Policy Project

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Advocates' Guide to Underservice Recommendations: SIM Equity and Access Council

Connecticut's State Innovation Model (SIM) is seeking to radically transform our state's $30 billion health system by aligning incentives to build value. SIM has chosen a shared savings payment model for those reforms. Advocates are concerned about incentives to deny necessary care under the new payment model, as happened in the past. SIM's Equity and Access Council was charged with developing protections to limit and prevent underservice. The Council has offered its report with recommendations; one was opposed by insurers only and consequently did not reach consensus.

Background

Shared savings is a very new, untested model of payment, but it shares many features of capitation, which has a troubled history in Connecticut. There is very little experience from Connecticut or other states about shared savings programs, whether they work or any best practices.

Under shared savings, provider networks are rewarded for lowering the total cost of care for their panel of consumers. The expected total-cost-of-care is risk adjusted by technically complex methods to account for the different health care needs of people by diagnosis, age, demographics, and past use of health care services. Risk adjustment is meant to level the playing field so providers are fairly compensated for the care each patient needs, and to remove any reason to cherry pick, or select patients based on their health needs.

Typically provider networks, called Accountable Care Organizations (ACOs), receive half the savings achieved on their panel, as long as they meet a relatively small set of quality benchmarks. Under this typical "upside only" or "one-sided" risk arrangement, providers and ACOs are not responsible for losses if the total-cost-of-care for their patients is higher than expected. However many insurers and public programs are clear that they eventually expect providers and ACOs to enter into "downside" or "two-sided" risk arrangements. In downside risk models, the ACO will share in both gains and losses. "De facto" downside risk occurs when base rates paid to providers do not cover their perceived costs of delivering care, as can occur in Medicaid, requiring that they achieve savings to break even.

To ensure the system is rewarding value and not random variation, most shared savings plans require savings to reach a benchmark Minimum Savings Rate (MSR) before they will make payments to the ACO. The idea is to reward ACOs that are good at getting flu shots for members, not to reward a mild flu season. However the MSR has been a very high bar for

ACOs to meet. Often ACOs achieve savings but not enough to exceed the MSR, and so receive no payments for their efforts.

Advocates have been concerned about the impact of shared savings payment models on access to needed care. There are two ways to reduce the total-cost-of-care. The best way is to reduce unnecessary overtreatment, duplication of services and fragmentation. The other way is underservice -- to deny appropriate and necessary services and treatments, or cherry picking -- to select patients that are more likely to generate savings. In the 1990's similar financial incentives led to reductions in necessary care, especially in our Medicaid program. Connecticut's health system and consumers are still recovering from the damage done during those years. Since that payment model ended for Medicaid, three years ago through the efforts of advocates, quality of care is up, 32% more providers participate in the program, and the cost of care per person is down slightly savings the state hundreds of millions of dollars. No one wants to jeopardize that progress by returning to financial risk models that could reward underservice or patient selection/cherry picking.

Advocates were successful in getting a commitment in the SIM final plan that providers and ACOs that "are determined to have achieved savings through systematic under-service, will not receive shared savings." It fell to the SIM Equity and Access Council (EAC) to develop a plan to implement this provision. The EAC included representatives from the insurance industry, providers, state agencies, and consumer advocates. The EAC met often over almost a year to develop policy recommendations to prevent incentives for underservice and cherry picking. These were very difficult discussions about complex, sensitive issues. Through detailed exploration of the issues and finding common ground, the Council was able to come to consensus on all but one recommendation, and only insurer representatives objected to that one provision (see below).

On June 25th, the EAC published its report, with twenty-eight recommendations. We expect the report to be available for public comment soon. This summary is intended as a guide to the 72-page report to assist advocates in understanding the findings and facilitating comment.

Short summary of recommendations

- Patients will have the freedom to choose their own providers. Patients must be notified when they are connected to a provider, and notified of their rights.
- Consumers and providers must be fully informed about shared savings, what it could mean for them, and how to protect themselves as necessary. Consumer information must be effective, consistent, relevant and available both in advance and at the point of care. An experienced, diverse workgroup should be convened to develop effective consumer communications.
- Consumers will be linked to their provider at the beginning of the contract time period, rather than the end. Ensuring that providers know up-front the group of people they are responsible for, reduces any incentive to drop difficult or less lucrative patients.
- When savings are denied an ACO because they were generated by underservice or cherry picking, those savings should be invested back into improvements in care.

