

NATIONAL QUALITY FORUM

+ + + + +

MEASURE APPLICATIONS PARTNERSHIP
POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

+ + + + +

TUESDAY
DECEMBER 15, 2015

+ + + + +

The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Carol Raphael and Debra Saliba, Co-Chairs, presiding.

PRESENT:

CAROL RAPHAEL, MPA, Co-Chair
DEBRA SALIBA, MD, MPH, Co-Chair
JOSEPH AGOSTINI, MD, Aetna
ROBYN GRANT, MSW, The National Consumer Voice
for Quality Long-Term Care
E. LIZA GREENBERG, RN, MPH, Visiting Nurses
Association of America
ROGER HERR, PT, MPA, COS-C, American Physical
Therapy Association
BRUCE LEFF, MD, Johns Hopkins University School
of Medicine
JAMES LETT II, MD, CMD, National Transitions of
Care Coalition
CARI R. LEVY, MD, PhD, CMD, AMDA -- The Society
for Post-Acute and Long-Term Care Medicine
SANDY MARKWOOD, MA, National Association of Area
Agencies on Aging
SEAN MULDOON, MD, Kindred Healthcare
PAMELA ROBERTS, PhD, OTR/L, SCFES, CPHQ, FAOTA,
American Occupational Therapy Association

SUZANNE SNYDER KAUSERUD, PT, American Medical
Rehabilitation Providers Association
CAROL SPENCE, PhD, National Hospice and
Palliative Care Organization
ARTHUR STONE, MD, National Pressure Ulcer
Advisory Panel
JENNIFER THOMAS, PharmD, American Society of
Consultant Pharmacists
LISA WINSTEL, Caregiver Action Network

SUBJECT MATTER EXPERTS (Voting):

KIM ELLIOTT, PhD, CPH
GERRI LAMB, PhD
PAUL MULHAUSEN, MD, MHS
EUGENE NUCCIO, PhD

FEDERAL GOVERNMENT LIAISONS (Non-voting):

ALAN LEVITT, MD, Centers for Medicare &
Medicaid Services (CMS)
ELIZABETH PALENA HALL, MIS, MBA, RN, Office of
the National Coordinator for Health
Information Technology (ONC)

MAP DUAL ELIGIBILITIES WORKGROUP LIAISON:

CLARKE ROSS, DPA

NQF STAFF:

ELISA MUNTHALI, Vice President, Quality
Measurement
MARCIA WILSON, Senior Vice President, Quality
Measurement
TAROON AMIN, Senior Advisor
LAURA IBRAGIMOVA, Project Analyst
ERIN O'ROURKE, Senior Project Manager
KATHRYN STREETER, Senior Project Manager
MARGARET TERRY, PhD, RN, Senior Director
SARAH SAMPSEL, NQF Consultant

ALSO PRESENT:

ANDREW BAIRD, HealthSouth

**MICHELLE BRAZIL, Centers for Medicare &
Medicaid Services (CMS)**

LAURIE FEINBERG, MD, Acumen

**TROY HILLMAN, Uniform Data System for Medical
Rehabilitation**

**TERESA LEE, MPH, JD, Alliance for Home Health
Quality and Innovation**

**TARA McMULLEN, MD, PhD, Centers for Medicare &
Medicaid Services (CMS)**

**KIM SPALDING-BUSH, Centers for Medicare &
Medicaid Services (CMS)**

C O N T E N T S

Recap of Day 1 and Goals for Day 2 5

Presentation on Measures Under
Development Pathway. 6

Public Comment28

Opportunity for Public Comment on
Measures Under Consideration for
IMPACT Act: Medicare Spending Per
Beneficiary.36

Pre-Rulemaking Input on Measures
Under Consideration for IMPACT Act:
Medicare Spending Per Beneficiary.45

Opportunity for Public Comment on Measures
Under Consideration for Hospice Quality
Reporting Program. 108

Pre-Rulemaking Input on Measures Under
Consideration for Hospice Quality Reporting
Program. 109

MAP PAC/LTC Core Concepts Discussion 134

MAP PAC/LTC Measurement Gaps:
IMPACT Act and Federal Programs. 157

Public Comment 181

Summary and Next Steps 189

Adjourn

1 P-R-O-C-E-E-D-I-N-G-S

2 9:02 a.m.

3 CO-CHAIR RAPHAEL: Before we begin
4 this morning's work, which involves several
5 measures related to the IMPACT Act and several
6 measures related to the Hospice QRP, a few people
7 have approached Deb and me with some questions
8 about the process that we are engaged in.

9 And I think everyone needs to
10 recognize that two things have occurred. First
11 of all, we're doing our work at a much earlier
12 stage in the development of measures than we
13 traditionally have.

14 And secondly, the National Quality
15 Forum has really tried to step back and
16 constantly assess how the process can be
17 improved. And to make adjustments.

18 So, as we're in this period of
19 evolution, I thought it would be valuable to have
20 Taroon, who is the staff to the MAP Coordinating
21 Committee, and I thought I -- there he is.

22 Taroon, I am calling on you to kind of

1 just speak a little bit about the process. And
2 then we can turn to CMS and kind of hear their
3 perspective on the process as well.

4 So, Taroon, take it away.

5 MR. AMIN: Thank you, very much Carol.

6 Good morning everyone. My name's Taroon Amin. I
7 am an NQF consultant supporting the MAP
8 Coordinating Committee, along with some of my
9 other colleagues here, in particular Erin, and
10 some other colleagues in the back.

11 So, we wanted to just raise a few
12 topics of conversation that seemed to emerge
13 during the discussion yesterday. It seems
14 there's additional conversation over dinner with
15 the Committee yesterday -- or with the workgroup
16 yesterday around the measure under development
17 pathway.

18 And then also, the voting procedure.

19 And to see if there's any conversation among the
20 workgroup, or any concerns, outstanding concerns.
21 Just to make sure that we're all feeling
22 comfortable about the decisions and the decision

1 making process.

2 And also, that I can provide you as
3 much context as possible in terms of how these
4 decisions are made. And where these decisions
5 are made.

6 So, in particular, I'd like to sort of
7 articulate that the MAP in general, and the
8 Coordinating Committee, has really been
9 undertaking a significant amount of process
10 improvement activities over the last two to three
11 years, to really try to enhance the ability for
12 the Coordinating -- for the various workgroups
13 and the Coordinating Committee itself, to focus
14 on the major issues that emerge in conversation.

15 And less -- reduce the over processing
16 if you will, given the number of measures that
17 are put in front of the various workgroups and
18 the Coordinating Committee during the time for
19 evaluation.

20 And make sure that there's
21 conversation around some of the key issues. And
22 so, with that said, one of the key enhancements

1 last year was the introduction of the consent
2 calendars.

3 The purpose of introducing the consent
4 calendar was not to limit discussion, by any
5 means. Which is the intent of why any member of
6 the workgroup is welcome to pull any of the
7 measures for additional discussion.

8 And really focus and create sort of a
9 cohesive group of measures so that we're
10 discussing them in an efficient way. One of the
11 key elements, and also, I would just sort of
12 point out, that we are trying to continue to --
13 we continue to try to ensure that there's a
14 reduction of unneeded variation between the
15 different workgroups.

16 Granted, we're looking at different
17 settings, where the different programs are, in
18 various different stages. So, with all that
19 being said, we're trying to make sure that the
20 process is relatively consistent.

21 One of the key pieces of input that we
22 heard at the end of last year's pre-rulemaking,

1 from the various different workgroups, and
2 particularly the hospital workgroup and the
3 clinician workgroup that are -- the hospital
4 workgroup in the sense of how many programs that
5 they're evaluating, a significant number of
6 programs.

7 And last year with the clinician
8 workgroup, the number of measures was
9 significant. That the -- there were a number of
10 individual workgroup members that sort of counted
11 up the number of times that we asked them to
12 vote.

13 And given, you know, how much we
14 respect and value the time that you're spending
15 here with us, and providing this input to CMS, we
16 realized that that was not necessarily the best
17 use of time.

18 When there is general agreement, or
19 unanimous agreements on certain decisions, to
20 focus the discussion really more on the
21 conversation and less the voting procedure and,
22 you know, putting Laura through the pain of

1 finding the extra two votes that happen to be
2 around the table.

3 And you know, going through that. The
4 extra minutes that we take to do these votes end
5 up actually taking a significant amount of time.

6 So, with that, one of the questions
7 that had emerged, was whether there was a need
8 for a final vote on the consent calendars after
9 the discussion. And one of the policy changes
10 that occurred was really, you know, asking the
11 Chairs to look to the Committee to see if there
12 was unanimous agreements on accepting the
13 workgroup -- or I mean, the preliminary analysis
14 recommendation from Staff.

15 And then, if any workgroup member
16 wanted to change that recommendation, open to
17 having that conversation. But, otherwise, there
18 was not a need to go through the formal clicking
19 process.

20 So, that was one issue I just wanted
21 to clarify where that came from. That might not
22 be as much of an issue for this workgroup, given,

1 you know, the type of measures and the programs
2 and whatnot.

3 But, clearly we had a robust
4 conversation around all these topics yesterday.
5 But, that sort of explains why the Coordinating
6 Committee and the workgroups, the other
7 workgroups had a little bit of a concern and
8 recommendation around improvements for this year,
9 around removing that element of the deliberation.

10 So, before I move on, I just wanted to
11 clarify that component. Ask the Chairs if that's
12 a sufficient response to that discussion.

13 And then I'll move onto the measure
14 under development pathway. Which is a little bit
15 more complicated.

16 CO-CHAIR RAPHAEL: Okay. Are there
17 any questions on that? Robyn?

18 MEMBER GRANT: I muted myself again.
19 Okay, I just wanted to make sure that we're on
20 solid ground legally.

21 That this, you know, holds. That it's
22 not something that could come back to bite us

1 later or be, you know, maybe a loophole could be
2 exploited down the road because we didn't
3 technically vote.

4 So, I just wanted to --

5 MR. AMIN: That's fair. And again,
6 any --

7 MEMBER GRANT: Get some assurance
8 there.

9 MR. AMIN: Any concerns that the
10 workgroup has, I mean, we're in an environment of
11 continuous improvement. I mean, the goal would
12 be not to try to change some of these processes
13 while we're in this rulemaking cycle.

14 But if there are concerns like, this
15 is why we what to have a conversation about it.
16 And you know, we can address them if they're
17 needed.

18 So, thank you for that. And you know,
19 from what I understand again, this particular
20 element of the decision making was broad. And we
21 had a conversation with the Coordinating
22 Committee, it's generally accepted with the

1 Chairs I should say, the Coordinating Committee.

2 And it was generally accepted. So,
3 you know, I'll just put that aside.

4 I think the second issue requires a
5 little bit more conversation and an
6 acknowledgment that there's a reasonable -- there
7 are reasonable concerns that have been raised by
8 commenters around the question of, and I would
9 welcome comments and reflections from our CMS
10 colleagues, around the measure under development
11 pathway.

12 So, for some historical context, you
13 know, when we started with MAP a number of --
14 five years ago, you know, there was sort of a
15 viewpoint that a lot of what MAP would be doing
16 was looking at endorsed measures and making a
17 decision around selection of these measures for
18 programs.

19 As the MAP has evolved and these
20 programs evolved, and the statutory requirements
21 have evolved, MAP has found itself in a position
22 of actually commenting much more on measures much

1 further upstream.

2 And basically what this translates to,
3 and this is what created the measure under
4 development pathway last year, which is why
5 there's this decision around continue further
6 development or do not continue further
7 development, was that there was a clear goal that
8 CMS asked for the MAP to provide early input on
9 measure concepts, given potentially a short
10 turnaround time for potential implementation.

11 Or that they wanted early input before
12 the significant investment was taken to continue
13 on measure testing. And so, the -- a large
14 number of measures sort of fell into this measure
15 under development pathway.

16 And we wanted to make it clear in the
17 MAP decision making that it wasn't just using the
18 same decision categories as fully developed
19 measures. Which is why we created this --
20 different decision making categories for measures
21 under development.

22 Which is continue further development.

1 Or do not continue further development.

2 I think one of the concerns that have
3 been raised during the comment session last --
4 yesterday, and is something that the Coordinating
5 Committee will be taking up during their January
6 meeting.

7 Which, this will be an issue that's
8 going to be spanning all of the workgroups. Is
9 that this has created a potential concern in the
10 view and from the perspective of many
11 stakeholders.

12 Which is that some of these measures
13 that are very early in development, get a
14 decision from the MAP, which is go ahead and
15 continue development. And that may be perceived
16 as, you know, go ahead, this is approved with no
17 conditions, given that these measures may not
18 have even gone through the endorsement process.

19 And you know, again, one of the
20 challenge here, one of the challenges here is
21 that clearly the MAP is making recommendations to
22 CMS. And these recommendations are about

1 measures, you know, these are about measures that
2 are still under development.

3 And so this is a reasonable concern
4 that has been raised. I would just sort of
5 characterize that what the intent of the measure
6 under development pathway was to clarify that
7 these are not measures that have enough
8 information, meaning the testing information in
9 the setting that they're intended to be used, for
10 the MAP to really make an up or down decision
11 fully.

12 And so, this was intended to create a
13 separate pathway. So, maybe I'll just stop
14 there. And sort of -- in terms of what the
15 context is.

16 I would welcome sort of comments or
17 reflections from our CMS colleagues or any other
18 MAP Staff. Or the Chairs if there's any place
19 else I can sort of expand.

20 CO-CHAIR RAPHAEL: Okay. Let me turn
21 to our CMS representatives. And ask if you have
22 any comments as we're shaping this new process?

1 MEMBER LEVITT: Well, first of all,
2 thank you. Thank you for the explanation. And
3 really, thank you for the workgroup.

4 I thought that we had a very, very
5 constructive meeting, and talking about very
6 important measures yesterday. Some of the
7 measures which have statutory time lines on them.
8 And other measures that don't.

9 And you know, at CMS we, you know, we
10 really try, and I think we're successful at being
11 as transparent as we can, possibly can, in terms
12 of, you know, discussing these measures and
13 getting feedback from you.

14 I think many of you came to me
15 yesterday and mentioned that you appreciated the
16 openness that we have in terms of some of the,
17 you know, issues going on. And the opinion that
18 we wanted from the MAP.

19 As we move forward with these
20 measures, if the measures are opposed for any of
21 the programs, certainly what's gone on here today
22 will be discussed and will be explained. And you

1 know, will not be ignored at all.

2 And as to, you know, what any sort of
3 future time line might be with the measures, that
4 really depends on, you know, our policy decisions
5 and decisions, you know, in terms of the
6 importance of, you know, moving forward the
7 measures. But we always take the MAP's opinion
8 and the importance of the NQF into account in
9 terms of these things.

10 CO-CHAIR RAPHAEL: Bruce?

11 MEMBER LEFF: Yes. Just a
12 clarification. I really appreciated that
13 explanation. And I too thought yesterday's
14 conversation was terrific.

15 So, tell me if I'm still not
16 completely understanding this. But, it feels
17 that even within the measures under development
18 category, those that have statutory, you know,
19 statutes standing behind them, seem to be in even
20 a different category.

21 Like that train is going to move
22 forward. Our role here is truly advisory input.

1 Is that fair?

2 And if that's so, it may mean you need
3 a slightly different designation for those.

4 Because I think it would help. I think that's
5 where I was really very confused yesterday.

6 And also, if you could clarify for me,
7 I think I have it, but I'm not 100 percent sure.
8 How the measure under development framework and
9 the endorsement framework ultimately come
10 together.

11 MR. AMIN: Okay. I will try to start
12 with the -- I'll start with the second. And then
13 I would actually ask some of my colleagues, maybe
14 Erin, or even the Chairs to reflect on the first.

15 Which is around the role of the MAP
16 sort of being advisory. And what the decisions
17 of the MAP sort of represent in terms of the
18 process that CMS uses.

19 I mean, inherently it is an advisory
20 -- in an advisory role. But, again, I'll take a
21 step back from that and ask others to sort of
22 reflect on that.

1 You know, this is another topic that
2 the Coordinating Committee is going to spend some
3 time on in January. Because the relationship
4 between MAP and the consensus development
5 process, the endorsement process, is an evolving
6 discussion.

7 So, with that being said, you know,
8 when measures under development sort of come into
9 the MAP process, you know, the MAP is making a
10 decision on whatever information is available at
11 that time.

12 It may be because the measures are
13 still early in development. That's generally the
14 reason. And the definition, one of the main
15 reasons why measures go into the measure under
16 development pathway is because there's not
17 testing.

18 And that testing, not even the quality
19 of the testing, it's just whether it's fully been
20 tested for that setting and the data source.
21 Which is information we get from our colleagues
22 at CMS.

1 So, with that being said, that's why
2 NQF feels relatively strongly that it's difficult
3 to really make a full -- a recommendation from
4 the MAP. Given the type of information that's
5 available at the current state.

6 So, you know, that's the measure under
7 development pathway. That's the definition.
8 That's how you get into it. There's just not
9 full testing.

10 And that's what the Staff uses to sort
11 of bifurcate the measures that go into this
12 pathway. It's the measures under development
13 pathway versus fully developed measures.

14 Now, how does that interact with the
15 endorsement process? The NQF endorsement process
16 really looks at measures that are fully
17 developed, fully tested, and fall into an
18 endorsement project cycle.

19 So, a measure that's sort of developed
20 in let's just say neurology, just using that as
21 an example, that's, you know, still a concept.
22 It can be looked at by the MAP.

1 That information is then translated to
2 the Neurology Standing Committee that looks at
3 all of the new fully developed measures and
4 tested measures. And they make a decision, a
5 scientific evaluation of the quality, of the
6 reliability, validity of the measure, and the
7 evidence supporting the measure in summary.

8 And that endorsement information
9 ideally is then translated back to the MAP if
10 they are looking at measures that are fully
11 developed. And that information in turn is
12 provided back to you in terms of the preliminary
13 analysis.

14 Which is what Staff pulls from to
15 make, you know, for fully developed measures. If
16 you're considering fully developed measures.

17 So, they're relatively independent.
18 I mean, just because the MAP recommends continued
19 development, doesn't mean that the measure's
20 going to be endorsed. In fact, I mean it -- I
21 mean, it's sort of interesting information.

22 But, the endorsement process is

1 looking at a much more robust set of information.
2 And it's looking at it much more, you know,
3 looking at all the scientific testing information
4 and all the evidence to support the measure.

5 Which obviously, given the volume of
6 what you're looking at, would not be possible.
7 And, you know, the way that the Committees are
8 seated is slightly different as well.

9 So, I don't know if that answers your
10 question. I don't want to just continue to sort
11 of --

12 MEMBER LEFF: No. No, it does. And
13 just a quick follow up, if we have a moment. So,
14 if you're a measure developer, is there an
15 advantage to first going through measure under
16 development as a lead to endorsement?

17 Or are they just independent that it
18 doesn't matter?

19 MR. AMIN: I mean, currently there's
20 really no, you don't have any insider path.

21 CO-CHAIR RAPHAEL: Clarke?

22 MR. ROSS: I wanted to speak about how

1 pleased I was that the National Quality Forum
2 developed this measure development process. I
3 was a member, and am a member, for the last three
4 years, with a workgroup on persons dually
5 eligible for Medicare and Medicaid.

6 And we continually were frustrated
7 because we do have very limited measures that are
8 performed in isolated communities and States.
9 That address very important concepts that the
10 full duals workgroup supports.

11 And so, when the National Quality
12 leadership came up with this second process,
13 we're delighted that there's this opportunity to
14 elevate something that's not ready for full stage
15 implementation. But, is not ignored because it's
16 not ready for full time implementation.

17 So, I know there are some stakeholders
18 with financial interests who don't like that
19 status. But, from a consumer point of view, and
20 the majority of the duals workgroup, this is a
21 wonderful opportunity.

22 And we're excited. And we're

1 proposing different kinds of isolated measures
2 that we'd like to see brought to scale.

3 CO-CHAIR RAPHAEL: All right. Thank
4 you. I don't know if anyone else from NQF Staff
5 wants to weigh in.

6 Oh, Bruce, you were asking --

7 MEMBER LEFF: Was there an answer to
8 the question about the statutory issue on some
9 measures?

10 MS. O'ROURKE: So, I can try to take
11 that. And may look to Tara and Alan for some
12 help.

13 I think for a number of the programs
14 that were created by legislation that has some
15 fairly strict requirements about what's to go
16 into that program, and what measures are to be
17 used, MAP does have a more limited ability on
18 what input you could really provide.

19 I think the idea of perhaps an
20 alternate designation for those where you're more
21 looking at the -- how a certain measure might be
22 implemented, may be more useful than how we're

1 currently putting it to you, since for some
2 there's not a lot of choice.

3 There's some, you know, some of these
4 statutes as Joel was presenting yesterday, you
5 know, for the SNF EDP program, basically only one
6 measure can go in there.

7 So, I think that would probably be
8 another good item for the Coordinating Committee
9 to take up on how we can most handle --
10 effectively handle those programs where MAP has
11 a limited box to play in if you will.

12 That there's some fairly strict
13 requirements put on things by Congress. And how
14 you can weigh in, in the most effective manner.

15 Taroon, would you add anything? Tara?
16 Alan?

17 MEMBER LEVITT: I think, I mean, every
18 measure is different in terms of, you know, where
19 a particular measure might be in terms of its
20 development. Some measures may already be being
21 used in other programs and be NQF endorsed.

22 And you know, they may be brought

1 because they want to be considered for a
2 different program. So they're already endorsed
3 measures, but yet they're under consideration for
4 a different or a new program.

5 So, they can be going there. Some
6 measures that are -- have statutory mandates may
7 already have been, you know, fully developed.

8 For example, you know, Joel's -- one
9 of the measures for the Value-Based Purchasing
10 Program yesterday was already in. You know, a
11 measure that had gone through the endorsement
12 process.

13 So, it's a hard question to answer.
14 I mean, like I said originally, we value this
15 input. And we want to use it as best as we
16 possibly can, you know, within the -- within the
17 limits as to what the schedule can be here and
18 what schedule we, you know, need to go by as
19 well.

20 And I think that we've noticed,
21 thankfully that, you know, in continuing to try
22 to make this better and better that we need to

1 relook at this and say well, considering how
2 things are, and the schedules that are, you know,
3 everyone's under, what is best to move forward?

4 So, I mean, I think it is a
5 constructive time to do it.

6 CO-CHAIR RAPHAEL: Let me just check
7 and make sure that we accommodate any public
8 comment. So, let me ask the operator to see if
9 there are anyone on the line who wants to make a
10 comment on this issue around the process we're
11 engaged in.

12 OPERATOR: Okay. At this time if you
13 would like to make a comment, please press star
14 then the number one.

15 (No response.)

16 OPERATOR: There are no public
17 comments at this time.

18 CO-CHAIR RAPHAEL: Okay. Let me turn
19 to our audience. And see if there's anyone in
20 the audience who wants to weigh in on this.

21 DR. GIFFORD: Hello. So, I think that
22 the whole NQF MAP process is an incredibly

1 important process in this review process.

2 And actually in the IMPACT Act, we
3 advocated really strongly that in the original
4 language there was nothing in there about NQF
5 review of IMPACT Act measures. And we advocated
6 that that be inserted into the measure process.

7 And so we see this as a vital thing.
8 I think you've heard a lot today from CMS about
9 statutory requirements and time lines. And they
10 are in a real bind.

11 If I was in their shoes developing the
12 measures that they're developing, I would do
13 exactly what they're doing. And I'd have the
14 exact process they're doing.

15 They are under staffed and under
16 resourced. And they have unrealistic time
17 frames.

18 However, NQF also has a statutory
19 requirement. And this body has a statutory
20 requirement to review the measures and provide
21 feedback.

22 And so while CMS is moving forward on

1 a fast time frame, the requirement, they do not -
2 - this is a body and NQF is an advisory process.
3 Their requirement is that what comes out of the
4 MAP process, they have to address in rules.

5 And they have to explain when they use
6 measures that are not NQF endorsed measures that
7 have gone through the process. And so they just
8 have to explain that. And they have to give the
9 rationale.

10 And so if there's concerns here, my
11 concern on the new process, of creating this
12 loophole of measure under endorsement, it allows
13 them to then just sort of say yes, let's go
14 forward.

15 And it diminishes the feedback and
16 concern that many of you have raised around that
17 to not having to necessarily be addressed in the
18 rulemaking as they go forward on these fast
19 measures.

20 So what Congress said, do these
21 measures and do quickly. Congress also said, we
22 want a balancing entity, a consensus by the

1 entity to review and give feedback to the
2 Secretary on these rules.

3 So, I would strongly urge you to think
4 about as you go through and vote on these
5 measures, to make sure it's clear what feedback
6 you want to address.

7 Because in the past, I think a lot of
8 these measures were used for quality improvement
9 purposes. And were just thrown up as reporting.

10 They are now being used fundamentally
11 differently. They are now being used in payment
12 models.

13 They're being used to create post-
14 acute care networks. They're being used to
15 provide information by providers to consumers on
16 making post-acute care decisions.

17 And so, some of these issues and
18 feedback for these measures, the denominator
19 definitions that are not fully specified, the
20 risk adjustment can really have profound impact,
21 unintended impacts that many people brought up.

22 So, I would strongly encourage you as

1 you go forward, to think about that. And the
2 current process of measure and develop -- or not
3 pursue, does not allow that sort of robust more
4 feedback that the Secretary then has to address
5 as it goes forward.

6 And so, I think as you think about the
7 voting and reviewing process that you consider
8 that more carefully. I also would, not being a
9 lawyer, slept at a Holiday Inn last night, I
10 would -- haven't been on a lot of boards.

11 I would recommend that, and I would
12 agree with Robin's point, I would bundle at the
13 end. And I agree that their intent was to
14 decrease all the measures. And I support the
15 consent calendar.

16 But usually a process is that consent
17 calendars get a vote. And there's a process with
18 Staff with consensus. There's not even a verbal
19 vote going on here.

20 This is a small thing. And I don't
21 want to take up extra time. Maybe you bundle it
22 all at the end. Because, if not, it's

1 technically there is not a vote on it. And
2 technically it's not clear.

3 Now there doesn't have to necessarily
4 -- there's been a laid out vote process by the
5 MAP. But in the statute there is no voting
6 process.

7 So, I'm not sure where the legal issue
8 is, but I think -- I'll just give you some
9 concern and pause about that. Then there is the
10 workgroup's or maybe it's the MAP's. It doesn't
11 matter.

12 And so I don't know. I defer to legal
13 counsel at NQF. But, I give you some pause to
14 think about how you go through and consent to it.

15 CO-CHAIR RAPHAEL: Thank you. Tara,
16 did you want to say anything? Or was it Alan?

17 MEMBER LEVITT: No. Thank you. And
18 thank you for the comment.

19 I do want to -- I do want to make a
20 couple of comments. First, we are developing
21 these measures based on certainly looking at
22 Congress' recommendations and Congress' vision.

1 And Congress' time lines that they've
2 set up based on feedback that they've received
3 from people in the room, in terms of some of the
4 needs that are here. We certainly do not
5 consider ourselves under-staffed or under-funded
6 to meet these needs of the consumers as well as
7 our stakeholders.

8 We are proposing these measures for
9 the programs that we are proposing them in. As I
10 said the other -- said yesterday, these are
11 quality reporting programs.

12 These are programs that will be
13 reporting the measures that you gave us advice on
14 yesterday if they, you know, when it got proposed
15 in those programs. For the -- our consumers to
16 be able to look at and for you to be able to use
17 in your quality activities.

18 If any type of Value-Based Purchasing
19 Programs were to be statutorily mandated, those
20 programs would use measures that I would assume,
21 I don't write the statutes, but I would assume be
22 similar, would require a similar process too.

1 Which would include coming back to a
2 body -- a consensus body such as the MAP. So
3 that when you are viewing the measures, view them
4 to the program that the measures are being looked
5 at for.

6 Don't -- please don't assume anything
7 else. Because if other programs do come along in
8 the future, those programs would have their own
9 statutory requirements as to, you know, how
10 measures could be proposed or, you know, be part
11 of that program.

12 CO-CHAIR RAPHAEL: Thank you. And
13 we're going to hear from Paul. And then we're
14 going to close up this discussion and move onto
15 other business we need to conduct today.

16 So, Paul?

17 MEMBER MULHAUSEN: Yes, just in terms
18 of procedure. It's my understanding that we have
19 taken a vote on each of these consent calendar
20 deliberations.

21 We've essentially approved them
22 through affirmation. And if we wanted, any

1 individual one of us should have had the -- have
2 the opportunity to have asked for a formal vote.

3 But, from my point of view, we have
4 voted on the consent calendar. And that each of
5 those action items were approved through
6 affirmation.

7 So, I don't think it's a fair
8 characterization to say we have not used this
9 opportunity to vote on the consent calendar.

10 CO-CHAIR RAPHAEL: And in line with
11 that, we just checked with the NQF Staff this
12 morning to affirm that everything we did was
13 consistent. Reflecting the processes that had
14 been put in place and legal.

15 So, just to give everyone a sense of
16 confidence in the process thus far.

17 MR. AMIN: Carol, can I just ask one
18 question? Sorry.

19 CO-CHAIR RAPHAEL: Sure.

20 MR. AMIN: I think Paul characterized
21 exactly the intent of the voting procedure. I
22 just wanted to clarify or ask if any of the

1 workgroups felt that, you know, the final
2 recommendations, which was essentially unanimous
3 across the different consent calendars for
4 accepting this, you know, Staff recommendations.

5 There was a number of measures that
6 were pulled off and voted separately. But, if
7 anyone doesn't feel that we sort of reflected
8 Paul's vision or Paul's discussion here of, you
9 know, I would ask you to raise those concerns.

10 We certainly don't want this to be a,
11 you know, process that doesn't reflect your
12 input. And we can do a separate vote on those
13 measures if it's required again.

14 But that is the -- that was the intent
15 if, you know, if the measures aren't being
16 pulled, you're accepting the Staff
17 recommendations. And that is your formal vote.

18 So, I just wanted to be clear about
19 that. And I would really like to thank the
20 public commenters on these issues.

21 They're certainly ones that need to be
22 considered more thoughtfully and across all the

1 workgroups. So, it's certainly something we will
2 bring back to the Coordinating Committee for
3 further discussion as well.

4 CO-CHAIR RAPHAEL: All right. I think
5 we are going to move onto the next part of our
6 agenda, which has to do with measures on the
7 consideration for the IMPACT Act.

8 This is one I'm particularly
9 interested in. Because when we did our core
10 measure set, I would have to say one of the areas
11 we grappled with was how to deal with costs.

12 And we had one of our core measures
13 had to do with cost and access. And so, let me
14 first ask the Operator to open the lines to see
15 if we have any public comments on this particular
16 set of measures.

17 Operator?

18 OPERATOR: To ask a question, please
19 press star then the number one.

20 (No response.)

21 OPERATOR: There are no comments at
22 this time.

1 CO-CHAIR RAPHAEL: Thank you so much.
2 Let me again turn to Members of the audience to
3 see if anyone wants to make a comment on this.
4 Okay.

5 MR. BAIRD: Thank you. Good morning.
6 My name is Andrew Baird from HealthSouth. Thanks
7 for your discussion yesterday on some of these
8 measures.

9 We are a post-acute care provider. I
10 think I've introduced myself as of yesterday.
11 I'll just note that as an avid observer of this
12 process, there is very little for us to provide a
13 comment on in way of this measure.

14 And since that the specifications are
15 relatively opaque, especially about when
16 particular accounting for a cost for different
17 types of post-acute care. Post-acute care
18 providers would begin what portions of different
19 post-acute episodes would be attributed across
20 the entirety of a post-acute episode.

21 AKA, when a patient's entire post-
22 acute experience, and how that would be divided.

1 Or if that would be divided at all.

2 So, I'd just like to reiterate for
3 this group that the amount of specifications that
4 are currently published, are very opaque. And
5 it's been hard for anyone at least on the
6 stakeholder side, to get an idea of what exactly
7 this measure looks like.

8 We've heard from several people that
9 discussions at the TEP were also somewhat
10 ambiguous in terms of whether or not they settle
11 on the measure framework.

12 But again, I just wanted to underscore
13 the fact that the amount of information that is
14 out there to say this is a good or a bad measure,
15 seems to be relatively low compared to the
16 measures that we discussed yesterday. Thank you.

17 CO-CHAIR RAPHAEL: Okay. Thank you.

18 DR. GIFFORD: I would amplify that in
19 that the measure specifications are not provided
20 for this. And I would encourage you to vote
21 insufficient information at this time.

22 This one can piece together what the

1 measure may look like from different pieces of
2 information out there. But, even the TEP itself
3 has not received a measure -- a set of measure
4 specifications to work on on this measure.

5 So, I think this is an important
6 measure. I think it's an important issue to go
7 forward.

8 It's specified in the IMPACT Act and
9 statute as a time frame. But there currently is
10 insufficient information at this time. I would
11 encourage you to vote on that level.

12 CO-CHAIR RAPHAEL: Okay. Okay, can
13 you please introduce yourself. We know David
14 Gifford.

15 But we want to just be sure that each
16 person introduces herself or himself.

17 MS. LEE: Sure.

18 CO-CHAIR RAPHAEL: Okay.

19 MS. LEE: Teresa Lee with the Alliance
20 for Home Health Quality and Innovation. And
21 thank you again to this body, NQF and CMS for the
22 opportunity to comment.

1 I agree with the former commenters.
2 We greatly look forward to seeing the specific
3 measure specifications for this measure.

4 We have in the past looked at the MSPB
5 measure for hospitals. And so, you know, my
6 comments are based on, you know, the assumption
7 that this might look somewhat like the MSPB
8 measure for hospitals.

9 And vis-a-vis that measure, I think
10 that our concerns are somewhat similar from a
11 home health perspective to the concerns about the
12 hospital MSPB measure. First and foremost, that
13 we continue to be concerned about just looking at
14 costs alone.

15 And that that might be confusing for
16 consumers. Because cost alone does not
17 necessarily mean anything vis-a-vis quality.

18 Low Medicare spending per beneficiary
19 might mean efficient care. But it might not. It
20 might just mean low spending. And that might
21 actually mean poor quality of care.

22 So, that continues to be an issue. If

1 that track is pursued, we strongly urge
2 consideration of a measure that relates to access
3 to care.

4 I definitely think that MSPB is a
5 significant consideration for payers, for the
6 Government. Probably increasingly for
7 accountable care organizations and those running
8 bundled payment arrangements.

9 But likewise, I would think that for
10 consumers and patients, it's very much of
11 interest to have some kind of a measure that
12 relates to access to care.

13 So, those are probably my primary
14 considerations. And just as with any measure, we
15 believe very strongly in the need for adequate
16 testing and validation of the measure.

17 And would urge sufficient time and
18 reporting to providers before making any measure
19 like this public. Thank you.

20 CO-CHAIR RAPHAEL: What do you mean by
21 that?

22 MS. LEE: You know, I think that what

1 we mean by access isn't, you know, we'd be very
2 interested in working with CMS on a measure that
3 relates to access. Because I think that we
4 haven't given enough thought to it.

5 But, I remember at the inception of
6 the Medicare Shared Savings Program, I want to
7 say that RAND did an analysis of what kind of
8 measures should be developed in -- for the
9 Medicare Shared Savings Program.

10 And one recommendation and, you know,
11 identification of a gap, was that there needed to
12 be some kind of measurement that relates to
13 ensuring that patients have adequate access to
14 care.

15 Simply because in any kind of shared
16 savings arrangement or bundled payment paradigm,
17 there might be a concern about inadequate, I'll
18 just say, you know, under use as opposed to over
19 use.

20 So, that's a question that I think I
21 and many might have with these types of
22 arrangements. And when you're looking at

1 Medicare spending for beneficiary, you know,
2 there's clearly going to be an opportunity to use
3 this measure as a way to select providers who are
4 spending lower over the course of an episode.

5 CO-CHAIR RAPHAEL: Okay. Let me see
6 if Laura has anything in the chat box?

7 MS. IBRAGIMOVA: No, there is nothing.

8 CO-CHAIR RAPHAEL: Okay. So now, this
9 is I guess something where we really do want to
10 understand this measure.

11 Sarah, I'm going to turn to you to
12 start us off given that we have heard that the
13 measure spec is not very, very illuminating.

14 MS. SAMPSEL: Okay. So, this is very
15 much a -- all four of these are similar measures.
16 The Medicare spending per beneficiary post-acute
17 care and being on the MUC List for use in home
18 health QRP, inpatient rehab QRP, long term care,
19 as well as skilled nursing facility.

20 These are all -- the preliminary
21 analysis are all very much similar in that we had
22 the information, you know, that we had when we

1 received the MUC List this year.

2 And so it was very preliminary
3 information. So, the information in your
4 discussion guide would be the descriptions that
5 were available to us.

