

Value-driven Health Care Frequently Asked Questions

1. *What is the intent of the President's Executive Order 13410: "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Healthcare Programs?"*

There is overwhelming evidence that the quality and affordability of health care in America can be dramatically improved. The Executive Order is intended to ensure that healthcare programs administered or sponsored by the Federal government build on collaborative efforts to promote quality and efficient delivery of health care through the use of interoperable information technology (IT), transparency of quality information, transparency of cost or price information, and better incentives for all key stakeholders. This includes healthcare providers, consumers, payers, and purchasers.

2. *Why is the Secretary promoting a public-private collaborative effort to advance health information technology, transparency, and increased incentives for performance measurement and consumer engagement?*

Efforts to improve healthcare quality and efficiency will be most effective if public and private purchasers send consistent messages to the market. Further, the market will benefit substantially if public and private sector purchasers actively collaborate to establish and support uniform standards for health IT interoperability and measuring and reporting quality and cost or price information. Considerable efforts to develop more extensive, uniform standards are already underway and need to be reinforced. This information is necessary for employees to make effective decisions about their own health care, particularly those enrolled in consumer-directed health plans, and to work towards improved consumer literacy for better care.

3. *Where should we return the Statement of Support for the Four Cornerstones of Value-driven Health Care?*

Interested organizations may choose one of two methods for declaring support:

- Online submission is available at www.hhs.gov/transparency/employers, or
- Signed statements may be returned via mail or fax to:

Department of Health and Human Services
Value-driven Health Care
200 Independence Avenue, SW
Room 738G
Washington, D.C. 20201
Fax: (202) 205-7897

4. *Is the Statement of Support for the Four Cornerstones of Value-driven Health Care a binding legal commitment?*

This commitment is not a legally binding commitment, nor do the goals or support for the goals represent legal requirements. Rather, by committing to support implementation of these objectives, employers and other purchasers are indicating their intent to make a good faith effort to use their purchasing power to advance interoperable health IT, quality and cost or price transparency, and incentives for providers and consumers, such as pay-for-performance and consumer-directed health plans, as set forth in the Executive Order. The extent to which an employer obligates its contracted health insurance plans to implement these goals is a matter for each employer to determine.

5. *What is the potential cost or benefit to my organization if we commit to support the Four Cornerstones of Value-driven Health Care?*

Your potential costs will be determined by how you decide to use your purchasing power to advance the goals of the Executive Order. There could be short term administrative or implementation costs related to health insurance plans' efforts to achieve these goals. Any potential costs could be minimized if you or the health insurance plans with which you contract have similar initiatives already underway. However, these costs should be modest compared to the potential efficiency gains. Promoting interoperable health IT adoption, quality and cost or price transparency, and increased incentives for employees to consider the value of their healthcare choices could reduce administrative costs in the short term and improve care delivery, saving significant resources over the longer term for you and your employees.

6. *What are we committing to regarding the advancement of health IT interoperability standards?*

Significant progress has already been made in working with industry experts to develop healthcare terminology and messaging standards which allow for greater interoperability. Employers are encouraged to request that the health insurance plans, third party administrators, providers, and others with which they contract adopt those standards to promote the more efficient and accurate flow of information among insurers and healthcare providers.

7. *What are we committing to regarding the selection and use of standardized quality measures for providers?*

Significant progress has already been made in collaborative efforts to develop consistent, valid, and reliable measures of the quality of health care. Employers are encouraged to request that the health insurance plans, third party administrators, providers, and others with which they contract adopt these consistent measures and promote the further development of such measures.

At the present time, the measures most fully developed are those endorsed by the National Quality Forum (NQF) and adopted by the AQA (a multi-stakeholder group focused on physician quality measures) or the Hospital Quality Alliance (HQA). For the benefit of their employees, employers are encouraged to request that the health insurance plans, third party administrators, providers, and others with which they contract use and report standard performance measures for quality that are adopted by the AQA or the HQA. To the extent employers wish to measure the quality of care in additional areas not addressed by these sets of measures, they are encouraged to use measures endorsed by the NQF or approved by other national collaborations that include broad representation of providers and other key healthcare stakeholders. The current process, whereby the private and public sectors rely on the NQF to endorse measures and broad-based stakeholder groups to determine which ones to adopt, has helped to unify efforts to measure physician and hospital quality.

