

**Research Report**

# **Consumer Protections in New Medicare Payment and Delivery Models: A Checklist**

**Julie Carter**  
Medicare Rights Center



## Acknowledgments

Support for this work was provided by AARP. The views presented here are those of the author and not necessarily those of AARP or its directors, officers, or staff.

The author would like to thank the participants in our panel of health care experts, including Karen Nelson, Cristina Boccuti, Stephanie Glover, and Kathleen Shure. Special thanks are due to Harriet Komisar, Lina Walker, and Leigh Purvis at AARP's Public Policy Institute.

Julie Carter, federal policy associate at the Medicare Rights Center, served as the author of this paper. Stacy Sanders, federal policy director, served as primary editor, with additional editorial support provided by Rachel Bennett, vice president for program and product development, and Casey Schwarz, senior counsel, education and federal policy.

AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis, and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.



# Table of Contents

<b>ACKNOWLEDGMENTS .....</b>	<b>I</b>
<b>THE CHECKLIST .....</b>	<b>1</b>
A. Models Should Offer More Effective Information and Assistance to Consumers .....	1
<i>Recommendations for CMS/CMMI.....</i>	<i>1</i>
<i>Recommendations for Plans and Providers.....</i>	<i>1</i>
B. Models Should Engage Consumers .....	2
<i>Recommendations for CMS/CMMI.....</i>	<i>2</i>
<i>Recommendations for Plans and Providers.....</i>	<i>2</i>
C. Models Should Improve Transparency and Oversight.....	2
<i>Recommendations for CMS/CMMI.....</i>	<i>2</i>
<i>Recommendations for Plans and Providers.....</i>	<i>2</i>
<b>I. INTRODUCTION.....</b>	<b>3</b>
<b>II. THE CHECKLIST IN DETAIL.....</b>	<b>4</b>
A. Models should offer more effective information and assistance to consumers to enable them to make good decisions and protect their interests.....	4
<i>Recommendations for CMS/CMMI.....</i>	<i>4</i>
<i>Recommendations for Plans and Providers.....</i>	<i>5</i>
B. Models should engage consumers to help improve systems and communications. ....	7
<i>Recommendations for CMS/CMMI.....</i>	<i>8</i>
<i>Recommendations for Plans and Providers.....</i>	<i>9</i>
C. Models should improve transparency and oversight to allow consumers and their advocates to monitor models and protect consumer interests.....	10
<i>Recommendations for CMS/CMMI.....</i>	<i>10</i>
<i>Recommendations for Plans and Providers.....</i>	<i>12</i>
<b>III. CONCLUSION .....</b>	<b>13</b>



# The Checklist

The following checklist provides a set of concrete consumer protections for policy makers and providers to use in any new or existing Medicare value-based payment and delivery model. Such models aim to reward value over volume and to improve health outcomes for people with Medicare, while reducing costs to the Medicare program. As new models are tested, it is critically important that any changes to Medicare payment do not diminish access to care, care quality, or the overall consumer experience with the Medicare system.

While we believe these protections should be required in all applicable models, we recognize that model building takes time. Further, we recognize that not every one of these protections will be well suited to every model; these protections have wide

applicability and should be tailored to specific model types. In addition, many of these protections, such as better information for consumers and family caregivers, should also apply to fee-for-service Medicare and Medicare Advantage plans.

Below are three main categories of consumer protections, followed by specific recommendations for the Medicare program and for health care providers engaged in new models. A more detailed description of each recommendation is provided in the accompanying paper. While this checklist is targeted specifically at the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI), we believe it will prove useful in any future model development by any agency or organization.

## A. MODELS SHOULD OFFER MORE EFFECTIVE INFORMATION AND ASSISTANCE TO CONSUMERS

### Recommendations for CMS/CMMI

- #1. Develop standard consumer communication templates for CMS and providers.**  
Templates should be developed jointly with focus groups and experts to include information about the model's design, how it affects consumers' cost and care, how it affects providers, and what consumer rights and options are.
- #2. Develop customized scripts for 1-800-MEDICARE.**  
These scripts would help ensure that consumers can access model-specific information from a widely known and trusted source.
- #3. Develop model-specific training for State Health Insurance Assistance Programs (SHIPs).**  
Trainings would capitalize on SHIPs' valuable individualized services and their connections to state-specific resources.

### Recommendations for Plans and Providers

- #4. Promote shared decision making.**  
Shared decision making is a process in which providers collaborate with patients to share information and together develop treatment plans. Decisions are made with, not for, the patient.
- #5. Provide robust plan- and provider-specific information to consumers, including how personal information is protected and how it may be shared.**  
Information should include which providers are in network or part of the care team; benefits; specific costs; how to opt in or out of various features; how privacy will be protected; how any data may be used; what the individual's rights and choices are; and a mechanism for patients to see, correct, and update their personal data.
- #6. Use CMS-/CMMI-developed templates.**  
These templates can ensure plans and providers are offering clear, timely, consistent information to consumers.