6 And through that information and
7 knowing that these measures all support and are
8 being offered forward as components of the IMPACT
9 Act and the statutory requirements as well as
10 overall and knowing there are other similar
11 measures specifically for hospital, made us come
12 down to the side of recommending these measures
13 and encourage continued development as you've
14 seen previously.

15 I think I would also say, you know, in
16 light of our conversation this morning, this
17 would be -- these would be a great example of
18 where CMS is really early in the process of fully
19 specifying the measures, taking in information,
20 meeting this advisory input so that as they move
21 forward with testing and using the data they have
22 available to them, that they do come up with the

1 best measure.

2 But, the staff recommendation for all
3 four of these measures, is encourage continued
4 development.

5 CO-CHAIR RAPHAEL: Okay. Let me turn
6 now to CMS.

7 MEMBER LEVITT: Okay. Well, thank
8 you. I'll just -- I'll start off. First of all,
9 thank you again for the review and all the
10 comments.

11 I wanted to introduce Kim Spalding-
12 Bush. Kim and her team have developed this
13 measure as well as the other Medicare spending
14 per beneficiary measures throughout the various
15 programs that we have.

16 I need to apologize I guess a little
17 bit to the workgroup and to Kim. Because you
18 know, historically we haven't given presentations
19 of measures prior to the measure being done.

20 We responded very much in the way that
21 we responded yesterday. In terms of, you know,
22 responding back to the comments.

1 And I apologize for the confusion that
2 that may have undertaken. Because there is more
3 to the measure than meets the eye.

4 And I'll turn to Kim now if she can
5 maybe give some of that. So, thank you.

6 MS. SPALDING-BUSH: Thanks Alan. I'm
7 Kim Spalding-Bush from CMS. And I apologize. I
8 don't have a placard either.

9 So, I do understand the importance of
10 providing more detail around the measure in order
11 to get more meaningful comment. And I think at
12 this point, the measure has been through a
13 Technical Expert Panel.

14 And we've gotten some really good and
15 meaningful feedback from the TEP members with
16 regard to exclusions and that type of thing. So,
17 one of the commenters mentioned the Medicare
18 spending per beneficiary on the hospital side,
19 which is the name of the measure, as Congress
20 gave us in the IMPACT Act.

21 So, these measures do look a lot like
22 the hospital level Medicare spending per

1 beneficiary. I think there's an important
2 distinction that we've begun to explore with the
3 TEP, which is what types of services will we want
4 to actually exclude from this measure?

5 So, for the hospital level measure,
6 it's all Part A and B. Everything's in. For
7 this measure, we are taking a look at things like
8 congenital, you know, treatment for congenital
9 issues that the beneficiary may have that could
10 be wholly outside of the scope, or the influence
11 of the post-acute care provider that we might
12 want to exclude.

13 The TEP also suggested issues that may
14 arise on the first day of a post-acute care stay.
15 Where they may actually reflect more or something
16 that could have happened in the hospital and then
17 a UTI maybe appears and they need treatment for
18 that in the post-acute care setting.

19 So, those types of things that we
20 received from the TEP, we are exploring. And we
21 will be providing the detailed measure
22 specifications after, you know, we receive your

1 input and we do the public -- and get more
2 stakeholder and public comment on these measures.

3 So, I also wanted to speak to the
4 concern that this is a resource use measure. And
5 I understand that as well.

6 And that it was sort of delineated as
7 such in the law. But that CMS, you know,
8 historically has used resource use measures when
9 they do become a part of any sort of a Value-
10 Based Payment Program used alongside with quality
11 measures so that you do take the total picture as
12 more of a value.

13 We understand that a resource use
14 measure just inherently is looking at costs. The
15 things that we could expect to recognize that,
16 you know, may reflect better quality within a
17 resource use measure are limited.

18 So, things like improved care
19 coordination that reduces unnecessary services,
20 prevents readmissions, those types of things,
21 will show up as better performance in a resource
22 use measure.

1 But, we don't present the measure as
2 sort of an inclusive quality and cost measure.
3 It is really a resource measure. And I think
4 with regard to the access of care issue that's
5 also an important one.

6 While the measure itself isn't, as you
7 know, set up to consider that, it is something
8 that we have done analysis on in a hospital
9 level. And we intend to continue that type of
10 monitoring analysis as we move forward with these
11 measures.

12 And we were able to look at things
13 like, was there a spike in resource use after the
14 end of this post-discharge window. Were
15 providers delaying needed care to try to avoid,
16 you know, those services being captured in the
17 measure.

18 And we have found in our analysis at
19 the hospital level, that that did not occur. But
20 it's something that certainly with post-acute
21 care setting, we will continue to monitor for.

22 And I think that's about all I have in

1 response to the comments that we've heard so far.
2 Alan, is there anything else that you might want
3 to add about the measures?

4 I'll put you on the spot.

5 MEMBER LEVITT: No, I mean I guess
6 maybe we'll turn to the workgroup and see how the
7 workgroup -- questions the workgroup may have.

8 And maybe you can help. You and your
9 team can help in terms of clarifying the
10 questions.

11 CO-CHAIR RAPHAEL: Gene, you're our
12 lead discussant on this. So, before we turn to
13 the entire workgroup, do you want to weigh in?

14 MEMBER NUCCIO: Thank you. Again, I'm
15 not representing any particular provider. I am
16 one of the technical representatives.

17 Certainly, we support the idea of
18 measurement of cost across providers. And that's
19 clear that that's one of the charges that we all
20 have in terms of -- in addition to giving
21 quality.

22 I do have three concerns or concerns

1 in three parts. First, the concern of inherent
2 differences among the four different post-acute
3 care health group providers.

4 They clearly serve very different
5 patient populations in terms of the medical needs
6 and resources and interventions that need to be
7 given. Why else would we have four different
8 kinds of groups if we did not have at least four
9 different kinds of patients.

10 The patients are served in quite
11 different physical environments. Quite notably,
12 home health is not in a bricks and mortar kind of
13 environment.

14 The three -- three of the groups have
15 a payment, the SNF, IRF, and LTC -- LTCH, excuse
16 me, LTCH. Have primarily a fee-for-service kind
17 of payment model.

18 Whereas home health has a perspective
19 payment model where people who have the same
20 diagnosis are -- the agency receives the same
21 payment. And so, there will be inherent
22 differences in terms of variation found within

1 these four different groups.

2 The second concern is the comparison
3 format. While the methodology is quite clear, I
4 mean, it's very standardized of a 60-day period
5 with a provider and a 30-day post provider
6 period.

7 The -- there's a -- some inherent
8 differences in terms of the settings. And we
9 discussed this yesterday when we talked about
10 both readmission and discharge.

11 What does it mean to be discharged?
12 Or what's the likelihood of being discharged from
13 an IRF to a -- to the home setting?

14 And so, the payers that are likely to
15 occur in this 60-day period, and then the added
16 30-day period, will look quite different amongst
17 these four different groups.

18 There is something that we also
19 discussed yesterday, and excuse me, and also
20 parenthetically with that, there are also quite
21 clear empirical differences in region in terms of
22 what these care patterns are.

1 So, the regional differences are --
2 could be within State, or it could it be across
3 the ten CMS regions. So, those regional
4 differences would be of concern.

5 Yesterday, we discussed the role of
6 risk adjustment in these models and the previous
7 models. And again, perhaps because it's such an
8 early development phase, that -- the whole risk
9 adjustment process, and how the clinical case mix
10 is going to be addressed, is not quite clear in
11 these and needs to be much more explicit.

12 The third area is sort of psychometric
13 issues. And the language of the average of the
14 ratio of standardized episodes spending level,
15 and the expected episode spending for each
16 provider, is somewhat technical.

17 And maybe not exactly as accurate as
18 some of the technical people would like. What do
19 you mean by standardized? Not very clear. And
20 how would that differ from setting to setting?

21 You use the term expected episode
22 spending, which suggests some sort of a risk

1 model. Again, not clear in how this needs to be
2 developed.

3 The exclusions, I was curious whether
4 or not dual eligibles would be included or
5 excluded in the setting. There is some language
6 about whether or not, you have to be fee-for-
7 service for the entire period of time.

8 But, if you're -- and then there's
9 also language about your primary payer source.
10 And so, if you move from a Medicare to Medicaid
11 kind of model in that, you have a -- there might
12 be an issue.

13 In terms of the denominator, there is
14 a -- the description of a weighted median. And
15 while Alan certainly knows, I have no objection
16 to using the median in computations, I need to
17 know what the weighted is.

18 Also, with regard -- the third -- this
19 third part, is the issue of unintended
20 consequences. And I think we've already heard
21 some of that.

22 And in fact it's called out in some of

1 the descriptions that you provided. Notably, the
2 cherry picking issue for -- in some care
3 settings. But, I thought also there might be a
4 positive.

5 That is, if we have this -- if a SNF
6 has a -- is on the hook if you will, for 60 days
7 in the SNF, and then 30 days elsewhere, they
8 might begin to partner with the most effective
9 home health agencies around. And so, there might
10 be some inherent positive in this 60 day/30 day
11 idea.

12 But again, -- again an unintended
13 consequence, we do have four measures. I am
14 concerned that there might ultimately be a
15 comparison of costs across each of these four --
16 post-acute care settings that again, going back
17 to my first comment, we serve inherently
18 different patients.

19 And so I would, you know, be aware
20 that, you know, that this comparison across
21 groups as opposed to within groups, is an issue.

22 And one last comment just to

1 summarize. You know, again I do support the idea
2 of measuring costs, costs of care.

3 But I want to ensure that the -- that
4 what we're really all about here is measuring the
5 value and the quality of care given to patients
6 first.

7 And understanding that that cost of
8 care involves both the integration of both
9 outcomes and processes that are delivered to
10 them.

11 So, sorry for it being so long.

12 CO-CHAIR RAPHAEL: Okay. So, I'm
13 going to turn now to workgroup members. And I
14 think the first thing we have to decide is if we
15 want to pull these from the consent calendar.

16 And I -- Gene, I'm going to ask you
17 your thoughts. You know, you said that you're in
18 favor of beginning to really measure costs.

19 But, you gave us a lot of caveats.
20 So?

21 MEMBER NUCCIO: Can I say that there's
22 a lot of work to do? I worry that if we use the

1 insufficient --

2 CO-CHAIR RAPHAEL: Information.

3 MEMBER NUCCIO: Information, which
4 there probably is. Okay, in reality there is
5 insufficient information.

6 I don't want to discourage the amount
7 of work that needs to be done in order to bring
8 this measure perhaps back to the MUC in a more
9 detailed and mature form.

10 CO-CHAIR RAPHAEL: I mean, I would say
11 that's something that I'm grappling with here in
12 the sense that I haven't found the house that I
13 would like to inhabit.

14 Because the house, you know, if
15 insufficient information doesn't feel like the
16 appropriate house because I think we as a
17 workgroup, have really tried to foster some work
18 on cost and access.

19 And so, this is the first time we have
20 seen some work in that area. And we want to kind
21 of continue that.

22 On the other hand, if we say encourage

1 continued development, to what extent are we
2 endorsing, in quotation marks, the road that
3 we're traveling?

4 So, that's just something that I'm
5 kind of trying to deal with here. So, if you
6 have anything that's enlightening, that would
7 help.

8 MS. O'ROURKE: Sure. So, I don't
9 think I can really answer the question about what
10 to pull or how to vote.

11 But, I did want to clarify that we
12 capture all of your discussions. And we do pass
13 that along in the Statement of Rationale that
14 goes along with whatever decision the workgroup
15 ultimately comes to about each measure.

16 So, your recommendations are not going
17 to CMS in a vacuum. There is a detailed
18 Statement of Rationale that captures all sides of
19 the workgroup discussion, and sends that along
20 with it.

21 So, if that helps you for your
22 decision making.

1 CO-CHAIR RAPHAEL: Okay. Yes. Lisa?

2 MEMBER WINSTEL: I know that this has
3 been addressed, so forgive me for asking it
4 again. But, I really would like just a really
5 direct, simple answer as possible on this.

6 If this measure or any of these
7 measures are voted for continued development,
8 after they have been developed more, will those
9 measures come back to this Committee? That's a
10 yes or a no question.

11 MEMBER LEVITT: I apologize. Can you
12 say it again?

13 MEMBER WINSTEL: Oh, if there -- if
14 any of these measures were to be voted for
15 continued development, will that measure come
16 back to this Committee for review before
17 implementation?

18 MS. SPALDING-BUSH: So, that may be
19 more of an NQF process question.

20 MEMBER LEVITT: No. Yes, again, I was
21 hoping before we kind of looked procedurally as
22 to how to vote, whether or not Kim could give the

1 workgroup some more answers to Gene's very
2 thorough analysis.

3 I think you're seeing right now why it
4 was great to have Gene as a member of the
5 Committee. Because he really does a great job of
6 looking at things.

7 And give Kim a chance to talk about
8 it.

9 CO-CHAIR RAPHAEL: Okay. So, what I'm
10 going to do, Kim, I'm going to hold off. Because
11 I think we want to make sure we get the whole
12 range of issues.

13 And then I'm going to turn to you.
14 So, that's asking a lot of you. But, I think
15 you're up to it.

16 All right. Suzanne, you were first.

17 MEMBER KAUSERUD: I think you had
18 asked if we wanted to take it off of the consent
19 calendar for the discussion. And I would like to
20 move to do that.

21 I think it needs some more in-depth
22 conversation. And I feel like there's going to

1 be some contention around this one. So, I think
2 it would be important to get those details.

3 And then from the measure, from the
4 information, you know, as stated it's very
5 limited. It's hard to, you know, give a lot of
6 input just because there's not a lot that we have
7 at this point in time.

8 But I think looking to the inpatient,
9 or the acute care Medicare spent per beneficiary,
10 some of the things we would want is to make sure
11 that any of the risk adjustment done on severity
12 would be done off of the case mix groups instead
13 of DRGs.

14 Because the case mix groups in
15 inpatient rehab in particular, -- and I would
16 assume it's the same for skilled nursing, you
17 know, as well as home health.

18 And well, LTAC would be off the
19 inpatient. But, because the severity is captured
20 through those payment systems a little bit
21 better.

22 Also, risk adjustment on socioeconomic

1 status as well as other characteristics such as
2 availability of care giver and community supports
3 would be important. Because that's a huge
4 variation at least in patient rehab, of whether a
5 patient is going to be able to return to the
6 community with a lifelong disability.

7 Also, just some concerns, and this
8 might be a little selfish because I am in a
9 facility that takes a lot of unfunded and
10 underfunded patients. And so, our low income
11 provider adjustment is quite sizeable.

12 We're also a teaching facility. And
13 so, we have been told by our Medicare
14 Administrative Contractor before that per case,
15 we are the highest paid inpatient rehab facility
16 in their area.

17 And it's because of our facility
18 characteristics. So, I think that it would feel
19 wrong to me.

20 And it's just my opinion, but it would
21 feel wrong to be penalized as a provider who
22 takes low income patients and is a teaching

1 facility, to be penalized for those
2 characteristics of our facility.

3 So, I think those would be important.
4 As well as any other, maybe a rural adjuster.
5 We're not rural.

6 But I think a rural facility gets an
7 increased payment as well because of their
8 setting. So, I think normalizing that would be
9 important if you're going to compare between
10 facilities.

11 And then the numerator description,
12 there's several terms. And this is why I'm kind
13 of thinking -- personally I'm thinking about
14 insufficient information.

15 Because a lot of the terms could go --
16 there's terms that I'm not familiar with that
17 standardize episode spending, expected episode
18 spending, average standardized episode spending,
19 information about the weighting methodology.

20 And then the terms about planned and
21 -- planned care and routine screening. I think
22 we would need to know what planned care is.

1 And what routine -- what falls into
2 those categories to make intelligent decisions
3 about the measure. So, I'll stop at that point.

4 CO-CHAIR RAPHAEL: Liza?

5 MEMBER GREENBERG: Thank you, Suzanne.
6 I would like to amplify Suzanne's remarks.

7 I think we do need a lot of the
8 definition. And I agree that we should vote on
9 it individually.

10 I think it's a statutory measure.
11 It's an important measure. But, I feel like we
12 don't really have enough information to really
13 get into the weeds about what it's -- what's
14 going to happen with it.

15 I know I'm concerned about possible
16 double counting. And wonder if there's like some
17 way that we could, you know, have a couple of
18 models of patient pathways through post-acute
19 care.

20 Where we could, you know, look at a
21 patient that goes from a hospital to SNF and then
22 to home health. Or a patient that goes, you

1 know, different models like LTAC to SNF to home
2 health.

3 So that we can kind of standardize
4 what is happening to the patients. Because
5 although I know that CMS will have every
6 intention of looking at costs paired with quality
7 that Congress might not.

8 And that might affect sort of how
9 different path providers are viewed in future
10 payment increases. So, the cost and quality
11 pairing I think is really critical.

12 I'm concerned about the safety net
13 providers and what this might do to safety net, I
14 think is also a very valid concern. And mainly
15 also just more detail on how to interpret and
16 understand the specs.

17 CO-CHAIR RAPHAEL: Roger?

18 MEMBER HERR: My first is a process
19 question. If one person requests a poll, are we
20 then polling?

21 CO-CHAIR RAPHAEL: Yes.

22 MEMBER HERR: Okay. So then, I'm just

1 making sure that was clear to everybody. And my
2 second part is, I think we're having a really
3 rich discussion.

4 So, I hope if that's how we're doing
5 it, wonderful. I think all I'm hearing from the
6 group are very important details that are needed.

7 But overall, these are measures that
8 we were encouraging from the beginning. And
9 we're finally getting some direction. I
10 understand Gene's issues of comparing settings.

11 But, if we're able to capture all of
12 our feedback here and give that as future
13 development in this area, I think we're going in
14 the right direction.

15 CO-CHAIR RAPHAEL: Okay. All right,
16 Jim?

17 MEMBER LETT: Oh, thank you. These
18 measures feel profoundly different to me than
19 anything I've ever discussed in this forum
20 before.

21 I mean, we are the National Quality
22 Forum. I feel very comfortable in hashing

1 through measures of quality. I am far less
2 comfortable in considering this the National Cost
3 Forum instead.

4 I think I support not only the ability
5 and right of CMS to understand what it costs to
6 render care. As a taxpayer, I think they should
7 be obligated to do that.

8 And I think it's an excellent thing.
9 I am having a hard time finding a bright line
10 between costs and quality in this discussion.

11 And I am concerned that cost may at
12 some point become more relevant. I'm reminded of
13 the famous and probably apocryphal story about
14 Gus Grissom, one of our first astronauts.

15 That they supposedly interviewed him
16 before he was blasted off into space. And they
17 said so, how do you feel, Astronaut Grissom,
18 about this? Are you nervous?

19 He said, how would you feel if every
20 part in your rocket was the lowest bidder. So,
21 I'm -- I want us to be clear what we're measuring
22 and why we're measuring it.

1 I again, firmly support the need to
2 have cost as part of the discussion. I'm worried
3 about the blurring line with quality.

4 And I think there's insufficient
5 evidence both from the technical standpoint and
6 from the moral standpoint as to where we're
7 headed with these measures. Thank you.

8 CO-CHAIR RAPHAEL: Robyn?

9 MEMBER GRANT: I have a couple of
10 things. And one of them is a process question.

11 And that's what does happen if we go
12 with insufficient information? Does it just
13 disappear off the books?

14 Or does CMS continue to work on it and
15 then bring it back? And we need to look at it
16 again.

17 MS. SAMPSEL: I'll start. And does it
18 fall off the books? No.

19 I mean, we feed back to NQF the full
20 list of all the measures discussed and your final
21 disposition, based on your votes and your
22 recommendations. Along with, as Erin has already

1 commented, all of the rationale behind them.

2 Past that, it's then up to CMS
3 internally to figure out, you know, what kind of
4 -- where that measure goes. The direction for
5 development as well as where it comes back. And
6 if it comes back to NQF.

7 CO-CHAIR RAPHAEL: Erin, do you want
8 to add anything?

9 MS. O'ROURKE: I would just echo that
10 Sarah's point, it would be up to CMS at that
11 point. They don't have an obligation to bring
12 things back to us, no matter what the disposition
13 is.

14 So, in an ideal world, yes, they would
15 bring it back the next year with the measure more
16 fully tested. And allow the group another chance
17 to weigh in.

18 And hopefully, that is what would
19 happen. But, from a process wise, we don't have
20 any guarantee.

21 CO-CHAIR RAPHAEL: Okay. So it goes
22 back to you Robyn.

1 MEMBER GRANT: Okay, thank you. So
2 just a couple of comments. One, is just from a
3 consumer perspective, I think what matters is
4 that you get the care you need when you need it.
5 And that it's good care.

6 And that quality -- that the cost of
7 it is not what the consumer is really thinking
8 about and making a decision. And those other
9 factors are, I think, the real key ones.

10 I want to amplify or build on what
11 Gene said in terms of unintended consequences.
12 In addition to the cherry picking, I'm concerned
13 that, as he's mentioned, might result in
14 individuals getting less care than they need in
15 order to keep the cost down. Or look at
16 premature discharge.

17 Because again, that's the way the
18 provider to keep his cost down. So, I really
19 worry about that across the measures.

20 CO-CHAIR RAPHAEL: Cari?

21 MEMBER LEVY: Thank you. I just
22 wanted to ask a question about is there -- are

1 there any thoughts about characterizing provider
2 markets?

3 And the reason I ask is I know we have
4 a number of rural communities where there's
5 really a substitution of home health for SNFs,
6 where SNFs don't exist.

7 And so, if we're really doing a lot
8 more home health for example in an area that
9 doesn't have a SNF, will they be penalized
10 because they've ramped up those services to
11 substitute for no SNF?

12 I don't know if there will be. I know
13 there's a rural/urban adjustment. But that may
14 not account for this rural substitution.

15 CO-CHAIR RAPHAEL: We'll hold off on
16 that one. Paul?

17 MEMBER MULHAUSEN: So, thank you.
18 This has been a really excellent discussion.

19 I guess I'm a little concerned that
20 we're contemplating the vote of insufficient
21 information. And I guess I want to speak to that
22 personally.

1 So, from my world, any time we
2 consider value in the delivery of services, we
3 worry about the unintended consequences. Of the
4 cost side of that equation.

5 So, I think it's an inherent concern
6 whenever any of us try to raise the issue of
7 value. But, I think anybody who contemplates the
8 cost of care to our community, recognizes that we
9 simply have got to try to grapple with this
10 particular issue.

11 I think these are worthy measures. I
12 don't know if they fall into the framework of
13 quality as Jim has pointed out.

14 And I do think they are certain --
15 there is certainly insufficient evidence here to
16 endorse them as an NQF endorsed measure. Which
17 in my world of trying to develop programs,
18 picking NQF measures means something.

19 But I'm also uncomfortable giving the
20 message to our colleagues at CMS and say to them,
21 you know, there's not enough information here.
22 We can't even advise you to move forward on this.

1 I'm pretty comfortable that I want to
2 give them the message. Yes, you grapple with
3 this. Find the risk models.

4 Develop the details that Gene says are
5 missing. Because we can't endorse them as unique
6 measures without that information.

7 But, I would be loath to vote that
8 there's insufficient information to endorse
9 moving forward on this. That's my comment.

10 CO-CHAIR RAPHAEL: Thank you. Bruce?

11 MEMBER LEFF: Yes, thanks. So, just
12 another potential unintended consequence that
13 comes by having each of these measures on a
14 separate ledger as it were.

15 So, I wonder whether accounting for
16 these different venues each separately, could
17 actually lead to discouraging imaginative
18 partnerships within health systems?

19 So, if you think about at least in
20 theory perhaps, a lot of the fat in care delivery
21 being in the hospital, it could be that a good
22 home health agency would partner with a hospital

1 that's not particularly efficient.

2 Take some of those people out of the
3 hospital earlier. Help the hospital keep their
4 costs down. Maybe raise the costs on the home
5 health side.

6 And if they're engaging in some sort
7 of shared savings arrangements, that's something
8 that by keeping separate ledgers might be
9 discouraged in this kind of system.

10 The other question I have is, are
11 costs that are not covered by Medicare captured
12 in this equation?

13 So, I don't know if anyone saw the
14 front page of the New York Times today, looking
15 at, you know, basically prices.

16 Price is God, right? People are
17 finally coming to the realization that you really
18 have to think about price of things.

19 So, it seems like there was actually
20 very little relationship between Medicare costs
21 in the market and private insurer costs in the
22 market. And those needs depends a lot more on

1 the characteristics of the providers in the
2 market.

3 So, I'm just wondering whether in any
4 way that was being captured. Is there price
5 shifting going on, you know, in the secondary --
6 on the secondary side? Secondary insurer side.

7 Just some things to think about. And
8 I agree. I would just endorse Paul's comments as
9 well.

10 CO-CHAIR RAPHAEL: Okay. Sean?

11 MEMBER MULDOON: Clarify for me -- and
12 it matters more on this one because it is costs
13 where cost shifting is probably desirable under a
14 lot of these arrangements.

15 This only applies to fee-for-service
16 traditional Medicare. And therefore, creative
17 arrangements done under ACOs, bundles, and risk
18 sharing arrangements would be systematically
19 excluded from this.

20 Is that true?

21 CO-CHAIR RAPHAEL: I only know that
22 Medicare Advantage is excluded. And I don't want

1 to say that ACOs and bundled payments.

2 My assumption had been that they were
3 excluded. But I would want to have that
4 confirmed.

5 MEMBER MULDOON: That was -- well,
6 that would be the caveat to your concern.
7 Because we really do want post-acute care in the
8 next five years to be saying, this use to be good
9 for me.

10 But not good for the whole episode.
11 And let's move those dollars around, so again.

12 And second question, I think is a
13 comment. And being that these are statutorily
14 required, these -- development is going to
15 continue regardless of what this Committee votes.
16 Correct?

17 So, if that's the case, then, you
18 know, we either just punt the thing and say too
19 messy, we don't want to mess with it. Or we get
20 on this slow moving train and say we'll figure it
21 out as part of the process.

22 So, that would -- if that is true, it

1 would lean towards a vote to -- with a lot of
2 reservations, to continue development.

3 CO-CHAIR RAPHAEL: I think that's an
4 important point. Because to be realistic, if,
5 you know, we're not -- none of the votes that we
6 would in fact engage in, would pull the train off
7 the track.

8 The train is going to continue on the
9 track. So, we need to be aware of that.

10 This is tied to the IMPACT Act. It
11 has time frames dependent on it. So, just so
12 that we are doing this wide-eyed, if not bushy-
13 tailed.

14 Okay. Deb?

15 CO-CHAIR SALIBA: So, this follows up
16 on some comments that folks have made. And Ms.
17 Lee made this comment as well.

18 I do want to -- I understand that the
19 MSPB is moving forward. And that's a good thing.

20 But, I want to make sure that in
21 parallel, there is consideration given to how
22 this translates into value measures. Because I

1 think that ultimately is where we want to head.

2 And it may be important as you're
3 developing these measures to bear in mind that
4 you want them to be part of a value-based
5 measure. It may influence some of the ways that
6 you set this up ultimately.

7 Because I do think we don't want to
8 just be going to the lowest bidder. I thought
9 Jim's -- I smiled because Jim always has great
10 stories to tell. So, thank you for another one.

11 Because we really don't want to be in
12 a position where it's just about cost. It's got
13 to be the combination of, you know, bang for the
14 buck kind of approach.

15 CO-CHAIR RAPHAEL: Cari and Suzanne,
16 do you want to add anything at this point? And
17 then we're going to turn it over to Kim.

18 MEMBER LEVY: In following on what Deb
19 said. And I know this will be accounted for, and
20 I guess I can't understand and I probably should
21 be able to.

22 But, will this be something that's

1 reported in real time? I mean, will this
2 potentially be a hot potato patient?

3 Because we've had this happen where we
4 know that there's people who are spending a lot
5 in our system. And they suddenly become this hot
6 potato where we didn't want them.

7 We didn't want to touch them anymore
8 because they were spending so much. And we had
9 some who spent \$3 million over the span of a
10 year.

11 And they became a hot potato and no
12 service wanted them. Because they were causing
13 all these troubles.

14 And so, if it's going to be obvious to
15 anyone that this is one human being who's costing
16 them a lot, that is probably not a great
17 situation.

18 MEMBER MARKWOOD: My question was
19 primarily a process question too. I mean, it
20 sounds like because statutorily this will move
21 forward that the best value that we can have in
22 this discussion, and we've had a lot of

1 discussion about concerns raised about elements
2 of this moving forward.

3 Is, if we did vote to keep it under
4 consideration, would there be other opportunities
5 for this Committee to have to dig deeper into
6 some of these issues that we've raised as major
7 concerns?

8 CO-CHAIR RAPHAEL: Lisa?

9 MEMBER WINSTEL: I just wanted to
10 raise one more unintended consequence. Because
11 as people are discharged, whether it's from home
12 health or from an IRF or whatever, if they are
13 discharged sooner, if there is a goal of reducing
14 costs, the burden of care is going to fall on the
15 family care giver.

16 And that family care giver is going to
17 ultimately, and we know this from comprehensive
18 research, then be forced with a choice of whether
19 or not they have to leave the workforce themselves.

20 They're going to be forced to either
21 pay for care that is not covered. That is home
22 helpers and aids. Hence, bringing on more out of

1 pocket costs.

2 And then ultimately, and again, we
3 know this from research, that family care giver,
4 who could also be a Medicare beneficiary, will
5 then have their own health issues.

6 Because it is well documented that the
7 family care givers because of stress and the fact
8 that they're taking care of somebody else and
9 ignoring their own issues, then becomes a
10 patient.

11 So, as we transfer the burden of care
12 out of the system and into the home, we might
13 ultimately be driving costs up.

14 CO-CHAIR RAPHAEL: Suzanne, back to
15 you.

16 MEMBER KAUSERUD: Thank you. I just
17 want to amplify Deb's comments about value. The
18 value conversation here.

19 And I know that we try to look at the
20 measures kind of in a vacuum. But, it's
21 important to also put them in context.

22 The -- I think there's general support

1 for Medicare spend for beneficiary measure. I
2 think it's a really important measure.

3 But, I think it becomes pretty weighty
4 if -- in the inpatient rehab setting because our
5 one proposed measure for value-based purchasing,
6 we have only one measure listed in the proposal.
7 And it is Medicare spent for beneficiary.

8 So, for that setting, it's really
9 important that the measure be -- not be -- that
10 it be done well.

11 Because I would anticipate that if the
12 measure gets passed through as one of the quality
13 IMPACT Act measures, it would be the same one
14 that would be used in the Value-Based Purchasing
15 Program.

16 So, I do definitely, I don't want to
17 say that we're not supportive of them, the
18 measure. I think just the details are very
19 important.

20 CO-CHAIR RAPHAEL: Okay. Kim?

21 MS. SPALDING-BUSH: Okay. Thanks
22 everyone for all of your feedback.

1 So, I think first I just want to speak
2 to something that I understand, I wasn't present
3 yesterday. That Alan addressed yesterday about
4 whether or not we would be able to bring the
5 measures back with further information.

6 Which is something we can't guarantee
7 we that we would do. But even if our statutory
8 time lines don't permit us to do that, I just
9 want to assure the panel that we are held
10 accountable for your comments.

11 So, when these measure, you know, go
12 forward for further stakeholder feedback, we do
13 have to respond to the things that you have
14 raised. We do address all of those.

15 So, I don't want you to feel like even
16 if they don't come back that they won't be
17 considered. That they won't be taken into
18 account.

19 I mean, that we won't be responsive to
20 them. Either in adjusting the measure to address
21 them. Or explaining clearly why we weren't able
22 to, you know, given our construct here.

1 So, just to start with that. And then
2 I think the other big point I want to make, is
3 that we are actually looking at setting specific
4 measures here.

5 So, I think a lot of the concerns that
6 were just raised, aside from that maybe a one
7 measure across all settings would actually
8 potentially in a sense some increased care
9 coordination.

10 But, I think there are some issues
11 with doing that. And at this point, we're
12 actually looking at setting specific measures.

13 So, there are things like that the
14 patients are inherently different in these
15 settings. That we may not be able to recognize
16 those differences in our claims.

17 So, therefore we wouldn't be able to
18 appropriately risk adjust for them. That's an
19 issue that we don't have to deal with because
20 we're doing setting specific measures here.

21 So, LTAC patients are compared to LTAC
22 patients. The risk adjustment is being done at

1 this case mix level because it allows us to
2 better predict what the spending would be for a
3 patient within that setting that falls into a
4 certain case mix type group.

5 And then the rationale for not using
6 the DRGs for the RUG codes, is that those are, at
7 least to some extent, under the influence of the
8 providers. When they do their assessments.

9 When they classify those patients.
10 When they predict what level of therapy they're
11 going to need in the SNF. They've set them into
12 a RUG group.

13 And so if we risk adjust based on
14 those, I mean, it's a less objective, I think
15 measurement. Whereas the, you know, the group
16 that they fall in based on their diagnosis is a
17 more objective way for us to estimate what we
18 expect the spending to be.

19 So I want to also apologize that we
20 didn't provide a little bit more background
21 information for you. I think it would have made
22 it a little easier to digest some of this.

1 I think we made an assumption about
2 what's out there around the hospital level
3 measure. And some of the information that we
4 provided to the panel, didn't get into those
5 technical terms that we used in that measure.

6 But, so just to sort of explain, I
7 think some of the questions that I heard around
8 expected spending, et cetera. So the numerator
9 of the measure is the observed spending divided
10 by the expected spending.

11 So, what that observed spending is, is
12 what we see within the treatment window. Which
13 is 30 days for most of the settings. It's 60
14 days for home health.

15 And we look at what we observed during
16 the window and the post-discharge set time frame.
17 We adjust for things like geographic wage index
18 differences.

19 So, we take out those urban/rural
20 payment differences that the Medicare program
21 imposes through our payment systems. We also
22 adjust for add on payments for teaching

1 hospitals.

2 So, the IME payment comes out. You're
3 not looking more expensive because you're a
4 teaching hospital. Disproportionate share
5 payments come out.

6 So, the standardization kind of levels
7 the playing field so to speak. So, we take out
8 wage index, geographic practice cost index, and
9 some of those incentive payments that are in
10 there to support broader Medicare program goals.

11 So that the facilities and providers
12 who receive those aren't looking more expensive
13 just by virtue of providing those services that
14 CMS has decided are important.

15 It also takes out any other value-
16 based incentive payments that people may have.
17 So, if they're receiving a penalty for example,
18 under some program, they're not going to look
19 less expensive.

20 It sort of neutralizes all of that.
21 So, the numerator of the measure is that observed
22 spending, standardized payments divided by the

1 expected spending. Which is the risk adjusted
2 amount.

3 So, that's how we get our risk
4 adjusted spending. We take a look at the
5 patient's diagnosis prior to the start of the
6 episode, as well as some other factors.

7 You know, and we'll provided detailed
8 specifications of course, you know, as the
9 measures move forward with what exactly is in the
10 risk adjustment methodology for each setting.
11 And then that's divided by the national weighted
12 median.

13 And what we mean by that is that it's
14 case weighted. So a larger facility that has
15 more cases for a given price, is going to weigh
16 more into the denominator than a smaller facility
17 that has fewer cases.

18 So, I hope that makes sense. It's
19 sort of the facility or the agency's own spending
20 amount divided by the national average. Where
21 their own spending amount has been adjusted for
22 the patient's severity of illness and their age

1 and some other factors.

2 So we don't do socioeconomic status
3 adjustment as the measure is currently
4 constructed. We do hear the concern with that.

5 It's something that we're continuing
6 to explore. But we're cognizant of the work
7 that's going on in parallel in that space.

8 So that NQF has undertaken is in the
9 middle of this two year, you know, trial of
10 looking at socioeconomic status adjustment. The
11 Assistant Secretary for Planning and Education,
12 ASPE has also been required by the IMPACT Act to
13 take a look at socioeconomic status adjustments.

14 So, at this point as the measure is
15 currently constructed, it doesn't include an
16 adjuster for that. The idea being that we're
17 just looking at the patient's clinical status and
18 their clinical picture to describe how we expect
19 their Medicare costs to look.

20 And so, it becomes more incumbent on
21 the provider to manage some of those other
22 issues. But, we are willing and open to taking

1 into consideration any of the results that come
2 out of the work that's going on concurrently in
3 the socioeconomic adjustment space.

4 So, I think -- what are some of the
5 other questions that I heard? We don't exclude
6 the dual eligibles. They're in there because we
7 have a full Medicare claims picture for them
8 since Medicare would be their primary payer.

9 They don't appear to be less
10 expensive. Unlike a Medicare Advantage patient,
11 where we wouldn't have the Medicare Advantage
12 claims in our claim system.

