NATIONAL QUALITY FORUM

+ + + + +

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE

+ + + + +

THURSDAY
JANUARY 25, 2018

The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Charles Kahn III and Harold Pincus, Co-Chairs, presiding.

PRESENT:
CHARLES KAHN III, MPH, Co-Chair
HAROLD PINCUS, MD, Co-Chair
RICHARD ANTONELLI, MD, MS, Individual Subject Matter Expert*
JOE BAKER, Medicare Rights Center
LEAH BINDER, MA, MGA, The Leapfrog Group
JOHN BOTT, MSSW, MBA, Consumers Union
MARY BETH BRESCH WHITE, American Nurses Association
RAJESH DAVDA, MD, America's Health Insurance Plans
TRICIA ELLIOTT, MBA, CPHQ, The Joint Commission
DAVID GIFFORD, MD, MPH, American Health Care Association
BRUCE HALL, MD, PhD, MBA, FACS, American College of Surgeons
GAIL HUNT, National Alliance for Caregiving
DAVID INTROCASO, PhD, American Medical Group Association
MAUREEN KAHN, RN, MHA, MSN, Blessing Health System*
MIRA IRONS, MD, American Board of Medical Specialties*

WILLIAM KRAMER, MBA, Pacific Business Group on Health
RACHEL LA CROIX, PhD, PMP, National Association of Medicaid Directors
SAMUEL LIN, MD, PhD, MBA, MPA, MS, American Medical Group Association
ERIN MACKAY, MPH, National Partnership for Women & Families
AMY MULLINS, MD, FAAFP, American Academy of Family Physicians
SHAUN O'BRIEN, JD, AFL-CIO
AMIR QASEEM, MD, PhD, MHA, FACP, American College of Physicians
CHRIS QUERAM, MS, Network for Regional Healthcare Improvement
DEREK ROBINSON, MD, MBA, FACEP, CHCQM, Health Care Service Corporation
MARISSA SCHLAIFER, MS, RPh, Academy of Managed Care Pharmacy
CARL SIRIO, MD, American Medical Association
STEVE WOJCIK, MA, National Business Group on Health

FEDERAL GOVERNMENT LIAISONS (NON-VOTING):

ROB ANTHONY, Office of the National Coordinator for Health Information Technology (ONC)
MARY BARTON, MD, Agency for Healthcare Research and Quality (AHRQ)
KATE GOODRICH, MD, MHS, Centers for Medicare and Medicaid Services (CMS)

NQF STAFF:

TAROOQ AMIN, PhD, MPH, Consultant
JOHN BERNOT, Senior Director
KATHRYN BUCHANAN, Project Manager
KAREN JOHNSON, MS, Senior Director, Performance Measures
MELISSA MARINELARENA, Senior Director
KATE McQUESTON, Project Manager
ELISA MUNTHALI, MPH, Acting Senior Vice President, Quality Measurement
YETUNDE OGUNGBEMI, Project Analyst
ERIN O'ROURKE, Senior Director
JEAN-LUC TILLY, Senior Project Manager, Data Analytics

ALSO PRESENT:
BRUCE BAGLEY, MD, Clinician Workgroup Co-Chair*
ROSE DO, MD, Acumen*
GERRI LAMB, PhD, RN, FAAN, PAC/LTC Workgroup Co-Chair*
AMY MOYER, Clinician Workgroup Co-Chair*
PAUL MULHAUSEN, MD, FACP, PAC/LTC Workgroup Co-Chair*
SRI NAGAVARAPU, PhD, Acumen*
COLLETTE PITZEN, RN, MSN, Minnesota Community Measurement*
JESSE ROACH, MD, Centers for Medicare and Medicaid Services (CMS)
KORYN RUBIN, American Medical Association
STEPHANIE GLIER, MPH, Pacific Business Group on Health*
CRISTIE TRAVIS, Hospital Workgroup Co-Chair*
RON WALTERS, MD, MBA, MHA, Hospital Workgroup Co-Chair*
PIERRE YONG, MD, MPH, MS, Centers for Medicare and Medicaid Services (CMS)

* present by teleconference

C-O-N-T-E-N-T-S

Page

Introductions, Disclosures
of Interest, Review of Meeting
Objectives 5

Welcome Remarks. 22

MAP Pre-Rulemaking Approach. 30

Opportunity for Public Comment on
PAC/LTC Programs 70

Pre-Rulemaking Recommendations for
PAC/LTC Programs 71

Opportunity for Public Comment on

Clinician Programs 169

Pre-Rulemaking Recommendations for

Clinician Programs 179

Opportunity for Public Comment on

Hospital Programs. 358

Pre-Rulemaking Recommendations for

Hospital Programs. 359

Adjourn. 406

1 P-R-O-C-E-E-D-I-N-G-S
2 9:16 a.m.
3 CO-CHAIR KAHN: It is the witching
4 hour. It's 9:15, so we're going to start, so if
5 everybody would take a seat and Harold and I will
6 take off here as our chairs today.
7 And I want to thank everybody for
8 coming and thank everyone for all the time and
9 effort that you put in, both on the Coordinating
10 Committee and some of you were on the workgroups,
11 or work with the workgroups, and thank you for
12 your time and effort there.
13 It's what makes NQF and our process
14 work, and also thank you to the CMS people for
15 allowing us to work with you on these really
16 important issues.
17 I think I should give it to you then,
18 and then I do the objectives. Do you have
19 anything to say?
20 CO-CHAIR PINCUS: Just I totally agree
21 with everything Chip says.
22 CO-CHAIR KAHN: Okay, so I'll review

1 the objectives today. So, our primary objective
2 is to finalize our recommendations to HHS on the
3 measures for use in Federal programs for
4 clinician, hospital, post-acute long-term care
5 settings.
6 We're also going to consider strategic
7 issues that span across the MAP workgroups and
8 discuss potential improvements to the way we
9 interact with the pre-rulemaking process.
10 I know that we had a lot of
11 discussions on the phone about the different
12 categories.
13 And I know from one of the workgroups
14 there were process issues regarding -- it seems
15 like it's a proverbial -- I mean it's the
16 constant discussion in my experience with NQF as
17 to what is a consensus?
18 So, we'll probably have some
19 discussion about that. I guess one man's
20 consensus is not another person's consensus -- or
21 I should say persons, persons.
22 So, with that, I guess I'll turn it

1 over to Elisa to conduct the questions about our
2 disclosures of interest, which we'll need to
3 review before we begin.
4 MS. O'ROURKE: I actually just want to
5 make a few housekeeping announcements before
6 turning it to Elisa.
7 If you're having any trouble accessing
8 materials from the NQF website, we do have a
9 public SharePoint site with all of the materials
10 for today's meeting at public.qualityforum.org.
11 You'll see a little folder for MAP and
12 then MAP Coordinating Committee. So, any
13 materials you might need you can access that way.
14 And for anyone on the phone, if you're
15 having trouble getting an open line, please just
16 let us know through the webchat, or email the MAP
17 Coordinating Committee at qualityforum.org email,
18 and we will work with our operator to get your
19 line open.
20 So, please let us know if you're
21 having any trouble speaking. I think, otherwise,
22 I can turn it to Elisa to take you through

1 disclosures.
2 MS. MUNTHALI: Great, thank you, Erin,
3 and welcome, everyone.
4 Good morning, my name is Elisa
5 Munthali, and I'm the Senior Vice President for
6 Quality Measurement at the National Quality
7 Forum.
8 So, I welcome you and thank you so
9 much for serving on this Committee.
10 We're going to combine the disclosures
11 of interest with introductions, and we're going
12 to do this in two parts because there are two
13 types of members on this Committee. There are
14 organizational representatives and there are also
15 subject-matter experts. And so we'll start with
16 the organizational members.
17 Organizational members represent a
18 particular organization perspective, and we
19 expect you to come to the table sharing those
20 views. Because of your status as an
21 organizational member, we asked you just one
22 question about you as an individual.

1 We asked you if you had an interest of
2 $10,000 or more in an entity that is related to
3 the work that's in front of you. And so how
4 we're going to do this today is go around the
5 table. First, we'll start off with the
6 organizational members.
7 It's a little easier today because we
8 only have three subject-matter experts. Those
9 are Harold and Chip and Rich Antonelli, who's on
10 the phone.
11 And so we'll start with our
12 organizational members. Sorry, Chip was trying
13 to figure out: how did he become a subject-matter
14 expert?
15 (Laughter.)
16 MS. MUNTHALI: So, we're going to
17 start with all the organizational members.
18 We're going to go clockwise, so to my
19 left, in the room first, then we'll go to the
20 folks on the phone that are organizational
21 members, then go to our subject-matter experts,
22 and then welcome our federal partners.

1 And so I think, David, you might be
2 the first organizational member here?
3 MR. INTROCASO: So, I'm going to just
4 introduce myself, David Introcaso, AMGA, and I
5 have no conflicts.
6 MS. MUNTHALI: Perfect, just like
7 that.
8 MR. KRAMER: I'm Bill Kramer,
9 representing Pacific Business Group on Health.
10 No conflicts to report.
11 MS. MULLINS: Amy Mullins, American
12 Academy of Family Physicians. No conflicts.
13 MR. BAKER: I'm Joe Baker,
14 representing the Medicare Rights Center, and I
15 have no conflicts.
16 MR. HALL: Bruce Hall, representing
17 the American College of Surgeons.
18 Other than income from American
19 College of Surgeons and my healthcare hospital
20 chain, BJC Healthcare, I have no conflicts of
21 interest.
22 MS. HUNT: Gail Hunt, representing the

1 National Alliance for Caregiving, and no
2 conflicts of interest.
3 MR. BOTT: John Bott with Consumer
4 Reports, and no conflicts of interest.
5 MR. QUERAM: Morning, I'm Chris
6 Queram, representing the Network for Regional
7 Healthcare Improvement. No conflicts.
8 MR. O'BRIEN: Shaun O'Brien,
9 representing the AFL-CIO. No conflicts.
10 MS. BINDER: Leah Binder from the
11 Leapfrog Group. No conflicts.
12 MR. ROBINSON: Good morning, Derek
13 Robinson, Healthcare Service Corporation. No
14 conflicts.
15 MR. GIFFORD: David Gifford
16 representing the American Healthcare Association.
17 I am extremely conflicted. I actually have to
18 recuse myself on one of the discussions today for
19 a measure steward of a measure coming forward to
20 you all.
21 Second, if there's any discussion of
22 Medicaid-related measures, I have a family member

1 involved in Medicaid so I have to recuse myself
2 personally, but I have my alternate who would
3 step in in that case.
4 And then all my retirement accounts
5 are in 401Ks, I have no idea what they're
6 invested in, but I know some are in healthcare so
7 I'm sure there's some conflicts there.
8 MS. ELLIOTT: Good morning, I'm Tricia
9 Elliott, representing the Joint Commission, and I
10 have no conflicts.
11 MR. SIRIO: Hi, good morning, Carl
12 Sirio, American Medical Association. No
13 conflicts.
14 MS. SCHLAIFER: Marissa Schlaifer,
15 representing the Academy of Managed Care
16 Pharmacy, and as a formal CVS Health employee, I
17 have CVS Health stock.
18 MR. DAVDA: Raj Davda, I'm employed by
19 Cigna Healthcare. I'm representing AHIP. I have
20 no conflicts.
21 MS. LA CROIX: Rachel La Croix, and
22 I'm representing the National Association of

1 Medicaid Directors, and I have no conflicts.
2 MR. QASEEM: Amir Qaseem, American
3 College of Physicians. I mean, you have my
4 disclosures. You guys need to decide if I have
5 conflicts or not. I think it should be the other
6 way around.
7 (Laughter.)
8 MS. MACKAY: Erin Mackay, representing
9 the National Partnership for Women and Families.
10 I have no conflicts.
11 MS. MUNTHALI: Thank you to all of our
12 organizational members in the room. So, now
13 we'll go to the phone and I'll call your name out
14 as it appears on the roster.
15 So, do we have a representative from
16 the American Board of Medical Specialties?
17 MS. IRONS: Yes, this is Mira Irons.
18 I'm representing the American Board of Medical
19 Specialties, and I'm an employee of ABMS, but no
20 conflicts otherwise.
21 MS. MUNTHALI: Thank you, Mira. Do we
22 have a representative from Blessing Health

1 System? Maureen, by any chance are you on the
2 phone? Okay, we'll come back to that.
3 Rich, are you on the phone? But
4 you're an SME, so we'll skip you for now.
5 And finally, the National Business
6 Group on Health?
7 MR. WOJCIK: Yes, hi, this is Steve
8 Wojcik, representing National Business Group on
9 Health. No conflicts.
10 MS. MUNTHALI: Great, thank you so
11 much. And so now we'll go to our subject-matter
12 experts.
13 And for everyone who's a subject-
14 matter expert -- it's your co-chairs and Rich,
15 who's on the phone -- you received a lengthier
16 Disclosure of Interest form.
17 And in that form, we asked you to
18 supply us with all of the professional activities
19 that were relevant to the work in front of you.
20 So, we don't want you to recite your
21 resumes, but what we want you to do is let us
22 know if there is anything that you think is

1 important or relevant to the work of the
2 Coordinating Committee.
3 Just a couple of reminders, you sit on
4 this group as an individual. You do not
5 represent your employer or anybody who may have
6 nominated you for the Committee.
7 We're also interested in disclosures
8 of interest that are paid and unpaid, so things
9 that you may have volunteered for, like this
10 Committee.
11 Serving on the Committee would be an
12 example of that, and we wanted to remind you that
13 just because you disclose does not mean you have
14 a conflict of interest.
15 We do this in the spirit of
16 transparency and openness. And so I'll start off
17 with Chip?
18 CO-CHAIR KAHN: Well, I work at the
19 Federation of American Hospitals, and so on other
20 issues, I represent hospitals.
21 So, I guess that, in a sense, is the
22 major area. Other than that, I don't think

1 there's anything significant.
2 MR. PINCUS: Hi, Harold Pincus, I also
3 am employed by Columbia University and also the
4 New York Presbyterian Hospital.
5 I'm also an adjunct staff at RAND, a
6 consultant for Mathematica, I'm on the American
7 Psychiatric Associations Quality Counsel, and
8 also I'm on the NCQA Behavioral Health Advisory
9 Committee.
10 MS. MUNTHALI: Thank you both. And so
11 we'll go to the phone to Rich Antonelli? Rich,
12 are you on the phone? Okay, he may have not
13 joined us yet.
14 So, thank you so much for disclosing
15 your conflicts of interest. We're going to now
16 ask our federal partners to introduce themselves.
17 So, we'll start with Kate?
18 MS. GOODRICH: Hi, everyone, Kate
19 Goodrich, Centers for Medicare and Medicaid
20 Services.
21 I'm Chief Medical Officer and Director
22 of the Center for Clinical Standards and Quality.

1 I will just disclose that I am a
2 member of the NCQA Committee on performance
3 measurement. I don't think that's a conflict but
4 I will disclose it.
5 In other ways, I have no disclosures.
6 MR. YONG: Hi, Pierre Yong, CMS as
7 well; I work with Kate. And no disclosures,
8 thank you.
9 MS. MUNTHALI: Great, do we have any
10 other Federal Liaisons in the room?
11 MR. ANTHONY: Rob Anthony,
12 representing the Office of the National
13 Coordinator for Health Information Technology.
14 I have nothing to disclose.
15 MS. MUNTHALI: Thank you very much.
16 And so before I leave or we leave this
17 session, I just wanted to remind you if you have
18 a conflict or you remember something in the
19 middle of the meeting, please speak up.
20 You can do so in real time or you can
21 come to any one of your chairs or approach the
22 NQF staff, or you can go directly to the staff.

1 Likewise, if you feel that any one of
2 your colleagues has a conflict or is acting in a
3 biased manner, we want you to speak up as well.
4 And you can approach the co-chairs or any of the
5 staff.
6 So, after hearing the conflicts of
7 interest that have been disclosed, do you have
8 any questions of me or of your colleagues?
9 It doesn't sound like it, so thank you
10 very much.
11 Okay, Maureen, are you on the phone
12 now?
13 MEMBER KAHN: Yes, I am. When you
14 called me, somehow I was disconnected.
15 MS. MUNTHALI: Oh, sorry about that.
16 MEMBER KAHN: So, I'm back. Not a
17 problem, but I'm back, and I have no conflicts.
18 MS. MUNTHALI: Great, thank you. And
19 just a reminder, Maureen is an organizational
20 rep. So, thank you, everyone.
21 CO-CHAIR KAHN: Boy, I was so caught
22 up in disclosures.

1 Okay, the NQF staff and MAP workgroup
2 co-chairs will outline the measures and the
3 programs evaluated by the workgroups.
4 That's going to be our task over
5 today, including the top strategic issues that
6 emerged from the year's pre-rulemaking meetings.
7 The MAP co-chairs will identify the
8 pre-pulled measures, and ask the Coordinating
9 Committee members if there are any additional
10 individual measures that they need to be pulled
11 for discussion before ratification of the
12 workgroup recommendation.
13 So, we'll be able to cover every
14 measure that anyone has an issue or question or
15 problem with. And we'll emphasize that the
16 workgroups are populated with experts relevant to
17 their care settings, and that the Coordinating
18 Committee should express a strong preference for
19 the workgroups' initial recommendations, which we
20 generally have in the past and I assume would do
21 today.
22 If a Coordinating Committee member

1 would like to pull a measure for discussion, they
2 must clearly identify which part of the workgroup
3 recommendation they have disagreement with to
4 begin discussion.
5 And I think the word "disagreement" --
6 I think we can just use the word "issue", or
7 "question", because there are really a number of,
8 there are an array of, recommendations from the
9 workgroups for these measures. All other
10 measures will be considered ratified by the MAP.
11 So, we're obviously focusing on
12 measures of disagreement or question, but as I
13 said, I don't think people should be shy about
14 bringing up a measure, even if they don't have a
15 disagreement but they have a question.
16 Because this is an important process.
17 Obviously, CMS is here and will listen to the
18 discussion or answer questions for us.
19 And part of this, I think, is
20 clarifying, as well as potentially correcting or
21 changing or revising.
22 CO-CHAIR PINCUS: Let me just add one

1 thing. We had a discussion about this earlier.
2 The term "pull" has sometimes confused people.
3 And in some ways there's two types of
4 pull. If you're pulling because you disagree
5 with it and you actually want to have a vote on
6 it, let us know that's your intent.
7 On the other hand, if you just have a
8 question about it, you don't need to pull it and
9 have us re-vote.
10 So, it would be important to
11 distinguish between, if you do want to bring a
12 measure up for discussion, whether you really
13 are intending for it to be a re-vote, or actually
14 a vote, that would be outside of the consent
15 calendar, versus just wanting to clarify
16 something.
17 CO-CHAIR KAHN: Yes, I think this is
18 important. Clearly, we -- I don't remember
19 whether at the beginning we did, because I've
20 been on the Coordinating Committee the whole
21 time, whether we at one point actually went
22 through everything.

