Supporting Statement

Chartering Value Exchanges for Value-driven Health Care

A. Justification

1. Circumstances Requiring Data Collection

The Secretary of Health and Human Services has created and is implementing a Value-driven Healthcare Initiative to enhance person and population-centered care by improving the quality of healthcare services and reducing healthcare costs. This initiative is part of HHS's response to the President's Executive Order 13410: *Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs (August 2006.* In response to the Executive Order, HHS established the following goals and objectives:

1) Promote the establishment of health information technology interoperability standards for exchanging price and quality healthcare data;
2) Promote the availability and use of transparent, nationwide consensus based and endorsed quality measures;
3) Promote the availability and use of transparent, nationwide consensus based and endorsed measures of price/cost; and
4) Promote the use of provider and consumer incentives for high quality and cost efficient healthcare.

This initiative's design is based on the following three fundamental principles:

1. At its core, healthcare is "local"--provided in uniquely constituted cultural and market-based environments. As such, improving the value of healthcare requires a critical mass of community stakeholders: public and private purchasers, health plans, providers, and consumers, as well as other relevant community entities (eg, local health information exchange organizations, Quality Improvement Organizations, state data organizations) investing their time and resources toward

shared cost and quality improvement goals. We refer to such representative community entities as local multi-stakeholder collaboratives. Scattered across the country there are community collaboratives in various stages of development ranging from mature multi-stakeholder collaboratives (defined as ongoing collaboration among representatives from purchasers, health plans, providers, and consumers) to communities where collaboration does not include representatives from all four groups.

2. Broad access to accurate, meaningful information will improve the value of healthcare services by 1) stimulating provider improvement, 2) engaging consumers in provider selection and treatment choices, and 3) enabling purchasers to align consumer and provider incentives. Generating the information needed to accomplish this is maximized when performance measures can be calculated based on all payer data.

3. Establishing a nation-wide learning network will accelerate market-based health care improvement. Learning networks are an evidence-based organizational mechanism to achieve rapid identification, dissemination and adoption of best practices. They are comprised of individuals or groups focused on achieving common broad goals.

Based on the above, AHRQ plans to 1) identify and designate qualified mature community-based multi-stakeholder groups as Chartered Value Exchanges and establish a nation-wide learning network for them.

Chartered Value Exchanges (CVEs)

AHRQ envisions Chartered Value Exchanges as having four core and three important non-core functions as described below.

Four (4) Core Functions

<u>Engagement of Stakeholders in Collaboration:</u>

Effectively engaging representatives from all four critical stakeholders--purchasers, health plans, providers, and consumers--as well as from Health Information Exchanges, Quality Improvement Organizations, state data organizations and other community stakeholders in *ongoing* collaboration is a core CVE function.

Use of Measures:

Getting nationwide consensus based and endorsed performance measures locally adopted and used is a core CVE function. Developing new measures is not. Measures could be generated nationally or generated locally based on clear protocols. Optimally, measures would be constructed by pooling information from all relevant sources and would ultimately address all six Institute of Medicine performance domains of safety, timeliness, effectiveness, efficiency, equitableness, and patient-centeredness.

Provider Engagement in Improvement:

Directly engaging providers to use performance information is a core CVE function and is not limited to informing providers of results. Engagement requires active ongoing dialogue that includes but is not limited to improving data accuracy and data interpretability. While provider engagement is anchored locally, CVEs will operate in a national environment and should encourage involvement, support and ongoing dialogue between national, regional, and local entities.

Consumer Engagement:

Engaging consumers to use performance information is a core CVE function and is not limited to reporting of information. This function may be met, however, by assuring usable information is made available to other entities that would use and distribute that information to consumers.

Three (3) Important (Non-core) Functions

Promoting HIT and HIE:

The role of the CVE is to: 1) facilitate the use of interoperable health information technologies and health information exchange either directly or through alignment with regional health information networks and 2) promote the ongoing migration of measure calculation based solely on aggregated claims data to measure calculation that includes aggregated electronic clinical data and fosters real time patient care improvement.