13 And so for ease of implementing the
14 measure, you know, reducing the burden on the
15 providers, this is a claims-based measure. So,
16 we do exclude patients who become enrolled in
17 Medicare Advantage for part of this -- the
18 episode window.

19 Because they would look less expensive
20 just because Medicare Advantage was paying for
21 some of the services. Which isn't the case with
22 the duals.

1 CO-CHAIR RAPHAEL: So, before we move
2 to a vote here, let me just check. Pam, did you
3 want to make a comment?

4 MEMBER ROBERTS: I just had a little
5 bit of clarification. You just mentioned, so the
6 start of the episode is -- the diagnose for the
7 start of the episode is from their acute care
8 start diagnosis. Not from where they're going?

9 MS. SPALDING-BUSH: Can I -- and I'll
10 invite the Acumen Team on the phone to correct me
11 if I misspeak. Because they're the technical
12 experts.

13 But it's from prior to the start of
14 the episode, we take a look at claims submitted
15 for 90 days prior to the admission to the
16 setting. And then Acumen, is the diagnosis
17 billed at the actual post-acute care setting also
18 included in the risk adjustment model? Or if
19 Lori's here.

20 DR. FEINBERG: Yes, I'm -- hi, I'm
21 Laurie Feinberg. I'm a physician from Acumen.

22 And the 90-day look back is for the

1 risk adjustment. The post-acute care episode
2 starts with admission to the specific post-acute
3 setting.

4 It's in that way unlike the hospital
5 measure, which does three days before. We
6 thought that in this setting, our -- that it
7 would -- and the TEP agreed with this. That the
8 look back of three days is different.

9 So it starts with the admission. It
10 goes through the end of the admission. Or, in
11 the case of the home health agency, a 60-day
12 period, which would be the episode of care even
13 though the patient might have had less than 60
14 days.

15 And then it continues for 30 days
16 beyond that time of discharge, or the 60-day
17 episode.

18 CO-CHAIR RAPHAEL: All right, that --

19 MEMBER ROBERTS: Wait, I have one more
20 question.

21 CO-CHAIR RAPHAEL: Oh, I'm sorry.

22 MEMBER ROBERTS: So, the other

1 question is, for States that have nursing staff
2 ratios, is that included? Because that would
3 increase their costs.

4 DR. FEINBERG: I'm sorry, could you
5 repeat that?

6 MEMBER ROBERTS: Yes. For States that
7 have nursing staff ratios that have for different
8 levels of care that will increase their costs.
9 Has that been adjusted for?

10 DR. FEINBERG: Remember we're looking
11 at Medicare expenditures. So the expenditures
12 are not their costs.

13 In other words, it's what Medicare
14 pays the facility.

15 MEMBER ROBERTS: Okay. Thank you for
16 the clarification.

17 CO-CHAIR RAPHAEL: Deb?

18 CO-CHAIR SALIBA: Thank you. I
19 understand that it's claims-based. And about
20 expenditures.

21 And I certainly understand the issues
22 with the RUGs being, you know, often based on

1 utilization as opposed to just the
2 characteristics of the individual.

3 With that said, I think it's really
4 important to think about functional status as an
5 adjuster. I mean, you've got those data sets
6 available to you. I know they're not in the
7 claims.

8 But, it -- study after -- work after
9 work after work, these forward have shown that
10 that's a huge predictor of cost. So, I would
11 encourage you to think about it.

12 You're nodding, so.

13 MS. SPALDING-BUSH: Yes. Thank you
14 for that. And we are interested in learning a
15 little bit more about how the functional status
16 indicators impact cost.

17 As the measure is currently
18 constructed, we don't intend to use the
19 functional status indicators. It has a lot to do
20 with the way that the statute was written for us.

21 Which says that we can use claims
22 elements as well as standardized assessment

1 items. Which are currently in the works of CMS.

2 So, it's certainly something that we'd
3 be open to future refinements for the measure
4 when those become standardized. And then the law
5 would clearly allow us to use them to adjust our
6 predicted cost for the measure.

7 So, yes.

8 CO-CHAIR RAPHAEL: And I have three
9 concluding comments. And then we're going to
10 move to a vote. Liza?

11 MEMBER GREENBERG: This sounds
12 granular. But it will help me conceptualize the
13 measure a little bit more.

14 So, if a patient is admitted to a
15 hospital from home health, does it matter how
16 expensive that hospital is? Or is there like a
17 standardized, we're dinging you this much for
18 your admission.

19 It doesn't matter if you went to an
20 expensive university hospital or one that's not
21 going to do many interventions. And so, your
22 total cost for that would be lower.

1 MS. SPALDING-BUSH: We would include
2 that -- unless it was an excluded admission,
3 which we have some exclusions for planned
4 admissions that are consistent with the
5 readmission measure. That was the Yale RTI
6 Methodology.

7 So, if it was not a planned admission
8 that got excluded, or a treatment for a
9 congenital issue, but if the hospitalization is
10 included, we include all of the Part A and B
11 Medicare payments that occurred during that stay.

12 And we do take out the teaching
13 hospital adjustment, those kinds of things when
14 we standardized the cost. But, if they do go to
15 a hospital that provides them with more
16 treatment, more complex care, more expensive
17 care, it would be captured in the measure.

18 It's important to note too, though
19 that this measure also exists in the hospital
20 space, which is nice. I mean, we are now working
21 at aligning our incentives across our programs.

22 So, in the hospital Value-Based

1 Purchasing Program, the measure does exist. So
2 there is that incentive there as well.

3 But that hospital most likely would
4 generate an episode around this admission also.
5 So, we've got an incentive there for them to try
6 to provide efficient and effective care that
7 would reduce their own downstream costs.

8 So, they're sending the patient back
9 to that SNF, you know, with the hope that that
10 patient's healthy, isn't going to get readmitted.
11 And I guess healthy that's not a good choice of
12 words.

13 But, you know, the patient is stable.

14 You know, unlikely to be readmitted. You know,
15 and that they've managed the care well within a
16 hospital setting.

17 CO-CHAIR RAPHAEL: Bruce?

18 MEMBER LEFF: Yes. Another -- I'm
19 just trying to think of this here, and it's
20 fuzzy.

21 But is it possible another unintended
22 consequence since it's per beneficiary cost,

1 could this scheme provoke say unsavory actors,
2 not so much from cherry picking, but taking more
3 easy cases to extend their denominator reduce per
4 beneficiary cost?

5 I'm just wondering about that. So,
6 you take people into home health or a SNF who,
7 you know, were kind of on the border.

8 But now, you know, now that's actually
9 good for me. Because I'm going to reduce my per-
10 bene cost. I might look bad in the claims. Or I
11 might just kind of sneak by in the claims.

12 So, could this actually one unintended
13 consequence be to actually increase unnecessary
14 utilization?

15 CO-CHAIR RAPHAEL: And Gene, the last
16 comment?

17 MEMBER NUCCIO: Just two quick
18 comments. One, I'd like to support Deb's comment
19 about conceptualizing this in terms of how it
20 might be used in a value-based model. Which we
21 are clearly all going to.

22 And the second part is, again is a --

1 I was a member of the NQF TEP on sociodemographic
2 risk adjustment. And you need to think broadly
3 beyond socioeconomic to more demographic issues.
4 Which includes health literacy and those kinds of
5 matters.

6 And clearly that -- we were talking
7 about patient compliance, which we did yesterday,
8 in terms of these things. And you need to think
9 very broadly about that.

10 CO-CHAIR RAPHAEL: You know, as I've
11 listened, this is clearly more complicated than
12 trying to measure Medicare spending in a
13 hospital. I must say.

14 You know, I think we started with
15 different populations in the different settings.
16 You have patients who go to multiple settings
17 that you have to capture.

18 And that's expected. That's good. We
19 want them to go to multiple settings.

20 And I think the whole issue of what's
21 excluded to me is complicated. Because you bring
22 someone in who's had a hip replacement and

1 they're depressed.

2 Their diabetes goes out of control.
3 And they land back in the hospital. And how you
4 ferret through what's attributable, what's not
5 attributable, I think becomes very complicated
6 for certain patient populations.

7 And I think functional status really
8 does become an important factor as well. That
9 being said, I think for us the question is, given
10 that this train is on the track, given that we
11 would like to influence the station that it ends
12 up in, what is the message that we want to send
13 to CMS?

14 We have three options here in our
15 voting. To support continue, encourage continued
16 development, not encourage continued development,
17 or insufficient information.

18 I mean, two messages that I heard, but
19 I don't know that we can put this into our
20 categories, is this really needs to be connected
21 to value. Because it can't just be cost alone.

22 And the other thing is, there's just

1 a whole variety of unintended consequences that
2 we have identified. I think the panoply is
3 pretty broad.

4 So, we can -- I don't know if we have
5 the prerogative to recommend that CMS bring this
6 back to us. There's no way we can ensure they're
7 going to follow our recommendation.

8 But, we can make a wholehearted
9 recommendation that they do bring it back to us.
10 So, those are just some thoughts that I have.

11 And I don't know if NQF Staff want to
12 say anything. But, I would like to see if we can
13 add a recommendation to whatever vote we take.
14 Right?

15 MS. O'ROURKE: Absolutely. And we've
16 been capturing all of the caveats and the lists
17 of unintended consequences that the group has
18 been discussing.

19 And we will summarize those and put
20 them in the rationale. And we can also include
21 that these measures are a particularly unique
22 case.

1 And make a strong request for CMS to
2 bring them back for MAP review in the future.
3 With the caveat that that is CMS's decision.
4 That we can't guarantee anything.

5 CO-CHAIR RAPHAEL: Right. Okay. So
6 now, can you please all take your device. And we
7 are going to vote.

8 And can you just review the three
9 categories, Laura, so everyone is aware? One,
10 category one is --

11 MS. IBRAGIMOVA: So, right now we'll
12 be voting on the recommendation for IMPACT Act
13 Medicare Spending Per Beneficiary, MUC15-1134.

14 Your choices are encourage continued
15 development, 1. Do not encourage continued
16 development, 2. Or insufficient information, 3.

17 (Voting.)

18 MS. IBRAGIMOVA: So today we only have
19 20 voters. So the results are 65 percent
20 encourage continued development. Five percent do
21 not encourage continued development. And 30
22 percent insufficient information.

1 CO-CHAIR RAPHAEL: So, given our rules
2 of 60 percent, then it's number one. Is that
3 correct?

4 MS. IBRAGIMOVA: Yes. So, combining
5 -- yes, so it's 65 percent.

6 CO-CHAIR RAPHAEL: Okay. So it's go
7 onto the next one.

8 Okay. Laura, this is the second one.

9 MS. IBRAGIMOVA: So now you'll be
10 voting on MUC15-287. Your choices are 1
11 encourage continued development, 2 do not
12 encourage continued development, and 3
13 insufficient information.

14 (Voting.)

15 MS. IBRAGIMOVA: So the results are 70
16 percent encourage continued development. Zero
17 percent do not encourage continued development.
18 And 30 percent insufficient information.

19 CO-CHAIR RAPHAEL: Okay. So it's
20 number one, right? Onto our third one, 289.

21 MS. IBRAGIMOVA: So now you'll be
22 voting on MUC15-289. And your choices are 1

1 encourage continued development, 2 do not
2 encourage continued development, and 3
3 insufficient information.

4 (Voting.)

5 MS. IBRAGIMOVA: So the results are 71
6 percent encourage continued development. Zero
7 percent do not encourage continued development.
8 And 29 percent insufficient information.

9 CO-CHAIR RAPHAEL: Okay. And now
10 we're at number four, the last one, 291.

11 All right, this is our last vote.

12 MS. IBRAGIMOVA: So now -- you are now
13 voting on MUC15-291. Your choices are 1
14 encourage continued development, 2 do not
15 encourage continued development, and 3
16 insufficient information.

17 (Voting.)

18 MS. IBRAGIMOVA: The results are 71
19 percent encourage continued development. Zero
20 percent do not encourage continued development.
21 And 29 percent insufficient information.

22 CO-CHAIR RAPHAEL: Okay. So let me

1 thank everyone. And we're going to break for ten
2 minutes.

3 Forgive the shortened break. But we
4 are a little behind schedule.

5 Before we break, I just want to be
6 sure I welcome Carol Spence, who was on the phone
7 yesterday. And I'm glad she can join us today in
8 person.

9 So, see you back at 11:50 -- 10:55.

10 (Whereupon, the above-entitled matter
11 went off the record at 10:45 a.m. and resumed at
12 11:03 a.m.)

13 MEMBER LEVITT: Okay. I'd like to
14 thank everybody for coming back from the break on
15 time. And we're going to ask the back of the
16 room to resume their seats, please. So I thank
17 everyone for coming back on time. And let's get
18 started. We're moving on to looking at the
19 Hospice Quality Reporting Program. Is the
20 Operator with us? Are we back online?

21 OPERATOR: Yes, you are.

22 CO-CHAIR SALIBA: Thank you. Can you

1 open the lines for public comment.

2 OPERATOR: If you wish to make a
3 comment, please press star one.

4 There are no comments at this time.

5 CO-CHAIR SALIBA: Okay, thank you. The
6 measures on the consent calendar are Hospice
7 Visits when Death is Imminent, and Hospice and
8 Palliative Care Composite Process Measure. I'd
9 like to invite members of the audience to come to
10 the mic and make comments. Is there anyone?
11 Okay.

12 (No response.)

13 So hearing no one's at the mike, so
14 we'll move on. Laura, is there anyone on the
15 chat box?

16 MS. IBRAGIMOVA: There are no chats.

17 CO-CHAIR SALIBA: Okay, great. So I'd
18 like to move on to ask Peg to give a brief
19 overview of the QRP and the measures that we're
20 talking about.

21 DR. TERRY: Can you hear me? So great.
22 So I'm going to start with the Hospice and

1 Palliative Care Composite Process Care Measure,
2 and many people here may know about this measure.
3 It is a composite of seven NQF-endorsed measures.
4 And I'm going to just mention them, so you hear
5 what they are. People in the world of hospice
6 understand these measures quite well.

7 The first is treatment preferences,
8 the least values addressed, pain screening, pain
9 assessment, dyspnea screening, dyspnea treatment,
10 and patients treated with an opioid who are given
11 a bowel regime. This is, as both measures are,
12 encouraged to continue development.

13 The second measure is Hospice Visits
14 when Death is Imminent. And the death which is
15 imminent is one week prior to death. This is a
16 measure that measures basically -- let me scroll
17 down and find this real quickly -- it's a measure
18 that measures the visits by certain individuals,
19 certain professionals, as well as individuals who
20 are volunteers.

21 And included in the visits in the last
22 week before death are visits by nurses, licensed

1 professional nurses, nurse practitioners, hospice
2 aides, physicians, physician assistants if acting
3 as the attending physician, chaplains, spiritual
4 counselors, therapists, which includes physical,
5 occupational or speech therapy, medical social
6 workers and volunteers. So it's a broad array of
7 professionals and volunteers that are included in
8 visits in the last week prior to death. As I
9 said, these are both measures that are encouraged
10 to continue development.

11 CO-CHAIR SALIBA: Thank you. CMS.

12 MEMBER LEVITT: Thank you. Thank you
13 very much. I guess the first comment is the
14 second measure that was mentioned, actually
15 there's been a change in the measure. I think we
16 sent the updated specs to NQF based on the
17 changes. I apologize, Peg, if you didn't get the
18 changed specs. But is it okay if I just explain
19 --

20 DR. TERRY: Sure.

21 MEMBER LEVITT: So the second measure,
22 same concept that we are all -- I think that's

1 been a noted concern of the care giver community,
2 stakeholder community as well to ensure that, you
3 know, visits are done prior to death being
4 present. And this has gone through care giver
5 workgroups. It's gone through TEPs as well, and
6 even pilot testing of what would be some new
7 items that would be added to the hospice item set
8 to account for and be able to look at these sorts
9 of visits.

10 And what came out of the testing and
11 the TEP was that we need to have more than just
12 what was kind of listed initially as this one
13 single measure. And we've actually broken it up
14 now into two different measures. I'll have to
15 look a little bit at my notes. But the first
16 measure is a measure that's really looking more
17 at clinical care and care coordination. And
18 that's look at, specifically at a 3-day window.
19 And the visits on those would be from what you
20 would think they'd be from: physician, nurse,
21 nurse practitioner or physician's assistant that
22 we'd want to have a visit from one of those

1 within the last three days prior to death.

2 And then we've also got then a second
3 component to the measure. And the second
4 component is again this concept of the last week.
5 And that this would be more towards the
6 individualized type of care that a person or a
7 family would want to have during that final week
8 prior to death. And that would be for social
9 workers, chaplains, spiritual counselors,
10 licensed practical nurses and hospice aides. And
11 the requirement would be to have at least two
12 visits in the last week.

13 The volunteers was actually, was
14 actually taken out of the measure because during
15 the testing there were concerns of excess burden
16 for volunteers. So that was actually removed
17 from the measure. But it's absolutely the same
18 concept that was brought in the initial
19 specifications but just want it to be more, more
20 clear about it.

21 To us it's a very important measure.
22 It's a measure, like I said, that's really been

1 asked of us multiple different ways. It was
2 pilot tested, like I said, in the summer at nine
3 different hospices. It will require more testing
4 now that we, you know, changed to have these two
5 different measure specifications. But and the
6 TEP has been very favorable to everything that
7 we've done. In fact, we followed the TEP's
8 recommendations on this.

9 The first measure is, as Peg said, is
10 a composite measure of the existing measures that
11 are on the hospice item set. They would -- again
12 those, that, there would be no excess burden
13 associated with that.

14 One thing just to note about that is
15 that in the midst of us developing this
16 composite, we are requesting, because we don't --
17 we normally seem to own a lot of these measures,
18 but we don't own these measures in terms of being
19 the measure steward on these measures. And as of
20 now, there's a length of stay restriction on
21 these measures in terms of 7-day exclusion that
22 we really think should be brought down to one

1 day. And so we're going to try to work with the
2 steward while we're also having this composite,
3 to work at changing what we think is an exclusion
4 that needs to be changed. That's it.

5 CO-CHAIR SALIBA: Okay, thank you. And
6 Carol and Art were our reviewers on this.

7 MEMBER STONE: I would, I would defer
8 to my eminent member of the panel, Carol, who is
9 the expert on this part of it.

10 MEMBER SPENCE: Thank you. So I'm not
11 sure which one to start with. Let's go with the
12 imminently dying one. This is a really, really
13 important area. And we're very happy to see that
14 CMS has focused on, on this, you know, care of
15 the dying patient, imminently dying patient. Not
16 only is it a critical time for symptom management
17 to the patient but, don't forget, the majority of
18 hospice happens in the patient's home or in their
19 residence, which could be a nursing home.

20 And that means the family is providing
21 the day-to-day hands-on care. So support for the
22 family is also a very critical piece.

1 Patient/family is unit of care. You've heard me
2 say that in here before, but I can't, I can't
3 emphasize it enough for hospice. So this is why
4 a broad look at everyone who is going in there is
5 really important, because the entire hospice
6 interdisciplinary team is providing the care.
7 Each one has a role to play, especially at this
8 time. And so to be able to take this broad look
9 at everyone who's going in really does round out
10 the picture, not only of the care being provided,
11 but of the holistic approach to hospice care.

12 So having said that, there are a
13 couple of issues. However, I also didn't
14 understand the official update on the measure.
15 So that does address one of our concerns with the
16 length, you know, length of stay issue.

17 The other complication on this, and
18 you all may not all be that familiar with hospice
19 payment, but payment reform for hospice was part
20 of the ACA, and that has been implemented in the
21 last final rule and will start January 1. And
22 part of this is an increased payment for RN and

1 social work visits in these last seven days. And
2 so having a, you know, a look at most of this, --
3 let's put it this way: that will have some
4 influence in this too because there, you know,
5 there may be an increase in RN and social work
6 visits just because of the payment structure.

7 So there needs to be a focus on
8 quality of care from this measure, measure
9 standpoint, with just the idea that payment piece
10 is in the background. So the other piece of this
11 is -- and this is what makes hospice care rather
12 difficult to create quality measures for --
13 hospice is not one size fits all, it is
14 individualized care. The patient and family have
15 a lot of say. They are partners in determining
16 their care; it is not prescriptive.

17 And so there is a possible unintended
18 consequence, we've heard lots of those, for every
19 single measure, of hospices wanting to look like
20 they're providing -- they want to be outstanding
21 when public reporting in the STAR system comes
22 for Hospice Compare. We need to be careful that

1 the care provided is suited and matches the needs
2 and the wishes of the patient and family. And
3 while this may sound a little silly, we don't
4 want care being provided or we don't want people
5 going in that the patient and family don't want.

6 And we want those visits to be
7 meaningful, thoughtful, directed visits and not
8 somebody just stopping by so they can get the
9 check box that they, you know, had a visit by
10 each of these disciplines as it's being measures.
11 Should I go on and talk about the composite one
12 since you were talking about it earlier?

13 CO-CHAIR SALIBA: Yes, Carol, that
14 would be good. Thank you.

15 MEMBER SPENCE: Okay. So the
16 composite, as Peg pointed out, what it does is
17 take seven measures that are already in place.
18 Data collection is ongoing for those, creates a
19 composite. And there has been no public release
20 of data on performance on those measures.
21 However, we have reason to believe that these are
22 basic process measures, that performance on those

1 measures is probably pretty, pretty high. And,
2 therefore, having a composite for those measures
3 does make sense.

4 One of the problems here, length of
5 stay, though, comes into play. And in hospice
6 there are -- there's a 48-hour window to have a
7 comprehensive nursing assessment. There's a 5-
8 day window to have the rest of the comprehensive
9 assessment by the rest of the team. And so for a
10 third of the patients in hospice, you know, die
11 within, you know, within seven days.

12 So those length of stay restrictions
13 on the original measures could eliminate a third,
14 you know, of the patient population. On the
15 other hand, hospices that have even a more
16 significant proportion of their patient
17 population with a short length of stay, three
18 days, you know, less than three days -- three
19 days is not, you know, I can't give you the
20 proportion but it's also very high -- may not be
21 able to get all of those seven measures
22 accomplished.

1 And again, we don't want unintended
2 consequences. We don't want the check box being
3 predominant because of the quality measure. When
4 you go into a home and that patient, on day of
5 admission is actively dying -- and I've had that
6 as an admission nurse. It is not an unusual
7 occurrence. In that situation, you are going to
8 think about what parts of that assessment are
9 relevant to that patient and you are going to
10 want to be providing the care and addressing the
11 family's concerns and needs based on your
12 assessment of those needs, not the check box of
13 the quality measures that are supposed to be
14 covered. So, you know, that is a concern.

15 And then the other piece for public
16 reporting -- again these are process measures --
17 the public is not familiar with hospice
18 processes. And then when you create a composite
19 measure, that complicates that even more. So
20 there's going to need to be a lot of succinct but
21 thoughtful and very explicit explanation of what
22 these measures mean and the significance of them

1 when it comes to public reporting. Thank you.

2 CO-CHAIR SALIBA: Thank you very much.
3 Art, did you have anything to add? Art, did you
4 have anything to add?

5 MEMBER STONE: No.

6 CO-CHAIR SALIBA: Okay, thank you. So
7 these two items are on the consent calendar. Did
8 anyone want to request that they be removed from
9 the consent calendar for individualized voting?

10 (No response.)

11 Okay. So we'll proceed with
12 discussion of these two items. And the floor is
13 open, so anyone that would like to comment? Jim,
14 your tent is up.

15 MEMBER LETT: Thank you. Just a couple
16 of things. One is only it may be hard to fulfill
17 this because only in retrospect do you know the
18 last seven days of life. So I presume there is
19 some -- and if you know what those markers are,
20 let me know, because I'm going to be intensely
21 interested, personally --

22 MEMBER SPENCE: It's a crystal ball

1 that each hospice nurse gets, you know, when
2 she's --

3 (Laughter.)

4 MEMBER LETT: The second thing is,
5 putting on my SNF hat, skilled nursing facility
6 hat, we in long-term care in the post-acute arena
7 see a fair number of hospice patients, both for
8 respite and even for post-acute care.

9 So I would just ask as you all go
10 ahead with this measure -- part of it is what
11 personnel see them in the last seven days in
12 life. Well, in the nursing home you're going to
13 have all the same players that you do in hospice.
14 So which, does the SNF nurse count, does the SNF
15 chaplain count, does the SNF attending physician
16 count because we often take care of the instead
17 of the hospice medical director when they're in
18 long-term care?

19 So that was one. The other thing is
20 under the exclusions was asking what is meant by
21 general in-patient care? Does that include a
22 skilled nursing facility, as an in-patient care,

1 or is it only hospitals? So some clarification I
2 think would help.

3 And the other thing is maybe an
4 exclusion around if death occurs within a
5 predetermined amount of time from the hospice
6 referral, that is, if the hospice gets the
7 referral and the patient dies that day, which
8 sadly is not all that rare, or within a few days,
9 is that really an adequate period of time to
10 fulfill this multi-headed other measure? Thanks.

11 CO-CHAIR SALIBA: Sean?

12 MEMBER MULDOON: Looking at the
13 numerator of the number of people who received,
14 essentially, any touch from a hospice person in
15 the last week of life, implies that a lot of
16 people are in hospice and aren't seen at least
17 once a week. Is that true? Because if it's not
18 true then the -- it is true?

19 CO-CHAIR SALIBA: So for folks on the
20 phone there was a head nod from some of the
21 content experts on that. So, Paul, did you want
22 to?

1 MEMBER MULHAUSEN: So I'm a former
2 hospice medical director and attending physician.
3 And we, you know, especially in the sphere of
4 dementia care and staged dementia care it would
5 be not unusual for a person to go a week and not
6 be seen by one of the formal hospice providers
7 until nearing death.

8 CO-CHAIR SALIBA: Lisa.

9 MEMBER WINSTEL: Thank you. Thank you
10 for the clarification, Alan, because I think that
11 some of the changes that you described addressed
12 many of my concerns. Because while all of the
13 different and varied hospice providers are
14 important, since some families prefer to not have
15 some, but medical care is different and the
16 visits, separating out the visits by a clinician,
17 by the doctor or the nurses as one group, and the
18 other hospice workers as another, I think is a
19 step in the right direction.

20 Because too often we hear that it was
21 really great that the volunteer came by, but
22 there was still a pain medication that was not

1 being delivered. So capturing those both I think
2 is very important. I also want to continue --
3 encourage you to continue looking at that period
4 of time, that window, because it's limiting to
5 seven days you are actually not only just
6 excluding a third of the population, but some of
7 the families and the patients who are in the most
8 distress.

9 CO-CHAIR SALIBA: So we've heard
10 seven's probably not what people want. Any, any
11 comments about what the alternative might be?

12 MS. BRAZIL: Hi. My name is Michelle
13 Brazil. I'm a lead for the Hospice Quality
14 Reporting Program. For the hospice visits when
15 death is imminent, we do not have a length of
16 stay exclusion.

17 CO-CHAIR SALIBA: Liza?

18 MEMBER GREENBERG: I just wanted to
19 indicate support for both measures. I think
20 they're really important and will be important in
21 the sense of providing quality. I think there
22 are a few technical things to be addressed in

1 terms of, you know, requirements about when
2 visits occur, when assessments occur, figuring
3 out which touches count towards it.

4 And also, maybe, some finesse about
5 how exactly we want to impose accountability for
6 those very urgent referrals that occur within 24
7 hours of death, or three days of death, when we
8 really need to focus on making sure the patient
9 gets what they need, not necessarily hitting
10 certain metric and milestones. But I think it's
11 overall incredibly important measures, so thanks.

12 CO-CHAIR SALIBA: Tara?

13 DR. McMULLEN: Lisa, so the second part
14 of the death when imminent assesses patients
15 receiving at least two visits from the social
16 workers, chaplains, spiritual counselors within
17 the last seven days of life, where the exclusion
18 it seems to me to be the overall aim of that
19 intent, of that measure. I saw your face of
20 confusion, so I just wanted to clarify that for
21 you.

22 CO-CHAIR SALIBA: Alan?

1 MEMBER LEVITT: I guess further
2 clarification, but also to answer a question.
3 The measure, the measure that has the two
4 measures in it, it does exclude patients with one
5 day length of stay because the feeling is that
6 the two visits that would be necessary for that
7 second component to the measure would not be able
8 to occur in that. But otherwise there is no
9 length of stay exclusion.

10 As Tara just mentioned, there are
11 different time windows for both measures. And
12 that was the choice of the technical expert panel
13 that felt that if the care coordination and
14 clinical care one, which is actually three days,
15 you know, one visit within the last three days,
16 if that was extended out to seven days, we would
17 see, very quickly, a topped-out measure.

18 The technical expert panel felt that
19 we needed to have a shorter window on that first
20 component to the measure, whereas the second
21 component was the two visits within seven days.
22 So it really is two different time windows, two

1 different purposes almost. The general in-
2 patient care, I'm going to need to look at
3 Michelle Brazil for a nod on this, but that did
4 also include nursing homes; right? Nursing home
5 and in-patient hospice? Waiting for a nod.

6 Okay.

7 CO-CHAIR SALIBA: She's checking on
8 that.

9 MEMBER LEVITT: Yes, yes. It also
10 excludes, if you didn't notice in your measure,
11 if you have continuous home care it would exclude
12 it as well, so. Michelle, you need to turn it
13 on.

14 MS. BRAZIL: For residential nursing
15 home visits it would be included. So if the
16 patient is receiving that residential level of
17 care that would, the nursing visits and the
18 hospice interdisciplinary team visits would be
19 included.

20 MEMBER LEVITT: And the other levels?

21 MS. BRAZIL: So if a hospice has a
22 contract to offer in-patient care, whether it's a

1 hospital, a nursing home or their own facility,
2 then it would be excluded from that piece. So
3 patients that are continuous home care, patients
4 that are receiving respite, and patients that are
5 receiving in-patient care, because that care is
6 being provided around-the-clock for that patient.

7 MEMBER LEVITT: Does that answer your
8 question, Jim?

9 MEMBER LETT: It does.

10 MEMBER LEVITT: Okay.

11 CO-CHAIR SALIBA: Carol?

12 MEMBER SPENCE: I was just going to
13 back up a little bit from what Michelle said in
14 that I'm not sure everybody here even understands
15 the four levels of hospice care. These are
16 designated levels. It's not setting specific.
17 The level of care is an intensity, you know, so
18 to speak, designation. So that GIP, that general
19 in-patient care, there's a separate, there's
20 additional regulations that go with that. There
21 are additional requirements.

22 I can be provided in a nursing home.

1 You know, the setting is not the critical piece.
2 It can be a, you know, a free-standing in-patient
3 unit that the hospice owns. It can be a hospital
4 that contracted that. It can be a nursing home
5 contracted, but the main thing is that the
6 hospice is responsible for this more intense
7 level of care.

8 It's for acute management of symptoms
9 and then you move back to a less intense, you
10 know, level of care. So and the same things for
11 continuous care. It's one of those designations,
12 expressed as one of those designations. Though,
13 Alan, you just said respite. And how does this
14 measure fit or not fit? Is respite also not part
15 of this?

16 MEMBER LEVITT: That is correct.
17 That's an exclusion for the first measure.

18 CO-CHAIR SALIBA: Other comments?
19 Questions? Thoughts? Any comments or thoughts
20 about this exclusion window? Carol, did you --
21 and there's different exclusion windows for the
22 different items. Any comments that you wanted to

1 bring up about that?

2 MEMBER SPENCE: No, again I just
3 because I haven't seen the second or the newest,
4 the latest version of this, the one-day exclusion
5 applies to both measures, or just the imminently
6 dying one?

7 MEMBER LEVITT: It's to the measure
8 itself. If you have a length of stay of one day,
9 because you can't complete both measures, so.

10 MEMBER SPENCE: But it doesn't apply to
11 the composite?

12 MEMBER LEVITT: No. The composite
13 measure is not. The only exclusion for the
14 composite measure would be any exclusion from the
15 component measures.

16 MEMBER SPENCE: Okay, so you're
17 including those? Because that wasn't clear under
18 the exclusions. Again, the list said, you know,
19 18 years was the only exclusion, but it also said
20 that you had to be in the numerator from the
21 other measures. And those other measures -- six
22 of those other measures have a 7-day exclusion.

1 MEMBER LEVITT: Right. And again, that
2 was one of the other discussion was that we'll
3 be working with the measure developer to change
4 that.

5 MEMBER SPENCE: To change that.

6 MEMBER LEVITT: Yes. Yes.

7 MEMBER SPENCE: Yes, okay. All right.

8 CO-CHAIR SALIBA: That's why I was
9 inviting comment, because since that is under
10 development and being considered, if there were
11 other comments about what that should be if it's
12 not set out.

13 MEMBER SPENCE: You know, it cuts both
14 ways because, again, you don't want to take out a
15 third of that patient population but you want to
16 be fair to hospices who, as the example I gave,
17 where you're walking in and that patient is dying
18 that day, you know, your bowel program opioid
19 measure is not relevant. It wouldn't even begin
20 to address it. So some, some way to understand
21 that you still need to put the patient and family
22 first and not measure box check-off first.

1 CO-CHAIR SALIBA: Thank you. Cari?

2 MEMBER LEVY: Just a quick

3 clarification. This might be in the updated

4 material. But it does say on this specification

5 that respite is not an exclusion. And I'm

6 assuming that the reason for having general, in-

7 patient and continuous is because they're in, the

8 staff are in there so frequently it wouldn't make

9 sense. But respite wouldn't necessarily be that

10 way. Would that be correct?

11 MEMBER SPENCE: That was why I was

12 double-checking on respite. Respite done in a

13 nursing home?

14 MEMBER LEVITT: Right. Correct me, but

15 my exclusions were patients receiving continuous

16 home care, in-patient respite care, and then the

17 general in-patient care.

18 MS. BRAZIL: That's correct. I'm

19 sorry, yes, it was in-patient respite care. My

20 mistake.

21 MEMBER SPENCE: Okay.

22 CO-CHAIR SALIBA: So, Carol, you --

1 MEMBER SPENCE: So I'm still confused
2 about where a nursing home comes in in this
3 because in-patient respite is not the same as
4 GIP. Respite is done -- has to be in a facility.

5 MEMBER LEVITT: Right. And that's
6 true. It's in-patient respite

7 MEMBER SPENCE: That's what you're
8 calling it?

9 MEMBER LEVITT: Right.

10 MEMBER SPENCE: Okay. So respite is
11 off the table then.

12 MEMBER LEVITT: In-patient.

13 DR. McMULLEN: And, Carol, I think
14 there's a deep knowledge that a lot of these
15 measures, the population of case mix, will tie
16 into that nursing home setting. And so, since we
17 have the Nursing Home Quality Initiative and the
18 SNF Quality Reporting Program, we're looking at
19 those trends, and the confluence of data, what
20 those mean when you have that one patient who is
21 maybe in that nursing home setting whose using
22 that health benefit. We call it the hospice

1 benefit on the MDS, so we are looking into that.

2 And those are discussions we have at CMS a lot.

3 CO-CHAIR SALIBA: Yes. Okay, any other
4 questions, comments?

5 (No response.)

6 Okay. So, we have agreed that this
7 was by assent, that it would stay on the consent
8 calendar, and so there is not voting at this
9 point. So we'll move on to the next agenda item.

10 The next agenda item is looking at the, let's
11 see, we're looking at the -- oh, this is Erin.
12 Erin.

13 MS. O'ROURKE: Yes.

14 CO-CHAIR SALIBA: We wanted to have you
15 talk about the MAP and long-term care core
16 concepts discussion.

17 MS. O'ROURKE: Great. Thank you, Deb.
18 So, given how much has changed in the post-acute
19 care/long-term care world and the number of new
20 faces that we have around the table, I wanted to
21 give you a little bit of the history of the core
22 concepts, and then open it up for discussion to

1 see if these are something that we need to re-
2 look at, do they need to be refreshed? Does the
3 group still agree with our core concepts, since
4 they've really been a framework that the PAC/LTC
5 Workgroup had used to guide their decisions about
6 measures under consideration.

7 So to give you a little bit of the
8 history, the PAC/LTC core concepts were a key
9 element of the coordination strategy that the
10 PAC/LTC Workgroup developed back in 2012. The
11 group realized at the time it was not possible to
12 align around a particular measure across settings
13 due to issues such as differing populations,
14 services provided, and data sources.

15 However, the group realized that a
16 person-centered approach that assessed care
17 across an episode could allow measurement to move
18 beyond the current silo of -- or the site-
19 specific approaches and better integrate PAC/LTC
20 measurement with hospital and clinician
21 measurement.

22 So the group identified six highest

1 leverage opportunities for measurement for post-
2 acute care and long-term care providers. And
3 within these areas the group identified a set of
4 13 core measure concepts. And the group has used
5 these measure concepts to unify their work across
6 the various settings where they review measures,
7 recognizing that while aligning at the measure
8 level might not be possible, progress can be made
9 by assessing the same concepts across types of
10 care.