1 We couldn't. It was hard then, now we
2 just can't go through everything. So, obviously,
3 we're going to focus on the issues that you want
4 us to focus on. But I'll just repeat: pulled
5 measures will be discussed and/or voted on.
6 So, Harold, I'll pass it on to you?
7 CO-CHAIR PINCUS: So, anyways, I'll
8 just say if you do want to pull something, quote,
9 pull, let us know what's your intent.
10 CO-CHAIR KAHN: So, now you introduce
11 --
12 CO-CHAIR PINCUS: Oh, of course. So,
13 we have here Kate Goodrich, who really is
14 somebody who's really taken the lead from CMS for
15 putting all of this together, and putting
16 together the MUC list.
17 And, Kate, will you sort of bring us
18 up to date?
19 MEMBER GOODRICH: Absolutely, I don't
20 think I'll take the full 15 minutes allotted to
21 me on the agenda.
22 So, first, just want to say very, very

1 good to be here with you guys. I look around the
2 room, and I've known many of you for the last six
3 or seven years -- mostly seeing you in this room
4 or in the old building.
5 And it's always really fun to be here
6 this time of year to be talking about our
7 measurement programs and the measures that we put
8 in front of the Committees.
9 So, just very excited to be here and
10 talk about the measures today.
11 I do want to emphasize -- especially
12 for folks who are maybe new to the MAP Committee
13 or haven't been on the Committee as long -- I
14 want to just really be sure that I say and
15 emphasize the importance of this work to CMS.
16 This is the sixth or seventh year
17 we've been doing this. We definitely had some
18 fits and starts the first couple of years, as we
19 were learning together about how to do this well
20 and what it all meant, and how we use the input.
21 It is now an integral part of our work
22 that, for us, is every bit as important as the

1 rest of the measure development and
2 implementation lifecycle, including putting
3 measures out for public comment.
4 Your input to us in getting that
5 multi-stakeholder input on measures for our
6 programs is as important as it has ever been.
7 This year, if you have been on the
8 Committees in the past or have been following
9 along with the work of the MAP over the past
10 seven years, you will see that there are fewer
11 measures on the list that went forward to the
12 three Committees this year than ever before.
13 And there's a couple of reasons for
14 that. I think you were harkening back, Chip, to
15 the days when we had, I forget, it was like 500?
16 I don't know; I've probably inflated
17 it in my mind.
18 CO-CHAIR PINCUS: It was like 300.
19 MEMBER GOODRICH: But there was one
20 year where we literally had multiple hundreds of
21 measures, which is just insane. There were
22 reasons for that, but we are past that time.

1 But the reason you see fewer this year
2 is really two main reasons, I would say. The
3 first really just has to do with where we at CMS
4 are in our measure-development lifecycle.
5 So, a lot of measures that came up
6 over the last two or three years were a result of
7 multi-year contracts we had to develop measures.
8 So, we always knew that over time, as
9 our measures kind of went through the review
10 process, there would come a time where we'd have
11 fewer, just by the nature of the lifecycles that
12 we have in our contracting cycles for measure
13 development. So, that's one reason.
14 But, really, the main reason that you
15 were seeing fewer measures this year -- and this
16 credit goes entirely to the person to my left,
17 Dr. Yong -- is because Pierre and his team really
18 thought hard about the experiences that we and
19 you have had with this process over the last
20 several years, the kinds of measures we brought
21 forward, at sort of varying times in their
22 lifecycles, and really what the MAP needed to be

1 able to make a robust, informed recommendation
2 for CMS.
3 And also, with the development of the
4 Meaningful Measures Framework that I'm sure you
5 all have heard us talk about a number of times,
6 and I know Pierre presented on a webinar to this
7 Committee last year, we really, very genuinely
8 looked at every single measure through that lens.
9 And also said, you know, it's got to
10 be far enough along that the Committee can truly
11 have enough information to be able to weigh in on
12 this measure in a meaningful way.
13 And that actually led to a significant
14 number of measures not going on the list this
15 year, in great part because a lot of them just
16 weren't ready.
17 We may see a number of those come
18 through next year as their development continues.
19 But we felt like we tried -- I think
20 we experimented over the last couple of years
21 with bringing measures forward that maybe weren't
22 as far along, to get input from the MAP as to

1 whether or not that measure was in the right
2 direction for us.
3 But what we found, I think, was that
4 people just felt like they just didn't have
5 enough information, and so we decided to sort of
6 step back and take a little bit of a different
7 approach.
8 I also want to acknowledge that,
9 obviously, this is the first MAP meeting in a new
10 administration with some new priorities.
11 And so CMS remains very committed to
12 the move to paying for value, and as we do that
13 with the new administration, we do have some new
14 priorities.
15 And that is very reflected in the
16 Meaningful Measures Framework, where our
17 direction has been to really focus on the areas
18 of quality of care that really matter the most.
19 Which really does mean not only, I
20 think, honing the measures within each program,
21 but for our own measure development, the signals
22 we give to other measure-developers and other

1 agencies about where we think are the things that
2 we really should be measuring.
3 So, for our ongoing and future
4 development, it's really focusing on those key
5 areas.
6 Another big initiative that many of
7 you have been involved with or at least heard us
8 talk a lot about is our Patients Over Paperwork
9 initiative, which is really around reducing the
10 burden on a variety of fronts, certainly not just
11 related to quality measurement, but the burden of
12 actually the work that's required to report on
13 quality measures.
14 And that is with a recognition that
15 for the really important areas that are part of
16 meaningful measures, sometimes it's worth some of
17 that burden to collect data if it's on a measure
18 that actually can help drive improved patient
19 outcomes.
20 So, we think about Patients Over
21 Paperwork as burden reduction in the service of
22 patient safety, better patient outcomes, and

1 program integrity.
2 So, it's been actually, for me
3 personally, a tremendous opportunity to sit back
4 and take another look at everything that we are
5 doing across the board, and making sure that what
6 we are asking of clinicians and providers at
7 facility types and dialysis facilities and so
8 forth is that it really is going to drive
9 improvement for patients.
10 So, I think that when you look at the
11 list of measures, a number that are being brought
12 here today, but if you look at the whole list
13 that came forward to all three committees, you
14 will see that that is reflected in the list that
15 came forward.
16 And so finally, the last thing I just
17 want to say, since I have the mic, is just to
18 thank the CMS staff, Pierre and his team, for the
19 incredible amount of work that goes into
20 preparing for these series of meetings, and the
21 thoughtfulness with which the staff undertook
22 preparing the Measures Under Consideration list

1 this year.
2 And then finally, I want to thank the
3 NQF staff, because as usual, you guys have done a
4 spectacular job at getting everybody ready.
5 The thoughtfulness that you all
6 provide into this process, working
7 collaboratively with our team, always through the
8 spirit of continuous improvement, as we will talk
9 about tomorrow more, is very, very much
10 appreciated by me personally and by the
11 administration.
12 So, thank you so much.
13 CO-CHAIR KAHN: Kate, you're going to
14 walk us through the process?
15 MS. BUCHANAN: I am. So, let me just
16 pull up the slides, one moment. Hi, everyone, my
17 name is Kate Buchanan.
18 I'm a Senior Project Manager here
19 working with the Coordinating Committee. So, we
20 wanted to take a couple minutes and review the
21 MAP pre-rulemaking approach. So, the approach to
22 the analysis and selection of measures is a

1 three-step process.
2 The first is to provide a program
3 overview, the second is to review current
4 measures within the programs, and the third is to
5 evaluate the Measures Under Consideration -- also
6 known as MUCs -- for what they would add to the
7 program measure set.
8 MAP workgroups must reach a decision
9 about every measure under consideration, and as
10 you all know, the MAP workgroups met in December
11 of this year -- or last year, December 2017 -- to
12 review the current MUCs.
13 The decision categories are
14 standardized for consistency across measures and
15 programs, and each decision was provided with one
16 or more statements of rationale.
17 To facilitate MAP's consent calendar
18 voting process, NQF staff working with the
19 workgroups conducted a preliminary analysis of
20 each measure under consideration. The
21 preliminary analysis is intended to provide MAP
22 members with a succinct profile of each measure,

1 and to serve as a starting point for MAP
2 discussions.
3 Staff used an algorithm developed by
4 the MAP measure-selection criteria to evaluate
5 each measure. The preliminary analysis algorithm
6 uses a series of criteria to determine if a
7 measure receives a recommendation of support for
8 rulemaking, conditional support for rulemaking,
9 refine and resubmit prior to rulemaking, or a do-
10 not-support designation.
11 And here on this slide, you can see
12 the MAP measure-selection criteria, and the
13 measure-selection criteria are intended to assist
14 the MAP with identifying characteristics that are
15 associated with ideal measure sets used for
16 public reporting and payment programs.
17 It's important to note that the
18 measure-selection criteria are not absolute
19 rules. Rather, they are meant to provide general
20 guidance on measure-selection decisions and to
21 complement program-specific statutory and
22 regulatory requirements.

1 The central focus should be on the
2 selection of high-quality measures that optimally
3 address the national quality strategy's three
4 aims, fill critical measurement gaps, and
5 increase alignment.
6 Although competing priorities often
7 need to be weighed against one another, the
8 measure-selection criteria can be used as a
9 reference when evaluating the relative strengths
10 and weaknesses of a program measure set, and how
11 the addition of an individual measure would
12 contribute to the set.
13 As discussed previously, there are
14 four voting decision categories. They are:
15 support for rulemaking, conditional support for
16 rulemaking, refine and resubmit prior to
17 rulemaking, and do-not-support for rulemaking.
18 The MAP may support a measure for
19 rulemaking for a number of reasons, including
20 that it may address a previously-identified gap
21 in a program or help to promote alignment.
22 The MAP may conditionally support a

1 measure if the group thinks it is ready for
2 rulemaking but needs NQF endorsement.
3 And the refine and resubmit, which the
4 MAP implemented to allow a way to express its
5 support for the concept of a measure, but to
6 stipulate that it needs modifications, such as
7 testing before implementation.
8 The MAP may not support a measure for
9 rulemaking if it overlaps with existing measures,
10 or if a different measure better addresses the
11 needs of a program.
12 During the Fall 2017 workgroup
13 meetings, workgroup members raised concerns about
14 the refine and resubmit category.
15 You all, as the Coordinating
16 Committee, created this category with the thought
17 that MUCs receiving this designation will be
18 brought back to the MAP before implementation.
19 But it is important to note that the
20 HHS Secretary has statutory authority to propose
21 measures after considering MAP's recommendations.
22 And tomorrow the Coordinating

1 Committee will review this decision category and
2 decide if they would recommend changes for the
3 upcoming cycles.
4 CO-CHAIR PINCUS: But it's important
5 to note that for this process today, we're going
6 to go with the current way which it's been
7 interpreted in the state.
8 MS. BUCHANAN: Yes, thank you. That's
9 very important.
10 And so we thought that it would be
11 helpful as a reminder to review the guidance that
12 you as the Coordinating Committee made during
13 your November 30th, 2017 meeting in reaction to
14 the concerns raised.
15 And you all reiterated the intent of
16 the decision was to support the concept of a
17 measure but recognize a potentially significant
18 issue that should be addressed.
19 The Committee suggested that this
20 category be used judiciously -- for example, when
21 a measure needs a substantive change. And the
22 Committee also noted the need for workgroups to

1 clarify the suggested refinements to the
2 measures.
3 So, with that, we will now discussion
4 the voting instructions.
5 CO-CHAIR KAHN: May I ask a question
6 before you do?
7 MS. BUCHANAN: Of course.
8 CO-CHAIR KAHN: In terms of the
9 recommendations from the staff, and I didn't
10 think about this until you were just reviewing
11 it, on the consent calendar of the
12 recommendations, how many do-not-supports came
13 out of the algorithm process?
14 MS. BUCHANAN: That is a very good
15 question. I don't know if I have the number off
16 the top of my head.
17 Erin, do you happen to know? Oh, we
18 need to turn one mic off.
19 CO-CHAIR KAHN: Were there any?
20 DR. AMIN: So, just a quick question,
21 are you asking what the staff preliminary
22 recommendations were before the workgroups met or

1 after the workgroups met?
2 CO-CHAIR KAHN: Before the workgroups,
3 because the algorithm is run on all the measures.
4 DR. AMIN: Right, that's true.
5 CO-CHAIR KAHN: And then put on the
6 consent calendar that the workgroup considers, if
7 I understand the process?
8 DR. AMIN: Yes, that's correct.
9 CO-CHAIR KAHN: So, what I'm asking
10 is, in terms of that algorithm, how many do-not-
11 supports, if any, were produced from the
12 algorithm process?
13 MS. O'ROURKE: I'm looking to John in
14 the background for some of the clinician
15 measures. I think there may have been one across
16 the algorithm. So, I think that's something we
17 can look at tomorrow.
18 Katie, if you go back to the slide
19 that had the decision categories, there's some
20 information here of how you end up,
21 algorithmically, into the do-not-support.
22 And it's generally when you fail one

1 of the first three assessments, or when a measure
2 fails one of the first three assessments.
3 And those right now really ask
4 questions about the importance of the measure and
5 if it's addressing a quality problem.
6 So, after that, we go into the other
7 three categories for the workgroup members on the
8 Coordinating Committee to consider if there's
9 specific issues with the measure they'd like
10 addressed.
11 So, to your point, with the algorithms
12 that currently stand, only a few do end up in
13 this do-not-support for rulemaking. But I think
14 that is something that would sit, maybe, on the
15 table for tomorrow.
16 CO-CHAIR KAHN: It may not be
17 possible, but I think for our discussion
18 tomorrow, it would be useful if it could be done
19 easily. If it can't be done easily, then don't
20 do it.
21 But if it can be done easily, if we
22 could get some array of just the number that fell

1 into each of the categories from the algorithmic
2 process, so we can just get a sense for what your
3 process -- now, of course, it's apples and
4 oranges between the different measures, but it'll
5 give us, I think, some sense and help that
6 discussion.
7 CO-CHAIR PINCUS: It would also,
8 actually, probably be a good idea if you're doing
9 that, to sort of do it as kind of a matrix.
10 So, have the second column of what
11 came out of the workgroups.
12 CO-CHAIR KAHN: Right, right, yes, I'm
13 sorry, I should have said that, too.
14 DR. AMIN: So, we can try to pull that
15 together. I think one of the things that I would
16 just quickly point out is that the inputs, the
17 number of the measures and the process that CMS
18 has used into the algorithm has also changed,
19 meaning the number of measures that are going
20 through the algorithm.
21 Meaning there's a lot more, in my
22 opinion, precision about what CMS is recommending

1 or even putting forward to the MAP has sort of
2 changed over the last years as well.
3 So, I just want to keep that in mind
4 as we think about and look at the context of how
5 the algorithm is working.
6 CO-CHAIR KAHN: Yes, I guess I'm just
7 looking at this slice in time, and the question
8 is what is -- and maybe the algorithm works fine.
9 And I think, actually, comparing it to what came
10 out of the discussion will just tell us
11 something, I'm not sure what, but I think it'll
12 give us some information, I think, that we can
13 then delve into when we look at the categories.
14 Because how it does it in the algorithm I think
15 tells us a lot about your thought processes.
16 Okay, thanks.
17 MS. BUCHANAN: Great. Thank you very
18 much. So, we will now review the voting
19 instructions.
20 MEMBER QASEEM: Can I ask a quick
21 question? Because I might have missed it. The
22 conditional support that we do, can you just

1 remind me what happens? Because I still was just
2 thinking about there were a lot of conditional
3 supports we approved last time around as well,
4 and I'm not sure the Committee ever hears back
5 what happened to what did CMS decide to do? Or
6 even if they agreed or didn't agree? Was there
7 any change?
8 I mean, I was trying to figure out if
9 there was going to be feedback. But if this is
10 not the right time to talk about it, maybe we can
11 talk about it later.
12 MS. O'ROURKE: Sure, so I think maybe
13 that's something we could also get some input on
14 the feedback loop for tomorrow.
15 At the workgroup's Fall web meeting,
16 we did implement a feedback process where CMS
17 brings back information about some of the
18 measures that were under consideration on prior
19 lists, and gives an update about where they are
20 in their development, how MAP's input has been
21 taken, which ones have gone in for endorsement.
22 It's not comprehensive, given,

1 essentially, the accumulation of measures since
2 the beginning of MUC makes it a little impossible
3 to go back over every MUC list.
4 But I think that might be something
5 you could also put on the table for tomorrow, to
6 find out what information would be most valuable
7 to you all but you'd like to see come back, and
8 then how we can collaborate with CMS, what NQF
9 can track internally and bring back to the
10 workgroups.
11 MEMBER QASEEM: Yes, so what I'm
12 looking for is very simple because I know
13 everyone is busy and no one will have time to go
14 through it.
15 So, we have let's say 30 measures this
16 time and there's going to be two columns where we
17 say MAP said that this is conditional support
18 only, and whether it was agreed by CMS or not.
19 Just check yes or check no so we can
20 start getting a feel for percentage of measures
21 we are saying are conditional, and what percent
22 of them are being changed or not being changed by

1 CMS.

2 So, we can start having that kind of
3 discussion. Because at this point in time at
4 least, I have no feel for what's going on.

5 We make these recommendations, I do
6 know what happens of course, but it'll be more
7 transparency, bringing transparency to the
8 process, so we can start figuring out that the
9 work we are doing, a lot of us are spending a lot
10 of time.

11 It's a very important group. But the
12 time and effort we spend, what happens to that
13 time and effort?

14 MS. O'ROURKE: Okay, so just to make
15 sure I'm understanding what you're saying, going
16 through the rules for the previous year and just
17 tracking which measures ended up being proposed
18 and finalized, and if not supported or did-not-
19 support.

20 CO-CHAIR PINCUS: Kate, and then Carl,
21 and then Marissa.

22 MEMBER GOODRICH: Sorry, just to

1 respond to that, so I agree that's helpful; we
2 actually did used to do this in MAP, where the
3 next year, we would do exactly --
4 CO-CHAIR PINCUS: Yes, but usually
5 it's before the MUC list gets presented. Usually
6 it's in the earlier meeting.
7 MEMBER GOODRICH: I don't remember.
8 You guys would remember better than I. So, I
9 think that's a great idea.
10 We should definitely do that, and then
11 as Erin said, we have committed to the feedback
12 loop and to figuring out the best way to do that.
13 So, we've started some of that this
14 year; I want to build on that. So, I think what
15 you're talking about is actually not that hard
16 to do and would be helpful.
17 CO-CHAIR PINCUS: Carl and then
18 Marissa?
19 MEMBER SIRIO: Yes, I was going to
20 make a similar point, and I just want to put a
21 little bit sharper of a finality to it, which is
22 I do think we need to spend some considerable

1 time tomorrow.

2 I was reminded this morning that,

3 ultimately, our recommendations are just that,

4 they're recommendations, and CMS can do as it

5 sees fit.

