VALUE-DRIVEN HEALTH CARE

A PURCHASER GUIDE

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THE PURCHASER GUIDE TO VALUE-DRIVEN HEALTH CARE

MEETING THE COMMITMENT

- **I. Introduction** page 3
- **II. Quick Reference Guide** page 5
- **III. Value-driven Health Care: *What Purchasers Need to Do*** page 8
  - A. The Four Cornerstones of Value-Driven Health Care
  - B. A Six-Step Strategy
- **IV. Examples of Current Value-driven Initiatives and Strategies** page 16
- **V. Appendices** page 29
  - A. Executive Order 13410 and How it is Being Implemented by Federal Agencies
  - B. Ways to Volunteer with the Certification Commission for Healthcare Information Technology (CCHIT)
  - C. Regional Health Information Organizations (RHIOs) and Others Focusing Upon Data Exchange and Interoperability
  - D. Template Request for Information (RFI)
  - E. Collaboratives and Coalitions Sponsoring Transparency Activities
  - F. Collaboratives Developing Strategies to Measure the Cost of Services
  - G. Sample Letters to Insurers, Third Party Administrators (TPAs) and Other Contractors
  - H. Sample Insurer and Other Contractor Contract Language

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"This document is based on Value-Driven Health Care: A Purchaser Guide Version 1.0, available at http://www.leapfroggroup.org/news/leapfrog_news/Purchaser_Guide, but has been modified by ____. This document has not been endorsed or approved by any members of the overseeing working group or the authors of the Value-Driven Health Care: A Purchaser Guide Version 1.0, and may differ in material respects from that guide."

I. Introduction

Dear employers and other purchasers,

Following many private sector transparency initiatives, President Bush signed an Executive Order in August 2006 to promote transparency in the health care programs administered or sponsored by the federal government. United States Department of Health and Human Services (HHS) Secretary Michael Leavitt has issued a broader challenge extending to other purchasers to implement "four cornerstones of value-driven health care": utilizing health information technology, measuring and publishing quality information, measuring and publishing price information, and creating positive incentives for high quality, efficient health care. The Secretary's call to action affords employers and other health care purchasers, a unique opportunity to accelerate this movement.

The four cornerstones provide a solid foundation for the development of a value-driven health care system. Value-driven health care employs standardized methods for measuring health care quality and pricing information and then puts this information into the hands of consumers, empowering and motivating them to make informed decisions about their health care. Informed consumers are able to seek the best available care, which stimulates the entire health care system to provide better quality, more efficient care. High quality, efficient health care translates into savings – in terms of both lives *and* dollars.

Secretary Leavitt is soliciting support for his Value-Driven Health Care initiative. If you agree with the concepts put forward by the four cornerstones, we urge you to register your support at www.hhs.gov/transparency/employers/. On the website, purchasers can read the full statement of support and sign up. An HHS representative will contact you after you have registered to confirm your organization's support. Once these steps have been completed, your organization's name will be added to the list of supporters. Purchasers can obtain a list of those who have registered support at www.hhs.gov/transparency/employers/statements.html.

In addition to registering support for the initiative, purchasers have an array of choices available to help them achieve the cornerstone goals. We recognize that navigating the ways purchasers can support the four cornerstones can be daunting.

With this in mind, the Purchaser Guide was developed to assist purchasers to quickly identify which initiatives they can undertake to meet each of Secretary Leavitt's cornerstones. The front of this guide contains a "quick reference" section. This section is broken down by cornerstone; beneath each is a list of actions purchasers can take and, where applicable, a list of corresponding existing initiatives that support the goals of the cornerstones. The remainder of

the guide provides more detailed information about each of the cornerstones and the ways that purchasers can achieve their goals.

We hope that the guide encourages more employers to become actively engaged in the movement towards nationwide value-driven health care. Should you find yourself in need of additional information or assistance as you contemplate responding to Secretary Leavitt's challenge, you may contact any of our organizations for support. Thank you for your interest in this important initiative.

Sincerely,

American Benefits Council
Bridges to Excellence
Business Roundtable
Corporate Health Care Coalition
The ERISA Industry Committee
HR Policy Association
The Leapfrog Group
National Association of Manufacturers
National Association of Wholesaler-Distributors
National Business Coalition on Health
National Business Group on Health
National Federation of Independent Businesses
National Retail Federation
Society for Human Resource Management
U.S. Chamber of Commerce

II. Quick Reference Guide

This quick reference guide provides an overview of ways for purchasers to take practical steps that support the four Cornerstones for Value-driven Health Care. Purchasers should initially seek to take *at least one* specified action for each of the four cornerstones. It is not expected that all purchasers at the outset will be able to take all of the actions within the cornerstones. Section III of this document provides more detail around each cornerstone and ways in which they may be met.

Cornerstone #1: Interoperable Health Information Technology

- Request that health insurance plans, third party administrators (TPAs), providers and other contractors monitor the activities of the Certification Commission for Healthcare Information Technology (CCHIT℠) and the American Health Information Community (AHIC) and encourage them to participate in those activities.

- Request that health insurance plans and TPA contractors encourage ambulatory care providers to use electronic health records (EHRs) that have been certified by CCHIT and that meet other interoperability standards as they are developed.

- Request that health insurance plans, TPAs, providers and other contractors participate in and support community and state efforts to create health information exchanges and organizations.

- Measure health plan performance using the Template RFI (or the more comprehensive eValue8 RFI) and request that health plans implement one or more of the health information technology practices identified on page two of the Template RFI.

Cornerstone #2: Transparency of Quality

- Request that health insurance plans and TPA contractors use and publicly report measures of provider quality adopted by the AQA or the HQA, and for measures not addressed by either, then those measures endorsed by the NQF or approved by other national consensus-based collaboratives that include representation of providers and other key stakeholders.

- Request that health insurance plans and TPA contractors participate in the AQA, HQA, NQF or another national quality transparency collaborative.

- Participate in regional or national public-private collaborative committees or work groups, which include provider representatives, to establish and support uniform standards for measuring or reporting quality information, and to promote provider performance transparency.
  - Bridges to Excellence
  - Leapfrog
  - eValue8
  - NCQA
  - Care Focused Purchasing
  - Regional collaboratives and coalitions

- Become a member of NQF.

Cornerstone #3: Transparency of Price

- Request that health insurance plans and TPA contractors make available to enrollees the cost or price of care.

- Assure that cost or price information is made available *with* quality information to the maximum extent possible.

- Participate in broad-based public-private collaborative efforts to develop strategies to measure the overall cost of services.
  - AQA Efficiency Measurement
  - HQA Efficiency Measurement
  - NCQA MD Benchmarking Project
  - PBGH-CalPERS Hospital Value Initiative
  - Wisconsin Collaborative for Healthcare Quality
  - Another broad-based public-private collaborative to develop such strategies

- Participate in regional or national public-private collaborative committees or work groups to establish and support uniform standards for measuring or reporting quality information, and to promote provider performance transparency.
  - Bridges to Excellence
  - Leapfrog
  - eValue8
  - NCQA
  - Care Focused Purchasing
  - Regional collaboratives and coalitions

Cornerstone #4: Incentives for High-Value Health Care

- Adopt *at least one* of the following strategies:
  - Encourage beneficiaries to use providers with the highest quality and the lowest cost.
    - Tiered network PPOs
    - Narrow or high performance network HMOs
    - Enrollee incentives to select high value providers, including centers of excellence

- Offer providers incentives and rewards for delivering high-value care.
  - Bridges to Excellence
  - Leapfrog Hospital Rewards
  - Another provider incentive program offered by the purchaser or its insurer/TPA
- Provide direct financial incentives and/or public recognition to providers who demonstrate superior performance.
- Provide employees the option of a consumer-directed health plan with a health savings account or health reimbursement account.
- Implement incentive programs to encourage provider adoption of electronic health records and health information exchange.
  - Bridges to Excellence
  - Another electronic health record and health information exchange incentive program

- Provide beneficiaries with incentives for prevention and wellness.
  - Purchaser wellness program (self-administered or contracted)
  - Health coaching (self-administered or contracted)
  - Another wellness program
- Providing beneficiaries with incentives for self-management of chronic illness.
  - Disease management program (self-administered or contracted)
  - Health coaching (self-administered or contracted)
  - Another chronic illness self-management program

III. Value-driven Health Care: *What Purchasers Need to Do*

A. The Four Cornerstones of Value-driven Health Care

U.S. Department of Health and Human Services Secretary Michael Leavitt extended a challenge to U.S. employers in November 2006 to support Executive Order 13410 establishing "Four Cornerstones of Value-driven Health Care." (See **Appendix A** or www.hhs.gov/transparency for the Executive Order.) These "cornerstones" are consistent with the philosophy and principles espoused by many of the leading purchasers and purchaser coalitions across the country. The cornerstones address practices that employers and other purchasers should advance with contracted health insurance plans, third party administrators (TPAs), providers and other contractors. The cornerstones read as follows:

- **Interoperable Health Information Technology** – Support the development and use of interoperable health information technology. Interoperability promises to enable the exchange of clinical data and to create greater efficiency in health care delivery by eliminating significant redundancy and providing data to measure and improve the quality of care.
- **Transparency of Quality** – Promote use of national consensus-based standardized quality measures for public reporting purposes, working with regional collaboratives whenever possible. Also, support development of new standardized measures.
- **Transparency of Price** - Promote use of price measures for public reporting purposes, working with regional collaboratives whenever possible. Also, support development of standardized measures and methods for price measurement. Finally, present such data in tandem with quality data to the maximum extent possible.
- **Incentives for High-Value Health Care** – Adopt one or more of four strategies: a) encourage beneficiaries to use providers with the highest quality and the lowest cost, b) offer providers incentives and rewards for delivering high-value care, c) provide beneficiaries with incentives for prevention and wellness and for self-management of chronic illness, or d) offer consumer-directed health plan products.

While many leading purchasers and purchaser organizations are in agreement with these four cornerstones, there remain significant opportunities for concrete purchaser action to advance their implementation. The following sections of the guide specify exactly what purchasers need to do in order to advance Value-driven Health Care as articulated by the four cornerstones.

As advancements are made in Value-driven Health Care, this guide, and the resources and examples provided within it, will be updated.

B. A Six-Step Strategy

Secretary Leavitt has urged purchasers to develop a strategy that aggressively moves toward advancing all key goals in the Executive Order. He has recognized, however, that it may be necessary for some purchasers to implement the strategy over time depending upon size, geography, and other situational considerations. Purchasers should initially seek to take *at least one* specified action for each of the four cornerstones. It is not expected that all purchasers at the outset will be able to take all of the actions within the cornerstones.

A purchaser can speed its achievement of the Four Cornerstones of Value-driven Health Care through two primary avenues:

- by joining national initiatives such as Bridges to Excellence and The Leapfrog Group, or by joining regional purchaser coalitions on health that exist in most states. These organizations have been committed to Value-driven Health Care for many years, and have multiple initiatives in place to advance each of the cornerstones (Step 3 below), and
- by contracting with health insurance plans and TPAs that operate in a fashion that are consistent with the cornerstone practices (Steps 4-6 below).

A purchaser might best develop a strategy to implement the cornerstones by taking the following six steps:

Step 1: Review the cornerstones to develop a clear understanding of what is being asked of purchasers.

Step 2: Submit the statement of support to communicate to Secretary Leavitt your organization's commitment to the cornerstones.

Step 3: Consider joining one of the national, state or regional initiatives currently available to purchasers focused on advancing all or some of the cornerstones.

Step 4: Use the Template Request for Information (RFI) with contracted health insurance plans, TPAs and other appropriate contractors to determine to what degree they may already be operating in a fashion that is consistent with the cornerstone practices.

Step 5: Identify where your contractor(s) needs to progress in order to fully address the cornerstones and communicate your expectation to your contractor(s) in writing that it will act to implement the practices.

Step 6: Incorporate specific implementation requirements in health insurance plan and TPA contracts as they come up for renewal, if not sooner, and plan to review the plan's adherence to those requirements to ensure accountability.

We now discuss in more detail how to take each of the aforementioned six steps.

Step 1: Review the Cornerstones

The cornerstones have been written as broad principles. These can only be effective if they are translated into concrete action that purchasers and their contractors can understand.

Cornerstone #1: Interoperable Health Information Technology

1. Collaborate to establish and support uniform standards for health information technology interoperability in the following manner:

    a. Request that health insurance plans, third party administrators, providers and other contractors monitor the activities of the Certification Commission for Healthcare Information Technology (CCHIT℠), a Recognized Certification Body designated by the Secretary, and the American Health Information Community (AHIC) and encourage them to participate in those activities. See **Appendix B** for a description of ways to volunteer with CCHIT. More information is available on these organizations at www.cchit.org and www.hhs.gov/healthit/ahic.

2. Request that health insurance plans, third party administrators, providers and other contractors promote interoperability[1] in the following fashion:

    a. Request that health insurance plans and TPA contractors encourage ambulatory care providers to use electronic health records (EHRs) that have been certified by CCHIT and that use other interoperability standards as they are developed.

    b. Request that health insurance plans, third party administrators, providers and other contractors participate in and support community and state efforts to create health information exchanges and organizations. See **Appendix C** for a listing of Health Information Exchanges (HIEs) and Regional Health Information organizations (RHIOs). In addition, a listing of state-sponsored HIE initiatives can be obtained at www.nascio.org/publications/documents/NASCIO-ProfilesOfProgress.pdf.

    c. Measure health plan performance using the Template RFI (or the more comprehensive eValue8[2] RFI) and request that health plans implement one

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[1] Additional interoperability standards are being developed through Health Information Technology Standards Panel (HITSP) use cases and American Health Information Community (AHIC) adoption of HITSP use cases. (For more information, see the HITSP web site at www.ansi.org/standards_activities/standards_boards_panels/hisb/hitsp.aspx?menuid=3.)

[2] "eValue8" is an RFI developed and used by members of the National Business Coalition on Health.

or more of the health information technology practices identified on page two of the Template RFI. See **Appendix D** for the Template RFI. This RFI is part of the HHS employer toolkit and can also be found HHS' web site at www.hhs.gov/transparency/employers/.

Cornerstone #2: Transparency of Quality

1. Request that health insurance plans, third party administrators, providers and other contractors do as follows:

    a. Use and publicly report measures of provider quality adopted by the AQA[3] or the HQA[4]. See the footnoted links for the AQA and HQA measures.

    b. If measuring quality in areas not addressed by the AQA or HQA, use measures endorsed by the NQF[5] or approved by other national consensus-based collaboratives, such as Bridges To Excellence and The Leapfrog Group, that include broad representation of providers and other key stakeholders.

    c. Promote further development of such measures by volunteering to participate in the AQA, HQA, NQF or other national collaboratives.

2. Participate in regional or national public-private collaboratives, which include provider representatives, for the following purposes:

    a. to establish and support uniform standards for measuring or reporting quality and cost or price information, and

    b. to promote provider performance transparency.

