VALUE-DRIVEN HEALTH CARE
PUBLIC COMMENTS WITH RESPONSES TO FR NOTICES

PART ONE: COMMENTS AND RESPONSES TO 60 DAY FR NOTICE

General Themes:

1) Request for clarification of composition, functions, and number of Chartered Value Exchanges (CVEs) within a community
2) Recommendations for Review Committee composition
3) Request for simplification of the application process to become CVE
4) Data Issues: collecting and aggregating data, using data, and access to raw CMS claims data
5) Resources
6) Legal issues

Specific Comments (in black) and how addressed by AHRQ (in blue):

1. **American Association of Neurological Surgeons with the Congress of Neurological Surgeons:**

   a. Measuring Quality: want to give preference to community collaboratives that test alternative ways to measure quality in acute care settings: AHRQ received contrary recommendations from the Quality Alliance Steering Committee Expansion Workgroup and chose to accept the latter's opinion that quality and price transparency is more directly accomplished by having community collaboratives implement endorsed, consensus-based measures rather than test alternative ways to measure quality. (See response xxx below).

   b. Review Committee: want consideration to be given to surgical specialties: AHRQ identified the Chairman of the Society of Thoracic Surgeons as a volunteer Review Committee member.

   c. Data Aggregation and Use
      i. AHRQ should more specifically outline rules for aggregating such data and for ensuring that such data comes from a credible source: The BQI pilots are testing data aggregation and attribution methods and will recommend a standardized approach by October 31, 2008 for use by CVEs.
      ii. AHRQ should more clearly outline ways CVEs may use data: AHRQ added the statement "AHRQ expects CVEs to adopt nationwide consensus based and endorsed principles and standards where they exist and as they are made available." This includes the AQA Alliance principles and parameters for performance measurement, data aggregation, and reporting to consumers and other stakeholders.

2. **The American Health Quality Association**

   a. CVE Composition: recommends the application process stress the importance of including QIOs in local partnerships: AHRQ added QIOs to the phrase "other relevant community entities" in sentences describing community stakeholders required to improve the value of healthcare and AHRQ added an application question specifically on engagement of QIOs.
   b. Review Committee: want participation of QIO on committee: AHRQ added that review teams would include experts from the QIO community.

3. **The eHealth Initiative**

   a. CVE Functions: want CVE work aligned with HIEs networks: AHRQ added "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.
   b. Entities should indicate how they will work with HIEs in their area: AHRQ added an application question specifically on engagement of HIEs.
   c. Review Committee: want representatives from HIEs: AHRQ added that review teams would include experts from Health Information Exchanges.

4. **Leapfrog Group**

   a. Data Access: CVEs 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: AHRQ emphasized that CMS plans to provide CVEs with numerators and denominators such that CVEs will be able to merge Medicare results with private sector results to create all-payer results (with adequate case numbers).

   b. Resources:
      i. Concerned that start up costs immense particularly for sophisticated IT analysts and systems: AHRQ clarified the role of the CVE as getting measurement results adopted and acted upon, thus minimizing the need for massive investment in analytics and databases.
      ii. ROI not guaranteed without access to Medicare data: See response to 4ai and 4bi.
      iii. Need detailed framework for IT interoperability, databases, measures, and research methods: See response to 1cii, which includes complying with AHIC recommended interoperability standards. Also see 4ai and 4bi.

5. **Consumer-Purchaser Disclosure Project**

   a. CVE Functions: want "terms of engagement" that assures active dialogue, information sharing and participation from representatives of all stakeholder groups. Wants meaningful engagement of consumers and purchasers monitored in on-going evaluation efforts: AHRQ clarified that consumers and purchasers were *critical* stakeholders, that engagement meant *ongoing collaboration*, and that consumer engagement went beyond merely reporting performance information to them.

6. **National Business Coalition on Health**

   a. CVE Functions and Number:
      i. A multi-stakeholder collaborative should not have to demonstrate all eight capacities to qualify as a Value Exchange. How will they be evaluated against capacities? AHRQ clarified functions as 4 core and 3 important non-core ones. AHRQ added detailed selection process and evaluation calculations to the FR Notice Supporting Statement.
      ii. Multiple CVEs should be allowed and encouraged in each geographic area: AHRQ added "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."
      iii. Single stakeholder led organizations can establish and lead effective multi-stakeholder collaboratives and should be allowed as CVEs unless the single stakeholder is a provider: See response to 6aii.
      iv. Providers should not parent a CVE unless its designation is only to conduct quality improvement: See response to 6aii.

   b. CVE Data: CVEs should have access to Medicare data, not just performance results: See response to 4a and 4bi.

   c. Resources: US Federal Government should contribute fiscal resources to Value Exchanges: AHRQ responded that 1) 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, and 2) 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.

   d. Application Process: Community Leader designation should not be required to be eligible to become a CVE: AHRQ responded by clarifying the simplicity of becoming a Community Leader, namely, accessing and signing a publically available Certification Statement that designates them as a Community Leader.