6 So, it seemed to me that for,

7 actually, all three of the categories under

8 support -- so conditional, refined, and do-not-

9 support -- we not only need some kind of feedback

10 loop, but some way to, in fact, re-look at the

11 measure potentially the following year to have a

12 dialog with respect to a decision that may have

13 been contrary to something we recommended, one,

14 to understand what CMS is doing and why, and two,

15 potentially to persuade you of the fact that

16 there may be an alternative way to look at a

17 measure.

18 And in addition, it would seem to me,

19 to the point, we spend a lot of time with a

20 process where the ball has moved over time, which

21 is fine, as we evolve this.

22 But it seems to me that in the process

1 over the last year or two, we've lost a bit of
2 that feedback that at least gives me comfort
3 that, in fact, the input is adhered to, given the
4 thought and the work that goes into it.
5 So, I would ask Chip and Harold that
6 tomorrow, when we have the process discussion,
7 that we spend a fair amount of time thinking
8 about how we will revise this process in a way
9 that at least makes some of us feel a little
10 closer to the end result, as opposed to what,
11 really, can be viewed as an intermediate step,
12 which is we make the recommendations and stuff
13 happens, and then it is what it is.
14 CO-CHAIR PINCUS: Yes, I think that's
15 an excellent idea to get more of the sense of the
16 flow of decisionmaking that occurs.
17 And I think also, tomorrow we're going
18 to have some discussion also about issues around
19 the removal of measures.
20 So, Marissa?
21 MEMBER SCHLAIFER: Not just to create
22 extra work, but probably to create extra work,

1 rather than just doing a list of the
2 recommendations where we had conditional support
3 and then whether or not they went forward, I
4 think it would be important, just because
5 sometimes the conditions do get met, that what
6 the condition was and whether that got met.
7 Because otherwise it might not be as meaningful.
8 MEMBER GIFFORD: Yes, I think it's
9 been an evolution of this process, but I think
10 it's become clear that, you know, as everyone's
11 realizing, none of our recommendations are
12 binding to the Secretary.
13 But what is binding is the comments we
14 make have to be addressed in rules. And I think
15 we have put way too much emphasis on the vote and
16 not on what our comments are. Because that's
17 where there's binding aspect on the Secretary,
18 and there's also a real tension often here,
19 because CMS is in a position where Congress has
20 mandated they do something, and Congress has also
21 mandated that they get recommendations from us on
22 it, and there's often a conflict there.

1 And so CMS has to figure out all that,
2 and so their comments often might be we accept it
3 but we have to move forward because Congress has
4 said we have to do something. And we've seen
5 that a number of times here.
6 And I think there's always been --
7 sometimes a misperception that our
8 recommendations and vote is somehow binding to
9 CMS, and it's clearly not.
10 And I think we've seen that as
11 Congress has been more aggressive with
12 measurement development.
13 So, in tomorrow's discussion, I think
14 it would be helpful to talk about not just the
15 vote or reaching a consensus, but it's more
16 almost the recommendations.
17 In many ways, it doesn't even really
18 matter what the vote is, it's more the
19 recommendations.
20 CO-CHAIR PINCUS: That's something
21 that Kate and her colleagues at CMS have really
22 emphasized all the way through, that a discussion

1 is at least as important, if not more important,
2 than the actual voting.
3 MS. BUCHANAN: Okay, wonderful; thank
4 you. And so we'll now review the voting
5 instructions.
6 So, here we have several key voting
7 principles. So, the MAP has to establish a
8 consensus of greater than 60 percent for a motion
9 to pass.
10 And importantly, abstentions do not
11 count into the denominator, but if you are
12 abstaining from a vote, we ask that you let us
13 know so that helps us.
14 CO-CHAIR KAHN: Can I ask a question
15 here?
16 MS. BUCHANAN: Yes.
17 CO-CHAIR KAHN: I can't remember.
18 This rule, I guess, we approved, but is that a
19 MAP rule or is that a broader rule in terms of
20 the way the 60 percent is treated?
21 MS. BUCHANAN: So, I think Erin can --
22 MS. O'ROURKE: Sure, so when we

1 brought 60 percent to the Coordinating Committee
2 to approve, it actually ties back across NQF and
3 we use 60 percent in the endorsement work.
4 And correct me if I'm wrong, I believe
5 that come out of our consensus taskforces that we
6 did on the CDP side, and then we adopted it on
7 the MAP side.
8 CO-CHAIR KAHN: Now, on the MAP side,
9 do we have the power, considering what you just
10 described, when we consider this tomorrow to say
11 60 or greater rather than greater than 60? Or is
12 that not even within our power because of the
13 broad rule in NQF?
14 MS. O'ROURKE: I think we'd certainly
15 be interested in your feedback and input, and
16 then maybe seeing how that would work across NQF.
17 I think the balance of ensuring that
18 the MAP is comfortable with your process, but
19 also that it's easier understandable to everyone.
20 And it's confusing to have one standard for CDP
21 and another for MAP.
22 So, I think if we could just get the

1 feedback on the table, and then I'll iterate with
2 everyone in the fall for what works for next year
3 and how to best operationalize a definition of
4 consensus across NQF.
5 MEMBER KRAMER: I might be able to
6 offer some context on this since I was part of
7 the NQF insights development process work that
8 was done several years ago, which has evolved to
9 this.
10 This actually is expressed as a voting
11 rule and it was developed as part of a consensus-
12 development process. And in fact, the 60 percent
13 was not intended to be a voting decision rule
14 either in NQF's decisionmaking process or in
15 MAP's.
16 What was intended was, in both NQF's
17 decision-making and MAP's decisionmaking, was
18 intended to be a consensus process, which is not
19 based on voting. And the 60 percent was used as
20 an intermediate process.
21 After some discussion, if there did
22 not appear to be broad agreement or consensus,

1 there would be a straw vote in which they said,
2 okay, let's just do a straw vote and see how we
3 feel.
4 If it didn't reach a 60 percent
5 threshold, something like we need to have more
6 discussion here to try to reach consensus. It
7 was not intended to be the end-point in the
8 decisionmaking process.
9 Now, I think that's a complicated
10 process, it takes longer, it's not as efficient,
11 and it's not as easy to explain.
12 But I think we've in some ways
13 devolved to a more simplistic voting rule, which
14 is basically a super-majority vote.
15 And if that's how it's been applied in
16 a number of NQF Committees and in MAP, I think a
17 lively discussion tomorrow, a worthwhile
18 discussion, would be: How do we actually want to
19 use this going forward?
20 I, both to my personal preference and
21 I think principles of how NQF and MAP are
22 supposed to work, and the historical context of

1 how this came about, would lead us back to a more
2 robust consensus development process, which might
3 use straw voting along the way, but not dumb it
4 down to a super-majority of 60 percent voting as
5 the way we make all our decisions.
6 CO-CHAIR KAHN: We'll have this
7 discussion tomorrow. I would say I think people
8 should think about it overnight because on the
9 one hand, I totally understand, I mean I
10 understand now better the history of this, and I
11 understand why this is a consensus group.
12 On the other hand, the trouble is
13 consensus takes a lot of skill as well as a will,
14 and the trouble is on some of these matters --
15 and potential for agreement -- and on some of
16 these matters, it doesn't exist or you've got
17 taskforces with a lot of work to do.
18 And they don't necessarily have the
19 right makeup of leadership, frankly, to figure
20 out how to get everybody on the same wavelength.
21 So, I think tomorrow we need to
22 discuss from a process standpoint, and maybe we

1 come up with a hybrid.
2 Because I think that one of the
3 problems we have is that these processes, even
4 when there's 60 percent, we don't want to come
5 out of it with dissidence rather than consensus.
6 And I think we have some dissidence
7 from the process we had, and so we've got to
8 figure something out, at least for MAP. But
9 that's for tomorrow.
10 MS. BUCHANAN: Excellent. So, for
11 right now, we have greater than 60 percent, which
12 is what we'll be implementing today and did want
13 to ask if people are abstaining from votes to
14 please let us know. This will help us calculate
15 the scores.
16 And a couple of the other principles
17 are that every measure under consideration
18 receives a decision either individually or as
19 part of a consent calendar.
20 And in their December in-person
21 meetings, the workgroups had to reach a decision
22 on each measure under consideration. There were

1 no split decisions allowed.
2 This is a process issue that the CC
3 can discuss tomorrow if it's something they want
4 to explore further for future cycles.
5 Continuing on, how we will run today
6 is that staff will provide an overview of the
7 process for establishing consensus at the start
8 of each in-person meeting, which is what I'm
9 doing right now.
10 And then staff from our workgroups, as
11 well as the workgroup co-chairs who provide an
12 overview of their discussions and decisions, and
13 then the MAP CC can begin identifying measures
14 for either further discussion or measures they
15 would like to submit a new motion on.
16 The discussion guide is available on
17 public.qualityforum.org, and it is organized by
18 setting-specific workgroup.
19 So, PAC/LTC, clinician, and hospital,
20 and did want to just take a quick pulse check to
21 make sure that everyone had access to the
22 discussion guide, because that will be very

1 important in guiding our decisions.
2 And so it's public.qualityforum.org.
3 And if you have any difficulties, please email
4 MAPcoordinatingcommittee@qualityforum.org and we
5 can help you get set up.
6 And so within the discussion guide,
7 each measure has the measure specifications, a
8 summary of the workgroup decision and
9 deliberations. So, this is why it will be so
10 important as we go through today.
11 So, the voting procedure. We will now
12 walk through the actual steps of a voting
13 process.
14 The first is that the workgroup staff
15 and co-chairs will present their recommendations
16 from their December 2017 in-person meetings.
17 And I apologize, this is a text-heavy slide, but
18 we'll go through the important parts.
19 So, second, the Coordinating co-
20 chairs, Harold and Chip, will ask if there are
21 any members that identified any Measures Under
22 Consideration that they would like to discuss

1 further. And during our pre-work, we requested
2 that members identify measures.
3 The co-chairs can start with those
4 measures previously identified, and then we can
5 open it up to measures that members would like to
6 pull that were not identified. There is no limit
7 to the number of measures a member can identify.
8 The co-chairs will ask each member to
9 clarify if they are pulling a measure for further
10 discussion or because they would like to submit a
11 new motion on it. Measures identified for
12 further discussion will focus on clarifying
13 questions.
14 If during the course of discussion, a
15 Committee member determines that the discussion
16 has shown a need for a new vote, the Committee
17 member can put forth a new motion.
18 Some reasons why a member may want to
19 put forth a new voting measure is if the member
20 disagrees with the workgroup's recommendation, or
21 if there's new information available that would
22 change the algorithm.

1 Please note we will only focus on one
2 measure discussion or one motion at a time.
3 One moment.
4 And once all the measures the
5 Committee would like to discuss are removed from
6 the consent calendar, the co-chair will ask if
7 there was any objection to accepting the
8 workgroup recommendation on the MUCs remaining on
9 the consent calendar.
10 And so if a measure is not removed
11 from the consent calendar, we will still vote on
12 it in accepting it.
13 So, now we will talk about the
14 instances in which a Committee member wants to
15 put forth a new measure or a new motion on a
16 measure.
17 In the instances when a Committee
18 member identified a need for a new motion, the
19 member should describe their perspective on the
20 use of the measure and how it differs from the
21 recommendation from the workgroup.
22 If a motion is up for conditional

1 support or a refine-and-resubmit, the Committee
2 member making the motion should clarify and
3 announce the conditions, or suggest refinements.
4 We have tapped some members to be lead
5 discussants for the different program areas and
6 what we ask is that they can be some of the first
7 reactors.
8 So, if a Committee member identifies
9 a measure either for further discussion or to put
10 forth a new motion, the people who are identified
11 as lead discussants, we ask them to open up the
12 conversation.
13 And they should state their own point
14 of view, regardless of whether or not it agrees
15 with the workgroup recommendation.
16 Following input from the lead
17 discussants, the co-chair will then open it up
18 for discussion among the Committee, and we ask
19 that in the interest of time, people refrain from
20 repeating points that have already been
21 identified.
22 After the discussion, the Committee

1 member who made the motion has the option to
2 withdraw. Otherwise, the Committee will vote.
3 And we want to emphasize again if the
4 motion is for conditional support or refine-and-
5 resubmit, we will ask you to list out what the
6 conditions or the recommendations are. And this
7 will be able to inform the discussion as well as
8 the vote.
9 So, tallying the votes. So, before we
10 begin voting, which we will be doing later on, my
11 colleague, Yetunde, will do a quick run-through
12 of our clickers, but everyone should have a blue
13 clicker in front of them.
14 For those members participating on the
15 phone, we ask that you email your vote to
16 mapcoordinatingcommittee@qualityforum.org, and we
17 will actually tally your vote.
18 If the motion receives greater than 60
19 percent, the motion will pass. If the motion
20 does not receive greater than 60 percent, the co-
21 chairs will resume discussion to develop another
22 motion.

1 If no motion put forward from the
2 Committee achieves greater than 60 percent, the
3 workgroup's original recommendation will stand.
4 And abstentions are discouraged but will not
5 count to the denominator. So, as we said
6 earlier, please announce if you are abstaining
7 from a vote.
8 I now just kind of want to take some
9 time to talk about the commenting guidelines.
10 So, comments from both public periods,
11 public commenting periods, are available in the
12 discussion guide. They are linked with each
13 measure.
14 There will be an opportunity for the
15 public to comment either in the room or over the
16 phone, prior to the discussion for each setting-
17 specific workgroup. Commenters are asked to make
18 any comments on MUCs or opportunities to improve
19 the current measure set at this time.
20 We ask that you limit your comments to
21 two minutes, and then we will additional have a
22 global public commenting period at the end of

1 each day.
2 Here, you can see our calendar of
3 where we are with our activities, and we are
4 coming towards the end of this MAP cycle.
5 Following this meeting, our
6 recommendations will be sent to CMS on February
7 1st. We will then be releasing a series of
8 reports for each of the setting-specific
9 workgroups. And the clinician one will be
10 released on March 15th; the hospital PAC/LTC
11 programs, that report will be released on
12 February 15th. And then as I said earlier, the
13 actual recommendations will be released on
14 February 1st.
15 And before we go into questions on
16 this, I did just want to take a quick opportunity
17 to talk about the MAP Rural Health Workgroup
18 feedback on the Measures Under Consideration.
19 So, as many of you know, the MAP Rural
20 Health Workgroup is a new MAP workgroup that was
21 established this year.
22 And during their December 2017 web

1 meeting, the Rural Health Workgroup engaged in a
2 high-level discussion of the MUC list using the
3 perspective of the appropriateness for their
4 patients in their communities.
5 And there were several observations
6 that they had that we would just like you to keep
7 in mind as we go through the three program areas.
8 The MAP Rural Health Workgroup members
9 emphasize the importance of considering the low
10 case-volume challenge for rural providers for
11 several measures on the MUC list.
12 For example, applicability to rural
13 providers may be challenging for the cancer
14 readmission measure.
15 On the other hand, they noted that the
16 shingles vaccination measure would likely be
17 resistant to the low case-volume challenge.
18 Workgroup members identified the topic
19 areas of diabetes care, vascular care, opioid-
20 related care and events, HIV screening, prostate
21 screening, and simple pneumonia hospitalization,
22 as areas of interest and rural relevancy to them.

1 I will now turn it over to I believe
2 Harold to facilitate the discussion? Chip,
3 sorry. Chip?
4 CO-CHAIR KAHN: Any other questions
5 about the voting process?
6 MEMBER HALL: Just a minor
7 clarification, what's our total denominator on
8 this Committee and our quorum?
9 It seems like having a quorum, but I
10 suppose if there were abstentions, we could lose
11 it.
12 CO-CHAIR KAHN: How many people do we
13 have on the phone in total here?
14 MS. O'ROURKE: I'm going to punt that
15 one to Kate and Yetunde to get us our numbers.
16 CO-CHAIR PINCUS: And also, Rich, are
17 you on the phone yet?
18 MS. BUCHANAN: So, we'll do a quick
19 calculation because I know Rick hasn't joined us
20 yet, but we'll get you that number very soon.
21 CO-CHAIR KAHN: I've got to believe
22 we're --

1 MS. BUCHANAN: Without Rich, we have
2 32 right now.
3 CO-CHAIR KAHN: We have well over a
4 quorum?
5 MS. BUCHANAN: Yes.
6 CO-CHAIR KAHN: That was the question,
7 whether we had a quorum? Yes, I don't think the
8 quorum's a problem.
9 MEMBER O'BRIEN: I just wanted to
10 clarify, for this year, for pulled measure, the
11 Committee member is making a motion for a
12 different recommendation, so is the vote,
13 essentially, this year going to be a yes or not
14 vote, an up or down vote on the motion?
15 Okay. Thank you.
16 CO-CHAIR KAHN: Wait, and I guess if
17 I understand it, for us to change the
18 recommendation, it's got to be in excess of 60
19 percent.
20 So, it's not just having the vote;
21 it's not just the majority. It has to be, in the
22 sense, the super-majority.

1 Even though I understand what Bill
2 described as a process, we still have the formal
3 --
4 MEMBER O'BRIEN: Right, I just wanted
5 to clarify that we weren't loading on all the
6 categories of potential recommendations.
7 CO-CHAIR PINCUS: No, no.
8 Now, if that motion doesn't pass, then
9 we go back to discussion and see if somebody
10 wants to make a motion for a different category.
11 CO-CHAIR KAHN: I think, and we spent
12 time talking about the problems that came up in
13 the Hospital Taskforce, and I'm not sure this
14 really matches with coming to a consensus, but I
15 think we have to be linear in terms of the
16 process.
17 It's sort of Robert's rules that we
18 have motions and let's say somebody puts a motion
19 to remove and it gets 59 percent, whatever the
20 number, it doesn't get to the 60, then the floor
21 is open and after the vote, somebody can bring
22 another motion.

1 And I think if people stop bringing
2 motions, then it reverts back to -- and we don't
3 get more than 60 -- it reverts back to the
4 recommendation of the task force where they may
5 have been above 60, or to the base consent
6 calendar.
7 MEMBER O'BRIEN: Right, that sounds
8 like the right approach to me.
9 CO-CHAIR PINCUS: And of course, all
10 the discussion about all the different motions
11 would then be input to CMS.
12 CO-CHAIR KAHN: Right, and I think
13 tomorrow we really need to talk about what we
14 want to do, because I think Bill's raised an
15 important point, what we define as a consensus
16 process.
17 But at the end of the day, I'm
18 concerned because of just lack of time and
19 effort, the best we can probably do with some of
20 these is have the substantive input.
21 I mean the text of why we were
22 concerned as much as the vote, because it's going

1 to be difficult to get to a vote, frequently, of
2 more than 60.
3 MS. O'ROURKE: And just to echo what
4 Chip was saying, and Harold, and we do capture
5 all of your input for the various reports Kate
6 went through.
7 So, as we're going around, please feel free
8 to express any opinions you have about the
9 measure.
10 We don't only pass on the vote to CMS;
11 in the report, we document how the group came to
12 that, what the opinions of people who supported
13 that decision were.
14 Also, if there were any minority
15 opinions who disagreed with what MAP put forward,
16 we put all of that in the text of report that
17 goes to CMS.
18 So, to Chip's point earlier that they
19 weigh those heavily, so please share your input,
20 and we do include all of it in the report.
21 So, while I know there's some concerns
22 about the voting process and if that really lets

1 everyone truly reflect their opinion, we do
2 capture all of your discussion, and that goes
3 along with the vote.
4 It's not just a 61 percent of the
5 Coordinating Committee said this. It's a nuanced
6 report of the decision.
7 So, I'll just let you know that that
8 is heard.
9 CO-CHAIR KAHN: Okay, any more
10 questions? We're 15 minutes ahead.
11 MS. O'ROURKE: Should we do the voting
12 test before we start PAC public comment so that
13 we're all ready to go? Did you have a test --
14 CO-CHAIR KAHN: So, how does the
15 voting test work? Who's in charge of the voting
16 test?
17 MS. O'ROURKE: Just to make sure that
18 your clickers are working and everyone knows how
19 to use them before we get into --
20 CO-CHAIR KAHN: So, everybody should
21 pick it up.
22 MS. O'ROURKE: One second, it ties to

1 a slide that we need to bring up.