11 So if you take a look at this slide it
12 shows you the high-leverage areas and the
13 associated core concepts. It's a little bit
14 small, so I will read them out for everyone.
15 You'll see the core concepts are functional and
16 cognitive status assessment, mental health,
17 establishment of patient/family care giver goals,
18 advanced care planning and treatment, experience
19 of care, shared decision making, transition
20 planning, falls, pressure ulcers, adverse drug
21 events, inappropriate medicine use, infection
22 rates and avoidable admissions.

1 So on this slide you will see where
2 each of these core concepts are currently
3 addressed in the Quality Reporting Program for
4 each setting. If the box is gray, there is at
5 least one measure addressing the concepts for
6 that program. So there are still some fairly
7 significant gaps in the programs around the
8 PAC/LTC core concepts, particularly around some
9 of these more challenging to measure issues.

10 Next slide. So with that, I'm happy
11 to take any questions or welcome any reflections
12 from some of the longstanding workgroup members
13 who were around when we developed these, if
14 anyone wanted to jump in. If not, we can turn
15 back to Deb for discussion.

16 CO-CHAIR SALIBA: Don't worry about
17 showing your age by commenting. Can we go back
18 to the slide that shows the core concepts? Back
19 one more. That shows that. I think that will
20 help if people can reference that as we're, as
21 we're talking. Jim, you have your tent up.

22 MEMBER LETT: Yes. I'd be remiss as a

1 representative of the National Transitions of
2 Care Coalition not to point out that we do not
3 have care transitions called out. We talk about
4 transition planning, which is not the same as
5 actually by gum doing it. So I think either
6 effective, or quality, or whatever other
7 adjectives we want to put with it, but I think
8 that's a big gap and a big hole, personally.
9 Thanks.

10 MEMBER LAMB: I think when we started
11 this -- and I'm not afraid to say I was here in
12 the beginning -- was that care transitions really
13 was a huge priority, and that we needed to get a
14 handle on that before we looked more broadly at
15 the concept of care coordination.

16 Since that time there has been a
17 measurement gaps group that has re-looked at the
18 whole framework for care coordination. And I
19 think it might be a good time for this group to
20 re-look at the care coordination framework and
21 think beyond just transitional care, and to look
22 more broadly at the whole framework. Because I

1 think a lot of the discussion that we've been
2 having over the last day-and-a-half really is it
3 has a transitional care and a lot of the
4 unintended consequences were related to that, but
5 I think we could have a bigger frame that is much
6 more consistent with the current thinking that
7 came out last summer.

8 CO-CHAIR SALIBA: Gene.

9 MEMBER NUCCIO: Perhaps because I'm
10 part of the new group, can you go to the next
11 slide that shows the coverage area? There is
12 experience with care, there is the CAHPS measures
13 that are out there. Have they not come through
14 NQF for endorsement?

15 MS. O'ROURKE: So they've come through
16 NQF for endorsement. This slide shows where
17 they're being currently used in each of the
18 quality reporting programs, so a little different
19 from their endorsement status or what MAP has
20 reviewed. So this is actually used in a program.

21 MEMBER NUCCIO: Thank you for the
22 clarification.

1 CO-CHAIR SALIBA: Other -- yes, go back
2 to the other slide. There you go. Thank you.
3 So, were there any other comments or questions?
4 So let's start with just asking, from these high-
5 leverage areas, are we good on those? Robyn.

6 MEMBER GRANT: So under goal attainment
7 it talks about establishing the goals and
8 advanced care planning and treatment, but there's
9 not necessarily anything there about attaining
10 the goals. So you could establish them, but not
11 necessarily achieve them.

12 CO-CHAIR SALIBA: Okay, thank you. I
13 noticed that too. Okay, other thoughts about the
14 high-leverage? Yes, Gerri.

15 MEMBER LAMB: Along the same lines that
16 Robyn was just talking about, one of the areas
17 that's being looked at in care coordination as a
18 meaningful outcome is not related to goal
19 attainment, and if you look at the new framework
20 it's not framed that way. But the other one is
21 unmet need, and that seems really very
22 appropriate to our discussions here, so we may

1 want to look at kind of the shifts in concepts
2 and focus.

3 CO-CHAIR SALIBA: And for unmet need,
4 are you thinking of that as a high-leverage area
5 or as a concept that would go within one of those
6 high-leverage areas?

7 MEMBER LAMB: You know, it's not clear
8 to me because goal attainment is an outcome. But
9 that one in the care coordination framework is --
10 there was huge discussion about whether that was
11 the relevant way to frame it. And so it could go
12 under an outcome for the leverage area of care
13 coordination, but it may be also worthwhile to
14 look at goal attainment and whether it is high
15 leverage, or whether that needs to be re-looked
16 at.

17 CO-CHAIR SALIBA: Liz.

18 MS. PALENA HALL: So under the category
19 again of care coordination I just wanted to point
20 out that one of the IMPACT areas that is required
21 is also around the area called accurately
22 communicating health information and care

1 preferences when a patient is transferred. I
2 just wanted to point out to you that, you know,
3 in terms of IMPACT -- and another key point of
4 IMPACT is around interoperability.

5 So we, I think there are a number of
6 -- this is also an area under 1.C and I think
7 also through other HHS programs where we're
8 certainly looking at transitions of care and how
9 health IT can support that. So there's a lot of
10 work that's going on through our -- our work, at
11 least 12 states that are looking at post-acute
12 care settings and those transitions and how --
13 and the information that's needed to be
14 exchanged, as well as the work flow and
15 processes.

16 So I think as measures such as this
17 come forth there will be some information to
18 share. I just wanted to point out, though, that
19 that is an area that is an area that is taught
20 out by IMPACT.

21 CO-CHAIR SALIBA: Thank you. Jim.

22 MEMBER LETT: One area that I think

1 might be worth expanding is education. That is,
2 as -- of the family/patient unit. As we move
3 further into establishment of their goals,
4 advanced care planning, experience of care,
5 shared decision making as we move more and more
6 towards a patient engagement empowerment role, we
7 have to give them the tools to make those good
8 decisions.

9 I don't want them flipping the coin as
10 to whether or not they should put in a feeding
11 tube. We have to at some point educate them on
12 what is good and what is not good about that, and
13 then engage them in, okay, help me with your
14 goals, help me with your decision and we'll
15 follow it. So I'm not seeing education anywhere
16 there.

17 CO-CHAIR SALIBA: And are you thinking
18 of that as a core measure concept that would go
19 under one of the high-leverage areas? Safety?

20 MEMBER LETT: I'm not sure. I don't
21 see a high level -- high-leverage area that it
22 fits under well. Maybe goal attainment, or

1 patient engagement. Oh, thank you.

2 CO-CHAIR SALIBA: Great, thank you,
3 Jim. Paul.

4 MEMBER MULHAUSEN: I had a couple of
5 thoughts. I don't know how helpful they'll be,
6 but I thought rather than not share them I would
7 share them, as my error. So the first one would
8 be symptom management, and I think about what I
9 do as a physician in long-term care settings
10 besides helping achieve these goals. Symptom
11 management to me is a very important area in
12 which I think it would be helpful to get feedback
13 on how we're doing. Although I think you could
14 potentially put that under goal attainment, the
15 two core measure concepts here in my mind don't
16 quite capture that.

17 And then the other one is a reflection
18 on what I think is happening in long-term care
19 which is intensification of the medical side of
20 care in the spirit of improved efficiency, and I
21 worry that it might lead to some degradation of
22 quality of life. And I know that's a nebulous

1 kind of concept, but -- and you could even wrap
2 all those into, well, if you achieve those
3 things, the quality of life is better.

4 But are we capturing the quality of
5 just living out one's life in these settings that
6 we're discussing as we feel the pressure to make
7 it part of a more efficient care flow?

8 CO-CHAIR SALIBA: Thank you. Joe,
9 Joseph.

10 MEMBER AGOSTINI: Yes, it strikes me in
11 looking at these that even though inherently a
12 team-based care is required to achieve a lot of
13 these performance areas, you don't explicitly
14 mention interdisciplinary expertise, whether it's
15 physical therapy, behavioral health, nursing, you
16 know, all experts working together to achieve
17 some of these performance areas and goals.

18 CO-CHAIR SALIBA: Thank you. Tara.

19 DR. McMULLEN: Yes. I was going to
20 note that these type of conversations really,
21 really -- it's productive, it's important to CMS.
22 We like to hear what's important to NQF and our

1 stakeholders. And I was wondering if after the
2 conversation today and receiving feedback in the
3 summary report, if panel members had any
4 recommendations for measures, primarily goal
5 attainment. That's something that definitely
6 stands out to me as something that's a very
7 important concept.

8 So are there measures that are being
9 developed or are currently used as your gold
10 standard in your setting or your practice or
11 whatnot that, you know, would be a good concept
12 to assess? I think that would be most helpful.
13 I don't know if that's what this is about, but.

14 CO-CHAIR SALIBA: Bruce.

15 MEMBER LEFF: Yes, just to -- I would
16 amplify Paul's comments regarding, you know,
17 potentially quality of life as a high-leverage
18 area might be something to add to that list.

19 CO-CHAIR SALIBA: Carol.

20 CO-CHAIR RAPHAEL: I just wanted to
21 also affirm what Paul said. One of the things
22 that I often think about is how to not over-

1 medicalize goal attainment, because as we try to
2 work on metrics, I think we often move toward
3 things that are quantifiable.

4 So that if someone's goal is to get to
5 their grandson's graduation, or to be able to
6 meet for coffee with his or her buddies in the
7 morning, that's what they want to do, you know,
8 and mobility is kind of on the road, and
9 functional status is on the road to doing it. To
10 me it's how do you capture those things that
11 really matter to people that's part of the fabric
12 of their quality of life that we never think
13 about as we think about what are the goals that
14 we can count and really weigh?

15 So that's just something that I want
16 to be sure we don't lose sight of as we move
17 along on that path to goal attainment. And that
18 is what motivates people. That's what's going to
19 help them to recover. That's what's going to
20 lower the cost of care and produce a better
21 quality of life and patient experience.

22 CO-CHAIR SALIBA: Thank you. Other

1 thoughts, comments? Oh, I'm sorry. I
2 hemianopsia here.

3 (Laughter.)

4 MEMBER MARKWOOD: That's okay. We're
5 sitting over here in the corner. I just wanted
6 to echo those thoughts as well. And just to
7 ensure that the social determinants of health get
8 incorporated into, directly into the work.

9 Because I think that, you know, to echo Carol's
10 comment, I mean oftentimes the goal attainment is
11 to be able to walk my dog rather than it is to be
12 chronically free of pain. So I think the thing
13 is is just to have that as an overlay into the
14 work that we do.

15 MEMBER WINSTEL: Well, Carol and Sandy
16 have been very, rather, eloquent about this but I
17 want to add to it the other issue of perhaps we
18 need to, as facility-focused as we are, look at
19 that perhaps a patient and family's choice is
20 that the patient wants to stay at home, for
21 example, as long as possible. And that if the
22 goal is to age in place, the goal is to not go

1 into a facility, then measuring the days in in-
2 patient rehab, for example, starts to take on a
3 different measure. Of if a patient declines an
4 in-patient setting and prefers more home health,
5 and taking that and sort of translating that into
6 the facility outcome.

7 CO-CHAIR SALIBA: Liza.

8 MEMBER GREENBERG: I think in looking
9 at this list it's extremely important, and very
10 patient centered, and I really like the direction
11 it's going. If we could develop our measurement
12 approach around these, I think we would move the
13 system towards more patient-centeredness. I
14 wanted to amplify two suggestions from the room.
15 One was around symptom management, which I think
16 is also palliative care, and I think that's a
17 very important component to many patients.

18 And unmet need was called, but which
19 is also access. And I think not having access
20 drives patients to higher levels of intensity,
21 which can potentially be around higher cost
22 levels as well.

1 So I think putting those in there,
2 plugging them in, could be an important element.
3 And I think once that list is in place, you know,
4 if CMS can look at it in terms of alignment of
5 benefit coverage as well, I think that would be
6 real important. Because a lot of times we drive
7 things to really perverse directions because we
8 don't have the right benefit coverage, and so
9 patients have to seek, you know, meeting their
10 needs in other places. So that's another
11 element.

12 And I just wanted to return to the
13 first slide which said the LTC Workgroup said it
14 was not possible to development an alignment
15 strategy due to differing populations, services
16 provided and data sources, and point out that the
17 IMPACT Act has really transformed that equation.
18 And with 75 million bucks and some legislation
19 you can go there.

20 So I think that's pretty awesome. And
21 maybe the care coordination might be the next
22 thing that we could tackle with one of those

1 incredibly complicated statistical measures that
2 does capture a lot of elements, so.

3 CO-CHAIR SALIBA: Thank you, Liza.

4 Kim.

5 MEMBER ELLIOTT: I think one thing that
6 we just really need to specifically state in
7 there is family involvement, family engagement.

8 MEMBER LAMB: I wanted to go back to
9 what Sandra was saying. You know, when I look at
10 the high leverage areas I don't know that it
11 quite fits, but I think it's really critical that
12 we -- particularly for this group, that the
13 social determinants be called out in some way.

14 I was at a meeting last week where I
15 was hearing about new measures of social
16 complexity. And for the first time they were
17 beginning to really pull out the stuff that we
18 deal with in the community really that makes it
19 difficult or easier to achieve outcomes. And
20 while it's not sort of the pillar, it's a cross-
21 cutting. And I'd hate to lose what Sandra was
22 talking about. And I thought that whole construct

1 of social complexity that folks are beginning to
2 deal with is really a critical one for us to
3 consider.

4 CO-CHAIR SALIBA: And we might could
5 see it as something that's a concept under cost
6 and access. It's certainly an access issue, so.

7 Other -- Liza, did you have more
8 thoughts? Okay.

9 Anyone else that had thoughts or
10 comments? This has been really, really helpful,
11 and great ideas. Is there anything? And as Tara
12 said -- Clarke.

13 MR. ROSS: I just wanted to share with
14 the group two measurement systems used in the
15 world of intellectual disability that might be
16 helpful in making some of these concepts come to
17 life. And one is the National Core Indicators
18 and the other one is the Personal Outcome
19 Measures. Both of these systems are 20 years in
20 operation.

21 And the National Core Indicators just
22 in the last two-and-a-half years has been

1 expanded through the National Association of
2 States United for Aging and Disability to apply
3 to persons with physical disabilities and people
4 who are aging. And I just will read the three
5 major domains in both of these areas to give you
6 how important some of these concepts are and how
7 less important some other concepts are.

8 So in the National Core Indicators we
9 have a whole bunch of measures around individual
10 outcomes, how the individual beneficiary sees
11 their world and how the world responds to them.

12 We have family outcomes, how the
13 family who supports the individual beneficiary
14 sees the world and how they can be helpful and
15 supportive to the individual.

16 And then we have the more traditional
17 health and wellness and systems kinds of measures
18 that most of you are very comfortable with.

19 In the area of personal outcome
20 measures, similar -- slightly different concepts
21 but similar three domains.

22 Myself. And so these are a series of

1 person interview questions around the individual
2 about how the person views themselves in the daily
3 world.

4 My world. My world is more where I
5 live and how the structure of who I live with and
6 the rules of where I live and what rights and
7 freedoms I have to get a beer at four o'clock in
8 the afternoon or have a guest spend the night or
9 something like that. So my world domain
10 questions.

11 And then personal outcome measures
12 have my dreams. Given where you're at today and
13 then these are measures for all adults who have
14 intellectual disabilities, so we're talking about
15 young adults, you know, 20, 21 through 80 and 90-
16 year-old folks. But my dreams are you have a
17 reality of where you live and how that's
18 structured today, but where do you want to live
19 in the coming five years? And how do you want to
20 get there? And can we help you get there?

21 So I just wanted to report that there
22 is 20 years of operational experience in the

1 intellectual disability world with two different
2 measurement systems. And we are experimenting
3 and piloting them with the Administration on
4 Community Support Financing in the area of
5 physical disability and aging.

6 CO-CHAIR SALIBA: Thank you.

7 Robyn.

8 MEMBER GRANT: I wanted to thank Clarke
9 for raising those points because I think that's
10 very helpful. And as you were saying that, that
11 made me think of a core concept that comes up in
12 our work with consumers all the time, and that's
13 autonomy and control. And I guess, you know, you
14 could work that into some of these. But it seems
15 to me that it's so important that it might rise
16 into a highest level or a organizational concept.

17 CO-CHAIR SALIBA: Thank you, Robyn.

18 MR. ROSS: Can I respond to that?

19 CO-CHAIR SALIBA: Yes.

20 MR. ROSS: So I was going to wait till
21 we discussed the next topic, measure gaps, that
22 the Duals Workgroup has developed seven measure

1 gaps that we developed in 2013 that were
2 reaffirmed in '14 and reaffirmed in 2015. But
3 three of them are exactly -- three of the seven
4 are exactly what Robyn has identified.

5 The first is goal-directed person-
6 centered planning and implementation.

7 The second is shared decision making.

8 And the third is beneficiary sense of
9 control, autonomy and self-determination.

10 And, again, we do have, through the
11 National Core Indicators and the Personal Outcome
12 Experience, questions and measures on how to get
13 to these. But we don't have it for the broader
14 population. That's why it's a measure gap.

15 And that's why this morning I spoke
16 about how important measure development is
17 because we have these little -- I mean there are
18 hundreds of thousands of people that are
19 affected, but we have these population-targeted
20 measures. And we need to pilot them and adapt
21 them for the larger population.

22 But three of the seven measure gaps in

1 the Duals Group are the points Robyn raised.

2 CO-CHAIR SALIBA: Thank you.

3 So to recap, and we have a lot of
4 great ideas. I took two pages of notes while
5 everyone was talking. So thank you. And to echo
6 what Tara said, if you have other ideas, please
7 let the MAP work team know and/or Tara. Thank
8 you.

9 So that was a great transition to the
10 next item on the agenda which is identifying gaps
11 or discussing gaps. So, Sarah, would you like to
12 pick up?

13 MS. SAMPSEL: Sure. And I feel like
14 we've already crossed over this -- into this
15 quite well. But I think what we wanted to do in
16 this portion is kind of review not only the
17 measures that had previously gone through
18 rulemaking and the gaps and the core concepts
19 that have been filled previously in multiple
20 areas, but also these tables don't reflect
21 anything that's in this current rulemaking cycle.
22 So it doesn't reflect anything that has not yet

1 gone through the Coordinating Committee and out
2 for public comment, et cetera.

3 So in some cases you are going to have
4 to shade in your head in where we filled in some
5 holes. But we wanted to use these, too, to
6 continue to draw out those gaps and those
7 measurement ideas. And I think we really heard
8 in the discussion about the core concepts some of
9 those areas. But we wanted to open the floor,
10 too, to exactly what Tara asked is where are
11 there measures in development that we may not
12 know about, that CMS may not know about, that we
13 could really start doing some outreach and some
14 follow-up?

15 Because you also heard Chris talk
16 about, you know, NQF really working on getting
17 the measure incubator up and going. And so this
18 is an ideal opportunity for us to look for
19 additional partners on filling those gaps and
20 what might be the NQF/CMS role, et cetera.

21 So, Erin just showed you this slide.
22 This slide identifies across the four QRP

1 programs where the core concepts have been
2 identified previously and where we'll obviously
3 do some morphing of this based on our most recent
4 conversation. But, you know, is anybody aware
5 right now of any measures that we're missing in
6 these areas that could give a leg up to the next
7 step towards measure development and testing?

8 Clarke.

9 MR. ROSS: Well, one, most everybody
10 around the table probably is aware it's
11 happening, that's the CMS Home and Community-
12 Based Service Experience Survey which is an
13 adaptation of the CAHPS measures. So sitting on
14 the Duals Workgroup we have learned for three
15 years how the survey is designed but we haven't
16 seen any results. And so we're getting antsy
17 because this holds tremendous potential.

18 And they've interviewed thousands of
19 people in 13 states or something, and
20 experimented with how to frame the questions and
21 which questions work in what environments. So we
22 just want results as quickly as possible.

1 And the other area, the National
2 Institute of Disability funds a university-
3 affiliated program at Westchester Institute in
4 New York. And the Westchester Institute people
5 have taken the CAHPS survey for clinicians and
6 adapted it for people with severe intellectual
7 disability. So the assumption that certain
8 people can't answer their own questions, there's
9 a lot of work being done to demonstrate they can.
10 But this is three years and we still have -- we
11 have findings of how adaptations have been made
12 but not any recommended CAHPS changes.

13 But those are two very important
14 things that are happening that we're hoping we
15 can translate into delivery one of these days.

16 CO-CHAIR SALIBA: Thank you.

17 Lisa.

18 MEMBER WINSTEL: I am sure that many of
19 you around the table are familiar with the
20 current PCORI-funded project, Project ACHIEVE,
21 which is looking extensively at transitions of
22 care, at patient-reported outcomes, at caregiver

1 experience. It's a multi-year project. We're
2 not going to have outcomes from the project for a
3 while. But I do believe that since they are
4 going to be looking at many of the things that
5 we're looking at here, that it's going to be able
6 to either recommend or inform some very
7 substantive and well-informed measures around
8 this.

9 CO-CHAIR SALIBA: Will you spell out
10 that acronym, please?

11 MEMBER WINSTEL: Oh, P-C-O-R-I.

12 CO-CHAIR SALIBA: No, not PCORI.

13 MEMBER WINSTEL: Oh, sorry. Oh,
14 Project ACHIEVE. Oh, the acronym for ACHIEVE.

15 Oh, I pulled this up here. It is
16 Achieving Patient-Centered Care and Optimized
17 Health in Care Transitions by Evaluating the
18 Value of Evidence.

19 CO-CHAIR SALIBA: The brainpower that
20 went into that. Thank you. I just wanted to
21 make sure I heard you correctly.

22 MEMBER WINSTEL: Yeah. ACHIEVE.

1 CO-CHAIR SALIBA: Okay. All right,
2 thank you. Kim.

3 MEMBER ELLIOTT: Along with what Clarke
4 was talking about, there is also a functional
5 assessment that's being tested in the home and
6 community-based setting by many states. So that
7 might also be beneficial.

8 CO-CHAIR SALIBA: Thank you.

9 And I think I jumped the gun.
10 Apparently Sarah has more slides. Sorry, Sarah.

11 MS. SAMPSEL: It's totally fine. Why
12 don't we just go ahead and go through the slide -
13 - the next slide.

14 So, you know, just as another exhibit.
15 And, of course, this is the great example of
16 where there are some more holes that we could be
17 filling in this slide in the near future. And as
18 -- certainly as CMS is taking into consideration
19 the feedback that you've all provided them in the
20 additional development of their measures but, you
21 know, we felt it was important to bring up the
22 IMPACT Act domains.

1 And as you've rightly identified
2 earlier, you know, the core concepts came out
3 before the IMPACT Act. So now we're kind of
4 seeing everything come together. And one of the
5 things I think we'll have to consider as a
6 workgroup and with staff and with CMS, is do we
7 need both the core concepts and the IMPACT Act?

8 We certainly have heard from Tara and
9 Stacy in our fall webinar that while these are
10 the main IMPACT Act domains right now, we're not
11 limited to those domains, and CMS is not limited
12 to those domains. So they really do want to
13 think broadly.

14 So we just -- we wanted to bring this
15 up as an additional exhibit of, you know, where
16 work is being done, where some focus is being
17 made. And, obviously, we've talked about many of
18 these areas so far today.

19 Next slide.

20 And then with the Hospice QRP which is
21 a little bit different since it's not falling
22 under the IMPACT Act, these again are areas that

1 have been identified as high priority areas for
2 measurement, and then where we can map across
3 where there are existing measures in the Hospice
4 QRP. You know, this is an example of a program
5 that does have the CAHPS survey in it already
6 with the Hospice Experience of Care survey. And
7 that recently came through as an endorsed measure
8 as well through the person- and family-centered
9 care work.

10 But there continues to be holes here.
11 And you see at the bottom there's not only what
12 we've talked about is the unmet need, but then
13 there's the unwanted treatments. And so how do
14 you change that dynamic when we're talking about
15 the hospice patients? And I really do think
16 that's a different discussion to have.

17 And I think Karen is still here.
18 Karen Johnson in the back, who will be leading
19 NQF's palliative care work for consensus
20 development coming up in the spring and in next
21 year, so that we will be seeing more measures
22 coming out there.

1 Next slide.

2 So before we go to public comment,
3 just again this is our last call -- well, not
4 last call, you are welcome to email us at any
5 time. But really want to know did this generate
6 any additional ideas for measures, measure
7 concepts that should be prioritized that we can
8 make sure get into our final report to CMS?

9 CO-CHAIR SALIBA: So now discussion.
10 Jim.

11 MEMBER LETT: Well, I'm going to be the
12 one-trick pony around care transitions again.
13 Thirty-day re-admissions is not a particularly
14 good quality measure. Hasn't been. Won't be,
15 according to the experts that I've talked to and
16 read from.

17 So I'd like to see us go more to
18 measuring did your transition actively give the
19 correct information in a timely fashion, in the
20 proper way to the next site of care? And does
21 that site of care then respond to the sending
22 entity that says, hey, I got it, I have a few

1 questions. Or, I didn't get it. Or, Ms. Jones
2 got here and things are fine.

3 We have a very passive, I think,
4 posture in terms of measures around transitions.
5 Did Site A send all the information they should
6 to Site B? Not did Site A ensure Site B got that
7 information, ask for feedback and be responsive
8 to questions? And then did Site B take that
9 information and act on it?

10 So it's a difference between hearing
11 and listening. That is, just sending a package
12 of information to Site B from Site A doesn't
13 ensure any action, doesn't improve quality,
14 doesn't even mean anybody read it. So I would
15 like to see us create measures that reach across
16 those divides. And God forbid practitioners
17 actually talk to each other about patients as
18 they move through sites of care, and of course
19 involving the patient and family with it.

20 The other piece of that is if there is
21 some way NQF -- I know that we are not a
22 measurement development organization -- is there

1 some way you can connect organizations who want
2 to develop measures? I have the part of two of
3 them that would love to. But it is just
4 prohibitive in terms of resources and time in
5 volunteer organizations to try and pony up cash
6 and get the statistical work done behind them.

7 So if you can find an organization
8 that will fund or assist, hook it up, put it out
9 there so that other organizations with great
10 ideas can put them into action. I think it would
11 help a lot with the gaps.

12 CO-CHAIR SALIBA: Thank you.

13 Alan.

14 MEMBER LEVITT: I may be hastening my
15 departure from CMS, but I just wanted to make
16 sure, I know it just came up about should we
17 still be doing our work here because the IMPACT
18 Act is out there. And does measurement gaps,
19 core concepts, does any of that matter?

20 I mean I just want to reinforce that
21 the answer is yes. That, you know, I think
22 Congress did get it right in terms of the IMPACT

1 Act and the domains it has chosen. And we can
2 argue about the time lines. But, again, I think
3 that's all important.

4 But what this represents is what we
5 all in the post-acute care community -- now I'll
6 put on my post-acute care hat -- feel is really
7 important as well and that, you know, we need to
8 continue to promote what we think our core
9 concepts are, what the gaps are. Because we
10 shouldn't just cede the entire quality of the
11 programs that are so important to us to Congress.
12 This is our job and it's an important job. And,
13 you know, in both my hats I find that this sort
14 of dialogue is really important, so.

15 CO-CHAIR SALIBA: Thank you. And the
16 long-term care piece as well, I think -- I'll
17 have to think about.

18 Gene.

19 MEMBER NUCCIO: I'd just like to ask
20 that NQF look at or encourage measure developers
21 to think more integratively, if you will, joining
22 process and outcome. Much like we talked about

1 yesterday with the falls measure where what the
2 provider does and the outcome of that.

3 If I can coin a term or semi-
4 officially, I would call that an efficacy class
5 of measures which joins process, outcome and
6 perhaps even cost, and when they begin developing
7 these measures within the domains that you've
8 already provided.

9 So just as we've seen our process
10 measures come to NQF historically as, did you
11 assess? Did you put it in a plan to make a
12 difference? And did you do something? And have
13 each of those individual ones endorsed by NQF,
14 we've now seen today -- in these last two days,
15 composite measures where you take the entire set
16 of steps and put them into a position.

17 I encourage that the measure
18 developers think to integrate both process and
19 outcome, okay, in the future set of measures that
20 we begin to consider.

21 CO-CHAIR SALIBA: Thank you.

22 Liza.

1 MEMBER GREENBERG: Whenever I hear
2 anyone ask for what more measures do we need, it
3 sort of strikes fear in my heart from the
4 provider's side because being new in my job I've
5 had to learn about the 26 Home Health Compare
6 measures and all the value-based purchasing
7 measures and the, you know, coordinated care for
8 joint replacement measures. And there's a lot of
9 measures out there.

10 So I would just also urge us to maybe
11 consider as part of the MAP role, you know,
12 working towards NQF submission of parsimony, and
13 trying to think about what needs to come off the
14 table or what can be clustered in a composite
15 measure.

16 Because, again, not only is it
17 burdensome to agencies to -- it's not that the
18 reporting is as burdensome as it used to be, but
19 thinking about them all and improving them all,
20 especially when they've topped out. But it's
21 confusing to consumers. You know, to a consumer
22 when you try to go through Home Health Compare

1 and you're like, you know, expanding and
2 contracting the little buttons to figure out
3 what's what. I think that the stars are a huge
4 step forward. But you know, then really looking
5 at what we can retire.

6 CO-CHAIR SALIBA: Thank you.

7 Gerri.

8 MEMBER LAMB: Two things. Wanted to
9 just reinforce what Liza and Jim were saying in
10 terms of working on more composite measures that
11 really close the loop. That's been a real issue
12 for the care coordination domain of getting these
13 one-part check-listing things coming forward,
14 plus not getting anything coming forward in the
15 last year.

16 So I really would just support what
17 Liza was saying is maybe this can be a focus area
18 as we look at more complex measures in the
19 future.

20 The other was to go back to what
21 Joseph was talking about with teamwork and
22 interprofessional care. And the National Center

1 for Interprofessional Practice and Education is
2 really looking at kind of best in class measures.
3 And there is a new measure of teamness that folks
4 at the University of Oregon, Virginia Tilden, has
5 been developing, and the psychometrics are quite
6 good. And so we may be on the verge of looking
7 at better measures for how teams perform as a
8 process measure for linking to outcomes. And
9 that may be really important as we get to
10 attribution.

11 CO-CHAIR SALIBA: So, Gerri, National
12 Center for Interprofessional --

13 MEMBER LAMB: -- Practice and
14 Education.

15 CO-CHAIR SALIBA: -- Practice and
16 Education. Okay.

17 Sean.

18 MEMBER MULDOON: I'll take some risk at
19 piling on with the providers' viewpoint. But I
20 would like to reiterate that providing people
21 with data is just the first step of a long
22 process of interpreting the data, troubleshooting

1 the data, developing plans, and then starting
2 your own PDCA cycle.

3 And it reminds that when balanced
4 score cards are discussed, one of the -- one of
5 the key components is the fact that if you've got
6 30 elements on your balanced score card, you
7 don't have anything that people will ever respond
8 to.

9 So if ultimately we're trying to help
10 consumers make better decisions, and providers do
11 some QI and ultimately use some of that for VBP.
12 Just recognize that at some point the pendulum
13 goes the other way, and the more you know, the
14 less you actually can act on.

15 CO-CHAIR SALIBA: Thank you.

16 Cari.

17 MEMBER LEVY: Yeah, and following on
18 that, I'm just thinking of I review a lot of
19 post-acute care charts, and 98 percent of what I
20 look at has nothing to do with the human being,
21 it has everything to do with meeting
22 requirements. Right? And it's checking a box

1 and it's generating paper. And there's so little
2 about the human in a chart.

3 And so to the extent that what we're
4 doing here can increase the amount of attention
5 we pay to the person that's there, I think that
6 would be a wonderful thing to be able to do with
7 what we're trying to accomplish.

8 CO-CHAIR SALIBA: Thank you.

9 Carol.

10 CO-CHAIR RAPHAEL: I just wanted to
11 kind of follow up on what Sean said, because I
12 always try to think about what can we do that's
13 actionable and that sort of really moves the bar
14 for quality upwards.

15 And, you know, AARP, the SCAN
16 Foundation and the Commonwealth Fund have done
17 this score card on long-term care. And it takes
18 the states and it scores them. And I think it's
19 five domains: access, affordability, something on
20 quality, there was caregiver support. And I
21 can't remember the fifth.

22 And they first did it in 2011. And I

1 have to tell you I got calls from four different
2 governors' offices like, how could this be? What
3 does this mean? You know, how could we be 41 on,
4 you know, the list of states here? Because
5 Americans, I've discovered, love rankings. And
6 then they just re-did it this past year in 2015,
7 and almost every state improved.

8 So, you know, I do think there is
9 something to be said for kind of keeping it in a
10 manageable group that you can really digest and
11 act on. Doesn't mean, you know, that we don't
12 have many roads to travel here, but I think the
13 core should be really what is consequential.

14 CO-CHAIR SALIBA: Clarke.

15 MR. ROSS: I wanted to report on one
16 other measure gap identified by the Duals
17 Workgroup. And this will make Sandy's day too.

18 One of the measure gaps is the
19 absolute importance of non-medical, frequently
20 non-profit community-based organizations for both
21 people with disabilities and elders. And they
22 get neglected by both CMS and the National

1 Quality Forum because the funding are hospitals
2 and the four IMPACT groups and, fortunately,
3 home- and community-based services. But they're
4 all siloed. And they're siloed at the National
5 Quality Forum.

6 And so one recognized the absolute
7 importance of these non-profit community
8 organizations, thousands and thousands of them
9 across the country. That's the daily interface
10 that most people who are outside an institutional
11 setting have who are disabled and elderly are
12 with those organizations, not with the ones that
13 we're focused on.

14 And then related to that concept, I
15 don't know how many of you know that ONC and ACL
16 have a long-term care electronic record
17 discussion group that has been going on every
18 week for almost a year. And it's one little
19 domain, the domain of electronic health records,
20 and how do we make this link between medical
21 facilities and the non-profit community-based
22 organizations?

1 So there's this little network that
2 has no official standing, it's just whoever wants
3 to join. But there are a lot of state disability
4 and elderly -- aging folks on the calls who just
5 brainstorm about this linkage issue through the
6 vehicle of the electronic health record.

7 CO-CHAIR SALIBA: Liz.

8 MS. PALENA HALL: I'll elaborate a
9 little bit more on that because I am one of the
10 federal leads for that effort. And so behind
11 that is actually some CMS Medicaid work. And so
12 there's a grant called TEFT as we affectionately
13 know, and part of that -- so there's four
14 components of TEFT, some of which is the CAHPS --
15 the CAHPS tool that was discussed, the care
16 assessment and modifications to that, and also
17 the standards work.

18 So in partnership with CMS we have a
19 weekly group. It's through the ONC Standards and
20 Interoperability Framework. And so there are
21 seven states that participate in that work,
22 they're grantees. And so they are required to,

1 as part of their grant work, to pilot standards
2 that are being identified.

3 And so we also coordinate quite a bit
4 with the NQF HCBS Workgroup. And so right now
5 the standards work is in a phase where we are
6 starting pilots. So it's not only states but
7 also non-private sector entities that are
8 beginning to pilot some of this work.

9 So I think we certainly would have --
10 I think there was some discussion about
11 potentially presenting to one of the other
12 workgroups on where those pilot organizations are
13 at. And so we can share some of that, inform,
14 you know, some of the NQF workgroups.

15 So but there is -- and I would say
16 that in terms of the standards work, it will go
17 through a number of phases of piloting. So it
18 will not only -- they'll not only be piloting
19 this year but also through 2017.

20 CO-CHAIR SALIBA: Thank you. And the
21 other part of your comment, we -- our center at
22 the VA just got a large grant from the VA to do a

1 better job of integrating at the point of
2 discharge from the hospital, integrating our
3 veterans with community-based organizations and
4 services. So I think that's also an area that is
5 coming along but, correct, it's still a gap.

6 So any other? So I think there was
7 one -- there were three topics that Sarah brought
8 up that she wanted us to think about. And I
9 think we've covered some of them: measure gaps
10 and domain, domain sufficiency from the IMPACT
11 Act. But we didn't talk about Hospice QRP. Did
12 anyone have any comments that they wanted to talk
13 about in terms of the Hospice QRP?

14 Lisa.

15 MEMBER WINSTEL: Just to really
16 encourage development around the timeliness and
17 responsiveness of care.

18 CO-CHAIR SALIBA: Anyone else?

19 Clarke.

20 MR. ROSS: My brother-in-law died in
21 May and was the recipient of hospice. But the
22 thing I want to share is that the professional --

1 the professions were great, the nurses and social
2 workers. The support personnel, the people who
3 were supposed to come and help with bathing and
4 toileting, were absolutely horrible and not
5 dependable.

