VT Health Care Innovation Project
Quality and Performance Measures Work Group Meeting Agenda

Monday, February 10, 2014; 10:00 AM to 12 Noon

4th Floor Conference Room, Pavilion Office Building, Montpelier

Call-In Number: 1-877-273-4202 Passcode: 9883496

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00-10:10	Welcome and Introductions; Approval of Minutes	Attachment 1 - January Minutes	Yes
2	10:10-10:25	Work Group Charter – Comments and Discussion ***Public Comment***	Attachments 2a & 2b - QPM Charter Draft 6	Yes
3	10:25-10:40	Draft Work Plan ***Public Comment***	Attachment 3 - QPM Draft Work Plan	Yes
4	10:40-11:10	Presentation from Vermont Department of Health on Measures and Data ***Public Comment***	Attachment 4a – Public Health Frameworks Attachment 4b – Healthy Vermonters 2020 - Quick Reference	
5	11:10-11:30	Shared Savings Program-ACO Measures: Decision on who generates patient names for samples (ACOs, payers, or analytics contractor), GMCB Oversight Role, Timing for Review of Measures ***Public Comment***	Attachment 5 - Process for Review and Modification of Measures Attachment 5a – GMCB Oversight of ACOs	Yes (sample generation)
6	11:30-11:50	Review of Criteria for Selection of Shared Savings Program-ACO Measures ***Public Comment***	Attachment 6 - Measure Selection Criteria	
7	11:50-12:00	Next Steps, Wrap-Up and Future Meeting Schedule; Requests for Presentations (e.g., Blueprint for Health, Health Plans, VPQHC, The Dartmouth Institute, Vermont Oncology Project, etc.)		Yes

VT Health Care Innovation Project
Quality & Performance Measures Work Group Meeting Minutes

January 13, 2014 am to 12:00pm; 4th Floor Conference Room, Pavilion Office Building, Montpelier

Attendees: Cathy Fulton, Co-Chair; Catherine Burns, Howard Center; Peter Cobb, VT Assembly of Home Health Agencies; Paul Harrington, VT Medical Society; Susan Johnson, Northern Counties Health Care; Carol Kulczyk, VITL; Kim McLellan, NW Counseling and Support; Dana Noble, Bennington Blueprint; Colleen Sinon, NE VT Regional Hospital; Lila Richardson and Julia Shaw, Vermont Legal Aid; Heather Skeels, Bi-State; Marlys Waller, Vermont Council; Norman Ward, MD, OneCare; Alicia Cooper, Cynthia Thomas, and Aaron French, DVHA; Heidi Klein and Robin Edelman, VDH; Fran Keeler and Marybeth McCaffrey, DAIL; Shawn Skaflestad and Eileen Underwood AHS; Susan Onderwyzer, DMH; Janet McCarthy, Franklin County Home Health; Jenney Samuelson, Blueprint; Pat Jones, Annie Paumgarten, Betty Rambur, PhD and Allan Ramsay, MD, GMCB; Michael Bailit and Kate Bazinsky, Bailit Health Purchasing; Georgia Maheras, AOA; Nelson LaMothe and George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome; Approval of Minutes; Conflict of Interest; Members vs. Interested Parties	Cathy Fulton brought the meeting to order. Cathy offered an opportunity to discuss the Minutes of the prior Dec 18th Meeting. No discussion ensued. Heidi Klein made a motion to accept Minutes; Heather Skeels seconded the motion, motion passed with none opposed and no abstentions. Cathy reminded Members and Interested Parties to read the COI Policy, sign the Acknowledgement and return to George Sales of the Project Management Team.	
2 ACO Measures; decision on sample size for medical records measures; who generates patient names –	Alicia Cooper presented on the sample size: Preliminary discussions about sample size suggested that using the Medicare Shared Savings Program sample size of 411 would be appropriate. Later discussions suggested that 411 might be administratively and financially burdensome, and an alternative approach would be to combine the BCBSVT and MVP populations to obtain the sample of 411 for the commercial SSP (the Medicaid SSP would require a separate sample of 411 Medicaid beneficiaries). Sharon Winn sent a suggestion via e-mail that perhaps a sample size of 30 could instead be used, in accordance with NCQA minimum guidelines for public reporting. Pat clarified that 30 is the minimum	

Agenda Item	Discussion	Next Steps
ACO's? Payers? Or Analytics Contractor?	number of eligible patients required by NCQA for public reporting of results when there are fewer than 411 eligible patients. Paul Harrington supported combining commercial payers to achieve lowest administrative burden for providers, assuming none of the health plans had concerns about combining the populations in this way. Norm Ward suggested combining Medicaid with Blue Cross and MVP into a single sample of 411. Jenney Samuelson noted that combining commercial and public payers would mask any differences in quality between payers. Pat confirmed that NCQA has different benchmarks for Commercial vs. Medicaid populations, and the results for these populations often differ. Pat also suggested that the work group might reconsider the requirements in subsequent years if Year 1 results are similar across payer populations. Julia Shaw agreed that separate reporting for Medicaid is appropriate. Paul inquired whether the chart review would be the responsibility of the ACO or the payers, and expressed a preference for the payers to assume that task. Aaron French suggested that it should instead be the role of ACO, though the payers may contribute to alleviate administrative/financial burden. Norm expressed concern about ACOs being distracted from delivering care by yet another administrative step. He also suggested that there may be broader concerns with ACOs self-reporting their clinical quality metrics. Jenney asked whether insurers would continue to conduct their own chart reviews for NCQA reporting, noting that it may be an added burden for practices to have chart review occurring by both payers and ACOs during the year Heidi noted that there will need to be a recommendation as to who will be responsible for collecting ACO-specific information for non-NCQA measures that are not already being collected by payers. Paul suggested that the analytics contractor should select the samples. Norm reminded the group that the goal is to have all data available electronically, so the administrative burden will be reduced over time. Michael Bailit confirmed that the intent is for data collection to transition away from chart review and toward electronic review. Paul described the most recent HIE Work Group meeting where the 3 ACOs' proposal to further develop electronic reporting was heard but not acted upon. Paul agreed that important steps toward electronic data collection are being made, but noted that there is still a long way to go and that chart reviews and the related administrative burden will continue to be considerations in the near future. Motion made by Cathy Fulton: For Year 1 ACO Clinical Reporting Measures for non-electronically sourced information and combining all commercial payer populations for sampling, the sample size for each clinical measure shall be 411 randomly sampled eligible patients. In the event that there are fewer than 411	

Agenda Item	Discussion	Next Steps
	eligible patients for a given measure, the total universe of eligible patients will be included. Separate random samples of 411 for each measure will be required for the Medicaid Shared Savings Program. Heidi Klein seconded the Motion. No further discussion. Motion passed, no Nays, no Abstentions.	
3 Proxy Voting	Paul supported the proxy voting, but requested clarification about whether State employees would be considered voting members. He is concerned that perhaps half of all voting members are VT State Agency employees. Pat Jones informed the Group that Project Management and Staff are working to identify Voting Members vs. Interested Parties, and noted that Georgia was in the process of clarifying the voting status of state employees. Paul suggested that the voting/proxy voting process may be too formal for an advisory group. Norm appreciated the work group's response to the earlier suggestion of a need for a proxy voting policy. Norm also noted that it is difficult to know whether and how members participating by phone vote in the absence of a roll call vote. Cathy responded that when a vote is not unanimous, then a roll call may be appropriate. Allan Ramsay suggested that roll call votes allow Members to go on record representing their constituencies. Julia clarified for the group that Vermont Legal Aid and the Office of Health Care Advocate (Ombudsman) each have one vote. Aaron French made a motion to accept the draft proxy policy. Fran Keeler seconded the motion. No further discussion. Motion passed, no Nays, no Abstentions.	
4 Measure Modification Standard	Pat presented on the topic and relayed that comments received from OneCare were incorporated into the new draft shared today. A suggestion from staff was that the Work Group complete all recommendations for changes to the measure sets by 7/31/14 to facilitate timely Steering Committee and Core Team action. Norm suggested a moratorium on modifications to measures in Year 1. Paul expressed concern that measures may change during the 3 year pilot, and objects to this proposal overall. Paul suggested that the work group should focus on evaluating a stable set of measures, and noted that he would abstain from a vote on this subject Susan Johnson suggested that we need a method to change measures to accommodate shifts in understanding, and that this document provides a framework for addressing any potential modifications encountered during the pilot. Lila suggested clarifying the language in Item 3 about new measures "relating" to MSSP measures. Lila also expressed concerns about the limited representation of non-Medicare populations in the measures. Pat noted that the MSSP measure specifications often apply to populations beyond the traditional Medicare population, including broader age groups, etc. She suggested editing that sentence to say "…the Work	