2 Apologies, I've put Yetunde on the

3 spot but this, I think, was going to happen after

4 Jean-Luc did some of the presentation on PAC/LTC.

5 But to that we respect that we told

6 the public the comment period would start at

7 10:30 a.m. and we're running a little -- I

8 thought we could get this test vote out of the

9 way and make sure everyone understands the

10 clickers and is comfortable.

11 Oh, well, then we could go. Do you

12 want to skip the test vote or just do it since I

13 brought it up? Okay, never mind.

14 Okay, so let's transition to the

15 PAC/LTC.

16 CO-CHAIR KAHN: So, now we're going to

17 the public comment on PAC/LTC, and I'll ask

18 whether anyone would like to make a public

19 comment on the PAC/LTC programs.

20 And remember the guidelines for public

21 comment; they're up on the screen. Limit

22 comments to just PAC/LTC recommendations, limit

1 comments to no more than two minutes if possible,
2 make any comments on MUCs or opportunities to
3 improve the current PAC/LTC measure set at this
4 time.
5 So, why don't I do this? Obviously,
6 I'm hoping no one is going to come at 10:30 a.m.
7 that isn't here already, so do we have any
8 comments in the room from anyone?
9 Okay, not seeing any comments in the
10 room, let me go to the phones. And the
11 operator's supposed to say something now.
12 OPERATOR: At this time, if you'd like
13 to make a comment, please press Star then the
14 number 1.
15 CO-CHAIR KAHN: Okay, any comments?
16 OPERATOR: There are no public
17 comments at this time.
18 CO-CHAIR KAHN: Okay, well, we are
19 ahead of schedule but I think we should go on. I
20 think we gave people ample opportunity.
21 And so I guess now we're going to pre-
22 rulemaking recommendations on the PAC/LTC, and

1 Leah and Gail Hunt are the primary lead
2 discussants.
3 We're going to discuss the key themes
4 from the workgroup meeting, review and finalize
5 the broader guidance, and review and finalize
6 workgroup measure recommendations.
7 So, I think I'm turning it over to
8 Jean-Luc to coordinate this.
9 MR. TILLY: So, good morning,
10 everyone, I'm Jean-Luc Tilly. I'm joined today
11 on the phone by both my co-chairs for the PAC/LTC
12 Committee, Gerri Lamb and Paul Mulhausen.
13 So, we actually just had one measure
14 under consideration this past cycle for the SNF
15 QRP, the CoreQ short-stay discharge, which we'll
16 get into a little bit later.
17 This slide kind of summarizes the
18 overall themes, and we'll dive into each of these
19 in turn.
20 But broadly speaking, we're talking
21 most about making a move to high-value measures
22 and trying to give some guidance to CMS on future

1 measure development for these programs.
2 And it just says record the short-stay
3 discharge, so let me just move one more.
4 All right, so of course, most PAC
5 programs are affected by the IMPACT Act, which
6 requires PAC providers to provide Center S
7 patient assessment data, and guides the adaption
8 of new measures in those programs.
9 CO-CHAIR PINCUS: Talk a little bit
10 more into the mic.
11 MR. TILLY: So, the workgroup
12 encouraged continued alignment of those measures
13 and recognized that the measure under
14 consideration in the CoreQ was consistent with
15 those principles.
16 The MAP Workgroup did note several
17 opportunities to continue to address quality in
18 IMPACT settings.
19 So, here, we're thinking primarily of
20 patient-reported outcome measures that were
21 emphasized, as well as measures of transfer of
22 information of care preferences, and finally,

1 medication management.
2 Now, see, I have care preferences
3 beyond the end of life, but presumably someone
4 else is in charge of that. We meant more care
5 preferences beyond just end-of-life care. So,
6 shared accountability across the care continuum
7 is also a big theme.
8 So, of course, we mean partnerships
9 between providers, between hospitals and PAC/LTC
10 providers, but then also the inter-operability of
11 health IT technology.
12 So, now looking at considerations for
13 specific programs in turn, first, for SNF, a
14 number of opportunities for new measurement were
15 advanced.
16 So, that includes measures of shared
17 accountability between stints in hospitals,
18 measures around transfer, measures around
19 advanced directives.
20 And of course, one measure was
21 submitted for this program.
22 So, turning now to the IRF QRP, MAP

1 had some similar notes about the transfer of
2 information, and then a setting-specific
3 consideration around opioid use in IRF
4 facilities. There's a special consideration
5 there.
6 And then the workgroup also thought
7 about some of the infection measures that are
8 used in IRF settings have a relatively low
9 incidence rate relative to other settings, and
10 thought those measures could be re-examined.
11 And finally, for the LTEC QRP, the
12 workgroup cited measures addressing mental and
13 behavioral health and particularly for
14 depression, which is maybe a bigger problem
15 around setting than in others.
16 For the Home Health QRP, the workgroup
17 highlighted the importance of social determinants
18 of health, which can have a much greater impact
19 in that setting.
20 The workgroup noted that measures
21 around the maintenance of ADL capability could
22 have particular value in this setting.

1 So, not just improvement but also
2 maintaining a relatively good performance.
3 And then, finally, for the hospice
4 program, the last program, a program not covered
5 by the IMPACT Act, the workgroup cited several --
6 - including medication management, caregiver
7 support, bereavement, and then finally, safety
8 and functional status measures.
9 So, turning now to the CoreQ, our
10 measure under consideration, the workgroup
11 supported the measure.
12 The measure addresses an important
13 CAHP; it's a patient-reported outcome but it was,
14 actually recently in 2017, endorsed by the
15 Person-and-Family-Centered Care Standing
16 Committee.
17 The workgroup did note that the
18 measure introduces the possibility of some burden
19 for SNF, and actually, the one public comment we
20 received very closely mirrored the
21 recommendation.
22 It supported the measure but they

1 noted that what seemed like the timing of
2 implementation in 2019 seemed maybe too soon for
3 that setting.
4 So, I think at this point, I'll turn
5 it over to my co-chairs, Gerri and Paul, who are
6 both on the line.
7 I think they might have a few things
8 they'd like to add.
9 MS. LAMB: Good morning, this is Gerri
10 Lamb. Thanks, Jean-Luc, and I just would like to
11 acknowledge the NQF team.
12 We had a very, I think, productive,
13 robust discussion in December.
14 And Erin and Jean-Luc and Miranda
15 really put a lot of time and effort into setting
16 context and helping us really look at the gaps in
17 how we could move forward on some of these gap
18 areas.
19 So, we also had discussions about how
20 the measures, the post-acute measures, fit into
21 IMPACT, MACRA, had a great discussion about
22 attribution issues.

1 So, as you all know, we had one MUC
2 measure so we spent a lot of time looking at how
3 to move this field forward.
4 And as Jean-Luc gave you the overview,
5 some really key areas, key discussion points,
6 were related to transition and information
7 exchange.
8 And with this one MUC measure, that
9 came up as well in terms of the feasibility of
10 EHRs to accommodate this.
11 And I think people felt that this
12 whole field was moving ahead, that patient
13 experience was critically important, and this was
14 sufficient time for the EHRs to catch up.
15 We heard a lot about beginning to
16 bring in functional performance, and also some of
17 the national issues like opioid use.
18 So, really, I think great meeting,
19 lots of discussion concerned about the gap areas
20 and being able to get measures that will move the
21 field forward.
22 Paul, comments?

1 DR. MULHAUSEN: Yes, thanks Gerri.
2 This is Paul Mulhausen, and I'm the sort of
3 rookie co-chair with Gerri. It's a pleasure to
4 be here.
5 I don't know that I have a lot to add
6 to context; that's already been shared with you
7 by Jean-Luc and Gerri.
8 I do want to reflect a little bit
9 about the deliberations around the one measure
10 that we had on our MUC list, which is the survey,
11 the patient experience of care survey or the
12 survey that we had talked about.
13 And I think the deliberations were
14 heavily influenced by the observation that this
15 was an NQF-endorsed measure.
16 It was a measure that was put forth by
17 the industry, it was put forward by the American
18 Healthcare Association, and most of the testing
19 and development was done by them.
20 And an occasional member of our
21 Committee raised concerns about that.
22 People already perform fairly well

1 with this measure. It has an 80 percent
2 satisfaction, good score.
3 And although that was framed as
4 there's lots of room for improvement, the
5 deliberations included some observations that
6 people already perform fairly well in this
7 measure.
8 Gerri and Jean-Luc have already
9 highlighted that we have a deficit of
10 patient-reported, or resident-reported, or
11 family-reported, measures and this was an
12 important gap.
13 And you may wonder at this point,
14 whatever happened to the nursing home CAHPS?
15 Which was my question.
16 So, although we had nursing home CAHPS
17 for the patient experience of care, that is no
18 longer endorsed by the NQF.
19 So, having this CoreQ measure as a
20 reflection of the patient's or resident's
21 experience of care ends up being very important
22 at this particular moment.

1 And then the only other sort of issue
2 around the measure in our deliberations was
3 actually how to most effectively implement it.
4 You've heard Jean-Luc and Gerri
5 discuss sort of the burden issue of having to
6 send out survey mailings to get the results.
7 And then there's also the actual
8 testing and validation has all been done around
9 time-limited survey processes.
10 And I think CMS is going to have to
11 think very hard about how to actually implement
12 this measure as part of a rolling quality-
13 reporting system.
14 So, in balance, everybody's excited
15 about the measure because it does fill that gap
16 of patient experience, but there were some
17 reservations that were primarily swayed by the
18 observation that it was a very well-vetted NQF
19 endorsed measure.
20 So, anyway, thanks for having me on
21 the phone today, appreciate the opportunity to
22 share what I think happened during our meeting.

1 And I, like Gerri, have to thank
2 everybody at NQF who helped us coordinate and
3 support a very robust and engaging conversation
4 at our face-to- face meeting.
5 So, thank you.
6 CO-CHAIR KAHN: Great, thanks, Paul.
7 Okay, are there other comments from -- I guess
8 we have discussed this but are there any other
9 comments from --
10 MS. O'ROURKE: So, no one's pulled it
11 but if we still want to ask our lead discussants,
12 since we do only have one measure, if they have
13 any comments?
14 MEMBER HUNT: It's Gail Hunt. I would
15 just echo what's been said.
16 I think it's critically important to
17 get the patient-reported viewpoint of this, and
18 this is, obviously, a short-stay discharge
19 measure and not for the longer-term people who
20 are in the hospital.
21 But I just wanted to say that I think
22 it's really important and we should be supportive

1 of that because it does represent the patient-
2 reported outcome that we don't often hear from.
3 CO-CHAIR KAHN: Just to ask a
4 clarification, so this is, I guess, beside the
5 testing and validation, this particular
6 instrument is done by mail you said?
7 MS. O'ROURKE: I believe, correct me
8 if I'm wrong, there's several modes of
9 administration. Mail is also in the EHR, am I
10 incorrect?
11 MEMBER GIFFORD: No, it's currently
12 mail or telephone.
13 CO-CHAIR KAHN: You know, I'm going to
14 just make a comment. And I assume it's mail or
15 telephone because of the rules of CMS, or the way
16 you did it?
17 MEMBER GIFFORD: Kate may want to
18 comment on the issue about rulemaking, what to
19 do.
20 I mean this is actually a suite of
21 five measures we have for long-stay and AL, but
22 traditionally, our long-stay measures are not put

1 in rule.

2 So, all of our long-stay measures,

3 none of them are ever put in rule, a five-star is

4 not in rule.

5 Only the measures related to short-

6 stay are put in the rule, and so I believe that's

7 why this is coming forward here and why you're

8 not seeing some of the longer issues.

9 As far as how they propose to acquire

10 the administration of this, we do not know

11 because they have not yet, that we're aware, put

12 it in any rulemaking.

13 It would be within the CoreQ program

14 and, of course, there's a lot of details and I

15 think we would support as well a lot of details

16 to work out how this would roll out.

17 But we put it forth in the call.

18 Understanding the MUC list, it's not just

19 measures that CMS puts forth.

20 They put a call out to the general

21 public right about now, right? And anyone can

22 put measures in.

1 They then review whether they are
2 worthy of putting into future rulemaking.
3 CO-CHAIR KAHN: I just meant in terms
4 of the response.
5 Because in terms of the feedback, the
6 vehicles for feedback from the patient are
7 limited, and I guess I'm sort of reacting here to
8 HCAHPS more than this.
9 MEMBER GIFFORD: Yes, it's either
10 telephone or mail.
11 CO-CHAIR KAHN: Yes, which I just
12 think is -- my mother's 91 and my father's 92,
13 and they're very capable people and they're in
14 and out of institutions and they spend more time
15 on the computer than they do on the phone.
16 And I just don't understand it.
17 MEMBER GOODRICH: Yes, so we don't
18 have any kind of restrictions, or philosophical
19 restrictions either, around the mode for these
20 surveys.
21 As long as they have been tested and
22 found to be validated, you have to go through

1 that rigorous testing process.
2 I will just say for everybody, we are
3 conducting testing now for several of our CAHPS
4 family of surveys, web-based administration as
5 well, but that does have to go through the
6 rigorous testing process.
7 But we know folks are eager to move in
8 that direction.
9 CO-CHAIR KAHN: I'm with you, but it
10 really needs to be done because I'm sure it can
11 be validated and the response rates are not
12 sufficient, and that will really help the
13 response rate.
14 MEMBER KAHN: This is Maureen. I echo
15 a lot of the comments made and I think it's
16 important, as someone who also has an again
17 parent, and I lived through this survey process
18 with the parent, they are being overwhelmed with
19 surveys from physician offices, hospitals, and
20 now another center.
21 And I think we need to make sure as we
22 go through the testing that it's clear where it's

1 coming from and what they're being asked
2 questions on.
3 Because I know it takes a lot of time;
4 these are not quick surveys.
5 CO-CHAIR KAHN: That's a good point.
6 But we're sort of in a dilemma because if you're
7 going to be patient-centered, you're going to be
8 patient-centered.
9 MEMBER KAHN: I don't disagree.
10 CO-CHAIR KAHN: And everybody's
11 getting the same message, too.
12 MEMBER KAHN: Yes, I just think there
13 has to be clarity on what they're being asked to
14 comment on.
15 CO-CHAIR KAHN: I understand.
16 MEMBER KAHN: Because I just went
17 through an experience with a rehab hospital, five
18 days in a rehab hospital, and so she has now
19 received I think four different surveys that I'm
20 now working with her to help her because of her
21 vision and the complexity.
22 What are you evaluating?

1 DR. MULHAUSEN: This is Paul
2 Mulhausen. May I make an observation?
3 CO-CHAIR KAHN: Yes, and then after
4 that --
5 DR. MULHAUSEN: All right, so this
6 particular CoreQ survey is very simple, certainly
7 relative to the CAHPS surveys.
8 It's four questions; it's basically a
9 satisfaction survey ranging from very unsatisfied
10 to very satisfied.
11 And so I think in terms of something
12 that's quite simple to complete, you would find
13 this meets the bill for that.
14 MEMBER KAHN: Fantastic.
15 CO-CHAIR KAHN: Okay, Leah?
16 MEMBER BINDER: I just wanted to make
17 one comment about the comment, the public
18 comment, that was received on this measure and
19 about the potential burden of this measure.
20 I'm not familiar with short-stay, I'm
21 not familiar with this particular area of the
22 healthcare system so I don't pretend to know the

1 level of burden.
2 But I would say that it's my
3 recommendation to CMS not to slow down the
4 implementation of this measure in any way. It's
5 a really urgent thing.
6 I think it's very important to start
7 to get more patient feedback and have that inform
8 the ongoing operations and quality that's
9 delivered at these organizations.
10 So, I do think that it's a very
11 important measure. I congratulate everyone for
12 putting this forward and I do strongly support
13 it.
14 CO-CHAIR KAHN: Okay, so Harold has a
15 comment, and then we don't really have any
16 actions, it's just the discussion on the measure?
17 Okay, so Harold will comment, and does
18 anybody else have -- do we have any comments on
19 this measure?
20 Okay, then, Harold, why don't you
21 comment and then we'll go --
22 CO-CHAIR PINCUS: So, I had two

1 questions, one for CMS and one sort of more
2 generally to the workgroup.
3 The one for the workgroup is I noticed
4 that for the hospital long-term care program, a
5 recommended priority was behavioral health
6 measures to be developed.
7 But I didn't see that as a
8 recommendation for the Home Health or the hospice
9 one, and I'm curious, was there some distinction
10 there, and concern?
11 Because I think that, in some ways,
12 those may be as important or more important in
13 terms of behavioral-health criteria.
14 And then the second question I had,
15 Kate, to you was the comment about sort of the
16 no-longer endorsement or continuation of the
17 CAHPS long-term care measure, just to get some
18 sense of where is CMS in terms of the
19 continuation of CAHPS and other forms of patient-
20 reported outcomes?
21 MEMBER GOODRICH: So, Pierre maybe
22 needs to help me here, I'm not sure. The

1 nursing-home CAHPS, I'm not sure we've ever even
2 used that.
3 As long as I've been at CMS, we
4 haven't used it, and I don't know if that's
5 because it never got NQF endorsement, or lost NQF
6 endorsement, I'd have to go back.
7 I know we've got Alan Levitt on the
8 phone and he may be able to answer that question.
9 But that --
10 MR. LEVITT: But not specifically.
11 MEMBER GOODRICH: Right.
12 CO-CHAIR PINCUS: But just the broader
13 program?
14 MEMBER GOODRICH: Right, no, CAHPS and
15 patient experience are as important to us as they
16 have ever been, so the fact that we don't have
17 one in nursing homes, and I know we've been in a
18 lot of communication with Giff.
19 And the AHCA team on this measure have
20 been very supportive of this measure, to have
21 something out there that can be used in this
22 setting.