**#7. Include resource contacts on all consumer-facing communications.**

These would include contact information for independent ombudsman program(s), 1-800-MEDICARE, and SHIPs, along with contacts at the model who are available to answer questions and resolve issues.

**#8. Provide communications in plain and linguistically and culturally competent language and alternative formats.**

Alternative formats may include large print, audio, Braille, and/or electronic text.

---

## **B. MODELS SHOULD ENGAGE CONSUMERS**

### **Recommendations for CMS/CMMI**

**#9. Ensure meaningful consumer participation in model design, monitoring, and evaluation.**

By building consumers' perspectives directly into new models and consulting regularly with consumers and providers, CMS can improve how models function for consumers.

**#10. Avoid unintended consequences of beneficiary incentives in model design.**

Incentives that increase patient costs may drive them away from needed care.

### **Recommendations for Plans and Providers**

**#11. Monitor and assess meaningful consumer engagement.**

A commitment to engaging consumers is only as strong as the ability to ensure that it is actually occurring. Engagement with providers is also essential.

**#12. Include methods to integrate, train, and support consumer advocates.**

Without integration, training, and supports, consumer advocates may not be able to fully engage with new models, which risks wasting this valuable resource. Ideally, this process would receive financial support from CMS.

---

## **C. MODELS SHOULD IMPROVE TRANSPARENCY AND OVERSIGHT**

### **Recommendations for CMS/CMMI**

**#13. Establish an independent ombudsman program.**

Such a program or programs would assist with consumer issues and questions and help monitor model successes and challenges.

**#14. Publicize all audit and evaluation results and incoming data in a timely manner.**

These transparent data would permit consumers, their families, and third parties to assess success and challenges with models, plans, and providers.

**#15. Share with consumers meaningful information about financial incentives included in model designs.**

Understanding their providers' incentives will allow consumers to trust the model.

### **Recommendations for Plans and Providers**

**#16. Publish accurate, up-to-date information about networks, benefits, costs, options, and processes.**

Provide valuable consumer information and allow third parties to assist consumers effectively and to monitor potential problems.

**#17. Disclose full information about potential conflicts of interest.**

This includes financial incentives and relationships with other entities that could create a conflict of interest, and full information about plan and provider governance.

---

# I. Introduction

The Patient Protection and Affordable Care Act established the Center for Medicare & Medicaid Innovation (CMMI) to find ways to reduce the cost of health care while improving its quality. The Centers for Medicare & Medicaid Services (CMS) and CMMI are now developing and employing value-based payment and delivery system models to test new ways for Medicare to pay for care. These models aim to reward value over volume and improve health outcomes for people with Medicare while reducing costs to the Medicare program. As new models are tested, it is critically important that any changes to Medicare payment do not diminish access to care, care quality, or the overall consumer experience of the Medicare system.

To help CMS ensure that new models meet the needs of people with Medicare, the Medicare Rights Center<sup>1</sup> joined with the AARP Public

Policy Institute<sup>2</sup> to identify a number of consumer protections that we believe should be integrated into the design of all Medicare models. This checklist of needed protections is intended to provide examples of concrete and achievable safeguards that could be considered for current and future model development. While we recognize that not every one of these protections will be well suited to every model, these protections have wide applicability and should be tailored to specific model types.

Medicare is a vital source of health care for 57 million older adults and people with disabilities. A shift in payment design to reward value may help the program continue to provide high-quality care with fewer resources, but we believe these payment reforms will reach their goals only if people with Medicare are given the information they need and a voice in the process.

---

1 The Medicare Rights Center (Medicare Rights) works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights seeks to ensure that people with Medicare are given the tools to be engaged and active participants in their care. For further information on Medicare Rights' work in delivery and payment system reform, see the upcoming United Hospital Fund-supported paper on New York State's health system transformation.

2 AARP's Public Policy Institute (PPI) is the focal point of public policy research, analysis, and development at AARP. PPI develops creative policy solutions to address the common need for financial security, health care, and quality of life. Founded in 1985, PPI publishes policy analyses and provides updates on a range of topics, including current AARP priorities and emerging issues that will affect older adults in the future.

## II. The Checklist in Detail

### A. MODELS SHOULD OFFER MORE EFFECTIVE INFORMATION AND ASSISTANCE TO CONSUMERS TO ENABLE THEM TO MAKE GOOD DECISIONS AND PROTECT THEIR INTERESTS.