There are many such collaboratives, the majority of which have been fully or partly purchaser-initiated, and many of which have emerged in the past few years. Several are pooling data across insurers in order to create uniform provider quality measurement, and sometimes cost or efficiency measurement as well. A partial listing of regional and national transparency collaboratives and of purchaser coalitions sponsoring transparency activities can be found in **Appendix E**.

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[3] The AQA is a national multi-stakeholder group focused on physician quality measures. The AQA measures can be found at http://www.aqaalliance.org/performancewg.htm.

[4] The HQA is the Hospital Quality Alliance, a national multi-stakeholder group focused on hospital quality measures. The HQA measures can be found at www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalStarterSet200512.pdf.

[5] The NQF is the National Quality Forum, a national multi-stakeholder group created to develop and implement a national strategy for healthcare quality measurement and reporting. NQF-approved quality measures can be found at www.qualityforum.org. Employers can join the Purchaser Council of the NQF and take an active role in influencing NQF's work to define a national performance measurement set. For information on how to join the NQF, visit their web site.

3. Become a member of the NQF.

   Employers and employer organizations involved in NQF as of January 2007[6] included the Buyers Health Care Action Group, Central Florida Health Care Coalition, Employer Health Care Alliance Cooperative (The Alliance), Ford Motor Company, General Motors, Health Care 21, HR Policy Association, The Leapfrog Group, Lehigh Valley Business Conference on Health, Maine Health Management Coalition, Michigan Purchasers Health Alliance, National Business Coalition on Health, National Business Group on Health, Pacific Business Group on Health, St. Louis Business Health Coalition, and Washington State Health Care Authority.

Cornerstone #3: Transparency of Price

1. Request that health insurance plans, third party administrators, providers and other contractors do as follows:

    a. Make available the cost or price of care to enrollees.

    b. Assure that cost or price information is made available *with* quality information to the maximum extent possible.

    a. Join broad-based public-private collaborative efforts to develop strategies to measure the overall cost of services for common episodes of care and the treatment of common diseases. See **Appendix F** for a list of such public-private collaboratives.

2. As consensus develops on uniform approaches to measuring or reporting cost or price information for the benefit of consumers, request the use of these approaches.

3. Directly participate in collaborations to establish and support uniform standards for measuring or reporting quality and cost or price information. (See **Appendix E**.)

Cornerstone #4: Incentives for High-Value Health Care

Purchasers can provide incentives for the delivery of high value care through a range of strategies that seek to motivate provider and consumer behavior change.

1. Purchasers should implement one or more of the following incentive strategies either through contracted health insurance plans or TPAs, or when appropriate, directly with providers. Purchaser implementation through contracted health insurance plans means purchasing health insurance plan and TPA services with one or more of the following characteristics and encouraging employee enrollment into the product(s).

    a. Adopt high performance network strategies that encourage beneficiaries to use providers with the highest quality and the lowest cost. These strategies may include the use of tiered network PPOs, narrow or high performance

[6] www.qualityforum.org/pdf/list_of_members.pdf, accessed January 5, 2007.

network HMOs, and provision of other enrollee incentives to select high value providers, including centers of excellence (e.g., waived deductible for selection of a high quality hospital).

  b. Provide direct financial incentives and/or public recognition to providers who demonstrate superior performance.

  c. Provide the option of a consumer-directed health plan with a health savings account or health reimbursement account.

  d. Implement incentive programs to encourage provider adoption of electronic health records and health information exchange.

2. Purchasers should also provide employees and their dependents with incentives to promote health and wellness, as well as to self-manage chronic illness through the following strategies. Purchaser implementation may occur either directly by the purchaser or through contracted health insurance plans, TPA, providers or other contractors.

  a. Provide covered employees and their dependents with incentives to make timely use of evidence-based prevention services and to live healthy lives.

  b. Provide covered employees and their dependents with support to help them self-manage their chronic conditions.

  c. Design benefits that reduce or eliminate financial barriers to essential treatments (e.g., place essential brand drugs for which there is no generic alternative on tier 1 with the same co-payments as generic drugs).

In many cases purchasers may find that they are already participating in activities that address elements of the cornerstones. The Quick Reference Guide on pages 5 through 7 provides a checklist that purchasers can use to gauge to what extent their practices may already be aligned with the cornerstones.

Purchaser examples of each of these strategies are provided in the next section of this guide.

Step 2: Submit the Statement of Support

Secretary Leavitt asks purchasers to submit an online statement of support that conveys the purchaser's commitment to support the cornerstones and to encourage contracted health insurance plans, third party administrators, providers, and other contractors to take consistent actions to achieve these goals. The statement of support should be submitted by the CEO or CEO designee at http://transparency.cit.nih.gov/#sign-up. An HHS representative will contact you after you have registered to confirm your organization's support. Upon confirmation, your organization's name will be added to the list of supporters.

Step 3: Consider Joining One of the National, State or Regional Initiatives Currently Available to Purchasers Focused on Advancing All or Some of the Cornerstones

Health care markets in the U.S. continue to operate at local and regional levels. Much of the current and future development and implementation work supporting health IT interoperability, price transparency, quality transparency and use of incentives for high-value and cost efficient health care is taking place through national and regional coalitions and collaboratives.

Regional coalitions typically are composed of insurers, providers, consumer advocates, and purchasers. The voice of purchasers can sometimes be underrepresented in the discussions. It is essential that purchasers take a strong, visible role in coalitions to advance Value-driven Health Care.

Other regional coalitions are primarily comprised of purchasers, but are also working to advance supporting health IT interoperability, price transparency, quality transparency and use of incentives as a means to attaining high-value health care.

See **Appendix E** for a listing of some of the many regional coalitions that purchasers may join.

Step 4: Use the Template RFI

The Template RFI has been developed by HHS to serve as an efficient means for purchasers to determine the degree to which their contractors are currently operating in alignment with the cornerstones. The National Business Coalition on Health also has an RFI named "eValue8" that contains a comprehensive set of highly vetted measures that have evolved over more than ten years. Large insurers will be familiar with eValue8 and may already have responses that they have previously prepared.

Should a purchaser belong to an NBCH-member coalition and have access to eValue8 responses for its contracted health insurance plans, it may want to utilize those data instead of utilizing the Template RFI.

See **Appendix D** for the Template RFI.

Step 5: Identify Where Your Contractor(s) Needs to Progress and Communicate Your Expectation to Your Contractors in Writing

Should the purchaser utilize the Template RFI or eValue8 and obtain contractor responses, there should be a clear understanding of the degree to which the purchaser's contractors are currently operating in alignment with the cornerstones.

Should there be opportunities for contractor improvement, and there will be in many cases, the purchaser should communicate the following in writing to a senior level executive of their health insurance plan(s), TPA(s) or other appropriate contractors:

1. Where the purchaser identified opportunities for the health insurance plan or TPA to improve performance relative to the cornerstones.
2. The purchaser's expectation that the health insurance plan or TPA will take actions to align its operations with the cornerstones.
3. A request for a response describing what steps the contractor will take to make the necessary changes, and when.

Should the purchaser elect *not* to utilize the Template RFI or eValue8, the purchaser should instead communicate the following in writing to the same individual(s):

1. The purchaser's expectation that the health insurance plan or TPA will take actions to align its operations with the cornerstones.
2. A request for the contractor's self-assessment of how closely its operations are comporting with the cornerstones.
3. A request for a response describing what steps the contractor will take to make the necessary changes, and when.

See Appendix G for letter templates to be used with contractors, assuming both the use and non-use of the Template RFI or eValue8.

Step 6: Incorporate Specific Implementation Requirements in Health Insurance Plan and TPA Contracts and Plan to Review the Plan's Adherence to those Requirements.

Purchasers should incorporate specific implementation requirements in health insurance plan and TPA contracts as they come up for renewal, if not sooner. Implementing such requirements into contract language strengthens the contractor's commitment to supporting Value-driven Health Care.

Once the language has been incorporated into the contract, the purchaser should periodically, but not less than annually, review the steps that the health insurance plan or TPA has taken towards the cornerstones, as specified in the contract language.

See **Appendix H** for sample contract amendment language that a purchaser can directly apply or adapt for its own use.

As stated earlier, Secretary Leavitt has recognized that it may be necessary for some purchasers to implement their Value-driven Health Care strategy over time depending upon size, geography, and other situational considerations. The approach used by each purchaser should be tailored to its own circumstances.

IV. Examples of Current Value-driven Initiatives and Strategies

This section of the report provides examples of current purchaser activities that address elements of each of the four cornerstones. Some multi-employer organizations, including Bridges to Excellence and The Leapfrog Group and the many state and regional purchaser coalitions identified in **Appendix E** have activities in place that already address elements of all of the cornerstones. Joining one or more of these organizations will accelerate purchaser efforts to meet the challenges of the cornerstones.

Examples from National Organizations

National organizations frequently have initiatives in place that span more than one cornerstone. Two examples are provided below.

Bridges To Excellence® (BTE) is a not-for-profit organization that designs and creates programs that encourage physicians and physician practices to deliver safer, more effective and efficient care by giving them financial and other incentives to do so. BTE is a national program in which purchasers and health plans can participate and thereby meet three of the four cornerstones: Interoperable Health Care Information Technology, Transparency of Quality and Incentives. All of the national health plans have licensed BTE[7] and purchasers can simply work with their health plan to participate in BTE, any where in the country. As of February 2007 there were three Bridges to Excellence programs, with two additional programs due to be released in 2007:

- *Diabetes Care Link*, offering physicians a bonus based on demonstrating good control of diabetes in patients;
- *Physician Office Link*, offering physicians a bonus for investing in information technology and care management tools, and
- *Cardiac Care Link*, offering physicians a bonus based on demonstrating that they are top performers in providing cardiac care.

Cornerstone #1: Interoperable Health Information Technology – the Physician Office Link Program is focused on promoting the office practice's use of health care information technology to enhance patient care and provides incentives to providers who adopt electronic health records. Bridges to Excellence has three levels of recommended award:

- *Basic*: which rewards providers for, among other things using evidence-based standards of care, having patient registries for at risk patients, and giving educational materials to patients. BTE recommends a suggested $15 per member per year in rewards for achievement at this level;

[7] As of January 9. 2007, Aetna, Blue Cross Blue Shield of North Carolina, CareFirst Blue Cross Blue Shield, CDPHP, CIGNA, Kaiser of Georgia, MVP Health Care, UnitedHealth Group, Humana and Wellpoint are all licensing BTE, per www.bridgestoexcellence.org/employers_hp/home.htm, accessed January 9, 2007.

- *Intermediate*: which rewards providers for, having electronic systems to maintain health records, electronic decision support, computerized physician order entry of pharmaceuticals and lab tests, and patient reminders. BTE recommends a $30 per member per year reward for achievement at this level, and
- *Advanced*: which rewards providers for having interconnected electronic systems that are interoperable with other systems. BTE recommends a $50 per member per year reward for achievement at this level.

Cornerstone #2: Transparency of Quality – Bridges to Excellence makes available to its participants and to the general public the names of physicians and practices that meet the performance measures in all three programs on its web site. In addition, BTE works with national measurement standards organizations to develop new programs. For example, Spine Care Link, based on the NCQA Back Pain Recognition Program, and the Internal Medicine Care Link, based on the ABIM Comprehensive Care Practice Improvement Module will be available in 2007.

Cornerstone #4: Incentives for High-Value Health Care - Bridges to Excellence is a program that pays bonuses to physicians that meet standard performance measures. Purchasers can encourage their health plans to license Bridges to Excellence. If a purchaser has a large enough number of covered lives in a geographic area, (e.g., 50,000 or 8-10% of the population), it may be able to support a Bridges to Excellence program on its own, as General Electric, UPS and Verizon have done. Purchasers can also join with other area purchasers, either collectively or through a coalition, to create a BTE program. Several insurers now also license BTE.

For more information, go to www.bridgestoexcellence.org.

The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to advance America's health industry toward big leaps in health care safety, quality and customer value. Leapfrog is a national program in which purchasers and health plans can participate and thereby meet all four of the cornerstones.

Cornerstone #1: Interoperable Health Information Technology – Leapfrog's annual Hospital Quality and Safety Survey assesses hospital practices in the area of patient safety. The patient safety practices have all been identified through rigorous research as resulting in improved quality of care and reduced costs. Among these practices is the use of a breakthrough health information technology – Computer Physician Order Entry (CPOE). With CPOE systems, hospital staff enter medication orders via a computer linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50%.

Cornerstone #2: Transparency of Quality – Leapfrog advances transparency of quality in two ways. First, results from Leapfrog's two hospital performance transparency initiatives—the Leapfrog Hospital Quality and Safety Survey and Leapfrog Hospital Insights-- are posted on the Leapfrog web site so that consumers, purchasers, providers and insurers can see how hospitals stand against the Leapfrog-specified quality and safety practices. Second, the employer purchasers comprising the Leapfrog Health Plan Users'

Group annually communicate their goals to the nation's five largest commercial insurers regarding provision of provider quality data to health plan members, and then assess each insurer's performance relative to those goals.

Cornerstone #3: Transparency of Price – Leapfrog also advances transparency of price information and advocates that the information be made available *with* quality data to the maximum extent possible. The employer purchasers comprising the Leapfrog Health Plan Users' Group regularly communicate their goals to the nation's five largest commercial insurers regarding provision of provider efficiency data to health plan members, and then assess each insurer's performance relative to those goals.

Cornerstone #4: Incentives for High-Value Health Care - The Leapfrog Hospital Rewards Program™ is a tool for employers and health plans to use to provide incentives and rewards to hospitals that demonstrate excellence or show improvement on important measures of quality and efficiency.

The Leapfrog Hospital Rewards Program identifies five conditions that can deliver significant opportunity for increased quality and affordability in the working population: coronary artery bypass graft, angioplasty, heart attack care, community acquired pneumonia and deliveries/neo-natal care. The Program has designed an actuarially sound mechanism for rewarding hospitals for excellence and improved performance in these important clinical areas.

For more information, go to www.leapfroggroup.org.

The **National Business Coalition on Health** (NBCH) is a non-profit organization of employer-based health coalitions committed to finding innovative ways to enhance and strengthen the capacity of its members to improve the quality and affordability of health care. In addition to acting as a vehicle for its members to introduce Leapfrog and Bridges to Excellence in their communities, NBCH owns and maintains eValue8, a health plan performance tracking program that addresses all four cornerstones.

Cornerstone #1: Interoperability of Health Information – Health plans are a primary source of health information ranging from eligibility and claims transactions to performance measurement of doctors and hospitals. The eValue8 Request for Information (RFI) captures not only the five Template RFI elements contained in **Appendix D** of this guide, but assesses the internal coordination of the plan's rich sources of information to engage consumers and improve member health through mechanisms such as disease management programs, personal health records, and objective treatment choice information.