Savings generated at the expense of needed care should be returned to the original purpose – to build value – rather than remain with the insurer. The insurer will still retain the other half of the inappropriately savings generated by underservice.
    - Note: This was the only recommendation that did not reach consensus by the Council. Only insurance company representatives objected to the recommendation, which received strong support from consumers, providers and one state agency on the Council.
- Providers and ACOs that improve quality should be rewarded even if cost savings are not achieved within the payment timeframe. This removes an overly strong incentive to achieve savings that could result in underservice.
- Shared savings payments should be paid only to the ACO level, to reflect the broad team of providers responsible for the savings. Directly paying providers based on savings from only their panel of patients is a very strong incentive to reduce care inappropriately.
- Rewarding improvements in quality, rather than only meeting a single standard, gives every practice a reason to invest in care.
- Incentives should be tied to the level of quality improvement, removing an all-or-nothing, "cliff" effect that could encourage aggressive savings to reach.
- It is only fair that insurers, employers and government should share in the initial investments to create an ACO, as they will share in the savings.
- Do not use an MSR. Eliminating the MSR ensures that providers and ACOs benefit from all the savings they achieve, even modest ones. MSRs create another "cliff" effect that intensifies incentives to underserve and cherry pick.
- Provider payments must be adjusted for unpredictable, uncontrollable costs (i.e. bad flu season, costly new treatments), costs associated with social determinants of health, and exceptionally high cost patients.
- There should be extensive public reporting on underservice in shared savings arrangements.
- ACOs should make meaningful monitoring and elimination of underservice a priority.
- ACOs that are serious about reducing underservice will encourage peer review of cases. Reviewers must have whistleblower and professional protections.
- There must be robust evaluations of risk adjustment, underservice monitoring, mystery shopper surveys, and the will to make adjustments to ensure fairness and effectiveness at preventing underservice and cherry picking patients.
- ACOs should have a right to appeal a finding of systematic underservice or cherry picking and, if verified, should have a corrective action plan to assist in addressing the problem.
- All Connecticut ACOs should eventually be recognized by an independent, national certification authority.
- The state should create a single source of information and accountability for underservice and cherry picking.

Longer version of EAC recommendations organized into five content areas, with a summary, the current status of the policy and the report recommendation text.

1. Patient Attribution – 3 recommendations

How consumers are connected to providers or ACOs for purposes of payment and responsibility for quality, underservice and patient selection

Recommendation 1.1	**Patient Attestation**
Summary	Patients will have the freedom to choose their own providers. If their chosen provider's panel is closed or they don't choose, they will be connected to the provider they visited most often in the past. *This is a requirement under Medicaid law and for traditional Medicare members.*
Recommendation text	Patients should be able, though not required, to identify their primary care provider through an attestation (designation) process as a primary attribution technique. In the event that the chosen provider's panel is closed, the patient will either select a different provider or be attributed through the plurality of visits process. Patients who choose not to pick a primary care provider through attestation will be assigned based on the plurality of their visits.
Recommendation 1.2	**Patient Notification**
Summary	Patients must be notified when they are connected to a provider and notified of their rights. *It is unclear if this is happening and unlikely that the communications are meaningful for consumers.*
Recommendation text	Patients should be made aware when they are attributed to a physician who is participating in a shared savings program. Notification should be in a manner that is accessible and understandable by all patients. Notifications should make clear that patients retain the right to choose or change provider.
Recommendation 1.3	**Timing of Attribution**
Summary	Consumers will be linked to their provider at the beginning of the contract time period, rather than the end. Ensuring that providers know up-front the group of people they are responsible for reduces any incentive to drop difficult or less lucrative patients.

	This wasn't traditionally how attribution occurred, based on bonus programs, but more shared savings programs are moving to prospective attribution including Medicare and private insurers.
Recommendation text	Prospective attribution provides a vehicle for generating provider and patient awareness and promoting effective care management and coordination, and provides a degree of protection against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment. When prospective attribution is utilized, it should be accompanied by an end-of- year retrospective reconciliation that de-attributes prospectively attributed patients who no longer qualify (based on plurality of visits or patient attestation) to be attributed to a physician. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year. In instances in which the retrospective reconciliation process determines that a patient should be de-attributed, that patient will not be re-attributed to another ACO.