Agenda Item	Discussion	Next Steps
	Group shall recommend following the MSSP measure specifications *as closely* as possible." Work Group members concurred with this change. Heidi asked if the Quality & Performance Measures WG could re-evaluate the criteria developed by the predecessor ACO Measures WG for evaluating measures. Cathy agreed that this would be an appropriate activity for the QPM WG prior to considering any changes to the ACO measures. Susan Johnson made a motion to approve the standard for the Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs, with edits to the sentence regarding MSSP measures in paragraph 3 to read "…the Work Group shall recommend following the MSSP measure specifications as closely as possible." Aaron French seconded the motion. No further discussion. Motion Passed, no Nays, 1 Abstention by Paul Harrington.	
5 Work Group Charter	Alicia incorporated feedback and edits from members in the version that the work group discussed. Minor changes were made to purpose and scope. A significant change was made to milestones, which were removed altogether and will be populated at a later date based on contents of the work plan (in development). Paul Harrington expressed concerns about the work group's role in reviewing and selecting measures for Episode of Care and Pay for Performance payment models, believing that to be the purview of the Payment Models Work Group. Alicia responded that the QPM work group will work with the PM work group to develop measures for additional payment models being tested. Pat Jones echoed Alicia's comment suggesting a parallel approach with cross-communication among WGs. Lila Richardson mentioned that using both SIM and VHCIP terminology is confusing. Shawn Skaflestad suggested adding a sentence to differentiate between members and Interested parties. Paul Harrington suggested that the Charter include the list of Members. Norm Ward agreed that the Charter should name Members. Cathy Fulton indicated that a revised draft of Charter is necessary. Pat asked Members to review and send comments within a week to Alicia, Pat, and Co-Chairs.	
6 Draft Work Plan	Pat Jones asked Members to please review the draft Work Plan and send comments within a week to Alicia, Pat and Co-chairs.	
7Engaging with other Groups	Not discussed.	
8 Schedule	Not discussed.	

Agenda Item	Discussion	Next Steps
Presentations on Other Measurement Activities		
9 Next Steps, Wrap up, and Future Meeting	Next meeting: Monday February 10, 2014 - 10am to 12pm; 4th Floor Conference Room - Pavilion Office Building, Montpelier	

Vermont Health Care Innovation Project (VHCIP)
Quality and Performance Measures Work Group Charter

DRAFT

PURPOSE

The purpose of the Quality and Performance Measures Work Group is to develop and recommend a standard set of performance measures, including metrics on quality, utilization, and cost to the VHCIP Steering Committee, the VHCIP Core Team, and the GMCB. The performance measures will allow the group to evaluate Vermont's payment reform models relative to public policy goals; to make recommendations regarding the manner in which quality performance will influence payments for payment models that are tested; and to make recommendations about how and when to communicate quality performance relating to payment reform to consumers.

SCOPE OF WORK

- Develop criteria and expectations for measure selection.
- Prioritize the use of nationally endorsed measures that can be benchmarked, to the extent possible.
- Develop consolidated and standardized sets of quality and performance measures for alternative payment and delivery system structures that are adopted for testing.
- ~~Troubleshoot~~ Understand measurement ~~collection~~ and reporting barriers and support ~~measurement~~ issue resolution.
- Review performance measures on at least an annual basis and determine measures to be added, revised, retired, or replaced.
- Learn about, inform, and integrate relevant activities of other ~~Vermont Health Care Innovation Project (~~VHCIP~~)~~ work groups.
- Collaborate with other VHCIP work groups to achieve broader project goals.

DELIVERABLES

- Review selection criteria used to develop ACO shared savings measures and expand to episodes of care, pay-for-performance, and other payment models adopted for testing, as appropriate.
- Recommend how measurement should impact payment.

- Review and recommend for approval the "Process for Review and Modification of Measures" standard for ACO shared savings measures.
- Annually review measures for the ~~SIM~~ VHCIP Driver Diagram, and modify or recommend measures as needed.
- Work in conjunction with the Payment Models work group to ~~D~~develop and recommend~~ed~~ measure sets for other payment models that are adopted for testing.
- Review and recommend measures to be added, revised, retired, or replaced as appropriate, on at least an annual basis.
- Review and recommend benchmarks to be used in conjunction with adopted measures for assessing and rewarding performance.
- Provide technical assistance to other multi-payer payment reform projects as requested and as work group resources allow.

MILESTONES

To be populated with specific tasks (and associated dates) included in the QPM WG Work Plan.

MEMBERSHIP REQUIREMENTS

The Quality and Performance Measures Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Each organization shall identify one individual to serve as a primary voting member. Voting ~~M~~members are expected to communicate with their colleagues and constituents about the activities and progress of the work group and to represent their organizations and constituencies during work group meetings and activities. Organizations shall also have the option of identifying additional individuals to serve as interested parties in the work group. Interested parties will not be considered voting members. However, an interested party may be identified in advance as a proxy for the designated voting member if the voting member is unable to attend a work group meeting.

Member Organizations

Agency of Administration
Agency of Human Services – Central Office
Agency of Human Services – Department of Aging and Independeng Living

Agency of Human Services – Department of Mental Health
Agency of Human Services – Department of Vermont Health Access
Agency of Human Services – Vermont Department of Health
Bi-State Primary Care
Blue Cross Blue Shield of Vermont
Green Mountain Care Board
HowardCenter for Mental Health
Northeastern Vermont Regional Hospital
Northern Counties Health Care
Northwest Counseling and Support Services
Office of Health Care Advocate
OneCare Vermont
Upper Valley Services
Vermont Assembly of Home Health and Hospice Agencies
Vermont Council of Developmental and Mental Health Services
Vermont Health Care Association
Vermont Information Technology Leaders
Vermont Legal Aid
Vermont Medical Society
Vermont Program for Quality in Health Care

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Catherine Fulton, Executive Director, Vermont Program For Quality in Health Care
  CatherineF@vpqhc.org
- Laura Pelosi, MacLean, Meehan & Rice
  Laura@mmrvt.org

Work Group Staff:

- Pat Jones, Green Mountain Care Board
  Pat.Jones@state.vt.us
- Alicia Cooper, Department of Vermont Health Access
  Alicia.Cooper@state.vt.us

Additional resources may be available to support consultation and technical assistance to the work group.

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- Annually review measures for the VHCIP Driver Diagram, and modify or recommend measures as needed.
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DRAFT 1/7/14 – Work Plan for VHCIP Quality and Performance Measures Work Group

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Group logistics: charter, membership, meeting schedule, etc.	• Review and refine draft charter • Review membership list for gaps • Obtain signed conflict of interest statements • Develop 2013-2014 meeting schedule • Identify resource needs and how to meet those needs	January 2014	Staff; co-chairs; work group members	• Draft charter • Membership list developed • Conflict of interest policy presented	• Final Charter • Comprehensive membership list • Signed conflict of interest statements • 2014 meeting schedule • Resources adequate to accomplish objectives
Obtain consultant to assist with selected work group activities	• Identify activities that could benefit from consultant expertise • Determine if RFP needed or if existing vendor can perform work • Engage in RFP process and/or recommend vendor • Execute contract or contract amendment • Work with successful vendor to develop scope of work and accomplish specified activities	January 2014	Staff; co-chairs; work group members	• Recommendation to retain existing vendor sent to Core Team	• Contract or contract amendment in place
Recommend process for reviewing and modifying SSP measures to VHCIP Core Team and GMCB	• Review and comment on draft process • Develop revised process • Vote on process • Send recommendation to VHCIP Core Team	January 2014	Staff; co-chairs; work group members	• Second draft under review	• Adopted process for review and modification of SSP measures
Review SSP pending and new measures and make Year 2 recommendations to VHCIP Steering Committee, Core Team and GMCB	• Carefully consider measure selection criteria and applicability of MSSP measure specifications • Develop recommendations for VHCIP Steering Committee, Core Team and GMCB	August 2014	Staff; co-chairs; work group members; consultant		• Recommendations to VHCIP Steering Committee, Core Team and GMCB
Review SSP Payment, Reporting, Monitoring and Evaluation Measures and make Year 2 recommendations to VHCIP Steering Committee, Core Team and GMCB	• Consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines • Develop recommendations for VHCIP Steering Committee, Core Team and GMCB	August 2014	Staff; co-chairs; work group members; consultant		• Recommendations to VHCIP Steering Committee, Core Team and GMCB

