



**MINNESOTA HEALTH CARE VALUE EXCHANGE**  
**ACCORD**

**ARTICLE I – NAME**

The name of this alliance shall be Minnesota Health Care Value Exchange, serving as Minnesota’s Chartered Value Exchange (CVE).

**ARTICLE II – VISION**

Minnesota has a history of successful collaboration in addressing challenges in our community. We believe it is critical for community stakeholders to identify and work together on shared health-related community priorities. We have begun to make strides in using standard performance information to engage providers to improve, facilitate consumer decision making through public reporting, and promote effective public and private payment policies and consumer incentives that reward or foster better provider performance. We are driven to continue to lengthen our steps in this direction.

**ARTICLE III – PURPOSE**

The purpose of the Minnesota Health Care Value Exchange is to actively support the four cornerstones of value-driven health care in Minnesota:

1. **Interoperable Health Information Technology (Health IT Standards):** Interoperable health information technology has the potential to create greater efficiency in health care delivery. Significant progress has been made to develop standards that enable health information systems to communicate and exchange data quickly and securely to protect patient privacy. Additional standards must be developed and all health care systems and products should meet these standards as they are acquired or upgraded. All standards should be developed with the patient and consumer defined as the ultimate beneficiary of health IT gains and no standard shall limit the individual’s ability to manage their own health information. In addition, all standards must work in accordance with the work of the Minnesota eHealth Steering Committee and support health information exchange efforts in Minnesota.
2. **Measure and Publish Quality Information (Quality Standards):** To make confident decisions about their health care providers and treatment options, consumers need quality of care information. Similarly, this information is important to providers who are interested in improving the quality of care they deliver. Quality measurement should be based on measures that are developed

through consensus-based processes involving all stakeholders, such as the processes used by the AQA (multi-stakeholder group focused on physician quality measurement) and the Hospital Quality Alliance.

3. **Measure and Publish Price Information (Price Standards)**: To make confident decisions about their health care providers and treatment options, consumers also need price information. Efforts are underway to develop uniform approaches to measuring and reporting price information for the benefit of consumers. In addition, strategies are being developed to measure the overall cost of services for common episodes of care and the treatment of common chronic diseases.
4. **Promote Quality and Efficiency of Care (Incentives)**: All parties - providers, patients, insurance plans, and payers - should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively-priced health care. Such arrangements may include implementation of pay-for-performance methods of reimbursement for providers or the offering of consumer-directed health plan products, such as account-based plans for enrollees in employer-sponsored health benefit plans.

## ARTICLE IV – MEMBERSHIP

**Section 1.** While actions of the Minnesota Health Care Value Exchange will involve many stakeholders and partners, the member of the Minnesota Health Care Value Exchange shall include five organizations:

- Buyers Health Care Action Group
- Institute for Clinical Systems Improvement
- Minnesota Community Measurement
- Smart Buy Alliance
- Stratis Health

*BHCAG* is a not for profit coalition of private and public employers working to redirect the health care system to focus on a collective goal of optimal health and total value.

*ICSI* is an independent, non-profit organization, which facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people who live and work in Minnesota and surrounding states.

*MNCM* is a community-based, nonprofit organization dedicated to accelerating the improvement of health in Minnesota through measurement and public reporting of health care performance. *Smart Buy Alliance* is an affiliation of health care purchasers from all sectors – public, private, group, union and individual - working together to ensure that health care reforms are focused on improving the health and health care delivery for all Minnesotans

*Stratis Health* is a non-profit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

### Section 2. Coalition Member Responsibilities

**Meeting Attendance.** The CVE shall convene as regularly as strategies and activities deem appropriate, and shall strive for efficiency in meeting logistics, including meeting by conference call when feasible. CVE Members agree to attend a minimum of fifty (50) percent of scheduled meetings each year with not more than two (2) consecutive absences.

**Committees.** If CVE committees are chartered, CVE Members agree to actively participate in committee work, and are expected to volunteer their services for Coalition projects.

**Collaboration.** As the CVE strategizes and implements activities which are better accomplished as the CVE (rather than any of the individual Member organizations), each Member shall commit to open and transparent communication, shared decision making, equal and fair representation of the CVE, and clarity of position.

## **ARTICLE V – CONVENORS & REPRESENTATIVES**

**Section 1.** The Minnesota Health Care Value Exchange shall elect Members to facilitate the business of the Coalition. These positions shall include Convener, AHRQ Contact, and Financial Representative, which shall rotate as determined by the Members.