In many ways, consumer information is the foundation on which all other protections rest. If individuals have the information and assistance they need to make health decisions for themselves, they will be better able to thrive.<sup>3</sup> Information, and understanding how to use it, is vital to enable a person to navigate the health care system. In addition, the information can help patients to understand and share personal details such as health history, to engage in healthy behaviors that include management of chronic disease, and to comprehend important medical concepts that are dependent on basic mathematics or statistics, including risk and probability.<sup>4</sup>

Lack of needed information and assistance is correlated with worse health outcomes, skipping preventive care, mismanaging chronic conditions, and increased hospitalization.<sup>5</sup> Increasing access to vital information could then both improve a patient's health and make it easier for providers to deliver care.

#### Recommendations for CMS/CMMI



***Develop standard consumer communication templates for CMS and providers.***

Communication about new models needs to strike a balance between providing too much information and too little. Too much can overwhelm people—especially when those people are struggling with significant health issues—leaving them confused about what they have heard, concerned about their health coverage and access to care, or even suspicious of vague references to “value,” which may sound like cutting corners, not improving health. Too little information means people may be unable to

make good decisions; may not understand high-quality, high-value care; or may reject enrollment in models that could benefit them.

We believe it would be advantageous for CMS to develop standard notice templates including scripts for oral communication, text for websites and written materials, and distribution plans for materials, especially for complex topics such as accessing high-value health care providers. Focus groups are important to ensure that the intended recipients of the information can access it and use it to their benefit, while experts can help both with language development and with design and timing issues.

The timing and nature of information delivery are important. For example, a complex, multipage single mailer that a beneficiary receives at home might be less effective than a short explanation delivered in person by a provider. In designing any standard templates, CMS should consider if it would be beneficial to clearly designate which entities should provide which communications and when, again with the help of focus groups and experts to ensure consumers will receive and process the information in the most helpful way.

Providers may steer patients in appropriate or inappropriate ways. Appropriate ways include referrals based on a provider's experience of another provider's quality or ability to meet the patient's needs. But CMS should always be alert to the potential for inappropriate provider steering, where providers improperly encourage or discourage individuals to participate in a model, often based on the individual's health status and cost, or based on business relationships among providers. One additional benefit of a communication template is its potential to limit inappropriate steering by curtailing opportunities to engage in “off script” communications.

3 “Health Literacy Basics,” US Department of Health and Human Services, accessed February 9, 2017, <https://health.gov/communication/literacy/quickguide/factsbasic.htm>

4 Ibid.

5 “Health Literacy and Healthy Outcomes,” US Department of Health and Human Services, accessed February 9, 2017, <https://health.gov/communication/literacy/quickguide/factsliteracy.htm>.



## **2** *Develop customized scripts for 1-800-MEDICARE.*

Whenever a new model is put into place, a customized model-specific script for any calls to 1-800-MEDICARE that relate to that model would be beneficial to ensure callers can access and understand the appropriate information. As one of the most visible resources for Medicare beneficiaries, 1-800-MEDICARE can play a vital role in keeping model enrollees or potential enrollees informed of the model's purpose, the potential changes they will see, and their rights.

In addition to informational purposes, this resource can serve as an oversight tool. CMS could establish a process for auditing calls to 1-800-MEDICARE for complaints about models and develop a standardized process for following up on any such complaints.<sup>6</sup>



## **3** *Develop model-specific training for State Health Insurance Assistance Programs (SHIPs).*

People with Medicare would benefit if SHIPs received training and information on models to help them assist with beneficiary inquiries. Currently, the 54 SHIPs provide valuable, in-depth, one-on-one counseling for people with Medicare and fill an important role in helping beneficiaries understand what Medicare Advantage or prescription drug plans may be right for them. SHIPs are perfectly placed to add help with model enrollment to their portfolio, but to do this, SHIP counselors must themselves understand the model at sufficient depth to be able to help navigate its unique system. Importantly, SHIP programs must be sufficiently resourced to manage these specific counseling needs, in addition to assistance they are already obligated to provide on enrollment, billing, appeals, coverage options, and other Medicare concerns and issues.

The educational materials should also, along with the scripts in Checklist #2, be made available to provider and plan staff to help them understand and explain the model to beneficiaries.