Providers take a leadership role in all of these organizations and are integrally involved with the development of measures. The hospital measures are the result of years of research, the experience of CMS' hospital quality improvement program, and extensive input from hospitals. The physician AQA measures come from primarily two sources, the National Committee for Quality Assurance (NCQA) and the AMA-convened Physician Consortium for Performance Improvement. The Consortium is comprised of over 100 national medical specialty and state medical societies and expects to have a portfolio of 150 physician performance measures this Fall.

Creating a uniform, consistent approach, including the use of common metrics, for quality measurement will align the interests of employers, health insurance plans, providers, and consumers to make informed decisions. Employers and plans will have the information necessary to provide higher value to their employees and enrollees. Provider efforts to improve quality will be more effectively focused, and they will have confidence in the measures used. And consumers will be able to make quality comparisons across providers and treatment options in order to make more informed decisions.

8. *What are we committing to related to price disclosure?*

For the benefit of their employees, employers are encouraged to request that the health insurance plans, third party administrators, providers, and others with which they contract make available to enrollees in the health plans they sponsor the cost or price of their care. As consensus develops through broad-based national collaborations on approaches for measuring and reporting cost or price information for the benefit of consumers, employers are encouraged to adopt these approaches and to request that those with which they contract do the same. Employers are encouraged to work to assure that cost or price information is made available with quality information. Employers also are encouraged to request that those with which they contract 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 chronic diseases.

9. *What are we committing to related to incentives for providers? How would proposed standardization affect existing pay-for-performance programs?*

There are a variety of ways that employers can introduce pay-for-performance or other incentives. They can partner with health insurance plans to adopt high performance network strategies that encourage beneficiaries to use the providers with the highest quality and lowest cost. Employers can also partner with health insurance plans to provide direct financial incentives and/or public recognition to providers who demonstrate superior performance. It is also important that employers support the programs the health insurance plans they contract with develop. There are also ways to design pay-for-performance programs to encourage the adoption of electronic health records and health information exchange to better coordinate patient care and automate quality measurement and reporting.

10. *What are we committing to related to incentives for consumers?*

Employers are encouraged to develop consumer incentives that encourage and facilitate high-quality and cost-effective health care. One important step may be for an employer to provide the option of a consumer-directed health plan with a health savings account to their employees. This type of plan, which is growing rapidly in availability, creates demand for transparent quality and cost or price information. Employers are also encouraged to use other strategies such as prevention and wellness programs and care for the chronically-ill.

11. *Can a company adopt some of the goals but not all of them?*

Employers are encouraged to develop a strategy that aggressively moves toward advancing all key goals in the Executive Order, but may need to implement the strategy over time. For example, employers may promote interoperable health IT standards and adoption without immediately introducing transparency or pay-for-performance. Conversely, they may request that health insurance plans or provider networks report consensus provider performance measures without immediately linking financial incentives to the measures. Employers may also provide the option of a consumer-directed health plan to their employees and educational tools to encourage their employees to make informed healthcare choices. The more aggressively employers support health IT, transparency, and incentives for employees and providers, the sooner the market will begin to respond and deliver higher quality care more efficiently. Overall, these goals support the broader efforts of employers to provide high-quality and cost-effective health care.

12. *How will this effort interact with other collaborations and initiatives (e.g., Leapfrog, Bridges to Excellence) in which my company is participating?*

There is great value in strongly supporting the efforts of AQA and HQA to standardize uniform methods for quality measurement, reflecting broad-based consensus of key hospital and physician organizations. Consistent, valid measures of

quality and cost or price are essential to the success of this initiative. However, these measures do not yet include all aspects of health quality and cost or price. Other leading efforts, including Leapfrog and Bridges to Excellence (BTE), advance transparency, pay-for-performance and other incentives for health insurance plans, providers, and enrollees. Further, Leapfrog and BTE measures are often NQF-endorsed, and support the principles of value-driven health care. Consequently, employers are encouraged to adopt AQA and HQA measures where available, and to support broad-based national collaborations to create additional measures in areas not addressed by these measure sets.