7. America's Health Insurance Plans (AHIP)

a. Data:
- i. Believe EHR data will be increasingly important over time: See response to 3a.
- ii. Believe public/private entities have responsibility to set uniform operating rules and standards for sharing and aggregating data: See response to 1c and 1d.
- iii. Recommend a clearer commitment to AQA principles of public reporting: See response to 1c.

b. CVE Functions: clarify the relationship of CVEs with HIEs: See response to 3a.

8. Greater Detroit Area Health Council

a. Application Process: want 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 key stakeholders rather than upon organizational structure: See response to 6aii. Also, AHRQ added: "We agree the emphasis should be on the presence of effective, collaborative working relationships rather than on a particular organizational structure."

b. CVE Composition: AHRQ added: "We agree purchaser, health plan, provider, and consumer representatives must work together as core members of a CVE."

c. CVE Functions:
- i. Recommend AHRQ require CVEs share performance data with legitimate interested parties: AHRQ clarified by describing what CMS planned to provide CVEs (see response to 4ai), and by adding that AHRQ expects CVEs to adopt national consensus based principles (see response 1c).
- ii. AHRQ should adopt a flexible approach to the way CVEs carry out the 8 functions: See responses to 6a.

9. Puget Sound Health Alliance

a. Application Process: request a straight forward process: See response to 6ai
b. Data Access: want Medicare raw claims: See response to 4a.
c. Resources: request federal funding: See response to 6c.

10. Quality Alliance Steering Committee Expansion Workgroup

a. CVE Functions:
- i. Recommend 4 core functions--engagement of stakeholders, use of measures, provider engagement in improvement, and consumer engagement: AHRQ clarified the functions as 4 core and 3 important non-core (see response to 6a.)

ii. Wants AHRQ to adopt suggested clarifications by Function: AHRQ accepted and added all clarifications to FR Notice for each Function.

11. Large State QIO Consortium (LSQC) submitted by Attorneys Epstein Becker and Green

a. Wants AHRQ to consider coordinating the CVE concept more closely with the QIO program: AHRQ added that the function of stakeholder engagement should include effectively engaging the community QIO. Also see response to 2a and 2b.

b. CVE Composition:

i. Wants clarification on types and minimum number of stakeholder groups required: AHRQ clarified representation from four stakeholders--purchasers, health plans, providers, and consumers—as critical.

ii. Questions whether a CVE must be a non-profit that engages only in that activity (single purpose non profit) or whether it is acceptable for non-profit to facilitate or convene a VE activity in addition to other roles it plays and functions in a community: AHRQ clarified that the CVE designation applies to the collective work occurring within a community regardless of how many organizations divide up the work. AHRQ also clarified that it does not require a CVE to be an incorporated non-profit entity.

c. CMS Statutory Authority:

i. Questions whether SSA Section 1851 (d) provides CMS with sufficient authority to allow the collection and publication of provider performance data: AHRQ noted in AHRQ's Response to Comments Received document that "all applicable statutes, federal rules and regulations will be followed in implementing all aspects of this initiative."

ii. Questions the propriety of the use of QIO program funds for efforts to BQIs and the fact that these were done sole source: AHRQ noted in AHRQ's Response to Comments Received document that additional legal comments that reference BQI activities rather than planned CVE activities are outside the scope of this initiative.

iii. Uncertain that CMS can legally make physician identifiable performance information public under the restrictions of SSA Section 1106: See response to 11ci.

d. Resources/funding: comments that the source of funding for Value Exchanges is unclear: AHRQ responded by describing what AHRQ is funding. See response to 6c.

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PART TWO: COMMENTS AND RESPONSES TO 30 DAY FR NOTICE

1. Quality Alliance Steering Committee Workgroup Chairs (Infrastructure and Expansion)

a. Application Process:

i. Scoring: wants to lower minimum average score for engagement of stakeholders from 4.5 to 4.0 (scale 1-5, 5 best): AHRQ believes the importance of

this function and the response scale definitions justify having the average minimum score of 4.5. Response categories lower than 4.0 refer to the adequacy of a plan to engage all four stakeholders, while the response category of 4.0 requires that stakeholder engagement is partially in progress and accompanied by an effective plan to further mature. The response category of 5.0 indicates engagement of all 4 stakeholders already in progress. If a 5 member review team can't agree on whether ANY engagement of ANY of the critical stakeholders has occurred by the applicant, the applicant is not ready to be chartered.

ii. Review Process: wants all applications scored at the end of the enrollment rather than having a rolling review within the enrollment period: AHRQ believes the process as designed is optimal to maximize inter-rater reliability, provide a simplified application process, and maintain fairness to all applicants. AHRQ specifically cites the review team discussions in addition to having the final decisions on how many and which applicants will be chartered occurring at the end of the first enrollment month and at the close of the enrollment period as justification.

iii. Inter-rater Reliability: wants review team discussion of applications prior to scoring: It was always AHRQ's intent for review teams to discuss applications prior to submitting individual reviewer scores.

2. National Athletic Trainers Association:

a. CVE Composition: want athletic trainers to be part of the AHRQ learning network: The FR Notice background describes the need for critical community stakeholders… "as well as other relevant community entities, e.g., local health information exchange organizations, Quality Improvement Organizations," to work together. No document describes any restriction on participation within a community. If an athletic trainer is part of a CVE they will be in the Learning Network. NATO as a group can also pursue Community Leader status. The FR Notice directs the public to the hhs.gov website for additional information on Community Leader recognition. The list of current Community Leaders is also available on that website.