## **Recommendations for Plans and Providers**



## **4** *Promote shared decision making.*

With shared decision making, people who receive care and their family caregivers work with providers to make joint health care decisions. Shared decision-making models, like the Agency for Healthcare Research and Quality's (AHRQ's) SHARE Approach,<sup>7</sup> consider "the patient's condition, treatment options, the medical evidence behind the treatment options, the benefits and risks of treatment, and patients' preferences, and then arrive at and execute a treatment plan."<sup>8</sup>

Shared decision making has several advantages: (a) it supports autonomy and dignity; (b) it includes patient preferences from the outset, making it more likely to arrive at treatment options the patient can tolerate; (c) it creates buy-in from patients, who feel as if they have options; and (d) it leads to better outcomes. For example, a study shows, the benefits of shared decision making:

*One group of patients received enhanced decision-making support by trained health coaches over the phone, by mail, and via the Internet. The other group received only a usual level of support from these coaches. In both cases, the coaches gave patients knowledge and awareness of their treatment options, helped them to sort out their treatment preferences, and encouraged them to communicate those preferences to their health care providers. ... Patients who received enhanced decisionmaking [sic] support ultimately had overall medical costs that were*

6 See, for example, "Announcement of Medicare Advantage Value-Based Insurance Design Model Test," US Department of Health and Human Services, Center for Medicare & Medicaid Innovation, September 1, 2015, <https://innovation.cms.gov/Files/reports/VBID-Announcement-REVISED-10-9-15.pdf>.

7 "The SHARE Approach," Agency for Healthcare Research and Quality, accessed August 2, 2017, <https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html>.

8 Julia James, "Patient Engagement: People Actively Involved in Their Health and Health Care Tend to Have Better Outcomes—and, Some Evidence Suggests, Lower Costs," *Health Affairs Health Policy Brief*, February 14, 2013, [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_86.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_86.pdf).

5.3 percent lower than for those receiving only the usual support. They also had 12.5 percent fewer hospital admissions and 20.9 percent fewer preference-sensitive heart surgeries. The authors concluded that shared decision making through these relatively low-cost, remote models can extend the benefits of patient engagement to broad populations.<sup>9</sup>

Shared decision making also benefits providers by improving the quality of care delivered, patient satisfaction with the care, and patient trust and loyalty. These results can be very important in models that include risk sharing for providers.<sup>10</sup>

Ideally, providers would be encouraged to discuss all treatment options with patients and unbiased care team members as early as feasible. This can help to avoid stressed, last-minute, or emergency decisions that might be less beneficial for the patient.



***Provide robust plan- and provider-specific information to consumers, including how personal information is protected and how it may be shared.***

This information should include which physicians are in network or part of the care team (see also Checklist #16), benefits, specific costs, and how to opt in or out of various features. Included information must describe how privacy will be protected, how any data may be used, what individuals' rights and choices are, and how to opt out of data sharing if they choose to. Consumers should be told which data are shared with whom—for example, whether data sharing means that employees of all affiliated providers can see all personal data including doctors' notes, test results, and financial information. Further, mechanisms should be included that allow patients to see, correct, and update their personal data. For example, they may need to update their medical history or indicate a change in medications.



***Use CMS-/CMMI-developed templates.***

Developing templates will have no effect if they are not used. When a template exists, it should be used to ensure information is packaged in the most readable, consumer-driven way. These templates can ensure plans and providers are offering clear, timely, convenient information to consumers. Ideally, plans and providers would use local consumers and families to test new templates to ensure they are easily understood and accessible. To further accessibility, written materials should be available online when possible.



***Include resource contacts on all consumer-facing communications.***

Every model-related communication from plans or providers should ideally include contact information for the established independent ombudsman (see Checklist #13), 1-800-MEDICARE, and the local SHIP, as well as any applicable quality improvement organization. Ideally, these communications would also include contact information for individuals available at the model level who can answer questions, assist consumers (e.g., with patient portals, opt-out options, and more), and resolve issues. This would ensure that enrollees are always aware of their rights and options and can secure help as needed.



***Provide communications in plain and linguistically and culturally competent language and alternative formats.***

Plain language is a strategy used to ensure that written and oral communications are as easy to understand as possible and allows recipients to “find what they need, understand what they find, and act appropriately on that understanding.”<sup>11</sup> The audience for any given communication varies considerably. Because of that wide range, communication should be geared toward

9 Ibid.

10 “The SHARE Approach,” Agency for Healthcare Research and Quality.