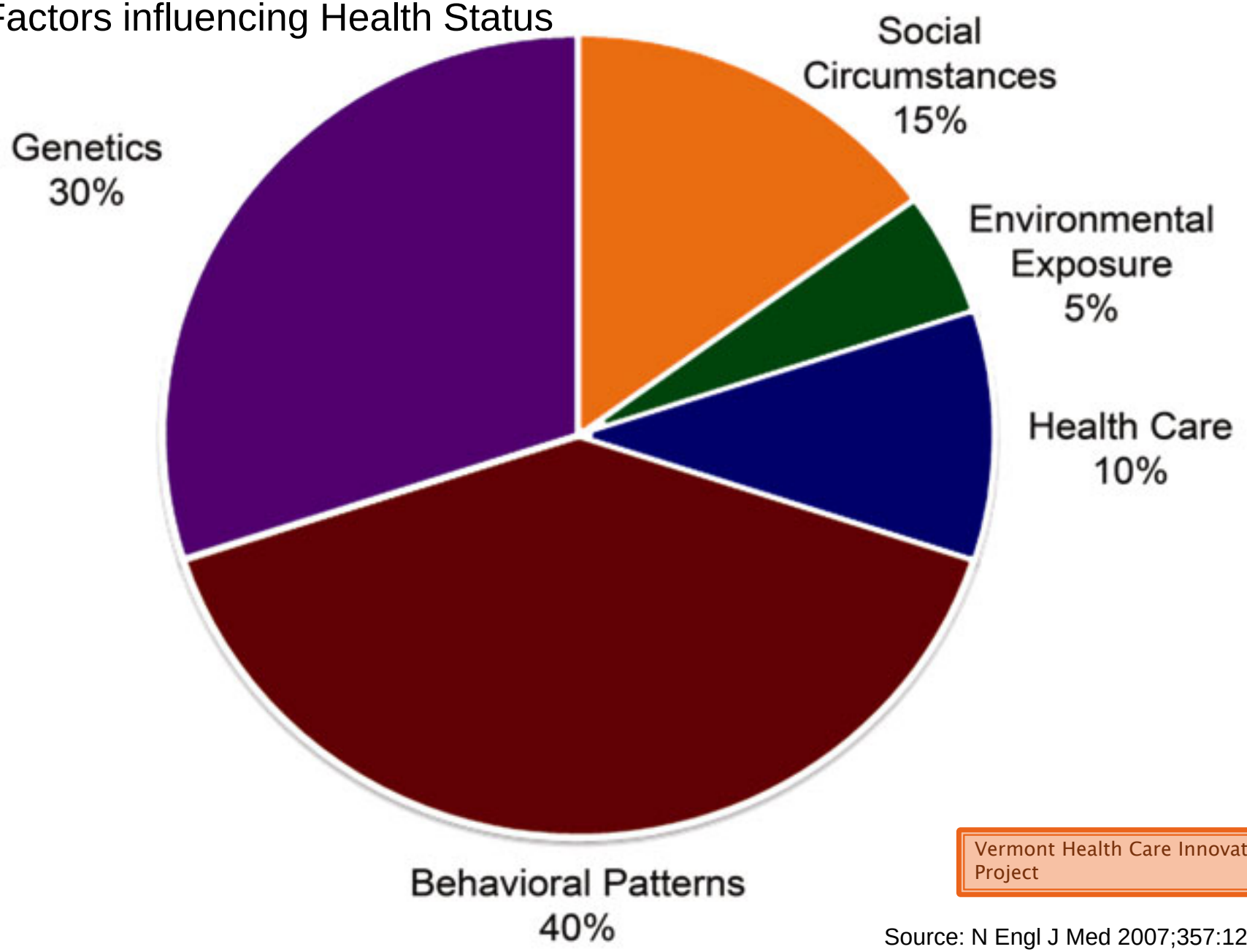
Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Review SSP Payment Measures targets and benchmarks and make Year 2 recommendations to VHCIP Steering Committee, Core Team and GMCB	• For each Payment Measure, consider whether the benchmark employed as the performance target should remain constant or change for the next pilot year • Consider setting targets that increase incentives for quality improvement.	August 2014	Staff; co-chairs; work group members; consultant		• Recommendations to VHCIP Steering Committee, Core Team and GMCB
When requested by Payment Models Work Group, recommend measures for Episode of Care reforms to Payment Models Work Group, VHCIP Steering Committee, Core Team and GMCB	• Identify measure selection criteria • Review potential measures • Consider alignment with existing measure sets • Recommend measure set to VHCIP Steering Committee, Core Team and GMCB	December 2014?	Staff; co-chairs; work group members; consultant		• Recommendations to VHCIP Steering Committee, Core Team and GMCB
When requested by Payment Models Work Group, recommend measures for Pay for Performance reforms to Payment Models Work Group, VHCIP Steering Committee, Core Team and GMCB	• Identify measure selection criteria • Review potential measures • Consider alignment with existing measure sets • Recommend measure set to VHCIP Steering Committee, Core Team and GMCB	June 2015?	Staff; co-chairs; work group members; consultant		• Recommendations to VHCIP Steering Committee, Core Team and GMCB
Coordinate and collaborate with other work groups	• Identify activities led by other work groups that relate to activities of the QPM Work Group • Develop mechanisms for reporting about related activities to other work groups, and for obtaining information about related activities from other work groups	Ongoing	Staff; co-chairs; work group members; other work groups		• Well-coordinated and aligned activities among work groups
Develop understanding of current measurement activities in Vermont, in other states, and nationally	• Identify entities and programs that engage in quality and performance measurement • Identify focus of their work and related measures • As requested by work group, ask selected entities to attend work group meetings to describe their activities in greater detail • Summarize information in writing	Ongoing	Staff; co-chairs; work group members; consultant; organizations engaging in measurement		• Written summary of current measurement activities • Aligned measure sets

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
For all measure sets, identify implementation needs (e.g., learning collaboratives, electronic and other information, provider engagement) and potential resources to meet those needs.	• Review measure sets to identify implementation needs • Identify mechanisms and resources to meet implementation needs	Ongoing	Staff; co-chairs; work group members; consultant		• Written recommendations, including proposed learning collaboratives, HIE needs, provider engagement activities, implementation resources