Facilitating Rewards for Better Performance:

The role of the CVE is to *facilitate or enable* the use of performance measures to reward and foster better provider performance and consumer behavior. This function may be met by serving as a catalyst attempting to influence regional or national health plans and purchasers.

Supporting Knowledge Transfer and Conducting Ongoing Improvement of Efforts:

Sharing discoveries and lessons learned within the CVE community, the CVE learning network, and interested public at large is an expectation of how a CVE conducts itself. Likewise, it is an expectation that a CVE will practice continuous quality improvement in all that it does.

The Chartered Value Exchange designation will be applied to the collective work occurring within a community regardless of how many organizations divide up the work. AHRQ does not plan, however, to impose a particular definition of community based on geography or population density. AHRQ recognizes the need to respect local culture, relationships, and priorities, and will maintain a flexible and inclusive approach to selection and designation. AHRQ does not require a Value Exchange to be an incorporated non-profit entity. AHRQ expects CVEs to adopt nationwide consensus based and endorsed principles and standards where they exist and as they are made available. To be eligible, interested parties must first be recognized by HHS Secretary Michael O. Leavitt as a Community Leader for Value-driven Healthcare. For additional information on Community Leader recognition, see www.hhs.gov/transparency/communities/communityleaders/communities.html

Learning Network

Goals of the Learning Network will be to facilitate sharing of CVE experiences and lessons learned; identify and share promising practices that improve healthcare value; identify gaps where innovation is needed; raise issues to be addressed by national consensus-building organizations; and provide on-the-ground perspective to inform and participate in setting national priorities for healthcare quality and cost improvement. The Learning Network will provide technical assistance in such areas as collaborative production of public reports, effective pay for performance, and use of consumer incentives, and will ultimately work with CVEs to implement a core measure set derived from nationwide consensus based and endorsed measures.

2. Purpose and Use of the Information Collection:

In the Value-driven Healthcare Initiative the following two tiers of collaboratives are envisioned:

1. Tier I Community Leaders—community based groups who aspire to establish mature multi-stakeholder collaboratives comprised of representatives from purchaser, health plan, provider, and consumer groups but where only a limited number of organizations within a single stakeholder group or a limited number of stakeholder groups are working together. Many of these groups have pledged to support the cornerstones of Value-driven Healthcare. They have done so by accessing and signing a publically available Certification Statement that designates them as a Community Leader for Value-driven Healthcare. This designation has been available to interested parties since January 1, 2007. To date, 73 local collaboratives have signed the Certification Statement and been so designated. For additional information on Community Leader designation, see www.hhs.gov/transparency/communities/communityleaders/communities.html
2. Tier II Chartered Value Exchanges—All Community Leaders will be invited to apply to be chartered as Value Exchanges

This request is for approval of the form and collection methods used to charter Value Exchanges.

Method of Collection

AHRQ will issue semi-annual public Requests for Proposals (RFPs) and conduct a selection process immediately thereafter to identify and charter Value Exchanges.

Each RFP will be posted on the AHRQ public website (www.ahrq.gov) with a link to the AHRQ site on the HHS transparency website as well. The RFP instructions will direct interested parties to electronically submit narrative information (maximum 3000 words) to AHRQ that describes their current activities and/or plans to perform the four core functions and three important non-core functions. In addition, applicants will be asked to describe their staff/consultant/in-kind resource arrangements to provide needed expertise; their ability to raise funds or in-kind support from multiple stakeholders; and their ability to manage projects and finances as indications of their organizational capacity to accomplish the four core functions. Review teams will be drawn from the Quality Alliance Steering Committee Workgroups and supplemented as needed to generate 3-4 teams comprised of purchaser, health plan, provider, consumer, and federal representatives. Review teams will include experts from Health Information Exchanges and the Quality Improvement Organization community. Each enrollment period will be open for two months. Applications will be assigned and scored as they are received at AHRQ. AHRQ staff will screen the application for Community Leader status then distribute it to each member of the 5 member review team. The application will be individually scored by each of the review team members within two weeks. The completed scoring forms will be returned to AHRQ who will then generate the team's average scores per function for that applicant. The Scoring Form uses the following rating scale and definitions to guide the evaluation:

