



June 9, 2007

Doris Lefkowitz
Reports Clearance Officer
Agency for Healthcare Research and Quality
540 Gaither Road
Room #5036
Rockville, Maryland 20850

Re: Comments on "Chartering Value Exchanges for Value-driven Health Care"

Dear Ms. Lefkowitz:

The National Business Coalition on Health (NBCH) is pleased to submit these comments on AHRQ's notice announcing the agency's intent to request proposals semi-annually from parties interested in becoming chartered as Value Exchanges for Value-driven Health Care (Federal Register, May 8, 2007). We applaud the Secretary's ongoing efforts to promote value-driven health care. We see the Value Exchange program as an important component of that initiative.

The goals of value-driven health care and, thus, the Value Exchange program are consistent with the mission of NBCH and its member organizations. NBCH is a national, non-profit, membership organization of employer-based health coalitions. Our nearly 70 member coalitions across the United States represent over 6,000 employers and approximately 34 million employees and their dependents. These business coalitions are composed mostly of mid- and large-sized employers in both the private and public sectors in a particular city, county, or region. NBCH and its member coalitions are committed to health care system reform, through value-based purchasing, community by community.

NBCH supports and endorses the Value Exchange program. In fact, NBCH member coalitions have fulfilled many of the roles associated with the Value Exchange concept in their communities. We are pleased that federal policy leaders recognize the need for local health care leadership, coordination, and solutions.

Our comments on the Federal Register notice center around four key issues:

- Value Exchange capacity,
- Multi-stakeholder collaborative criteria,
- Value Exchange benefits, and
- Community Leader designation.

Value Exchange capacity

Recommendations:

- 1. A multi-stakeholder collaborative should not have to demonstrate all eight capacities to qualify as a Value Exchange.*
- 2. Multiple Value Exchanges should be allowed and should be encouraged in each geographic area.*

The AHRQ notice outlines eight primary capacities required to become a Value Exchange. The notice, however, does not indicate whether or not a multi-stakeholder collaborative is required to demonstrate each capacity. The notice is also silent both on how Value Exchange applicants will be evaluated against each of these capacities and on how each capacity is weighted with regard to an organization's overall application.

Because these areas are not addressed in the notice, NBCH is concerned that AHRQ will require Value Exchange applicants to perform each of the eight capacities. We believe that this approach is flawed. Requiring one multi-stakeholder collaborative to perform each of the eight capacities places the authority and charge to reform the local health care system into one organization. Likewise, it implies that multi-stakeholder collaboratives are expected to influence both supply- and demand-side change. This is an enormous burden to place on a single, community-level organization and it dilutes the resources and impact these multi-stakeholder collaboratives are able to achieve in any given change area. As an organization's mission broadens, the less likely it is to be effective in any capacity. We also believe that this approach is at odds with how community-level organizations are currently functioning and, as a result, it would place undue limits on the types and kinds of organizations qualified to become Value Exchanges.

AHRQ does not indicate in the notice whether or not it will limit the number of organizations designated as Value Exchanges in a given community or geographic area. NBCH urges AHRQ to allow all qualifying organizations in a community to be designated as Value Exchanges. Currently, multiple community-level collaboratives work in tandem to reach complementary goals. For example, one organization might focus on promoting the use of interoperable health information technologies for measurement and information sharing, while another focuses on performance and cost measurement reporting with the goal of improving provider performance and reducing health care costs. Both organizations are advancing the concepts of value-driven health care in their community; they simply concentrate on different core functions. AHRQ should foster broad participation in the program by not limiting the number of qualified organizations allowed Value Exchange designation in a given community.

Multi-stakeholder collaborative criteria

Recommendations:

3. *Single stakeholder-led organizations can establish and lead effective multi-stakeholder collaboratives and should be allowed as Value Exchanges.*
4. *Provider-driven organizations should not parent a multi-stakeholder collaborative (unless its designation is with regard to quality improvement only).*

AHRQ defined Value Exchanges as mature, community-based multi-stakeholder collaboratives. The notice does not, however, define multi-stakeholder collaboratives and NBCH is concerned that AHRQ might characterize multi-stakeholder collaboratives in a way that limits the number of organizations qualified to become Value Exchanges and, thus, limit health care cost and quality improvement options in communities.

NBCH agrees that Value Exchanges should represent a variety of health care stakeholders, but we also believe that organizations dedicated to value based purchasing or quality improvement can and do engage all critical stakeholders even if their Boards are comprised of only a limited stakeholder perspective. NBCH represents and advances the interests of local business coalitions on health – all of which are focused on improving the cost and quality of health care in their communities. Although, many local business coalitions on health are comprised only of local employers, coalitions actively seek out the perspective and influence of other community, health care stakeholders and engage them in collaborative processes and decision making. These local coalitions demonstrate how single stakeholder-led organizations can establish effective multi-stakeholder collaboratives. We believe that there must be explicitly demonstrated, meaningful engagement of all stakeholders, but control of a Value Exchange can be through a single stakeholder group.

While we support the notion of single-stakeholder leadership of multi-stakeholder collaboratives, we believe that organizations driven or controlled by providers should not be eligible for Value Exchange designation. Many of the strategies of potential Value Exchanges are linked to the four cornerstones of value-driven health and focus on activities aimed at changing provider behavior – provider incentives, public reporting on provider performance, and health information exchange; as a result, having providers at the helm of Value Exchanges presents a conflict of interest. NBCH has no objection to provider-led organizations receiving Value Exchange designation, if the designation applies to the performance of quality improvement functions only.

Value Exchange benefits

Recommendations:

5. *Value Exchanges should have access to Medicare data, not just performance results.*
6. *The US Federal Government should contribute fiscal resources to Value Exchanges as improvements and changes sown locally reap national benefits for the federal government as a purchaser of health care services.*

Organizations designated as Value Exchanges will participate in an AHRQ-managed Learning Network and are eligible to request Medicare-inclusive, multi-payer, patient de-identified, physician-level performance measurement results. NBCH supports both of these initiatives.

We are concerned, however, that the performance results made available would be of important but limited use in communities. To truly impact community-level activities, communities should be able to aggregate Medicare data provided by CMS with their own community level data to provide all-system results across multiple measures of performance. Access to just performance results will limit a community's opportunity to understand their local health care system and to influence real change.

Moreover, we believe that Medicare data, if available to Value Exchanges, should be made public. Organizations other than Value Exchanges, including Community Leaders, are promoting the goals of enhancing person and population-centered care by improving the quality of health care services and reducing health care costs. We believe that all organizations pursuing these common goals should be granted access to Medicare data that will facilitate achievement of these goals.

If AHRQ and the Secretary of Health and Human Services truly want to drive community-level health care cost and quality improvement, funding should be provided to Value Exchanges. The US government provides or subsidizes health care coverage for over 100 million lives (through Medicare, Medicaid, and the Federal Employees Health Benefit Plan) throughout the nation. Health care cost and quality improvements realized at the community level will positively benefit the U.S. government as a public purchaser of health care, with taxpayers being the ultimate beneficiaries. The government should, therefore, actively support community efforts by investing financial resources, which are necessary to sustain meaningful efforts to engage all stakeholders in the re-engineering of the health care system.