Public Health Frameworks

Determinants of Health

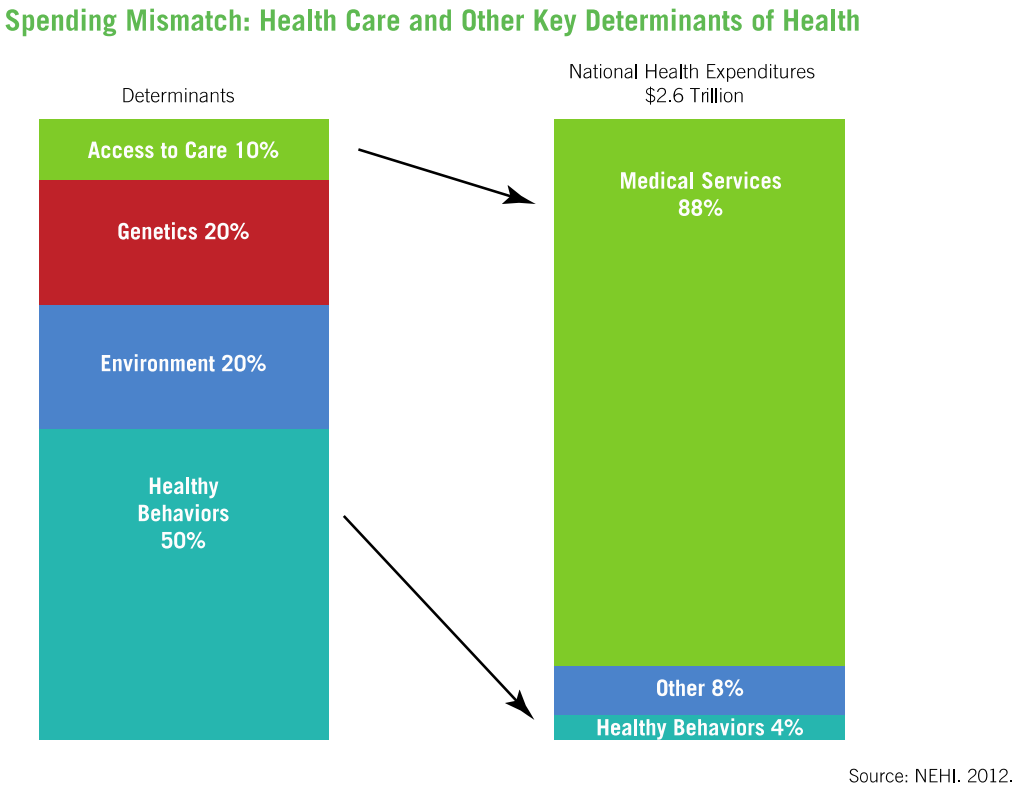
Factors influencing Health Status



Vermont Health Care Innovation Project

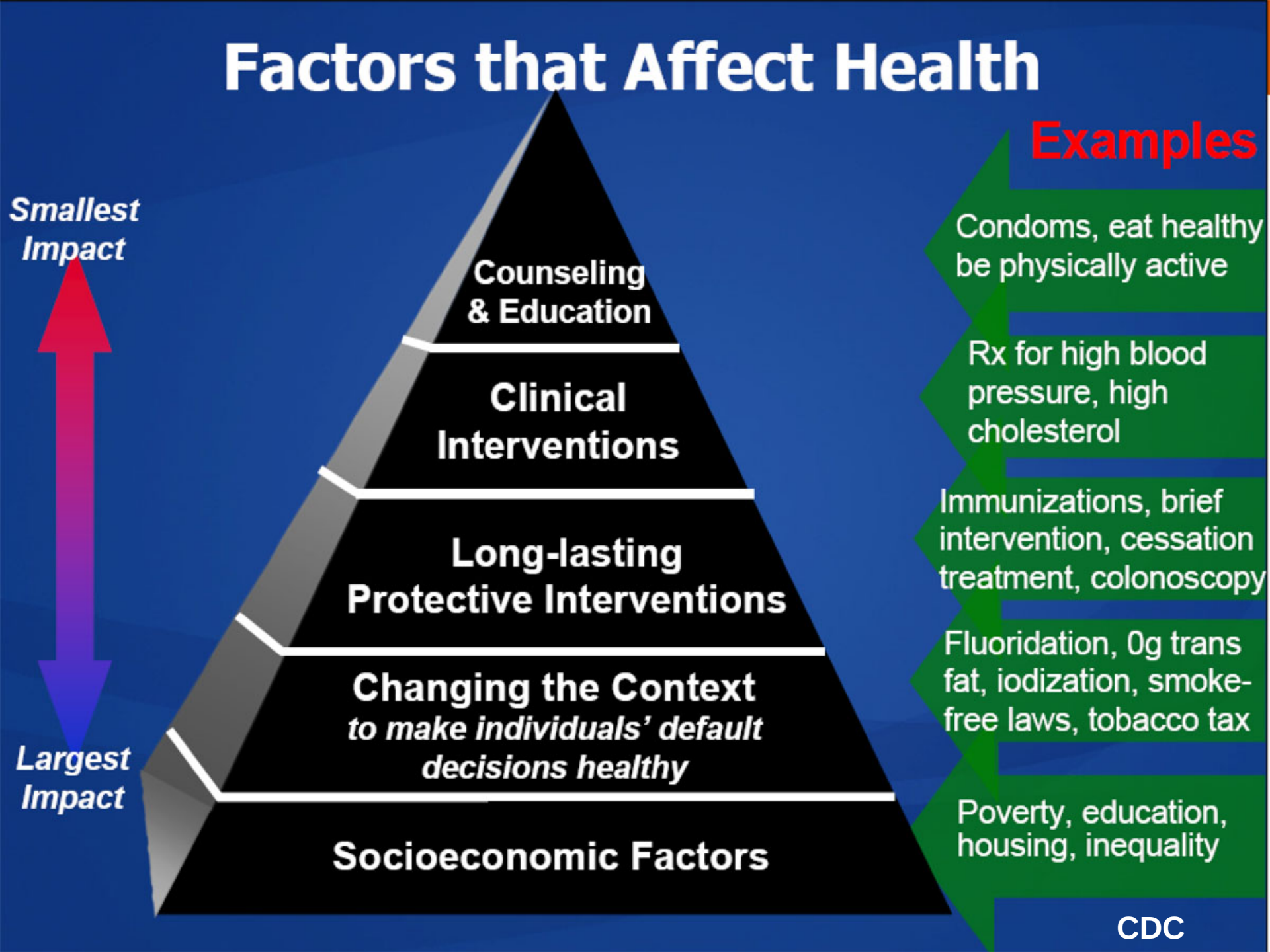
Source: N Engl J Med 2007;357:1221-8.

MISMATCH

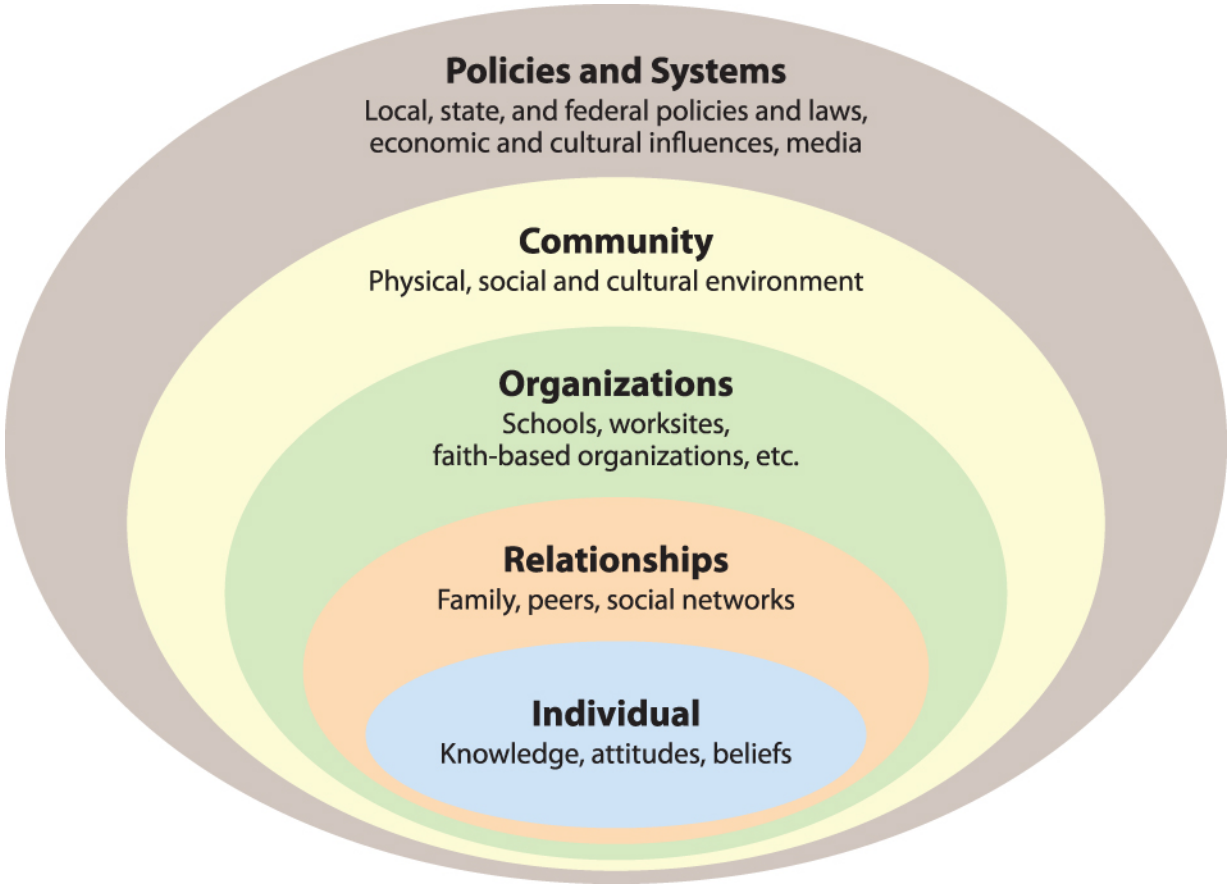


Source: NEHI. 2012.