Cornerstone #2: Transparency of Quality – eValue8 determines in measure-specific detail the quality information that each plan uses. AQA, HQA and other important measures are listed in their entirety and plans are scored according to whether these standard measures are used for benchmarked feedback to providers, consumer reporting and/or incentives.

Cornerstone #3: Transparency of Price – eValue8 determines each plan's approach to price transparency. Detailed distinctions are recorded, including whether cost estimates are provider-specific or based on market averages, and whether plans are able to assist consumers in determining the likely costs for episodes of care rather than just procedure-specific information. Further information is captured for high deductible/HSA plans, where price transparency is especially important.

Cornerstone #4: Incentives for High-Value Health Care – In its Provider Module eValue8 distinguishes three forms of incentives for superior performance and expects that plans report their impact: periodic rewards to providers, differential payment schedules and consumer incentives through plan design (i.e., lower copayments/deductibles for selection of higher performing providers). The form, magnitude and performance basis of the incentives (e.g., efficiency, quality, health information technology, etc.) are also determined. eValue8 also examines high deductible/HSA plans, which in themselves are one vehicle for heightening consumer awareness and engagement in health care decisions. eValue8 assesses the plan's capabilities, consumer support and coordination of resources for high deductible/HSA plans.

For more information go to www.nbch.org

Examples from State and Regional Initiatives

There are many regional coalitions and collaboratives that operate initiatives that are advancing value-driven health care and address one or more cornerstones. A few examples of these efforts are briefly described below.

A. Cornerstone #1: Interoperable Health Information Technology

Purchasers are beginning to focus on the need for interoperable health information technology. One example of a multi-purchaser collaborative effort in this area follows on the next page.

Interoperable Health Information Technology
A coalition of employers, including Applied Materials, BP America, Intel, Pitney Bowes, and Wal-Mart have announced the founding of a non-profit institute called Dossia to develop a web-based data warehouse to store employee personal health records. The warehouse will give employees the ultimate responsibility for owning their health record. The system will be portable, allowing employees to take their information with them if they change doctors, health plans or employers. The founders of this initiative hope to encourage, through consumer engagement, the adoption of electronic health records by providers.[8] The system will be based on the Connecting for Health Common Framework, a set of policy and design standards established by a wide variety of industry stakeholders and funded by the Markle and Robert Wood Johnson Foundations.

In response, Dr. Julie Gerberding, Director of the Centers for Disease Control and Prevention, said “"The use of interoperable Personal Health Records holds tremendous potential to improve population health by making it easier for individuals and families to stay healthy through prevention.” John Engler, the president of the National Association of Manufacturers, stated that "the National Association of Manufacturers fully supports this effort to enable employees, their dependents and retirees to maintain lifelong electronic health records.” [9]

In addition, there are many state and regional organizations, including Regional Health Information Organizations (RHIOs) and Health Information Exchanges (HIEs) that are focusing upon data exchange and interoperability issues. Employers are important stakeholders and participating on the governing boards of these organizations. A list of these organizations can be found in **Appendix C**.

B. Cornerstone #2: Transparency of Quality
and
C. Cornerstone #3: Transparency of Price

Several purchaser coalitions and multi-stakeholder collaboratives have launched efforts to make physician and/or hospital performance on quality and/or price transparent.

Transparent Quality and Cost Information
The Pacific Business Group on Health publishes data on its web site, www.healthscope.org. The data profile California medical group performance based on the results of a survey answered by over 50,000 state residents. The measures assess experience with getting treatment and specialty care, doctors communicating with patients, coordination of patient care, and timely care and service.

[8] Hopkins C. “Major U.S. Employers Announce Development of Health Records Framework”, *CQ HealthBeat*, December 11, 2006.
[9] “Major U.S. Employers Join to Provide Lifelong Personal Health Records for Employees” Intel press release, December 6, 2006.

Transparent Quality and Cost Information
The Maine Health Management Coalition publishes data on its web site, http://www.mhmc.info/. The data profile the performance of Maine hospitals and physicians. Hospitals are rated based on patient satisfaction survey data, patient safety data regarding medication safety practices and Leapfrog Group hospital patient safety survey data, and measures specific to the following clinical conditions: heart attack, heart failure, pneumonia and surgical infection. The coalition also rates internal and family medicine practices based on their use of clinical office systems, and their measurement of results of diabetes care and heart disease treatment.

Transparent Quality and Cost Information
Minnesota Community Measurement publishes data on its web site, www.mnhealthcare.org. The data profile Minnesota medical groups and clinics based on data submitted by seven health plans and one regional county alliance that maintains a health plan. The measures assess performance for 12 separate services and conditions, including asthma, depression, diabetes, high blood pressure, appropriate tests for children with sore throats, breast cancer screening, cervical cancer screening, colorectal cancer screening, chlamydia screening, childhood immunizations and well-child visits.

For additional examples of transparency initiatives, visit the web sites of the collaboratives and coalitions listed in **Appendix E**.

D. Cornerstone #4: Incentives for High-Value Health Care

Purchasers can provide incentives for the delivery of high-value care through a range of strategies that seek to motivate provider and consumer behavior change. Purchasers have implemented many different incentive strategies either through contracted health insurance plans or TPAs, or when appropriate, directly with providers. Selected examples of incentive strategies are listed below.

- **Adopt high performance network strategies that encourage beneficiaries to use providers with the highest quality and the lowest cost.**

Narrow or High Performance Network HMOs,
The Business Health Care Group of Southeastern Wisconsin offers its members a Humana Preferred narrow network product. It covers about 50,000 enrollees and dependents, about one third of those eligible. Quality and efficiency measures are used as criteria for creating the network, along with the traditional marketability requirements of including enough hospitals and physicians to make the product a viable choice for a large number of employers throughout the region. Briggs and Stratton, an engine manufacturer for lawn and garden equipment, based in Wauwatosa, Wisconsin, had about 32% of eligible employees enroll in this plan in 2006 and expects enrollment to grow in 2007.[10]

[10] Fisher, B. "Giving up choice in exchange for cheaper health costs", *Business Journal of Milwaukee*, August 11, 2006.

Tiered Network PPOs

The Harvard Pilgrim Independence Plan is a tiered network PPO that is offered to employees of the Commonwealth of Massachusetts through the Group Insurance Commission (GIC). The GIC is the largest employer purchaser in the market. It has been working with health plans to control costs and improve quality and has challenged insurance plans to create products that would assist in attaining this goal. Harvard Pilgrim Health Care created a product that tiers specialist groups by resource utilization and quality. The specialist groups being measured are Cardiology, Dermatology, Gastroenterology, General Surgery and Orthopedics. This program created two tiers of office visit co-pays: one for PCPs and the high performing specialist groups in the measured specialties, and one for all other specialists, those in the unmeasured specialties, and the lower performing specialist groups in the measured specialties.[11]

Purchaser Provision of Enrollee Incentives to Select High Value Providers, Including Centers of Excellence

Hannaford Brothers, a supermarket chain based in Maine, has an incentive program where patients going to hospitals that meet certain quality standards and are designated as centers of excellence receive a more favorable level of coverage. For example, Hannaford waives the $250 co-payment for employees who choose high performing hospitals for specific surgical procedures. Centers of Excellence have been designated for complex cancers and transplants, and employees are required to use them to receive any benefits for these treatments.[12]

High performance network strategies, while growing in prevalence nationally and now supported by most of the nation's largest insurers, sometimes face considerable provider opposition. Physicians and hospitals often object to being excluded from a network or receiving an undesirable rating. For example, Regence Blue-Shield in Washington State has halted development of a new performance-based network. The Washington State Medical Association and the American Medical Association/State Medical Societies Litigation Center sued Regence to stop the creation of the Select Network. The suit claimed that the data used to score physicians on cost and quality was inaccurate[13]. Other insurers have faced similar opposition.[14] Purchasers and their contractors should proceed in a thoughtful manner that engages providers in a meaningful manner when pursuing these strategies so as to address provider concerns that could lead to opposition.

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[11] Herman R., Senior Vice President & Chief Medical Officer Harvard Pilgrim Health Care. "The Harvard Pilgrim Independence Plan", presented at The Leapfrog Group and the National Business Coalition on Health 2nd Annual Incentives and Rewards Workshop, July 19, 2006, Chicago, IL.

[12] The Alliance (Employer Health Care Cooperative), "Getting What You Pay For: Early Reports from Value-Based Steerage Pioneers", April 2006. See www.alliancehealthcoop.com/ReportsResources/Value-based%20white%20paper.pdf

[13] Sorrel, AL, "Regence Halts Network Opposed by Washington State Doctors", *American Medical News*, December 25, 2006.

[14] Sybert L. "BJC fights United Healthcare over coverage", *St. Louis Business Journal*, August 20, 2004.

- **Provide direct financial incentives and/or public recognition to providers who demonstrate superior performance.**

Direct Financial Incentives to Hospitals
Anthem Blue Cross Blue Shield Midwest (now part of Wellpoint) developed an agreement in 2003 with 38 hospitals (5 in KY and 33 in OH and IN) that linked reimbursements to quality measurements. The performance measures include clinical outcomes, such as post-surgery infection rates and how often heart-bypass patients have to return to surgery within 24 hours. The measures also include practices that logically would have an effect on the quality of care, such as how long patients wait in the emergency room before getting treatment or how quickly someone with chest pain gets an electrocardiogram. They also include whether systems or processes that enhance patient safety are in place, such as computerized prescription order entry systems.[15]

Direct Financial Incentives to and Public Recognition for Physicians
The Hotel Employees and Restaurant Employees International Union Health Fund in Las Vegas, Nevada, has a provider incentive and reward program that rewards high performing physicians with public recognition, financial incentives, and penalizes poor performing physicians. The union covers approximately 134,000 lives and contracts with approximately 2,000 health care providers. The union maintains an incentive and rewards program for primary care physicians based on measures of quality and efficiency. High performing providers are rewarded with Gold Stars in the provider directory and financial rewards. Those physicians and groups that are low performing are advised to take corrective action. Should they remain low performing, the union plan excludes the physician from its network.[16]

While the provision of financial incentives would appear at the outset to be popularly received with providers, this is not always the case.[17] Once again, purchasers and their contractors should proceed in a thoughtful manner and engage providers in a meaningful manner when pursuing these strategies.

For additional examples of high performance network and direct provider incentive strategies, please see the Leapfrog Incentive and Reward Compendium at www.leapfroggroup.org/leapfrog_compendium.

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[15] "Incentive and Reward Compendium Guide and Glossary", The Leapfrog Group. Accessed January 29, 2007 at http://ir.leapfroggroup.org/compendium/.
[16] Reeves J. "Impacts of Rewarding Physicians", presented at The Leapfrog Group and the National Business Coalition on Health 2nd Annual Incentives and Rewards Workshop, July 20, 2006, Chicago, IL.
[17] Adams D and Henry TA. "Pay-for-performance draws doctors' ire", *American Medical News*, December 4, 2006.

- **Provide the option of a consumer-directed health plan with a health savings account or health reimbursement account.**

Consumer-directed health plans have grown in popularity over the past few years. These plans put consumers in the position of taking a more active role in paying for their health care. Typically, the employer offers a high deductible health plan, which may be used with a tax-preferred health savings account (HSA) or health reimbursement account (HRA). The HSA is funded by the employer or employee with pre-tax or tax- deductible dollars. Any interest earned on the account is not taxed. An HSA is portable, meaning that the employee can take the account should he or she change jobs. Health reimbursement arrangements are employer-funded arrangements that reimburse employee health care expenses and are generally not portable. Twenty-nine percent of employers offered a high-deductible plan with an HSA or HRA in 2006, and 33% are planning to offer one in 2007.[18] Deductibles and other design features of consumer-directed health plans vary. For example, some plans may require higher out-of-pocket costs, while others may cover preventive care not subject to the deductible, including annual physicals, mammograms, prenatal care visits, well baby visits, and cancer screening tests. Annual deductibles also vary.

Consumer-Directed Health Plan with a Health Savings Account
Baylor Health System in Dallas introduced a consumer-directed health plan in 2003, and moved to a full replacement of all of its health insurance plans in 2006. Thirty percent of the health system's employees enrolled in the first year, when it was offered along side traditional managed care options.[19] Baylor has reported that its consumer-driven plans provide tools and support information that a physician is not able to provide.[20]

Consumer-Directed Health Plan with a Health Savings Account
Wendy's International, the restaurant chain, moved to a full replacement HSA-based consumer-directed health plan product in 2005. Wendy's claimed that, for the first time in the history of the company it was able to hold premiums flat for three years in a row, 2005, 2006 and 2007. Wendy's contributes approximately 60% of the plan's deductible to an employee's HSA. In addition, Jeff Cava, Wendy's executive vice president for human resources and administration, noted there has been a significant increase in access to preventative care, specifically in annual physicals which have increased as a percentage of participants from 20% in 2004, to 30% in 2005 and 38% in 2006; in addition to positive increases in other specific preventative procedures.[21]

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[18] Watson Wyatt Worldwide, "Delivering on Health Care Consumerism: Strategies for Employer Success-Eleventh Annual National Business Group on Health/Watson Wyatt Survey Report 2006", Washington, DC, 2006.
[19] "The Pioneers of Consumer Directed Care: Where Are They Now?" *Inside Consumer Directed Care*, April 14, 2006.
[20] U.S. Department of Labor "Final Report of the Working Group on Health Care Security Consumer-Directed Health Care Arrangements", November 7, 2003.
[21] Personal communication with Jeff Cava, Wendy's International, January 31, 2007.

While employers and insurers have reported promising results[22], some research findings have been more equivocal.[23,24] Employers should assess whether consumer-directed health plans might meet the needs of their workforce.

➢ **Implement incentive programs to encourage provider adoption of electronic health records and health information exchange.**

There are many ways that purchasers are encouraging provider adoption of electronic health records and health information exchange. Some of these strategies involve direct incentives, while others do not.

Non-Incentive-Based Strategy to Encourage Provider Adoption of Electronic Health Records and Health Information Exchange
The eHealth Initiative is an independent, non-profit organization whose mission is to drive improvement in the quality, safety, and efficiency of healthcare through information and information technology. Purchasers may join and participate as members. The eHealth Initiative has developed the Connecting Communities Toolkit to help communities develop local information technology initiatives. The eHealth Initiative has formed a new business relationship with Bridges to Excellence and will be acting as its administrative arm. [25]

Incentive-Based Strategy to Encourage Provider Adoption of Electronic Health Records and Health Information Exchange
Bridges to Excellence (BTE), as noted earlier provides incentives thorough Physician Office Link to providers who adopt electronic health records. Bridges to Excellence has three levels of recommended award:

- *Basic*: rewards providers for, among other things using evidence-based standards of care, having patient registries for at risk patients, and giving educational materials to patients. BTE recommends a suggested $15 per member per year in rewards for achievement at this level;
- *Intermediate*: rewards providers for, having electronic systems to maintain health records, electronic decision support, computerized physician order entry of pharmaceuticals and lab tests, and patient reminders. BTE recommends a $30 per member per year reward for achievement at this level, and
- *Advanced*: rewards providers for having interconnected electronic systems that are interoperable with other systems. BTE recommends a $50 per member per year reward for achievement at this level.