Community Leader designation

Recommendations:

- 7. Community Leader designation should not be required to be eligible to become a Value Exchange.***

As described in the notice, to be eligible for Value Exchange designation, organizations must first be recognized by Secretary Leavitt as a Community Leader for Value-driven Health Care. We believe that this creates redundancy and places an unjustified burden on organizations qualified to be Value Exchanges. Given the fact that Value Exchanges are essentially more mature Community Leaders, we propose that organizations be allowed to apply directly for Value Exchange status, and that Community Leader designation would be automatically granted to approved Value Exchanges.

Conclusion

On behalf of its member coalitions, NBCH appreciates the opportunity to comment on the important policy notice crafted by AHRQ, and we look forward to working with the Agency and Secretary Leavitt to achieve our common goal of a health care system that consistently delivers the right care, at the right time, in the right setting. NBCH enthusiastically supports the stated vision of a national network of Value Exchange entities, guided by multi-stakeholder dialogue and direction, and dedicated to health care reform, community by community. If you have any questions, or require clarification of our comments, please don't hesitate to contact me.

Sincerely,



Andrew Webber
President and Chief Executive Officer

July 9, 2007

Doris Lefkowitz
Reports Clearance Officer
AHRQ
540 Gaither Road, Room #5036
Rockville, MD 20850

Re: Quality Alliance Steering Committee, Expansion Workgroup
Comments on "Chartering Value Exchanges for Value-driven Health Care"

Dear Ms. Lefkowitz:

The Quality Alliance Steering Committee (QASC) Expansion Workgroup is greatly appreciative of the efforts of the Agency for Healthcare Research and Quality and the Health and Human Services Department to be informed by the long and inclusive process that we engaged in to develop recommendations on the formation of Value Exchanges that will promote national standardization while fostering local action. We are providing these comments based on our deep concern that there is a lack of clarity among many stakeholders about the appropriate role of the Chartered Value Exchanges (CVEs). While the Federal Register notice does a good job of identifying the fundamental principles underlying the concept of Value Exchanges, it is less successful at capturing the texture of the Workgroup's discussions, recommendations and efforts to incorporate the concerns expressed by members of the Quality Alliance Steering Committee and many who commented on the appropriate role for the CVEs.

The Expansion Workgroup believes that there needs to be a clearer articulation of what CVEs should and should not be doing. In particular, the Workgroup believes that there needs to be clarification about what is the appropriate balance of functions (or parts of functions) that should be done locally (by CVEs or other entities) versus at the national level. It is in this context that the Expansion Workgroup recommends that AHRQ provide more detailed guidance regarding the role of the CVEs. The comments that follow seek to inform the development of that guidance.

Collection of Data/Piloting and Role of CVEs and BQIs. The Workgroup believes it is particularly important to clarify that the primary role of the CVEs is to use and promote the use of nationally endorsed measures — not to develop and test new measures. The Workgroup believes that data aggregation, while not necessarily a core function of the CVEs, can and should only be undertaken when the entity demonstrates its capacity and either receives from other sources or aggregates data in its community to generate approved national performance measures. The Workgroup recommends that AHRQ develop specific criteria that delineate the specific capacities that would assure a CVE was able to do or oversee the disciplined processes required to assure that performance measurement is well conducted.

With regard to developing and testing measures, the Workgroup specifically does not believe this should be a function of CVEs. The Better Quality Information for Medicare Beneficiaries (BQI) pilot sites — selected specifically because of their expertise in collection and aggregation of data — are an example of appropriate entities to undertake the collection of data and testing of measures and methods. The Workgroup believes that there may be groups other than just the

original six selected BQIs that could have the demonstrated capacity to perform these functions. To the extent other groups are used for piloting and testing, distinct from their CVE functions, they should demonstrate their management of disciplined processes to assure valid measure testing and development.

The Workgroup would like to emphasize that nothing in our remarks is intended to stifle innovation, which we view as critical to improving quality of care across the health care system. While the Workgroup believes that the primary role of the CVEs is to use and promote the use of measures, we see measure development/testing and data aggregations as a logical potential by-product of this work for those CVEs with demonstrated capacity. For example, the Workgroup believes that there is an urgent need to have testing to address gaps in measures and that special concern needs to be taken that such testing is done well. Where a CVE, acting outside of its role as a CVE, does test or develop measures, the Workgroup believes it must expressly agree to consider national priority setting around measurement gaps and forward new measures at the appropriate time to the National Quality Forum for endorsement.

Identification of "Core" VCE Functions. The Federal Register notice identifies eight capacities for the CVEs but does not prioritize their importance or offer any guidance as to what role a CVEs should play in addressing each of these functions. For example, the Federal Register notice does not make clear whether some of the eight capacities should be considered "core" functions or the extent to which some can and should be done at the national as well as local level. The Workgroup's deliberations included identifying functions that were indeed "core" and we had extensive discussion about which functions for which the CVE role could be more one of being an "enabler" and where there was more or less potential relationship with national or broader support to fulfill the function.

Turning to the eight capacities identified in the Federal Register notice, the Expansion Workgroup offers the following recommendations:

1. **Collection of Measures**—The Expansion Workgroup recommends that AHRQ clarify that the role of value exchanges is not to create measures, but to get into use nationally endorsed performance measures. Collection and aggregation should be handled nationally where it can be, although some local-level collection may be needed. The primary role for CVEs in this arena is to use nationally endorsed performance measures; thus, CVEs should make available for local use measures that are either generated nationally or that are collected locally based on clear protocols. The Workgroup believes that CVEs may either receive and use performance results that they share with providers and consumers or receive raw data from which they produce results based on approved national standard measures. Before a CVE were to receive data from which it would generate performance reports, it would need to demonstrate the capacity and expertise to undertake this activity. AHRQ should articulate explicit criteria by which groups would demonstrate their disciplined process for being successful being able to do so.
2. **Public Reporting**—The Expansion Workgroup recommends that the language in this section be clarified to emphasize the importance of engaging consumers to use performance information. The intent was not merely to "report" but to disseminate information that would be "actionable". The Workgroup sees this as a critical function, but one that could be fulfilled in part by assuring that others in the community are making such information public

(e.g., health plans, local public entities, private vendors) and to assure that the *underlying performance information to entities that will use and distribute that information to consumers* is made available (Workgroup-AHRQ, February 22, 2007). The Workgroup believes that much public reporting is likely to be done from national or state sites (e.g., from national health plans, or the CMS HospitalCompare site).

3. Provider Rewards—The Expansion Workgroup believes that the language in this section must be clarified to make clear that not all value exchanges are positioned to use performance measures to reward and foster better performance. Hence, this capacity should not be a core function. The workgroup recommends that the language be amended to make clear that the CVEs should *seek to achieve* this objective, but this will be more likely to be a catalyst activity, largely dependent on regional or national health plans and purchasers.
4. Quality Improvement—The Expansion Workgroup believes that AHRQ should make clear that quality improvement is a critical role for all value exchanges. Health care is delivered locally and needs to be improved locally. The Workgroup recognizes that some critical support from improvement may come from national sources, such as medical specialty societies and regionally, such as from Quality Improvement Organizations or health plans. However, this function is one that must be anchored in local and direct engagement with the providers. The workgroup believes that the language regarding this capacity must be amended to reflect the role of CVEs to *engage* providers actively around quality improvement. The current language (“informing providers of their results”) suggests a process that may be “passively” providing a report and not engaging providers with assistance—which was not the intent of the Expansion Workgroup’s earlier discussions.