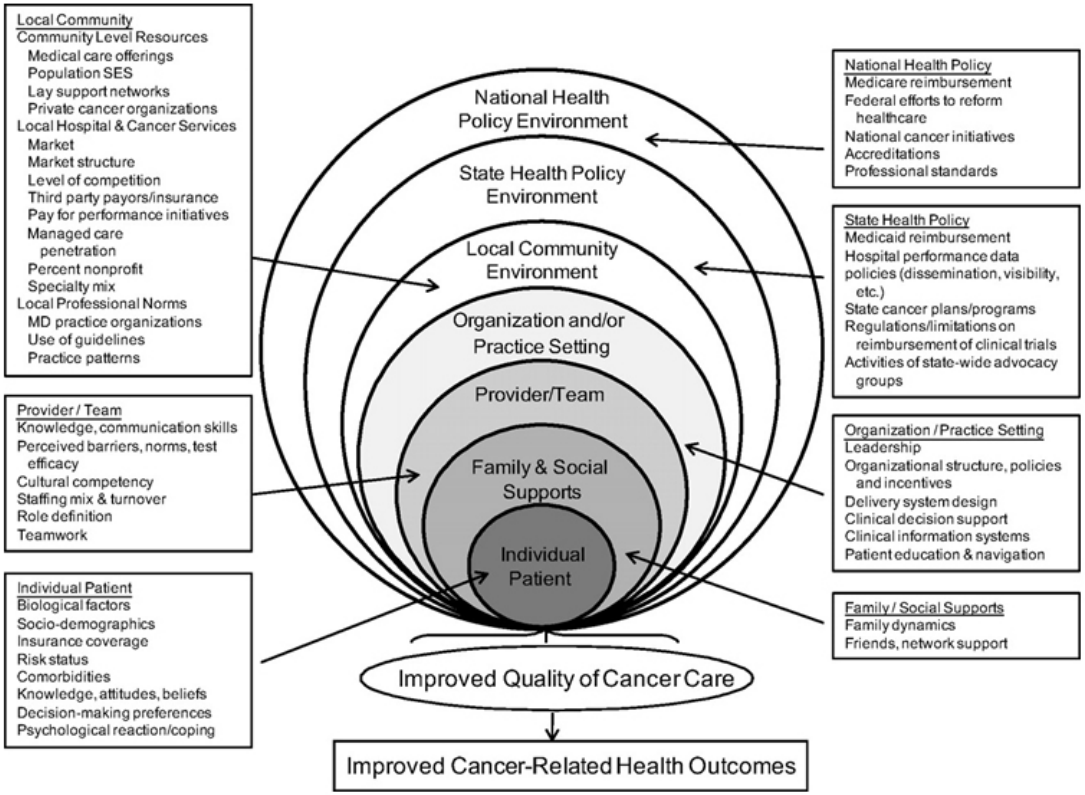
Factors that Affect Health



Vermont Prevention Model

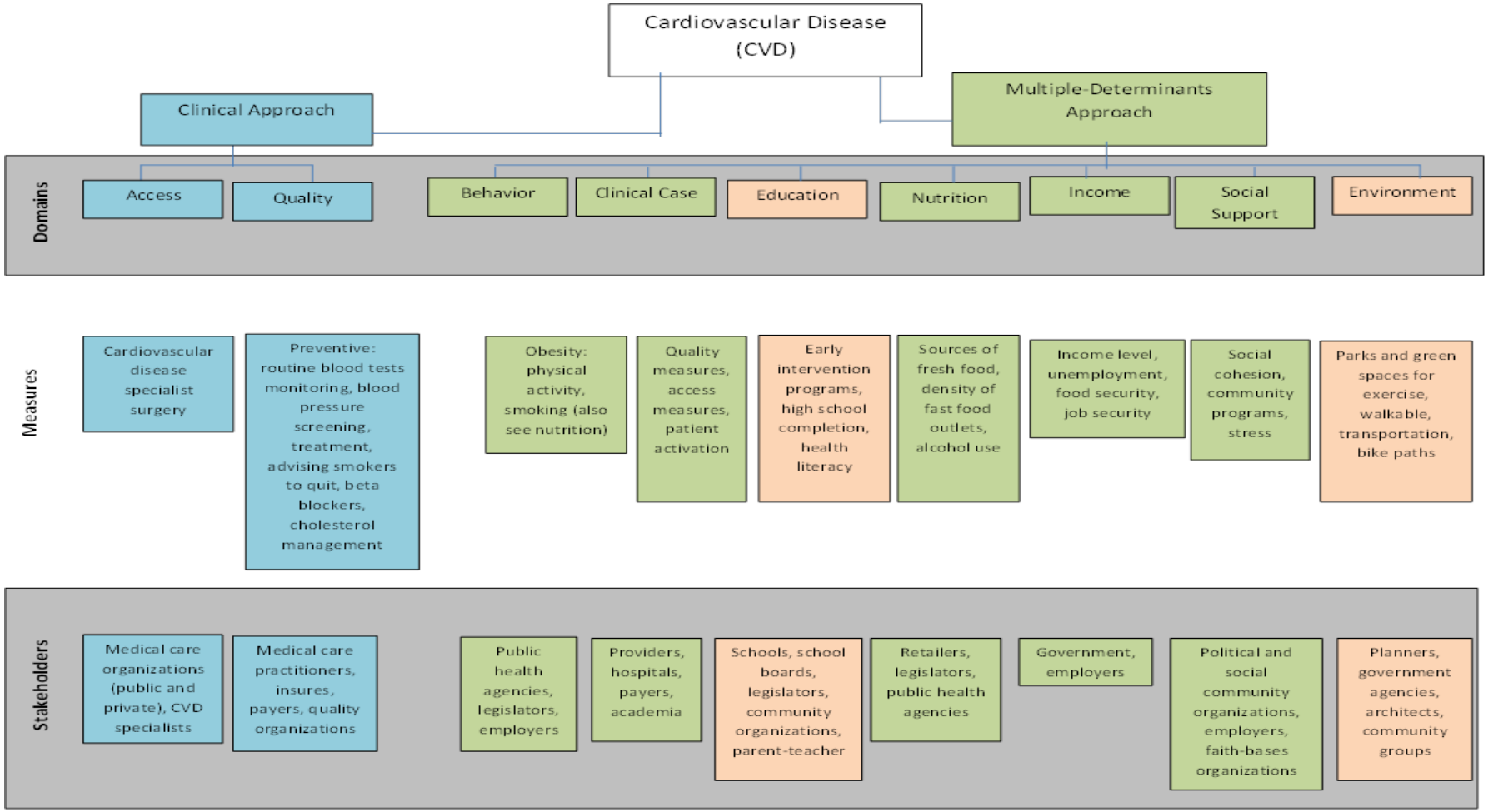


Multilevel influences on Health and Healthcare (Cancer Example)



Taplin S H et al. J Natl Cancer Inst Monogr 2012;2012:2-10

Contrasting Multiple-determinants and Clinical Approaches

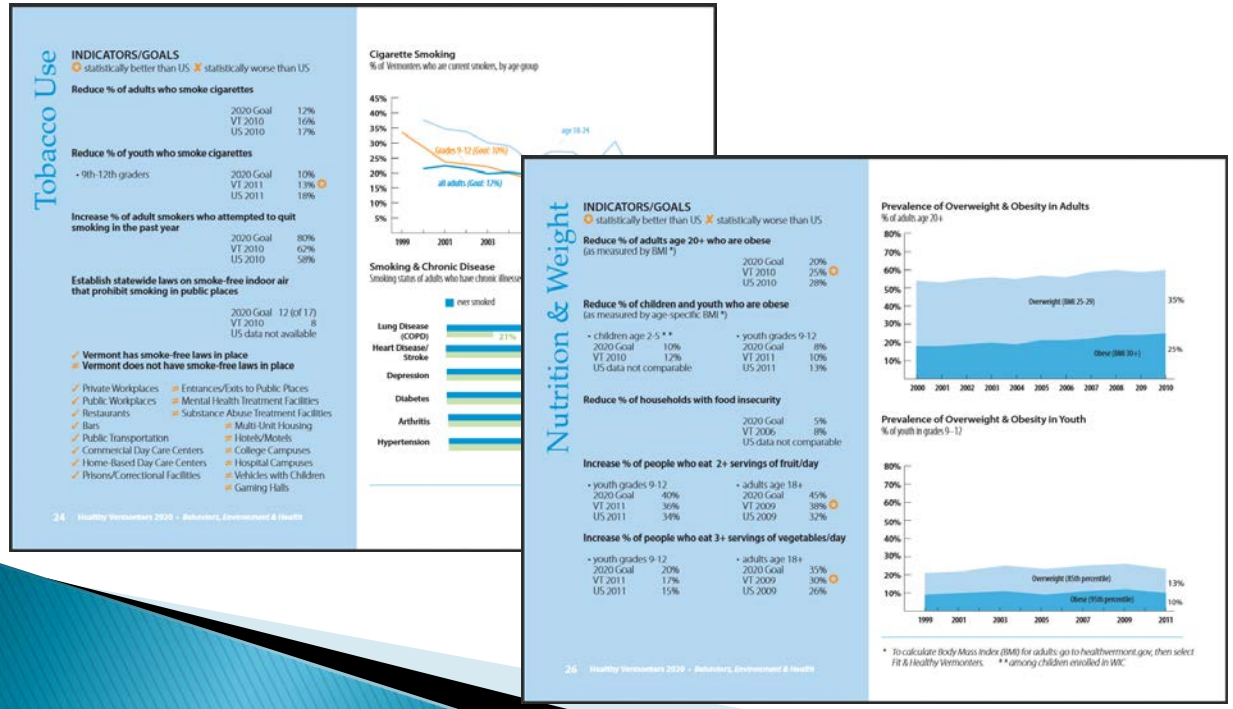


IOM (Institute of Medicine). 2011. For the Public's Health: The Role of Measurement in Action and Accountability. Washington, DC: The National Academies Press.