6 So when we think about quality
7 measures we tend to focus what should the nurse
8 do and that's great. But the day-to-day grunt
9 work that makes quality of life is frequently the
10 non-professional aide kind of person. And so
11 please remember that.

12 CO-CHAIR SALIBA: And I was assuming,
13 Lisa, that your interprofessional group included
14 that type of --

15 MEMBER WINSTEL: Well actually, most
16 specifically I was referring to medical
17 assistants, talking about end of life when
18 there's an absolute need for pain relief and the
19 next time you see somebody is 36 hours later.
20 That's not acceptable.

21 CO-CHAIR SALIBA: Earlier when you
22 mentioned the National Center for

1 Interprofessional Practice and Education, was
2 that you? Maybe that was Gerri.

3 All right, any other comments,
4 thoughts about Hospice QRP?

5 (No response.)

6 Okay, thank you, guys.

7 So we'd like to open the floor now for
8 public comment. Can we check -- have the operator
9 check on the line and see if there's anyone that
10 would like to contribute online, on the phone?

11 OPERATOR: Okay, and at this time if
12 you would like to make a comment please press
13 star then the number one.

14 There are no comments at this time.

15 CO-CHAIR SALIBA: Thank you.

16 And in the audience here today, is
17 there anyone that would like to make a comment,
18 please?

19 MS. LEE: Teresa Lee with the Alliance
20 for Home Health Quality and Innovation.

21 I want to thank this group again.
22 You're clearly just a really thoughtful group.

1 And I appreciate the candor and openness from CMS
2 as to where things are today.

3 And, you know, the one thing that
4 occurs to me in this conversation about
5 measurement gaps is that there's just been a lot
6 of ground covered today. I've just heard so many
7 different comments, all really meaningful, all
8 really constructive. And we've sort of focused
9 in today mostly on the IMPACT Act domains that
10 are enumerated. But it is contemplated in the
11 IMPACT Act that there might be future domains
12 identified and pursued.

13 And I think that this body could be a
14 good one to sort of think comprehensively and in
15 a streamlined, meaningful fashion about what
16 further domains CMS might wish to take up once
17 they get past the enumerated domains that have
18 specific statutory deadlines.

19 So it's just something to think about
20 for the future. Certainly something that I would
21 want this group to be very careful about. I, like
22 Liza, you know, worry about just more measures.

1 You know, there -- home health, we're the poster
2 child for lots of measures. We've got lots and
3 lots of measures. And it's, you know, there's
4 not -- I think that a lot of them are meaningful,
5 but now we worry that, you know, how do we focus
6 our quality improvement activities when there are
7 so many measures?

8 So if there's a way to think about it
9 comprehensively to give CMS some recommendations
10 about, you know, what's the way forward, I think
11 that all of us would be very interested in
12 helping to support those activities. Thank you.

13 MR. HILLMAN: Thank you to the
14 committee again.

15 This is Troy Hillman from the Uniform
16 Data System for Medical Rehab. We represent
17 roughly 900 subscribers, both in the in-patient
18 rehab skilled nursing facility and long-term
19 facility that are collecting data utilizing the
20 FIM instrument as well as all of these quality
21 initiatives and measurements that are being
22 examined by the NQF and created by CMS and other

1 measure developers.

2 A lot has been stated today about the
3 IMPACT Act and about the specific deadlines. And
4 one of the things I really question is, at what
5 point do we require that these measurements that
6 we're all being held up to and that we need to
7 consult, educate, train, and have each of these
8 providers the ability to collect the data and
9 examine their -- when do we require that these go
10 through a fully developed and tested process?

11 A number of you on the panel today
12 asked whether these measures would come back
13 through the NQF process for endorsement. Now,
14 while we know that there are specific deadlines
15 stated within the IMPACT Act, there's also
16 provisions that the Secretary can remove and/or
17 suspend any of these measures at any time through
18 justification in the Federal Register. Do we, as
19 part of this NQF process request, as part of our
20 recommendations forward, that the Secretary
21 examine the potential for removing or suspending
22 these requirements until such a time as they can

1 answer your questions that you've asked today?

2 We truly appreciate all of the
3 consideration given by this committee and by this
4 panel, and especially for CMS and their measure
5 developers in the process. But, again, we come
6 back to the question of we have measures that
7 look to be implemented this coming October or the
8 next October or, depending on which program
9 you're in, being implemented where you begin
10 collecting the data.

11 At this stage we're becoming the data
12 collectors for the validation of measures that
13 have not met these requirements yet. And at what
14 point do we, as a committee, or you, as a
15 committee, and we, as an industry, begin to ask
16 that these measures go through these fully
17 developed and tested measurement endorsement
18 processes?

19 Again, thank you so much for your
20 time. I hate being the last one, as I was
21 yesterday as well. But again, thank you so much
22 for your time, for your consideration and for

1 your thoughtfulness. Thank you.

2 CO-CHAIR SALIBA: Are there any other
3 comments from the audience so that Troy's not the
4 last one?

5 (No response.)

6 Okay, thank you so much. So I think
7 we're now going to talk -- just summarize the
8 meeting for the day. Carol, do you want to?

9 CO-CHAIR RAPHAEL: Well, let me just
10 very briefly -- first of all I want to thank CMS
11 and Alan and Tara. Really, you know, you do not
12 need to go through a multi-stakeholder process.
13 You are not required to. You chose to. And I
14 think you have exhibited the fact that you really
15 value the guidance and input that this group has
16 provided.

17 So I really want to thank you. And,
18 you know, you have -- we have seen a real
19 evolution in that partnership over the time that
20 we have all been involved in this. So thank you
21 for that.

22 Secondly, we are involved in a new

1 process that, you know, I don't know if I would
2 call it its infancy, but maybe it's even before
3 giving birth. Who knows what stage we're in, but
4 we're in an early stage in developing a process
5 that really works, when measures are kind of not
6 yet crystallized and not at the scientific level
7 that we have historically been accustomed to.

8 So we have used something that we've
9 been doing in other workgroups with the consent
10 process. I'm assuming, unless someone raises a
11 hand at this juncture, that everyone understands
12 the process, that you have assented in all
13 instances to the actions that we've discussed and
14 agreed upon. And that we still continue to wish,
15 and particularly in certain areas, that we will
16 have more involvement and ability to shape the
17 final measures that emerge and that will be
18 worked out.

19 I wanted to just ask Erin to review
20 next steps. Where do we go from here?

21 CO-CHAIR SALIBA: One person has their
22 tent up. So, Jim.

1 MEMBER LETT: Tell me if this is the
2 appropriate time. Just a suggestion for process
3 for next time.

4 I really backed into liking the Lead
5 Discussant concept. When I got the agenda and I
6 saw I was the Lead Discussant for a number of
7 those, I first panicked. And it -- but it made
8 me really in depth read the measures, look at the
9 exceptions, even do some research, background
10 research about them, which I think helped me
11 understand these measures a great deal more.

12 There are, frankly, I think too many
13 for any one person, who also has a job, to be
14 able to go through them in significant depth. I
15 would probably suggest that next time that we
16 meet, when you assign Lead Discussants, as you
17 obviously have topic based on the organization or
18 the person involved, to make them responsible
19 basically for knowing that core set of measures
20 they're going to comment on so that they can
21 really make some terrific refinements,
22 suggestions to this panel, as well as to CMS and

1 our other partners.

2 CO-CHAIR SALIBA: Thank you.

3 Erin, I'll hand it back.

4 MS. O'ROURKE: Thanks, Deb.

5 So just to briefly run through the
6 upcoming steps.

7 We'll be releasing the draft
8 recommendations for public comment on December
9 23rd. And that will run I believe through
10 January 12th. January 12th. So please be on the
11 lookout for that if you'd like to make any formal
12 written comments on the draft deliverables. I
13 will be putting out the workgroup recommendations
14 as well as the draft programmatic guidance. So
15 we'd appreciate any feedback and input from the
16 public or from members of the workgroups.

17 The MAP Coordinating Committee will be
18 meeting on January 26th and 27th to review and
19 finalize the MAP pre-rulemaking input. So we'd
20 welcome anyone who is interested in following
21 that meeting to attend as a member of the public
22 or dial in. You can see the MAP webpage for more

1 information.

2 And then, finally, February 1 we'll be
3 releasing the spreadsheet of every measure, with
4 the recommendation and rationale. And on
5 February 15th, we'll be releasing the
6 programmatic guidance, or the written deliverable
7 that goes a little bit more into the workgroups'
8 guidance and more cross-cutting issues.

9 CO-CHAIR RAPHAEL: Are there any
10 questions about the process moving ahead here?

11 CO-CHAIR SALIBA: I just want to thank
12 everybody for their input today and yesterday. I
13 think we heard a wide range of input and very
14 constructive and extremely helpful. So I just
15 wanted to thank you all. It was a pleasure
16 working with you.

17 Alan.

18 MEMBER LEVITT: I really wanted to
19 thank everybody again. I can't thank you enough
20 for the support you give us, for the input you
21 give us. We have differences sometimes, but we
22 actually really -- we have the same goal in

1 heart, so to speak, at hand here.

2 We need to think back, as Carol was
3 saying, you know, where we were and where we are
4 now, and how much progress we've really made, and
5 how good the future looks too. I know we talked
6 all about the IMPACT Act measures. But as I was
7 mentioning to Teresa and Liza I guess a week ago,
8 the IMPACT Act also has all standardized
9 interoperable data that's going to be able to be
10 used and useful for our patients longitudinally
11 across settings. And that's such a remarkable
12 feat to see that beginning.

13 And that is a beginning for us. And
14 it's going to be so important to implement that
15 and, hopefully, implement it not beyond this
16 workgroup into other settings as well.

17 But, again, we hope to continue the
18 dialogue, to be back, to continue, you know,
19 discussing future measures with you. And thank
20 you again.

21 CO-CHAIR RAPHAEL: To everyone a happy,
22 happy holiday. And thank you so much for going

1 above and beyond the call of duty.

2 MS. SAMPSEL: And just real quick.
3 Lunch will be here. It's on its way.

4 And on behalf of NQF, obviously we
5 want to thank everybody as well. And we are
6 open, Jim and everybody, to suggestions. You
7 know, right, MAP has been around for a while, but
8 year to year we are trying to improve and we'd
9 like to hear what thoughts that you have as we
10 prepare.

11 And we'd just like to recognize not
12 only the staff on this team, but there's a lot of
13 behind-the-network folks working on MAP for NQF
14 that pulled this all together. Amber and Wunmi
15 specifically in the back, who try to bring all
16 the staff together and promote consistency.

17 So thank you all. And we'll look
18 forward to talking to you in the future.

19 (Whereupon, the above-entitled matter
20 went off the record at 12:38 p.m.)
21
22

A	
\$3 81:9	167:10
a.m 1:9 5:2 107:11,12	actionable 174:13
AARP 174:15	actions 187:13
ability 7:11 25:17 69:4 184:8 187:16	actively 119:5 165:18
able 34:16,16 51:12 64:5 68:11 80:21 85:4 85:21 86:15,17 111:8 115:8 118:21 126:7 147:5 148:11 161:5 174:6 188:14 191:9	activities 7:10 34:17 183:6,12
above-entitled 107:10 192:19	actors 100:1
absolute 175:19 176:6 180:18	actual 93:17
absolutely 103:15 112:17 180:4	Acumen 3:12 93:10,16 93:21
ACA 115:20	acute 31:14 39:22 63:9 93:7 129:8 136:2
acceptable 180:20	adapt 156:20
accepted 12:22 13:2	adaptation 159:13
accepting 10:12 37:4 37:16	adaptations 160:11
access 38:13 43:2,12 44:1,3,13 51:4 59:18 149:19,19 152:6,6 174:19	adapted 160:6
accommodate 28:7	add 26:15 52:3 71:8 80:16 88:22 103:13 120:3,4 146:18 148:17
accomplish 174:7	added 54:15 111:7
accomplished 118:22	addition 52:20 72:12
account 18:8 73:14 85:18 111:8	additional 6:14 8:7 128:20,21 158:19 162:20 163:15 165:6
accountability 125:5	address 12:16 24:9 30:4 31:6 32:4 85:14 85:20 115:15 131:20
accountable 43:7 85:10	addressed 30:17 55:10 61:3 85:3 109:8 123:11 124:22 137:3
accounted 80:19	addressing 119:10 137:5
accounting 39:16 75:15	adequate 43:15 44:13 122:9
accurate 55:17	adjectives 138:7
accurately 141:21	Adjourn 4:22
accustomed 187:7	adjust 86:18 87:13 88:17,22 97:5
achieve 140:11 144:10 145:2,12,16 151:19 160:20 161:14,14,22	adjusted 90:1,4,21 95:9
Achieving 161:16	adjuster 65:4 91:16 96:5
acknowledgment 13:6	adjusting 85:20
ACL 176:15	adjustment 31:20 55:6 55:9 63:11,22 64:11 73:13 86:22 90:10 91:3,10 92:3 93:18 94:1 98:13 101:2
ACOs 77:17 78:1	adjustments 5:17 91:13
acronym 161:10,14	Administration 155:3
act 4:6,8,16 5:5 29:2,5 38:7 41:8 46:9 48:20 79:10 84:13 91:12 104:12 150:17 162:22 163:3,7,10,22 166:9 167:18 168:1 173:14 175:11 179:11 182:9 182:11 184:3,15 191:6,8	Administrative 64:14
acting 110:2	admission 93:15 94:2,9 94:10 97:18 98:2,7 99:4 119:5,6
action 2:5 36:5 166:13	admissions 98:4 136:22
	admitted 97:14
	adults 154:13,15
	advanced 136:18 140:8 143:4
	advantage 23:15 77:22 92:10,11,17,20
	adverse 136:20
	advice 34:13
	advise 74:22
	Advisor 2:18
	advisory 2:3 18:22 19:16,19,20 30:2 46:20
	advocated 29:3,5
	Aetna 1:13
	affect 67:8
	affectionately 177:12
	affiliated 160:3
	affirm 36:12 146:21
	affirmation 35:22 36:6
	affordability 174:19
	afraid 138:11
	afternoon 154:8
	age 90:22 137:17 148:22
	agencies 1:20 57:9 170:17
	agency 53:20 75:22 94:11
	agency's 90:19
	agenda 38:6 134:9,10 157:10 188:5
	aging 1:20 153:2,4 155:5 177:4
	ago 13:14 191:7
	AGOSTINI 1:13 145:10
	agree 32:12,13 42:1 66:8 77:8 135:3
	agreed 94:7 134:6 187:14
	agreement 9:18
	agreements 9:19 10:12
	ahead 15:14,16 121:10 162:12 190:10
	aide 180:10
	aides 110:2 112:10
	aids 82:22
	aim 125:18
	AKA 39:21
	Alan 2:10 25:11 26:16 33:16 48:6 52:2 56:15 85:3 123:10 125:22 129:13 167:13 186:11 190:17
	align 135:12
	aligning 98:21 136:7
	alignment 150:4,14
	Alliance 3:15 41:19 181:19
	allow 32:3 71:16 97:5 135:17
	allows 30:12 87:1
	alongside 50:10
	alternate 25:20
	alternative 124:11
	Amber 192:14
	ambiguous 40:10
	AMDA 1:18
	America 1:15
	American 1:15,22 2:1,4
	Americans 175:5
	Amin 2:18 6:5,6 12:5,9 19:11 23:19 36:17,20
	amount 7:9 10:5 40:3 40:13 59:6 90:2,20,21 122:5 174:4
	amplify 40:18 66:6 72:10 83:17 146:16 149:14
	analysis 10:13 22:13 44:7 45:21 51:8,10,18 62:2
	Analyst 2:19
	and/or 157:7 184:16
	Andrew 3:9 39:6
	answer 25:7 27:13 60:9 61:5 126:2 128:7 160:8 167:21 185:1
	answers 23:9 62:1
	anticipate 84:11
	antsy 159:16
	anybody 74:7 159:4 166:14
	anymore 81:7
	apocryphal 69:13
	apologize 47:16 48:1,7 61:11 87:19 110:17
	Apparently 162:10
	appear 92:9
	appears 49:17
	APPLICATIONS 1:3
	applies 77:15 130:5
	apply 130:10 153:2
	appreciate 182:1 185:2 189:15
	appreciated 17:15 18:12
	approach 80:14 115:11 135:16 149:12
	approached 5:7
	approaches 135:19
	appropriate 59:16 140:22 188:2
	appropriately 86:18
	approved 15:16 35:21 36:5
	area 1:19 55:12 59:20 64:16 68:13 73:8

114:13 139:11 141:4
 141:12,21 142:6,19
 142:19,22 143:21
 144:11 146:18 153:19
 155:4 160:1 171:17
 179:4
areas 38:10 136:3,12
 140:5,16 141:6,20
 143:19 145:13,17
 151:10 153:5 157:20
 158:9 159:6 163:18
 163:22 164:1 187:15
arena 121:6
argue 168:2
around-the-clock 128:6
arrangement 44:16
arrangements 43:8
 44:22 76:7 77:14,17
 77:18
array 110:6
Art 114:6 120:3,3
ARTHUR 2:3
articulate 7:7
aside 13:3 86:6
asked 9:11 14:8 36:2
 62:18 113:1 158:10
 184:12 185:1
asking 10:10 25:6 61:3
 62:14 121:20 140:4
ASPE 91:12
assent 134:7
assented 187:12
assess 5:16 146:12
 169:11
assessed 135:16
assesses 125:14
assessing 136:9
assessment 96:22
 109:9 118:7,9 119:8
 119:12 136:16 162:5
 177:16
assessments 87:8
 125:2
assign 188:16
assist 167:8
assistant 91:11 111:21
assistants 110:2
 180:17
associated 113:13
 136:13
Association 1:15,16,19
 1:22 2:1 153:1
assume 34:20,21 35:6
 63:16
assuming 132:6 180:12
 187:10
assumption 42:6 78:2
 88:1 160:7

assurance 12:7
assure 85:9
Astronaut 69:17
astronauts 69:14
attaining 140:9
attainment 140:6,19
 141:8,14 143:22
 144:14 146:5 147:1
 147:17 148:10
attend 189:21
attending 110:3 121:15
 123:2
attention 174:4
attributable 102:4,5
attributed 39:19
attribution 172:10
audience 28:19,20 39:2
 108:9 181:16 186:3
autonomy 155:13 156:9
availability 64:2
available 20:10 21:5
 46:5,22 96:6
average 55:13 65:18
 90:20
avid 39:11
avoid 51:15
avoidable 136:22
aware 57:19 79:9 104:9
 159:4,10
awesome 150:20

B

B 49:6 98:10 166:6,6,8
 166:12
back 5:15 6:10 11:22
 19:21 22:9,12 35:1
 38:2 47:22 57:16 59:8
 61:9,16 70:15,19 71:5
 71:6,12,15,22 83:14
 85:5,16 93:22 94:8
 99:8 102:3 103:6,9
 104:2 107:9,14,15,17
 107:20 128:13 129:9
 135:10 137:15,17,18
 140:1 151:8 164:18
 171:20 184:12 185:6
 189:3 191:2,18
 192:15
backed 188:4
background 87:20
 116:10 188:9
bad 40:14 100:10
Baird 3:9 39:5,6
balanced 173:3,6
balancing 30:22
ball 120:22
bang 80:13
bar 174:13

based 33:21 34:2 42:6
 50:10 70:21 87:13,16
 89:16 95:22 110:16
 119:11 159:3,12
 188:17
basic 117:22
basically 14:2 26:5
 76:15 109:16 188:19
bathing 180:3
bear 80:3
becoming 185:11
beer 154:7
beginning 58:18 68:8
 138:12 151:17 152:1
 178:8 191:12,13
begun 49:2
behalf 192:4
behavioral 145:15
behind-the-network
 192:13
believe 43:15 117:21
 161:3 189:9
bene 100:10
beneficial 162:7
beneficiary 4:7,9 42:18
 45:1,16 47:14 48:18
 49:1,9 63:9 83:4 84:1
 84:7 99:22 100:4
 104:13 153:10,13
 156:8
benefit 133:22 134:1
 150:5,8
best 9:16 27:15 28:3
 47:1 81:21 172:2
better 27:22,22 50:16
 50:21 63:21 87:2
 135:19 145:3 147:20
 172:7 173:10 179:1
beyond 94:16 101:3
 135:18 138:21 191:15
 192:1
bidder 69:20 80:8
bifurcate 21:11
big 86:2 138:8,8
bigger 139:5
billed 93:17
bind 29:10
birth 187:3
bit 6:1 11:7,14 13:5
 47:17 63:20 87:20
 93:5 96:15 97:13
 111:15 128:13 134:21
 135:7 136:13 163:21
 177:9 178:3 190:7
bite 11:22
blasted 69:16
blurring 70:3
boards 32:10

body 29:19 30:2 35:2,2
 41:21 182:13
books 70:13,18
border 100:7
bottom 164:11
bowel 109:11 131:18
box 26:11 45:6 108:15
 117:9 119:2,12
 131:22 137:4 173:22
brainpower 161:19
brainstorm 177:5
Brazil 3:10 124:12,13
 127:3,14,21 132:18
break 107:1,3,5,14
bricks 53:12
brief 108:18
briefly 186:10 189:5
bright 69:9
bring 38:2 59:7 70:15
 71:11,15 85:4 101:21
 103:5,9 104:2 130:1
 162:21 163:14 192:15
bringing 82:22
broad 12:20 103:3
 110:6 115:4,8
broader 89:10 156:13
broadly 101:2,9 138:14
 138:22 163:13
broken 111:13
brother-in-law 179:20
brought 25:2 26:22
 31:21 112:18 113:22
 179:7
Bruce 1:16 18:10 25:6
 75:10 99:17 146:14
buck 80:14
bucks 150:18
buddies 147:6
build 72:10
bunch 153:9
bundle 32:12,21
bundled 43:8 44:16
 78:1
bundles 77:17
burden 82:14 83:11
 92:14 112:15 113:12
burdensome 170:17,18
Bush 47:12
bushy 79:12
business 35:15
buttons 171:2

C

C 4:1
CAHPs 139:12 159:13
 160:5,12 164:5
 177:14,15
calendar 8:4 32:15

35:19 36:4,9 58:15
62:19 108:6 120:7,9
134:8
calendars 8:2 10:8
32:17 37:3
call 133:22 165:3,4
169:4 187:2 192:1
called 56:22 138:3
141:21 149:18 151:13
177:12
calling 5:22 133:8
calls 175:1 177:4
candor 182:1
capture 60:12 68:11
101:17 144:16 147:10
151:2
captured 51:16 63:19
76:11 77:4 98:17
captures 60:18
capturing 103:16 124:1
145:4
card 173:6 174:17
cards 173:4
care 1:3,14,18,19 2:2
31:14,16 39:9,17,17
42:19,21 43:3,7,12
44:14 45:17,18 49:11
49:14,18 50:18 51:4
51:15,21 53:3 54:22
57:2,16 58:2,5,8 63:9
64:2 65:21,22 66:19
69:6 72:4,5,14 74:8
75:20 78:7 82:14,15
82:16,21 83:3,7,8,11
86:8 93:7,17 94:1,12
95:8 98:16,17 99:6,15
108:8 109:1,1 111:1,4
111:17,17 112:6
114:14,21 115:1,6,10
115:11 116:8,11,14
116:16 117:1,4
119:10 121:6,8,16,18
121:21,22 123:4,4,15
126:13,14 127:2,11
127:17,22 128:3,5,5
128:15,17,19 129:7
129:10,11 132:16,16
132:17,19 134:15,19
135:16 136:2,2,10,17
136:18,19 138:2,3,12
138:15,18,20,21
139:3,12 140:8,17
141:9,12,19,22 142:8
142:12 143:4,4 144:9
144:18,20 145:7,12
147:20 149:16 150:21
160:22 161:16,17
164:6,9,19 165:12,20

165:21 166:18 168:5
168:6,16 170:7
171:12,22 173:19
174:17 176:16 177:15
179:17
care/long-term 1:3
134:19
careful 116:22 182:21
carefully 32:8
caregiver 2:5 160:22
174:20
Cari 1:18 72:20 80:15
132:1 173:16
Carol 1:9,12 2:2 6:5
36:17 107:6 114:6,8
117:13 128:11 129:20
132:22 133:13 146:19
148:15 174:9 186:8
191:2
Carol's 148:9
case 55:9 63:12,14
64:14 78:17 87:1,4
90:14 92:21 94:11
103:22 133:15
cases 90:15,17 100:3
158:3
cash 167:5
categories 14:18,20
66:2 102:20 104:9
category 18:18,20
104:10 141:18
causing 81:12
caveat 78:6 104:3
caveats 58:19 103:16
cede 168:10
center 171:22 172:12
178:21 180:22
centered 149:10 156:6
Centers 2:10 3:10,17
3:19
certain 9:19 25:21
74:14 87:4 102:6
109:18,19 125:10
160:7 187:15
certainly 17:21 33:21
34:4 37:10,21 38:1
51:20 52:17 56:15
74:15 95:21 97:2
142:8 152:6 162:18
163:8 178:9 182:20
cetera 88:8 158:2,20
Chairs 10:11 11:11 13:1
16:18 19:14
challenge 15:20
challenges 15:20
challenging 137:9
chance 62:7 71:16
change 10:16 12:12

110:15 131:3,5
164:14
changed 110:18 113:4
114:4 134:18
changes 10:9 110:17
123:11 160:12
changing 114:3
chaplain 121:15
chaplains 110:3 112:9
125:16
characteristics 64:1,18
65:2 77:1 96:2
characterization 36:8
characterize 16:5
characterized 36:20
characterizing 73:1
charges 52:19
chart 174:2
charts 173:19
chat 45:6 108:15
chats 108:16
check 28:6 93:2 117:9
119:2,12 181:8,9
check-listing 171:13
check-off 131:22
checked 36:11
checking 127:7 173:22
cherry 57:2 72:12 100:2
child 183:2
choice 26:2 82:18
99:11 126:12 148:19
choices 104:14 105:10
105:22 106:13
chose 186:13
chosen 168:1
Chris 158:15
chronically 148:12
claim 92:12
claims 86:16 92:7,12
93:14 96:7,21 100:10
100:11
claims-based 92:15
95:19
clarification 18:12 93:5
95:16 122:1 123:10
126:2 132:3 139:22
clarify 10:21 11:11 16:6
19:6 36:22 60:11
77:11 125:20
clarifying 52:9
Clarke 2:14 23:21
152:12 155:8 159:8
162:3 175:14 179:19
class 169:4 172:2
classify 87:9
clear 14:7,16 31:5 33:2
37:18 52:19 54:3,21
55:10,19 56:1 68:1

69:21 112:20 130:17
141:7
clearly 11:3 15:21 45:2
53:4 85:21 97:5
100:21 101:6,11
181:22
clicking 10:18
clinical 55:9 91:17,18
111:17 126:14
clinician 9:3,7 123:16
135:20
clinicians 160:5
close 35:14 171:11
clustered 170:14
CMD 1:17,18
CMS 2:11 3:11,18,20
6:2 9:15 13:9 14:8
15:22 16:17,21 17:9
19:18 20:22 29:8,22
41:21 44:2 46:18 47:6
48:7 50:7 55:3 60:17
67:5 69:5 70:14 71:2
71:10 74:20 89:14
97:1 102:13 103:5
104:1 110:11 114:14
134:2 145:21 150:4
158:12 159:11 162:18
163:6,11 165:8
167:15 175:22 177:11
177:18 182:1,16
183:9,22 185:4
186:10 188:22
CMS's 104:3
Co-Chair 1:12,12 5:3
11:16 16:20 18:10
23:21 25:3 28:6,18
33:15 35:12 36:10,19
38:4 39:1 40:17 41:12
41:18 43:20 45:5,8
47:5 52:11 58:12 59:2
59:10 61:1 62:9 66:4
67:17,21 68:15 70:8
71:7,21 72:20 73:15
75:10 77:10,21 79:3
79:15 80:15 82:8
83:14 84:20 93:1
94:18,21 95:17,18
97:8 99:17 100:15
101:10 104:5 105:1,6
105:19 106:9,22
107:22 108:5,17
110:11 114:5 117:13
120:2,6 122:11,19
123:8 124:9,17
125:12,22 127:7
128:11 129:18 131:8
132:1,22 134:3,14
137:16 139:8 140:1

- 140:12 141:3,17
142:21 143:17 144:2
145:8,18 146:14,19
146:20 147:22 149:7
151:3 152:4 155:6,17
155:19 157:2 160:16
161:9,12,19 162:1,8
165:9 167:12 168:15
169:21 171:6 172:11
172:15 173:15 174:8
174:10 175:14 177:7
178:20 179:18 180:12
180:21 181:15 186:2
186:9 187:21 189:2
190:9,11 191:21
- Co-Chairs** 1:9
Coalition 1:18 138:2
codes 87:6
coffee 147:6
cognitive 136:16
cognizant 91:6
cohesive 8:9
coin 143:9 169:3
colleagues 6:9,10
13:10 16:17 19:13
20:21 74:20
collect 184:8
collecting 183:19
185:10
collection 117:18
collectors 185:12
combination 80:13
combining 105:4
come 11:22 19:9 20:8
35:7 46:11,22 61:9,15
85:16 89:5 92:1 108:9
139:13,15 142:17
152:16 163:4 169:10
170:13 180:3 184:12
185:5
comes 30:3 60:15 71:5
71:6 75:13 89:2
116:21 118:5 120:1
133:2 155:11
comfortable 6:22 68:22
69:2 75:1 153:18
coming 35:1 76:17
107:14,17 154:19
164:20,22 171:13,14
179:5 185:7
comment 4:4,5,10,18
15:3 28:8,10,13 33:18
39:3,13 41:22 48:11
50:2 57:17,22 75:9
78:13 79:17 93:3
100:16,18 108:1,3
110:13 120:13 131:9
148:10 158:2 165:2
178:21 181:8,12,17
188:20 189:8
commented 71:1
commenters 13:8
37:20 42:1 48:17
commenting 13:22
137:17
comments 13:9 16:16
16:22 28:17 33:20
38:15,21 42:6 47:10
47:22 52:1 72:2 77:8
79:16 83:17 85:10
97:9 100:18 108:4,10
124:11 129:18,19,22
131:11 134:4 140:3
146:16 148:1 152:10
179:12 181:3,14
182:7 186:3 189:12
committee 5:21 6:8,15
7:8,13,18 10:11 11:6
12:22 13:1 15:5 20:2
22:2 26:8 38:2 61:9
61:16 62:5 78:15 82:5
158:1 183:14 185:3
185:14,15 189:17
Committees 23:7
Commonwealth 174:16
communicating 141:22
communities 24:8 73:4
community 64:2,6 74:8
111:1,2 151:18 155:4
159:11 168:5 176:7
community-based
162:6 175:20 176:3
176:21 179:3
compare 65:9 116:22
170:5,22
compared 40:15 86:21
comparing 68:10
comparison 54:2 57:15
57:20
complete 130:9
completely 18:16
complex 98:16 171:18
complexity 151:16
152:1
compliance 101:7
complicated 11:15
101:11,21 102:5
151:1
complicates 119:19
complication 115:17
component 11:11
112:3,4 126:7,20,21
130:15 149:17
components 46:8
173:5 177:14
composite 108:8 109:1
109:3 113:10,16
114:2 117:11,16,19
118:2 119:18 130:11
130:12,14 169:15
170:14 171:10
comprehensive 82:17
118:7,8
comprehensively
182:14 183:9
computations 56:16
concept 21:21 110:22
112:4,18 138:15
141:5 143:18 145:1
146:7,11 152:5
155:11,16 176:14
188:5
concepts 4:14 14:9
24:9 134:16,22 135:3
135:8 136:4,5,9,13,15
137:2,5,8,18 141:1
144:15 152:16 153:6
153:7,20 157:18
158:8 159:1 163:2,7
165:7 167:19 168:9
conceptualize 97:12
conceptualizing 100:19
concern 11:7 15:9 16:3
30:11,16 33:9 44:17
50:4 53:1 54:2 55:4
67:14 74:5 78:6 91:4
111:1 119:14
concerned 42:13 57:14
66:15 67:12 69:11
72:12 73:19
concerns 6:20,20 12:9
12:14 13:7 15:2 30:10
37:9 42:10,11 52:22
52:22 64:7 82:1,7
86:5 112:15 115:15
119:11 123:12
concluding 97:9
concurrently 92:2
conditions 15:17
conduct 35:15
Conference 1:8
confidence 36:16
confirmed 78:4
confluence 133:19
confused 19:5 133:1
confusing 42:15 170:21
confusion 48:1 125:20
congenital 49:8,8 98:9
Congress 26:13 30:20
30:21 33:22,22 34:1
48:19 67:7 167:22
168:11
connect 167:1
connected 102:20
consensus 20:4 30:22
32:18 35:2 164:19
consent 8:1,3 10:8
32:15,16 33:14 35:19
36:4,9 37:3 58:15
62:18 108:6 120:7,9
134:7 187:9
consequence 57:13
75:12 82:10 99:22
100:13 116:18
consequences 56:20
72:11 74:3 103:1,17
119:2 139:4
consequential 175:13
consider 32:7 34:5 51:7
74:2 152:3 163:5
169:20 170:11
consideration 4:6,8,10
4:12 27:3 38:7 43:2,5
79:21 82:4 92:1 135:6
162:18 185:3,22
considerations 43:14
considered 27:1 37:22
85:17 131:10
considering 22:16 28:1
69:2
consistency 192:16
consistent 8:20 36:13
98:4 139:6
constantly 5:16
construct 85:22 151:22
constructed 91:4,15
96:18
constructive 17:5 28:5
182:8 190:14
consult 184:7
consultant 2:4,21 6:7
consumer 1:13 24:19
72:3,7 170:21
consumers 31:15 34:6
34:15 42:16 43:10
155:12 170:21 173:10
contemplated 182:10
contemplates 74:7
contemplating 73:20
content 122:21
contention 63:1
context 7:3 13:12 16:15
83:21
continually 24:6
continue 8:12,13 14:5,6
14:12,22 15:1,15
23:10 42:13 51:9,21
59:21 70:14 78:15
79:2,8 102:15 109:12
110:10 124:2,3 158:6
168:8 187:14 191:17
191:18

continued 22:18 46:13
47:3 60:1 61:7,15
102:15,16 104:14,15
104:20,21 105:11,12
105:16,17 106:1,2,6,7
106:14,15,19,20
continues 42:22 94:15
164:10
continuing 27:21 91:5
continuous 12:11
127:11 128:3 129:11
132:7,15
contract 127:22
contracted 129:4,5
contracting 171:2
Contractor 64:14
contribute 181:10
control 102:2 155:13
156:9
conversation 6:12,14
6:19 7:14,21 9:21
10:17 11:4 12:15,21
13:5 18:14 46:16
62:22 83:18 146:2
159:4 182:4
conversations 145:20
coordinate 178:3
coordinated 170:7
Coordinating 5:20 6:8
7:8,12,13,18 11:5
12:21 13:1 15:4 20:2
26:8 38:2 158:1
189:17
coordination 50:19
86:9 111:17 126:13
135:9 138:15,18,20
140:17 141:9,13,19
150:21 171:12
Coordinator 2:12
core 4:14 38:9,12
134:15,21 135:3,8
136:4,13,15 137:2,8
137:18 143:18 144:15
152:17,21 153:8
155:11 156:11 157:18
158:8 159:1 163:2,7
167:19 168:8 175:13
188:19
corner 148:5
correct 78:16 93:10
105:3 129:16 132:10
132:14,18 165:19
179:5
correctly 161:21
COS-C 1:15
cost 38:13 39:16 42:16
51:2 52:18 58:7 59:18
67:10 69:2,11 70:2

72:6,15,18 74:4,8
77:13 80:12 89:8
96:10,16 97:6,22
98:14 99:22 100:4,10
102:21 147:20 149:21
152:5 169:6
costing 81:15
costs 38:11 42:14
50:14 57:15 58:2,2,18
67:6 69:5,10 76:4,4
76:11,20,21 77:12
82:14 83:1,13 91:19
95:3,8,12 99:7
counsel 33:13
counselors 110:4 112:9
125:16
count 121:14,15,16
125:3 147:14
counted 9:10
counting 66:16
country 176:9
couple 33:20 66:17
70:9 72:2 115:13
120:15 144:4
course 45:4 90:8
162:15 166:18
coverage 139:11 150:5
150:8
covered 76:11 82:21
119:14 179:9 182:6
CPH 2:7
CPHQ 1:21
create 8:8 16:12 31:13
116:12 119:18 166:15
created 14:3,19 15:9
25:14 183:22
creates 117:18
creating 30:11
creative 77:16
critical 67:11 114:16,22
129:1 151:11 152:2
cross 151:20
cross-cutting 190:8
crossed 157:14
crystal 120:22
crystallized 187:6
curious 56:3
current 21:5 32:2
135:18 139:6 157:21
160:20
currently 23:19 26:1
40:4 41:9 91:3,15
96:17 97:1 137:2
139:17 146:9
cuts 131:13
cutting 151:21
cycle 12:13 21:18
157:21 173:2