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[22] CIGNA Finds Consumer-Directed Care Lowers Expenses, Increases Preventive Care, *Inside Consumer Directed Care*, November 24, 2006.
[23] Fronstin, Paul, and Sara R. Collins, "Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey" The Commonwealth Fund, December 2005.
[24] Buntin "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality" *Health Affairs*, 25(6), November/December 2006.
[25] www.ehealthinitiative.org, accessed January 8, 2007.

Purchasers can also provide employees, dependents and beneficiaries with incentives to promote health and wellness, as well as to self-manage chronic illness through the following strategies.

- **Provide covered employees and their dependents with incentives to make timely use of evidence-based prevention services and to live healthy lives.**

<u>Incentives to Make Timely Use of Evidence-Based Prevention Services and to Live Healthy Lives</u>
IBM uses incentives to help employees lead healthy lives. IBM uses multiple strategies to effect changes in wellness. For example, new non-smoking employees, and smokers who complete a smoking cessation program get a cash bonus of $150. IBM also has a Healthy Living Rebate Program through which employees have the opportunity to earn a reward of $150 by achieving physical fitness goals.[26]

<u>Incentives to Make Timely Use of Evidence-Based Prevention Services and to Live Healthy Lives</u>
The Pennsylvania Employee Benefit Trust Fund introduced its Get Healthy initiative in 2005. Employees and their covered spouses who completed a health risk assessment (HRA) received a waived or reduced medical contribution from the first full pay period in July 2005. Employees had to actively participate in the Get Healthy program to continue their waived or reduced medical contribution past January 1, 2006. Members were stratified into one of three categories based on their HRA responses (Healthy, At Risk, Chronic). PEBTF also began offering online services to its members by telephone and online. These programs are designed to assist members to manage their health and wellness and provide measurable results.

Purchasers can also purchase health insurance plans that offer enrollees incentives for healthy living. One example from Michigan follows on the next page.

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[26] Miller J. "Savings by design: IBM's Dr. Martin Sepulveda saves millions with employee benefit design" *Managed Healthcare Executive*, December 1, 2006.

Provide Support to Help Employees and Their Dependents Self-Manage Their Chronic Conditions
Healthy Blue Living, a product from Blue Cross Blue Shield of Michigan, offers members lower co-payments and deductibles if they commit to living a healthier lifestyle. The program has two levels, standard and enhanced. Members are enrolled in the enhanced program, and to remain in it they have to complete a health risk appraisal and develop a care plan with their physicians within 90 days. Members are scored on: alcohol use, blood pressure, blood sugar, cholesterol, smoking status and weight. Members scoring 80 or above are able to remain in the enhanced level.[27] Members who have health conditions or unhealthy behaviors can remain in the enhanced plan so long as they follow the care plan they developed with their physician and work towards a healthier lifestyle.[28]

- **Provide covered employees and their dependents with support to help them self-manage their chronic conditions.**

Many companies are offering "health coaches" to help employees manage chronic illnesses. According to recent survey by the National Business Group on Health and Watson Wyatt 54% of the largest US firms will offer health coaching to their employees by the end of 2007. [29]

Provide Support to Help Employees and Their Dependents Self-Manage Their Chronic Conditions
United Parcel Service (UPS) contracts with nurses who call employees with chronic conditions and offer health advice on how they can manage their conditions. This advice can range from sending helpful brochures, to interpreting test results, to finding a doctor when necessary.[30]

Purchasers can and frequently do purchase health insurance plans that offer enrollees support in the self-management of their chronic illnesses.

[27] "New Blue Care Network Product Can Reduce Health Care Costs for Employers and their Employees by Rewarding Healthy Lifestyles" Blue Cross Blue Shield of Michigan press release, July 10, 2006.
[28] *AIS Health Product News*, July 17, 2006, http://www.aishealth.com/ManagedCare/ListProduct.html, accessed 1-7-2007.
[29] Kritz F. "Talk about follow-up healthcare: employers and insurance firms are providing 'health coaches' to help workers manage and prevent illnesses" *Los Angeles Times*, November 20, 2006.
[30] Ibid.

- **Design benefits that reduce or eliminate financial barriers to essential treatments**

Pitney Bowes, Marriott and the University of Michigan have all created "value-based plan designs" that increase compliance with clinical guidelines and prescribed treatments through reduction or elimination of financial barriers for essential pharmaceuticals. Reworking the typical "tiered" structure that places only generic drugs on the lowest copay tier, these organizations have added brand drugs that are essential to the treatment of diabetes and cardiovascular conditions.[31]

[31] For more information on the concept of value-based plan design, see "Promoting Consumerism Through Responsible Health Care Benefit Design" by the National Business Coalition on Health, November 2006 (http://nbch.org/resources/policypapers/health_benefit_design.pdf), or "Value-Based Insurance Design" by Chernew ME et. al. in *Health Affairs*, published online January 30, 2007, at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.2.w195.

V. Appendices

Appendix A
Executive Order 13410 and
How it is Being Implemented by Federal Agencies

Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs

By the authority vested in me as President by the Constitution and the laws of the United States, and in order to promote federally led efforts to implement more transparent and high-quality health care, it is hereby ordered as follows:

Section 1. Purpose. It is the purpose of this order to ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers. It is the further purpose of this order to make relevant information available to these beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector. Consistent with the purpose of improving the quality and efficiency of health care, the actions and steps taken by Federal Government agencies should not incur additional costs for the Federal Government.

Sec. 2. Definitions. For purposes of this order:
(a) "Agency" means an agency of the Federal Government that administers or sponsors a Federal health care program.
(b) "Federal health care program" means the Federal Employees Health Benefit Program, the Medicare program, programs operated directly by the Indian Health Service, the TRICARE program for the Department of Defense and other uniformed services, and the health care program operated by the Department of Veterans Affairs. For purposes of this order, "Federal health care program" does not include State operated or funded federally subsidized programs such as Medicaid, the State Children's Health Insurance Program, or services provided to Department of Veterans' Affairs beneficiaries under 38 U.S.C. 1703.
(c) "Interoperability" means the ability to communicate and exchange data accurately, effectively, securely, and consistently with different information technology systems, software applications, and networks in various settings, and exchange data such that clinical or operational purpose and meaning of the data are preserved and unaltered.
(d) "Recognized interoperability standards" means interoperability standards recognized by the Secretary of Health and Human Services (the "Secretary"), in accordance with guidance developed by the Secretary, as existing on the date of the implementation, acquisition, or upgrade of health information technology systems under subsections (1) or (2) of section 3(a) of this order.

Sec. 3. Directives for Agencies. Agencies shall perform the following functions:
(a) Health Information Technology.
(1) For Federal Agencies. As each agency implements, acquires, or upgrades health information technology systems used for the direct exchange of health information between agencies and with non-Federal entities, it shall utilize, where available, health information technology systems and products that meet recognized interoperability standards.

(2) For Contracting Purposes. Each agency shall require in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall utilize, where available, health information technology systems and products that meet recognized interoperability standards.
(b) Transparency of Quality Measurements.
(1) In General. Each agency shall implement programs measuring the quality of services supplied by health care providers to the beneficiaries or enrollees of a Federal health care program. Such programs shall be based upon standards established by multi-stakeholder entities identified by the Secretary or by another agency subject to this order. Each agency shall develop its quality measurements in collaboration with similar initiatives in the private and non-Federal public sectors.

(2) Facilitation. An agency satisfies the requirements of this subsection if it participates in the aggregation of claims and other appropriate data for the purposes of quality measurement. Such aggregation shall be based upon standards established by multi-stakeholder entities identified by the Secretary or by another agency subject to this order.
(c) Transparency of Pricing Information. Each agency shall make available (or provide for the availability) to the beneficiaries or enrollees of a Federal health care program (and, at the option of the agency, to the public) the prices that it, its health insurance issuers, or its health insurance plans pay for procedures to providers in the health care program with which the agency, issuer, or plan contracts. Each agency shall also, in collaboration with multi-stakeholder groups such as those described in subsection (b)(1), participate in the development of information regarding the overall costs of services for common episodes of care and the treatment of common chronic diseases.
(d) Promoting Quality and Efficiency of Care. Each agency shall develop and identify, for beneficiaries, enrollees, and providers, approaches that encourage and facilitate the provision and receipt of high-quality and efficient health care. Such approaches may include pay-for-performance models of reimbursement consistent with current law. An agency will satisfy the requirements of this subsection if it makes available to beneficiaries or enrollees consumer-directed health care insurance products.

Sec. 4. Implementation Date. Agencies shall comply with the requirements of this order by January 1, 2007.

Sec. 5. Administration and Judicial Review.
(a) This order does not assume or rely upon additional Federal resources or spending to promote quality and efficient health care. Further, the actions directed by this order shall be carried out subject to the availability of appropriations and to the maximum extent permitted by law.
(b) This order shall be implemented in new contracts or new contract cycles as they may be renewed from time to time. Renegotiation outside of the normal contract cycle processes should be avoided.
(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

GEORGE W. BUSH
THE WHITE HOUSE
August 22, 2006.

How the Executive Order is Being Implemented by Federal Agencies (as of 1-26-07)

The Executive Order directs, to the extent permitted by law, healthcare programs administered or sponsored by the Federal government to promote quality and efficient delivery of health care through the use of interoperable health information technology, transparency regarding healthcare quality and

price, and better incentives for program beneficiaries, enrollees, and providers. This includes actions taken by CMS, and other Federal health benefits programs, such as Federal Employees Health Benefit Program (FEHBP) and TRICARE. For example, the Office of Personnel Management (OPM) which administers FEHBP is working with its carriers to provide quality and price information to enrollees and to ensure that FEHBP enrollees are able to access innovative health insurance options. The Federal government anticipates that the full implementation and use of all the measures and standards will be phased in over time. As all purchasers begin to align expectations, these efforts should expand and move more quickly.

Each agency that administers such a program is directed to utilize, where available, health information technology systems and products that meet recognized interoperability standards and to require such use in contracts or agreements with health insurance plans, third party administrators, providers, and others with which they contract. The Federal government is expanding its efforts to make available relevant quality and price information using national consensus measures as a foundation for beneficiaries, providers, and our own insureds in a useable manner and to work in collaboration with broad-based national public-private initiatives in the private sector and non-Federal public sector. To promote higher quality and efficiency of care, CMS is making available Medicare Savings Accounts (MSAs) and has initiated an MSA demonstration project for Medicare beneficiaries and is also exploring pay-for-performance and other value-based purchasing options for hospitals and other settings of care.

CMS reports publicly on consensus quality measures for hospitals, nursing homes, dialysis facilities, home health agencies, and Medicare Advantage plans. CMS also provides confidential quality performance reports to physicians voluntarily participating in the Physician Voluntary Reporting Program (PVRP). With regard to price information, CMS is also reporting publicly on Medicare payments to hospitals and ambulatory surgery centers, and outpatient and physician fee schedule payments. In addition, CMS has provided an unprecedented amount of information for Medicare beneficiaries to use to make decisions on prescription drug plans.

The Federal government also has initiated a Federal Health IT Interoperability scorecard to track and promote interoperability of Health IT and promulgate health data interoperability standards in the Federal government as required by the President's August 22, 2006 Executive Order, 'Promoting Quality and Efficient Care in Federal Government Administered or Sponsored Health Care Programs.' The scorecard will be used both as an accountability tool and also to promote health interoperability, standards adoption and health transparency. It is anticipated that this information will be made available to the public.

Appendix B
Ways to Volunteer with CCHIT[32]

The U.S. Department of Health and Human Services (HHS) has designated the Certification Commission for Healthcare Information Technology (CCHIT℠) as a Recognized Certification Body (RCB). The CCHIT was founded in 2004 with support from three leading industry associations in healthcare information management and technology – The American Health Information Management Association (AHIMA), the Healthcare Information and Management Systems Society (HIMSS) and The National Alliance for Health Information Technology (Alliance). In September 2005, CCHIT was awarded a contract by the U.S. Department of Health and Human Services to develop, create prototypes for, and evaluate the certification criteria and inspection process for electronic health records (EHRs) and the networks through which they interoperate. More information on CCHIT is available at www.cchit.org.

I. Commissioners on the Certification Commission for Healthcare Information Technology (CCHIT℠)

CCHIT is governed by a 19-member Board of Commissioners from academic, private sector and governmental agencies. The Commission oversees the work of CCHIT's professional staff and voluntary work groups. The roles of the Commissioners are to represent all stakeholders, provide strategic direction, ensure objectivity and credibility, provide guidance to and review the reports of the work groups, and approve the final certification criteria and processes.

The Commission is made up of at least two representatives each from the provider, payer, and vendor stakeholder groups, and at least one from seven other stakeholder groups, including safety net providers, health care consumers, public health agencies, quality improvement organizations, clinical researchers, standards development and informatics experts and government agencies. The Commissioners serve staggered two-year terms. Nominations open in the summer; they are submitted to the Commission by a joint Nominating Committee made up of internal and external members appointed by the Commission.

II. Certification Commission for Healthcare Information Technology (CCHIT) Work Groups

The products of the Commission are created by its five volunteer Work Groups, each with two co-chairs from different stakeholder groups and twelve to fourteen members representing the diversity of stakeholders.

CCHIT Work Group members are selected by the Commission for their individual expertise. (Public calls for Work Group volunteers occur annually.) The Work Groups focus on developing criteria – including health information technology product functionality, interoperability and security – and an inspection process by which products can be judged to be certified.

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[32] Information obtained from www.cchit.org, accessed January 8, 2007.

Current CCHIT Work Groups:

- Ambulatory Functionality Work Group
- Inpatient Functionality Work Group
- Interoperability Work Group
- Security Work Group
- Commercial Certification Process Work Group

III. Jurors for the Certification Commission for Healthcare Information Technology

CCHIT's inspection process is a rigorous test of electronic health record (EHR) products using two methods: jury-observed demonstration and inspection of self-attestation materials.

To complete this testing, CCHIT empanels a team of three clinical jurors, one of whom must be a practicing physician, and an IT security evaluator to assess a product's conformance to the CCHIT certification criteria. The inspection occurs by observing the performance of the applicant's product in executing a series of test scripts and reviewing required materials supplied by the applicant.

The jurors are selected by the Commission from those applying as individuals or as sponsored representatives of an organization. Juror performance will be monitored by CCHIT for consistency, reliability, and lack of bias. You may apply to become a juror.

May 2006 Juror Appointments:

- Physician Jurors
- Provider Jurors
- Security Inspectors

IV. Submit a Public Comment to the Certification Commission for Healthcare Information Technology

Each phase of CCHIT development – ambulatory electronic health records (EHR), inpatient EHR and networks – includes at least two cycles of public comment during development plus one cycle after the pilot test. In addition, the continuous maintenance program for each of these domains will likely result in additional public comment periods to solicit response to changes in the initial program. Announcements for these public comment periods are made via press release, Web site posting and CCHIT eNews.