1 But certainly, as it goes with CAHPS,
2 still a very high priority for us, that has not
3 changed.
4 CO-CHAIR PINCUS: And is there
5 anything going on with regards to behavioral-
6 health-specific CAHPS?
7 MEMBER GOODRICH: Do you know the
8 answer to that? Not that I'm aware of, but we
9 should talk about that.
10 CO-CHAIR PINCUS: I mean in my role as
11 being the person for behavioral health.
12 But also, the other issue had to do
13 with, specifically for the health home and the
14 hospice, there's not a specific recommendation
15 around development of behavioral and health-
16 related measures.
17 MEMBER GOODRICH: Recommendation by
18 the MAP?
19 CO-CHAIR PINCUS: In the priority.
20 Yes, by the MAP, and actually, it
21 wasn't so much directed at you but it was
22 directed towards the co-chairs of the workgroup

1 in terms of did that come up?
2 MS. LAMB: This is Gerri. I think we
3 were dealing with recommendations at two levels.
4 One went across all of the post-acute
5 services, and some were specific.
6 The behavioral health, mental health,
7 went across all of them, and then when we did the
8 drill-down, I think IRF and the long-term care
9 hospital went into it in more detail.
10 Home Health and also the IRF were also
11 looking at substance abuse as a subset of
12 behavioral health, but I don't think that it
13 wasn't a priority.
14 It went across, but there were
15 different drill-downs.
16 CO-CHAIR PINCUS: Thank you.
17 CO-CHAIR KAHN: Okay, so I think we've
18 completed our discussion of this particular
19 measure but -- I'm sorry, David?
20 MEMBER INTROCASO: Thank you. I'll
21 pick up on the spirt of the discussion as much as
22 the voting on this.

1 So, my first comment on this measure,
2 when you see these measures, I always find myself
3 asking, it took this long to get to this measure?
4 So, that's to say we're strongly
5 supportive of this measure, but I would like for
6 context and to make note of the importance of
7 this measure as it relates to spending variation.
8 We know it's mostly in post-acute and
9 we know as it comes to P-for-P, I don't think we
10 have P-for-V, but as it relates to pay-for-
11 performance programs, the bundles and ACOs, we
12 know the savings is on the post-acute side.
13 So, I would encourage, since Kate's
14 well aware I'm a big person on measuring for
15 value, I would say, beyond just collecting this
16 measure and data about it, is to correlate how
17 are beneficiaries in a P-for-P model scoring on
18 this measure? Because, obviously, P-for-P
19 providers are trying to save on spending to win
20 on their financial benchmarks.
21 So, if they're having particularly
22 these patients, who would be more likely short-

1 stay patients in an ACO possibly, are they more
2 dissatisfied than just SNF patients in fee-for-
3 service?
4 Thank you.
5 CO-CHAIR KAHN: Any other comments?
6 I guess no one wants to pull anything else, so
7 any just general comments like David's about this
8 area?
9 Okay, we do need to have a vote on the
10 consent calendar, so what I'm going to ask is
11 that we get an explanation of the voting now in a
12 moment, and that we then have our vote.
13 I, then, am going to suggest, because
14 we're doing well on our time, that we have a ten-
15 minute break post the voting and that we'll come
16 back right before 11:00 a.m.
17 And we'll take the attribution
18 discussion from tomorrow and staff will present
19 the terms of that discussion.
20 MEMBER GIFFORD: Sorry, I'm
21 misunderstanding.
22 So, I was staying silent because I

1 have to abstain from the voting on this so I want
2 to make sure we drop the denominator.
3 CO-CHAIR KAHN: We were about to.
4 MEMBER GIFFORD: I had more general
5 comments about post-acute measures and I didn't
6 know if we were going to take that up after this
7 vote.
8 That's why I've been staying silent
9 through that discussion.
10 CO-CHAIR KAHN: Why don't you make
11 those comments now before we vote, and then we'll
12 -- so, that may move our timing a little bit.
13 MEMBER GIFFORD: Sorry, they're not
14 going to be that long.
15 I do think that the one feedback I
16 think would be worth giving to CMS on these post-
17 acute settings and these measures, as pointed
18 out, post-acute setting is where a lot of really
19 sick, high-cost and high-acuity -- and people are
20 going through that; 40 percent of Medicare
21 beneficiaries use SNF or Home Healthcare, and
22 it's the big driver of costs.

1 Most of the measures still seem to be
2 very provider-centric and with new payment models
3 and everything else, I would encourage you think
4 about how these measures are developed across.
5 And I know the workgroup mentioned
6 this, but they sort of just talked about cross-
7 cutting themes of transitions, but really -- and
8 I think IMPACT Act was beginning to get at that
9 but I don't see -- there's still a very provider-
10 centric sort of siloed nature of all the measures
11 and the data collection.
12 And I think as we evolve in the
13 healthcare system, it would be very helpful, and
14 CMS could help drive that thought process about
15 how measures are really at the patient and
16 episodic-care measures, rather than triggered at
17 the provider level.
18 CO-CHAIR KAHN: Other comments about
19 that? That could probably be true for other
20 areas, I mean not just that setting, too. We'll
21 have a discussion of the consent calendar.
22 MS. OGUNGBEMI: So, when the Committee

1 has concluded their discussion and the motion is
2 set, I will announce that voting has opened.
3 I will also announce the motion so we
4 are clear what we are voting on.
5 Once voting is open, I ask that you
6 point your blue remote towards me because I have
7 the device that captures the votes here in the
8 corner.
9 And you make your choice by pressing
10 either one or two.
11 This is a binary vote, so we're either
12 voting on yes, we support the motion that's being
13 set, or, no, we disagree with the motion that's
14 being set.
15 Our N right now is 28, but if people
16 are abstaining from voting, I ask that you make
17 that known once I say voting is open so I can re-
18 calculate the N.
19 When voting is closed, I will announce
20 the result.
21 Additionally, Federal Liaisons should
22 not have remotes because they are non-voting

1 participants. So, if you do have a remote and
2 you're a Federal Liaison, please, you can give
3 that back to me, thank you.
4 And also, we will be proxy-voting for
5 our members on the phone.
6 So, I think what we've discussed is
7 that people will email their votes in, and I
8 think it might be easier to submit them through
9 the chat on the web platform.
10 So, email them into the Coordinating
11 Committee inbox, and that's
12 MAPcoordinatingcommittee@qualityforum.org and we
13 will do our best to capture your votes that way.
14 CO-CHAIR KAHN: We have 33 members of
15 the coordinating Committee, so we're well within
16 --
17 MS. OGUNGBEMI: Right, and four of
18 them are non-voting participants.
19 CO-CHAIR KAHN: Okay, so in terms of
20 the quorum question, we have a quorum.
21 MS. OGUNGBEMI: Yes.
22 CO-CHAIR KAHN: I wanted to make sure.

1 So, our test vote right now is a
2 recommendation for the SNF QRP, and again, this
3 is just a test because -- yes, well, this is just
4 a test, right? We're just testing?
5 Okay, just a test for now, and then we
6 will vote really on the next slide. So, we are
7 voting on the recommendation for the SNF QRP.
8 Let's say that the motion is to
9 support, and this is MUC 17 258, CoreQ Short-Stay
10 Discharge Measure; yes, support, no, do not
11 support the motion.
12 Voting is open. Yes, it's right there
13 on the screen.
14 CO-CHAIR KAHN: How long do we leave
15 it open?
16 MS. OGUNGBEMI: Until we get our N.
17 And just give us one second, thank you. We can
18 take a break and come back?
19 CO-CHAIR KAHN: So, the voting
20 software is not working. We have 39 votes so
21 there's some gremlins some place or somebody
22 pressed their button too many times.

1 So, in order to just keep things
2 moving while they're fixing the software, let's
3 vote the old-fashioned way, and let's see a show
4 of hands for all those -- I'm sorry?
5 Yes, this counts, and Cliff is going
6 to recuse himself. Cliff will completely recuse
7 himself from the room, so he can't even see how
8 people voted.
9 So, anyway, all those in favor of --
10 yes, that was the test. We're now going to vote
11 on the consent calendar.
12 For those who are in favor of the
13 consent calendar going forward as the
14 recommendations of the Coordinating Committee, as
15 well as, obviously, the workgroup, all those in
16 favor, raise your hands.
17 And I guess we need to get a count, so
18 raise your hands high and leave them up until
19 staff tells us that the time for voting has
20 closed.
21 Okay, and then on the phone, anyone
22 should send in their thing, and then are there

1 any noes from those who are eligible to vote?
2 Okay, so we've reached a consensus.
3 I'm sorry, question?
4 MEMBER HALL: I'm sorry, you were
5 saying there were 22 votes? We had just been
6 told a different number.
7 MS. BUCHANAN: Yes, so I want to
8 provide some clarification. So, we have 26
9 people who can vote today, 4 are on the phone, 22
10 are in the room.
11 Three of the people on the phone have
12 stepped away. One person in the room has
13 abstained so now we have an N of 22, so that's
14 the change.
15 So, we can update this throughout
16 because it will be a little challenging as
17 people, especially participating remotely, step
18 out during various times.
19 So, we have 22 voting people, and we
20 have 22 yes, zero no, and 1 abstention in support
21 of the consent calendar for the PAC/LTC program.
22 CO-CHAIR KAHN: A question.

1 DR. AMIN: The threshold will continue
2 to change as the denominator changes. So, Kate
3 will monitor that as we go through the day.
4 MS. MUNTHALI: So, it's 75 percent.
5 So, what we'll do for every vote is
6 announce the quorum and announce the end so you
7 aware of -- and I think that will help to clarify
8 everything.
9 CO-CHAIR KAHN: So, we had a quorum in
10 the case of the last vote, right?
11 MEMBER HALL: So, to be clear, 22
12 votes is 75 percent of the Committee? What's the
13 actual denominator of the full Committee?
14 CO-CHAIR KAHN: Well, that was the
15 issue, was that was the number that I'd asked
16 for. The problem was we have nine voting members
17 on the Committee as well as voting members.
18 So, in terms of the voting members on
19 the Committee, what's the threshold?
20 MS. BUCHANAN: So, we have, of voting
21 members on the Committee, 29.
22 Because we have four Federal Liaisons

1 and so 22 divided by -- so, it gives us just over
2 75 percent so we just have quorum.
3 CO-CHAIR KAHN: Okay, so I'm a liar
4 then. So, that 29 doesn't change from vote to
5 vote because that's the N.
6 MEMBER HALL: 22 is our quorum, that
7 won't change.
8 CO-CHAIR KAHN: Yes, that won't
9 change.
10 MEMBER HALL: We have to have 60
11 percent of every vote.
12 CO-CHAIR KAHN: Yes.
13 MS. O'ROURKE: Yes, we need 22 people
14 to participate.
15 (Laughter.)
16 CO-CHAIR KAHN: That is a technical
17 question. A recusal -- the person is present at
18 the meeting but he or she doesn't count towards
19 the quorum if they have to recuse.
20 MS. O'ROURKE: Yes, okay. And we will
21 monitor these numbers and announce them so
22 everyone is clear on what we need.

1 CO-CHAIR KAHN: I know, my wife keeps
2 calling me, and it actually was my wife.
3 Okay, so now we've moved a little in
4 time, so why don't we say we will reconvene at
5 ten after the hour?
6 And we really need you to be back here
7 at ten after to leave enough time for the
8 attribution discussion.
9 MS. O'ROURKE: And just to clarify,
10 we're going to move up the attribution
11 conversation from tomorrow morning, and do this
12 now so that we can maintain the time for public
13 comment for MIPs and the shared-savings programs.
14 So, we did let the public know that
15 that would be happening this afternoon.
16 CO-CHAIR KAHN: Yes, I think he said
17 that. You know, I think that was it.
18 (Whereupon, the above-entitled matter
19 went off the record at 10:55 a.m. and resumed at
20 11:12 a.m.)
21 MS. O'ROURKE: So, if you could go one
22 more slide?

1 CO-CHAIR KAHN: Okay, if we could get
2 everybody back to their seats?
3 CO-CHAIR PINCUS: So, because there
4 was relatively limited discussion on the PAC/LTC
5 workgroup, we're moving tomorrow's discussion of
6 attribution, some of the general concepts, to
7 right now.
8 Attribution has always been the issue
9 that hovers over sort of everything we do. Yes,
10 what?
11 DR. AMIN: I'm just trying to figure
12 out who's managing the slides. So, can I go?
13 CO-CHAIR PINCUS: Yes.
14 DR. AMIN: Okay, great, thank you very
15 much, everyone. For those that are following
16 along on the slides, we're on Slide 83.
17 So, we're going to be moving around a
18 little bit; this was a discussion that was slated
19 for tomorrow.
20 So, just to give you guys an
21 orientation about this discussion, we've been
22 working on the concept of attribution as a

1 measurement science project over the last about
2 year and a half, in two phases of work.
3 The first phase of work, we completed
4 and we're sort of starting a second phase of
5 work.
6 The discussion around attribution has
7 come up several times, both in our CDP consensus-
8 development process, but also our work in the
9 MAP.
10 And so if we move to the next slide,
11 the various components of the legislation are
12 related to the IMPACT Act and MACRA, and
13 demonstrated a continued focus on value-based
14 purchasing to drive improvements in quality and
15 cost by realigning incentives.
16 And as we start to implement these
17 various pay-for-performance programs, there needs
18 to be some discussion around knowing who can be
19 held responsible for the results of the quality
20 and efficiency measures used to judge
21 performance.
22 And we noticed through the endorsement

1 process, and again, through the MAP process, that
2 as we increasingly assess quality using outcome
3 measures rather than process and structural
4 measures, the ability to actually judge who is
5 reasonably responsible for those outcomes has
6 posed some challenges.
7 So, the concept of attribution is
8 really defined as the methodology used to assign
9 patients and their quality outcomes to providers
10 or clinicians, and to help identify the patient
11 relationship that can be used to establish this
12 accountability.
13 As we move to a system that's away
14 from fee-for-service to alternative payment
15 models, there needs to be more of -- this issue
16 around patient outcomes and who is ultimately
17 responsible becomes even more important,
18 especially as we move to a health system that's
19 built on shared accountability.
20 So, we moved ahead with an initial
21 project, and if you could move to the next slide,
22 which really looked to basically answer several

1 questions, which is as we think about the concept
2 of attribution, what is the definition of
3 attribution?
4 What are the elements of attribution,
5 and can we basically define some best practices
6 about how one should consider the development of
7 attribution models?
8 We engaged in an environmental scan
9 with our colleagues at the University of
10 Michigan, Andy Ryan and his group, to conduct
11 this environmental scan of 163 models that were
12 in use, or proposed in use.
13 And that sort of gives you the
14 breakdown of how many, where they fall, and
15 really characterized what these attribution
16 models -- and basically characterizes these
17 attribution models using program characteristics
18 and also measure characteristics.
19 If you could move to the next slide?
20 Thank you. So, the Commission paper had some
21 very interesting findings that are relevant to
22 the MAP, which is why we're bringing this

1 discussion --

2 CO-CHAIR PINCUS: And do we have

3 access to the Commission paper?

4 DR. AMIN: Absolutely, we can send it

5 along to the Panel if you'd like to take a look

6 at it as we're talking.

7 CO-CHAIR PINCUS: Yes, that would be

8 great.

9 DR. AMIN: Kate, maybe I could ask you

10 to pull that up? Thank you. So, the Commission

11 paper had several important findings.

12 First, the best practices for

13 developing attribution models have not yet been

14 determined, and existing models are largely built

15 off of previously-used approaches.

16 And the tradeoffs in the development

17 of attribution models should be explored, and

18 maybe, potentially more importantly, be

19 transparent.

20 In the attribution models that are out

21 being used or that have been proposed, there's

22 really not a standard definition for the

1 attribution models or the elements of an
2 attribution model.
3 One might think about this as sort of
4 attribution model specifications.
5 And there really is a lack of
6 standardization across the models, which really
7 limits the ability to evaluate them.
8 CO-CHAIR PINCUS: Can I interrupt you
9 for a minute? What do you mean when you say a
10 model?
11 DR. AMIN: And I'll get into that,
12 Harold. I think that was actually one of the
13 challenges we came up with, which was what
14 elements need to be made transparent?
15 Which is, essentially, the question
16 you're asking, wasn't really well-defined in what
17 we found. And so I'll get into that a little bit,
18 what we ultimately landed with.
19 Additionally, some of the challenges
20 are that we need greater standardization in order
21 to really be able to do comparisons between the
22 models, and really be able to then have a

1 conversation about best practices.
2 And then, again, the limited
3 consistency across them makes evidence and the
4 ability to build evidence challenging.
5 And then finally, I think this last
6 point, which has really led to the second phase
7 of our work, is the authors of the Commission
8 paper noted a lack of transparency on how the
9 results are attributed, and no way to appeal the
10 results of the attribution model that, quote,
11 unquote, and I use this very loosely, wrongly
12 assign responsibility.
13 And so to address these challenges, we
14 convened a multi-stakeholder committee to develop
15 guiding principles, make recommendations, and
16 create the Attribution Model Selection Guide,
17 with the hope that these products would be able
18 to allow for greater standardization,
19 transparency, and multi-stakeholder buy-in, and
20 allow for the evaluation of such attribution
21 models in the future, and lay the groundwork to
22 hopefully develop a more robust evidence base.

1 And so while we're doing this work,
2 and again, Harold, I'll get to your question,
3 there were several sort of guiding principles
4 that emerged as part of this work, which, again
5 noting that this was an area of measurement
6 science that was very developmental, the multi-
7 stakeholder group really felt strongly that we
8 needed to lay out some guiding principles.
9 And maybe, Erin, I can ask you to
10 start walking through this and then I can jump
11 back in as we get to some of the later slides?
12 MS. O'ROURKE: Sure, absolutely.
13 So, as part of this preamble, the
14 expert Panel wanted to acknowledge the complex
15 multi-dimensional challenges to implementing
16 attribution models, recognizing that the model
17 may change depending on its purpose and what data
18 is available.
19 The Panel used the national quality
20 strategy as their north star.
21 They grounded their principles in
22 advancing the NQS, and recognized that

1 attribution plays a critical role towards making
2 progress on healthcare goals.
3 They recognize that attribution refers
4 to both the attribution of patients for
5 accountability purposes, as well as the
6 attribution of the results of a performance
7 measure.
8 Going back to what you were saying
9 from the Commission paper, they highlighted that
10 right now there's really no gold standard for
11 designing or selecting a model, and that it's
12 crucial to understand the goals of each potential
13 use case.
14 They highlighted that some key
15 criteria for selecting an attribution model are
16 actionability, accuracy, fairness, and
17 transparency.
18 So, on this slide, you can see the
19 guiding principles that the Panel came up with: a
20 model should fairly and accurately assign
21 accountability, attribution models are an
22 essential part of measure development,

1 implementation, and policy and program design.
2 The considered choices among available
3 data are fundamental in the design of an
4 attribution model.
5 These models should be regularly
6 reviewed and updated, emphasizing these models
7 should be transparent as well as consistently
8 applied.
9 And the model should align with the
10 stated goals and the purpose of the program.
11 DR. AMIN: Thanks, Erin, I can jump
12 back in here.
13 So, the Attribution Model Selection
14 Guide, I think one of the things that's important
15 as we began this work was that there was a
16 tension between the desire from our stakeholders,
17 generally through the comments that we have had
18 from the MAP process and the CDP process, that
19 attribution models should be fit for purpose and
20 the science related to the attribution.
21 And there was really sort of a desire
22 for this, a desire as we set up this group, from

1 stakeholders that we should sort of clarify which
2 attribution models should really be used in a
3 given circumstance.
4 And really, we landed with the fact
5 that there's really not enough evidence to
6 support the development of such rules at this
7 time.
8 And so the goal of the attribution
9 model selection guide was really to sort of get
10 back to, basically, Harold's question, which was
11 to define the minimum elements that should be
12 shared with accountable entities, and basically
13 define the minimum specifications of what an
14 attribution model should be, and make those
15 transparent.
16 And so the elements that we sort of
17 landed on was, and this would basically be the
18 definition of what an attribute model is, and the
19 elements that one should consider when developing
20 an attribution model.
21 The first is what is the context and
22 goal of the accountability program?