D

D.C 1:9
daily 154:2 176:9
data 3:13 20:20 46:21
96:5 117:18,20
133:19 135:14 150:16
172:21,22 173:1
183:16,19 184:8
185:10,11 191:9
David 41:13
day 4:2,2 49:14 57:10
114:1 118:8 119:4
122:7 126:5 130:8
131:18 175:17 186:8
day-and-a-half 139:2
day-to-day 114:21
180:8
day/30 57:10
days 57:6,7 88:13,14
93:15 94:5,8,14,15
112:1 116:1 118:11
118:18,18,19 120:18
121:11 122:8 124:5
125:7,17 126:14,15
126:16,21 149:1
160:15 169:14
deadlines 182:18 184:3
184:14
deal 38:11 60:5 86:19
151:18 152:2 188:11
death 108:7 109:14,14
109:15,22 110:8
111:3 112:1,8 122:4
123:7 124:15 125:7,7
125:14
Deb 5:7 79:14 80:18
95:17 134:17 137:15
189:4
Deb's 83:17 100:18
Debra 1:9,12
December 1:6 189:8
decide 58:14
decided 89:14
decision 6:22 12:20
13:17 14:5,17,18,20
15:14 16:10 20:10
22:4 60:14,22 72:8
104:3 136:19 143:5
143:14 156:7
decisions 6:22 7:4,4
9:19 18:4,5 19:16
31:16 66:2 135:5
143:8 173:10
declines 149:3
decrease 32:14
deep 133:14
deeper 82:5
defer 33:12 114:7

definitely 43:4 84:16
146:5
definition 20:14 21:7
66:8
definitions 31:19
degradation 144:21
delaying 51:15
deliberation 11:9
deliberations 35:20
delighted 24:13
delineated 50:6
deliverable 190:6
deliverables 189:12
delivered 58:9 124:1
delivery 74:2 75:20
160:15
dementia 123:4,4
demographic 101:3
demonstrate 160:9
denominator 31:18
56:13 90:16 100:3
departure 167:15
dependable 180:5
dependent 79:11
depending 185:8
depends 18:4 76:22
depressed 102:1
depth 188:8,14
describe 91:18
described 123:11
description 56:14
65:11
descriptions 46:4 57:1
designated 128:16
designation 19:3 25:20
128:18
designations 129:11,12
designed 159:15
desirable 77:13
detail 48:10 67:15
detailed 49:21 59:9
60:17 90:7
details 63:2 68:6 75:4
84:18
determinants 148:7
151:13
determining 116:15
develop 32:2 74:17
75:4 149:11 167:2
developed 14:18 21:13
21:17,19 22:3,11,15
22:16 24:2 27:7 44:8
47:12 56:2 61:8
135:10 137:13 146:9
155:22 156:1 184:10
185:17
developer 23:14 131:3
developers 168:20

169:18 184:1 185:5
developing 29:11,12
 33:20 80:3 113:15
 169:6 172:5 173:1
 187:4
development 4:3 5:12
 6:16 11:14 13:10 14:4
 14:6,7,15,21,22 15:1
 15:13,15 16:2,6 18:17
 19:8 20:4,8,13,16
 21:7,12 22:19 23:16
 24:2 26:20 46:13 47:4
 55:8 60:1 61:7,15
 68:13 71:5 78:14 79:2
 102:16,16 104:15,16
 104:20,21 105:11,12
 105:16,17 106:1,2,6,7
 106:14,15,19,20
 109:12 110:10 131:10
 150:14 156:16 158:11
 159:7 162:20 164:20
 166:22 179:16
device 104:6
diabetes 102:2
diagnose 93:6
diagnosis 53:20 87:16
 90:5 93:8,16
dial 189:22
dialogue 168:14 191:18
die 118:10
died 179:20
dies 122:7
differ 55:20
difference 166:10
 169:12
differences 53:2,22
 54:8,21 55:1,4 86:16
 88:18,20 190:21
different 8:15,16,17,18
 9:1 14:20 18:20 19:3
 23:8 25:1 26:18 27:2
 27:4 37:3 39:16,18
 41:1 53:2,4,7,9,11
 54:1,16,17 57:18 67:1
 67:9 68:18 75:16
 86:14 94:8 95:7
 101:15,15 111:14
 113:1,3,5 123:13,15
 126:11,22 127:1
 129:21,22 139:18
 149:3 153:20 155:1
 163:21 164:16 175:1
 182:7
differently 31:11
differing 135:13 150:15
difficult 21:2 116:12
 151:19
dig 82:5

digest 87:22 175:10
diminishes 30:15
dinging 97:17
dinner 6:14
direct 61:5
directed 117:7
direction 68:9,14 71:4
 123:19 149:10
directions 150:7
directly 148:8
director 2:20 121:17
 123:2
disabilities 153:3
 154:14 175:21
disability 64:6 152:15
 153:2 155:1,5 160:2,7
 177:3
disabled 176:11
disappear 70:13
discharge 54:10 72:16
 94:16 179:2
discharged 54:11,12
 82:11,13
disciplines 117:10
discourage 59:6
discouraged 76:9
discouraging 75:17
discovered 175:5
discussant 52:12 188:5
 188:6
Discussants 188:16
discussed 17:22 40:16
 54:9,19 55:5 68:19
 70:20 155:21 173:4
 177:15 187:13
discussing 8:10 17:12
 103:18 145:6 157:11
 191:19
discussion 4:14 6:13
 8:4,7 9:20 10:9 11:12
 20:6 35:14 37:8 38:3
 39:7 46:4 60:19 62:19
 68:3 69:10 70:2 73:18
 81:22 82:1 120:12
 131:2 134:16,22
 137:15 139:1 141:10
 158:8 164:16 165:9
 176:17 178:10
discussions 40:9 60:12
 134:2 140:22
disposition 70:21 71:12
Disproportionate 89:4
distinction 49:2
distress 124:8
divided 39:22 40:1 88:9
 89:22 90:11,20
divides 166:16
doctor 123:17

documented 83:6
dog 148:11
doing 5:11 13:15 29:13
 29:14 68:4 73:7 79:12
 86:11,20 138:5
 144:13 147:9 158:13
 167:17 174:4 187:9
dollars 78:11
domain 154:9 171:12
 176:19,19 179:10,10
domains 153:5,21
 162:22 163:10,11,12
 168:1 169:7 174:19
 182:9,11,16,17
double 66:16
double-checking
 132:12
downstream 99:7
DPA 2:14
DR 28:21 40:18 93:20
 95:4,10 108:21
 110:20 125:13 133:13
 145:19
draft 189:7,12,14
draw 158:6
dreams 154:12,16
DRGs 63:13 87:6
drive 150:6
drives 149:20
driving 83:13
drug 136:20
dual 2:13 56:4 92:6
dually 24:4
duals 24:10,20 92:22
 155:22 157:1 159:14
 175:16
due 135:13 150:15
duty 192:1
dying 114:12,15,15
 119:5 130:6 131:17
dynamic 164:14
dyspnea 109:9,9

E

E 1:14 4:1
earlier 5:11 76:3 117:12
 163:2 180:21
early 14:8,11 15:13
 20:13 46:18 55:8
 187:4
ease 92:13
easier 87:22 151:19
easy 100:3
echo 71:9 148:6,9
 157:5
EDP 26:5
educate 143:11 184:7
education 91:11 143:1
 143:15 172:1,14,16
 181:1
effective 26:14 57:8
 99:6 138:6
effectively 26:10
efficacy 169:4
efficiency 144:20
efficient 8:10 42:19
 76:1 99:6 145:7
effort 177:10
either 48:8 78:18 82:20
 85:20 138:5 161:6
elaborate 177:8
elderly 176:11 177:4
elders 175:21
electronic 176:16,19
 177:6
element 11:9 12:20
 135:9 150:2,11
elements 8:11 82:1
 96:22 151:2 173:6
elevate 24:14
ELIGIBILITIES 2:13
eligible 24:5
eligibles 56:4 92:6
eliminate 118:13
ELISA 2:16
ELIZABETH 2:11
ELLIOTT 2:7 151:5
 162:3
eloquent 148:16
email 165:4
emerge 6:12 7:14
 187:17
emerged 10:7
eminent 114:8
emphasize 115:3
empirical 54:21
empowerment 143:6
encourage 31:22 40:20
 41:11 46:13 47:3
 59:22 96:11 102:15
 102:16 104:14,15,20
 104:21 105:11,12,16
 105:17 106:1,2,6,7,14
 106:15,19,20 124:3
 168:20 169:17 179:16
encouraged 109:12
 110:9
encouraging 68:8
endorse 74:16 75:5,8
 77:8
endorsed 13:16 22:20
 26:21 27:2 30:6 74:16
 164:7 169:13
endorsement 15:18
 19:9 20:5 21:15,15,18
 22:8,22 23:16 27:11

30:12 139:14,16,19
184:13 185:17
endorsing 60:2
ends 102:11
engage 79:6 143:13
engaged 5:8 28:11
engagement 143:6
144:1 151:7
engaging 76:6
enhance 7:11
enhancements 7:22
enlightening 60:6
enrolled 92:16
ensure 8:13 58:3 103:6
111:2 148:7 166:6,13
ensuring 44:13
entire 39:21 52:13 56:7
115:5 168:10 169:15
entirety 39:20
entities 178:7
entity 30:22 31:1
165:22
enumerated 182:10,17
environment 12:10
53:13
environments 53:11
159:21
episode 39:20 45:4
55:15,21 65:17,17,18
78:10 90:6 92:18 93:6
93:7,14 94:1,12,17
99:4 135:17
episodes 39:19 55:14
equation 74:4 76:12
150:17
Erin 2:19 6:9 19:14
70:22 71:7 134:11,12
158:21 187:19 189:3
error 144:7
especially 39:15 115:7
123:3 170:20 185:4
essentially 35:21 37:2
122:14
establish 140:10
establishing 140:7
establishment 136:17
143:3
estimate 87:17
et 88:8 158:2,20
EUGENE 2:8
evaluating 9:5 161:17
evaluation 7:19 22:5
events 136:21
everybody 68:1 107:14
128:14 159:9 190:12
190:19 192:5,6
everyone's 28:3
Everything's 49:6

evidence 22:7 23:4
70:5 74:15 161:18
evolution 5:19 186:19
evolved 13:19,20,21
evolving 20:5
exact 29:14
exactly 29:13 36:21
40:6 55:17 90:9 125:5
156:3,4 158:10
examine 184:9,21
examined 183:22
example 21:21 27:8
46:17 73:8 89:17
131:16 148:21 149:2
162:15 164:4
excellent 69:8 73:18
exceptions 188:9
excess 112:15 113:12
exchanged 142:14
excited 24:22
exclude 49:4,12 92:5
92:16 126:4 127:11
excluded 56:5 77:19,22
78:3 98:2,8 101:21
128:2
excludes 127:10
excluding 124:6
exclusion 113:21 114:3
122:4 124:16 125:17
126:9 129:17,20,21
130:4,13,14,19,22
132:5
exclusions 48:16 56:3
98:3 121:20 130:18
132:15
excuse 53:15 54:19
exhibit 162:14 163:15
exhibited 186:14
exist 73:6 99:1
existing 113:10 164:3
exists 98:19
expand 16:19
expanded 153:1
expanding 143:1 171:1
expect 50:15 87:18
91:18
expected 55:15,21
65:17 88:8,10 90:1
101:18
expenditures 95:11,11
95:20
expensive 89:3,12,19
92:10,19 97:16,20
98:16
experience 39:22
136:18 139:12 143:4
147:21 154:22 156:12
159:12 161:1 164:6

experimented 159:20
experimenting 155:2
expert 48:13 114:9
126:12,18
expertise 145:14
experts 2:6 93:12
122:21 145:16 165:15
explain 30:5,8 88:6
110:18
explained 17:22
explaining 85:21
explains 11:5
explanation 17:2 18:13
119:21
explicit 55:11 119:21
explicitly 145:13
exploited 12:2
explore 49:2 91:6
exploring 49:20
expressed 129:12
extend 100:3
extended 126:16
extensively 160:21
extent 60:1 87:7 174:3
extra 10:1,4 32:21
extremely 149:9 190:14
eye 48:3

F

fabric 147:11
face 125:19
faces 134:20
facilities 65:10 89:11
176:21
facility 45:19 64:9,12
64:15,17 65:1,2,6
90:14,16,19 95:14
121:5,22 128:1 133:4
149:1,6 183:18,19
facility-focused 148:18
fact 22:20 40:13 56:22
79:6 83:7 113:7 173:5
186:14
factor 102:8
factors 72:9 90:6 91:1
fair 12:5 19:1 36:7
121:7 131:16
fairly 25:15 26:12 137:6
fall 21:17 70:18 74:12
82:14 87:16 163:9
falling 163:21
falls 66:1 87:3 136:20
169:1
familiar 65:16 115:18
119:17 160:19
families 123:14 124:7
family 82:15,16 83:3,7
112:7 114:20,22
116:14 117:2,5
131:21 151:7,7
153:12,13 166:19
family's 119:11 148:19
family-centered 164:8
family/patient 143:2
famous 69:13
FAOTA 1:21
far 36:16 52:1 69:1
163:18
fashion 165:19 182:15
fast 30:1,18
fat 75:20
favor 58:18
favorable 113:6
fear 170:3
feat 191:12
February 190:2,5
federal 2:9 4:16 177:10
184:18
fee-for 56:6
fee-for-service 53:16
77:15
feed 70:19
feedback 17:13 29:21
30:15 31:1,5,18 32:4
34:2 48:15 68:12
84:22 85:12 144:12
146:2 162:19 166:7
189:15
feeding 143:10
feel 37:7 59:15 62:22
64:18,21 66:11 68:18
68:22 69:17,19 85:15
145:6 157:13 168:6
feeling 6:21 126:5
feels 18:16 21:2
Feinberg 3:12 93:20,21
95:4,10
fell 14:14
felt 37:1 126:13,18
162:21
ferret 102:4
fewer 90:17
field 89:7
fifth 174:21
figure 71:3 78:20 171:2
figuring 125:2
filled 157:19 158:4
filling 158:19 162:17
FIM 183:20
final 10:8 37:1 70:20
112:7 115:21 165:8
187:17
finalize 189:19
finally 68:9 76:17 190:2
financial 24:18
Financing 155:4

find 75:3 109:17 167:7
168:13
finding 10:1 69:9
findings 160:11
fine 162:11 166:2
finesse 125:4
firmly 70:1
first 5:10 17:1 19:14
23:15 33:20 38:14
42:12 47:8 49:14 53:1
57:17 58:6,14 59:19
62:16 67:18 69:14
85:1 109:7 110:13
111:15 113:9 126:19
129:17 131:22,22
144:7 150:13 151:16
156:5 172:21 174:22
186:10 188:7
fit 129:14,14
fits 116:13 143:22
151:11
five 13:14 78:8 104:20
154:19 174:19
flipping 143:9
floor 1:8 120:12 158:9
181:7
flow 142:14 145:7
focus 7:13 8:8 9:20
116:7 125:8 141:2
163:16 171:17 180:7
183:5
focused 114:14 176:13
182:8
folks 79:16 122:19
152:1 154:16 172:3
177:4 192:13
follow 23:13 103:7
143:15 174:11
follow-up 158:14
followed 113:7
following 80:18 173:17
189:20
follows 79:15
forbid 166:16
forced 82:18,20
foremost 42:12
forget 114:17
forgive 61:3 107:3
form 59:9
formal 10:18 36:2 37:17
123:6 189:11
format 54:3
former 42:1 123:1
forth 142:17
fortunately 176:2
forum 1:1,8 5:15 24:1
68:19,22 69:3 176:1,5
forward 17:19 18:6,22

28:3 29:22 30:14,18
32:1,5 41:7 42:2 46:8
46:21 51:10 74:22
75:9 79:19 81:21 82:2
85:12 90:9 96:9 171:4
171:13,14 183:10
184:20 192:18
foster 59:17
found 13:21 51:18
53:22 59:12
Foundation 174:16
four 45:15 47:3 53:2,7,8
54:1,17 57:13,15
106:10 128:15 154:7
158:22 175:1 176:2
177:13
frame 30:1 41:9 88:16
139:5 141:11 159:20
framed 140:20
frames 29:17 79:11
framework 19:8,9 40:11
74:12 135:4 138:18
138:20,22 140:19
141:9 177:20
frankly 188:12
free 148:12
free-standing 129:2
freedoms 154:7
frequently 132:8
175:19 180:9
front 7:17 76:14
frustrated 24:6
fulfill 120:16 122:10
full 21:3,9 24:10,14,16
70:19 92:7
fully 14:18 16:11 20:19
21:13,16,17 22:3,10
22:15,16 27:7 31:19
46:18 71:16 184:10
185:16
functional 96:4,15,19
102:7 136:15 147:9
162:4
fund 167:8 174:16
fundamentally 31:10
funding 176:1
funds 160:2
further 14:1,5,6,22 15:1
38:3 85:5,12 126:1
143:3 182:16
future 18:3 35:8 67:9
68:12 97:3 104:2
162:17 169:19 171:19
182:11,20 191:5,19
192:18
fuzzy 99:20

G

gap 44:11 138:8 156:14
175:16 179:5
gaps 4:15 137:7 138:17
155:21 156:1,22
157:10,11,18 158:6
158:19 167:11,18
168:9 175:18 179:9
182:5
Gene 52:11 58:16 62:4
72:11 75:4 100:15
139:8 168:18
Gene's 62:1 68:10
general 7:7 9:18 83:22
121:21 127:1 128:18
132:6,17
generally 12:22 13:2
20:13
generate 99:4 165:5
generating 174:1
geographic 88:17 89:8
Gerri 2:7 140:14 171:7
172:11 181:2
getting 17:13 68:9
72:14 158:16 159:16
171:12,14
Gifford 28:21 40:18
41:14
GIP 128:18 133:4
give 30:8 31:1 33:8,13
36:15 48:5 61:22 62:7
63:5 68:12 75:2
108:18 118:19 134:21
135:7 143:7 153:5
159:6 165:18 183:9
190:20,21
given 7:16 9:13 10:22
14:9 15:17 21:4 23:5
44:4 45:12 47:18 53:7
58:5 79:21 85:22
90:15 102:9,10 105:1
109:10 134:18 154:12
185:3
giver 64:2 82:15,16
83:3 111:1,4 136:17
givers 83:7
giving 52:20 74:19
187:3
glad 107:7
go 10:18 15:14,16
20:15 21:11 25:15
26:6 27:18 30:13,18
31:4 32:1 33:14 41:6
65:15 70:11 85:11
98:14 101:16,19
105:6 114:11 117:11
119:4 121:9 123:5
128:20 137:17 139:10
140:1,2 141:5,11

143:18 148:22 150:19
151:8 162:12,12
165:2,17 170:22
171:20 178:16 184:9
185:16 186:12 187:20
188:14
goal 12:11 14:7 82:13
140:6,18 141:8,14
143:22 144:14 146:4
147:1,4,17 148:10,22
148:22 190:22
goal-directed 156:5
goals 4:2 89:10 136:17
140:7,10 143:3,14
144:10 145:17 147:13
God 76:16 166:16
goes 32:5 60:14 66:21
66:22 71:4,21 94:10
102:2 173:13 190:7
going 10:3 15:8 17:17
18:21 20:2 22:20
23:15 27:5 32:19
35:13,14 38:5 45:2,11
55:10 57:16 58:13,16
60:16 62:10,10,13,22
64:5 65:9 66:14 68:13
77:5 78:14 79:8 80:8
80:17 81:14 82:14,16
82:20 87:11 89:18
90:15 91:7 92:2 93:8
97:9,21 99:10 100:9
100:21 103:7 104:7
107:1,15 108:22
109:4 114:1 115:4,9
117:5 119:7,9,20
120:20 121:12 127:2
128:12 142:10 145:19
147:18,19 149:11
155:20 158:3,17
161:2,4,5 165:11
176:17 186:7 188:20
191:9,14,22
gold 146:9
good 6:6 26:8 39:5
40:14 48:14 72:5
75:21 78:8,10 79:19
99:11 100:9 101:18
117:14 138:19 140:5
143:7,12,12 146:11
165:14 172:6 182:14
191:5
gotten 48:14
Government 2:9 43:6
governors 175:2
graduation 147:5
grandson's 147:5
grant 1:13 11:18 12:7
70:9 72:1 140:6 155:8

177:12 178:1,22
Granted 8:16
grantees 177:22
granular 97:12
grapple 74:9 75:2
grappled 38:11
grappling 59:11
gray 137:4
great 46:17 62:4,5 80:9
 81:16 108:17,21
 123:21 134:17 144:2
 152:11 157:4,9
 162:15 167:9 180:1,8
 188:11
greatly 42:2
GREENBERG 1:14 66:5
 97:11 124:18 149:8
 170:1
Grissom 69:14,17
ground 11:20 182:6
group 8:9 40:3 53:3
 68:6 71:16 87:4,12,15
 103:17 123:17 135:3
 135:11,15,22 136:3,4
 138:17,19 139:10
 151:12 152:14 157:1
 175:10 176:17 177:19
 180:13 181:21,22
 182:21 186:15
groups 53:8,14 54:1,17
 57:21,21 63:12,14
 176:2
grunt 180:8
guarantee 71:20 85:6
 104:4
guess 45:9 47:16 52:5
 73:19,21 80:20 99:11
 110:13 126:1 155:13
 191:7
guest 154:8
guidance 186:15
 189:14 190:6,8
guide 46:4 135:5
gum 138:5
gun 162:9
Gus 69:14
guys 181:6

H

HALL 2:11 141:18
 177:8
hand 59:22 118:15
 187:11 189:3 191:1
handle 26:9,10 138:14
hands-on 114:21
happen 10:1 66:14
 70:11 71:19 81:3
happened 49:16

happening 67:4 144:18
 159:11 160:14
happens 114:18
happy 114:13 137:10
 191:21,22
hard 27:13 40:5 63:5
 69:9 120:16
hashing 68:22
hastening 167:14
hat 121:5,6 168:6
hate 151:21 185:20
hats 168:13
HCBS 178:4
head 80:1 122:20 158:4
headed 70:7
health 2:12 3:15 41:20
 42:11 45:18 53:3,12
 53:18 57:9 63:17
 66:22 67:2 73:5,8
 75:18,22 76:5 82:12
 83:5 88:14 94:11
 97:15 100:6 101:4
 133:22 136:16 141:22
 142:9 145:15 148:7
 149:4 153:17 161:17
 170:5,22 176:19
 177:6 181:20 183:1
Healthcare 1:20
HealthSouth 3:9 39:6
healthy 99:10,11
hear 6:2 35:13 91:4
 108:21 109:4 123:20
 145:22 170:1 192:9
heard 8:22 29:8 40:8
 45:12 52:1 56:20 88:7
 92:5 102:18 115:1
 116:18 124:9 158:7
 158:15 161:21 163:8
 182:6 190:13
hearing 68:5 108:13
 151:15 166:10
heart 170:3 191:1
held 85:9 184:6
Hello 28:21
help 19:4 25:12 52:8,9
 60:7 76:3 97:12 122:2
 137:20 143:13,14
 147:19 154:20 167:11
 173:9 180:3
helped 188:10
helpers 82:22
helpful 144:5,12 146:12
 152:10,16 153:14
 155:10 190:14
helping 144:10 183:12
helps 60:21
hemianopsia 148:2
HERR 1:15 67:18,22

hey 165:22
HHS 142:7
hi 93:20 124:12
high 118:1,20 140:4
 141:14 143:21 151:10
 164:1
high-leverage 136:12
 140:14 141:4,6
 143:19,21 146:17
higher 149:20,21
highest 64:15 135:22
 155:16
Hillman 3:13 183:13,15
hip 101:22
historical 13:12
historically 47:18 50:8
 169:10 187:7
history 134:21 135:8
hitting 125:9
hold 62:10 73:15
holds 11:21 159:17
hole 138:8
holes 158:5 162:16
 164:10
holiday 32:9 191:22
holistic 115:11
home 3:15 41:20 42:11
 45:17 53:12,18 54:13
 57:9 63:17 66:22 67:1
 73:5,8 75:22 76:4
 82:11,21 83:12 88:14
 94:11 97:15 100:6
 114:18,19 119:4
 121:12 127:4,11,15
 128:1,3,22 129:4
 132:13,16 133:2,16
 133:17,21 148:20
 149:4 159:11 162:5
 170:5,22 176:3
 181:20 183:1
homes 127:4
hook 57:6 167:8
hope 68:4 90:18 99:9
 191:17
hopefully 71:18 191:15
hoping 61:21 160:14
Hopkins 1:16
horrible 180:4
hospice 2:2 4:10,12 5:6
 107:19 108:6,7,22
 109:5,13 110:1 111:7
 112:10 113:11 114:18
 115:3,5,11,18,19
 116:11,13,22 118:5
 118:10 119:17 121:1
 121:7,13,17 122:5,6
 122:14,16 123:2,6,13
 123:18 124:13,14

127:5,18,21 128:15
 129:3,6 133:22
 163:20 164:3,6,15
 179:11,13,21 181:4
hospices 113:3 116:19
 118:15 131:16
hospital 9:2,3 42:12
 46:11 48:18,22 49:5
 49:16 51:8,19 66:21
 75:21,22 76:3,3 88:2
 89:4 94:4 97:15,16,20
 98:13,15,19,22 99:3
 99:16 101:13 102:3
 128:1 129:3 135:20
 179:2
hospitalization 98:9
hospitals 42:5,8 89:1
 122:1 176:1
hot 81:2,5,11
hours 125:7 180:19
house 59:12,14,16
huge 64:3 96:10 138:13
 141:10 171:3
human 81:15 173:20
 174:2
hundreds 156:18

I

IBRAGIMOVA 2:19
 45:7 104:11,18 105:4
 105:9,15,21 106:5,12
 106:18 108:16
idea 25:19 40:6 52:17
 57:11 58:1 91:16
 116:9
ideal 71:14 158:18
ideally 22:9
ideas 152:11 157:4,6
 158:7 165:6 167:10
identification 44:11
identified 103:2 135:22
 136:3 156:4 159:2
 163:1 164:1 175:16
 178:2 182:12
identifies 158:22
identifying 157:10
ignored 18:1 24:15
ignoring 83:9
Il 1:17
illness 90:22
illuminating 45:13
imaginative 75:17
IME 89:2
imminent 108:7 109:14
 109:15 124:15 125:14
imminently 114:12,15
 130:5
impact 4:6,8,16 5:5

29:2,5 31:20 38:7
 41:8 46:8 48:20 79:10
 84:13 91:12 96:16
 104:12 141:20 142:3
 142:4,20 150:17
 162:22 163:3,7,10,22
 167:17,22 176:2
 179:10 182:9,11
 184:3,15 191:6,8
impacts 31:21
implement 191:14,15
implementation 14:10
 24:15,16 61:17 156:6
implemented 25:22
 115:20 185:7,9
implementing 92:13
implies 122:15
importance 18:6,8 48:9
 175:19 176:7
important 17:6 24:9
 29:1 41:5,6 49:1 51:5
 63:2 64:3 65:3,9
 66:11 68:6 79:4 80:2
 83:21 84:2,9,19 89:14
 96:4 98:18 102:8
 112:21 114:13 115:5
 123:14 124:2,20,20
 125:11 144:11 145:21
 145:22 146:7 149:9
 149:17 150:2,6 153:6
 153:7 155:15 156:16
 160:13 162:21 168:3
 168:7,11,12,14 172:9
 191:14
impose 125:5
imposes 88:21
improve 166:13 192:8
improved 5:17 50:18
 144:20 175:7
improvement 7:10
 12:11 31:8 183:6
improvements 11:8
improving 170:19
in-depth 62:21
in-patient 121:21,22
 127:5,22 128:5,19
 129:2 132:16,17,19
 133:3,6,12 149:4
 183:17
inadequate 44:17
inappropriate 136:21
incentive 89:9,16 99:2
 99:5
incentives 98:21
inception 44:5
include 35:1 91:15 98:1
 98:10 103:20 121:21
 127:4

included 56:4 93:18
 95:2 98:10 109:21
 110:7 127:15,19
 180:13
includes 101:4 110:4
including 130:17
inclusive 51:2
income 64:10,22
incorporated 148:8
increase 95:3,8 100:13
 116:5 174:4
increased 65:7 86:8
 115:22
increases 67:10
increasingly 43:6
incredibly 28:22 125:11
 151:1
incubator 158:17
incumbent 91:20
independent 22:17
 23:17
index 88:17 89:8,8
indicate 124:19
indicators 96:16,19
 152:17,21 153:8
 156:11
individual 9:10 36:1
 96:2 153:9,10,13,15
 154:1 169:13
individualized 112:6
 116:14 120:9
individually 66:9
individuals 72:14
 109:18,19
industry 185:15
infancy 187:2
infection 136:21
influence 49:10 80:5
 87:7 102:11 116:4
inform 161:6 178:13
information 2:12 16:8,8
 20:10,21 21:4 22:1,8
 22:11,21 23:1,3 31:15
 40:13,21 41:2,10
 45:22 46:3,3,6,19
 59:2,3,5,15 63:4
 65:14,19 66:12 70:12
 73:21 74:21 75:6,8
 85:5 87:21 88:3
 102:17 104:16,22
 105:13,18 106:3,8,16
 106:21 141:22 142:13
 142:17 165:19 166:5
 166:7,9,12 190:1
inhabit 59:13
inherent 53:1,21 54:7
 57:10 74:5
inherently 19:19 50:14

57:17 86:14 145:11
initial 112:18
initially 111:12
Initiative 133:17
initiatives 183:21
Inn 32:9
Innovation 3:16 41:20
 181:20
inpatient 45:18 63:8,15
 63:19 64:15 84:4
input 4:8,12 8:21 9:15
 14:8,11 18:22 25:18
 27:15 37:12 46:20
 50:1 63:6 186:15
 189:15,19 190:12,13
 190:20
inserted 29:6
insider 23:20
instances 187:13
Institute 160:2,3,4
institutional 176:10
instrument 183:20
insufficient 40:21 41:10
 59:1,5,15 65:14 70:4
 70:12 73:20 74:15
 75:8 102:17 104:16
 104:22 105:13,18
 106:3,8,16,21
insurer 76:21 77:6
integrate 135:19 169:18
integrating 179:1,2
integration 58:8
integratively 168:21
intellectual 152:15
 154:14 155:1 160:6
intelligent 66:2
intend 51:9 96:18
intended 16:9,12
intense 129:6,9
intensely 120:20
intensification 144:19
intensity 128:17 149:20
intent 8:5 16:5 32:13
 36:21 37:14 125:19
intention 67:6
interact 21:14
interdisciplinary 115:6
 127:18 145:14
interest 43:11
interested 38:9 44:2
 96:14 120:21 183:11
 189:20
interesting 22:21
interests 24:18
interface 176:9
internally 71:3
interoperability 142:4
 177:20

interoperable 191:9
interpret 67:15
interpreting 172:22
interprofessional
 171:22 172:1,12
 180:13 181:1
interventions 53:6
 97:21
interview 154:1
interviewed 69:15
 159:18
introduce 41:13 47:11
introduced 39:10
introduces 41:16
introducing 8:3
introduction 8:1
investment 14:12
invite 93:10 108:9
inviting 131:9
involved 186:20,22
 188:18
involvement 151:7
 187:16
involves 5:4 58:8
involving 166:19
IRF 53:15 54:13 82:12
isolated 24:8 25:1
issue 10:20,22 13:4
 15:7 25:8 28:10 33:7
 41:6 42:22 51:4 56:12
 56:19 57:2,21 74:6,10
 86:19 98:9 101:20
 115:16 148:17 152:6
 171:11 177:5
issues 7:14,21 17:17
 31:17 37:20 49:9,13
 55:13 62:12 68:10
 82:6 83:5,9 86:10
 91:22 95:21 101:3
 115:13 135:13 137:9
 190:8
item 26:8 111:7 113:11
 134:9,10 157:10
items 36:5 97:1 111:7
 120:7,12 129:22

J

JAMES 1:17
January 15:5 20:3
 115:21 189:10,10,18
JD 3:15
JENNIFER 2:4
Jim 68:16 74:13 80:9
 120:13 128:8 137:21
 142:21 144:3 165:10
 171:9 187:22 192:6
Jim's 80:9
job 62:5 168:12,12

170:4 179:1 188:13
Joe 145:8
Joel 26:4
Joel's 27:8
Johns 1:16
Johnson 164:18
join 107:7 177:3
joining 168:21
joins 169:5
joint 170:8
Jones 166:1
Joseph 1:13 145:9
 171:21
jump 137:14
jumped 162:9
junction 187:11
justification 184:18

K

Karen 164:17,18
KATHRYN 2:20
KAUSERUD 2:1 62:17
 83:16
keep 72:15,18 76:3 82:3
keeping 76:8 175:9
key 7:21,22 8:11,21
 72:9 135:8 142:3
 173:5
Kim 2:7 3:19 47:11,12
 47:17 48:4,7 61:22
 62:7,10 80:17 84:20
 151:4 162:2
kind 5:22 6:2 43:11
 44:7,12,15 53:12,16
 56:11 59:20 60:5
 61:21 65:12 67:3 71:3
 76:9 80:14 83:20 89:6
 100:7,11 111:12
 141:1 145:1 147:8
 157:16 163:3 172:2
 174:11 175:9 180:10
 187:5
Kindred 1:20
kinds 25:1 53:8,9 98:13
 101:4 153:17
know 9:13,22 10:3,10
 11:1,21 12:1,16,18
 13:3,13,14 15:16,19
 16:1 17:9,9,12,17
 18:1,2,4,5,6,18 20:1,7
 20:9 21:6,21 22:15
 23:2,7,9 24:17 25:4
 26:3,5,18,22 27:7,8
 27:10,16,18,21 28:2
 33:12 34:14 35:9,10
 37:1,4,9,11,15 41:13
 42:5,6 43:22 44:1,10
 44:18 45:1,22 46:15

47:18,21 49:8,22 50:7
 50:16 51:7,16 56:17
 57:19,20 58:1,17
 59:14 61:2 63:4,5,17
 65:22 66:15,17,20
 67:1,5 71:3 73:3,12
 73:12 74:12,21 76:13
 76:15 77:5,21 78:18
 79:5 80:13,19 81:4
 82:17 83:3,19 85:11
 85:22 87:15 90:7,8
 91:9 92:14 95:22 96:6
 99:9,13,14,14 100:7,8
 101:10,14 102:19
 103:4,11 109:2 111:3
 113:4 114:14 115:16
 116:2,4 117:9 118:10
 118:11,14,18,19
 119:14 120:17,19,20
 121:1 123:3 125:1
 126:15 128:17 129:1
 129:2,10 130:18
 131:13,18 141:7
 142:2 144:5,22
 145:16 146:11,13,16
 147:7 148:9 150:3,9
 151:9,10 154:15
 155:13 157:7 158:12
 158:12,16 159:4
 162:14,21 163:2,15
 164:4 165:5 166:21
 167:16,21 168:7,13
 170:7,11,21 171:1,4
 173:13 174:15 175:3
 175:4,8,11 176:15,15
 177:13 178:14 182:3
 182:22 183:1,3,5,10
 184:14 186:11,18
 187:1,1 191:3,5,18
 192:7
knowing 46:7,10
 188:19
knowledge 133:14
knows 56:15 187:3

L

laid 33:4
LAMB 2:7 138:10
 140:15 141:7 151:8
 171:8 172:13
land 102:3
language 29:4 55:13
 56:5,9
large 14:13 178:22
larger 90:14 156:21
latest 130:4
Laughter 121:3 148:3
Laura 2:19 9:22 45:6

104:9 105:8 108:14
Laurie 3:12 93:21
law 50:7 97:4
lawyer 32:9
lead 23:16 52:12 75:17
 124:13 144:21 188:4
 188:6,16
leadership 24:12
leading 164:18
leads 177:10
lean 79:1
learn 170:5
learned 159:14
learning 96:14
leave 82:19
ledger 75:14
ledgers 76:8
Lee 3:15 41:17,19,19
 43:22 79:17 181:19
 181:19
LEFF 1:16 18:11 23:12
 25:7 75:11 99:18
 146:15
leg 159:6
legal 33:7,12 36:14
legally 11:20
legislation 25:14
 150:18
length 113:20 115:16
 115:16 118:4,12,17
 124:15 126:5,9 130:8
let's 21:20 30:13 78:11
 107:17 114:11 116:3
 134:10 140:4
LETT 1:17 68:17 120:15
 121:4 128:9 137:22
 142:22 143:20 165:11
 188:1
level 41:11 48:22 49:5
 51:9,19 55:14 87:1,10
 88:2 127:16 128:17
 129:7,10 136:8
 143:21 155:16 187:6
levels 89:6 95:8 127:20
 128:15,16 149:20,22
leverage 136:1 140:5
 141:12,15 151:10
LEVITT 2:10 17:1 26:17
 33:17 47:7 52:5 61:11
 61:20 107:13 110:12
 110:21 126:1 127:9
 127:20 128:7,10
 129:16 130:7,12
 131:1,6 132:14 133:5
 133:9,12 167:14
 190:18
LEVY 1:18 72:21 80:18
 132:2 173:17