Also regarding quality improvement, the workgroup believes that additional context is needed to clarify that, while CVEs are local entities, they operate in a national environment and that quality improvement activities must take place at both the national and local levels. The Expansion Workgroup believes that there is a need to celebrate and respect local innovation while at the same time recognizing that, for many of these functions, there exists both a national infrastructure and a wealth of content on quality improvement.

5. Fostering Collaboration—The Expansion Workgroup believes that AHRQ must make clear that collaboration is a core function and area for demonstrated capacity for all value exchanges (see Workgroup-AHRQ, February 22, 2007, page 8) and should go beyond fostering to ensuring this capacity is met. The CVEs must be able to effectively engage all stakeholders at the local level, including groups that may be harder to bring to and keep at the table (e.g., consumers). (This capacity was appropriately highlighted in the Federal Register description of “minimum” demonstrated capacity – B.)
6. Promoting HIT— The Workgroup members agreed that the role of value exchanges is to engage, facilitate, and use health information technology.
7. Support Knowledge Transfer—The Workgroup agreed that this capacity addresses expectations rather than defined attributes.
8. Evaluation—The Workgroup agreed that this capacity addresses expectations rather than defined attributes.

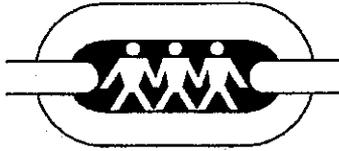
In addition to the "core capacities" of (1) collection/use of data and (2) ensuring collaboration, we also identified demonstrated organizational capacity to meet these two as well as other characteristics. This capacity is well reflected in the Federal Register.

Again, thank you for the opportunity to comment on this important initiative. Should you have any questions, feel free to contact Peter Lee, Chair of the QASC Expansion Workgroup or any of its members.

Sincerely,

Peter V. Lee
CEO, Pacific Business Group on Health
On Behalf of QASC Expansion Workgroup

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GDAHC is a United Way Community Services Agency.

July 3, 2007

Doris Lefkowitz, Reports Clearance Officer
AHRQ
540 Gaither Road, Room #5036
Rockville, MD 20850

RE: AHRQ Proposed Project – Chartering Value Exchanges for Value-driven
Healthcare

Dear Ms. Lefkowitz;

I am writing to provide comments regarding the information gathering project proposed by AHRQ in the May 8, 2007 Federal Register, entitled “Chartering Value Exchanges for Value-driven Healthcare.”

Overall, the Greater Detroit Area Health Council (GDAHC), supports the direction created by the Secretary of Health and Human Services in implementing this Value-driven Healthcare Initiative. This direction is consistent with a major GDAHC initiative, Save Lives Save Dollars, which was undertaken at the request, and with the support, of our multi-stakeholder constituency. We have already been designated by Secretary Leavitt as a Community Leader for Value-driven Healthcare and expect to respond to the RFP envisioned in this proposal to be chartered as a Value Exchange. In discussions with our leadership, and with colleagues in other coalitions around the country, we would like to offer several comments and recommendations, as follows:

1. The proposal indicates AHRQ will create a process, the result of which will be the identification and chartering of “mature multi-stakeholder collaboratives” as Value Exchanges. While there is no definition of “mature multi-stakeholder collaborative” contained in the proposal, the narrative does acknowledge that there are “community collaboratives” scattered across the country, that they are in various stages of development, and that some are organizations comprised of members of a single stakeholder group or a limited number of stakeholder groups.

Recommendation: We urge AHRQ to adopt a flexible approach to identifying “mature multi-stakeholder collaboratives” and place greater emphasis upon the presence of effective, collaborative working relationships involving all of the key stakeholders, than upon organizational structure.

2. The proposal indicates that one of the benefits of being designated as a Value Exchange will be eligibility to request “Medicare-inclusive multi-payer patient de-

identified individual physician-level performance measurement results." We agree that the ability to receive, manage and utilize such data will be essential to the success of Value Exchanges in achieving the Secretary's objectives. It is also essential, from the perspective of the larger community, that the new Value Exchanges not be permitted to limit access to these data to other parties with a legitimate interest.

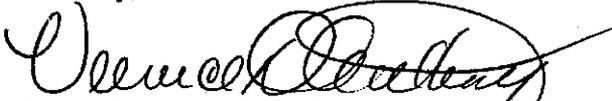
Recommendation: We suggest that AHRQ require the new Value Exchanges to establish reasonable methods by which other parties with a legitimate interest can access the Value Exchanges' performance data. Value Exchanges should not be permitted to limit, or create barriers to access to these performance data for parties with a legitimate interest. Alternatively, once these data are provided by AHRQ to the Value Exchanges, AHRQ should grant access to other parties with a legitimate interest.

3. The proposal indicates that Value Exchanges must have the capacity, or plans to develop the capacity, to carry out 8 functions. Some of the functions appear to require significant resources, while others do not. These multi-stakeholder collaboratives vary in their ability to access resources and some may find themselves exceedingly strained to obtain the resources necessary to carry out all of the functions. The resources and capabilities of each collaborative reflect the interests of its respective stakeholders.

Recommendation: AHRQ should adopt a flexible approach in its expectations of the Value Exchanges and the degree to which they carry out all of the identified functions. Unless AHRQ plans to provide funding to the Value Exchanges to carry out specific functions, it needs to accommodate the varying interests, priorities and support of the local stakeholders.

We appreciate the opportunity to comment on this proposal and have tried to be constructive in our recommendations. We look forward seeing the final language and hope that this initiative moves forward to implementation soon.

Sincerely,



Vernice Davis Anthony, President and CEO

cc: Bruce Bradley, Chair, Save Lives Save Dollars Program, GDAHC
Jan Whitehouse, Senior VP, Save Lives Save Dollars Program, GDAHC
Andrew Webber, National Business Coalition on Health

July 3, 2007

Doris Lefkowitz
Reports Clearance Officer
AHRQ
540 Gaither Road, Room #5036
Rockville, MD 20850

Re: Comments on "Chartering Value Exchanges for Value-driven Health Care"

Dear Ms. Lefkowitz:

Thank you for the opportunity to comment on the request for proposals on Chartering Value Exchanges for Value-driven Health Care. We applaud the work being led by the Secretary of Health and Human Services to create a value-driven health care system, of which this is one component in that initiative.