2. Cost target calculation – 5 recommendations
How the benchmark total-cost-of-care will be developed

Recommendation 2.1	**Rewarding Improvement**
Summary	Rewarding improvements in quality gives every practice a reason to invest in care. Using a single standard gives low performers less reason to make the effort, leaving their patients behind. As primary care is becoming more scarce in CT, it is important to improve quality across the entire system. *This is not uncommon in shared savings arrangements.*
Recommendation text	Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group.

Recommendation 2.2	**Adjustment for Unpredicted Systemic Costs**
Summary	Medicine changes quickly -- unexpected health problems arise and important new treatments are often costly. Adjusting payments to allow for this variability removes incentives to deny innovative treatments or reduce care to "make up" for random higher costs.
Recommendation text	An end of year assessment should be conducted to evaluate the need to adjust for any systemic factors (e.g. the advent of new treatments, severe flu season) that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year. An adjustment can be made to the historic cost benchmark or an identified treatment can be temporarily carved out of the cost benchmark calculation.
Recommendation 2.3	**Supplemental Payments for Complex Patients**
Summary	While risk adjustment is a critical protection against underservice or cherry picking for high-need patients, it is an evolving science. Not all populations' needs are included in the various methodologies yet. As the science catches up, it is critical to make payment adjustments to providers who care for underserved communities. *Outside payments and grants to safety net providers for these purposes are common.*
Recommendation text	An imperfect risk adjustment that does not account for hidden expenses associated with caring for socioeconomically complex patients may put some of the most vulnerable patients at greater risk for under-service and patient selection. To date, there is not a commonly accepted payment mechanism within shared savings programs to account for this, but payers should consider ways to financially incent provider organizations to care for the most vulnerable individuals.
Recommendation 2.4	**Retrospective Assessment for Risk Adjustment**
Summary	Programs should monitor the use of risk adjustment and identify opportunities to improve the methodology to guard against underservice and cherry picking.
Recommendation text	In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical

	or non- clinical factors.
Recommendation 2.5	**Cost Truncation and Service Carve Outs**
Summary	Some patients experience very high health care costs for unforeseen problems. Eliminating them from the payment methodology ensures that the hard work of provider teams to keep people healthy is not erased by one case. *This is common in shared savings arrangements.*
Recommendation text	Truncating costs based on a percentile cutoff, and/or carving out select services, will eliminate any incentive to withhold required care after a catastrophic event or diagnosis in an effort to minimize overall costs, and will help to keep providers focused on managing the more predictable types of utilization that value-based contracts seek to improve.

3. Incentive payment calculation and distribution – 7 recommendations

How savings will be calculated and paid to providers and ACOs

Recommendation 3.1	**Eligibility Thresholds**
Summary	This simply restates and confirms the EAC's commitment to deny shared savings payments that were generated by denial of necessary care or cherry picking patients. *This is unique among shared savings plans, however other states and programs are very interested in the concept and how Connecticut implements it.*
Recommendation text	ACOs should only be able to share in savings if they meet threshold performance on quality measures and are not found to have engaged in under-service or patient selection (as defined in the EAC charter and incorporated in payer-ACO contracts).
Recommendation 3.2	**Discrete Quality Payments**
Summary	Providers and ACOs that improve quality should be rewarded even if cost savings are not achieved within the payment timeframe. Providers will have less reason to deny necessary care to recoup their investments in quality. *This is very common in Medicaid shared savings programs but less common with private insurers.*
Recommendation text	Providing discrete incentive payments that reward quality improvement, irrespective of whether savings are achieved, will serve as a counter-balance against any incentive to