LIAISON 2:13
LIAISONS 2:9
licensed 109:22 112:10
life 120:18 121:12
 122:15 125:17 144:22
 145:3,5 146:17
 147:12,21 152:17
 180:9,17
lifelong 64:6
light 46:16
likelihood 54:12
likewise 43:9
liking 188:4
limit 8:4
limited 24:7 25:17
 26:11 50:17 63:5
 163:11,11
limiting 124:4
limits 27:17
line 18:3 28:9 36:10
 69:9 70:3 181:9
lines 17:7 29:9 34:1
 38:14 85:8 108:1
 140:15 168:2
link 176:20
linkage 177:5
linking 172:8
Lisa 2:5 61:1 82:8 123:8
 125:13 160:17 179:14
 180:13
list 45:17 46:1 70:20
 130:18 146:18 149:9
 150:3 175:4
listed 84:6 111:12
listened 101:11
listening 166:11
lists 103:16
literacy 101:4
little 6:1 11:7,14 13:5
 39:12 47:16 63:20
 64:8 73:19 76:20
 87:20,22 93:4 96:15
 97:13 107:4 111:15
 117:3 128:13 134:21
 135:7 136:13 139:18
 156:17 163:21 171:2
 174:1 176:18 177:1,9
 190:7
live 154:5,5,6,17,18
living 145:5
Liz 141:17 177:7
Liza 1:14 66:4 97:10
 124:17 149:7 151:3
 152:7 169:22 171:9
 171:17 182:22 191:7
loath 75:7
long 45:18 58:11
 148:21 172:21

long-term 1:14,19
121:6,18 134:15
136:2 144:9,18
168:16 174:17 176:16
183:18
longitudinally 191:10
longstanding 137:12
look 10:11 25:11 34:16
41:1 42:2,7 48:21
49:7 51:12 54:16
66:20 70:15 72:15
83:19 88:15 89:18
90:4 91:13,19 92:19
93:14,22 94:8 100:10
111:8,15,18 115:4,8
116:2,19 127:2 135:2
136:11 138:21 140:19
141:1,14 148:18
150:4 151:9 158:18
168:20 171:18 173:20
185:7 188:8 192:17
looked 21:22 35:4 42:4
61:21 138:14 140:17
looking 8:16 13:16
22:10 23:1,2,3,6
25:21 33:21 42:13
44:22 50:14 62:6 63:8
67:6 76:14 86:3,12
89:3,12 91:10,17
95:10 107:18 111:16
122:12 124:3 133:18
134:1,10,11 142:8,11
145:11 149:8 160:21
161:4,5 171:4 172:2,6
lookout 189:11
looks 21:16 22:2 40:7
191:5
loop 171:11
loophole 12:1 30:12
Lori's 93:19
lose 147:16 151:21
lot 13:15 26:2 29:8 31:7
32:10 48:21 58:19,22
62:14 63:5,6 64:9
65:15 66:7 73:7 75:20
76:22 77:14 79:1 81:4
81:16,22 86:5 96:19
113:17 116:15 119:20
122:15 133:14 134:2
139:1,3 142:9 145:12
150:6 151:2 157:3
160:9 167:11 170:8
173:18 177:3 182:5
183:4 184:2 192:12
lots 116:18 183:2,2,3
love 167:3 175:5
low 40:15 42:18,20
64:10,22

lower 45:4 97:22
147:20
lowest 69:20 80:8
LTAC 63:18 67:1 86:21
86:21
LTC 53:15 150:13
LTCH 53:15,16
Lunch 192:3

M

MA 1:19
main 20:14 129:5
163:10
major 7:14 82:6 153:5
majority 24:20 114:17
making 7:1 12:20 13:16
14:17,20 15:21 20:9
31:16 43:18 60:22
68:1 72:8 125:8
136:19 143:5 152:16
156:7
manage 91:21
manageable 175:10
managed 99:15
management 114:16
129:8 144:8,11
149:15
Manager 2:19,20
mandated 34:19
mandates 27:6
manner 26:14
map 2:13 4:14,15 5:20
6:7 7:7 13:13,15,19
13:21 14:8,17 15:14
15:21 16:10,18 17:18
19:15,17 20:4,9,9
21:4,22 22:9,18 25:17
26:10 28:22 30:4 33:5
35:2 104:2 134:15
139:19 157:7 164:2
170:11 189:17,19,22
192:7,13
MAP's 18:7 33:10
MARCIA 2:17
MARGARET 2:20
markers 120:19
market 76:21,22 77:2
markets 73:2
marks 60:2
MARKWOOD 1:19
81:18 148:4
matches 117:1
material 132:4
matter 2:6 23:18 33:11
71:12 97:15,19
107:10 147:11 167:19
192:19
matters 72:3 77:12

101:5
mature 59:9
MBA 2:11
McMULLEN 3:17
125:13 133:13 145:19
MD 1:12,13,16,17,18,20
2:3,8,10 3:12,17
MDS 134:1
mean 10:13 12:10,11
19:2,19 22:18,19,20
22:21 23:19 26:17
27:14 28:4 42:17,19
42:20,21 43:20 44:1
52:5 54:4,11 55:19
59:10 68:21 70:19
81:1,19 85:19 87:14
90:13 96:5 98:20
102:18 119:22 133:20
148:10 156:17 166:14
167:20 175:3,11
meaning 16:8
meaningful 48:11,15
117:7 140:18 182:7
182:15 183:4
means 8:5 74:18
114:20
meant 121:20
measure 1:3 6:16 11:13
13:10 14:3,9,13,14
16:5 19:8 20:15 21:6
21:19 22:6,7 23:4,14
23:15 24:2 25:21 26:6
26:18,19 27:11 29:6
30:12 32:2 38:10
39:13 40:7,11,14,19
41:1,3,3,4,6 42:3,3,5
42:8,9,12 43:2,11,14
43:16,18 44:2 45:3,10
45:13 47:1,13,19 48:3
48:10,12,19 49:4,5,7
49:21 50:4,14,17,22
51:1,2,3,6,17 58:18
59:8 60:15 61:6,15
63:3 66:3,10,11 71:4
71:15 74:16 80:5 84:1
84:2,5,6,9,12,18
85:11,20 86:7 88:3,5
88:9 89:21 91:3,14
92:14,15 94:5 96:17
97:3,6,13 98:5,17,19
99:1 101:12 108:8
109:1,2,13,16,17
110:14,15,21 111:13
111:16,16 112:3,14
112:17,21,22 113:5,9
113:10,19 115:14
116:8,8,19 119:3,19
121:10 122:10 125:19

126:3,3,7,17,20
127:10 129:14,17
130:7,13,14 131:3,19
131:22 135:12 136:4
136:5,7 137:5,9
143:18 144:15 149:3
155:21,22 156:14,16
156:22 158:17 159:7
164:7 165:6,14
168:20 169:1,17
170:15 172:3,8
175:16,18 179:9
184:1 185:4 190:3
measure's 22:19
measurement 2:17,18
4:15 44:12 52:18
87:15 135:17,20,21
136:1 138:17 149:11
152:14 155:2 158:7
164:2 166:22 167:18
182:5 185:17
measurements 183:21
184:5
measures 4:3,6,8,10,12
5:5,6,12 7:16 8:7,9
9:8 11:1 13:16,17,22
14:14,19,20 15:12,17
16:1,1,7 17:6,7,8,12
17:20,20 18:3,7,17
20:8,12,15 21:11,12
21:13,16 22:3,4,10,15
22:16 24:7 25:1,9,16
26:20 27:3,6,9 29:5
29:12,20 30:6,6,19,21
31:5,8,18 32:14 33:21
34:8,13,20 35:3,4,10
37:5,13,15 38:6,12,16
39:8 40:16 44:8 45:15
46:7,11,12,19 47:3,14
47:19 48:21 50:2,8,11
51:11 52:3 57:13 61:7
61:9,14 68:7,18 69:1
70:7,20 72:19 74:11
74:18 75:6,13 79:22
80:3 83:20 84:13 85:5
86:4,12,20 90:9
103:21 108:6,19
109:3,6,11,16,18
110:9 111:14 113:10
113:17,18,19,21
116:12 117:10,17,20
117:22 118:1,2,13,21
119:13,16,22 124:19
125:11 126:4,11
130:5,9,15,21,21,22
133:15 135:6 136:6
139:12 142:16 146:4
146:8 151:1,15

152:19 153:9,17,20
 154:11,13 156:12,20
 157:17 158:11 159:5
 159:13 161:7 162:20
 164:3,21 165:6 166:4
 166:15 167:2 169:5,7
 169:10,15,19 170:2,6
 170:7,8,9 171:10,18
 172:2,7 180:7 182:22
 183:2,3,7 184:12,17
 185:6,12,16 187:5,17
 188:8,11,19 191:6,19
measuring 58:2,4 69:21
 69:22 149:1 165:18
median 56:14,16 90:12
Medicaid 2:11 3:11,18
 3:20 24:5 56:10
 177:11
medical 2:1 3:13 53:5
 110:5 121:17 123:2
 123:15 144:19 176:20
 180:16 183:16
medicalize 147:1
Medicare 2:10 3:10,17
 3:19 4:6,9 24:5 42:18
 44:6,9 45:1,16 47:13
 48:17,22 56:10 63:9
 64:13 76:11,20 77:16
 77:22 83:4 84:1,7
 88:20 89:10 91:19
 92:7,8,10,11,17,20
 95:11,13 98:11
 101:12 104:13
medication 123:22
medicine 1:17,19
 136:21
meet 34:6 147:6 188:16
meeting 15:6 17:5
 46:20 150:9 151:14
 173:21 186:8 189:18
 189:21
meets 48:3
member 8:5 10:15
 11:18 12:7 17:1 18:11
 23:12 24:3,3 25:7
 26:17 33:17 35:17
 47:7 52:5,14 58:21
 59:3 61:2,11,13,20
 62:4,17 66:5 67:18,22
 68:17 70:9 72:1,21
 73:17 75:11 77:11
 78:5 80:18 81:18 82:9
 83:16 93:4 94:19,22
 95:6,15 97:11 99:18
 100:17 101:1 107:13
 110:12,21 114:7,8,10
 117:15 120:5,15,22
 121:4 122:12 123:1,9

124:18 126:1 127:9
 127:20 128:7,9,10,12
 129:16 130:2,7,10,12
 130:16 131:1,5,6,7,13
 132:2,11,14,21 133:1
 133:5,7,9,10,12
 137:22 138:10 139:9
 139:21 140:6,15
 141:7 142:22 143:20
 144:4 145:10 146:15
 148:4,15 149:8 151:5
 151:8 155:8 160:18
 161:11,13,22 162:3
 165:11 167:14 168:19
 170:1 171:8 172:13
 172:18 173:17 179:15
 180:15 188:1 189:21
 190:18
members 9:10 39:2
 48:15 58:13 108:9
 137:12 146:3 189:16
mental 136:16
mention 109:4 145:14
mentioned 17:15 48:17
 72:13 93:5 110:14
 126:10 180:22
mentioning 191:7
mess 78:19
message 74:20 75:2
 102:12
messages 102:18
messy 78:19
met 1:8 185:13
methodology 54:3
 65:19 90:10 98:6
metric 125:10
metrics 147:2
MHS 2:8
mic 108:10
Michelle 3:10 124:12
 127:3,12 128:13
middle 91:9
midst 113:15
mike 108:13
milestones 125:10
million 81:9 150:18
mind 80:3 144:15
minutes 10:4 107:2
MIS 2:11
missing 75:5 159:5
misspeak 93:11
mistake 132:20
mix 55:9 63:12,14 87:1
 87:4 133:15
mobility 147:8
model 53:17,19 56:1,11
 93:18 100:20
models 31:12 55:6,7

66:18 67:1 75:3
modifications 177:16
moment 23:13
monitor 51:21
monitoring 51:10
moral 70:6
morning 6:6 36:12 39:5
 46:16 147:7 156:15
morning's 5:4
morphing 159:3
mortar 53:12
motivates 147:18
move 11:10,13 17:19
 18:21 28:3 35:14 38:5
 46:20 51:10 56:10
 62:20 74:22 78:11
 81:20 90:9 93:1 97:10
 108:14,18 129:9
 134:9 135:17 143:2,5
 147:2,16 149:12
 166:18
moves 174:13
moving 18:6 29:22 75:9
 78:20 79:19 82:2
 107:18 190:10
MPA 1:12,15
MPH 1:12,14 3:15
MSPB 42:4,7,12 43:4
 79:19
MSW 1:13
MUC 45:17 46:1 59:8
MUC15-1134 104:13
MUC15-287 105:10
MUC15-289 105:22
MUC15-291 106:13
MULDOON 1:20 77:11
 78:5 122:12 172:18
MULHAUSEN 2:8 35:17
 73:17 123:1 144:4
multi-headed 122:10
multi-stakeholder
 186:12
multi-year 161:1
multiple 101:16,19
 113:1 157:19
MUNTHALI 2:16
muted 11:18

N

N 4:1,1
N.W 1:9
name 39:6 48:19
 124:12
name's 6:6
national 1:1,8,13,17,19
 2:2,3,12 5:14 24:1,11
 68:21 69:2 90:11,20
 138:1 152:17,21
 153:1,8 156:11 160:1
 171:22 172:11 175:22
 176:4 180:22
near 162:17
nearing 123:7
nebulous 144:22
necessarily 9:16 30:17
 33:3 42:17 125:9
 132:9 140:9,11
necessary 126:6
need 10:7,18 19:2
 27:18,22 35:15 37:21
 43:15 47:16 49:17
 53:6 56:16 65:22 66:7
 70:1,15 72:4,4,14
 79:9 87:11 101:2,8
 111:11 116:22 119:20
 125:8,9 127:2,12
 131:21 135:1,2
 140:21 141:3 148:18
 149:18 151:6 156:20
 163:7 164:12 168:7
 170:2 180:18 184:6
 186:12 191:2
needed 12:17 44:11
 51:15 68:6 126:19
 138:13 142:13
needs 5:9 34:4,6 53:5
 55:11 56:1 59:7 62:21
 76:22 102:20 114:4
 116:7 117:1 119:11
 119:12 141:15 150:10
 170:13
neglected 175:22
nervous 69:18
net 67:12,13
network 2:5 177:1
networks 31:14
neurology 21:20 22:2
neutralizes 89:20
never 147:12
new 16:22 22:3 27:4
 30:11 76:14 111:6
 134:19 139:10 140:19
 151:15 160:4 170:4
 172:3 186:22
newest 130:3
nice 98:20
night 32:9 154:8
nine 113:2
nod 122:20 127:3,5
nodding 96:12
non-medical 175:19
non-private 178:7
non-professional
 180:10
non-profit 175:20 176:7
 176:21

Non-voting 2:9
normalizing 65:8
normally 113:17
notably 53:11 57:1
note 39:11 98:18
 113:14 145:20
noted 111:1
notes 111:15 157:4
notice 127:10
noticed 27:20 140:13
NQF 2:15,21 6:7 18:8
 21:2,15 25:4 26:21
 28:22 29:4,18 30:2,6
 33:13 36:11 41:21
 61:19 70:19 71:6
 74:16,18 91:8 101:1
 103:11 110:16 139:14
 139:16 145:22 158:16
 166:21 168:20 169:10
 169:13 170:12 178:4
 178:14 183:22 184:13
 184:19 192:4,13
NQF's 164:19
NQF-endorsed 109:3
NQF/CMS 158:20
NUCCIO 2:8 52:14
 58:21 59:3 100:17
 139:9,21 168:19
number 7:16 9:5,8,9,11
 13:13 14:14 25:13
 28:14 37:5 38:19 73:4
 105:2,20 106:10
 121:7 122:13 134:19
 142:5 178:17 181:13
 184:11 188:6
numerator 65:11 88:8
 89:21 122:13 130:20
nurse 110:1 111:20,21
 119:6 121:1,14 180:7
nurses 1:14 109:22
 110:1 112:10 123:17
 180:1
nursing 45:19 63:16
 95:1,7 114:19 118:7
 121:5,12,22 127:4,4
 127:14,17 128:1,22
 129:4 132:13 133:2
 133:16,17,21 145:15
 183:18

O

O 4:1
o'clock 154:7
O'ROURKE 2:19 25:10
 60:8 71:9 103:15
 134:13,17 139:15
 189:4
objection 56:15

objective 87:14,17
obligated 69:7
obligation 71:11
observed 88:9,11,15
 89:21
observer 39:11
obvious 81:14
obviously 23:5 159:2
 163:17 188:17 192:4
occupational 1:22
 110:5
occur 51:19 54:15
 125:2,2,6 126:8
occurred 5:10 10:10
 98:11
occurrence 119:7
occurs 122:4 182:4
October 185:7,8
offer 127:22
offered 46:8
Office 2:11
offices 175:2
official 115:14 177:2
officially 169:4
oftentimes 148:10
oh 25:6 61:13 68:17
 94:21 134:11 144:1
 148:1 161:11,13,13
 161:14,15
okay 11:16,19 16:20
 19:11 28:12,18 39:4
 40:17 41:12,12,18
 45:5,8,14 47:5,7
 58:12 59:4 61:1 62:9
 67:22 68:15 71:21
 72:1 77:10 79:14
 84:20,21 95:15 104:5
 105:6,8,19 106:9,22
 107:13 108:5,11,17
 110:18 114:5 117:15
 120:6,11 127:6
 128:10 130:16 131:7
 132:21 133:10 134:3
 134:6 140:12,13
 143:13 148:4 152:8
 162:1 169:19 172:16
 181:6,11 186:6
ONC 2:12 176:15
 177:19
once 122:17 150:3
 182:16
one's 108:13 145:5
one-day 130:4
one-part 171:13
one-trick 165:12
ones 37:21 72:9 169:13
 176:12
ongoing 117:18

online 107:20 181:10
opaque 39:15 40:4
open 10:16 38:14 91:22
 97:3 108:1 120:13
 134:22 158:9 181:7
 192:6
openness 17:16 182:1
operation 152:20
operational 154:22
operator 28:8,12,16
 38:14,17,18,21
 107:20,21 108:2
 181:8,11
opinion 17:17 18:7
 64:20
opioid 109:10 131:18
opportunities 82:4
 136:1
opportunity 4:5,10
 24:13,21 36:2,9 41:22
 45:2 158:18
opposed 17:20 44:18
 57:21 96:1
Optimized 161:16
options 102:14
order 48:10 59:7 72:15
Oregon 172:4
organization 2:2
 166:22 167:7 188:17
organizational 155:16
organizations 43:7
 167:1,5,9 175:20
 176:8,12,22 178:12
 179:3
original 29:3 118:13
originally 27:14
OTR/L 1:21
outcome 140:18 141:8
 141:12 149:6 152:18
 153:19 154:11 156:11
 168:22 169:2,5,19
outcomes 58:9 151:19
 153:10,12 160:22
 161:2 172:8
outreach 158:13
outside 49:10 176:10
outstanding 6:20
 116:20
overall 46:10 68:7
 125:11,18
overlay 148:13
overview 108:19
owns 129:3

P

P-C-O-R-I 161:11
P-R-O-C-E-E-D-I-N-G-S
 5:1

p.m 192:20
PAC/LTC 4:14,15 135:4
 135:8,10,19 137:8
package 166:11
page 76:14
pages 157:4
paid 64:15
pain 9:22 109:8,8
 123:22 148:12 180:18
paired 67:6
pairing 67:11
PALENA 2:11 141:18
 177:8
palliative 2:2 108:8
 109:1 149:16 164:19
Pam 93:2
PAMELA 1:21
panel 2:3 48:13 85:9
 88:4 114:8 126:12,18
 146:3 184:11 185:4
 188:22
panicked 188:7
panoply 103:2
paper 174:1
paradigm 44:16
parallel 79:21 91:7
parentetically 54:20
parentimony 170:12
part 35:10 38:5 49:6
 50:9 56:19 68:2 69:20
 70:2 78:21 80:4 92:17
 98:10 100:22 114:9
 115:19,22 121:10
 125:13 129:14 139:10
 145:7 147:11 167:2
 170:11 177:13 178:1
 178:21 184:19,19
participate 177:21
particular 6:9 7:6 12:19
 26:19 38:15 39:16
 52:15 63:15 74:10
 135:12
particularly 9:2 38:8
 76:1 103:21 137:8
 151:12 165:13 187:15
partner 57:8 75:22
partners 116:15 158:19
 189:1
partnership 1:3 177:18
 186:19
partnerships 75:18
parts 53:1 119:8
pass 60:12
passed 84:12
passive 166:3
path 23:20 67:9 147:17
pathway 4:3 6:17 11:14
 13:11 14:4,15 16:6,13

20:16 21:7,12,13
pathways 66:18
patient 53:5 64:4,5
 66:18,21,22 81:2
 83:10 87:3 92:10
 94:13 97:14 99:8,13
 101:7 102:6 114:15
 114:15,17 116:14
 117:2,5 118:14,16
 119:4,9 122:7 125:8
 127:2,16 128:6
 131:15,17,21 132:7
 133:20 142:1 143:6
 144:1 147:21 148:19
 148:20 149:2,3,10
 166:19
patient's 39:21 90:5,22
 91:17 99:10 114:18
Patient-Centered
 161:16
patient-centeredness
 149:13
patient-reported
 160:22
patient/family 115:1
 136:17
patients 43:10 44:13
 53:9,10 57:18 58:5
 64:10,22 67:4 86:14
 86:21,22 87:9 92:16
 101:16 109:10 118:10
 121:7 124:7 125:14
 126:4 128:3,3,4
 132:15 149:17,20
 150:9 164:15 166:17
 191:10
patterns 54:22
Paul 2:8 35:13,16 36:20
 73:16 122:21 144:3
 146:21
Paul's 37:8,8 77:8
 146:16
pause 33:9,13
pay 82:21 174:5
payer 56:9 92:8
payers 43:5 54:14
paying 92:20
payment 31:11 43:8
 44:16 50:10 53:15,17
 53:19,21 63:20 65:7
 67:10 88:20,21 89:2
 115:19,19,22 116:6,9
payments 78:1 88:22
 89:5,9,16,22 98:11
pays 95:14
PCORI 161:12
PCORI-funded 160:20
PDCA 173:2

Peg 108:18 110:17
 113:9 117:16
penalized 64:21 65:1
 73:9
penalty 89:17
pendulum 173:12
people 5:6 31:21 34:3
 40:8 53:19 55:18 76:2
 76:16 81:4 82:11
 89:16 100:6 109:2,5
 117:4 122:13,16
 124:10 137:20 147:11
 147:18 153:3 156:18
 159:19 160:4,6,8
 172:20 173:7 175:21
 176:10 180:2
perceived 15:15
percent 19:7 104:19,20
 104:22 105:2,5,16,17
 105:18 106:6,7,8,19
 106:20,21 173:19
perform 172:7
performance 50:21
 117:20,22 145:13,17
performed 24:8
period 5:18 54:4,6,15
 54:16 56:7 94:12
 122:9 124:3
permit 85:8
person 41:16 67:19
 107:8 112:6 122:14
 123:5 154:1,2 156:5
 164:8 174:5 180:10
 187:21 188:13,18
person-centered
 135:16
personal 152:18 153:19
 154:11 156:11
personally 65:13 73:22
 120:21 138:8
personnel 121:11 180:2
persons 24:4 153:3
perspective 6:3 15:10
 42:11 53:18 72:3
perverse 150:7
Pharmacists 2:4
PharmD 2:4
phase 55:8 178:5
phases 178:17
PhD 1:18,21 2:2,7,7,8
 2:20 3:17
phone 93:10 107:6
 122:20 181:10
physical 1:15 53:11
 110:4 145:15 153:3
 155:5
physician 93:21 110:2
 110:3 111:20 121:15

123:2 144:9
physician's 111:21
physicians 110:2
pick 157:12
picking 57:2 72:12
 74:18 100:2
picture 50:11 91:18
 92:7 115:10
piece 40:22 114:22
 116:9,10 119:15
 128:2 129:1 166:20
 168:16
pieces 8:21 41:1
piling 172:19
pillar 151:20
pilot 111:6 113:2
 156:20 178:1,8,12
piloting 155:3 178:17
 178:18
pilots 178:6
placard 48:8
place 16:18 36:14
 117:17 148:22 150:3
places 150:10
plan 169:11
planned 65:20,21,22
 98:3,7
planning 91:11 136:18
 136:20 138:4 140:8
 143:4 156:6
plans 173:1
play 26:11 115:7 118:5
players 121:13
playing 89:7
please 28:13 35:6 38:18
 41:13 104:6 107:16
 108:3 157:6 161:10
 180:11 181:12,18
 189:10
pleased 24:1
pleasure 190:15
plugging 150:2
plus 171:14
pocket 83:1
point 8:12 24:19 32:12
 36:3 48:12 63:7 66:3
 69:12 71:10,11 79:4
 80:16 86:2,11 91:14
 134:9 138:2 141:19
 142:2,3,18 143:11
 150:16 173:12 179:1
 184:5 185:14
pointed 74:13 117:16
points 155:9 157:1
policy 10:9 18:4
poll 67:19
polling 67:20
pony 165:12 167:5

poor 42:21
population 118:14,17
 124:6 131:15 133:15
 156:14,21
population-targeted
 156:19
populations 53:5
 101:15 102:6 135:13
 150:15
portion 157:16
portions 39:18
position 13:21 80:12
 169:16
positive 57:4,10
possible 7:3 23:6 61:5
 66:15 99:21 116:17
 135:11 136:8 148:21
 150:14 159:22
possibly 17:11 27:16
post 31:13 39:21 54:5
 136:1
post-acute 1:3,19 31:16
 39:9,17,17,19,20
 45:16 49:11,14,18
 51:20 53:2 57:16
 66:18 78:7 93:17 94:1
 94:2 121:6,8 134:18
 142:11 168:5,6
 173:19
post-discharge 51:14
 88:16
poster 183:1
posture 166:4
potato 81:2,6,11
potential 14:10 15:9
 75:12 159:17 184:21
potentially 14:9 81:2
 86:8 144:14 146:17
 149:21 178:11
practical 112:10
practice 89:8 146:10
 172:1,13,15 181:1
practitioner 111:21
practitioners 110:1
 166:16
pre-rulemaking 4:8,12
 8:22 189:19
predetermined 122:5
predict 87:2,10
predicted 97:6
predictor 96:10
predominant 119:3
prefer 123:14
preferences 109:7
 142:1
prefers 149:4
preliminary 10:13
 22:12 45:20 46:2

premature 72:16
prepare 192:10
prerogative 103:5
prescriptive 116:16
present 1:11 3:7 51:1
 85:2 111:4
Presentation 4:3
presentations 47:18
presenting 26:4 178:11
President 2:16,17
presiding 1:10
press 28:13 38:19
 108:3 181:12
pressure 2:3 136:20
 145:6
presume 120:18
pretty 75:1 84:3 103:3
 118:1,1 150:20
prevents 50:20
previous 55:6
previously 46:14
 157:17,19 159:2
price 76:16,18 77:4
 90:15
prices 76:15
primarily 53:16 81:19
 146:4
primary 43:13 56:9 92:8
prior 47:19 90:5 93:13
 93:15 109:15 110:8
 111:3 112:1,8
prioritized 165:7
priority 138:13 164:1
private 76:21
probably 26:7 43:6,13
 59:4 69:13 77:13
 80:20 81:16 118:1
 124:10 159:10 188:15
problems 118:4
procedurally 61:21
procedure 6:18 9:21
 35:18 36:21
proceed 120:11
process 5:8,16 6:1,3
 7:1,9 8:20 10:19
 15:18 16:22 19:18
 20:5,5,9 21:15,15
 22:22 24:2,12 27:12
 28:10,22 29:1,1,6,14
 30:2,4,7,11 32:2,7,16
 32:17 33:4,6 34:22
 36:16 37:11 39:12
 46:18 55:9 61:19
 67:18 70:10 71:19
 78:21 81:19 108:8
 109:1 117:22 119:16
 168:22 169:5,9,18
 172:8,22 184:10,13

184:19 185:5 186:12
 187:1,4,10,12 188:2
 190:10
processes 12:12 36:13
 58:9 119:18 142:15
 185:18
processing 7:15
produce 147:20
productive 145:21
professional 110:1
 179:22
professionals 109:19
 110:7
professions 180:1
profound 31:20
profoundly 68:18
program 4:11,13 25:16
 26:5 27:2,4,10 35:4
 35:11 44:6,9 50:10
 84:15 88:20 89:10,18
 99:1 107:19 124:14
 131:18 133:18 137:3
 137:6 139:20 160:3
 164:4 185:8
programmatic 189:14
 190:6
programs 4:16 8:17 9:4
 9:6 11:1 13:18,20
 17:21 25:13 26:10,21
 34:9,11,12,15,19,20
 35:7,8 47:15 74:17
 98:21 137:7 139:18
 142:7 159:1 168:11
progress 136:8 191:4
prohibitive 167:4
project 2:19,19,20
 21:18 160:20,20
 161:1,2,14
promote 168:8 192:16
proper 165:20
proportion 118:16,20
proposal 84:6
proposed 34:14 35:10
 84:5
proposing 25:1 34:8,9
provide 7:2 14:8 25:18
 29:20 31:15 39:12
 87:20 99:6
provided 22:12 40:19
 57:1 88:4 90:7 115:10
 117:1,4 128:6,22
 135:14 150:16 162:19
 169:8 186:16
provider 39:9 49:11
 52:15 54:5,5 55:16
 64:11,21 72:18 73:1
 91:21 169:2
provider's 170:4

providers 2:1 31:15
 39:18 43:18 45:3
 51:15 52:18 53:3 67:9
 67:13 77:1 87:8 89:11
 92:15 123:6,13 136:2
 172:19 173:10 184:8
provides 98:15
providing 9:15 48:10
 49:21 89:13 114:20
 115:6 116:20 119:10
 124:21 172:20
provisions 184:16
provoke 100:1
psychometric 55:12
psychometrics 172:5
PT 1:15 2:1
public 4:4,5,10,18 28:7
 28:16 37:20 38:15
 43:19 50:1,2 108:1
 116:21 117:19 119:15
 119:17 120:1 158:2
 165:2 181:8 189:8,16
 189:21
published 40:4
pull 8:6 58:15 60:10
 79:6 151:17
pulled 37:6,16 161:15
 192:14
pulls 22:14
punt 78:18
purchasing 27:9 34:18
 84:5,14 99:1 170:6
purpose 8:3
purposes 31:9 127:1
pursue 32:3
pursued 43:1 182:12
put 7:17 13:3 26:13
 36:14 52:4 83:21
 102:19 103:19 116:3
 131:21 138:7 143:10
 144:14 167:8,10
 168:6 169:11,16
putting 9:22 26:1 121:5
 150:1 189:13

Q

QI 173:11
QRP 5:6 45:18,18
 108:19 158:22 163:20
 164:4 179:11,13
 181:4
quality 1:1,8,14 2:16,17
 3:16 4:10,12 5:14
 20:18 22:5 24:1,11
 31:8 34:11,17 41:20
 42:17,21 50:10,16
 51:2 52:21 58:5 67:6
 67:10 68:21 69:1,10

70:3 72:6 74:13 84:12
 107:19 116:8,12
 119:3,13 124:13,21
 133:17,18 137:3
 138:6 139:18 144:22
 145:3,4 146:17
 147:12,21 165:14
 166:13 168:10 174:14
 174:20 176:1,5 180:6
 180:9 181:20 183:6
 183:20
quantifiable 147:3
question 13:8 23:10
 25:8 27:13 36:18
 38:18 44:20 60:9
 61:10,19 67:19 70:10
 72:22 76:10 78:12
 81:18,19 94:20 95:1
 102:9 126:2 128:8
 184:4 185:6
questions 5:7 10:6
 11:17 52:7,10 88:7
 92:5 129:19 134:4
 137:11 140:3 154:1
 154:10 156:12 159:20
 159:21 160:8 166:1,8
 185:1 190:10
quick 23:13 100:17
 132:2 192:2
quickly 30:21 109:17
 126:17 159:22
quite 53:10,11 54:3,16
 54:20 55:10 64:11
 109:6 144:16 151:11
 157:15 172:5 178:3
quotation 60:2

R

R 1:18
raise 6:11 37:9 74:6
 76:4 82:10
raised 13:7 15:3 16:4
 30:16 82:1,6 85:14
 86:6 157:1
raises 187:10
raising 155:9
ramped 73:10
RAND 44:7
range 62:12 190:13
rankings 175:5
Raphael 1:9,12 5:3
 11:16 16:20 18:10
 23:21 25:3 28:6,18
 33:15 35:12 36:10,19
 38:4 39:1 40:17 41:12
 41:18 43:20 45:5,8
 47:5 52:11 58:12 59:2
 59:10 61:1 62:9 66:4