### **I. Convener**

Responsibilities of the Convener shall include convening CVE meetings, coordinating meeting agendas and logistics, engaging and serving as contact for outside meeting facilitators when needed, and recording and distributing meeting summaries.

### **II. AHRQ Contact**

Responsibilities of the AHRQ Contact include receiving and promptly sharing all relevant communication with other members, coordinating the preparation of required workplans and reports, and responding to inquiries from AHRQ.

### **III. Finance Representative**

Responsibilities of the Finance Representative shall include custody of records and funds for the CVE as needed for CVE projects or activities.

### **IV. Medicare Data Steward**

Responsibilities of the data steward shall be to accept and manage the Medicare data that comes as being a designated CVE. The data steward shall have in place both appropriate technical support structure (e.g., hardware and software) and the confidential and data protection policies and procedures.

## ARTICLE VI – COMMITTEES

- Section 1. Creation**  
Committees will be chartered on an ad hoc basis by the CVE.
- Section 2. Committee Leadership**  
All committees shall be convened by CVE Members. Committee participation may include non-CVE members.

## ARTICLE VII – MEETINGS

- Section 1. Annual Meeting**  
There shall be an Annual Meeting of the CVE, generally the first meeting of the fiscal year, at which time the CVE will review membership, roles (convener, AHRQ representative, and financial representative), committees, finances, annual goals and other business.
- Section 2. Meetings**  
Meetings of the CVE shall be held at least quarterly. Meetings may take place in-person or by technology-supported means.

## ARTICLE VIII – FISCAL AND PROCEDURAL POLICIES

- Section 1. Fiscal Year**  
The Coalition's fiscal year shall be from January 1<sup>st</sup> to December 31<sup>st</sup>.
- Section 2. Conflicts**  
No one may profit financially from membership in the CVE by sales or solicitation at meetings or workshops, without prior approval of the CVE.
- Section 3. Decision Making**  
In the spirit of the Minnesota Health Care Value Exchange vision, all CVE business shall be conducted based on the philosophy of mutual respect and consensus decision-making. If, after due discussion, consensus cannot be reached, a vote will be taken, a 4/5 agreement rule will apply. CVE Members are entitled to one vote per organization.
- Section 4. Voting**  
Voting on the business of the CVE may be conducted in person or via electronic means.
- Section 5. Communications**  
Documents bearing the CVE name, logo, or other communications representing the CVE to external audiences shall follow the communications oversight policy.

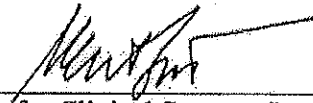
**ARTICLE IX – AMENDING THE ACCORD**

The members of the CVE may propose an amendment to this Accord by resolution at any regular meeting of the CVE. Proposed changes shall be circulated to all the CVE Members before the vote is taken, a 4/5 agreement rule of the members shall be required.



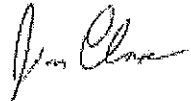
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Buyers Health Care Action Group  
Carolyn Pare, CEO



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Institute for Clinical Systems Improvement  
Kent Bottles, President



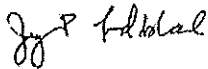
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Minnesota Community Measurement  
Jim Chase, President



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Smart Buy Alliance  
Cal Ludeman, Co-chair



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Stratis Health  
Jennifer Lundblad, President and CEO

**MINNESOTA HEALTH CARE VALUE EXCHANGE**  
**PROCEDURAL POLICIES**

**Communication Oversight Policy**

Documents bearing the Minnesota Health Care Value Exchange name, logo, or other communications representing the CVE to external audiences shall adhere to the following communication oversight policy:

- Whichever organizational Member develops the communication/document will e-mail the document to all members of the CVE, seeking approval of the document by a specified date and time.
- Approval is defined as being able to support the document, even if it is not worded in accordance with each Member's first choice.
- Failure to respond to the e-mail by the identified deadline will constitute implicit approval by a Member.
- If all CVE Members approve the document, the Member is free to publish the document.
- If full approval is not obtained, the Member will propose alternative language based on feedback obtained by CVE members and attempt to seek consensus on the revised document. If consensus is obtained, the Member is free to publish the document.
- If full approval of the revised document is not obtained, the Member may seek majority support, at which point the document can be published by the Member.