13. Do regional public-private collaboratives play a role in this initiative? Are employers required to participate?

Regional public-private collaboration is essential to the success of this initiative. At its core, health care is local. It is provided in a diverse range of environments that differ in their history, resources, populations served, market characteristics, and medical cultures. Because of this diversity, the most effective steps to achieving lasting improvements in health care require a critical mass of support from community stakeholders – including healthcare providers, consumers, payers and purchasers – investing their time and resources toward shared, meaningful, actionable goals.

Employers are already involved in numerous collaboratives across the country. The relationships formed in these collaboratives provide the foundation for employers, health insurance plans, providers, and consumers to work together to improve health care.

Regional public-private collaboratives are also working on the ability to share clinical data for quality measurement and reporting between and among collaboratives. For example, the National Health Information Network (NHIN) is enabling twelve regional public-private collaboratives to exchange clinical data for quality measurement and reporting.

Employers who are interested in a broad overview of provider performance are encouraged to participate in a new Medicare project through which Medicare claims data will be aggregated with claims data from other payors, and in some cases State Medicaid programs and providers, in order to produce comprehensive information on the quality of provider services. This Better Quality Information for Medicare Beneficiaries (BQI) project is designed to improve the quality of Medicare services, and provide quality information to Medicare beneficiaries. It is currently being implemented in six regional communities and CMS is also considering ways to expand this project to additional communities.

14. What role do the six regional Better Quality Information for Medicare Beneficiaries (BQI) project pilot communities play in this initiative? Are employers required to participate?

Currently, the BQI project is being implemented in six regional communities around the country. In these communities, employers, health insurance plans, and in some cases Medicaid programs and providers have formed collaboratives through which they have been combining their claims data or clinical information to provide consistent measures of the quality of healthcare services. Through the BQI project, CMS will allow the private data to be aggregated with Medicare claims data to produce more accurate, comprehensive measures of the quality of services at the provider level. This process is necessary to enable data to be aggregated effectively while ensuring the privacy and security of the information. Provider quality information based on this all-payer data will be made available to Medicare beneficiaries over internet web sites. The quality information will allow Medicare beneficiaries to get a better picture of the value of their healthcare purchases. Since this information will be made available to Medicare beneficiaries over publicly accessible internet websites, it will be accessible by anyone.

In addition to access to the all-payer quality data that will be displayed by CMS for Medicare beneficiaries on public websites, employers that participate in the BQI project potentially have the opportunity to assist the Medicare program by providing suggestions for additional measures for use in reporting quality data. Furthermore, they potentially may also have the opportunity to shape the measures to be developed through broad-based collaboration for use by Medicare and all payers, and ultimately improve the value of care for your own workforce. CMS is also considering ways to expand this project to additional communities.

15. When would my company be expected to begin implementing these goals?

Many large employers are already taking significant actions to promote health IT and quality and cost or price transparency and implement pay-for-performance and other incentives for their employees and providers. Many employers have already offered consumer-directed health plans. Employers are encouraged to take specific actions to support all of the goals set forth in the Executive Order. Employers are also encouraged to incorporate specific implementation requirements in health insurance plan contracts as they come up for renewal and to begin working with a regional collaborative. In this process, employers are encouraged to use a uniform approach in their discussions with health insurance plans regarding health IT, transparency, and pay-for-performance or other incentives. A set of sample RFI questions are included in this toolkit for your potential use. The questions illustrate RFI questions you may choose to use and may be modified as you deem appropriate in selecting health insurance plans and other contractors. Furthermore, this sample RFI may augment your efforts to identify and contract with health insurance plans and other contractors that are most effectively providing services consistent with the four cornerstones of care. This type of voluntary survey can help all stakeholders assess where they are

and how they can more effectively work together to increase value in our healthcare system.