- 67:17,21 68:15 70:8
71:7,21 72:20 73:15
75:10 77:10,21 79:3
80:15 82:8 83:14
84:20 93:1 94:18,21
95:17 97:8 99:17
100:15 101:10 104:5
105:1,6,19 106:9,22
146:20 174:10 186:9
190:9 191:21
rare 122:8
rates 136:22
ratio 55:14
rational 30:9 60:13,18
71:1 87:5 103:20
190:4
ratios 95:2,7
re-admissions 165:13
re-did 175:6
re-look 138:20
re-looked 138:17
141:15
reach 166:15
read 136:14 153:4
165:16 166:14 188:8
readmission 54:10 98:5
readmissions 50:20
readmitted 99:10,14
ready 24:14,16
reaffirmed 156:2,2
real 29:10 72:9 81:1
109:17 150:6 171:11
186:18 192:2
realistic 79:4
reality 59:4 154:17
realization 76:17
realized 9:16 135:11,15
really 5:15 7:8,11 8:8
9:20 10:10 16:10 17:3
17:10 18:4,12 19:5
21:3,16 23:20 25:18
29:3 31:20 37:19 45:9
46:18 48:14 51:3 58:4
58:18 59:17 60:9 61:4
61:4 62:5 66:12,12
67:11 68:2 72:7,18
73:5,7,18 76:17 78:7
80:11 84:2,8 96:3
102:7,20 111:16
112:22 113:22 114:12
114:12 115:5,9 122:9
123:21 124:20 125:8
126:22 135:4 138:12
139:2 140:21 145:20
145:21 147:11,14
149:10 150:7,17
151:6,11,17,18 152:2
152:10,10 158:7,13
158:16 163:12 164:15
165:5 168:6,14 171:4
171:11,16 172:2,9
174:13 175:10,13
179:15 181:22 182:7
182:8 184:4 186:11
186:14,17 187:5
188:4,8,21 190:18,22
191:4
reason 20:14 73:3
117:21 132:6
reasonable 13:6,7 16:3
reasons 20:15
recap 4:2 157:3
receive 49:22 89:12
received 34:2 41:3 46:1
49:20 122:13
receives 53:20
receiving 89:17 125:15
127:16 128:4,5
132:15 146:2
recipient 179:21
recognize 5:10 50:15
86:15 173:12 192:11
recognized 176:6
recognizes 74:8
recognizing 136:7
recommend 32:11
103:5 161:6
recommendation 10:14
10:16 11:8 21:3 44:10
47:2 103:7,9,13
104:12 190:4
recommendations
15:21,22 33:22 37:2,4
37:17 60:16 70:22
113:8 146:4 183:9
184:20 189:8,13
recommended 160:12
recommending 46:12
recommends 22:18
record 107:11 176:16
177:6 192:20
records 176:19
recover 147:19
reduce 7:15 99:7 100:3
100:9
reduces 50:19
reducing 82:13 92:14
reduction 8:14
reference 137:20
referral 122:6,7
referrals 125:6
referring 180:16
refinements 97:3
188:21
reflect 19:14,22 37:11
49:15 50:16 157:20
157:22
reflected 37:7
Reflecting 36:13
reflection 144:17
reflections 13:9 16:17
137:11
reform 115:19
refreshed 135:2
regard 48:16 51:4 56:18
regarding 146:16
regardless 78:15
regime 109:11
region 54:21
regional 55:1,3
regions 55:3
Register 184:18
regulations 128:20
rehab 45:18 63:15 64:4
64:15 84:4 149:2
183:16,18
Rehabilitation 2:1 3:14
reinforce 167:20 171:9
reiterate 40:2 172:20
related 5:5,6 139:4
140:18 176:14
relates 43:2,12 44:3,12
relationship 20:3 76:20
relatively 8:20 21:2
22:17 39:15 40:15
release 117:19
releasing 189:7 190:3,5
relevant 69:12 119:9
131:19 141:11
reliability 22:6
relief 180:18
relook 28:1
remarkable 191:11
remarks 66:6
remember 44:5 95:10
174:21 180:11
reminded 69:12
reminds 173:3
remiss 137:22
remove 184:16
removed 112:16 120:8
removing 11:9 184:21
render 69:6
repeat 95:5
replacement 101:22
170:8
report 146:3 154:21
165:8 175:15
reported 81:1
reporting 4:11,12 31:9
34:11,13 43:18
107:19 116:21 119:16
120:1 124:14 133:18
137:3 139:18 170:18
represent 19:17 183:16
representative 138:1
representatives 16:21
52:16
representing 52:15
represents 168:4
request 104:1 120:8
184:19
requesting 113:16
requests 67:19
require 34:22 113:3
184:5,9
required 37:13 78:14
91:12 141:20 145:12
177:22 186:13
requirement 29:19,20
30:1,3 112:11
requirements 13:20
25:15 26:13 29:9 35:9
46:9 125:1 128:21
173:22 184:22 185:13
requires 13:4
research 82:18 83:3
188:9,10
reservations 79:2
residence 114:19
residential 127:14,16
resource 50:4,8,13,17
50:21 51:3,13
resourced 29:16
resources 53:6 167:4
respect 9:14
respite 121:8 128:4
129:13,14 132:5,9,12
132:16,19 133:3,4,6
133:10
Respite 132:12
respond 85:13 155:18
165:21 173:7
responded 47:20,21
responding 47:22
responds 153:11
response 11:12 28:15
38:20 52:1 108:12
120:10 134:5 181:5
186:5
responsible 129:6
188:18
responsive 85:19 166:7
responsiveness 179:17
rest 118:8,9
restriction 113:20
restrictions 118:12
result 72:13
results 92:1 104:19
105:15 106:5,18
159:16,22
resume 107:16

resumed 107:11
retire 171:5
retrospect 120:17
return 64:5 150:12
review 29:1,5,20 31:1
 47:9 61:16 104:2,8
 136:6 157:16 173:18
 187:19 189:18
reviewed 139:20
reviewers 114:6
reviewing 32:7
rich 68:3
right 25:3 38:4 62:3,16
 68:14,15 69:5 76:16
 94:18 103:14 104:5
 104:11 105:20 106:11
 123:19 127:4 131:1,7
 132:14 133:5,9 150:8
 159:5 162:1 163:10
 167:22 173:22 178:4
 181:3 192:7
rightly 163:1
rights 154:6
rise 155:15
risk 31:20 55:6,8,22
 63:11,22 75:3 77:17
 86:18,22 87:13 90:1,3
 90:10 93:18 94:1
 101:2 172:18
RN 1:14 2:11,20 115:22
 116:5
road 12:2 60:2 147:8,9
roads 175:12
ROBERTS 1:21 93:4
 94:19,22 95:6,15
Robin's 32:12
robust 11:3 23:1 32:3
Robyn 1:13 11:17 70:8
 71:22 140:5,16 155:7
 155:17 156:4 157:1
rocket 69:20
Roger 1:15 67:17
role 18:22 19:15,20
 55:5 115:7 143:6
 158:20 170:11
room 1:8 34:3 107:16
 149:14
ROSS 2:14 23:22
 152:13 155:18,20
 159:9 175:15 179:20
roughly 183:17
round 115:9
routine 65:21 66:1
RTI 98:5
RUG 87:6,12
RUGs 95:22
rule 115:21
rulemaking 12:13 30:18

157:18,21
rules 30:4 31:2 105:1
 154:6
run 189:5,9
running 43:7
rural 65:4,5,6 73:4,14
rural/urban 73:13

S

S 4:1
sadly 122:8
safety 67:12,13 143:19
Saliba 1:9,12 79:15
 95:18 107:22 108:5
 108:17 110:11 114:5
 117:13 120:2,6
 122:11,19 123:8
 124:9,17 125:12,22
 127:7 128:11 129:18
 131:8 132:1,22 134:3
 134:14 137:16 139:8
 140:1,12 141:3,17
 142:21 143:17 144:2
 145:8,18 146:14,19
 147:22 149:7 151:3
 152:4 155:6,17,19
 157:2 160:16 161:9
 161:12,19 162:1,8
 165:9 167:12 168:15
 169:21 171:6 172:11
 172:15 173:15 174:8
 175:14 177:7 178:20
 179:18 180:12,21
 181:15 186:2 187:21
 189:2 190:11
SAMPSEL 2:21 45:14
 70:17 157:13 162:11
 192:2
Sandra 151:9,21
Sandy 1:19 148:15
Sandy's 175:17
Sarah 2:21 45:11
 157:11 162:10,10
 179:7
Sarah's 71:10
savings 44:6,9,16 76:7
saw 76:13 125:19 188:6
saying 78:8 151:9
 155:10 171:9,17
 191:3
says 75:4 96:21 165:22
scale 25:2
SCAN 174:15
SCFES 1:21
schedule 27:17,18
 107:4
schedules 28:2
scheme 100:1

School 1:16
scientific 22:5 23:3
 187:6
scope 49:10
score 173:4,6 174:17
scores 174:18
screening 65:21 109:8
 109:9
scroll 109:16
Sean 1:20 77:10 122:11
 172:17 174:11
seated 23:8
seats 107:16
second 13:4 19:12
 24:12 54:2 68:2 78:12
 100:22 105:8 109:13
 110:14,21 112:2,3
 121:4 125:13 126:7
 126:20 130:3 156:7
secondary 77:5,6,6
secondly 5:14 186:22
Secretary 31:2 32:4
 91:11 184:16,20
sector 178:7
see 6:19 10:11 25:2
 28:8,19 29:7 38:14
 39:3 45:5 52:6 88:12
 103:12 107:9 114:13
 121:7,11 126:17
 134:11 135:1 136:15
 137:1 143:21 152:5
 164:11 165:17 166:15
 180:19 181:9 189:22
 191:12
seeing 42:2 62:3
 143:15 163:4 164:21
seek 150:9
seen 46:14 59:20
 122:16 123:6 130:3
 159:16 169:9,14
 186:18
sees 153:10,14
select 45:3
selection 13:17
self-determination
 156:9
selfish 64:8
semi 169:3
send 102:12 166:5
sending 99:8 165:21
 166:11
sends 60:19
Senior 2:17,18,19,20,20
sense 9:4 36:15 59:12
 86:8 90:18 118:3
 124:21 132:9 156:8
sent 110:16
separate 16:13 37:12

75:14 76:8 128:19
separately 37:6 75:16
separating 123:16
series 153:22
serve 53:4 57:17
served 53:10
service 56:7 81:12
 159:12
services 2:11 3:11,18
 3:20 49:3 50:19 51:16
 73:10 74:2 89:13
 92:21 135:14 150:15
 176:3 179:4
session 15:3
set 23:1 34:2 38:10,16
 41:3 51:7 80:6 87:11
 88:16 111:7 113:11
 131:12 136:3 169:15
 169:19 188:19
sets 96:5
setting 16:9 20:20
 49:18 51:21 54:13
 55:20,20 56:5 65:8
 84:4,8 86:3,12,20
 87:3 90:10 93:16,17
 94:3,6 99:16 128:16
 129:1 133:16,21
 137:4 146:10 149:4
 162:6 176:11
settings 8:17 54:8 57:3
 57:16 68:10 86:7,15
 88:13 101:15,16,19
 135:12 136:6 142:12
 144:9 145:5 191:11
 191:16
settle 40:10
seven 109:3 116:1
 117:17 118:11,21
 120:18 121:11 124:5
 125:17 126:16,21
 155:22 156:3,22
 177:21
seven's 124:10
severe 160:6
severity 63:11,19 90:22
shade 158:4
shape 187:16
shaping 16:22
share 89:4 142:18
 144:6,7 152:13
 178:13 179:22
shared 44:6,9,15 76:7
 136:19 143:5 156:7
sharing 77:18
shifting 77:5,13
shifts 141:1
shoes 29:11
short 14:9 118:17

- shortened** 107:3
shorter 126:19
show 50:21
showed 158:21
showing 137:17
shown 96:9
shows 136:12 137:18
137:19 139:11,16
side 40:6 46:12 48:18
74:4 76:5 77:6,6
144:19 170:4
sides 60:18
sight 147:16
significance 119:22
significant 7:9 9:5,9
10:5 14:12 43:5
118:16 137:7 188:14
silly 117:3
silo 135:18
siloed 176:4,4
similar 34:22,22 42:10
45:15,21 46:10
153:20,21
simple 61:5
simply 44:15 74:9
single 111:13 116:19
site 135:18 165:20,21
166:5,6,6,8,12,12
sites 166:18
sitting 148:5 159:13
situation 81:17 119:7
six 130:21 135:22
size 116:13
sizeable 64:11
skilled 45:19 63:16
121:5,22 183:18
slept 32:9
slide 136:11 137:1,10
137:18 139:11,16
140:2 150:13 158:21
158:22 162:12,13,17
163:19 165:1
slides 162:10
slightly 19:3 23:8
153:20
slow 78:20
small 32:20 136:14
smaller 90:16
smiled 80:9
sneak 100:11
SNF 26:5 53:15 57:5,7
66:21 67:1 73:9,11
87:11 99:9 100:6
121:5,14,14,15
133:18
SNFs 73:5,6
SNYDER 2:1
social 110:5 112:8
116:1,5 125:15 148:7
151:13,15 152:1
180:1
Society 1:18 2:4
sociodemographic
101:1
socioeconomic 63:22
91:2,10,13 92:3 101:3
solid 11:20
somebody 83:8 117:8
180:19
someone's 147:4
somewhat 40:9 42:7,10
55:16
sooner 82:13
sorry 36:18 58:11 94:21
95:4 132:19 148:1
161:13 162:10
sort 7:6 8:8,11 9:10
11:5 13:14 14:14 16:4
16:14,16,19 18:2
19:16,17,21 20:8
21:10,19 22:21 23:10
30:13 32:3 37:7 50:6
50:9 51:2 55:12,22
67:8 76:6 88:6 89:20
90:19 149:5 151:20
168:13 170:3 174:13
182:8,14
sorts 111:8
sound 117:3
sounds 81:20 97:11
source 20:20 56:9
sources 135:14 150:16
space 69:16 91:7 92:3
98:20
Spalding 47:11
Spalding-Bush 3:19
48:6,7 61:18 84:21
93:9 96:13 98:1
span 81:9
spanning 15:8
speak 6:1 23:22 50:3
73:21 85:1 89:7
128:18 191:1
spec 45:13
specific 42:2 86:3,12
86:20 94:2 128:16
135:19 182:18 184:3
184:14
specifically 46:11
111:18 151:6 180:16
192:15
specification 132:4
specifications 39:14
40:3,19 41:4 42:3
49:22 90:8 112:19
113:5
specified 31:19 41:8
specifying 46:19
specs 67:16 110:16,18
speech 110:5
spell 161:9
Spence 2:2 107:6
114:10 117:15 120:22
128:12 130:2,10,16
131:5,7,13 132:11,21
133:1,7,10
spend 20:2 84:1 154:8
spending 4:6,9 9:14
42:18,20 45:1,4,16
47:13 48:18,22 55:14
55:15,22 65:17,18,18
81:4,8 87:2,18 88:8,9
88:10,11 89:22 90:1,4
90:19,21 101:12
104:13
spent 63:9 81:9 84:7
sphere 123:3
spike 51:13
spirit 144:20
spiritual 110:3 112:9
125:16
spoke 156:15
spot 52:4
spreadsheet 190:3
spring 164:20
stable 99:13
Stacy 163:9
staff 2:15 5:20 10:14
16:18 21:10 22:14
25:4 32:18 36:11 37:4
37:16 47:2 95:1,7
103:11 132:8 163:6
192:12,16
staffed 29:15
stage 5:12 24:14
185:11 187:3,4
staged 123:4
stages 8:18
stakeholder 40:6 50:2
85:12 111:2
stakeholders 15:11
24:17 34:7 146:1
standard 146:10
standardization 89:6
standardize 65:17 67:3
standardized 54:4
55:14,19 65:18 89:22
96:22 97:4,17 98:14
191:8
standards 177:17,19
178:1,5,16
standing 18:19 22:2
177:2
standpoint 70:5,6
116:9
stands 146:6
star 28:13 38:19 108:3
116:21 181:13
stars 171:3
start 19:11,12 45:12
47:8 70:17 86:1 90:5
93:6,7,8,13 108:22
114:11 115:21 140:4
158:13
started 13:13 101:14
107:18 138:10
starting 173:1 178:6
starts 94:2,9 149:2
state 21:5 55:2 151:6
175:7 177:3
stated 63:4 184:2,15
Statement 60:13,18
states 24:8 95:1,6
142:11 153:2 159:19
162:6 174:18 175:4
177:21 178:6
station 102:11
statistical 151:1 167:6
status 24:19 64:1 91:2
91:10,13,17 96:4,15
96:19 102:7 136:16
139:19 147:9
statute 33:5 41:9 96:20
statutes 18:19 26:4
34:21
statutorily 34:19 78:13
81:20
statutory 13:20 17:7
18:18 25:8 27:6 29:9
29:18,19 35:9 46:9
66:10 85:7 182:18
stay 49:14 98:11 113:20
115:16 118:5,12,17
124:16 126:5,9 130:8
134:7 148:20
step 5:15 19:21 123:19
159:7 171:4 172:21
steps 4:20 169:16
187:20 189:6
steward 113:19 114:2
STONE 2:3 114:7 120:5
stop 16:13 66:3
stopping 117:8
stories 80:10
story 69:13
strategy 135:9 150:15
streamlined 182:15
Street 1:9
STREETER 2:20
stress 83:7
strict 25:15 26:12
strikes 145:10 170:3

strong 104:1
strongly 21:2 29:3 31:3
 31:22 43:1,15
structure 116:6 154:5
structured 154:18
study 96:8
stuff 151:17
SUBJECT 2:6
submission 170:12
submitted 93:14
subscribers 183:17
substantive 161:7
substitute 73:1
substitution 73:5,14
successful 17:10
succinct 119:20
suddenly 81:5
sufficiency 179:10
sufficient 11:12 43:17
suggest 188:15
suggested 49:13
suggestion 188:2
suggestions 149:14
 188:22 192:6
suggests 55:22
suited 117:1
summarize 58:1 103:19
 186:7
summary 4:20 22:7
 146:3
summer 113:2 139:7
support 23:4 32:14
 46:7 52:17 58:1 69:4
 70:1 83:22 89:10
 100:18 102:15 114:21
 124:19 142:9 155:4
 171:16 174:20 180:2
 183:12 190:20
supporting 6:7 22:7
supportive 84:17
 153:15
supports 24:10 64:2
 153:13
supposed 119:13 180:3
supposedly 69:15
sure 6:21 7:20 8:19
 11:19 19:7 28:7 31:5
 33:7 36:19 41:15,17
 60:8 62:11 63:10 68:1
 79:20 107:6 110:20
 114:11 125:8 128:14
 143:20 147:16 157:13
 160:18 161:21 165:8
 167:16
survey 159:12,15 160:5
 164:5,6
suspend 184:17
suspending 184:21

Suzanne 2:1 62:16 66:5
 80:15 83:14
Suzanne's 66:6
symptom 114:16 144:8
 144:10 149:15
symptoms 129:8
system 3:13 76:9 81:5
 83:12 92:12 116:21
 149:13 183:16
systematically 77:18
systems 63:20 75:18
 88:21 152:14,19
 153:17 155:2

T

T 4:1,1
table 10:2 133:11
 134:20 159:10 160:19
 170:14
tables 157:20
tackle 150:22
tailed 79:13
take 6:4 10:4 18:7 19:20
 25:10 26:9 32:21
 50:11 62:18 76:2
 88:19 89:7 90:4 91:13
 93:14 98:12 100:6
 103:13 104:6 115:8
 117:17 121:16 131:14
 136:11 137:11 149:2
 166:8 169:15 172:18
 182:16
taken 14:12 35:19
 85:17 112:14 160:5
takes 64:9,22 89:15
 174:17
talk 62:7 117:11 134:15
 138:3 158:15 166:17
 179:11,12 186:7
talked 54:9 163:17
 164:12 165:15 168:22
 191:5
talking 17:5 101:6
 108:20 117:12 137:21
 140:16 151:22 154:14
 157:5 162:4 164:14
 171:21 180:17 192:18
talks 140:7
Tara 3:17 25:11 26:15
 33:15 125:12 126:10
 145:18 152:11 157:6
 157:7 158:10 163:8
 186:11
Taroon 2:18 5:20,22 6:4
 6:6 26:15
taught 142:19
taxpayer 69:6
teaching 64:12,22

88:22 89:4 98:12
team 47:12 52:9 93:10
 115:6 118:9 127:18
 157:7 192:12
team-based 145:12
teamness 172:3
teams 172:7
teamwork 171:21
technical 48:13 52:16
 55:16,18 70:5 88:5
 93:11 124:22 126:12
 126:18
technically 12:3 33:1,2
Technology 2:12
TEFT 177:12,14
tell 18:15 80:10 175:1
 188:1
ten 55:3 107:1
tend 180:7
tent 120:14 137:21
 187:22
TEP 40:9 41:2 48:15
 49:3,13,20 94:7 101:1
 111:11 113:6
TEP's 113:7
TEPs 111:5
Teresa 3:15 41:19
 181:19 191:7
term 45:18 55:21 169:3
terms 7:3 16:14 17:11
 17:16 18:5,9 19:17
 22:12 26:18,19 34:3
 35:17 40:10 47:21
 52:9,20 53:5,22 54:8
 54:21 56:13 65:12,15
 65:16,20 72:11 88:5
 100:19 101:8 113:18
 113:21 125:1 142:3
 150:4 166:4 167:4,22
 171:10 178:16 179:13
terrific 18:14 188:21
TERRY 2:20 108:21
 110:20
tested 20:20 21:17 22:4
 71:16 113:2 162:5
 184:10 185:17
testing 14:13 16:8
 20:17,18,19 21:9 23:3
 43:16 46:21 111:6,10
 112:15 113:3 159:7
thank 6:5 12:18 17:2,2
 17:3 25:3 33:15,17,18
 35:12 37:19 39:1,5
 40:16,17 41:21 43:19
 47:7,9 48:5 52:14
 66:5 68:17 70:7 72:1
 72:21 73:17 75:10
 80:10 83:16 95:15,18

96:13 107:1,14,16,22
 108:5 110:11,12,12
 114:5,10 117:14
 120:1,2,6,15 123:9,9
 132:1 134:17 139:21
 140:2,12 142:21
 144:1,2 145:8,18
 147:22 151:3 155:6,8
 155:17 157:2,5,7
 160:16 161:20 162:2
 162:8 167:12 168:15
 169:21 171:6 173:15
 174:8 178:20 181:6
 181:15,21 183:12,13
 185:19,21 186:1,6,10
 186:17,20 189:2
 190:11,15,19,19
 191:19,22 192:5,17
thankfully 27:21
thanks 39:6 48:6 75:11
 84:21 122:10 125:11
 138:9 189:4
themselves 82:19 154:2
theory 75:20
therapists 110:4
therapy 1:16,22 87:10
 110:5 145:15
they'd 111:20
thing 29:7 32:20 48:16
 58:14 69:8 78:18
 79:19 102:22 113:14
 121:4,19 122:3 129:5
 148:12 150:22 151:5
 174:6 179:22 182:3
things 5:10 18:9 26:13
 28:2 49:7,19 50:15,18
 50:20 51:12 62:6
 63:10 70:10 71:12
 76:18 77:7 85:13
 86:13 88:17 98:13
 101:8 120:16 124:22
 129:10 145:3 146:21
 147:3,10 150:7
 160:14 161:4 163:5
 166:2 171:8,13 182:2
 184:4
think 5:9 13:4 15:2
 17:10,14 19:4,4,7
 25:13,19 26:7,17
 27:20 28:4,21 29:8
 31:3,7 32:1,6,6 33:8
 33:14 36:7,20 38:4
 39:10 41:5,6 42:9
 43:4,9,22 44:3,20
 46:15 48:11 49:1 51:3
 51:22 56:20 58:14
 59:16 60:9 62:3,11,14
 62:17,21 63:1,8 64:18

- 65:3,6,8,21 66:7,10
67:11,14 68:2,5,13
69:4,6,8 70:4 72:3,9
74:5,7,11,14 75:19
76:18 77:7 78:12 79:3
80:1,7 83:22 84:2,3
84:18 85:1 86:2,5,10
87:14,21 88:1,7 92:4
96:3,4,11 99:19 101:2
101:8,14,20 102:5,7,9
103:2 110:15,22
111:20 113:22 114:3
119:8 122:2 123:10
123:18 124:1,19,21
125:10 133:13 137:19
138:5,7,10,19,21
139:1,5 142:5,6,16,22
144:8,12,13,18
146:12,22 147:2,12
147:13 148:9,12
149:8,12,15,16,19
150:1,3,5,20 151:5,11
155:9,11 157:15
158:7 162:9 163:5,13
164:15,17 166:3
167:10,21 168:2,8,16
168:17,21 169:18
170:13 171:3 174:5
174:12,18 175:8,12
178:9,10 179:4,6,8,9
180:6 182:13,14,19
183:4,8,10 186:6,14
188:10,12 190:13
191:2
thinking 65:13,13 72:7
139:6 141:4 143:17
170:19 173:18
third 55:12 56:18,19
105:20 118:10,13
124:6 131:15 156:8
Thirty-day 165:13
THOMAS 2:4
thorough 62:2
thought 5:19,21 17:4
18:13 44:4 57:3 80:8
94:6 144:6 151:22
thoughtful 117:7
119:21 181:22
thoughtfully 37:22
thoughtfulness 186:1
thoughts 58:17 73:1
103:10 129:19,19
140:13 144:5 148:1,6
152:8,9 181:4 192:9
thousands 156:18
159:18 176:8,8
three 7:10 24:3 52:22
53:1,14,14 94:5,8
97:8 102:14 104:8
112:1 118:17,18,18
125:7 126:14,15
153:4,21 156:3,3,22
159:14 160:10 179:7
thrown 31:9
tie 133:15
tied 79:10
Tilden 172:4
till 155:20
time 7:18 9:14,17 10:5
14:10 17:7 18:3 20:3
20:11 24:16 28:5,12
28:17 29:9,16 30:1
32:21 34:1 38:22
40:21 41:9,10 43:17
56:7 59:19 63:7 69:9
74:1 79:11 81:1 85:8
88:16 94:16 107:15
107:17 108:4 114:16
115:8 122:5,9 124:4
126:11,22 135:11
138:16,19 151:16
155:12 165:5 167:4
168:2 180:19 181:11
181:14 184:17,22
185:20,22 186:19
188:2,3,15
timeliness 179:16
timely 165:19
times 9:11 76:14 150:6
today 17:21 29:8 35:15
76:14 104:18 107:7
146:2 154:12,18
163:18 169:14 181:16
182:2,6,9 184:2,11
185:1 190:12
toileting 180:4
told 64:13
tool 177:15
tools 143:7
topic 20:1 155:21
188:17
topics 6:12 11:4 179:7
topped 170:20
topped-out 126:17
total 50:11 97:22
totally 162:11
touch 81:7 122:14
touches 125:3
track 43:1 79:7,9
102:10
traditional 77:16
153:16
traditionally 5:13
train 18:21 78:20 79:6,8
102:10 184:7
transfer 83:11
transferred 142:1
transformed 150:17
transition 136:19 138:4
157:9 165:18
transitional 138:21
139:3
transitions 1:17 138:1
138:3,12 142:8,12
160:21 161:17 165:12
166:4
translate 160:15
translated 22:1,9
translates 14:2 79:22
translating 149:5
transparent 17:11
travel 175:12
traveling 60:3
treated 109:10
treatment 49:8,17
88:12 98:8,16 109:7,9
136:18 140:8
treatments 164:13
tremendous 159:17
trends 133:19
trial 91:9
tried 5:15 59:17
troubles 81:13
troubleshooting
172:22
Troy 3:13 183:15
Troy's 186:3
true 77:20 78:22 122:17
122:18,18 133:6
truly 18:22 185:2
try 7:11 8:13 12:12
17:10 19:11 25:10
27:21 51:15 74:6,9
83:19 99:5 114:1
147:1 167:5 170:22
174:12 192:15
trying 8:12,19 60:5
74:17 99:19 101:12
170:13 173:9 174:7
192:8
tube 143:11
TUESDAY 1:5
turn 6:2 16:20 22:11
28:18 39:2 45:11 47:5
48:4 52:6,12 58:13
62:13 80:17 127:12
137:14
turnaround 14:10
two 5:10 7:10 10:1 91:9
100:17 102:18 111:14
112:11 113:4 120:7
120:12 125:15 126:3
126:6,21,22,22
144:15 149:14 152:14
155:1 157:4 160:13
167:2 169:14 171:8
two-and-a-half 152:22
type 11:1 21:4 34:18
48:16 51:9 87:4 112:6
145:20 180:14
types 39:17 44:21 49:3
49:19 50:20 136:9
-
- U**
-
- Ulcer** 2:3
ulcers 136:20
ultimately 19:9 57:14
60:15 80:1,6 82:17
83:2,13 173:9,11
unanimous 9:19 10:12
37:2
uncomfortable 74:19
under-funded 34:5
under-staffed 34:5
underfunded 64:10
underscore 40:12
understand 12:19
45:10 48:9 50:5,13
67:16 68:10 69:5
79:18 80:20 85:2
95:19,21 109:6
115:14 131:20 188:11
understanding 18:16
35:18 58:7
understands 128:14
187:11
undertaken 48:2 91:8
undertaking 7:9
unfunded 64:9
Uniform 3:13 183:15
unify 136:5
unintended 31:21
56:19 57:12 72:11
74:3 75:12 82:10
99:21 100:12 103:1
103:17 116:17 119:1
139:4
unique 75:5 103:21
unit 115:1 129:3 143:2
United 153:2
university 1:16 97:20
160:2 172:4
unmet 140:21 141:3
149:18 164:12
unnecessary 50:19
100:13
unneeded 8:14
unrealistic 29:16
unsavory 100:1
unusual 119:6 123:5
unwanted 164:13
upcoming 189:6

update 115:14
updated 110:16 132:3
upstream 14:1
upwards 174:14
urban/rural 88:19
urge 31:3 43:1,17
 170:10
urgent 125:6
use 9:17 27:15 30:5
 34:16,20 44:18,19
 45:2,17 50:4,8,13,17
 50:22 51:13 55:21
 58:22 78:8 96:18,21
 97:5 136:21 158:5
 173:11
useful 25:22 191:10
uses 19:18 21:10
usually 32:16
UTI 49:17
utilization 96:1 100:14
utilizing 183:19

V

VA 178:22,22
vacuum 60:17 83:20
valid 67:14
validation 43:16 185:12
validity 22:6
valuable 5:19
value 9:14 27:14 50:9
 50:12 58:5 74:2,7
 79:22 81:21 83:17,18
 89:15 102:21 161:18
 186:15
value-based 27:9 34:18
 80:4 84:5,14 98:22
 100:20 170:6
values 109:8
variation 8:14 53:22
 64:4
varied 123:13
variety 103:1
various 7:12,17 8:18
 9:1 47:14 136:6
VBP 173:11
vehicle 177:6
venues 75:16
verbal 32:18
verge 172:6
version 130:4
versus 21:13
veterans 179:3
Vice 2:16,17
view 15:10 24:19 35:3
 36:3
viewed 67:9
viewing 35:3
viewpoint 13:15 172:19

views 154:2
Virginia 172:4
virtue 89:13
vis-a-vis 42:9,17
vision 33:22 37:8
visit 111:22 117:9
 126:15
Visiting 1:14
visits 108:7 109:13,18
 109:21,22 110:8
 111:3,9,19 112:12
 116:1,6 117:6,7
 123:16,16 124:14
 125:2,15 126:6,21
 127:15,17,18
vital 29:7
Voice 1:13
volume 23:5
volunteer 123:21 167:5
volunteers 109:20
 110:6,7 112:13,16
vote 9:12 10:8 12:3
 31:4 32:17,19 33:1,4
 35:19 36:2,9 37:12,17
 40:20 41:11 60:10
 61:22 66:8 73:20 75:7
 79:1 82:3 93:2 97:10
 103:13 104:7 106:11
voted 36:4 37:6 61:7,14
voters 104:19
votes 10:1,4 70:21
 78:15 79:5
voting 2:6 6:18 9:21
 32:7 33:5 36:21
 102:15 104:12,17
 105:10,14,22 106:4
 106:13,17 120:9
 134:8

W

wage 88:17 89:8
wait 94:19 155:20
Waiting 127:5
walk 148:11
walking 131:17
want 23:10 27:1,15
 30:22 31:6 32:21
 33:16,19,19 37:10
 41:15 44:6 45:9 49:3
 49:12 52:2,13 58:3,15
 59:6,20 60:11 62:11
 63:10 69:21 71:7
 72:10 73:21 75:1
 77:22 78:3,7,19 79:18
 79:20 80:1,4,7,11,16
 81:6,7 83:17 84:16
 85:1,9,15 86:2 87:19
 93:3 101:19 102:12

103:11 107:5 111:22
 112:7,19 116:20
 117:4,4,5,6 119:1,2
 119:10 120:8 122:21
 124:2,10 125:5
 131:14,15 138:7
 141:1 143:9 147:7,15
 148:17 154:18,19
 159:22 163:12 165:5
 167:1,20 179:22
 181:21 182:21 186:8
 186:10,17 190:11
 192:5
wanted 6:11 10:16,20
 11:10,19 12:4 14:11
 14:16 17:18 23:22
 35:22 36:22 37:18
 40:12 47:11 50:3
 62:18 72:22 81:12
 82:9 124:18 125:20
 129:22 134:14,20
 137:14 141:19 142:2
 142:18 146:20 148:5
 149:14 150:12 151:8
 152:13 154:21 155:8
 157:15 158:5,9
 161:20 163:14 167:15
 171:8 174:10 175:15
 179:8,12 187:19
 190:15,18
wanting 116:19
wants 25:5 28:9,20 39:3
 148:20 177:2
Washington 1:9
wasn't 14:17 85:2
 130:17
way 8:10 23:7 39:13
 45:3 47:20 66:17
 72:17 77:4 87:17 94:4
 96:20 103:6 116:3
 131:20 132:10 140:20
 141:11 151:13 165:20
 166:21 167:1 173:13
 183:8,10 192:3
ways 80:5 113:1 131:14
we'll 52:6 73:15 78:20
 90:7 104:11 108:14
 120:11 131:2 134:9
 143:14 159:2 163:5
 189:7 190:2,5 192:17
we're 5:11,18 6:21 8:9
 8:16,19 11:19 12:10
 12:13 16:22 17:10
 24:13,22,22 25:22
 28:10 35:13,13 58:4
 60:3 64:12 65:5 68:2
 68:4,9,11,13 69:21,22
 70:6 73:7,20 79:5

80:17 84:17 86:11,20
 91:5,6,16 95:10 97:9
 97:17 106:10 107:1
 107:15,18 108:19
 114:1,2,13 133:18
 134:11 137:20,21
 142:7 144:13 145:6
 148:4 154:14 159:5
 159:16 160:14 161:1
 161:5 163:3,10
 164:14 173:9 174:3,7
 176:13 183:1 184:6
 185:11 186:7 187:3,4
we've 27:20 35:21 40:8
 48:14 49:2 52:1 56:20
 81:3,22 82:6 99:5
 103:15 111:13 112:2
 113:7 116:18 124:9
 139:1 157:14 163:17
 164:12 169:9,14
 179:9 182:8 183:2
 187:8,13 191:4
webinar 163:9
webpage 189:22
weeds 66:13
week 109:15,22 110:8
 112:4,7,12 122:15,17
 123:5 151:14 176:18
 191:7
weekly 177:19
weigh 25:5 26:14 28:20
 52:13 71:17 90:15
 147:14
weighted 56:14,17
 90:11,14
weighting 65:19
weighty 84:3
welcome 8:6 13:9 16:16
 107:6 137:11 165:4
 189:20
well-informed 161:7
wellness 153:17
went 97:19 107:11
 161:20 192:20
weren't 85:21
Westchester 160:3,4
whatnot 11:2 146:11
wholehearted 103:8
wholly 49:10
wide 190:13
wide-eyed 79:12
willing 91:22
WILSON 2:17
window 51:14 88:12,16
 92:18 111:18 118:6,8
 124:4 126:19 129:20
windows 126:11,22
 129:21

WINSTEL 2:5 61:2,13
82:9 123:9 148:15
160:18 161:11,13,22
179:15 180:15
wise 71:19
wish 108:2 182:16
187:14
wishes 117:2
wonder 66:16 75:15
wonderful 24:21 68:5
174:6
wondering 77:3 100:5
146:1
words 95:13 99:12
work 5:4,11 41:4 58:22
59:7,17,20 70:14 91:6
92:2 96:8,9,9 114:1,3
116:1,5 136:5 142:10
142:10,14 147:2
148:8,14 155:12,14
157:7 159:21 160:9
163:16 164:9,19
167:6,17 177:11,17
177:21 178:1,5,8,16
180:9
worked 187:18
workers 110:6 112:9
123:18 125:16 180:2
workforce 82:19
workgroup 1:3,8 2:13
6:15,20 8:6 9:2,3,4,8
9:10 10:13,15,22
12:10 17:3 24:4,10,20
47:17 52:6,7,7,13
58:13 59:17 60:14,19
62:1 135:5,10 137:12
150:13 155:22 159:14
163:6 175:17 178:4
189:13 191:16
workgroup's 33:10
workgroups 7:12,17
8:15 9:1 11:6,7 15:8
37:1 38:1 111:5
178:12,14 187:9
189:16 190:7
working 44:2 98:20
131:3 145:16 158:16
170:12 171:10 190:16
192:13
works 97:1 187:5
world 71:14 74:1,17
109:5 134:19 152:15
153:11,11,14 154:3,4
154:4,9 155:1
worried 70:2
worry 58:22 72:19 74:3
137:16 144:21 182:22
183:5

worth 143:1
worthwhile 141:13
worthy 74:11
wouldn't 86:17 92:11
131:19 132:8,9
wrap 145:1
write 34:21
written 96:20 189:12
190:6
wrong 64:19,21
Wunmi 192:14

X

Y

Yale 98:5
Yeah 161:22 173:17
year 8:1 9:7 11:8 14:4
46:1 71:15 81:10 91:9
164:21 171:15 175:6
176:18 178:19 192:8
192:8
year's 8:22
year-old 154:16
years 7:11 13:14 24:4
78:8 130:19 152:19
152:22 154:19,22
159:15 160:10
yesterday 6:13,15,16
11:4 15:4 17:6,15
19:5 26:4 27:10 34:10
34:14 39:7,10 40:16
47:21 54:9,19 55:5
85:3,3 101:7 107:7
169:1 185:21 190:12
yesterday's 18:13
York 76:14 160:4
young 154:15

Z

Zero 105:16 106:6,19

0

1

1 4:2 104:15 105:10,22
106:13 115:21 190:2
1.C 142:6
10:45 107:11
10:55 107:9
100 19:7
1030 1:8
108 4:11
109 4:13
11:03 107:12
11:50 107:9
12 142:11
12:38 192:20

12th 189:10,10
13 136:4 159:19
134 4:14
14 156:2
15 1:6
157 4:16
15th 1:8 190:5
18 130:19
181 4:18
189 4:20

2

2 4:2 104:16 105:11
106:1,14
20 104:19 152:19
154:15,22
2011 174:22
2012 135:10
2013 156:1
2015 1:6 156:2 175:6
2017 178:19
21 154:15
23rd 189:9
24 125:6
26 170:5
26th 189:18
27th 189:18
28 4:4
289 105:20
29 106:8,21
291 106:10

3

3 104:16 105:12 106:2
106:15
3-day 111:18
30 57:7 88:13 94:15
104:21 105:18 173:6
30-day 54:5,16
36 4:7 180:19

4

41 175:3
45 4:9
48-hour 118:6

5

5 4:2 118:7

6

6 4:3
60 57:6,10 88:13 94:13
105:2
60-day 54:4,15 94:11
94:16
65 104:19 105:5

7

7-day 113:21 130:22
70 105:15
71 106:5,18
75 150:18

8

8:30 1:9
80 154:15

9

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Post-Acute Care/Long-Term Care

Before: NQF

Date: 12-15-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701