Evaluation Guide: To standardize the interpretation of the rating scale, please use the following definitions to guide your choices:

- **Excellent (5 points)**: Clear demonstration of activity already in progress
- **Very Good (4 points)**: Activity partially in progress and effective plan to further mature articulated
- **Average (3 points)**: Effective plan articulated
- **Fair (2 points)**: Attempts to address but hasn't effectively articulated plan or success
- **Poor (1 point)**: Ignores issue

Minimum *average* scores have been set for each function, and are weighted to reflect the importance of the particular function. Engagement of critical stakeholders has a minimum *average* score of 4.5 while engagement of others, use of performance measures, provider engagement and consumer engagement each have minimum *average* scores set at 3.0. Non-core functions including promotion of HIT and HIE, facilitation of rewards for better performance, participation in knowledge transfer, and ongoing improvement of efforts each have minimum *average* scores set at 2.0. Organizational capacity requires a minimum *average* score of 2.0 also. Individual application scores can range from a possible high of 27 to a low of 10, but the acceptance of any applicant will be based on meeting the minimum average score required for each function as well as organizational capacity. A grid of *all* applicants' average scores by function will be presented to the AHRQ Director to make final decisions on how many and which applicants will be chartered at the end of the first month and at the close of the enrollment period. Attempts will be made to maximize geographical and population diversity. Successful applicants will be notified within one month of review.

3. Use of Automation

Electronic submission will be encouraged.

4. Duplication

This is a new activity.

5. Small business impact

It is not anticipated that small businesses will be impacted by this activity.

6. Consequence of less frequent data collection

Fewer Chartered Value Exchanges participating in the Learning Network

7. Special Circumstances

None

8. Federal Register Notice and Outside Consultations

8a. Federal Register Notice

Notice was published in the Federal Register on May 8, 2007 for 60 days. Eleven comments were received. Since many of the comments are similar, rather than address each comment individually, the comments and responses are summarized below. See the attachment titled "Public Comments on 60 Day Notice" for the individual comments.

Summary

A total of eleven sets of comments were received by July 9th, 2007. Comments reflected strong support for the overarching HHS Value-driven Healthcare Initiative as well as for AHRQ's plan to develop a learning network of community-based multi-stakeholder collaboratives. In general there were requests for greater specification on issues that clustered around the following themes:

- Composition, core functions, and number of Chartered Value Exchanges (CVEs) within a community
- Selection process for Value Exchanges
- Funding
- Access to Medicare data

Composition, Core Functions, and Number of Value Exchanges within a Community

Consistent with our belief that all health care is local, we agree with the recommendations to maintain a flexible and inclusive approach to the selection and designation of Chartered Value Exchanges. We agree the emphasis should be on the presence of effective, collaborative working relationships rather than on a particular organizational structure. We agree purchaser, health plan, provider, and consumer representatives must work together as core members of a CVE. In addition, we agree it is important for CVEs to engage 1) Health Information Exchanges in their region, 2) Quality Improvement Organizations, and 3) other local entities such as state data organizations. We believe the CVE designation should be reserved for the collective work occurring within a community to advance the concepts of value-driven healthcare regardless of how many organizations divide up the work. We do not plan, however, to impose a particular definition of community based on geography or population density.

Nor do we require the CVE to be an incorporated non-profit entity. We agree that CVEs should adopt nationwide consensus-based and endorsed principles and standards where they exist and as they are made available. We will ultimately also work with CVEs to implement a core measure set derived from nationwide consensus-based and endorsed measures. All applicable statutes, federal rules and regulations will be followed in implementing all aspects of this initiative.

AHRQ envisions Chartered Value Exchanges as having four core and three important non-core functions as described below.

Four (4) Core Functions

Engagement of Stakeholders in Collaboration:

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Supporting Knowledge Transfer and Conducting Ongoing Improvement of Efforts:

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Selection Process of Value Exchanges

There were several comments suggesting additional expertise be added to the review committee. Specifically, those with HIE expertise and QIO expertise will be recruited.