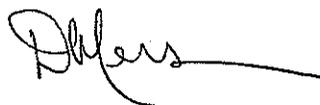
We wholeheartedly believe that broad access to meaningful information on performance is essential to improving the quality and affordability of health care and that local communities are a key element in making this a reality. We support the requirement that Chartered Value Exchanges (CVEs) demonstrate the capacity to collaborate across multiple stakeholders, but believe it should go beyond fostering such collaboration to ensuring this capacity is met. **In particular, we believe that there must be explicitly demonstrated meaningful engagement of consumers and purchasers.** We recognize that there are challenges to obtaining full involvement from these groups, however, without strong incentives there is a very real risk that "collaborative" enterprises will be dominated by those being measured – this is not a result that we should allow. The Chartered Value Exchanges should have "terms of engagement" that assure active dialogue, information sharing and participation from representatives of all stakeholder groups and this should be carefully monitored during on-going evaluation efforts.

Again, thank you for the opportunity to comment on this important initiative. If you have any questions, please contact either of the Disclosure Project's co-chairs, Peter Lee, CEO of the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,



Peter V. Lee
Chief Executive Officer
Pacific Business Group on Health



Debra L. Ness
President
National Partnership for Women & Families



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July 9, 2007

Carolyn Clancy, M.D.
Director
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, Maryland 20850

RE: Chartering Value Exchanges for Value-driven Health Care
ATTN: Doris Lefkowitz, Reports Clearance Officer

Dear Dr. Clancy:

I am writing to you in response to the May 8th Federal Register notice requesting comments on the Agency for Healthcare Research and Quality's (AHRQ) proposed application process for the designation of Value Exchanges. The Value Exchange application process notice refers to three principles underpinning Secretary Leavitt's Transparency Initiative:

1. Health care is local, therefore, "improving the value of health care requires a critical mass of community stakeholders...investing their time and resources toward shared cost and quality improvement goals."
2. "[B]road access to accurate, meaningful information will improve the value of health care services by stimulating provider improvement..."
3. "[E]stablishing a nation-wide learning network will foster market-based health care reform."

The state-based Quality Improvement Organizations (QIOs), working under contract with Medicare in every state, collectively form a vital national resource that can be accessed to promote the realization of each of the principles listed above. Every QIO works directly with hospitals, physician practices, nursing homes, and home health agencies in their state. Independent satisfaction surveys, commissioned by CMS, confirm that QIOs are trusted by providers in their local communities. In these surveys providers and other community stakeholders report very high satisfaction with QIOs; and three-quarters of these stakeholders across the nation attribute improvements in providers' care in part to the efforts of the QIOs. In addition to this strong history with providers, many QIOs are also building strong relationships with purchasers through partnerships with local business coalitions, ERISA health plans, union health plans, other public and private self-funded groups. These new and established relationships position QIOs well to serve and support the goals of the HHS Value-Driven Health Care Initiative.

In addition, all QIOs have a common set of skills developed through their Medicare work to support the infrastructure of Value Exchanges including: data collection & audit (chart abstraction); database manipulation and management; data aggregation, analysis, and interpretation; provider feedback, quality improvement & process redesign support; provider convening & collaboration support; process & project management; quality & utilization review; outreach & communication with Medicare beneficiaries about quality.

However, QIO also provide these services beyond the scope of their core Medicare contract. For example, most QIOs are active as “nodes” and coordinate local efforts in the IHI 100k Lives and 5 Million Lives Campaigns (see attached chart). Most QIOs also have separate contracts across the range of work detailed above for Medicaid, other government-funded health benefit agencies, public health agencies, private insurers, as well as conducting grant-supported research. The nature and volume of this business experience varies widely from one QIO to another and so the specific roles of QIOs in local Value Exchanges should also vary based on the dynamics of the local market. In some communities the QIO will be a logical convenor and host for a Value Exchange, and in other communities the QIO will be more effective as a participant within another existing or developing partnership led by another stakeholder or stakeholders. But in any case, we believe that QIOs are a unique resource in each state that should be included in each Value Exchange in order to ensure maximum effectiveness. The key capacities that QIOs can deliver to a Value Exchange partnership include:

- **Experience in outreach, communications, and collaboration** to help build awareness of and support for the work of Value-driven Health Care Initiative within the local community.
- **Project/program management skills** including: timeline and deliverables management, group process and convening skills, government contracting experience, financial management and budgeting skills, subcontractor management and oversight, process management skills, and workflow design capabilities. Many QIOs also act as “incubators” for new quality-related initiatives in their communities: providing technical support and fiscal management for key collaboratives outside their core work. Value Exchanges are likely need this kind of support as they commence activity in the local community.
- **Technical expertise in data collection, aggregation, and audit functions.** QIOs have done this kind of work expertly since the inception of the program and know about effective methods and efficient strategies. QIOs are experts in clinical data management.
- **Experience in Medicare claims data aggregation, database management and manipulation, and data analysis and interpretation.** Most all QIOs have biostatistical and analytic staff in place to analyze Medicare clinical and claims data. And most QIOs have direct experience working with the CMS Part B database for their state. In recent years, QIO local access to these data have been restricted to approved research projects by CMS, in favor of national analysis of the outpatient data sets. However, QIOs have the legal standing, systems and staffing in place to support such analysis at the local level.
- **Experience and expertise in linking clinical and claims databases.** QIOs have the data management capacity in their CMS systems and staff expertise in place to do this work at

the local level. At the national level, CMS has experience contracting with QIOs to be national data management vendors in a number of areas.

- **Privacy and confidentiality procedures** in place and a strong track record as a neutral party to assure the protection of data and information at the patient level.
- **Growing expertise in and understanding of electronic medical records** and methods for abstracting clinical data from these electronic tools, especially in physician offices. The QIO DOQ-IT program is the primary, operational national initiative working to promote IT adoption and use by physicians and to facilitate reporting of clinical data from Electronic Health Records (EHRs). Many QIOs have also been instrumental in developing and organizing Health Information Exchanges in their local communities.
- **Technical assistance to providers** in order to help them effectively report clinical data to a central database. For example, QIO help was instrumental in the effective national launch of the hospital quality alliance public reporting initiative and the implementation of the CMS pay for reporting infrastructure.
- **Interpretation and feedback of data, particularly to providers.** Many QIOs use both electronic and more traditional methods to accomplish this work for Medicare. A national infrastructure also exists for hospital, home health, and nursing home data reporting and feedback that have been developed through the QIO program.
- **Technical assistance with providers in improving performance on quality measures.** QIOs now employ group collaborative learning processes, one-on-one technical assistance, QI techniques, Lean Methodology, Root Cause Analysis, Six Sigma, Human Factors Science, etc. in working with providers to help them improve.

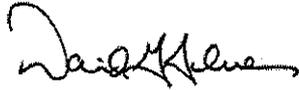
QIO organizations—named for their dedication to Quality Improvement—are already working in local, state and national medical communities, with advanced technology and years of experience bringing together diverse groups in pursuit of common goals. In fact, QIOs are the only national infrastructure of local organizations working right now in every State in the nation. We encourage you to build on this infrastructure as you implement the four cornerstones of the Value-Driven Health Care Initiative.

Given the pivotal role that QIOs can play as part of Value Exchanges, the American Health Quality Association (AHQA), representing the national network of QIOs, recommends that the Value Exchange application process stress the importance of including QIOs in local partnerships to ensure the maximum effectiveness of local Value Exchanges.