Page 40, Chart 2-1b

Population Health Status

HV2020 is the State Health Assessment that documents the health status of Vermonters at the start of the decade, and the population health indicators and goals that will guide the work of public health through 2020. It is aligned with Healthy People.



- Cancer
- Diabetes
- Heart Disease & Stroke
- Maternal & Infant Health
- Nutrition & Weight Status
- Older Adults
- Oral Health
- Physical Activity
- Respiratory Diseases
- Substance Abuse
- Tobacco Use

Vermont Health Care Innovation Project

Leading Health Indicators
Healthy Vermonters 2020

Healthy Vermonters 2020 Indicator	2010 Baseline	Target	Data Source*	Geo*
HEART DISEASE & STROKE				
Coronary heart disease death rate per 100,000	111.7 (2009)	89.4	Vital Statistics	(S/C/D/H)
Stroke death rate per 100,000	29.3 (2009)	23.4	Vital Statistics	(S/C/D/H)
% of adults with hypertension	25% (2009)	20%	BRFSS	(S/C/D/H)
% of children and adolescents with hypertension	No baseline	None	None	
% of adults with cholesterol check in past 5 years	75% (2009)	85%	BRFSS	(S/C/D/H)
NUTRITION & WEIGHT STATUS				
% of adults (20+) who are obese	25% (2010)	20%	BRFSS	(S/C/D/H)
% of children ages 2 to 5 (in WIC) who are obese	12% (2010)	10%	PedNSS/WIC	(S)
% of adolescents in grades 9-12 who are obese	10% (2011)	8%	YRBS	(S/C/D/H)
% of households with food insecurity	8% (2006)	5%	BRFSS	(S/C/D/H)
% of adults eating the daily recommended servings of fruit	38% (2009)	45%	BRFSS	(S/C/D/H)
% of adolescents eating the daily recommended servings of fruit	36%(2011)	40%	YRBS	(S/C/D/H)
% of adults eating the daily recommended servings of vegetables	30% (2009)	35%	BRFSS	(S/C/D/H)
% of adolescents eating the daily recommended servings of vegetables	17% (2011)	20%	YRBS	(S/C/D/H)
PHYSICAL ACTIVITY				
% of adults with no leisure time physical activity	17% (2010)	15%	BRFSS	(S/C/D/H)
% of adults meeting physical activity guidelines	59% (2009)	65%	BRFSS	(S/C/D/H)
% of adolescents meeting physical activity guidelines	24% (2011)	30%	YRBS	(S/C/D/H)
% of children ages 2 to 5 years with no more than 2 hours of television, videos, or video games	No baseline	None	PNSS/WIC	
% of children ages 2 to 5 years with no more than 2 hours of computer use	No baseline	None	PNSS/WIC	
% of adolescents with no more than 2 hours of screen time	64% (2011)	70%	YRBS	(S/C/D/H)

Healthy Vermonters 2020 - Quick Reference

Healthy Vermonters 2020 Indicator	2010 Baseline	Target	Data Source*	Geo**
ACCESS TO HEALTH SERVICES				
% of Vermonters with health insurance	91% (2010)	100%	Census - ACS	(S/C)
% of adults with health insurance	89% (2010)	100%	Census - ACS	(S/C)
% of children with health insurance	96% (2010)	100%	Census - ACS	(S/C)
Number of practicing Primary Care Providers – Medical Doctors (MD and DO)	492 (2010)	541	Physician's Survey	(S/C/D/H)
Number of practicing Primary Care Providers – Physician Assistant	67 (2010)	80	Physician's Survey	(S/C/D/H)
Number of practicing Primary Care Providers – Nurse Practitioner	83 (2010)	100	AHEC Survey	(S)
% persons with insurance coverage for clinical preventative services	No baseline	None	None	
% of adults with a usual primary care provider	90% (2010)	100%	BRFSS	(S/C/D/H)
% of all Vermonters with a specific source of ongoing care	No baseline	None	BRFSS	(S/C/D/H)
% who cannot obtain care or delay care (including medical care, dental care, or prescriptions)	9% (2010)	5%	BRFSS	(S/C/D/H)
ARTHRITIS & OSTEOPOROSIS				
% of adults with diagnosed arthritis who have activity limitations	45% (2009)	40%	BRFSS	(S/C/D/H)
% of adults with diagnosed arthritis who receive physical activity counseling	58% (2003)	65%	BRFSS	(S)
% of adults with diagnosed arthritis who receive arthritis education	12% (2003)	15%	BRFSS	(S)
% of adults 50 years and older with osteoporosis	12% (2007)	10%	BRFSS	(S/C/D/H)
CANCER				
Overall cancer death rate per 100,000	168.4 (2009)	151.6	Vital Statistics	(S/C)
% of cancer survivors always or usually getting emotional support	83% (2010)	90%	BRFSS	(S/C/D/H)
% of cancer survivors who report excellent or good general health	76% (2010)	85%	BRFSS	(S/C/D/H)
% of women receiving cervical cancer screening	84% (2010)	95%	BRFSS	(S/C/D/H)
% of adults receiving colorectal cancer screening	71% (2010)	80%	BRFSS	(S/C/D/H)
% of women receiving breast cancer screening	83% (2010)	95%	BRFSS	(S/C/D/H)
% of men discussing PSA screening for prostate cancer with their health care provider	No baseline	None	BRFSS	(S/C/D/H)
CHILDHOOD SCREENING				
% of infants screened for Autism Spectrum Disorder and other developmental delays before 24 months	No baseline	None	Screening in Primary Care Survey	
% children with Autism Spectrum Disorder diagnosis with first evaluation by 36 months	No baseline	None	CSHN Data	
% of newborns screened for hearing loss by 1 month age	95% (2009)	100%	CHHS	(S/C)
% of newborns not passing screening, who have an audiologic evaluation by 3 months	48% (2009)	55%	CHHS	(S/C)
% of infants with hearing loss who receive intervention services by 6 months age	50% (2010)	55%	CHHS	(S)
DIABETES & CHRONIC KIDNEY DISEASE				
Rate of new cases of end-stage renal disease (ESRD) per million population	222.0 (2009)	200.0	US Renal Data System	(S/C)
% of adults with diagnosed diabetes with A1C < 7%	No baseline	None	None	
% of adults with diagnosed diabetes with controlled blood pressure	No baseline	None	None	
% of adults with diagnosed diabetes who had an annual dilated eye exam	51% (2010)	60%	BRFSS	(S/C/D/H)
% of adults with diagnosed diabetes who had diabetes education	51% (2010)	60%	BRFSS	(S/C/D/H)
ENVIRONMENTAL HEALTH & FOOD SAFETY				
% of persons served by public water supplies that meet Safe Drinking Water Act standards	86% (2010)	95%	DEC Water Supply Compliance Division	(S)
% of children with elevated blood lead levels	0.6% (2010)	0%	VT Lead Database	(S/C/D/H)
Elevated blood lead level rate per 100,000 employed adults	10.3 (2009)	9.3	ABLES	(S)
% of homes with high radon levels (4pCi/L) with mitigation system	33% (2010)	35%	Post-radon testing mitigation	(S)
% of schools with an indoor air quality management system	7% (2010)	10%	VT Envision program	(S)
% of inspections that find critical food safety violations	43% (2010)	35%	F&L Program Inspection	(S)
FAMILY PLANNING				
% of pregnancies that are planned	54% (2008)	65%	PRAMS	(S)
% of adolescents who used contraception at most recent intercourse	86% (2011)	95%	YRBS	(S/C/D/H)
% of female adolescents who receive education on STDs	No baseline	None	None	
% of male adolescents who receive education on STDs	No baseline	None	None	
HEART DISEASE & STROKE				
Coronary heart disease death rate per 100,000	111.7 (2009)	89.4	Vital Statistics	(S/C/D/H)
Stroke death rate per 100,000	29.3 (2009)	23.4	Vital Statistics	(S/C/D/H)
% of adults with hypertension	25% (2009)	20%	BRFSS	(S/C/D/H)
% of children and adolescents with hypertension	No baseline	None	None	
% of adults with cholesterol check in past 5 years	75% (2009)	85%	BRFSS	(S/C/D/H)
HIV & STD				
Number of new HIV diagnoses among all persons	9 (2006-10)	5	HIV Surveillance	(S)
% of adults tested for HIV in past 12 months	5% (2010)	10%	BRFSS	(S/C/D/H)
% of adolescents ever tested for HIV	10% (2011)	15%	YRBS	(S/C/D/H)
% condom use among sexually active females	41% (2008)	45%	BRFSS	(S/C/D/H)
% condom use among sexually active males	59% (2008)	65%	BRFSS	(S/C/D/H)
% condom use among sexually active adolescent females	58% (2011)	65%	YRBS	(S/C/D/H)
% condom use among sexually active adolescent males	68% (2011)	75%	YRBS	(S/C/D/H)
% of females 15-24 with Chlamydia infections	1.6% (2010)	1.0%	STD Surveillance	(S)
IMMUNIZATION & INFECTIOUS DISEASE				
% of children (19-35 months) receiving recommended vaccines (4:3:1:4:3:1:4)	41% (2010)	80%	NIS	(S)
% of kindergarteners with 2 or more MMR doses	91% (2010–11)	95%	UMass School Health	(S)
% of adolescents ages 13 to 17 with at least 1 Tdap booster	83% (2010)	90%	NIS	(S)
% of adults 65 years and older who receive annual flu shot	71% (2010)	90%	BRFSS	(S/C/D/H)
% of adults 65 years and older who ever had pneumococcal vaccine	73% (2010)	90%	BRFSS	(S/C/D/H)
% of identified active TB case contacts with newly-diagnosed LTBI who started and then completed treatment	88% (2006-10)	90%	NTIP	(S)
Infection ratio for central-line associated bloodstream infections	0.59 (2010-11)	0.15	NHSN	(S)