1 And again, there's certain sub-
2 elements here that should be considered by those
3 program-implementers and measure-developers
4 related to the outcomes and results of the
5 program, whether the goals of the program are
6 aspirational or evidence-based, and the
7 accountability mechanism of the program.
8 The second is how do the measures
9 relate in the context in which they're being
10 used?
11 And these really look at some of the
12 measure-specification elements related to
13 inclusion/exclusion criteria, and really, the
14 sample size of whether or not there's enough
15 individuals to draw fair conclusions.
16 And I know this might generate some
17 conversation around what is a sufficient number
18 of individuals to draw fair conclusions? Which,
19 again, the testing elements here have really
20 triggered a second phase of work.
21 I'll also draw sort of a connection
22 between this element and many of the public

1 comments that we received in this Committee's
2 work related to whether or not there's a
3 sufficient sample size at various levels of
4 analysis.
5 And we hear this a lot, related to the
6 clinician programs around whether or not we can
7 take measures that have been developed for other
8 levels of analysis, and whether they're
9 appropriate to be attributed to individual
10 providers.
11 Again, I think that's just an example.
12 There's other care settings that we've seen this
13 discussion sort of play out through.
14 Third is who are the entities
15 receiving the attribution? What are the units
16 eligible for attribution? What's the conceptual
17 rationale between the accountable unit?
18 And whether or not they can
19 meaningfully influence the outcome, again, issues
20 of sample size and whether or not multiple units
21 are actually used to be held for that outcome.
22 And how is the attribution performed,

1 the data, how the services are assigned, and the
2 details of the algorithm and methodology.
3 And so as we look forward to the
4 recommendations of the attribution models, the
5 recommendations are built on the principles and
6 are intended to be applied broadly to developing,
7 selecting, and implementing attribution models in
8 the context of both public and private-sector
9 accountability programs.
10 I just wanted to sort of reiterate
11 that the environmental stand that was evaluated
12 really very much focused on private-sector
13 programs as well, to inform the work of this
14 group.
15 And thirdly, recognize the current
16 state of the science and what is able to be
17 achieved now, and the ideal future state of
18 attribution models.
19 And then also stress the importance of
20 aspirational attribution models in order to drive
21 a greater accountability for our patients as we
22 move the field forward.

1 And so Erin, maybe I can ask you to
2 also just sort of review some of the factors as
3 one selects an attribution model?
4 MS. O'ROURKE: Sure, so the final
5 product that the Committee put out in this first
6 phase of work was a series of recommendations.
7 The first was to use the attribution
8 model selection guide that Taroon just ran
9 through to evaluate these factors.
10 When making this recommendation, they
11 emphasized right now there is no gold standard.
12 Different approaches may be more
13 appropriate depending on the situation and what
14 you're trying to achieve with an attribution
15 model.
16 They emphasize that the model choice
17 should be dictated by the context in which it
18 will be used and supported by evidence.
19 They highlighted that developers and
20 program-implementers need to be transparent about
21 the potential tradeoffs between the
22 accountability mechanism, the room for

1 improvement, the level of influence that the
2 entity you're holding accountable might have over
3 the outcome you're measuring, as well as the
4 scientific properties of the performance measure
5 you're considering for use.
6 The second recommendation they made
7 was that models should be tested.
8 Attribution models offer quality
9 initiative programs to be subject to some degree
10 of testing for things like goodness of fit,
11 scientific rigor, and potential unintended
12 consequences.
13 They did highlight the degree may vary
14 based on the stakes. Perhaps for public
15 reporting or payment, it's higher than a program
16 that's for internal quality improvement.
17 Using a mandatory accountability
18 program, the Panel emphasized that the model
19 should be subject to testing demonstrates there's
20 an adequate sample size, that outliers are
21 appropriately dealt with through either
22 exclusions or risk adjustment to allow fair

1 comparisons, and that the data source is
2 sufficiently accurate.
3 The third recommendation is that
4 attribution models should be subject to a multi-
5 stakeholder review.
6 The Panel really built on the current
7 lack of evidence, noting that without a gold
8 standard, stakeholder perspectives are key in
9 this area and recommended that a process be
10 developed that allows the stakeholders to weigh
11 in and come to consensus about what might be the
12 best way to attribute performance.
13 The Panel emphasized that attribution
14 model selection and implementation in both the
15 public and private sectors should use a multi-
16 stakeholder review process to determine the best
17 model for their purposes.
18 The next recommendation, attribution
19 models should attribute care to entities who can
20 influence care and outcomes.
21 The Panel recognized that currently,
22 there are models that could unfairly assign

1 results to an entity -- that was the word they
2 used for providers, just to clarify -- who may
3 have little control or influence over the
4 patient's outcomes, and that for a model to be
5 fair and meaningful, the accountable entity needs
6 to be able to influence the outcomes that they're
7 being held accountable for, either directly or
8 through collaborating with other groups.
9 And then the Panel highlighted that as
10 we continue to move to team-based care, our
11 facilities become more integrated.
12 I think, to some of the points that
13 just came up in the PAC discussion as we're
14 moving to an ACO world and trying to really
15 emphasize team-based care, attribution models
16 need to reflect what an accountable entity is
17 able to influence, rather than necessarily
18 directly control.
19 Then, finally, the Panel recommended
20 that attribution models used in mandatory public
21 reporting or payment programs should meet a set
22 of minimum criteria.

1 They highlighted the need for
2 transparent, clearly articulated, reproducible
3 methods of attribution to identify an accountable
4 entity that is able to meaningfully influence the
5 measured outcomes, that you have an adequate
6 sample size, that outliers are excluded, or you
7 used risk adjustment to fairly compare results,
8 that the model has undergone sufficient testing
9 with scientific rigor at the level of
10 accountability being measured, that the model
11 demonstrates accurate enough data sources to
12 support our policies, the measure-developer or
13 the program-implementer demonstrates that their
14 data is sufficiently accurate to support the
15 model.
16 And the Panel finally recommended
17 there's a need for an adjudication process for
18 attribution models that are open to the public,
19 that allow for a timely and meaningful appeal by
20 the entity being measured when they may be
21 attributed a patient that they've never seen, or
22 they feel they don't actually have the ability to

1 influence their outcomes.
2 So, we sort of wanted to bring up the
3 fact that we have a second phase of work, and
4 then the purpose of introducing it back to the
5 MAP Coordinating Committee is the fact that,
6 obviously, these issues related to attribution
7 are very relevant to the work that we do.
8 So, we're looking for input.
9 I just wanted to close out by just
10 describing the second phase of work that we're
11 currently in the middle of, which is to expand on
12 the first piece of work that received a lot of
13 interest in terms of public comments and input
14 from you all, and then, obviously, the
15 stakeholders of NQF, as well as our colleagues
16 from CMS.
17 And so the second phase of work to
18 continue to develop additional guidance in this
19 area of measurement was to really pressure-test
20 the Attribution Model Selection Guide against
21 different use cases, both, again, private-sector
22 and public-sector use cases in which we sort of

1 looked at some advanced APM models and then also
2 some work by our colleagues at health partners in
3 Minnesota.
4 So, pressure-test the Attribution
5 Model Selection Guide and then consider
6 attribution guidance as it relates to several
7 important subcategories related to team-based
8 care, attributing complex patients and special
9 populations, thinking about data integrity and
10 data collection, and then other unintended
11 consequences that should be monitored as we
12 deploy attribution models.
13 And so these are the areas that we're
14 continuing to explore in the second phase of
15 work.
16 And so with that, I think the main
17 question that we've raised to the group is as we
18 continue to developed additional guidance in this
19 area, is there feedback that you all have based
20 on the work that we've done together, that we
21 should consider as we deploy this next phase of
22 work relating to attribution?

1 So, I'll stop there and welcome
2 comments and feedback from the Coordinating
3 Committee.
4 CO-CHAIR PINCUS: I just want to kick
5 off the discussion by just raising a couple of
6 issues, then we'll go down one side and up the
7 other.
8 So, Taroon and Erin, I have a good
9 idea of what are the issues in attribution but I
10 still don't understand what the unit of analysis
11 is in terms of what is a model?
12 And when I think about attribution and
13 how to apply it, I think about it in terms of,
14 number one, what are the changes we want to
15 achieve or what are the goals we want to achieve?
16 Number two, who do we expect, who
17 needs to lead and participate in achieving those
18 goals?
19 And number three, what incentives or
20 supports will induce them to engage in that role?
21 Those are the ways I think about it.
22 And what you've laid out is a lot of

1 the issues you need to think about in terms of
2 appropriately identifying and motivating groups,
3 entities, to achieve those goals.
4 But I still don't know what the unit
5 of analysis is.
6 Like when you said over 160 different
7 -- are you talking about programs, or are you
8 talking about actually conceptual frameworks?
9 DR. AMIN: Yes, so, Erin, feel free to
10 jump in here.
11 So, when we looked at what was out
12 there, it was really the programs, and what we
13 were trying to extract from those programs is
14 what are the elements that define what those
15 models are?
16 And so I think some of the questions
17 that you're sort of raising, Harold, and maybe I
18 could just go back a little bit to at least the
19 way that we were thinking about this, it's that
20 the elements that really need to be -- because we
21 didn't see this very clearly laid out for all
22 those 160 programs that were out there.

1 And I think just the first piece of
2 work was just to take those 160 and say what do
3 you actually need to make transparent as you're
4 deploying any attribution model?
5 And these are the things that we need
6 to be able to see so that we can actually at
7 least just understand what you're doing, what
8 each of these programs are.
9 And so I think you've laid out several
10 of these considerations.
11 I think where the Expert Panel sort of
12 landed as a first piece of work was that given
13 the heterogeneity of what we were seeing out
14 there in terms of the programs, we wanted to at
15 least lay out the elements that need to be very
16 clearly specified and made transparent.
17 Now, I think the question is then, how
18 do you look at that and make some sort of
19 subjective evaluation of that? And I think we're
20 still not there yet.
21 This was really just laying out, at
22 least if you sort of think about it as the

1 specifications of when you talk about an
2 attribution model, these are the elements that
3 should be made transparent.
4 CO-CHAIR PINCUS: No, I think these
5 are important issues. Two other quick points,
6 then we'll go around.
7 One is I think one thing that's not
8 there, what I think needs to be included, is a
9 theory of change. So, what is the conceptual
10 approach in terms of how you go about achieving
11 it?
12 What are the different steps that
13 would have to take place in terms of some causal
14 pathway that would theoretically impact the goal?
15 And the other thing is we've done a
16 lot of work around integration of mental health,
17 behavioral health, and general medical care, and
18 of the issues we've talked about is shared
19 accountability or shared responsibility.
20 So, for example, if I'm a
21 psychiatrist who has a patient with schizophrenia
22 and diabetes, which is not uncommon, I'm

1 responsible not just for the outcomes for
2 schizophrenia, but also for the outcomes for
3 diabetes.
4 And my colleague, who's their
5 internist or diabetologist who is treating their
6 diabetes, also has responsibility and
7 accountability for the diabetes outcomes, but
8 also for the schizophrenia outcomes.
9 Which means that we have to talk to
10 each other, and so that's one concept to think
11 about in terms of the way in which accountability
12 is shared.
13 So, why don't I stop there and call on
14 Andy?
15 CO-CHAIR KAHN: I just want to make
16 sure it's clearer.
17 I know you mentioned something
18 concrete. Can you walkthrough one of these
19 concrete programs and then present the problem,
20 before we have the discussion?
21 I'm just sort of simple-minded, I'm
22 having trouble visualizing it exactly, so what

1 would be a good example? Readmissions?
2 I don't know, just think of an
3 example and then walk us through, just so we all
4 know what the terms are that you're discussing.
5 MS. O'ROURKE: Sure, and I'll take
6 some liberties.
7 One example the Committee played with
8 in their meeting was the use of the Medicare-
9 spending-for-beneficiary measure, and the
10 hospital, value-based purchasing program.
11 So, I think not to necessarily put
12 words in CMS's mouth, but maybe you would say the
13 goal of this program is to improve care in acute-
14 care hospitals, use a cost measure that is the
15 cost for the hospital episode, plus 30 days after
16 to try to get some shared accountability around
17 cost savings, ask the hospital to innovate who
18 they're partnering with, examining what happened
19 to the patient after discharge, might be the type
20 of things we'd ask under this first box.
21 Thinking about how the measures relate
22 to the context in which they're being used, that

1 measure is developed for a facility-level
2 analysis in an acute-care hospital.
3 But when it was being endorsed, some
4 question around this 30-day post-discharge window
5 is that something the hospital can reasonably
6 influence is a fair time period post-discharge to
7 consider costs.
8 So, I think that's the type of
9 questions we'd ask someone to think about in this
10 second box.
11 DR. AMIN: Can I just jump in on that
12 last one? So, I think this is actually really
13 helpful.
14 So, as we look at that measure of the
15 30-day spending, part of what you would look at
16 there is also how much of the variation in that
17 measure is related to what's going on in the 30
18 days, versus hospital performance, if you're
19 attributing it to a hospital, in the context of a
20 hospital, value-based purchasing program.
21 And so that would be another sort of
22 discussion that we would expect to have, as the

1 measures relate to the program that's being used.
2 MS. O'ROURKE: So, then thinking about
3 this third question about accountability
4 entities, obviously, the program attributes to
5 the hospital.
6 But the spending within the measure
7 can be driven by post-acute providers and
8 clinicians in the community.
9 So, that kind of dissonance for those
10 30 days, who is responsible for the cost versus
11 who is being attributed, and in the program, the
12 performance would be held to the hospital.
13 And then, finally, how was the
14 attribution performed? Asking some questions
15 about the data.
16 So, in this example, claims data, does
17 everyone have access to it? What are the
18 services, the cost for the inpatient episode plus
19 30 days?
20 Asking some questions about the
21 details of the algorithm, and I think we've
22 already covered a little bit.

1 CO-CHAIR KAHN: Okay, thank you.
2 But I think just in terms of your
3 example, you really have to be careful with
4 proportionality because let's say you have an
5 episode of illness over the 30 days without a
6 readmission, a readmission throws everything off.
7 The hospital's paid a DRG so assuming
8 that the DRG is the correct DRG for that ailment,
9 it could end up taking the weight of the
10 proportionality of the total spend.
11 But if there's no readmission, then if
12 there's higher than normal spend post, that may
13 or may not be something the hospital could or
14 could not affect.
15 So, it's a very difficult thing to
16 assess. I'm sorry, I just wanted to get the
17 example out there.
18 Amy's got some questions?
19 MEMBER MULLINS: So, I think that we
20 really need to -- building on that, are we
21 attributing to measures or are we attributing to
22 hospitals, or are we attributing to clinicians?

1 Because I think that when I was
2 hearing the explanation, I could kind of hear you
3 saying all of those three different things.
4 So, I think we need to be really clear
5 about who or what we are attributing to. So, we
6 need to ask ourselves why we do attribution to
7 begin with?
8 We do attribution because physicians
9 need to know who their patients are so they can
10 do quality improvement work. If I don't know who
11 my patients are, I can't improve their quality of
12 care.
13 So, if we want to do quality
14 improvement, we have to know who we are taking
15 care of.
16 We know who we're taking care of
17 because we have an attribution model that tells
18 us who belongs to us.
19 So, I think, at its root, that is what
20 attribution is for, is to be able to do quality
21 improvement.
22 And if you make it too complicated,

1 clinicians aren't going to be able to understand
2 it or be able to utilize it, or work within that
3 system, to do the quality improvement work that
4 we're all so desperately trying to do.
5 So, 130 models, too many, most of them
6 too complicated to understand and too complicated
7 to use, so we need to have something that's
8 simple, something that is the same, something
9 that's harmonized across payers.
10 How many times do we say this about
11 other things that we're working on? But I think
12 we also need to work in patient choice.
13 So, the AAFP just submitted an APCAPM
14 proposal to PTAC that was accepted for testing,
15 and we have to come up with an attribution model.
16 So, the first step in our attribution
17 model was why don't you ask the patient who their
18 physician is and attribute them to that person?
19 I mean, it seems quite simple when you
20 think about it, but that's probably who the
21 patient's physician is. It's whoever they say
22 their physician is.