3. The American Health Quality Association:

a. CVE Composition:
   i. Wants QIO listed as core stakeholder: AHRQ believes it adequately emphasizes the QIO by citing the QIO as one of the relevant community entities to be engaged and by having one of the ten application questions specifically asking about the engagement of HIEs and QIOs (and other community stakeholders). All community collaborative participation is voluntary, and each community collaborative decides how it wants to organize itself to accomplish the CVE functions. To the extent the QIO is a CMS contractor, it is the purview of CMS, not AHRQ, to determine QIO scopes of work.
   ii. Believes statements about non-profit status are conflicting: AHRQ believes there is no conflict. Being an informal nonprofit organization is different than being an

incorporated non profit organization. Incorporation creates a separate legal entity and requires a board of directors. CVEs are not required to be legal entities.

b. Data Issues:
   i. Requests guidance on which national measures are available for implementation: AHRQ believes it adequately addresses this issue since the measures available will be increasing over time. AHRQ repeatedly uses the phrase "nationwide consensus based and endorsed" measures and notes the measures would "ultimately address all six IOM performance domains of safety, timeliness, effectiveness, efficiency, equitableness, and patient-centeredness." CMS recently shared plans to award a QIO contract to calculate an initial list of 12 ambulatory care quality measures. CMS plans to share numerators and denominators calculated at the physician group level with CVEs. Estimated time of sharing is Summer 2008. As more information becomes available, that information will be made public.
   ii. Recommends AHRQ develop protocols that would allow CVEs to develop local measures: AHRQ believes it has adequately emphasized that the measurement focus of this initiative is getting nationwide consensus based and endorsed principles, standards, and measures adopted and used within communities—where those principles, etc. exist and as they are made available. As such, AHRQ does not believe it is appropriate as a single Agency to develop the protocols recommended above nor does it believe this initiative places AHRQ in the position of allowing or disallowing what local communities do. AHRQ believes the Learning Network goals of facilitating the sharing of CVE experiences and lessons learned; identifying and sharing promising practices; identifying gaps where innovation is needed; and raising issues to be addressed by national consensus-building organizations more appropriately characterizes AHRQ's approach to facilitating national standardization and local innovation.

4. National Business Coalition on Health:

a. CVE Composition and Functions:
   i. Facilitating rewards for better performance should be a CVE core function aligned with the Quality Alliance Steering Committee (QASC) vision: AHRQ is committed to maintaining optimal alignment as consensus and clarity emerge on the use of language to describe individual constructs and how constructs relate to each other. AHRQ believes this will necessitate minor updating over time. More importantly, there is no concern with the more detailed description of the CVE role.
   ii. Replace "use of measures" with "use of standard performance information": See response to immediately preceding 30 day FR Notice comment 4ai.
   iii. Multiple CVEs should be allowed and encouraged in each geographic area: AHRQ believes it adequately responded to this comment on the 60 day FR Notice by clarifying in the 30 day Notice that AHRQ did not plan to impose a particular definition of community based on geography or population density. Also, the application process supports the inclusion of all qualifying CVE candidates.

b. Data Access: CVEs should have access to Medicare provider performance information and access to Medicare claims level data upon request: As mentioned previously, CMS plans to share physician group level numerators and denominators for 12 ambulatory care

measures with CVEs. AHRQ believes access to claims level data upon request is the purview of CMS and does not need to be resolved before the first open enrollment.

c. Resources: US Federal government should contribute resources to CVEs: AHRQ believes it adequately addresses this in its Response to 60 Day Comments document: "1) 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, and 2) 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. "

d. Application Process: Utilize an application process that relies on discussion and consensus, rather than an averaged and rigid scoring system. See response to 30 day FR Notice comments 1aii and 2aii.

5. American Health Information Management Association (AHIMA):

a. CVE Composition and Function:
   i. Overlap between QIO program and CVEs: QIOs may participate as part of a CVE and take the lead on particular functions, as determined by the CVE. They do not replace the need for employers, health plan, provider and consumer representation.
   ii. Overlap with other AHRQ initiatives: AHIC Quality Workgroup is one of the national consensus building groups that develop principles, standards, or measures that CVEs would get adopted and used within their communities. The AHRQ RFI regarding the development of a National Health Data Stewardship entity is similar.
   iii. Use of measures: CVEs will need uniform implementation guidance: AHRQ concurs and believes the mechanisms of the national consensus building alliances, AHRQ supported resources, and resources contributed by others will all be important to support the implementation and validation of results.

b. Application Process: Duration of CVE status: All participation is voluntary. Therefore once chartered, AHRQ anticipates CVEs will continue to participate in the Learning Network as long as they see value in doing so. There is no reapplication, compliance monitoring, or criteria for dismissal. Being accepted as a CVE is based on meeting the qualifications and does not involve a contract.

c. Resources: See response to 30 day FR Notice comment 4c.