NOTES:

* Data Source abbreviations, please see Maps & Trends at: healthvermont.gov/hv2020

** Geo = geographies available for this indicator (S/C/D/H) = (State/County/Health District/Hospital Service Area)

2/6/2014

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VERMONT DEPARTMENT OF HEALTH

Healthy Vermonters 2020 - Quick Reference

Healthy Vermonters 2020 Indicator	2010 Baseline	Target	Data Source*	Geo**
INJURY & VIOLENCE PREVENTION				
Nonfatal motor vehicle crash-related injury rate per 100,000	873.1 (2008)	785.8	VUHDDS	(S/C/D/H)
Fall-related death rate per 100,000 adults age 65 and older	120.3 (2009)	116.9	Vital Statistics	(S/C/D/H)
ED visits for self-harm rate per 100,000	154.6 (2009)	139.1	VUHDDS	(S/C/D/H)
MATERNAL & INFANT HEALTH				
Sudden, Unexpected death rate for Infants (per 1,000 live births)	0.69 (2005-09)	0.62	Vital Statistics	(S)
% of pregnant women who abstain from alcohol	88% (2008)	100%	PRAMS	(S)
% of pregnant women who abstain from smoking cigarettes	81% (2009)	90%	Vital Statistics	(S/C/D/H)
% of pregnant women who abstain from illicit drug use	95% (2009)	100%	PRAMS	(S)
% women delivering a live birth who discussed preconception health prior to pregnancy	29% (2008)	40%	PRAMS	(S)
% of women delivering a live birth who had a healthy weight prior to pregnancy	52% (2008)	65%	PRAMS	(S)
% of infants breastfed exclusively for six months	22% (2007)	40%	NIS	(S)
MENTAL HEALTH				
Rate of Suicide per 100,000 Vermonters	13.0 (2009)	11.7	Vital Statistics	(S/C/D/H)
% of adolescents with a suicide attempt that requires medical attention	1.6% (2009)	1.0%	YRBS	(S/C/D/H)
% of adult (19+) PCP visits that include depression screening	No baseline	None	None	
% of adolescent PCP visits that include depression screening	No baseline	None	None	
NUTRITION & WEIGHT STATUS				
% of adults (20+) who are obese	25% (2010)	20%	BRFSS	(S/C/D/H)
% of children ages 2 to 5 (in WIC) who are obese	12% (2010)	10%	PedNSS/WIC	(S)
% of adolescents in grades 9-12 who are obese	10% (2011)	8%	YRBS	(S/C/D/H)
% of households with food insecurity	8% (2006)	5%	BRFSS	(S/C/D/H)
% of adults eating the daily recommended servings of fruit	38% (2009)	45%	BRFSS	(S/C/D/H)
% of adolescents eating the daily recommended servings of fruit	36%(2011)	40%	YRBS	(S/C/D/H)
% of adults eating the daily recommended servings of vegetables	30% (2009)	35%	BRFSS	(S/C/D/H)
% of adolescents eating the daily recommended servings of vegetables	17% (2011)	20%	YRBS	(S/C/D/H)
OLDER ADULTS				
% of older adults who use the Welcome to Medicare Benefit	No baseline	25%	None	
% of males age 65 and over who are up to date on a core set of clinical preventive services	50% (2010)	55%	BRFSS	(S/C/D/H)
% of females age 65 and over who are up to date on a core set of clinical preventive services	47% (2010)	55%	BRFSS	(S/C/D/H)
ORAL HEALTH				
% of children ages 6 to 9 with dental caries	34% (2010)	30%	Children's BSS OH Survey	(S)
% of adults ages 45 to 64 with tooth extraction	52% (2010)	45%	BRFSS	(S/C/D/H)
% of children ages 6 to 9 using dental system yearly	95% (2010)	100%	Children's BSS OH Survey	(S)
% of children in grades K through 12 using dental system yearly	65% (2009-10)	85%	School Nurse Report	(S/D)
% of adults using dental system yearly	74% (2010)	85%	BRFSS	(S/C/D/H)
% of the population with optimally fluoridated water	57% (2010)	65%	WRFS	(S/C)
PHYSICAL ACTIVITY				
% of adults with no leisure time physical activity	17% (2010)	15%	BRFSS	(S/C/D/H)
% of adults meeting physical activity guidelines	59% (2009)	65%	BRFSS	(S/C/D/H)
% of adolescents meeting physical activity guidelines	24% (2011)	30%	YRBS	(S/C/D/H)
% of children ages 2 to 5 years with no more than 2 hours of television, videos, or video games	No baseline	None	PNSS/WIC	
% of children ages 2 to 5 years with no more than 2 hours of computer use	No baseline	None	PNSS/WIC	
% of adolescents with no more than 2 hours of screen time	64% (2011)	70%	YRBS	(S/C/D/H)
RESPIRATORY DISEASES				
Asthma hospitalization rate per 10,000 children less than age 5	19.0 (2009)	14.0	VUHDDS	(S/C/D/H)
Asthma hospitalization rate per 10,000 persons ages 5 to 64	4.9 (2009)	4.2	VUHDDS	(S/C/D/H)
Asthma hospitalization rate per 10,000 adults age 65 and older	11.8 (2009)	9.3	VUHDDS	(S/C/D/H)
% of adult non-smokers exposed to secondhand smoke	43% (2010)	30%	ATS	(S/C/D/H)
% of adults who have a written asthma management plan from a health care provider	32% (2010)	40%	ACBS	(S/C/D/H)
% of children who have a written asthma management plan from a health care provider	48% (2010)	65%	ACBS	(S)
% of adults with asthma advised to change things in home, school, or work environments	35% (2010)	45%	ACBS	(S/C/D/H)
% of children with asthma advised to change things in home, school, or work environments	33% (2010)	50%	ACBS	(S)
SCHOOL AGE HEALTH				
% of kindergarteners ready for school in all five domains of healthy development	56% (2011-12)	65%	Ready Kindergarteners Survey	(S)
% of middle schools that require newly hired staff who teach health education to be licensed or endorsed by the State	No baseline	None	SHPPS	
% of youth ages 10-17 who have had a wellness exam in past 12 months	57% (2010-11)	65%	School Nurse Report	(S/D)
% of students absent due to illness or injury	No baseline	None	None	
SUBSTANCE ABUSE				
% of persons (12+) who need and do not receive alcohol treatment	7% (2008-09)	5%	NSDUH	(S)
% of adolescents who used marijuana in the past 30 days	24% (2011)	20%	YRBS	(S/C/D/H)
% of adolescents (12-17 yrs) binge drinking in the past 30 days	11% (2008-09)	10%	NSDUH	(S)
TOBACCO USE				
% of adults smoking cigarettes	16% (2010)	12%	BRFSS	(S/C/D/H)
% of adolescents smoking cigarettes	13% (2011)	10%	YRBS	(S/C/D/H)
% of adult smokers who attempted to quit in the last year	62% (2010)	80%	BRFSS	(S/C/D/H)
# of statewide laws on smoke-free indoor air to prohibit smoking in public places	8 of 17	12 of 17	STATE VT Statutes	(S)
PUBLIC HEALTH PREPAREDNESS				
Time necessary to issue official information regarding a public health emergency	No baseline	60 min	PHEP - CDC PERFORMS	(S)
Time necessary to activate personnel for a public health emergency	66 min (2009)	60 min	PHEP - CDC PERFORMS	(S)
Time to produce after-action reports and improvement plans following an emergency	60 d (2008-09)	40 d	PHEP - CDC PERFORMS	(S)
Proportion of crisis and emergency risk messages intended to protect the public's health that demonstrate the use of best practices	No baseline	None	None	