11 “What Is Plain Language?,” US Department of Health and Human Services, Plain Language Action and Information Network, accessed July 13, 2017, <http://www.plainlanguage.gov/whatisPL/index.cfm>.

maximum comprehension as quickly as possible: well-organized, simple, active, and broken into understandable chunks.<sup>12</sup>

Cultural competence is the recognition of culture's influence on how individuals "communicate, understand, and respond to health information."<sup>13</sup> Similarly, linguistic competence is "the capacity of an organization and its personnel to effectively communicate with persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities."<sup>14</sup> For the sake of patients and their own ability to deliver care, providers need to be aware of how and if patients receive, understand, and incorporate provided information into their health and health care decision making. A person who has limited English proficiency is not likely to understand complex information or instructions that are presented solely in English, so it is imperative that patients receive information in a language in which they are fluent. The widespread use of family members—including young children—as interpreters may exacerbate the fear or embarrassment of people with limited English proficiency, and may result in them receiving insufficient or inaccurate translations or in their refusal to engage with the health care system at all.<sup>15</sup>

Alternative formats—including large print, specialized fonts, color contrast, audio format, Braille, and more—can be an indispensable way to provide needed information to diverse populations. Because the Medicare program serves many individuals with age- or disability-related communication issues, alternative formats

can mean the difference between effective communication and no communication.

## **B. MODELS SHOULD ENGAGE CONSUMERS TO HELP IMPROVE SYSTEMS AND COMMUNICATIONS.**

Research demonstrates that engaged patients have better health outcomes and better care experiences,<sup>16</sup> and may be less expensive to treat.<sup>17</sup> Patients with high activation scores—demonstrating the "knowledge, skills, ability, and willingness to manage his or her own health and care"—generally incur significantly lower costs than those with lower scores.<sup>18</sup> And activation is not an innate skill—people can learn how to be engaged through well-designed interventions, and incremental gains can reduce costs.<sup>19</sup>

As a result, we believe that models, as well as fee-for-service Medicare and Medicare Advantage, should involve patients and consumers at every possible juncture, allowing people to speak for themselves whenever possible. At their best, models would also include strategies for patient activation and partnership, encouraging patients and providers to work together to develop care plans and participate in shared decision making. By working in partnership, providers and patients could identify and overcome any barriers that might impede care, such as a patient's lack of transportation, difficulty asking questions of doctors, or confusion about how insurance works.

12 Ibid.

13 "Health Literacy Basics," US Department of Health and Human Services.

14 Suzanne Bronheim and Suganya Sockalingam, "A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials," Georgetown University Center for Child and Human Development, National Center for Cultural Competence (Winter/Spring 2003), [https://nccc.georgetown.edu/documents/Materials\\_Guide.pdf](https://nccc.georgetown.edu/documents/Materials_Guide.pdf).

15 Gregory Juckett and Kendra Unger, "Appropriate Use of Medical Interpreters," *American Family Physician* 90, no. 7 (October 1, 2014): 476–80, <http://www.aafp.org/afp/2014/1001/p476.html>.

16 Judith H. Hibbard and Jessica Greene, "What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs," *Health Affairs* 32, no. 2 (February 2013): 207–214, <http://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1061>.

17 Julia James, "Patient Engagement."

18 Julia James, "Patient Engagement." ("Patients with the lowest activation scores—having the least skills and confidence to actively engage in their own health care—incurred costs up to 21 percent higher than patients with the highest activation levels.")

19 Kristin L. Carman et al., "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies," *Health Affairs* 32, no. 2 (February 2013): 223–231, <http://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1133>.

## Recommendations for CMS/CMMI



### **9** *Ensure meaningful consumer participation in model design, monitoring, and evaluation.*

People with Medicare are uniquely positioned to explain how changes to the program might affect them. By building Medicare users' perspectives directly into new models, CMS can improve how such models function. Beneficiaries and their family members can provide insights into how to effectively and appropriately inform patients, and can ensure that model evaluation draws on metrics relevant to patients and their families. Beneficiaries can also help identify ways to avoid inappropriate consumer incentives and help prevent communication breakdowns among patients and providers. Perhaps most importantly, CMS can learn what people truly want from their providers and care plans, the kinds of help they need navigating their insurance coverage and care, and how they define successful care.

Beneficiary and stakeholder participation is critical for several reasons:

- **Perspective:** By exploring the perspectives of people with Medicare, CMS can better fit the model's design to the needs, abilities, and desires of affected populations.
- **Barriers:** People with Medicare and their families and family caregivers may be better able to identify participation barriers they might face within a model—for example, a requirement to access information online when many people do not have online access.
- **Buy in:** People who feel a system reflects their needs and concerns are more likely to be willing and engaged participants.
- **Stickiness:** People who feel they are heard are more likely to stay with a particular model, plan, or provider, making possible longer-term analysis of patient outcomes and increasing

the chance of positive provider influence over behaviors.

Many of the risk factors for a lack of engagement are overrepresented in the populations most served by CMS: older adults, people with historic lack of access to health care or with low incomes, and people with chronic diseases or other significant health issues.<sup>20</sup> Consequently, it is especially important that models have a strong focus on bringing people receiving care into the informational fold and enabling them to become active participants.