Funding

AHRQ recognizes the importance of nurturing the development and sustainability of Value Exchanges and is supporting a mechanism to provide ongoing group and individual technical assistance, virtual and face to face facilitated meetings, tools, access to experts, and a web-based knowledge management system for all CVEs. AHRQ recognizes the need for continued national public and private sector dialogue about how to fund performance measure development and maintenance and optimal data processing for the healthcare system nationwide.

Access to Medicare Data

As indicated in the Federal Register Notice, once chartered, CVEs will have access to Medicare provider performance results that could be pooled with private payer results to generate an all payer dataset. Additional legal comments that reference BQI activities rather than planned CVE activities are beyond the scope of our response to comments on the learning network and CVEs.

8b. Outside Consultations

The following people were consulted and have tentatively volunteered to serve as reviewers:

Representation Type	Quality Alliance Expansion Work Group	Quality Alliance Infrastructure Work Group
Chair	Peter Lee, CEO Pacific Business Group on Health San Francisco, CA 94105 Tel: 415-615-6368 Fax: 415-281-0960 plee@pbgh.org Assistant: Alison Park Tel: 415-615-6308 apark@pbgh.org	Chris Queram, President/CEO Wisconsin Collaborative for Healthcare Quality P. O. Box 258100 Madison,WI 53725-8100 Tel: 608-250-1505 Fax: TBA cqueram@wchq.org Assistant: TBA
Physician Leaders	Bruce Bagley, MD Medical Dir., Quality Improvements	Jeff Rich, MD Chairman, Society of Thoracic

	AAFP 11400 Tomahawk Creek Parkway Leewood, KS 66211 Tel: 913-906-6000 x4120 Fax: TBA bbagley@aafp.org Assistant: Chris Donahue Tel: 913-906-6000 x4149 cdonahue@aafp.org	Surgeons The Society of Thoracic Surgeons 633 N. Saint Clair Street, Suite 2320 Chicago, IL 60611 Phone: (312) 202-5800 Fax: (312) 202-5801 ALSO: Mid-Atlantic Cardiothoracic Surgeons, Ltd. 400 W. Brambleton Ave., Suite 200 Norfolk, VA 23510 Tel: 757- 622-2677 Fax: 757-623-2707 rich@macts.com
Hospital Leaders	Elliot Sternberg, MD SVP and Chief Medical Officer St. Joseph Health System 500 South Main Street, STE 1000 Orange, CA 92868 Tel: 714/347-7500 Fax: TBA e-mail: TBA Assistant: TBA	
Purchasing Coalitions	Louise Probst, Executive Director Gateway Purchasers Coalition for Health 8888 Ladue Road, Suite 250 St. Louis, MO 63124 Tel: 314-721-7800 Fax: 314-721-6874 fax lprobst@stlbhc.org Assistant: TBA	Andrew Webber,President National Business Coalition on Health 1015 18th Street N.W., Suite 730 Washington, DC 20036 Tel: 202-775-9300 ex. 20 Tel 2: 202-955-5102 Fax: TBA Mobile: 202-701-5860 awebber@nbch.org Assistant: Maria Cornejo Tel: TBA Washington, DC
Purchasers/ Employer	Lawrence M. Becker,Director-Benefits Xerox Corporation 100 Clinton Ave. Xrx2-027 Rochester, New York 14604-1801 Tel: 585-423-5653 Fax: 216-423-3915 Lawrence.m.becker@usa.xerox.com Assistant: TBA	Margaret Stanley, Executive Director Puget Sound Health Alliance Washington
Health Plans	Reed Tuckson, MD Senior Vice President United Health Care 9900 Bren Road East	Jeffrey L. Kang, MD Senior Vice President, Clinical Programs & Policies Medical Management