	inappropriately reduce costs.
Recommendation 3.3	**Rewarding Quality Improvement**
Summary	Incentives should be tied to the level of quality improvement, removing an all-or-nothing, "cliff" effect that could encourage aggressive savings to reach it. Performance and payment should be adjusted to account for new, more challenging patients. *This is not uncommon in Medicaid shared savings programs.*
Recommendation text	ACO quality goals should be based, at least in part, on an ACO's prior performance, and should contain a range of goals (i.e. threshold, target, and stretch). By correlating the opportunity to earn savings with quality performance, increasing the share of savings the ACO receives on a sliding scale based on quality performance between their own threshold and stretch goal, payers can incent a pattern of continuous performance improvement. To ensure that ACOs are not penalized for accepting new patients who may be more challenging to care for, year over year changes in ACO quality performance should be calculated using patients who have been continuously attributed to the ACO during the prior year and the performance year.
Recommendation 3.4	**Minimum Savings Rates (MSRs)**
Summary	Eliminating the MSR ensures that providers and ACOs benefit from all the savings they achieve, even modest ones. It also removes the "cliff" problem of intensive incentives to reach that bar which could encourage underservice or cherry picking. If MSRs are used, it is important to take a long view. If an ACO is achieving only 1% savings but consistently over several years, it is not random variation and should be rewarded. *MSRs are common in shared savings plans.*
Recommendation text	MSRs should not be utilized, or should be structured in a way that allows for deferred recoupment of savings. In the former case, any savings achieved should be shared with providers (assuming quality thresholds are met), thereby reducing the "all or nothing" aspect of reaching or not reaching an MSR. In the latter case, if an ACO demonstrates savings over a multi-year period which failed to meet an MSR in individual years, but which in combination are statistically significant, the ACO should be retroactively eligible to share in those savings.

Recommendation 3.5	**Reinvestment of Non-Retained Savings**
Note: This is the only recommendation on which the EAC could not come to consensus. The only opposition to this recommendation came from private insurers. The provision enjoyed strong support from consumer advocates, providers and at least one state agency.	
Summary	Savings generated at the expense of needed care should be returned to the original purpose – to build value. This recommendation would use those savings, paid for by the consumers who were harmed, back into fixing the problem and getting them the care they paid for. Without this provision, all the savings (both halves) generated by underservice would default to the insurer, employer or government giving them twice the incentive to encourage underservice. Insurers have several tools to encourage underservice that often result in denials of necessary care, including prior authorization and formularies. Since insurers will know which metrics are being monitored for underservice, but ACOs will not, insurers are potentially both in a position to engineer underservice and to double their profits from it. The lack of this protection not only violates the original SIM commitment to deny savings for underservice, increases the risk of people being denied necessary care, and denies resources necessary to build value. *Like the original provision to deny savings generated by underservice, this related provision is unique among shared savings plans. But there is a great deal of interest in the concept.*
Recommendation text	When an ACO demonstrates cost savings, but is not eligible to receive the savings because it was found to have stinted on care or inappropriately discontinued patients, the funds should be reinvested in the community's delivery system via an independent entity that administers the funds and ensures that they are earmarked to support improvements in access and quality.
Recommendation 3.6	**Advance Payments**
Summary	It is only fair that insurers, employers and government should share in the substantial investments to create an ACO, as they will share in the savings. Upfront funding also softens the need for ACOs to recoup their investment by generating shared savings, which could result in

	underservice. *This is not uncommon in shared savings arrangements.*
Recommendation text	Providing ACOs with up-front funding dedicated to infrastructure will allow them to invest in the resources required to effectively manage care for defined populations. This incentive is especially important for smaller organizations or ACOs that are considering participating in MQISSP as ACOs. In addition, ACOs that have sufficient infrastructure will be more likely to lower costs through effective care management and less likely to lower costs by stinting on care or discontinuing patients.
Recommendation 3.7	**Payment Distribution Methods**
Summary	If done right, coordinating and improving care will be a team effort including not only primary providers, but also specialists, nutritionists, care coordinators, behavioral health specialists, and many others. Rewards should return to the ACO level to reflect the broad community responsible for the savings. Directly paying providers based on the savings they are able to generate on only their panel of patients is a very strong incentive to reduce care inappropriately. *This is common in Medicaid shared savings arrangements.*
Recommendation text	To reduce the incentive for providers to under-serve in order to generate savings, provider groups at the sub-ACO level and individual providers should not be rewarded based on the portion of savings they individually generate. Rather, provider groups and individual providers should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel.
4. Rules, monitoring and accountability – 9 recommendations	
How the polices are operationalized	
Recommendation 4.1	**ACO Internal Monitoring**
Summary	ACOs should make meaningful monitoring and elimination of underservice a priority. *Connecticut will be unique among shared savings programs in monitoring for underservice.*
Recommendation text	ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers

	accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under- service and patient selection.
Recommendation 4.2	**ACO Accreditation**
Summary	All Connecticut ACOs should eventually be recognized by an independent, national certification authority. *This is likely to become standard practice, following the success of other certification programs.*
Recommendation text	Over time, payers and/or the state should consider requiring that ACOs obtain accreditation (e.g. URAC or NCQA ACO accreditation). This might apply to all ACOs or only to ACOs that do not demonstrate capabilities via consistent performance on quality and other outcomes.
Recommendation 4.3	**Retrospective Monitoring Guidelines**
Summary	ACOs must conduct robust monitoring for underservice annually. *Connecticut will be unique among shared savings programs in monitoring for underservice.*
Recommendation text	Each payer that enters into shared savings contracts should monitor for under-service and patient selection on an annual basis using a set of analytic methods that it establishes. At a minimum, the standard under- service and patient selection monitoring performed by payers should include: a) Under-service should be monitored by assessing utilization and cost of care, over time and between groups, (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to identify patterns of variation. b) Patient selection should be monitored by evaluating the change in risk adjustment of a population assigned to an ACO over time. c) For both under-service and patient selection, payers should identify populations that may be at particular risk (i.e. characterized by particular clinical conditions and/or socioeconomic attributes), and conduct population-specific

	analysis. For example, under-service should also be monitored by evaluating variations in utilization (i.e. of different interventions) by diagnosis where there is a specific under-service concern and well-established intervention guidelines. To be a more effective deterrent of under- service payers should not necessarily disclose to providers which diagnoses will be monitored. d) Claims data analysis should only be used as a first cut to flag potential under-service or patient selection. When potential under-service or patient selection are flagged, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or patient selection is likely to have occurred.
Recommendation 4.4	**Concurrent Monitoring: Nurse Consultant**
Summary	The state should create a single source of information and accountability for underservice and cherry picking. *Ombudsman programs are very common.*
Recommendation text	A nurse consultant (i.e. ombudsman) will play a key role as a one-stop source of information related to under-service and patient selection for consumers and providers. The nurse consultant should be dedicated to addressing in a timely manner under-service and patient selection concerns arising from shared savings and related value-based contracting programs. OHA, with input from stakeholders, should devise a policy to define in more detail the nurse consultant's role and the protocol for handling and routing consumer inquiries and complaints.
Recommendation 4.5	**Mystery Shopping**
Summary	ACOs should be evaluated regularly by a mystery shopper survey to assess whether potential patients are being turned away for financial reasons. *Mystery shopper surveys are used routinely and very successfully in evaluating many health programs, including Connecticut Medicaid.*
Recommendation text	Mystery shopping programs should be designed and implemented to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to the type of

	activity being detected and to each payer population.
Recommendation 4.6	**Accountability: Corrective Action**
Summary	ACOs should have a right to appeal a finding of systematic underservice or cherry picking and, if verified, should have a corrective action plan to assist in addressing the problem and ending underservice and/or cherry picking. *Corrective Action Plans are standard practice.*
Recommendation text	When a payer, via monitoring and follow up investigation, determines that an ACO or its member provider(s) have engaged in repeated or systematic under-service and/or patient selection, it should provide the ACO with a written finding of relevant facts. The ACO should have an opportunity to appeal any such finding. If the finding is verified, the payer should place the ACO on a corrective action plan (CAP) for a period of time during which the ACO will not be eligible for receiving shared savings. If after the CAP period is complete, performance concerns are not addressed, the ACO may face termination from the shared savings program. The same process should apply if ACOs do not abide by required rules for participation in a shared savings program. Initially when an ACO is placed on a CAP support should be provided through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern.
Recommendation 4.7	**Retrospective Monitoring: Long-Term Analysis**
Summary	With time, Connecticut should engage an independent evaluation of the effectiveness of policies to prevent and address underservice. *Independent program evaluations are not common enough; the will to follow through on the results is even more rare.*
Recommendation text	After Connecticut gains more experience with shared savings contracting, an independent third party (non-payer, non- provider) should conduct a retrospective, multi-payer evaluation of how value-based contracting is impacting service delivery. This analysis may rely on the all-payer claims database (APCD) and/or other sources of data. This analysis should be overseen by a committee of clinical and analytic experts who will use available data (i.e. claims data, patient feedback, clinical data) to evaluate the impact of shared savings contracts on healthcare delivery practices and outcomes. This will include patterns of under-service and patient selection. The analysis will seek to understand