For participation to benefit both the people and the process, it should be meaningful and genuinely encourage and incorporate feedback. Participation that is limited in scope, duration, or intensity, or that includes only a lone beneficiary or consumer advocate in a room full of dominating voices, is not as likely to be meaningful.

In addition to consulting with engaged recipients of care, the model design process would benefit from consultation with other stakeholders through varied methods such as: comment opportunities on new model proposals; model-specific technical expert panels; and meetings with stakeholders including clinicians and other providers, consumer advocates, and advisory panels. Stakeholders can be especially valuable in identifying the potential for exploitation and in finding ways to mitigate negative incentives.



### **10** *Avoid unintended consequences of beneficiary incentives in model design.*

Models sometimes include attempts to influence behaviors through some form of beneficiary-targeted financial incentives. A model might include not just a network but a preferred provider network-within-a-network that reduces costs for patients who use those preferred providers.<sup>21</sup> Such a design can potentially provide a strong cost-saving incentive for participants. Other beneficiary-targeted incentives could

20 Alexandra King, "Editorial: Poor Health Literacy: A 'Hidden' Risk Factor," *Nature Reviews: Cardiology* 7 (September 2010): 473-474, <http://www.nature.com/nrcardio/journal/v7/n9/full/nrcardio.2010.122.html>.

21 Anna D. Sinaiko, "How Do Quality Information and Cost Affect Patient Choice of Provider in a Tiered Network Setting? Results from a Survey," *Health Services Research* no. 2 (April 2011): 437-456, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3064913/>.

include targeted cost sharing by condition or treatment,<sup>22</sup> or formulary tiers.

But our experience shows us that such incentives are not likely to be successful on their own. Even in traditional Medicare's fee-for-service universe, people with Medicare may already struggle to understand how providers are paid, what incentives there are for treatment, and what choices they may make. As incentives shift from something that resembles retail to more complex arrangements, that confusion may increase. Take the case of preferred provider networks, which seek to encourage beneficiaries to visit particular health care providers. Although potentially an effective way to reduce patient costs, these networks are not well understood by many beneficiaries. What it means for a provider to be preferred, or what standard nonpreferred providers did not meet, is important information for participants.

Consumer confusion about other incentives could also imperil a model. For example, if cost sharing will vary based on value, the beneficiary must understand how to identify what treatments are considered high value and must accept that this designation is accurate. Without this vital understanding, attempts to incentivize these choices are unlikely to succeed.

It is also important to recognize that incentives that increase patient costs may just drive patients away from needed care. "A large and growing body of evidence demonstrates that in response to increased cost sharing, patients decrease the use of both high-value (e.g., immunizations, cancer screening, appropriate prescription drug use) and low-value services, and may have worse health outcomes as a result."<sup>23</sup>

Because of these concerns, we do not support incentives that penalize consumers for their choices. While positive incentives that lower

costs do not include these harmful side effects, plan- and provider-focused incentives such as risk-adjusted payments, shared savings based on performance on quality measures, or financial penalties for stinting on care may prove more effective. Transparency in all data and incentives is key to both proper implementation and patient trust.

## Recommendations for Plans and Providers



### **11** *Monitor and assess meaningful consumer engagement.*

To help ensure that patients, consumers, family caregivers, their families, providers, and other community stakeholders can fully participate in models, plans and providers should review their engagement efforts. For example, AHRQ has created a set of implementation guidelines for engaging patient and family advisers that includes measurable outcomes such as the number of advisers recruited or retained, the number of programs or processes involving advisers, examples of deliverables, and the number of hours of adviser time.<sup>24</sup> Such measures could be adopted, along with a requirement that they be publicly reported or, at a minimum, that complaints or grievances be reported to the independent ombudsman (see also Checklist #13).

Ideally, diverse consumers and consumer advocates would participate in committees whose work involves patient care to ensure differing perspectives are available and that the representatives reflect the diversity of the community served. Consumers and advocates would be at their most effective if encouraged to participate fully, with regular assessment of their satisfaction in their role, their suggestions for further engagement, and their perception of their effectiveness.

22 Currently, all Medicare Advantage plan benefits must be offered uniformly to all enrollees residing in the service area of the plan. For more information, see Center for Medicare & Medicaid Services, "Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections," (Rev. 121, Issued April 22, 2016), Sec. 10.5.1, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>.

23 Pierre L. Yong et al., eds., "Chapter 4: Approaches to Improving Value—Consumer Incentives" in *Value in Health Care: Accounting for Cost, Quality, Safety, Outcomes, and Innovation: Workshop Summary* (Washington, DC: National Academies Press, 2010), <https://www.ncbi.nlm.nih.gov/books/NBK50927/>.