16. What is the responsibility of my company vs. the responsibility of the health insurance plans and providers?

Most employers rely on health insurance plans to implement key healthcare benefit strategies and programs; in turn, health insurance plans rely on providers to implement specific initiatives to improve quality and lower costs. Employers are encouraged to define a strategy that meets their business needs while promoting consistent health IT, quality and cost or price transparency, pay-for-performance and other incentives for employees and providers. They are also encouraged to negotiate contract terms with health insurance plans to implement those strategies and support the contracted plans' implementation of these goals. In some cases, employers may directly implement programs and work with healthcare providers to advance these goals.

17. Will this commitment affect how we design our benefit plans?

Employers will continue to have complete discretion to design benefit plans based on their unique needs. However, an employer can fulfill several of the four cornerstones by offering options to their employees that are designed to reward effective purchasing by employees. For example, consumer-directed health plans, including account-based plans, are one design that encourages consumer-centered purchasing. Possible RFI questions are included in this toolkit to help implement these approaches.

18. How will the private sector interact with the Federal government to coordinate the selection of measures?

Currently, the private sector and the Federal government rely heavily on the NQF-endorsement process to identify potentially useful measures. To promote effective adoption and use of these measures without undue administrative burdens on providers, broad-based national stakeholder groups, such as the AQA and the HQA (in which the Federal government is involved) have adopted subsets of NQF-endorsed measures for hospital and physician measurement efforts. In the case of the HQA, CMS is using those measures to meet the Congressional directive for hospitals to report on a set of quality measures to receive their full annual update payments. This process has helped to unify both Federal and private sector provider quality measurement efforts. For example, because the data on the "Hospital Compare" website is all-payer data on widely accepted hospital clinical quality measures, it can be used by all employers to measure the quality of care across hospitals. CMS plans to continue to support these broad-based national collaborative efforts to endorse and adopt measures and to report on quality and encourage employers to use data from these efforts.

In addition, the BQI project, referenced above, will be using quality measures that were adopted by AQA and HQA and endorsed by NQF. Employers can help the effort by actively participating in these initiatives. For example, employers can become members of the NQF, which is playing a key role in defining the national consensus performance measurement set, and can provide input into the AQA or HQA processes. As part of this effort, employers also are encouraged to closely monitor and use standard measures adopted by the AQA and HQA, which are playing a key role in driving the implementation of standard measures for physicians and hospitals, and to encourage the AQA or HQA processes to promote the national adoption of additional measures as consensus develops. Employers are also encouraged to participate in regional public-private collaboratives and provide input into measure implementation as well.

19. How will the private sector interact with the Federal government to coordinate the implementation of measures?

Extensive progress has already been made in defining consensus-based quality measures that can be adopted by both public and private sector interests. The Federal government will continue to promote broad public-private partnerships for the development and adoption of additional measures and will be coordinating with existing partnerships across the country to advance the use of these measures. Consequently, employers are encouraged to request that health insurance plans adopt standard nationally accepted measures in their approaches. Employers and other purchasers also are encouraged to work with health insurance plans to actively participate in regional public-private collaboratives and incorporate the results of these efforts into their broader efforts to promote transparency and performance measurement. Employers are also encouraged to participate in the BQI project, as described above.

20. How will the private sector interact with the Federal government to advance the adoption of health IT?

Extensive progress has already been made in defining consensus-based interoperability standards that can be adopted by both public and private sector interests. The Federal government will continue to promote public-private partnerships for the development and harmonization of interoperability standards. These standards will be made publicly available as they are defined, allowing purchasers to incorporate them into their health plan and provider contract requirements. The Federal government will also be coordinating with the public-private partnerships that exist today across the country to advance the adoption of health information technology and the exchange of clinical data. Public-private partnerships will continue to be the vehicle to engage both sectors to advance the adoption of electronic health records and the health information exchange needed for quality measurement and reporting.

21. What actions will the Federal government be taking to change its programs to promote transparency, adoption of health IT, and pay-for-performance or other incentives for providers and consumers?

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 this Fall, 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.