	Minnetonka, MN 55343 Tel: 952-936-1253 Fax: TBA Reed_Tuckson@uhc.com Assistant: Jane Devine Tel: 952-936-1256	Cigna Health Care 900 Cottage Groave Road, B227 Hartford, Connecticut0615201136 Tel: 860-226-2550 Fax: 860-226-4363 Jeff.kang@cigna.com Assistant: (name) Tel: 860-226-1567
QIOs	Jennifer P. Lundblad, PhD, MBA President and CEO Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425 Tel: 952- 853-8523 Fax: 952- 853-8503 JLUNDBLAD@mnqio.sdps.org Assistant: TBA	Marc H. Bennett, President and CEO HealthInsight 348 East 4500 South, Suite 300 Salt Lake City, Utah 84107 Tel: 801-892-0155 Fax: 801-892-0160
Collaboratives	Marc Overage, MD, PhD President and CEO Regenstrief Institute, Inc. 1050 Wishard Blvd. Indianapolis, IN 46203 Tel: 317-630-7070 Mobile: 317-490-4911 Fax: 317-630-6962 moverhage@regenstrief.org Assistant: Sandy Poremba Tel: 317-630-7070	Barbara Rabson, Executive Director Massachusetts, Health Quality Partners Watertown, MA02471 Tel: 617-972-9071 Fax: 617-972-9474 e-mail: TBA
Group Practices	George Isham, MD Medical Director Health Partners 8100 34th AvenueSouth Minneapolis, MN 55440 Tel: 952-883-6805 george.j.isham@healthpartners.com Assistant: TBA	Scott Young, MD Kaiser Care Management Institute California
Consumer/Patient Advocates/Labor	Elizabeth (Betsy) Gilbertson, President Hotel Employees and Restaurant Employees International Union Welfare Fund (H.E.R.E.I.U.) 1901 S. Las Vegas Blvd. South, Suite 101 Las Vegas, NV 89104-1309 Tel: 702-892-7331 Mobile: 805-680-7786	Katherine Browne, Director National Partnership for Women & Families 1875 Connecticut Ave NW Washington, DC 20009 Tel: 202-986-2600 Tel 2: 202-238-4820 Mobile: 202-257-1518 Fax: 202-986-2539 kbrowne@nationalpartnership.org

	ebgfund@earthlink.net Assistant: Myra Lundin mlundin@hereiu-fund-lv.com	Assistant: Debbie Wilkes wilkesd@nationalpartnership.org
CMS	Jane Thorpe, JD, Office of Policy Michael Rapp, MD, JD, Office of Clinical Standards and Quality	Jane Thorpe Michael Rapp

9. Remunerations

AHRQ will not be providing payments or gifts to applicants.

10. Confidentiality

The applications received will not be disclosed in such a way as to identify individuals and organizations. Individuals and organizations will be assured of the confidentiality of their replies under Section 924(c) of the Healthcare Research and Quality Act of 1999. The names of approved applicants will be made public.

11. Sensitive information

No sensitive information is being requested.

12. Burden

The collaborative manager will spend an estimated eight hours to draft a narrative to the RFP, and an additional eight hours making revisions based on review by the collaborative executive committee. The collaborative executive committee will spend an estimated one hour to review the draft narrative. A collaborative assistant will spend an estimated two hours assembling the narrative with any supporting documents.

Exhibit 1. Estimate of Hour and Cost Burden to Respondents

Data Collection Effort	Number of Respondents	Responses per respondent	Time per Respondent in Hours	Total Burden Hours	Average Hourly Wage Rate	Annual cost Burden to Respondents
Draft, and make revisions to, narrative response to RFP by Collaborative Manager	50	2	8	800	$34.67	$27,736
Narrative reviews* by 1-2 members of Collaborative executive committee	75	1	1	75	$57.90	$4, 342.50
Assembly of narrative with any supporting documents by Collaborative Assistant	50	1	2	100	$12.58	$1,258
Total	**225**			**950**		**$33,336.50**

13. Annual total cost to respondents

This information collection will not impose a cost burden on the respondent beyond that associated with their time to provide the application-requested information. There will be no additional costs to respondents for capital equipment, software, computer services, etc.

14. Annual cost to the Federal Government

The total cost to the government for its proposal review activity is estimated to be $500,000 annually.

15. Changes in burden

This is a new collection

16. Publication Plans

Descriptive stories of Value Exchange lessons learned and promising practices will be shared by the participants on a voluntary basis.

17. Exemption for Display of Expiration Date

AHRQ is not seeking an exemption to display the expiration date for OMB approval.