1 So, I think that step doesn't need to
2 be missed, is ask the patient who they need to be
3 attributed to. But I think we've got to tease
4 out this work attribution into a measure.
5 That's not where attribution belongs;
6 attribution belongs at the clinician level and
7 not at the facility level and not at the measure
8 level.
9 CO-CHAIR KAHN: Bruce?
10 MEMBER HALL: Well, I certainly second
11 much of what's already been said so I can keep it
12 short.
13 I certainly enjoyed this paper when it
14 was first released, and as a measure-developer
15 formally serving on multiple NQF Panels --
16 CO-CHAIR PINCUS: A little bit closer
17 to the mic?
18 MEMBER HALL: -- I think it's an
19 important work. There are some gold standards
20 about attribution that I think should be included
21 in the deliberations.
22 So, for instance, sometimes whoever

1 got paid for the service, there shouldn't be any
2 question about attributing to them.
3 But there's another gold standard,
4 which Harold alluded to, and that is based on
5 theory of change, who can actually effect a
6 change.
7 And that may be totally different than
8 whoever delivered a service or got paid for
9 service, and I think that should be considered as
10 well.
11 But I think the one area where the NQF
12 can be more strict is that I think we should
13 stand firmly against use of measures that are not
14 consistent with their development attribution.
15 And I know there's kind of a grey
16 history in the past about stating what the
17 intended use of a measure is.
18 But when the development and testing
19 and science behind a measure is based on
20 attribution at a particular level, I don't think
21 anyone should conflict with that.
22 So, if all the testing shows

1 reliability at the individual level, that's one
2 thing. That doesn't mean you can go use it for
3 institutional or vice-versa.
4 And I think the NQF can stand pretty
5 firmly on that, when use of a measure conflicts
6 with the development attribution that was tested.
7 CO-CHAIR KAHN: Leah?
8 MEMBER BINDER: I want to suggest an
9 addition to the model, or an enhancement to the
10 model perhaps, that there needs to be monitoring
11 of attribution at later stages once data has
12 actually been collected on a measure.
13 It is one thing to theoretically
14 surmise who would be responsible for what
15 outcome.
16 But I think when we're actually
17 looking at the data, often, we recognize,
18 especially when we see variation, that for
19 example, a high performer in a particular measure
20 may have a different way of achieving the
21 outcome, if it's an outcome measure.
22 And so that can update an attribution

1 model in a way that will also drive overall
2 quality improvement because we begin to identify
3 best practices for achieving a given outcome by
4 looking at the variation in the outcomes.
5 And it's kind of like healthcare's a
6 team sport; it's kind of like a baseball team.
7 Who is responsible for winning the game?
8 Was it the batter who hit the winning
9 run, or was it really the whole team because they
10 had some participation at some point?
11 And then once we see a whole bunch of
12 games, we can start to analyze and begin to
13 understand which role had which impact.
14 So, I think the attribution model
15 should be an evolving phenomenon and not
16 something we see as just a theoretical part of
17 the launch of a measure.
18 CO-CHAIR KAHN: Rob?
19 MEMBER ANTHONY: I just wanted to
20 speak very firmly with my ONC hat in place and
21 ask that as we move into this and we think about
22 it with this project, to think about the role

1 health IT occupies in this area or, I think more
2 importantly, could occupy in this area.
3 I think not only where it can
4 facilitate that attribution model currently, but
5 perhaps in the way health IT can be used to
6 innovate in this area and think about how we do
7 electronic measurement, ECQMs very much now are
8 modeled on the same way that we do chart
9 abstraction.
10 I do think as you start to look at
11 attribution across multiple systems and multiple
12 settings, you open up some new ways of looking at
13 how that measurement is done.
14 I realize that's not necessarily the
15 central driving part of it, but it very well
16 could be as we move forward.
17 CO-CHAIR KAHN: Giff?
18 MEMBER GIFFORD: I reiterate Bruce's
19 point that the testing is an important issue.
20 But I'd say one of the things I think
21 is for the Committee to really consider is the
22 mindset we bring, and that you don't

1 inadvertently, through attribution, reinforce the
2 existing siloed nature of healthcare issues.
3 The tension clearly is that the
4 payment models are siloed, and so you could have
5 measurements that are not. But the payment is
6 siloed, so how do you do it?
7 But I will say the mindset that,
8 generally, most of us bring to the table is very
9 clinically-oriented and we forget about the
10 systems.
11 And so taking the hospital example,
12 what launched all this was Steve Jenk's article
13 looking at CHF discharges and showing that a
14 large proportion of them had no follow-up care at
15 all in the next 30 days, because it wasn't
16 arranged by the hospitals.
17 And then as soon as the hospitals were
18 starting to have attribution to re-
19 hospitalizations after discharge, they started to
20 change their practice.
21 We're seeing the same thing in the
22 nursing-home settings and elsewhere.

1 So, I caution going too far down this
2 attribution level to basically have us pull back
3 from this idea of systems and episodes of care,
4 and going there.
5 But I understand and appreciate that
6 the payment systems don't really lend itself to
7 doing that at the same time.
8 So, I give a lot of credit to a really
9 thoughtful, I think, process going forward.
10 Because I would make sure that that's out there.
11 Don't let the dominant view of the
12 current practice reinforce attribution, because I
13 think we will not make progress then.
14 CO-CHAIR PINCUS: Other comments,
15 questions? Oh, Dave, sorry.
16 MEMBER INTROCASO: So, I haven't read
17 this document but I'm extremely interested in
18 doing so, and AMJ would have a great deal of say
19 about this.
20 This is an extremely important subject
21 so I applaud your willingness to take it on, very
22 complicated. You'll invariably or inevitably

1 miff off some people or several people.
2 In the physician world, this is all
3 about largely P-for-P programs, principally,
4 MSSP.
5 There is a great deal of argument
6 about retrospective versus prospective
7 assignment, attribution.
8 There's no consensus relative around
9 how you do this.
10 But I will say just a generic point,
11 which is I don't see how you get to pay-for-value
12 unless you can intelligently, correctly,
13 appropriately, whatever --- attribution.
14 I can tell you the physicians could go
15 on for hours about their complaints in this
16 regard, but this work is sorely needed.
17 I will say I didn't see in these any
18 reference to MIP's or MACRA's patient
19 relationship category.
20 So, maybe as a question, I'm assuming
21 you looked at the Title 1 of MACRA and you talked
22 to CMS about how far down the road they are on

1 that?
2 DR. AMIN: Yes, so, Erin, correct me
3 if I'm wrong, the conversation did come up in our
4 first phase of work but it was really new in
5 terms of what -- we were sort of interested to
6 see how it would be deployed.
7 I don't know if there was anything
8 else to say about that.
9 Yes, I think when the first paper came
10 out, it was something.
11 They acknowledged the potential source
12 for the future, but I think in this new phase of
13 work, we can explore what's happened since then,
14 and maybe see if Kate and Pierre wouldn't mind
15 connecting us with their staff?
16 DR. YONG: Sure, so for folks who
17 aren't familiar with these patient relationship
18 codes, we had sought public comment and then
19 developed a new set of codes, which would be
20 included as part of the claims submission
21 process, in which the provider would self-
22 identify their relationship with the patient for

1 which that claim is being submitted, for that
2 service.
3 So, it ranges from whether it's an
4 acute or chronic, and then how close, whether
5 they're the referring physician or they're the
6 primary doctor, whether they a short-term
7 relationship or a long-term relationship with
8 that patient.
9 So, we are starting to collect that
10 data beginning in 2018 on a voluntary basis from
11 clinicians. Ultimately, in the long term, we'd
12 like to see how the data that comes in examine
13 that.
14 But certainly, there is the potential,
15 as David mentioned, for use of that data once we
16 have a firm sense of the data that's coming in,
17 to potentially include that as part of the
18 attribution methodologies that we use for the
19 variety of potentially quality and cost measures
20 that we have in the program.
21 CO-CHAIR PINCUS: Amir?
22 MEMBER QASEEM: I just want to

1 reiterate two points that Amy and Bruce made.
2 One is I think that the attribution
3 models, they need to be easier understood and
4 meaningful to patient's families and clinicians.
5 And I think that was one of the
6 guidance principles. It seemed like it
7 disappeared in this, and at least in the matrix.
8 I quickly tried to look at this and I didn't see
9 that.
10 And what Bruce brought up, that whole
11 issue of these measures are getting the whole
12 reliability, validity is happening at a certain
13 level.
14 But then they're getting applied at a
15 different level, and it continues to be a
16 problem. And I'm not entirely sure what is the
17 reason.
18 So, when you did this environmental
19 scan, I think that would have been interesting to
20 hear about why does that issue continue to
21 happen?
22 And the measures are getting tested at

1 health-plan level, but then clinicians are
2 getting attributed or just being applied over
3 there.
4 So, I'd like to hear a little bit more
5 and I think that's something that needs to be
6 looked at.
7 I think you guys have done a very good
8 job when you did the guiding principles. I really
9 like them, but then again, they were not even at
10 100,000-foot level, they were very, very high up
11 there.
12 And I think once you start applying
13 them, they started making more and more sense and
14 I like what you had on your Slide 18, in terms of
15 what should happen before attribution models are
16 used in mandatory public reporting or payment
17 programs.
18 And many do meet these criteria.
19 I'm not really entirely sure, still,
20 of what happened. Is this something that you
21 have now put out as an official statement and now
22 that's what we're hoping to follow?

1 What exactly does that slide mean?
2 Because I think that's the key and I'm really
3 glad that you're going to continue following.
4 You have the project where you're
5 going to do this white paper and all that going
6 forward, but if you already have that minimum
7 criteria, and of course we can debate those too,
8 it'll be good to get that going first before we
9 proceed to whatever is the next step of what
10 you're trying to achieve.
11 Because you already have a good model
12 in place.
13 And the final point I want to make is
14 I think since NQF does believe in harmonization
15 of efforts, there's a lot of good work that's
16 happening.
17 Other groups, PCPI comes to my mind;
18 I'd hate to have NQF come up with something and
19 PCPI have something -- I think if we can speak
20 with a single voice together, that would carry
21 more weight if we go do any of the pairs.
22 Just more comments and a couple of

1 questions in there.
2 CO-CHAIR PINCUS: Just one other point
3 just to add to that, I think in relation to the
4 PCPI and other groups, but there's also, I don't
5 know if it still exists, but the Healthcare
6 Payment, Learning, and Action Network also should
7 be in the loop in this.
8 Chip, did you have a comment?
9 CO-CHAIR KAHN: Yes, I thought
10 something that Cliff said was very profound and
11 important, and it's covered but I don't know,
12 frankly, how to deal with it here.
13 And part of the dilemma in terms of
14 this aspirational aspect, which I think is what
15 Cliff was talking about, that, on its face, as
16 the system works now, a measure may break the
17 system because the entity, the hospital, has
18 nothing to do with post-acute traditionally.
19 So, how can you say you're responsible
20 for it?
21 Well, once you make them responsible
22 for it, then something changes, even though you

1 don't receive it anymore for -- actually, you
2 could receive less money than you did before.
3 And you could then get into the fairness issue.
4 The trouble is that, part of the
5 problem is, having been in this position myself,
6 policy people have notions and aspirations that
7 may not be realistic.
8 And their attitude is, well, I'm just
9 going to break the current system, screw them.
10 And it may not actually reflect the reality of
11 what people can do.
12 On the other hand, then you've got
13 this issue of stretch, which is, well, but if you
14 don't stretch them, they're not going to do it.
15 And the distance between screw them
16 and stretch is a really difficult value judgment
17 that's really hard to make, and actually, is not
18 applicable in all situations.
19 Because in some of them, by
20 definition, it's going to be they're going to get
21 screwed, and then by definition in others, they
22 should have been thinking about it and now

1 they'll start thinking about it.
2 And actually, it makes a difference to
3 the patient.
4 So, I guess what Cliff brought up
5 really troubles me because I know that the gut
6 reaction of most is if I can't do something about
7 it directly, then don't bother me with that
8 measure, it's not fair.
9 But we've got to figure out how to
10 deal with that.
11 Also, I thought Amy's point was really
12 important, except I think of myself and I still
13 haven't done anything about my blood pressure.
14 And both my cardiologist and my
15 internist both talk to me about it separately,
16 and both are responsible for it and --
17 CO-CHAIR PINCUS: Have you talked to
18 your psychiatrist?
19 (Laughter.)
20 CO-CHAIR KAHN: No, I haven't done
21 that yet.
22 And so frankly, yes, they both take

1 the blood pressure so they pass the process
2 measure, and yes, they talk to me and I said,
3 well, you know, it's because you make me nervous
4 in the room and that's why the blood pressure is
5 what it is.
6 And I'll go home and do my own blood
7 pressure, and then if I sit down long enough at
8 home, I can get a blood pressure I like until I'm
9 fine. But this is a realistic issue.
10 If you ask me, so who is responsible
11 for your blood pressure? Well, first, actually
12 it should be me, but I don't know whether it's my
13 cardiologist, and I'm a relatively educated
14 patient.
15 So, I think that's a very difficult
16 one and then when you get to the seniors who have
17 -- I guess I may be almost a senior, I guess I am
18 a senior.
19 I don't have a lot of doctors. I'm
20 not sure they could answer that question. If I
21 ask my mother about a couple of her ailments, I'm
22 not sure she would know who to answer.

1 So, that's a very difficult one too.
2 Those are just two points.
3 Let me just add to that. I think in
4 addition to the screw them and stretch, I think
5 there's also a third thing, which is let's make
6 up another entity that's accountable.
7 And that, in some cases, may be a way
8 to fix the system, but it also comes with it
9 certain startup costs and sort of other kinds of
10 issues that sort of come up down the line.
11 So, in each of these cases, I don't
12 think there's one great solution and I think what
13 you're developing is a way to evaluate the
14 options in a systematic way.
15 DR. AMIN: And I would even maybe take
16 a step back to say maybe it's just to make it
17 transparent at least, and then to evaluate,
18 hopefully, at some point.
19 I know we're out of time. I'm not
20 going to try summarize everything that was said,
21 but I think that there's some key things here
22 that relate to what we were thinking and take it

1 a step further.
2 I think the first is this concept of
3 what's the theory of change that we're expecting,
4 and to make that transparent and at least to have
5 that conversation.
6 I think several times that we've --
7 whether it's through the MAP process or through
8 the CDP process, it's not always necessarily
9 clear what we're expecting when we're trying to
10 do the stretch in the conversations that we've
11 had.
12 Even in the initial conversations,
13 Giff, that you brought up around readmissions, we
14 went through the conversation around how much can
15 a hospital realistically be held accountable?
16 And then moving from one readmission
17 to multiple different settings, the question was
18 what really can each setting do to really handle
19 these readmissions?
20 And so I think if we maybe started
21 with some more conversation about this and made
22 it more transparent, it might have at least

1 added, contributed to the dialogue a little bit
2 more.
3 I think, Bruce, you sort of reinforced
4 that conversation as well.
5 The discussion around data is one
6 that's been perplexing quite a bit because many
7 of these models are really built on retrospective
8 and administrative claims data.
9 And so that in itself, going back to
10 the comment that was made around whether it's
11 retrospective or prospective, really, the data
12 elements really does make a meaningful difference
13 around what you can actually attribute, and more
14 importantly, offer providers, clinicians,
15 physicians, various different entities.
16 If you had the ability to sort of
17 prospectively understand your patient population,
18 your ability to do quality improvement,
19 obviously, would be enhanced.
20 So, many of these things we'll take
21 back and consider and we appreciate the
22 conversation, obviously, since we deal with this

1 every time we come into the conversation about
2 the various measures as they're used in the
3 programs.
4 We, collectively as a Committee, see
5 these challenges. So, I know this was a very big
6 topic to throw at everyone.
7 We would welcome comments once you
8 have an opportunity to review the paper as well
9 via email.
10 Feel free to send those along and
11 we'll be sure to consider those as we think about
12 the next phase of work.
13 CO-CHAIR PINCUS: Thank you. Is there
14 one additional point before we go to lunch?
15 MEMBER GIFFORD: I was just going to
16 say you can take immunization measure, it's
17 potential for a population measure down to the
18 individual.
19 Good immunization measures for
20 influenza, good population measure.
21 But until we started holding
22 individuals accountable, a lot of providers said

1 I don't want to be attributable to it.
2 But then they design the measures in
3 a way that people were acceptable, then it really
4 helped drive up immunization rates.
5 And so there is a balance between
6 these two and how to do it, and to Bruce's point,
7 about how you can't just take a population
8 measure and hold an individual position
9 accountable for it without changing the specs.
10 And so it might be a measure to think
11 about and how do you balance that tension between
12 stretching and screwing somebody?
13 Chip's measures terminology.
14 DR. AMIN: This point came up several
15 times. Bruce, you made it and, Amir, you made it
16 as well. The question is what are we doing with
17 this?
18 It's a 10,000-foot project. The way
19 that we were sort of thinking about this is when
20 we're talking about attribution, let's at least
21 develop the boundaries of what we're talking
22 about, make it transparent.

1 And now what we're starting to think
2 about is how do we make this actionable, either
3 through the CDP process or the MAP process so
4 that we can actually -- these are minimal
5 thresholds.
6 Amir, to your point, what do we do
7 with them? Are we going to implement this and
8 require this?
9 We're not necessarily sure yet, which
10 is part of the reason why we're having this
11 conversation here and in our endorsement
12 processes, to see if this is going to be a future
13 requirement?
14 Because right now, the endorsement
15 process is sort of use-agnostic.
16 It asks the question about level of
17 analysis, which is important and what I think the
18 basic elements of what Bruce is making clear, but
19 it doesn't necessarily go as far as what's being
20 asked for here.
21 And so all of that will be sort of
22 what we're striving to with at least this next

1 phase of work, and then potentially future
2 activities going forward.
3 Erin, anything else to add?
4 MS. O'ROURKE: Yes, I think it's
5 probably more a conversation for tomorrow when
6 we're going to ask you to take a look at the
7 preliminary analysis algorithm.
8 But we wanted to bring up this topic
9 and at least get you all thinking of are there
10 ways to do that algorithm or other things that
11 staff do that we could bring this type of
12 consideration to mind.
13 I think, Amir, to your point of how
14 could we make this actionable for the MAP
15 Committee, is there anything the Coordinating
16 Committee would like to add into the algorithm
17 about attribution?
18 Anything that staff should be calling
19 out about some of these issues?
20 So, something to think about overnight
21 as we bring you back tomorrow to take a look at
22 that algorithm, that we do prepare about each

1 measure is there a role for attribution questions
2 there?
3 And what would you like, as the
4 Coordinating Committee, the workers to have in
5 front of them when they're making their initial
6 recommendations to you?
7 CO-CHAIR KAHN: Okay, that was a great
8 discussion, and I appreciate everybody's input.
9 And it was a good opening for tomorrow, but now
10 let's come back to today.
11 And I know everybody's anxious to get
12 lunch, so we'll take between now and 12:30 for
13 lunch.
14 Then at 12:30, I guess we come back,
15 we'll reconvene, I guess we open up the phones
16 for public comment on the clinician programs, and
17 then we'll get into a full discussion of the
18 recommendations of the clinician programs.
19 And I have a feeling that we won't get
20 off as easy as we did earlier today from our
21 discussion on the post-acute area.
22 So, everybody go get lunch and we'll

1 reconvene at 12:30 p.m.
2 (Whereupon, the above-entitled matter
3 went off the record at 12:05 p.m. and resumed at
4 12:37 p.m.)
5 CO-CHAIR KAHN: Okay. So we're about
6 enter the clinician review which will begin
7 formally with the opportunity for public comment.
8 But before we do that, staff wanted to clarify
9 some of the voting issues, so Erin will -- I
10 guess Erin will take the lead on that and do that
11 for a moment and then we'll open the mics. I'll
12 say a few other things and we'll open the mics
13 for public comment.
14 MS. O'ROURKE: Apologies. We have a
15 visual aid that we are pulling up momentarily.
16 I just wanted to, before we take any
17 move votes, clarify some of the confusion from
18 the morning to hopefully avoid any process
19 concerns going forward.
20 So I misspoke on the rules about
21 quorum. For MAP; and this across MAP and CDP,
22 NQF defines quorum as 66 percent of the eligible

1 voters, however to pass a motion we have defined
2 consensus as greater than 60 percent of the
3 eligible voters. So those are the thresholds to
4 keep in your mind. Sixty-six percent is quorum;
5 greater than sixty percent is consensus. So we
6 wanted to break this down for you so you could
7 just be tracking exactly what numbers we need
8 here.
9 There are 32 members of the MAP
10 Coordinating Committee. Four of you are federal
11 liaisons, so you are not eligible voters; so you
12 come off the top if you're a fed, leaving us with
13 28 eligible voters. For our 66 percent threshold
14 of eligible voters that comes to 19 people are
15 needed to achieve quorum. If we do not have
16 quorum, we won't take a vote in the room. We
17 will follow up with you via SurveyMonkey after
18 the fact.
19 If you need to recuse yourself from a
20 vote, you will be removed from the denominator.
21 Going along with the federal liaisons you are not
22 eligible to vote. We define that as if you have