Appendix C
Regional Health Information Organizations (RHIOs) and Others Focusing Upon Data Exchange and Interoperability

Name	Location	Web Site or Phone Number
Alaska Native Tribal Health Consortium (ANTHC)	Alaska Anchorage	www.anthc.org
Arizona Health Care Cost Containment System (AHCCCS)	Arizona Phoenix	www.ahcccs.state.az.us
Arizona Health-e Connection	Arizona Phoenix	www.azgita.gov
Southern Arizona Health Information Exchange	Arizona Tucson	www.pcap.cc
CalRHIO	California San Francisco	www.calrhio.org
Community Chronic Care Network of Santa Cruz County	California Santa Cruz	www.chroniccarenetwork.org
Inland Empire Regional Health Information Organization Task Force	California Palm Desert	(760) 200-4856 or (760) 674-8806
Long Beach Network for Health	California City of Industry	www.lbnh.org.telusys.net
Mendocino Health Records Exchange	California Mendocino	www.mendocinohre.org
Colorado Regional Health Information Organization	Colorado	www.corhio.org
Waterbury Health Access Program	Connecticut Waterbury	www.waterburyhealth.org
Delaware Health Information Network	Delaware Dover	www.dhin.org
Brevard County Health Information Alliance	Florida	http://ahca.myflorida.com/
Big Bend Regional Health Care Organization	Florida Tallahassee	www.bbrhio.com
Central Florida RHIO	Florida Orlando	http://www.flhcc.com/rhio.cfm
Florida Health Information Network	Florida Tallahassee	http://ahca.myflorida.com/dhit/index.shtml
Heart of Florida RHIO	Florida Ocala	
Tampa Bay RHIO	Florida Tampa Bay	www.tampabay.org
Illinois Health Network	Illinois Springfield	www.illinoishealthnetwork.org
Northern Illinois Physicians for Connectivity	Illinois Glen Ellyn	www.niphysiciansforconnectivity.org
Indiana Health Information Exchange	Indiana Indianapolis	www.ihie.com
Michiana Health Information Network	Indiana South Bend	www.mhin.com
Kansas Health Information Technology/Health Information Exchange	Kansas Topeka	www.governor.ks.gov

Name	Location	Web Site or Phone Number
Kentucky eHealth Network	Kentucky Louisville	http://ehealth.ky.gov
Louisiana Health Information Exchange	Louisiana Baton Rouge	
Maine Health Information Center	Maine Manchester	www.mhic.org
Massachusetts eHealth Collaborative	Massachusetts Waltham	www.maehc.org
Massachusetts Health Data Consortium, Inc. (MA-SHARE is the RHIO)	Massachusetts Waltham	www.mahealthdata.org/ma-share/
Maryland/DC Collaborative for Health Information Exchange	Maryland Annapolis	www.collaborativeforhit.org
Capital Area Regional Health Information Organization	Michigan Okemos	
Michigan Health Information Network	Michigan Lansing	www.mihin.org
Upper Peninsula Health Care Network	Michigan L'Anse	www.uphcn.org
Community Health Information Collaborative	Minnesota Duluth	www.medinfosystems.org
Minnesota eHealth Initiative	Minnesota St. Paul	www.health.state.mn.us/e-health/
KC Carelink	Missouri Kansas City	www.kccarelink.org
Missouri Healthcare Information Technology Task Force	Missouri	www.dhss.mo.gov/HealthInfoTaskForce/
St. Louis Integrated Health Network	Missouri St. Louis	www.stlouisihn.org/index.php
Montana HIT Task Force	Montana Helena	
New Mexico Health Information Collaborative (NMHIC).	New Mexico Albuquerque	www.nmrhio.org
Health Information Exchange New York (HIXNY)	New York Albany	www.hixny.org
Bronx Regional Health Information Organization (BxRHIO)	New York Bronx	
Maimonides, Kingsbrook Jewish, Lutheran, VNSNY, Metropolitan Jewish	New York Brooklyn	
New York Clinical Information Exchange (NYCIX)	New York New York	
New York City Department of Health and Mental Hygiene /Community Health Exchange Project (CHEX)	New York New York	
Greater Rochester Regional Healthcare Information Organization (gRrhio)	New York Pittsford	
Taconic Health Information Network and Community (THINC)	New York Fishkill	www.taconicipa.com
North Carolina Healthcare Information & Communications Alliance, Inc. (NCHICA)	North Carolina Research Triangle Park	www.nchica.org
HealthBridge	Ohio Cincinnati	www.healthbridge.org

Name	Location	Web Site or Phone Number
Central Oregon RHIO	Oregon Bend	
Coos Bay RHIO	Oregon Coos Bay	
Lincoln City RHIO	Oregon Lincoln City	
Oregon Community Health Information Network	Oregon Portland	www.community-health.org
Roseburg RHIO	Oregon Roseburg	
Pittsburgh Regional Healthcare Initiative (PRHI)	Pennsylvania Pittsburgh	www.prhi.org
Pennsylvania eHealth Initiative	Pennsylvania Harrisburg	www.paehi.org
Rhode Island Quality Institute	Rhode Island Providence	www.riqi.org
CareSpark	Tennessee Kingsport	www.carespark.com
Innovation Valley Health Information Network	Tennessee Knoxville	www.ivhin.org
MidSouth eHealth Alliance	Tennessee Nashville	www.midsoutheha.org
Tennessee eHealth Initiative	Tennessee Nashville	
Vanderbilt Center for Better Health	Tennessee Nashville	www.volunteer-ehealth.org
Texas Health Information Technology Advisory Committee	Texas Dallas	www.dshs.state.tx.us/chs/shcc/hitac/hitac_default.shtm
Utah Health Information Network	Utah Murray	www.uhin.com
Vermont Information Technology Leaders	Vermont Montpelier	www.vitl.net
Virginia Statewide eHealth Initiative	Virginia Richmond	
Inland Northwest Health Services (INHS)	Washington Spokane	www.inhs.org
Washington State Health Care Authority	Washington Olympia	www.hca.wa.gov/hit/
Whatcom Health Information Network	Washington Whatcom	www.hinet.org
West Virginia eHealth Initiative	West Virginia	www.wvehi.org
Wisconsin Health Information Exchange	Wisconsin Milwaukee	www.whie.imedi.org
Wyoming Health Information Organization	Wyoming Casper	www.wyominghealthcarecommission.org

Appendix D

Template Request for Information: Version 1.0

The use of a common set of RFI/RFP (request for information/proposal) questions can help promote value-driven health care by assessing the degree to which health plans operate in a manner consistent with the principles of value-driven health care outlined in the Executive Order 13410. The following sample may be used as a guide by purchasers to inform their discussion with plans. This RFI tool:

- Supports the four cornerstones of the Executive Order 13410: (1) interoperable health information technology, (2) standardized and transparent quality measures, (3) transparent pricing information, and (4) incentives for high quality and efficient health care.
- Consists of questions compiled from a variety of sources, some of which are used to assess health plans today.
- Reinforces the use of standardized measures that have been adopted through broad-based national consensus processes, such as those in use by AQA and HQA. These efforts facilitate valid comparisons and consistent provider efforts to promote value, while at the same time reducing administrative burden for providers and plans that result from the use of inconsistent and non-validated measures.
- Identifies the type of quality and cost or price information that enrollees, especially those in consumer-directed health plans can use to make more informed healthcare decisions (see section on promoting quality and efficiency of care on page 10).

Note to purchasers:

- The Federal government is also currently analyzing this sample RFI to determine how to incorporate metrics from this tool into Federal health programs.
- Employers should not regard this survey as a specific Federal requirement or endorsement of a particular contracting approach with providers and plans.
- Some of the following information and metrics are more readily available than others and may be more easily gathered and reported over time.

HEALTH INFORMATION TECHNOLOGY

1. Describe the Plan's use of HIPAA-compliant or standardized data formats and the subsequent integration of those data. Check all that apply.

	Plan encourages use of standard	**Percent of transactions standard for which used**	**Data exchanged electronically under a different standard (describe):**	**Data integrated with other data sets for clinical quality measurement and improvement**	**Not applicable**
Accept claims/encounter data (ANSI ASC X12 837)					
Accept pharmacy data from PBM, pharmacy or other claims processors (NCPDP)					
Transmit pharmacy data to providers or disease management vendors (NCPDP)					
Accept 270 and 271 eligibility transactions					
Others as recommended by AHIC and recognized by the Secretary of HHS (as standards are available/recognized, add rows.)					

2. Indicate HIT applications or tools used by the Plan for the purposes of improving quality and engaging consumers. Indicate the approximate percentage of enrollees who either directly or through their clinician have access to the listed functionality.

Application	Percent of enrollees	Planned for future	Not available from plan
Electronic tools to support clinical decision-making			
Electronic means of identifying, tracking and monitoring patients with specific chronic conditions			
Integration of external pharmacy data			
Integration of external lab data			
Integration of external radiology data			
Integration of external hospital data			
Plan-specific formulary			
Pharmaceutical cost calculator specific to member's plan design			
Member personal health record			
Portable personal health record			
Secure online provider appointment scheduling			
Secure online prescription fills (mail-order)			
Other online provider communication			
Online non-urgent medical consultations			

3. What forms of financial, in-kind, or other incentives does the Plan provide to practitioners to promote the use of the following standards-based, interoperable IT tools for improving the quality and outcomes of patient care? Check all that apply.

	Financial reward (e.g., P4P)	Technical or workflow support	Member steerage	Other incentives not listed	Incentives not used
Electronic tools to support clinical decision-making at the point of care (a list of sample applications can be found at www.informatics-review.com)					
Electronic means of identifying, tracking and monitoring patients with specific chronic conditions					
Electronic prescribing applications					
Electronic health or medical records					
Online ordering and receipt of lab test results (indicate whether one or both)					
Online ordering and receipt of radiology results (indicate whether one or both)					
Integration of clinical electronic data from external sources					
Electronic communication with patients					
Other (describe):					

4. Recognizing that CCHIT began certifying ambulatory EHR systems in the summer of 2006 and is planning on developing an inpatient EHR certification program by Summer 2007, please indicate the ways in which the Plan encourages the use of CCHIT certified electronic health records by your providers. For more information the CCHIT website is www.cchit.org. If other certifying bodies are recognized by the Secretary for the functionality of EHRs, that certification process could be included here as well. Check all that apply. Add choices as more EHR functionality certification programs become available.

   - ☐ The Plan has distributed information to our providers regarding CCHIT and the benefits of certified EHR systems.
   - ☐ The Plan publicly recognizes providers with CCHIT certified EHRs with an icon in the Plan's provider directory or by some other similar means.
   - ☐ The Plan's pay-for-performance program rewards providers with CCHIT certified EHRs that are used to improve the quality and outcomes of patient care.
   - ☐ Other (describe) ___________________________________
   - ☐ The Plan does not specifically endorse or promote CCHIT certified EHRs.

5. Identify currently functioning community collaborative activities. If an initiative is implemented, indicate the start-up date ("go-live" date) marking the beginning of data transfer. If an initiative is in the planning stages, provide planned implementation date. Types of collaborative activities may include: (1) health information networks whereby authorized stakeholders have access to clinical data across settings, excluding data repositories or batched data exchanges, (2) clinical data repositories with member-specific information (possibly de-identified) to be used for provider performance reporting or access-protected reference by clinicians, (3) inter-plan data for eligibility management by providers, employers and/or plans, or (4) any other type of collaborative.

List types of collaborative activities	**Participating organizations and plans**	**Implementation date**	**No collaboration**

TRANSPARENCY OF QUALITY MEASUREMENTS

1. Indicate if quality performance is assessed and used for individual physicians/practice sites or medical group/IPAs for the following AQA measures. Additional information is available at www.aqaalliance.org, www.ncqa.org, or www.physicianconsortium.org. The measures listed below are the first 26 approved in the AQA starter set. The AQA continues to approve additional measures in other clinical areas. In some cases information will not be available through currently collected claims for some of these measures, but will need to be collected through surveys, flow sheets, chart review or CPT II or G-codes (See footnote +). The ability to collect information on these measures may vary by plan type.

	Individual physician/ practice site	**Medical group/IPA**	**Used for provider feedback & benchmarking**	**Used for payment rewards**	**Used for consumer reporting**	**Not tracked**
Prevention						
Breast Cancer Screening*						
Colorectal Cancer Screening*						
Cervical Cancer Screening*						
Tobacco Use# +						
Advising Smokers to Quit*+						
Influenza Vaccination*+						
Pneumonia Vaccination*+						
Coronary Artery Disease (CAD)						
Drug Therapy for Lowering LDL Cholesterol#						
Beta-Blocker Treatment after Heart Attack*						
Beta-Blocker Therapy—Post MI*						
Heart Failure						
ACE Inhibitor/ARB Therapy#+						
LVF Assessment#+						
Diabetes						
HbA1C Management*						
HbA1C Management Control*+						
Blood Pressure Management#+						
Lipid Measurement*						
LDL Cholesterol Level (<130mg/dL)*+						
Eye Exam*						
Asthma						
Use of Appropriate Medications for People w/ Asthma*						
Asthma: Pharmacologic Therapy#						
Depression						
Antidepressant Medication Management*						
Antidepressant Medication Management*						
Prenatal Care						
Screening for Human Immunodeficiency Virus#+						
Anti-D Immune Globulin#+						
Quality Measures Addressing Overuse or Misuse						
Appropriate Treatment for Children with Upper Respiratory Infection (URI)*						
Appropriate Testing for Children with Pharyngitis*						
Other AQA Measures as Approved						

* This performance measure was developed and is owned by the National Committee for Quality Assurance ("NCQA").
# This performance measure was developed and is owned by the AMA-convened Physician Consortium for Performance Improvement (the Consortium). All of the Consortium measures in this AQA starter set have published CPT-II codes for use.
+ This performance measure requires data not available through current claims data and will require other methods of data collection mentioned above.

2. Additional measures in areas not addressed by AQA. Indicate if quality performance is assessed and if the information is used for individual physicians/practice sites or medical group/IPAs for any of the following purposes. Check all that apply.

	Individual physician/ practice Site	**Medical group/IPA**	**Used for provider feedback & benchmarking**	**Used for payment rewards**	**Used for consumer reporting**	**Not tracked**
NCQA Recognition programs						
Non-AQA clinical quality measures in areas not included in AQA (NCQA, NQF or the AMA Consortium on Performance Improvement)						
Patient experience survey data (e.g., A-CAHPS)						
Disciplinary actions and malpractice history (with verification and explanations to help consumers interpret and use the information)						
Mortality or complication rates where applicable						

3. Identify community collaborative activities with local health plans on implementation of the following physician performance-related activities. Collaboration with a parent or owner organization or with one of the Plan's vendors would not apply. Participants should be named for each. Check all that apply.

