Sample 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[1]					
Inpatient Quality Indicators					
Patient Safety Indicators					
Pediatric Indicators					

[1] 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