24 "Working with Patient and Families as Advisors: Implementation Handbook," Agency for Healthcare Research and Quality, accessed November 3, 2017, [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1\\_Implement\\_Hndbook\\_508\\_v2.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf).



## **12** *Include integration, training, and supports for consumer advocates.*

Underlying the need for meaningful beneficiary and stakeholder participation is the need for explicit support, integration, and training processes for those beneficiaries and stakeholders as they prepare to participate in governance bodies and engagement opportunities. Beneficiary participants may be frail; may have one or more chronic or disabling conditions; and may require physical, technological, financial, or educational support. Many of the issues surrounding health care models are complex and unlikely to be intuitive. Even the terminology or structure of a model may be unclear to a beneficiary who is essentially starting from scratch.

Beneficiaries and advocates may be eager to be involved but may lack understanding about the financial, medical, delivery, or systemic issues the model attempts to address. If participants do not understand how a model will work or are intimidated or ignored, their valuable input may not be heard or effectively communicated.

Any integration process would ideally include details necessary for the smooth functioning of a group, including the objectives of the group, any necessary informational materials, introduction to participants in the group and their roles, the current state of the project, and group rules or standards about communication, participation, and decision making.

In addition to this foundational integration, some people may need additional support to participate fully. Supports might include transportation to meeting sites; communication aids; hardware or technical support; physical assistance before, during, or after a meeting; interpreters; or translated materials. If participation will be

extensive, some form of compensation may be advisable or necessary.<sup>25</sup>

Financial support for integration, training, and supports should be provided by CMS to help ensure that as many providers as possible can maximize these opportunities.

## **C. MODELS SHOULD IMPROVE TRANSPARENCY AND OVERSIGHT TO ALLOW CONSUMERS AND THEIR ADVOCATES TO MONITOR MODELS AND PROTECT CONSUMER INTERESTS.**

Oversight begins with CMS ensuring high standards for the quality of providers and facilities included in any new models. In addition, both consumers and their advocates must be able to see how a given model operates in the world. Without this information, informed choices are difficult, if not impossible. We could conceive of these items as simply an offshoot of the informational items from section II-A, but we feel elevating transparency and oversight in its own section demonstrates the importance of accessing big-picture information.

Such information can be used by consumers acting on their own or in conjunction with supports such as ombudsman programs or SHIPs, or advocacy organizations, like Medicare Rights or AARP, that may use the information to help inform policy efforts.

## **Recommendations for CMS/CMMI**



## **13** *Establish an independent ombudsman program.*

Although it has not yet been implemented, CMS recently made an important commitment to developing a new independent ombudsman program—the Alternative Payment Model (APM) Ombudsman—devoted to monitoring ongoing and emerging care models.<sup>26</sup> Such a program can

25 See, for example, “Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs,” US Department of Health and Human Services, Centers for Medicare & Medicaid Services, May 20, 2013, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>. See also “Stakeholder Engagement in Design, Implementation and Oversight,” Community Catalyst, accessed August 2, 2017, <http://www.communitycatalyst.org/resources/tools/mmltss/stakeholder-engagement-in-design-implementation-and-oversight>.

26 “Advancing Care Coordination through Episode Payment Models (Cardiac and Orthopedic Bundled Payment Models) Final Rule (CMS-5519-F) and Medicare ACO Track 1+ Model,” US Department of Health and Human Services, Centers for Medicare & Medicaid Services, December 20, 2016, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html>.

be an effective, centralized resource to evaluate models over time in terms of how well they are serving beneficiaries.

Although CMS has not revealed the exact parameters of the APM Ombudsman, we believe the essential components of any ombudsman program are (a) to provide individual information and assistance to beneficiaries, including appeals, troubleshooting, and resolving beneficiary problems, including billing; (b) to empower and engage with consumers to help build better systems; and (c) to track questions and complaints, and provide systemic data and feedback to CMS about what is working and what can be improved.

An appropriate ombudsman program can vary based on the type of model or models it would support:

*The most effective ombuds will have ties and trust in the communities covered by the demonstration or waiver program. Which organization or organizations would be most appropriate could depend on where the program will operate, for example, whether it is concentrated in a few urban counties or is statewide; whom it serves, for example, whether it covers all duals or particular subpopulations and similar factors. An organization serving as ombuds should be a good match with the needs of those being served.<sup>27</sup>*

Funding and staffing for the program can also vary. The program could be funded by grants and staffed by independent, community-based nonprofits in a model's region.<sup>28</sup> It could be one contracted statewide or nationwide entity that provides assistance and subcontracts with a network of local assistors.<sup>29</sup> Or it could be housed within a federal agency as a governmental body.<sup>30</sup>

To ensure that such programs can operate effectively, we envision that any model ombudsman program would be intended to address issues or questions that arise from the model, rather than general Medicare issues. Other ombudsman programs would still handle issues outside the model context.