Use questions 1 and 2 above to describe the corresponding measures	**Pooling data for physician feedback & benchmarking**	**Pooling data for consumer reporting**	**Pooling data for payment rewards**	**Other collaborative not involving data pooling**	**Participating organizations (for each initiative)**	**No collaborative activities In this area**

4. Indicate if quality performance is assessed for hospitals using any of the following HQA (Hospital Quality Alliance) measures. Scores based on all-payer data for most hospitals on many of these measures can be viewed at www.hospitalcompare.hhs.gov. Additional information on the measures is available at www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalOverviewOfSpecs200512.pdf. Check all that apply.

	Individual hospital site	**Used for provider feedback & benchmarking**	**Used for payment rewards**	**Used for consumer reporting**	**Not tracked**
Acute Myocardial Infarction (AMI)					
Aspirin at arrival					
Aspirin prescribed at discharge					
ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction					
Beta blocker at arrival					
Beta blocker prescribed at discharge					
Thrombolytic agent received within 30 minutes of hospital arrival					
Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival					
Adult smoking cessation advice/counseling					
30-day mortality					

Heart Failure (HF)					
Left ventricular function assessment					
ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction					
Discharge instructions					
Adult smoking cessation advice/counseling					
30-day mortality					
Pneumonia (PNE)					
Initial antibiotic received within 4 hours of hospital arrival					
Oxygenation assessment					
Pneumococcal vaccination status					
Blood culture performed before first antibiotic received in hospital					
Adult smoking cessation advice/counseling					
Appropriate initial antibiotic selection					
Influenza vaccination					
30-day mortality (subject to NQF-endorsement)					
Surgical Infection Prevention (SIP)					
Prophylactic antibiotic received within 1 hour prior to surgical incision					
Prophylactic antibiotics discontinued within 24 hours after surgery end time					
Prophylactic antibiotic selection for surgical patients					
Recommended venous thromboembolism prophylaxis ordered for surgery patients					
Recommended venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery					
Patient Experience					
H-CAHPS					
Other HQA Measures as Approved					

5. Additional indicators in areas not addressed by HQA. Indicate if quality performance is assessed for hospitals in any of the following areas. For more information see www.leapfroggroup.org, www.qualityindicators.ahrq.gov/, or www.qualityforum.org.

	Individual hospital site	Used for provider feedback & benchmarking	Used for payment rewards	Used for consumer reporting	Not tracked
Other quality measures endorsed by the National Quality Forum					
Leapfrog, NQF-endorsed indicators					
Adoption of CPOE					
Management of Patients in ICU					
Evidence-Based Hospital Referral indicators					
Adoption of Safe Practices					
AHRQ[33]					
Inpatient Quality Indicators					
Patient Safety Indicators					
Pediatric Indicators					

[33] AHRQ's quality indicators were sent to the National Quality Forum in September 2006 to be put through the Forum's consensus development process.

6. Identify community collaborative activities with local health plans on implementation of the following hospital performance-related activities. If the State provides hospital reports, that source may be claimed as collaboration only if all of the collaborating plans: 1) have agreed on a common approach to the use of State data by selecting which indicators to use (all or a specific subset), 2) use the State indicators/data for incentives and/or reporting, and if used for reporting, 3) have at least a hyperlink to the State's public reports. Check all that apply.

Use questions 4 and 5 above to describe the measures used in the collaborative	**Pooling data for hospital feedback & benchmarking**	**Pooling data for hospital payment rewards**	**Pooling data for consumer reporting**	**Other collaborative not involving pooling data**	**Participating organizations (for each initiative)**	**No collaborative activities**

TRANSPARENCY OF PRICE INFORMATION

The price information reported here is intended to assist consumers in making healthcare decisions. None of these metrics are directed at reporting to consumers the underlying cost structure of providers. Multiple approaches are being tested in the marketplace with regard to price transparency and health plans are still evaluating what strategies will be successful in engaging consumers. To achieve greater uniformity, plans are encouraged to work with broad-based national consensus processes to identify high priority areas and useful price or cost measures. Plans should work towards reporting price or cost information along with quality information.

1. Describe activities to identify those providers (hospitals and/or physicians) that are more efficient and/or low cost.

2. Describe the web-based cost estimation tools that the plan makes available for physician and professional services. Plans are not expected to engage in all the activities described below. Further, plans should only be expected to provide this type of information to their own enrollees. Check all that apply.

   - ☐ Procedure search with average cost per service
   - ☐ Procedure search with regional (MSA, county or 3-digit zip code) cost per service
   - ☐ Procedure search with provider-specific cost per service (e.g., FFS rate or other bundled payment)
   - ☐ Condition-specific search with average cost per service
   - ☐ Condition-specific search with regional (MSA, county or 3-digit zip code) cost per service
   - ☐ Condition-specific or episode-based cost search for provider-specific services
   - ☐ Procedure is searchable by service description
   - ☐ Condition is searchable by general diagnostic category
   - ☐ Alternative treatment comparisons (e.g., surgical vs. non-surgical intervention)
   - ☐ Costs reflect amount charged by providers only
   - ☐ Costs reflect paid amount from average market index or external database source
   - ☐ Costs are tailored to member's benefit design and out-of-pocket coverage (co-payment or coinsurance, in-network or preferred provider cost differential)
   - ☐ Out-of-pocket costs are tailored to member's claims history and benefit coverage (e.g., deductible met or OOP max)
   - ☐ Other (describe):
   - ☐ Web-based cost estimation not available for physician services.

3. Describe the web-based cost estimation tools that the plan makes available for hospital services. Plans are not expected to engage in all the activities described below. Further, plans should only be expected to provide this type of information to their own enrollees. Check all that apply.

   - ☐ Procedure search with average cost per service (e.g., average payment assuming average LOS)
   - ☐ Procedure search with regional (MSA, county or 3-digit zip code) cost per service
   - ☐ Procedure search with provider-specific cost per service (e.g., contracted per diem or DRG payment)
   - ☐ Condition-specific search with average cost per service
   - ☐ Condition-specific search with regional (MSA, county or 3-digit zip code) cost per service
   - ☐ Condition-specific or episode-based cost search for provider-specific services
   - ☐ Procedure is searchable by service description
   - ☐ Condition is searchable by general diagnostic category
   - ☐ Alternative site of service (e.g., inpatient vs. ambulatory surgery center)
   - ☐ Costs reflect amount charged by providers only

- ☐ Costs reflect paid amount from average market index or external database source
- ☐ Costs are tailored to member's benefit design and out-of-pocket coverage (co-payment or coinsurance, in-network or preferred provider cost differential)
- ☐ Out-of-pocket costs are tailored to member's claims history and benefit coverage (e.g., deductible met or OOP max)
- ☐ Other (describe):
- ☐ Web-based cost estimation not available for hospital services

4. Identify pharmacy information available to enrollees via the Web. Plans are not expected to engage in all the activities described below. Check all that apply.

- ☐ Member formulary (specific to member's plan design)
- ☐ Formulary search by brand drug name or generic equivalents
- ☐ Alternative drugs/clinical comparisons
- ☐ Generic equivalent for branded products
- ☐ Drug's primary labeled purpose
- ☐ Drug cost management mechanisms/rationale (e.g. therapeutic equivalence or generic substitutes)
- ☐ Drug savings (e.g. cost calculator to determine member cost savings of generic vs. brand product)
- ☐ Drug savings sensitive to member benefit design (e.g. cost calculator to determine member cost savings of generic vs. brand product)
- ☐ Information regarding preferential reimbursement for using certain pharmacies
- ☐ Pill splitting options and associated cost savings opportunities
- ☐ Other (describe):
- ☐ Web-based pharmaceutical information not available

PROMOTING QUALITY AND EFFICIENCY OF CARE

The following section includes questions on two types of incentives—consumer-directed health plans and incentives for providers to improve the value of care. When answering questions numbered three and four, plans should refer to the quality and price metrics described in the previous sections.

1. Describe the types of consumer-directed health plan products you offer.
   a. Types
      - o High-deductible, no HSA
      - o High deductible, with HSA
      - o Health reimbursement account
      - o Other (please describe)
   b. Product design for account-based programs.
      - o Work with a single bank
      - o Provide smart card technology
      - o Other (please describe)

2. Describe other plan strategies for including incentives in current or planned products for consumers to purchase health care based on value.

3. Indicate the measures used for incentive programs for doctors. Examples of benefit design include tiered or narrow networks, as well as differential coinsurance, deductible or maximum out-of-pocket levels that steers patients to higher performing providers; public reporting may include identification in a provider choice tool or consumer guide. Check all that apply, along with the measures used from lists in previous sections.

Use the questions in the previous sections to describe the quality or price/cost measures	**Periodic "bonus"**	**Higher fees or capitation**	**Benefit design or high performance network**	**Public reporting or consumer information**	**Other (describe)**	**Incentives not Used**

4. Indicate the measures used in determining incentives for hospitals. Examples of benefit designs include tiered or narrow networks, as well as differential coinsurance amounts, deductibles or maximum out-of-pocket levels that steer patients to higher performing providers. Public reporting may include identification in a provider choice tool or consumer guide. Check all that apply, along with the measures used from above lists.

Use the questions in previous sections to describe the corresponding quality or price/cost measures	**Periodic "bonus"**	**Higher fees or capitation**	**Benefit design, Centers of Excellence or high performance networks**	**Public reporting or consumer information**	**Other (describe)**	**Incentives not Used**

Appendix E
National and Regional Transparency Collaboratives and Coalitions

National Collaboratives and Coalitions

Name	Location	Scope	Web Site
Bridges to Excellence	District of Columbia Washington	Bridges to Excellence (BTE) is a multi-state, multi-employer coalition developed by employers, physicians, healthcare services researchers and other industry experts. The BTE mission is to reward quality across the health care system. BTE is a not-for-profit organization created to encourage significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient and patient-centered care.	www.bridgestoexcellence.org
The Leapfrog Group	District of Columbia Washington	The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care.	www.leapfroggroup.org

National Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
National Business Group on Health	District of Columbia Washington	The National Business Group on Health, formerly the Washington Business Group on Health, representing over 200 large employers, health care companies, benefits consultants and vendors, is devoted exclusively to finding innovative and forward-thinking solutions to the nation's most important health care and related benefits issues. The Business Group also supports its members in the areas of disability, health/productivity, related paid time off and work/life balance issues.	www.businessgrouphealth.org
National Health Information Network (NHIN)	District of Columbia Washington	This collaborative is developing prototypes for a Nationwide Health Information Network architecture. It is sponsored by the U.S. Department of Health and Human Services, Office of the National Coordinator Health Information Technology (ONC).	www.hhs.gov/healthit/onc/contactus
Better Quality Information for Medicare Beneficiaries (BQI)	Maryland Baltimore	This effort is aggregating Medicare, private insurer, and in some cases, Medicaid and provider claims data. The initiative is currently being implemented in six regional communities with 1. Minnesota Community Measurement 2. Wisconsin Collaborative for Healthcare Quality 3. Indiana Health Information Exchange 4. Massachusetts Health Quality Partners 5. Phoenix Regional Healthcare 6. California Cooperative Healthcare Reporting Initiative The initiative is sponsored by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).	www.hhs.gov/transparency To become involved in this effort, purchasers should contact one of the six regional organizations through the web sites cited in the regional organization section of this appendix.

Regional Collaboratives and Coalitions

The following listing of regional collaboratives and coalitions will be updated periodically to identify which of the following organizations have been recognized by the Secretary as a "Community Leader." Community Leaders are multi-participant organizations whose efforts to advance the four cornerstones of value-driven health care in their communities have been recognized by the Secretary. Additional information about Community Leaders and a fuller list of criteria are posted on the HHS transparency website at www.hhs.gov/transparency.

Name	Location	Scope	Web Site or Phone Number
Employers Coalition for Healthcare Options	Alabama Huntsville	The Employers Coalition for Healthcare Options collaborates to ensure that accessible and valuable healthcare is available to Alabama companies, their employees and families. ECHOAL is a Leapfrog Regional Rollout sponsor.	www.echoal.com
Phoenix Healthcare Value Measurement Initiative	Arizona Phoenix	The Phoenix Healthcare Value Measurement Initiative collaborates to improve community health, build an IT infrastructure, ensure access to data, report value data, and promote beneficiary involvement.	www.slhi.org/ahf_projects/phvmi/over_descr.shtml
Southwest Health Alliance	Arizona Scottsdale	The Southwest Health Alliance is an independent, non-profit alliance of public and private sector employers located in the Southwest region of the U.S. who share a commitment to promote quality, cost-effective health care for its members.	www.swhealthalliance.org
Employers' Health Coalition	Arkansas Fort Smith	The Employer's Health Coalition works to aid our membership in the purchasing of quality health care services. EHCARK participates in Bridges to Excellence.	www.ehcark.org
California Cooperative Healthcare Reporting Initiative	California San Francisco	The California Cooperative Healthcare Reporting Initiative works to collect and report performance data, promote comparable quality measures, and create efficient data collection to reduce burden and cost.	www.cchri.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Pacific Business Group on Health	California San Francisco	The Pacific Business Group on Health (PBGH), a business coalition of 50 purchasers, seeks to improve the quality and availability of health care while moderating cost. PBGH is a Leapfrog Regional Rollout sponsor and participates in eValue8. HEALTHSCOPE is an independent public information source provided by PBGH to help consumers select the best quality health plans, hospitals, doctors, and medical groups.	www.pbgh.org www.healthscope.org
Colorado Business Group on Health	Colorado Denver	The Colorado Business Group on Health is a non-profit coalition representing large purchasers of one of your most important benefits – health care services. By working together, we can assure that consumers have the best possible information on health care quality. CBGH is a Leapfrog Regional Rollout sponsor and participates in eValue8 and Bridges to Excellence.	www.cbghealth.org
Florida Health Care Coalition	Florida Orlando	The Florida Health Care Coalition leads the push for quality health care in Florida. Comprised of employers and providers, it is an active promoter of clinical quality, and addresses those issues that result in actionable projects that will have a direct impact on the health care of consumers in Florida. FLHCC is a Leapfrog Regional Rollout sponsor and participates in eValue8.	www.flhcc.com
Employers Health Coalition	Florida Tampa	The Employers Health Coalition was created to improve methods and economies-of-scale in the procurement of health care benefits and related professional services.	www.ehcaccess.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Savannah Business Group on Health	Georgia Savannah	**The Savannah Business Group is a non-profit business coalition that group purchases health care services for self-funded employers. SBGH is a Leapfrog Regional Rollout sponsor and participates in Bridges to Excellence.**	www.savannahbusinessgroup.com
Hawaii Business Health Council	Hawaii Honolulu	**The Hawaii Business Health Council is working to measurably improving the quality of health care for Hawaii. HBHC participates in eValue8.**	www.hbhc.biz
Midwest Business Group on Health	Illinois Chicago	**MBGH is Chicago-based, non-profit coalition for large Midwest employers, offering educational and networking activities, group purchasing and community quality initiatives in Chicago and across the Midwest. MBGH is a Leapfrog Regional Rollout sponsor and participates in eValue8.**	www.mbgh.org
Heartland Healthcare Coalition	Illinois Morton	**The Heartland Healthcare Coalition is a non-profit association of employers committed to working together to promote quality and cost-effectiveness in the allocation, management and use of health care resources available in its members' communities.**	www.hhco.org
Tri-State Health Care Coalition	Illinois Quincy	The Tri-State Health Care Coalition supports and implements activities to develop and promote the availability of high quality health care for its membership. Through data analysis, education, group purchasing and quality improvement, purchasers, providers and users work together to achieve an efficient, effective, accessible regional health care system.	www.tri-statehealthcare.com