	root causes and recommend adjustments to contracting methods and supplemental safeguards going forward. The goal of this more comprehensive analysis will be to identify and address any programmatic elements or unwanted ACO/provider behaviors not captured by initial recommended monitoring that are contributing to equity and access problems, in particular under-service and patient selection.
Recommendation 4.8	**Accountability: Public Reporting**
Summary	There should be extensive public reporting on underservice in shared savings arrangements. *Public reporting is getting better in health care programs and is serving to improve performance and value.*
Recommendation text	Entities involved in the use of shared savings contracts in Connecticut should report information in order to inform the public and allow for the effect of these contracts to be evaluated using an array of relevant data points. At a minimum, this should include: a) Payers should publicly report on an annual basis: the names of the ACOs with which it has shared savings contracts, the number of lives attributed to each, a description of methods that it used during the prior year to monitor for under-service and patient selection, and a summary of the results of that monitoring which includes a statement describing any instances in which an ACO was placed on a corrective action plan and shared savings were withheld from an ACO. b) OHA should publicly report on an annual basis a summary of the activities it undertook related to under-service and patient selection including: patient complaints received by the nurse consultant, cases referred to payers, ACOs, provider groups, and/or licensing authorities for further evaluation, and actions taken to initiate corrective actions. c) ACOs participating in any payer's shared savings program should be required to have a compliance officer, and to publicly report information about their participating providers, leadership, quality performance, and shared savings, including payments (if any) received by the ACO, the total proportion of shared savings distributed among ACO participants, and the total proportion used to support

	quality performance and program goals.
Recommendation 4.9	**Peer Reporting**
Summary	Peer review is one of the most effective current underservice monitoring systems and a very powerful deterrent. ACOs that are serious about reducing underservice will build resources and processes to encourage peer review of cases. Protection for those who identify and alert leaders about cases of underservice is crucial. *Peer review is a time-honored evaluation system.*
Recommendation text	The State should ensure that adequate whistle-blower protections are in place for employees or contractors of an ACO who report evidence of under-service or patient selection, or of undue pressure from the ACO to engage in either type of activity.

5. Communications – 4 recommendations

How consumers and providers learn about the new payment system

Recommendation 5.1	**Consumer Communications: Scope**
Summary	Consumers must be fully informed about shared savings, what it could mean for them, and how to protect themselves if necessary. *Most ACOs do very little to inform consumers about the payment model and rarely explain any risks.*
Recommendation text	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 manage the total cost of care and improve quality, definitions of under-service and patient selection, and the manner in which financial incentives could lead to under- and over-service. 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.

Recommendation 5.2	**Consumer Communications: Accessibility and Consistency**
Summary	Consumer information about shared savings must be effective, consistent, relevant and available both in advance and at the point of care. *The science of effective consumer communications and informed consent is improving.*
Recommendation text	The type of information described in Recommendation 5.1 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 (e.g. at the time of insurance enrollment) and at the point of care (e.g. in writing 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.
Recommendation 5.3	**Consumer Communications: Content Development**
Summary	An experienced, diverse workgroup should be convened to develop appropriate, effective consumer communications.
Recommendation text	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 5.1, and also on the appropriate media through which messages should be distributed in a manner consistent with Recommendation 5.2. 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.

Recommendation 5.4	**Provider Communications**
Summary	Providers also need accurate, complete information about shared savings and its implications for their patients.
Recommendation text	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, definitions of under- service and patient selection, and methods that are in place to guard against such. Definitions of under-service and patient selection should be communicated in a consistent manner to all providers.