Finally, complaints and grievances reported to the APM Ombudsman should be included in public reporting.



**Publicize all audit and evaluation results and incoming data in a timely manner.**

To make good decisions, consumers, their families and family caregivers all need to be able to access meaningful results and data from current models, such as

- patient outcomes and satisfaction;
- meaningful participation (see also Checklist #11)
- compliance and sanctions;
- complaints, grievances, and appeals filed with the plan or provider;
- complaints, grievances, and appeals filed with the ombudsman (see also Checklist #13); and
- plan-wide savings.

This would allow everyone directly involved in the consumer's care to determine whether the model is working, if the consumer should participate or allow personal data to be used, and if the model providers are high quality. These data would also allow advocates and other third parties to assist and advise consumers about their best options.

27 AARP et al., "Designing State-Based Ombuds Programs in MLTSS and the Dual Eligible Demonstrations," August 2, 2017, [http://dualsdemoadvocacy.org/wp-content/uploads/2013/01/ombuds-1\\_8-2.pdf](http://dualsdemoadvocacy.org/wp-content/uploads/2013/01/ombuds-1_8-2.pdf).

28 See, for example, "Health Care Advocate Project," Vermont Legal Aid, accessed July 14, 2017, <https://www.vtlegalaid.org/health-care-advocate-project>.

29 See, for example, "Who We Are," Individual Consumer Advocacy Network, accessed July 14, 2017, <http://icannys.org/aboutican/who-we-are/>; "Who We Are," Health Consumer Alliance, accessed August 2, 2017, <http://healthconsumer.org/who-we-are/>.

30 See, for example, "Competitive Acquisition Ombudsman FAQ," Centers for Medicare & Medicaid Services, accessed July 14, 2017, [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Competitive\\_Acquisition\\_Ombudsman\\_FAQ.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Competitive_Acquisition_Ombudsman_FAQ.html).



**15** *Share with consumers meaningful information about financial incentives included in model designs.*

Interested consumers should be able to access and understand how the model rewards participating entities. By sharing this information in a consumer-friendly presentation, CMS can promote the trust of consumers who may be weighing participating in a model.

### **Recommendations for Plans and Providers**



**16** *Publish accurate, up-to-date information about networks, benefits, costs, options, and processes.*

In addition to providing this information directly to consumers, plans and providers should make data without personally identifiable information available to the public for its use and oversight, or for consumer assistance.



**17** *Disclose full information about potential conflicts of interest.*

As models are exploring new ways of exchanging money for services, it is especially important that patients feel they can understand and trust the providers' motivations, incentives, and relationships. A patient who is confused about how a provider benefits from the model may feel threatened by unclear references to "value," for example, which may sound like code for cutting costs. Ameliorating such concerns and keeping patient confidence requires full explanation of the model's mechanisms, including showing that potential conflicts of interest are fully vetted, cleared, and transparent.

## III. Conclusion

The Affordable Care Act created new incentives and avenues for Medicare to pursue delivery and payment system reforms, and we have reason to believe such reforms can lower costs for beneficiaries and systems, improve the quality of care, and limit the use of wasteful or low-quality interventions. However, new models are still in the process of being developed and tested. By ensuring that people's needs and desires are always at the forefront of value-based care models, we can prevent or correct potential problems while building on the most effective interventions and outreach.

A model's design will greatly affect both its usefulness and its appeal to plans, providers, and beneficiaries alike. The changes a model brings about, whether subtle or dramatic, can create

barriers for consumers, conflicts of interest for providers, and unexpected consequences for both. As such, it is essential to include consumer protections, and consumer voices, as early and as often in the model development process as possible.

We must not underestimate how much potential a given model might have to disrupt, confuse, or create barriers to care for the consumers it is meant to help. This checklist is one potential set of consumer protections and concrete tools intended to prevent any such outcomes. Additional protections could also be considered, and we encourage CMS to continue to explore all of the ways Medicare can continue to provide high-quality, affordable care to all beneficiaries.

Research Report 2017-09, November 2017

© AARP PUBLIC POLICY INSTITUTE  
601 E Street, NW  
Washington DC 20049

Follow us on Twitter @AARPolicy  
On facebook.com/AARPolicy  
[www.aarp.org/ppi](http://www.aarp.org/ppi)

For more reports from the Public Policy Institute, visit <http://www.aarp.org/ppi/>.



Real Possibilities

**Public Policy  
Institute**