Furthermore, the proposed Value Exchange application process details types of representatives to serve on an AHRQ committee to review applications for Value Exchange. These representatives include institutional health care purchasers, individual consumer representatives, health plans, and providers. AHQA would recommend that someone who is very familiar with the work of QIOs representatives be included in the Value Exchange application review committee, given the significant role that QIOs can be expected to play within successful Value Exchanges.

Thank you for the opportunity to provide comment and feedback on the implementation plans for this important initiative.

Sincerely,

A handwritten signature in black ink, appearing to read "David G. Schulke". The signature is fluid and cursive, with a prominent initial "D" and a long, sweeping underline.

David G. Schulke
Executive Vice President

cc: Marc Bennett, President, AHQA
Barry Straube, MD, Director, CMS OCSQ

Chartering Value Exchanges for Value-driven Health Care
Agency for Healthcare Research and Quality Public Comment Request
Comments submitted by the American Association of Neurological Surgeons (AANS) and
the Congress of Neurological Surgeons (CNS)
July 9, 2007

The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) thank the Agency for Healthcare Research and Quality (AHRQ) for giving us an opportunity to comment on the proposed information collection project, "Chartering Value Exchanges for Value-driven Health Care." The Value Exchange project, a learning network of model multi-stakeholder community health care collaboratives operated to measure, report, and improve the quality and cost of health care, is a rational approach to testing ways to fairly and accurately assess the value of health care.

The AANS and CNS believe this project will serve as an important testing ground for national quality standards and measurement guidelines. We appreciate that this project aims to improve the value of health care by focusing on local communities and recognizes that health care is provided in uniquely constituted cultural and market-based environments. We are also pleased that this project makes use of a learning network of model multi-stakeholder community health care collaboratives. This evidence-based organizational mechanism will help achieve rapid identification, dissemination and adoption of best practices. Finally, we are pleased that the review committee responsible for selecting which community collaboratives should be chartered as Value Exchanges will include a fair balance of stakeholders, including physicians.

Organized neurosurgery would appreciate if AHRQ would keep the following concerns in mind when finalizing the terms of this project:

- Current public reporting and pay-for-performance pilot programs and other quality improvement initiatives fail to address all aspects of medicine equally. These initiatives focus disproportionately on chronic care management models and process measures, which are most relevant to primary care. For neurosurgery and other surgical subspecialties, measuring and tracking outcomes is a much more effective way to evaluate quality care. In selecting Value Exchanges, preference should be given to community collaboratives that test alternative ways to measure quality in acute care settings.
- In selecting review committee members, consideration should be given to surgical specialties.
- AANS and CNS are concerned about the opportunity for Value Exchanges to request Medicare-inclusive multi-payer patient de-identified individual physician-level performance measurement results. While aggregated data tends to be more accurate and may prove to be useful in testing different reporting mechanisms, AHRQ should more specifically outline rules for aggregating such data and for ensuring that such data comes from a credible source. There are numerous private

payer programs that each employ different measurement and reporting mechanisms, some more accurate than others.

- AHRQ should also more clearly outline the ways in which Value Exchanges may use such data. When, for example, is data ready for publicly reporting and how will community leaders ensure that the data is reported in a fair and accurate manner? While there are advantages to publicly reporting quality data, we cannot ignore the fact that physicians continue to practice in a litigious environment. It is therefore imperative that quality data be used in a non-punitive fashion, similar to many patient safety initiatives that currently exist.
- The AANS and CNS recommend that AHRQ refer to the AQA principles on performance measurement, data aggregation, and public reporting program when setting more specific parameters for this program.

The AANS and CNS appreciate the opportunity to submit feedback on what we believe has the potential to be a valuable educational tool. Should you have any questions, please feel free to contact Rachel Groman, Senior Manager for Quality Improvement and Research, AANS/CNS, at 202-628-2072 or rgroman@neurosurgery.org.

July 9, 2007

The Honorable Carolyn Clancy, MD
Administrator
Agency for Healthcare Research and Quality
Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850.

Dear Dr. Clancy:

The eHealth Initiative (eHI) is a multi-stakeholder organization whose members are focused on improving the quality, safety and efficiency of healthcare through information and information technology. We are pleased to offer the following comments on the Agency's Request for Information (RFI) regarding chartering Value Exchanges for the Value-Driven Health Care Initiative.

We applaud the leadership of both HHS and AHRQ, in conjunction with public-private sector initiatives like the AQA, which are working to support market-based healthcare improvement with a specific focus on public reporting of cost and quality measures. We agree with the notion that "all healthcare is local," and in fact have seen this notion play out in communities across the country.

Building from this notion, eHI's 280-plus Connecting Communities members are working hard to establish and/or grow initiatives designed to support the electronic exchange of health information, with the ultimate goal of improving the quality and value of healthcare in America. Our comments regarding this RFI center primarily on the need to recognize, leverage and align the work of Value Exchanges with the work of these community-based health information exchange (HIE) networks.

As you know, eHI undertook an in-depth study of three advanced-stage HIEs in order to understand how they create value for local stakeholders, and how they became financially sustainable. This work indicated that there are two primary stages of HIE development:

- 1) A stage one "transactional model," where HIEs provide value to stakeholders by helping to lower administrative/transaction costs, and
- 2) A stage two "infomediary model" where HIEs become information intermediaries (i.e. infomediaries) providing clinical data and information to payers, providers, employers, public health agencies, and other critical stakeholders at the local level who stand to benefit from HIE.

From our research, we believe the Infomediary model is one key to the sustainability of health information exchange. Providing services to providers and to payers utilizing not only aggregated claims data but also aggregated electronic clinical data will be a core service for HIEs.

Further, delivering value to providers and to payers means utilizing not only aggregated claims data, but also electronic clinical data. Clinical data that is matched with

administrative data will provide a more complete picture of healthcare and provider performance, and will be even more effective in supporting improvements in quality and safety at the point of care. HIEs have the ability to perform such matching.

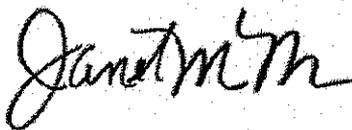
Several HIEs have been already designated as "Community Leaders" by HHS, and as such these entities anticipate providing services that include those of the Value Exchanges. However, in areas where the designated Value Exchange is not also an HIE, it is critical that those entities seeking to be chartered as a Value Exchange indicate in their response to the proposal how they are or plan to work with the HIEs in their region. The ongoing work of HIEs across the country must be leveraged and supported.

Because of the requirement for potential Value Exchanges to demonstrate how they are aligning with and leveraging HIEs in their states and communities, we believe it is important to include on the panel of RFP reviewers representatives from HIEs who are familiar with local healthcare markets and dynamics, as well as the clinical data contained in HIEs.

We are also pleased to see that Value Exchanges would provide aggregated performance data back to the individual provider for improvement purposes. We strongly believe that this function is critical to achieving the quality improvement goals outlined in the Secretary's Value-Driven Health Care initiative.

Please don't hesitate to contact Christine Bechtel, Vice President of Public Policy and Government Relations at Christine.Bechteler@ehealthinitiative.org (or 202-624-3241) if you have any questions or would like further information.