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Employer's Coalition on Health	Illinois Rockford	Headquartered in Rockford, Ill., the Employers' Coalition on Heath (ECOH) is a non-profit organization focused on continuously improving the value of healthcare and administrative services to member companies, employees and their families.	www.ecoh.com
Indiana Health Information Exchange	Indiana Indianapolis	The Indiana Health Information Exchange is a collaboration aimed at improving the quality of health care and creating a common, secure, electronic infrastructure to expand information sharing.	www.ihie.com
Tri-State Business Group on Health	Indiana Evansville (Bordering Kentucky)	TSBGH is a non-profit, member-driven association created to influence health care cost-effectiveness and quality through member education and by leveraging the collective strength of the employer members. TSBGH is a Leapfrog Regional Rollout sponsor.	www.tsbgh.evansville.net
Indiana Employers Quality Health Alliance	Indiana Indianapolis	The Indiana Employers Quality Health Alliance is an employer-driven membership organization committed to creating a quality focused Central Indiana health care system which will provide nationally competitive quality care, cost efficiency and customer service through partner health care providers. IEQHA is a Leapfrog Regional Rollout sponsor and participates in eValue8.	www.qualityhealthalliance.org
Four Rivers Health Care Purchasing Alliance, Inc.	Kentucky Calvert City	Four Rivers Health Care Purchasing Alliance works to purchase better and smarter quality health care through value purchasing and customer satisfaction.	www.fourrivershc.com

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Louisiana Business Group on Health	Louisiana Baton Rouge	The Louisiana Business Group on Health (LBGH) and the Louisiana Health Care Alliance (LHCA) represent a collaborative effort of health care purchasers, payers and providers seeking real solutions to concerns about health care in Louisiana.	www.lbgh.org
Maine Health Management Coalition	Maine Portland	MHMC is a group of Maine employers, doctors, health plans and hospitals working together to improve the safety and quality of healthcare in Maine. MHMC is a Leapfrog Regional Rollout sponsor.	www.mhmc.info
MidAtlantic Business Group on Health	Maryland Greenbelt	The MidAtlantic Business Group on Health is an association of major purchasers with a mission to share and analyze data; foster research, education and coordination among the members, promote solutions to health services issues, provide a cooperative, objective forum, that promotes the delivery of affordable, high quality, and accessible health care, and represent the voice of purchasers. MABGH participates in eValue8.	www.mabgh.org
Massachusetts Health Quality Partners	Massachusetts Boston	The Massachusetts Health Quality Partners is a broad-based health care coalition to promote valid, comparable measures to drive quality improvement.	www.mhqp.org/default.asp?nav=010000
Michigan Purchasers Health Alliance	Michigan Ann Arbor	The Michigan Purchasers Health Alliance is a regional not-for-profit tax-exempt membership organization dedicated to value-based purchasing for its members. Through the collective action of private and public purchasers, MICHPHA seeks to accelerate progress toward safe, efficient, high quality, transparent and consumer-centered health care in the region. MICHPHA participates in eValue8.	www.michpha.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
REAL Health Association	Michigan Grand Rapids	The REAL Health Association is a West Michigan, non-profit, membership organization of local employers dedicated to improving the cost and quality of health care in their communities. REAL Health provides its members a forum for collective action in working with health care organizations, physicians and purchasers.	www.realhealth.org
AFL-CIO Employer Purchasing Coalition	Michigan Bloomfield	The AFL-CIO Employer Purchasing Coalition of Detroit represents 70 Taft-Hartley funds, mostly from unions in the building trades, but also includes a public employee trust fund. AEPC participates in eValue8.	(248) 792-2187
Greater Detroit Area Health Council	Michigan Detroit	The Greater Detroit Area Health Council (GDAHC) is a multi-stakeholder regional coalition. Through innovative programming and activities, GDAHC advocates and leads change and improvement in the way health services are delivered, paid for and used within the seven counties of southeast Michigan. GDAHC participates in eValue8. The Greater Detroit Area Health Council has been recognized by the Secretary as a Community Leader.	www.gdahc.org
Alliance for Health	Michigan Grand Rapids	The Alliance for Health is a broad-based community coalition dedicated to the encouragement of optimal health for all residents through high quality health care services at the lowest cost. AFH participates in eValue8.	www.afh.org
Southwest Michigan Healthcare Coalition	Michigan Kalamazoo		(616) 342-5525

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site
Michigan Health and Safety Coalition	Michigan Southfield	The Michigan Health and Safety Coalition (MH&SC) is a collaborative effort to help improve health care quality in Michigan through cost-effective improvements in patient safety, including medical errors, across all health care settings.	www.mihealthandsafety.org
Minnesota Community Measurement	Minnesota Minneapolis	The Minnesota Community Measurement collaborative seeks to: improve care and support the quality initiatives; reduce reporting expenses; and communicate findings in a fair, usable and reliable way.	www.mnhealthcare.org/~main.cfm
Buyers Health Care Action Group	Minnesota Minneapolis	BHCAG is a coalition of employers dedicated to recreating the heath care market so people get the care they need at the right time, in the right place, and at the right price. BHCAG is a Leapfrog Regional Rollout sponsor and participates in eValue8 and Bridges to Excellence.	www.bhcag.com
Upper Midwest Labor Management Health Care Coalition	Minnesota Minneapolis	The Labor/Management Health Care Coalition, Upper Midwest is a non-profit 503c(6) organization that was founded to provide labor and management organization members and other participating member organizations in MN, WI, ND and SD with better healthcare through our innovative "centers of excellence" and other value purchasing program options.	www.labormanagementcoalition.org
Southeast Missouri Business Group on Health	Missouri Cape Girardeau		(573) 651-4688
Missouri Consolidated Health Care Plan	Missouri Jefferson City	The Missouri Consolidated Health Care Plan works to provide access to quality and affordable health insurance to state and local government employees.	www.mchcp.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Mid-America Coalition on Health Care	Missouri Kansas City	The Mid-America Coalition on Health Care seeks to: improve the health of employees and their families; promote employee and community wellness and illness prevention; develop strategies and initiatives for containing business health care costs, and generate and communicate health care information to the community.	www.machc.org
St. Louis Area Business Health Coalition	Missouri St. Louis	The SLABHC is a non-profit organization whose mission is to support employers in their efforts to enhance the quality and overall value of their investments in health benefits while seeking to improve the health of their enrollees. SLBHC is a Leapfrog Regional Rollout sponsor.	(314) 721-7800
Montana Association of Health Care Purchasers	Montana Missoula	The Montana Association of Health Care Purchasers is a nonprofit association that was formed in 1994 by several of the largest employers in Montana to pool their purchasing power to encourage competition and quality improvement among health care providers in Montana.	www.mahcp.info
Health Services Coalition	Nevada Las Vegas		(702) 892-7342
Nevada Health Care Coalition	Nevada Reno	The Nevada Health Care Coalition is a partnership between public and private sectors formed for the primary purpose of improving the total community's understanding and acceptance of cost-effective delivery and utilization of medical services through educational programs and seminars. NHCC is a Leapfrog Regional Rollout sponsor.	www.nhccreno.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Health Care Payers Coalition of New Jersey	New Jersey Edison	The Health Care Payers Coalition of New Jersey collaborates to ensure that quality, accountability and costs are closely linked in the delivery of health care services in New Jersey.	www.hcpc.org
New Jersey Health Care Quality Institute	New Jersey Trenton	NJHCQI is a non-profit foundation whose purpose is to undertake projects that will ensure that quality, accountability and cost containment are all closely linked to the delivery of health care services in New Jersey. NJHCQI is a Leapfrog Regional Rollout sponsor.	www.njhcqi.org
Niagara Health Quality Coalition	New York Buffalo	The Niagara Health Quality Coalition works to improve quality through cooperation. NHCQI is a Leapfrog Regional Rollout sponsor.	www.nhqc.com
New York Business Group on Health	New York New York	NYBGH is a not-for-profit coalition of 150 businesses that provides leadership and knowledge to employers to promote a value-based, market-driven healthcare system. NYBGH is a Leapfrog Regional Rollout sponsor and participates in eValue8.	www.nybgh.org
Western North Carolina Health Coalition	North Carolina Ashville	WNCHC is a Leapfrog Regional Rollout sponsor.	http://www.wnchc.com/
Piedmont Health Coalition, Inc.	North Carolina Burlington	Piedmont Health Coalition was created to: enhance the existing health delivery system; educate members; develop relationships; negotiate and develop competitive prices; evaluate the overall health of the community, and exchange.	www.piedmonthealthcoalition.org
North Carolina Business Group on Health	North Carolina Raleigh	The North Carolina Business Group on Health is an employer healthcare coalition that provides a forum for employers and providers to work together to improve the quality and reduce the costs of medical care delivered to our employees and their dependents.	(919) 264-4348

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Employers Health Purchasing Corporation of Ohio	Ohio Canton	EHCO focuses on community-wide health improvement projects and education and encourages quality improvement in the medical practice through the implementation of healthcare technology and evidence-based medicine. EHPCO participates in Bridges to Excellence.	www.ehpco.com
Employer Health Care Alliance	Ohio Cincinnati	It is EHCA's goal to positively impact health care not only for the Tristate's employer base, but for the general community as well.	www.cintiehca.com
Health Action Council of Northeast Ohio	Ohio Cleveland	The Health Action Council of Northeast Ohio is a non-profit group led by purchasers that offer health benefits to employees, dependents and retirees. They provide value to their members by working together, and with community stakeholders (physicians, hospitals and health plans), to improve the quality and moderate the cost of health care. HAC is a Leapfrog Regional Rollout sponsor and participates in eValue8. The Health Action Council of Northeast Ohio has been recognized by the Secretary as a Community Leader.	www.healthactioncouncil.org
Franklin County Cooperative Health Benefits Program	Ohio Columbus		(614) 462-5274
Tri-River Employers Healthcare Coalition	Ohio Dayton	The Tri-River Employers Healthcare Coalition is a non-profit Ohio corporation dedicated to improving healthcare value in the Miami Valley. It strives to achieve high quality, affordable healthcare for all residents of the region.	www.tri-river.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
FrontPath Health Coalition	Ohio Maumee	FrontPath Health Coalition is a not-for-profit corporation dedicated to supporting employers, unions, municipalities and public entities throughout the Western Lake Erie region. FrontPath collaborates with health care providers to help improve the quality of healthcare delivered in each community while ensuring it is delivered at an affordable price.	www.frontpathcoalition.com
Oregon Coalition of Health Care Purchasers	Oregon Portland	The Oregon Coalition of Health Care Purchasers (OCHCP) is a non-profit organization of private and public purchasers of group health care benefits collaborating to improve purchasers' ability to contract for high quality and cost-effective health care for their employees or members through support, education, tools, shared initiatives, and advocacy. OCHCP is a Leapfrog Regional Rollout sponsor and participates in eValue8.	www.ochcp.org
Pittsburgh Business Group on Health	Pennsylvania Ambridge	Pittsburgh Business Group on Health (PBGH) is a non-profit organization and business-only coalition that strives to improve the delivery, cost and quality of health care.	www.pbghpa.com
Hanover Area Health Care Alliance, Inc.	Pennsylvania Hanover		(717) 239-6954
Employer Care	Pennsylvania Lancaster		(717) 581-8382
Lancaster County Business Group on Health (LCBGH)	Pennsylvania Lancaster	LCBGH is an independent entity that encourages a responsible partnership between employers and employees to maximize the health benefit. We promote a collaborative dialogue among all key stakeholders – business, healthcare providers and insurers – to keep healthcare affordable.	www.lcbgh.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Northeast Pennsylvania Regional Healthcare Coalition, Inc.	Pennsylvania Orwigsburg	The Northeast Pennsylvania Regional Health Care Coalition, Inc. is a non-profit organization of employers. The Coalition's sole focus is employee health benefits, and its' function is to serve as a vehicle for employers to work together to manage health benefit costs.	www.nprhcc.com
South Carolina Business Coalition on Health	South Carolina	SCBCH is a Leapfrog Regional Rollout sponsor and participates in eValue8.	(864) 238-0554
HealthCare 21 Business Coalition	Tennessee Knoxville	HealthCare 21 Business Coalition is a non-profit, member driven organization committed to improving the quality and cost of healthcare in Tennessee and the surrounding region. HC21 is a Leapfrog Regional Rollout sponsor and participates in eValue8.	www.hc21.org
Memphis Business Group on Health	Tennessee Memphis	**The Memphis Business Group on Health is committed to facilitate the purchase of efficient and effective health care services for the Memphis community. MBGH is a Leapfrog Regional Rollout sponsor and participates in eValue8.**	www.memphisbusinessgroup.org
Dallas-Fort Worth Business Group on Health	Texas Dallas	**The DFWBGH is a coalition of Dallas and Fort Worth area employers committed to working with its partners in the community to promote and maintain a health care delivery system that provides quality, accountability and affordability for their employees DFWBGH is a Leapfrog Regional Rollout sponsor.**	www.dfwbgh.org
Texas Business Group on Health	Texas Dallas	**The Texas Business Group on Health (TBGH) is a regional, employer-sponsored healthcare coalition that brings together leaders and decision makers from a variety of businesses.**	www.tbgh.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Virginia Business Coalition on Health	Virginia Virginia Beach	**The Virginia Business Coalition on Health, formerly the Hampton Roads Health Coalition has a mission is to be the convener & collective resource for Virginia employers on issues relating to health care cost and quality (patient safety), productivity & wellness. VBCH is a Leapfrog Regional Rollout sponsor and participates in eValue8.**	www.myVBCH.org
Puget Sound Health Alliance	Washington Seattle	The Puget Sound Health Alliance is a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care cost increases across King, Kitsap, Pierce, Snohomish and Thurston Counties. The Puget Sound Health Alliance has been recognized by the Secretary as a Community Leader.	www.pugetsoundhealthalliance.org
Fond Du Lac Area Businesses on Health	Wisconsin Fond Du Lac	The purpose of FABOH is to help the employer community improve the cost effectiveness and quality of health care services.	www.faboh.com
Business Health Care Group of Southeast Wisconsin	Wisconsin Franklin	The Business Health Care Group (BHCG) is the business community's voice and collective action group for influencing the direction of health care costs and quality in its region.	www.bhcgsw.org
Employers Health Cooperative	Wisconsin Janesville	It is EHC's mission to build partnerships between providers, consumers and our employer members as purchasers of care to promote high quality, affordable health care for our region.	www.ehchealth.com
Wisconsin Collaborative for Healthcare Quality	Wisconsin Madison	The Wisconsin Collaborative for Healthcare Quality is working to develop verifiable measures for public reporting.	www.wisconsinhealthreports.org