NOTES:

* Data Source abbreviations, please see Maps & Trends at: healthvermont.gov/hv2020

** Geo = geographies available for this indicator (S/C/D/H) = (State/County/Health District/Hospital Service Area)

2/6/2014

healthvermont.gov/hv2020

VERMONT DEPARTMENT OF HEALTH

VHCIP Quality and Performance Measures Work Group
Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs
January 13, 2014 Work Group Recommendation

Standard:

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set at the beginning of the third quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes at the beginning of the third quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the

VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** during the third quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications for the next pilot year by no later than** October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work

Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

EXHIBIT B

GREEN MOUNTAIN CARE BOARD
REGULATORY OVERSIGHT ROLE

GMCB acknowledges, by affixing its signature to this Exhibit, that the following accurately describes the GMCB's regulatory oversight role with respect to the Parties' performance of this Agreement.

1. General XSSP Standards Compliance Oversight.

(a) Generally. GMCB will oversee compliance by ACO and Payer with XSSP Standards. It is the intention of the GMCB, that neither the ACO nor the Commercial Payer be deprived of the benefits of this Agreement as a result of insignificant, insubstantial or immaterial noncompliance with the XSSP Standards.

(b) Audits. GMCB, to the extent permitted by law, shall have access to Commercial Payor's and ACO's books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations, and compliance with the XSSP Standards available for inspection by the GMCB or a designee reasonably acceptable to Commercial Payer and ACO, at reasonable times and on reasonable notice. The GMCB will maintain as confidential and not subject to disclosure any information identified as confidential by a Party to the extent permissible under the law, including the Vermont Access to Public Records Act, 1 V.S.A. §§ 315-320. Payer and ACO will maintain books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations and compliance with the XSSP for ten (10) years from the termination of this Agreement.

(c) Noncompliance. In the event that ACO or Commercial Payer reports noncompliance to the GMCB, GMCB may provide the Parties with notice of noncompliance and the opportunity to object or cure.

(i) If the relevant Party objects to notice of noncompliance, it shall provide written notice of the objection to the GMCB and the other Party to this Agreement within ten (10) business days of receipt of the notice, with a reasonably specific description of its objection(s) and may additionally choose to present the objection at a meeting of the GMCB. The GMCB will review the objection and, after a hearing and the development of a factual hearing record sufficient to serve as the basis for judicial review if a hearing is requested, issue a written decision to the Parties as to whether it finds the Party to be in compliance with XSSP Standards with a detailed description of the reason(s) for that decision.

(ii) If, after receiving a notice of noncompliance or a GMCB decision finding it noncompliant, the Party chooses to cure noncompliance, it shall, within thirty (30) days of receipt of the notice of noncompliance or the GMCB's decision finding the Party noncompliant, provide the GMCB and the other Party with a written proposed corrective action plan. The GMCB will review and approve or modify the plan of correction within thirty (30) days of

receipt and notify the Parties of its decision. If the plan of correction is modified the Party may object as set forth above in subsection (i). After resolution of any objection, the Party will implement the plan of correction and the GMCB may reasonably monitor the implementation of that plan of correction.

(iii) To the extent the Parties are engaged in dispute resolution or have declared material breach as provided for in the Agreement, the GMCB will act in conformance with the time frames set forth in the Agreement.

2. Commercial Payer Oversight.

(a) Attributed Lives. GMCB may verify attribution and Commercial Payer's calculations of attribution and may require from Commercial Payer only such information necessary and permitted by law to achieve this purpose.

(b) Workgroup Participation. GMCB may require Commercial Payer to participate in work groups related to XSSP Standards.

3. ACO Oversight.

(a) Performance Against Core Measures for Payment. GMCB shall evaluate the ACO's performance against the Core Measures for Payment set forth in the XSSP Standards.

(b) Approval of Risk Mitigation Plan. GMCB shall review and approve ACO's Risk Mitigation Plan, as required in the XSSP Standards, and shall establish and evaluate financial reports regarding risk performance from ACO to evaluate its ability to bear downside risk in Performance Year 3 of this Agreement. If the GMCB reasonably determines that ACO is substantially unable to bear 3% - 5% financial risk in Performance Year 3, it may, after a hearing and the development of a factual hearing record sufficient to serve as the basis for judicial review, disqualify ACO from participation in the XSSP Program for Performance Year 3.

(c) Should ACO, in Performance Years 2 or 3, fail to meet the minimum quality scores, it may still be eligible to receive Shared Savings if the GMCB determines, after providing notice to and accepting written input from Commercial Payer and ACO (and input from ACO Participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior Performance Years. The Board will make this determination after conducting a public process that offers stakeholders and other interested persons sufficient time to offer verbal and/or written comments related to the issues before the Board.

(d) Workgroup Participation. GMCB may require ACO to participate in a reasonable number of work groups related to XSSP.

4. Reports.

(a) Quarterly Reports. GMCB will develop and deliver to ACO and Commercial Payers, quarterly reports that include: (a) performance on the measures in the Monitoring and Evaluation Measures Set in the XSSP Standards to be established as well as other performance metrics; and (b) findings from quarterly cost and utilization evaluations for ACO.

(b) Risk Performance Reports. GMCB shall review and approve of ACO Risk Mitigation Plans in accordance with Section 3(b) above and establish and evaluate financial reports regarding risk performance from the ACO.

5. Compliance with Privacy and Security Laws

The GMCB acknowledges that Commercial Payers and ACO are subject to regulatory and contractual obligations to comply with the Health Information Portability and Accountability Act ("HIPAA") which restricts their ability to disclose protected health information (PHI). GMCB acknowledges that it and any third-party it might engage to perform work on its behalf may only receive PHI or other data as permitted by law or by entering into an appropriate Business Associate Agreement or Data Sharing Agreement, to be agreed upon by the Parties and GMCB.

The GMCB hereby acknowledges that this Exhibit B is a fair and accurate representation of the GMCB's regulatory oversight role for compliance with the XSSP Standards.

GREEN MOUNTAIN CARE BOARD

By: _____

Printed Name: _____

Title:_____

Date Signed: _____

Proposed Objectives of the Vermont ACO Measures Work Group:

March 29, 2013 Draft

To identify standardized measures that will be used to:

1. evaluate the performance of Vermont's Accountable Care Organizations (ACOs) relative to state objectives for ACOs,
2. qualify and modify shared savings payments, and
3. guide improvements in health care delivery.

The measures selected will:

1. be representative of the array of services provided and beneficiaries served by the ACOs;
2. be valid and reliable;
3. be selected from NQF endorsed measures that have relevant benchmarks whenever possible;
4. align with national and state measure sets and federal and state initiatives whenever possible;
5. be focused on outcomes to the extent possible;
6. be uninfluenced by differences in patient case mix or be appropriately adjusted for such differences;
7. not be prone to the effects of random variation (measure type and denominator size);
8. not be administratively burdensome;
9. be limited in number and include only those measures that are necessary to achieve the state's goals;
10. be population-based; and
11. be consistent with the state's objectives and goals for improved health systems performance (e.g., present an opportunity for improved quality and/or cost effectiveness).