Sincerely,



Chief Executive Officer



THE LEAPFROG GROUP

Informing Choices. Rewarding Excellence.
Getting Health Care Right.

July 9, 2007

Doris Lefkowitz,
Reports Clearance Officer, AHRQ,
540 Gaither Road,
Room 5036
Rockville, MD 20850

Re: Comments on **Chartering Value Exchanges for Value-driven Health Care**

Dear Ms. Lefkowitz;

Thank you for the opportunity to provide comments on the **Chartering Value Exchanges for Value-driven Health Care** project.

Most organizations working towards implementing a value-based health care system, including The Leapfrog Group, have learned from experience that greater access to Medicare data is essential if we are going to reach this goal. While we applaud the intent of the Value Exchanges, we feel that the current CVE proposal provides inadequate access to the type of data that we need for assessing the performance of providers. Specifically, CVEs, as currently conceptualized, will not resolve the fundamental problem of the need for public-private claim level data-sharing in order to obtain adequate case numbers to accurately and fairly evaluate provider performance.

Claim-specific data needed: While it is true that health plans, as the representatives of private purchasers, have access to their own physician-level claims information, the percentage of any given physician's caseload for a single plan is small, making accurate performance reporting difficult and in many cases impossible. The approach suggested through the CVEs does not allow the plans to incorporate physician-specific information from Medicare into their own data set in order to assess the performance of an individual physician's care for specific conditions or for specific treatments. From the description in the Federal Register, it appears that information would be available on individual physicians, but that information would be summary in nature, and not claim-specific, which is necessary for linkage to plan data.

Technical support for collaboratives: The Federal Register states that it is looking for multi-stakeholder local collaboratives to focus on improving the value of healthcare. It is critical for AHRQ and DHHS to recognize that the framework for CVEs, as currently proposed, will face exceptional barriers to success.

- The start-up costs for this project will be immense. The need for highly sophisticated IT systems and highly sophisticated data analysts will be a deterrent to participation.
- It appears from the description in the Federal Register that even if one of these local collaboratives invests in the necessary infrastructure, they will not be

- guaranteed access to the Medicare database. It is difficult to see a ROI without this guarantee.
- o It is unclear from the Federal Register whether HHS has established standards for IT interoperability, databases, measures, or research methods. Without a detailed framework, we will lose the ability to maximize the work of these local collaboratives in a way that will allow us to reach the ultimate goal of a national value-based health care system.

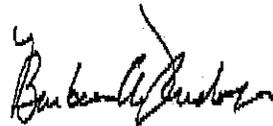
In closing, the members of The Leapfrog Group see this proposal for CVEs as a positive step towards enabling the critical sharing of public claims data. However, the requirements for participation are prohibitive, and therefore, will serve to delay the desperately need implementation of a rational, value-driven health care system. We urge you to revise the criteria and provide a reasonable return on investment.

Please feel free to contact us (Karen Linscott at 202-292-6709 or Barbara Rudolph at 608-210-6641) if you have any additional questions.

Best regards,



Karen Linscott
Chief Operating Officer
The Leapfrog Group



Barbara Rudolph
Director, Leaps and Measures
The Leapfrog Group

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July 9, 2007

Doris Lefkowitz
Reports Clearance Officer
Agency for Healthcare Research and Quality
540 Gaither Road
Room # 5036
Rockville, MD 20850

Dear Ms. Lefkowitz:

Thank you for the opportunity to comment on the proposed information collection project, "Chartering Value Exchanges for Value-driven Health Care." America's Health Insurance Plans (AHIP) is the national trade association representing the private sector in health care. AHIP's member companies provide health benefits to more than 200 million Americans. We are pleased to submit these comments on behalf of our members as well as several comments received from AQA Data Sharing and Aggregation Workgroup members.

GENERAL COMMENTS

In September 2004, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), AHIP, and AHRQ, joined together to lead an effort for determining, under the most expedient timeframe, how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in the ambulatory care setting. Originally known as the Ambulatory Care Quality Alliance, the coalition is now known as the AQA because its mission has broadened to incorporate all areas of physician practice.

The mission of this effort, a broad based collaborative of physicians, consumers, public and private purchasers, health insurance plans and others, is to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring performance at the physician or group level; collecting and aggregating data in the least burdensome way; and reporting meaningful information to consumers, physicians, and other stakeholders to inform choices and improve outcomes.

AHIP applauds AHRQ's development of a social network of organizations deploying health information exchanges that are working toward extracting value out of the exchanges in the form of quality measurement and reporting. This support of learning and dissemination of the information ascertained is a critical piece to the successful and timely transformation of health care to being value-driven. Detailed reporting of such information and having an open, transparent process that shares methodologies utilized and lessons learned, would be of great value to most health care organizations and the AQA.



SPECIFIC COMMENTS

Type of Data Used

Regarding the proposed project's three fundamental principles as outlined on page 26118 of the Federal Register notice, principle two states that broad access to accurate, meaningful information will improve the value of health care services. However, generating this information is referenced as measures based on all payer data. Although there is great value in payer data, as the health care system increases its use of information technology, particularly electronic health records (EHRs), provider data for calculation of performance will become equally important.

Data Aggregation

As this information collection project moves forward it will be necessary to understand the data flow and at what level in the system data will be aggregated; plan level, group, or individual provider. For example, once data from EHRs begin to be aggregated – what methodology will need to be used to aggregate both EHR and claims data?

The nation unfortunately lacks a uniform and coordinated strategy for aggregating physician or group level¹ performance data, which would enable us to effectively pinpoint gaps in quality and efficiency across the country. Currently, many disparate organizations are trying to solve this problem. However, the proliferation of multiple regional efforts to aggregate and report data on quality and efficiency, while well-intentioned, is creating significant burdens for physicians as they are faced with multiple, uncoordinated demands for data on performance with little input into the process; doing little to help the consumer; and wasting limited resources that can be used more effectively if combined in a uniform effort. These individual initiatives also do not comprehensively assess provider performance since the data collected are often insufficient to reliably measure quality and efficiency performance.

Given the significant and urgent need to address data aggregation issues, the AQA, through its Data Sharing and Aggregation Workgroup, has recommended that a public/private entity have the primary responsibility of setting uniform operating rules and standards for the sharing and aggregation of quality and efficiency data used in both the public and private sectors, for the purposes of performance measurement and reporting.² Such rules and standards are essential for enabling stakeholders to continuously improve quality and efficiency across the country and would serve to further enhance the work of the Value Exchanges.

¹ JCAHO, AHA, and FHA are leading efforts to help hospitals assess and improve quality of care through the Hospital Quality Alliance.

² The entity would operate as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104-113).



Public Reporting

We recommend a clearer commitment to publicly report the information collected, including feedback to the hospitals, physicians, and other health care professionals. The AQA's Principles for Reporting³ should be applied; including timeliness of results, transparency of methods, and overall usability of the reports.

Relationship with Other Health Information Exchanges

AHIP also recommends clarification of the relationship the Value Exchanges' activities will have with other Health Information Exchanges (HIEs), such as Regional Health Information Organizations and other existing local collaboratives. Value Exchanges should collaborate with existing HIEs and established local activities when possible to avoid unnecessary duplication of efforts.