Regional Collaboratives and Coalitions

Name	Location	Scope	Web Site or Phone Number
Wisconsin Healthcare Purchasers for Quality (Alliance)	Wisconsin Madison	The Alliance is a non-profit cooperative that helps companies manage the total cost of ensuring the health and well being of their workforce. The Alliance is a Leapfrog Regional Rollout sponsor.	www.alliancehealthcoop.com
Greater Milwaukee Business Foundation on Health, Inc.	Wisconsin Sussex	The Greater Milwaukee Business Foundation on Health's focus is to undertake studies, programs and activities which promote the general health of the persons residing in the greater Milwaukee area and advance their awareness of health and health care delivery issues affecting them.	www.gmbfh.org

Appendix F
National and Regional Collaboratives to Develop Strategies to Measure the Cost of Services

Name	Scope	Contact
AQA Efficiency Measurement (national)	The AQA, a national multi-stakeholder group focused on physician quality measures is developing efficiency measures for physician services. In October 2006 the AQA published a proposed "starter" set of conditions and procedures for cost of care measures related to specific conditions or procedures. This document can be obtained at: http://www.aqaalliance.org/files/CandidateListofConditionsforCostofCareMeasurementApproved.doc	Susan Pisano America's Health Insurance Plans 202-778-3245 www.aqaalliance.org
HQA Efficiency Measurement (national)	The HQA is the Hospital Quality Alliance, a national multi-stakeholder group focused on hospital quality measures. The HQA is currently developing efficiency measures or hospitals.	Purchasers may become involved in the HQA's activities through The Consumer Purchaser Disclosure Project. Katherine Browne kbrowne@nationalpartnership.org. 202-986-2600 www.healthcaredisclosure.org

Name	Scope	Contact
Measuring Provider Efficiency (national)	The Leapfrog Group and Bridges to Excellence sponsored a multi-stakeholder effort to determine how best to measure provider efficiency. The resulting report (Measuring Provider Efficiency Version 1.0) was published 12-31-04 and can be obtained at: www.bridgestoexcellence.org/bte/pdf/Measuring_Provider_Efficiency_Version1_12-31-20041.pdf	Barbara Rudolph, Ph.D. The Leapfrog Group brudolph@leapfroggroup.org 202-292-6713 www.leapfroggroup.org
NCQA MD Benchmarking Project	The Commonwealth Fund is supporting the National Committee on Quality Assurance (NCQA) in its efforts to develop benchmarks of physician performance using available electronic (administrative) data. NCQA is working with advisors from 11 regional initiatives and the leading software vendors to reach agreement on attribution of responsibility for cost of care to individual physicians.	Sarah Hudson-Scholle, M.D. NCQA 202-955-3500 www.ncqa.org
PBGH-CalPERS Hospital Value Initiative (California)	The Pacific Business Group on Health (PBGH), a business coalition of 50 purchasers, and CalPERS, the purchasing agency for state and local employees and retirees, have co-sponsored this initiative to advance improvements in hospital care and foster transparency in hospital costs.	Anne Castles Pacific Business Group on Health acastles@pbgh.org 626-564-0757 www.pbgh.org
Wisconsin Collaborative for Healthcare Quality (Wisconsin)	The Collaborative is a consortium of organizations learning and working to improve quality and cost-effectiveness of care in Wisconsin and in so doing has been developing measures of value that are inclusive of hospital quality and cost.	Chris Queram WI Collaborative for Healthcare Quality cqueram@wchq.org 608-250-1505 www.wchq.org

Appendix G
Sample Letters To Insurers

Letter For Those Purchasers Using The Template Rfi Or Evalue8
(Letter can be adapted for use with TPAs or other contractors)

Purchaser's Letterhead

Date

Purchaser's Health Plan
123 Plan Blvd.
Ourtown, CA 00000

Dear Plan Senior Manager:

As a large purchaser of health care benefits, we understand the importance of our working in partnership with you to take concrete steps to improve quality and reduce health care costs. We have decided to support the four Cornerstones of Value-driven Health Care as articulated recently by U.S. Department of Health and Human Services Secretary Michael Leavitt:

- Interoperable Health Information Technology;
- Transparency of Quality;
- Transparency of Price, and
- Incentives for High-Value Health Care.

A key step in promoting these principles is to provide each of our health plan vendors with concrete feedback as to where they need to improve their programs to fully address each principle. Based on our review of [insert name of plan's] responses to [insert either our recent RFI or eValue8], we have identified some important opportunities for [insert name of plan] to enhance its efforts. Outlined below are [insert name of your organization's] program expectations for [insert name of plan]:

[Include all specific programs listed below that are appropriate.]

1. Interoperable Health Information Technology
    a. Monitor and participate in the activities of the Certification Commission for Healthcare Information Technology (CCHIT℠) and the American Health Information Community (AHIC).
    b. Encourage ambulatory care providers to use electronic health records (EHRs) that have been certified by CCHIT and that meet national interoperability standards as they are developed.

c. Participate in and support community and state efforts to create regional health information exchanges and organizations.

2. Transparency of Quality
   a. Use and publicly report on your website or another equally accessible forum measures of provider quality adopted by the AQA or the Hospital Quality Alliance (HQA). If you are measuring quality in areas not addressed by these two organizations, use and publicly report measures endorsed by the National Quality Forum (NQF) or approved by another national collaborative that includes broad representation of providers and other key stakeholders.
   b. Identify a senior quality leader to participate in the activities of AQA, HQA, NQF or another national quality measurement collaborative.
   c. Identify a senior quality leader to participate in regional and national public-private collaboratives that are 1) addressing the development and use of uniform standards for measuring or reporting quality and cost/price information, and 2) promoting provider performance transparency.
   d. Become a member of the NQF.

3. Transparency of Price
   a. Make cost or price information available via your website in conjunction with quality information, to the maximum extent possible.
   b. Identify a senior leader to join broad-based public-private collaborative efforts to develop strategies to measure the overall cost of services for common episodes of care and the treatment of common diseases.
   c. As they develop, use the standard approaches to measuring and reporting cost or price information.
   d. Identify a senior leader to participate in collaborations to establish and support uniform standards for measuring or reporting quality and cost or price information.

4. Incentives for High-Value Health Care

   Work with us to develop one or more of the following:
   a. High performance network strategies that encourage beneficiaries to use providers with the highest quality and the lowest cost. Such strategies may include use of tiered network PPOs or narrow or high performance network HMOs, and provision of other enrollee incentives, such as waived deductibles, to select high value providers, including centers of excellence;
   b. A program to provide direct financial incentives and/or public recognition to superior performing providers;
   c. A consumer-directed health plan with a Health Savings Account (HSA) or Health Reimbursement Account (HRA);
   d. Provider incentives to adopt electronic health records and health information exchange, and

e. Enrollee incentives to promote health and wellness and to manage chronic illness, including 1) incentives to make timely use of evidence-based prevention services and to live healthy lives, 2) support for covered employees and their dependents to help them self-manage their chronic conditions; and design benefits, and 3) benefit designs that reduce or eliminate financial barriers to essential treatments, such as placing essential brand drugs for which there is no generic alternative on tier 1 with the same co-payments as generic drugs.

It is [insert the name of your organization]'s expectation that you will take all necessary actions to align your operations with the Cornerstones. Please send me a response describing what specific steps you and your organization will be taking to make the necessary changes, and a timeline for implementing these changes. Please let me know if you will need more than four weeks from the date of this letter to provide me with this response.

We at [insert the name of your organization] are committed to continuing efforts to pursue value-driven health care to control health care costs and improve quality. We are looking forward to working closely with you to move this agenda forward.

Very truly yours,

Vice President of Human Resources
Name of Purchaser

Letter for those Purchasers *Not* Using the Template RFI or eValue8

(Letter can be adapted for use with TPAs or other contractors)

Purchaser's Letterhead

Date

Purchaser's Health Plan
123 Plan Blvd.
Ourtown, CA 00000

Dear Plan Senior Manager:

As a large purchaser of health care benefits, we understand the importance of our working in partnership with you to take concrete steps to improve quality and reduce health care costs. We have decided to support the four Cornerstones of Value-driven Health Care as articulated recently by U.S. Department of Health and Human Services Secretary Michael Leavitt:

- Interoperable Health Information Technology;
- Transparency of Quality;
- Transparency of Price, and
- Incentives for High-Value Health Care.

A key step in promoting these principles is to provide each of our health plan vendors with concrete information as to where they need to improve their programs to fully address each principle. Outlined below are [insert name of your organization's] program expectations for [insert name of plan]:

1. Interoperable Health Information Technology
    a. Monitor and participate in the activities of the Certification Commission for Healthcare Information Technology (CCHIT℠) and the American Health Information Community (AHIC).
    b. Encourage ambulatory care providers to use electronic health records (EHRs) that have been certified by CCHIT and that meet national interoperability standards as they are developed.
    c. Participate in and support community and state efforts to create regional health information exchanges and organizations.

2. Transparency of Quality
    a. Use and publicly report on your website or another equally accessible forum measures of provider quality adopted by the AQA or the Hospital Quality Alliance (HQA). If you are measuring quality in areas not

addressed by these two organizations, use and publicly report measures endorsed by the National Quality Forum (NQF) or approved by another national collaborative that includes broad representation of providers and other key stakeholders.

b. Identify a senior quality leader to participate in the activities of AQA, HQA, NQF or another national quality measurement collaborative.
c. Identify a senior quality leader to participate in regional and national public-private collaboratives that are 1) addressing the development and use of uniform standards for measuring or reporting quality and cost/price information, and 2) promoting provider performance transparency.
d. Become a member of the NQF.

3. Transparency of Price
    a. Make cost or price information available via your website in conjunction with quality information to the maximum extent possible.
    b. Identify a senior leader to join broad-based public-private collaborative efforts to develop strategies to measure the overall cost of services for common episodes of care and the treatment of common diseases.
    c. As they develop, use the standard approaches to measuring and reporting cost or price information.
    d. Identify a senior leader to participate in collaborations to establish and support uniform standards for measuring or reporting quality and cost or price information.

4. Incentives for High-Value Health Care

    Work with us to develop one or more of the following:

    a. High performance network strategies that encourage beneficiaries to use providers with the highest quality and the lowest cost. Such strategies may include use of tiered network PPOs or narrow or high performance network HMOs, and provision of other enrollee incentives, such as waived deductibles, to select high value providers, including centers of excellence;
    b. A program to provide direct financial incentives and/or public recognition to superior performing providers;
    f. A consumer-directed health plan with a Health Savings Account (HSA) or Health Reimbursement Account (HRA);
    c. Provider incentives to adopt electronic health records and health information exchange, and
    d. Enrollee incentives to promote health and wellness and to manage chronic illness, including 1) incentives to make timely use of evidence-based prevention services and to live healthy lives, 2) support for covered employees and their dependents to help them self-manage their chronic conditions; and design benefits, and 3) benefit designs that reduce or eliminate financial barriers to essential treatments, such as placing essential brand drugs for which there is no generic alternative on tier 1 with the same co-payments as generic drugs.

It is [insert the name of your organization]'s expectation that you will take all necessary actions to align your operations with the Cornerstones. To further this process, please send me an assessment of how closely your organization's operations are comporting with the Cornerstones. Please include in your response a description of what specific steps you and your organization will be taking to make the necessary changes, and a timeline for implementing these changes. Please let me know if you will need more than four weeks from the date of this letter to provide me with the requested information.

We at [insert the name of your organization] are committed to continuing efforts to pursue value-driven health care to control health care costs and improve quality. We are looking forward to working closely with you to move this agenda forward.

Very truly yours,

Vice President of Human Resources
Name of Purchaser

Appendix H
Sample Insurer and Other Contractor Contract Language

Health Information Technology

The health plan agrees to use best efforts to promote the use of interoperable health information technology as follows:

1. Monitor and participate in the activities of the Certification Commission for Healthcare Information Technology (CCHIT℠) and the American Health Information Community (AHIC).
2. Encourage ambulatory care providers to use electronic health records (EHRs) that have been certified by CCHIT and that meet national interoperability standards as they are developed.
3. Participate in and support community and state efforts to create regional health information exchanges and organizations.

Transparency of Quality

The health plan agrees to use best efforts to promote transparency of quality information as follows:

1. Use and publicly report on its website or another equally accessible forum measures of provider quality adopted by the AQA or the Hospital Quality Alliance (HQA). If the health plan is measuring quality in areas not addressed by these two organizations, use and publicly report measures endorsed by the National Quality Forum (NQF) or approved by another national collaborative that includes broad representation of providers and other key stakeholders.
2. Identify a senior quality leader to participate in the activities of AQA, HQA, NQF or another national quality measurement collaborative.
3. Identify a senior quality leader to participate in regional and national public-private collaboratives that are a) addressing the development and use of uniform standards for measuring or reporting quality and cost/price information, and b) promoting provider performance transparency.
4. Become a member of the NQF.

Transparency of Price

The health plan agrees to use best efforts to promote transparency of price information as follows:

1. Make cost or price information available via the health plan's website or equally accessible forum inform in conjunction with quality information.
2. Identify a senior leader to join broad-based public-private collaborative efforts to develop strategies to measure the overall cost of services for common episodes of care and the treatment of common diseases.
3. As they develop, use the standard approaches to measuring and reporting cost or price information.

4. Identify a senior leader to participate in collaborations to establish and support uniform standards for measuring or reporting quality and cost or price information.

Incentives for High-value Health Care

The health plan agrees to use best efforts to promote high-value health care by developing one or more of the following:

1. High performance network strategies that encourage beneficiaries to use providers with the highest quality and the lowest cost. Such strategies may include use of tiered network PPOs or narrow or high performance network HMOs, and provision of other enrollee incentives, such as waived deductibles, to select high value providers, including centers of excellence;
2. A program to provide direct financial incentives and/or public recognition to superior performing providers;
3. A consumer-directed health plan with a Health Savings Account (HSA) or Health Reimbursement Account (HRA);
4. Provider incentives to adopt electronic health records and health information exchange, and
5. Enrollee incentives to promote health and wellness and to manage chronic illness, including 1) incentives to make timely use of evidence-based prevention services and to live healthy lives, 2) support for covered employees and their dependents to help them self-manage their chronic conditions; and design benefits, and 3) benefit designs that reduce or eliminate financial barriers to essential treatments, such as placing essential brand drugs for which there is no generic alternative on tier 1 with the same co-payments as generic drugs.