Thank you for the opportunity to provide comments on these important issues.

Sincerely,

A handwritten signature in cursive script that reads "Carmella Bocchino".

Carmella Bocchino
Executive Vice President,
Clinical Affairs & Strategic Planning

³<http://www.aqaalliance.org/reportingwg.htm>.

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July 9, 2007

VIA FIRST CLASS MAIL AND ELECTRONIC DELIVERY

Doris Lefkowitz
Reports Clearance Officer
Agency for Healthcare Research and Quality
540 Gaither Road
Room 5036
Rockville, MD 20850
doris.lefkowitz@ahrq.hhs.gov

**RE: Request for Comment Regarding Proposed Information Collection Project:
"Chartering Value Exchanges for Value-Driven Health Care"
Federal Register Notice, 72 Fed. Reg. 26117 (May 8, 2007)**

Dear Ms. Lefkowitz:

Thank you for the opportunity to comment on the Agency for Healthcare Research and Quality ("AHRQ") Notice referenced above. These comments are submitted on behalf of the Large State QIO Consortium ("the Consortium"). The Consortium consists of the following organizations holding Medicare QIO contracts: IPRO (NY), Healthcare Quality Strategies, Inc. (NJ), West Virginia Medical Institute (WV), Quality Insights of Delaware (DE), Quality Insights of Pennsylvania (PA), Ohio KePRO (OH), Iowa Foundation for Medical Care (IA), Illinois Foundation for Quality Health Care (IL), TMF Health Quality Institute (TX), MPRO (MI), and Lumetra (CA). The Consortium appreciates the opportunity to submit these comments and, on behalf of its members, we are available to discuss them with you at your convenience.

The QIO community is excited at the potential for using community-based multi-stakeholder collaboratives as part of the framework for quality measurement, improvement and value management initiatives. Under the current Statement of Work for Medicare QIO contracts, QIOs are engaged in many such collaborative efforts. In addition, many QIOs are currently convening, joining or supporting Community Leaders as a precursor to participating in the Value Exchange dynamic.

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In light of existing work currently being performed by QIOs, the Consortium urges AHRQ to consider coordinating the Value Exchange concept more closely with the QIO program as a means of strengthening both programs. Joining the programs will reduce the market confusion likely to be the result of several different locally based quality measurement, improvement and value management mechanisms and take advantage of the collaborative initiatives QIOs are already undertaking in many communities. It will also avoid inconsistencies in local responses to the Value Exchange agenda.

In addition, the Consortium is concerned that the parameters of Value Exchanges as proposed in the Notice raise questions that, if unanswered, may undermine the legitimacy of the program. We have set forth some of these issues below for your consideration.

I. DEFINITIONAL ISSUES

As a preliminary matter, we note that there are new terms and concepts embodied in the Notice that would benefit from further definition or description. For example:

A. "Mature community-based multi-stakeholder" organizations: The Notice contrasts such organizations to communities where collaboratives involve "only a limited number of organizations within a single stakeholder group or a limited number of stakeholder groups." It would be useful for AHRQ to clarify the types and the minimum number of stakeholder groups or constituent organizations required before a collaborative will be considered to meet the standard. For example, would the organizations need to match the composition of the applicant review committee to meet this standard or is there more flexibility in the application of this standard?

B. "Value Exchange:" The necessity of non-profit status for a Value Exchange is ambiguous. We respectfully request that AHRQ specify whether a Value Exchange must be a non-profit organization that engages only in that activity (*i.e.*, a dedicated, single purpose non-profit) or whether it is acceptable for a non-profit to facilitate or convene a Value Exchange activity in addition to other roles it plays and functions it serves in a community.

II. FUNDAMENTAL ISSUES

A. Statutory Authority: It is our understanding that the underlying authority CMS is relying upon for the Charter Value Exchanges (and the current Better Quality Information Pilot Initiative - BQI) is Section 1851(d) of the Social Security Act. This provision deals with Medicare + Choice, and it is entitled "Providing Information to Promote Informed Choice". We question whether this statutory provision provides sufficient authority to allow the collection and publication of provider performance data – by any party, including CMS – related to other parts of the Medicare program.

B. Funding: The source of funding for the Value Exchanges is unclear from the Notice. We understand that the current stage of the program, the Better Quality Information Pilot Initiative, was funded by providing QIO Funds to the BQI subcontractors as a pass-through under

Delmarva Foundation for Medical Care's QIO contract. Since the BQI efforts have been unrelated to the QIO work to date, and the Notice does not reflect any greater alignment of those efforts, we question the propriety of the use of QIO program funds for these efforts.

In accordance with general appropriations law, funds appropriated specifically to the Medicare Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund ("the Trust Funds") may be used only for the specific purposes authorized by law. (31 U.S.C. 1301(a)). Under the authority of the QIO statute (42 U.S.C. 1420c-8), Trust funds may be expended for the "administration" of QIO contracts "described in section 1395y(g)." We doubt that using a QIO as a pass-through enables the funding to comport with statutory limitations on the use of QIO funds as prescribed in the Trust Fund and we question whether allowing non-QIOs to expend QIO funds for something other than QIO contract administration falls within the statutory authority regarding the use of Trust Funds.

In addition, we believe the award of these directed contracts on a noncompetitive sole source basis violates a number of aspects of procurement law and regulation, beyond the scope of these comments. We assume that AHRQ will ensure that the Request for Proposals it intends to issue for Value Exchanges and any procurement it conducts fully complies with the requirements for a federal procurement.

C. Data Disclosure: We are concerned that the Notice, under "Method of Collection," appears to contemplate public sharing of physician-level performance evaluation data. The evaluation criteria set forth in the Notice in Section H, A.1 and A.2 also suggest that there are ongoing data aggregation efforts, the results of which will be made available to the Value Exchanges. To the extent this effort involves Medicare data, we are uncertain that CMS can legally make that data publicly available in view of the restrictions contained in Section 1106 (e)(3) of the Social Security Act, codified at 42 U.S.C. 1306 (e)(3). http://www.ssa.gov/OP_Home/ssact/title11/1106.htm It would seem that Section 1106 and the implementing regulations at 42 C.F.R. 401.126 (b)(1) prohibit the release of any performance evaluation information that identifies individual health care practitioners. Even the release of formal evaluations of providers of services is permitted only after the provider whose performance is evaluated has had a reasonable opportunity to review the report and offer comments. See Section 1106 (f); 42 C.F.R. 401.133 (b) and (c). These limitations on disclosure of information seem to apply to HHS, CMS and all contractors. Accordingly, Section 1106 appears to create a barrier against disclosure of practitioner-specific information.

To the extent the BQIs currently are tasked with releasing performance data, it would appear that such activities would violate prohibitions on disclosure of QIO information. Medicare data provided for the BQI pilot through the Delmarva QIO contract is "QIO information" subject to the same confidentiality requirements imposed upon QIOs that significantly restrict the ability of the QIOs to release data relating to individual practitioners or Medicare beneficiaries. (42 C.F.R. Part 480 generally; see also 42 C.F.R. 480.101; 480.132; 480.133; and QIO contract, clause H.8.) As such, to the extent any of the BQI subcontracts were legally awarded, those subcontracts were required to incorporate these confidentiality

Doris Lefkowitz

July 9, 2007

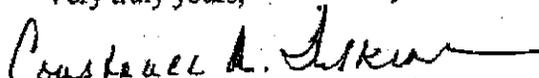
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requirements. The inclusion of these required clauses in the BQI subcontracts would prevent the BQIs from publicly disclosing certain data, which means that the BQIs could not legally do what they were contracted to do.

To the extent that Section 1106 does not prevent disclosure of this data, we believe that the regulations implementing Section 1160 of the Act could be modified to clarify that such comparative public reports of provider and physician performance data could be disclosable through the QIO program vehicle to Charter Value Exchanges. We believe a distinction could be made in the QIO regulations to allow such release, in contrast to current limitations on individual review determinations. Such a revision could clarify that physician-specific performance measurement or evaluation data (as opposed to an individual review of physician performance in a single case) is not considered confidential data under the QIO regulations. We recommend that consideration be given to such a regulatory change to enable this program to proceed pursuant to proper authority. Alternatively, we believe a statutory change to Section 1106 of the Act would be required, whether utilizing the QIO infrastructure or assembling and recognizing Value Exchanges independent of Medicare's QIO program.

Please feel free to contact us if you have any questions or require additional information in this regard. We will look forward to AHRQ's subsequent issuance of regulations governing the conduct of Value Exchanges.

Very truly yours,


Constance A. Wilkinson

cc: Carolyn M. Clancy, Director, AHRQ
Leslie Norwalk, Acting Administrator, CMS
Barry Straube, M.D. Chief Medical Officer, CMS and Director, OCSQ
Rodney Benson, Director, Office of Acquisition and Grants Mangement, CMS
Theodore Will, IPRO (NY)
Martin Margolies, Healthcare Quality Strategies, Inc (NJ)
John Wiesendanger, West Virginia Medical Institute, Quality Insights
of Pennsylvania, Quality Insights of Delaware
Debra Moss, MD, MPRO, (MI)
Gayle Smith, Ohio KePRO
Tom Manley, TMF Health Quality Institute (TX)
Don Lovasz, Iowa Foundation for Medical Care, Illinois Foundation
For Quality Health Care
Jo Ellen Ross, Lumetra (CA)

July 5, 2007

Doris Lefkowitz
Reports Clearance Officer, AHRQ
540 Gaither Road, Room 5036
Rockville, MD 20850

RE: Federal Register Notice on "Chartering Value
Exchanges for Value-driven Health Care"

Dear Ms. Lefkowitz:

On behalf of the Puget Sound Health Alliance, and the 152 participating organizations and 50 consumers who are members in our public-private regional coalition, we appreciate the opportunity to share our views regarding the important process of Chartering Value Exchanges for Value-driven Health Care.

As discussed with Health and Human Services Secretary Mike Leavitt and many other national leaders, the Alliance is intensely interested in becoming a Value Exchange to access Medicare data to include in public reports that measure health care quality and efficiency in the region. Our reports are based on recommendations from local clinical improvement teams, made up of medical professionals and other community leaders, who come together to review and select the national guidelines and measures to be used by the Alliance. Thus far, nearly all of the measures in our report are consistent with the starter set of measures from the Institute of Medicine and with HEDIS measures.

The Alliance is on track to produce the first regional report to the public, initially based on data that has been provided to us by sixteen health plans and self-insured purchasers. This aggregated data reflects ambulatory care provided to approximately 2.7 million people in the five-county region; however, the report results will be more robust, trusted and useful once we are able to include data from Medicare, too. The first of our regional performance reports is proceeding as expected, with the first report to be published in December of this year.

In reviewing the process description published in the Federal Register on May 8, 2007, we respectfully submit the following three points:

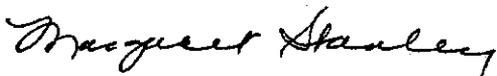
1. **Clear Process.** Regional coalitions need a straightforward process to be able to qualify for designation as a "Value Exchange." This includes enabling additional coalitions to enter into agreements similar to what has been designed for Better Quality Initiative (BQI) groups, to speed up the ability to gain access to Medicare data for transparency reporting in as many regions as possible.
2. **Medicare Raw Data.** To ensure that regional report results are consistent across all segments of the population, regional coalitions who meet the "Value Exchange" requirements need to receive Medicare raw data, not preprocessed results. This is critical to ensuring that coalitions can incorporate Medicare data into the reports in the same way that other regional data is being aggregated, processed and analyzed. Consistently processing the data involves many detailed decisions regarding measures and various technical parameters such as clinician-to-clinic and patient-to-clinician attribution, minimum sample size, and statistical confidence intervals. Such analytical consistency across a large volume of integrated data (including complete transparency about the analytical methods used to arrive at results) builds on the local trust that is created by the hands-on work in each of the regional coalitions, and creates useful "apples-to-apples" comparisons most useful for consumers, providers, purchasers and plans.

3. Federal Funding for Regional Coalitions. While receiving Medicare data is our top priority from the federal government, we also request that financial support be provided as part of the federal contribution to the public-private partnership work being done locally. Medicare data should be provided at no cost to regional coalitions who are "Value Exchanges" and with it should come dedicated funding. As a government entity promoting the social policy of value-driven health care, the federal government has an interest in ensuring the long-term continuation of regional coalitions who form the infrastructure for effective health care transparency nationwide (e.g., producing trusted reports on local health care performance). All regional coalitions wrestle with this challenge of developing a sustainable funding model and the federal government is a natural partner to assist.

The partnership between the federal government and regional public-private coalitions is powerful. While health care payment reform needs to be addressed at the federal level, ultimately "all health care is local." Each day, the value we get from our health care dollar is driven by local decisions that take place in provider-patient relationships, purchaser choices of health plan benefit design, and employment based wellness efforts. Coalitions are building local consensus around value-driven information, decisions and incentives in many communities, and such groundwork is essential to successfully transforming health care into a system driven by value.

A year ago this month, Health and Human Services Secretary Mike Leavitt met with our leaders in Seattle to begin discussions about the process to incorporate federal resources – both data and eventual funding – into the growing network of regional coalitions such as ours. Just six months later, Secretary Leavitt returned to the Northwest to designate the Puget Sound Health Alliance as the nation's first "Community Leader for Value-driven Health Care" and to reiterate the commitment to work with local regions to build the infrastructure needed to drive quality improvement and greater value in the health care system. We appreciate that commitment and look forward to working with the federal government as a data supplier and long term funding partner.

Sincerely,



Margaret Stanley
Executive Director
Puget Sound Health Alliance

Cc James Whitfield, Director, HHS Region X
David Fleming, Alliance Board Chair & Seattle King County Public Health Department
Michael Cochran, Alliance Executive Board Member & First VP, Washington Mutual
Lloyd David, Alliance Executive Board Member & CEO of The Polyclinic
Dr. Hugh Straley, Alliance Executive Board Member & Medical Director, Group Health
The Honorable Ron Sims, Alliance Board Member & King County Executive