1 a conflict of interest, if you participated in
2 the development of the measure, similarly to how
3 Elisa described it this morning. We don't think
4 anyone else has one for the rest of the day, so
5 -- but please let us know if you feel like you
6 might have a conflict and feel you need to be
7 recused from the denominator of eligible voters.
8 Abstentions are included in the
9 denominator for quorum, so abstaining is if you
10 just choose not to -- you could vote on a
11 measure, you choose not to for whatever reason.
12 So we've just played out some scenarios for you
13 for quorum. No number of abstentions will change
14 what we need for quorum. Nineteen is our magic
15 number. If we do have any more recusals, then
16 you'll see people drop out. Our N would change
17 from 28 to 27, so we would need 18 people around
18 the table to have a quorum.
19 For consensus this is we are looking
20 for greater than 60 percent of you to pass a
21 motion. So again, we have 28 eligible voters.
22 We would need 17 people to hit a 60 percent

1 threshold for consensus. Here again recusals are
2 removed from the denominator. For consensus we
3 also remove abstentions from the denominator.
4 So playing out some scenarios, if we
5 have one abstaining, we would need 17 people to
6 pass a motion. If there are two abstentions, we
7 need 16 people. Three, fifteen and then so on
8 and so forth.
9 So let me just pause and make sure
10 people are okay with this. Any questions? Any
11 process -- we'll obviously have a session on
12 fixing the process tomorrow, but before we get
13 into some of the heavier voting I just want to
14 pause and make sure people are comfortable.
15 John?
16 MEMBER BOTT: So this will come up in
17 the hospital thing. So I was on a TEP for the
18 hospital-wide mortality measure, one of the CMS
19 TEPs. I don't think that's a conflict the way I
20 read the paperwork. I wasn't a measure
21 developer, but we were -- the TEP provided
22 advisory -- had an advisory role to developing

1 the measure. So does that -- is that a conflict
2 where you shouldn't be commenting or is that
3 okay?
4 MS. MUNTHALI: Yes, that would be a
5 conflict, so we'd ask you to recuse yourself.
6 MEMBER BOTT: Oh.
7 MS. MUNTHALI: Yes.
8 MEMBER BOTT: Okay. Well, the
9 hospital session is later, right?
10 MS. MUNTHALI: Yes.
11 MEMBER BOTT: We're on the clinic one?
12 MS. MUNTHALI: So for that measure,
13 whatever measure is in front of you in which
14 you --
15 MEMBER BOTT: Oh, wow.
16 MS. MUNTHALI: -- participated in the
17 measure development process, even in an advisory
18 role, you would be conflicted on that.
19 MEMBER BOTT: Yes, okay. Is there a
20 break before then? There are some kind of
21 logistical things to discuss. Maybe it's just
22 best one on one.

1 MS. MUNTHALI: Yes, we do have a
2 break.
3 MEMBER BOTT: Okay.
4 MS. MUNTHALI: So we can talk further.
5 MEMBER BOTT: Great. Thanks.
6 CO-CHAIR KAHN: We're going to do the
7 clinician first.
8 MEMBER BOTT: Yes, okay.
9 CO-CHAIR KAHN: And then we'll do the
10 hospital.
11 MEMBER BOTT: Okay. Thanks.
12 MS. MUNTHALI: And also just to let
13 you know, since the other measures are not
14 competing, you could vote on the other measures.
15 It's just that one measure in which you had
16 involvement in.
17 MEMBER BOTT: Okay. Thanks.
18 CO-CHAIR KAHN: Is everything clear on
19 the voting? I mean, it is what it is, so it's --
20 I mean, it's the rules we work under, unless they
21 change, but they're not going to change today.
22 (No audible response.)

1 CO-CHAIR KAHN: Okay. So we'll now
2 proceed. And let me remind those in the room or
3 those on the phone who would like to make public
4 comment regarding the Clinician Programs Task
5 Force that you should limit your comments to the
6 clinician programs recommendations, that we need
7 you to limit it to no more than two minutes and
8 make comments on the MUC list or opportunities to
9 improve the current clinician measures that are
10 in the set at this time.
11 So I'll look back in the back of the
12 room, and I see that we have a speaker. And
13 could you identify yourself and then make your
14 point? Thank you.
15 MS. RUBIN: Koryn Rubin, American
16 Medical Association. Just two general kind of
17 comments related to hopefully improving the MAP
18 process, one specific to the Clinician Workgroup
19 and the other that could probably be applied
20 broadly across all the workgroups.
21 First, in terms of the Clinician
22 Workgroup there's been ongoing concern and

1 comment that's been made that there's a lack of
2 clinician expertise on the Clinician Workgroup.
3 And what really gets discussed and evaluated in
4 depth is based on whether that clinician or that
5 physician specialty has a seat at the table,
6 otherwise a lot of items really get overlooked
7 and are not considered as part of the discussion
8 when the public makes comment.
9 So for example, on the Clinician
10 Workgroup there are only four clinician
11 specialties represented on there, and as these
12 measures get -- become more complex, there really
13 is a need for more physician expertise and input
14 into what gets discussed and put forward by the
15 MAP.
16 Second is the need for consistency in
17 terms of testing data. If CMS is going to
18 require as part of proposing a measure to be
19 placed on the Measure Under Consideration list,
20 then all testing data like they require of the
21 private sector needs to be available and put into
22 place at the time of proposal. We know of

1 instances of many physician specialties proposing
2 measures on the MUC list last summer which was
3 due July 1, and they were rejected because they
4 didn't have their testing data available.
5 And some said they could have it
6 available by August and were told that that was
7 not acceptable, however, CMS was able to bring
8 forward measures that lacked testing data and in
9 some instances, particularly with the cost
10 measures, only an oral update was provided and
11 the testing data has yet to be released today to
12 the public for evaluation. Thank you.
13 CO-CHAIR KAHN: Any other public
14 comments on the floor?
15 (No audible response.)
16 CO-CHAIR KAHN: Any comments from the
17 group about the comments that were made? Any
18 thoughts?
19 (No audible response.)
20 CO-CHAIR KAHN: Does CMS have any
21 thoughts about what AMA said? Yes, Amir?
22 MEMBER QASEEM: I think actually --

1 thanks so much, Koryn, for bringing up some of
2 these issues.
3 So I do actually have a follow-up
4 questions for NQF. It was a little bit
5 surprising for me. I was -- Multi-stakeholder's
6 Group. I absolutely think it's sound. We need
7 them. But I got little concerned about hearing
8 that there are only four clinicians in Clinician
9 Workgroup. With that, I'm going to look at these
10 recommendations a whole different light versus my
11 -- because right now we're voting just yes and no
12 keeping in mind that there is enough expertise.
13 So four out of how many members are we talking
14 about are in that group that are clinicians?
15 MS. MUNTHALI: So I think what we're
16 trying to do is confirm, number one, the number
17 of clinicians that are on the group, but I think
18 the challenge we have is that we're trying to
19 bring multi-stakeholders to together. So
20 different perspective, not just clinicians, that
21 can help us to make these decisions.
22 With that said, we're not really

1 always sure what measures are coming forward to
2 us through the MUC because we've constituted
3 these groups well in advance of when the MUC is
4 released, but we do try to make sure there's a
5 balance. We may not have all of the specialties
6 represented on there because we have funding for
7 a finite number of people on the workgroups, but
8 we are trying to be sure there's bounds. So
9 we're trying to make sure we can confirm that
10 number.
11 MEMBER QASEEM: So, absolutely. And
12 I'm --
13 MS. MUNTHALI: And we want to change
14 that, yes.
15 MEMBER QASEEM: -- not questioning
16 that you need to have every single sub-specialty
17 represented there, but you still need to have
18 enough number of threshold. But you're passing
19 vote is 60 percent. We've all dealt with public
20 members, and we have public members actually
21 sitting here at the table, right? These measures
22 get quite technical and I think to be fair is

1 lots that goes into the measure. Now if you're
2 going to be using these measures for essentially
3 evaluating the care that's being provided, I
4 think you need to get the process right. But
5 these measures are as only as -- if the process
6 is right. So a little bit concerning now for me
7 and actually --
8 DR. BAGLEY: Chip, my hand's up.
9 MEMBER QASEEM: -- when based on that,
10 because after looking at some of the measures
11 that I think I'm going to be pulling, now I get a
12 better feel for it why those measures even make
13 it through for our discussion today. But I think
14 that my measures probably have been discussed at
15 that group level.
16 CO-CHAIR KAHN: Okay. Thanks, Amir.
17 From the phone?
18 DR. BAGLEY: Yes, Chip, this is Bruce
19 Bagley. I'm the co-chair of the Clinician
20 Workgroup. And let me remind the Coordinating
21 Committee that most of these measures, especially
22 the ones that have been through the NQF process,

1 have had a tremendous amount of very specialized
2 clinician input way back in the process. So it's
3 not like there's nobody who knows all the details
4 that's had a chance to look at these before.
5 As you move up the line, whether it's
6 to the Clinician Workgroup, or for that matter
7 it's the Coordinating Committee, you're going to
8 get people that are supposed to be looking at the
9 big picture a little more than the details of the
10 measure, because that's really already been done.
11 CO-CHAIR KAHN: Let me ask a question
12 though. There are measures that aren't endorsed
13 though, right? So they would not necessarily --
14 am I wrong?
15 DR. BAGLEY: That's correct. And
16 there would be less, but most of those have
17 actually been created by clinician groups or
18 specialty organizations, and we've looked at
19 those in the past. So you're right about that,
20 but there's still a fair amount of work by
21 clinicians that goes into the making of the
22 measures or the early evaluation of the measures.

1 CO-CHAIR KAHN: Yes, Sam?
2 MEMBER LIN: Thanks, Chip. Just a
3 point of clarification. On the Clinician
4 Workgroup there actually are -- there are 13
5 physicians, about 3 or 4 who actually represents
6 single specialty societies, but it's a broad
7 base. I don't think we could have a workgroup
8 with all of the specialty societies. Talk about
9 chaos.
10 So I think it's -- to me there's sort
11 of this effort to say what's the general
12 consideration of physicians? And then you want
13 to get into some specifics, perhaps some
14 specialty input on those. But I think you've got
15 to look at it generally, otherwise I don't think
16 it will move at all.
17 CO-CHAIR KAHN: And you also have the
18 dilemma I assume on the Task Forces -- are the
19 Task Forces under the rule that you have to have
20 a majority non-provider clinician, or are the
21 Task Forces mixed?
22 PARTICIPANT: No, they're mixed.

1 CO-CHAIR KAHN: Okay. Because that's
2 an issue I guess in other places in the
3 hierarchy.
4 CO-CHAIR PINCUS: If need be, I mean,
5 we could send it around to the different groups
6 that are represented on the Clinician Workgroup
7 who'd want to see it.
8 MS. O'ROURKE: Why don't we pull up
9 the clinician roster?
10 Sheila, I just sent you an email with
11 it.
12 It's also on NQF's web site if anyone
13 wants to pull it up for themselves, but we'll get
14 it up on the screen in the room.
15 CO-CHAIR KAHN: Okay. And are we
16 ready, Sam? John?
17 MR. BERNOT: I was just going to
18 comment while we're bringing this up. I think
19 Koryn said there were four specialties, not four
20 clinicians, and I am -- we're verifying the
21 number of that. There is -- just looking through
22 the roster of actually credentials, it looks like

1 there's at least a dozen M.D.s or advanced
2 practice providers, or advanced care providers,
3 nurse practitioners.
4 So we'll get the final numbers, but
5 it's not four. I want to reassure the group that
6 it is the vast majority of the group does have
7 clinician credentials. We'll get the specialty
8 breakdown for you.
9 CO-CHAIR KAHN: Any more comments from
10 the floor?
11 (No audible response.)
12 CO-CHAIR KAHN: Are there any comments
13 from the public on the phone?
14 OPERATOR: Okay. At this time if you
15 would like to make a comment, please press star
16 then the number one.
17 (Pause.)
18 OPERATOR: No, no public comments at
19 this time.
20 CO-CHAIR KAHN: Okay. So we will
21 proceed. And I guess I'll ask John to go through
22 what's on the table and then I've got a couple of

1 things to say. The Committee will have the
2 opportunity to both put more things on the table
3 or discuss further what we've got on the table.
4 MR. BERNOT: Great. Thank you so
5 much. And thanks, everyone, for being here and
6 welcome this afternoon back from lunch. If you
7 don't know me, my name is John Bernot. I am the
8 Senior Director on the Clinician Workgroup for
9 MAP. We also have two of our co-chairs on the
10 phone, which I know Bruce Bagley you heard. His
11 line is open. Amy Moyer is the other chair.
12 Amy, would you be able to just say
13 hello so that we know that your line is open and
14 you're able to hear us?
15 MS. MOYER: Sure. Hi, this is Amy.
16 Can you hear me?
17 MR. BERNOT: Yes. Great. Thank you
18 so much.
19 MS. MOYER: Thank you.
20 MR. BERNOT: So we'll just go over a
21 very brief overview of the two programs that the
22 Clinician Workgroup oversees, which is the MIPS

1 Program and the Medicare Shared Savings Program,
2 a little bit about the selection criteria, and
3 then a quick overview of the measures and the
4 results from the workgroup.
5 Next slide, please? So as you can see
6 here, I mentioned the two programs: the MIPS
7 Program, which is a merit-based incentive payment
8 system, as well as the Medicare Shared Savings
9 Program. The vast majority of these measures
10 were MIPS measures. The 22 measures were in the
11 MIPS Program and 3 in the Medicare Shared Savings
12 Program. I will note those three are also in the
13 MIPS. So there's 22 unique measures. Three of
14 those are duplicate, which happen to be the three
15 in the Medicare Shared Savings Program.
16 Next slide? So there were a few
17 themes that came up and I think we're already
18 starting to hear them from the public comments
19 that I will just to try to highlight what the
20 group spent a lot of time speaking on last
21 December.
22 One of them was the cost measurement.

1 This was something that there were eight cost
2 measures that came through to the Clinician
3 Workgroup, and there was a lot of discussion
4 around this topic. One of -- there was an
5 understanding and a discussion around the
6 importance in any value-based program of being
7 able to capture the cost aspect in addition to
8 the quality aspect. So that importance was
9 raised.
10 On the flip side, the concerns that
11 came up with the cost measures were -- I
12 shouldn't even say concerns, but the cautions
13 were to ensure that these measures are
14 appropriately risk-adjusted, both medically and
15 from a social risk factor so that we have -- we
16 know we have different populations, heterogeneous
17 populations in some of these measures and try to
18 make sure that that can level the playing field.
19 The last thing is since this is a
20 newer style measure for MIPS was that whatever
21 the decision is or whenever they are incorporated
22 into the MIPS Program to make sure that these are

1 reevaluated on a constant basis. And that came
2 up in the discussion a few times.
3 Next slide, please? The other topic
4 that I think we had a lot of robust discussion on
5 -- and you will see that there are some composite
6 measures that were on the MUC list this year.
7 And there was -- on the plus side, once again
8 these are really well-suited to capture the more
9 holistic view of the patient's care, a little
10 more comprehensive view of the performance for
11 the MIPS Program.
12 The challenges were raised that we see
13 for composite measures. We just talked about the
14 attribution. We had a discussion about that
15 attribution was one thing. So if there's
16 multiple components to a measure, is one
17 clinician able to effect the change on all of
18 those components of the composite measure? So
19 that was one of the discussions. And then just
20 the technical challenges that the composite
21 measures are more difficult measures from the
22 measure development perspective to create.

1 Next slide? So before I go on I
2 should ask, Bruce or Amy, any other comments on
3 those two major themes or anything that I did not
4 mention?
5 DR. BAGLEY: No, I -- and I think that
6 covers it. I'd be glad to answer questions
7 especially about the composite measures and the
8 confusion that sometimes occurs between a
9 composite measure and a composite all or nothing
10 measure. They're quite different.
11 MR. BERNOT: Great. Okay. I'll
12 just --
13 MS. MOYER: And this is --
14 MR. BERNOT: Go ahead. I'm sorry.
15 MS. MOYER: Oh, sorry. This is Amy.
16 I have nothing additional to add.
17 MR. BERNOT: Okay. We'll continue.
18 We will have time for discussion, as was
19 mentioned.
20 This -- I will not read this slide to
21 you in its entirely. This was -- each year CMS
22 does put out the priorities and needs for the

1 programs, so this is the language that the --
2 that guided our workgroup. And I mean, it's the
3 -- a lot of the topics that you've heard us talk
4 about before: outcome measures and the relevance
5 to the different specialties. There are some
6 high-priority domains which you can see, the
7 peer-reviewed aspect. So we're really seeing the
8 literature. And then not duplicative of -- in
9 other sets and really looking for the improvement
10 opportunities and keeping in mind the topped-out
11 measures. So that's what was provided.
12 The next slide just shows really the
13 topics on there that really I thought were
14 discussed at length within the workgroup. The
15 outcome measure was definitely something that
16 just -- that kept coming up. It was often
17 brought up in the counter-discussion of the
18 attribution. The composite measures we've
19 already mentioned has been a topic that was one
20 of the key themes of the meetings. Mentioned the
21 importance of the efficiency and cost reduction
22 measures. So these are falling in line quite

1 well with CMS' needs and priorities. And then
2 the other thing with the appropriate use
3 measures, but also considering the flip side of
4 the inappropriate use on those topics.
5 Next? So very similar not
6 surprisingly to MIPS, CMS puts out a list of the
7 priorities and needs for the Medicare Shared
8 Savings Program. A lot of these are very
9 similar. Again, I will not read each one of
10 these to you, but really are supportive of what
11 we saw in the MIPS, but do have their own
12 priorities and needs for each individual program,
13 including the last one, measuring did align with
14 the recommendations from the Core Quality
15 Measures Collaborative.
16 On this I will -- since the three
17 measures were duplicative, it's no surprise that
18 these are identical findings: the outcome
19 measures, the composites. And then that
20 alignment with MIPS was brought up in our
21 discussions about the Medicare Shared Savings
22 Programs.

1 So that is just an overview of the two
2 programs. And are we going to turn it over for
3 some discussion first and then present the
4 consent calendar?
5 CO-CHAIR KAHN: No. You mean about
6 the -- in terms of the general themes I guess the
7 question is do we want to have discussion or do
8 we want to get into the calendar itself? It's up
9 to the -- up to you guys. Sam?
10 MEMBER LIN: General themes, if you
11 would, for a couple seconds anyway.
12 CO-CHAIR KAHN: Okay. Sure. We have
13 time.
14 MEMBER LIN: A couple things. Thank
15 you, John. And I attended that workgroup in
16 December, and there was robust discussion
17 certainly and appreciate all their work.
18 A couple things. This paragraph at
19 the opening at the workgroup report about cost
20 measures, it's wonderful. And I think we ought
21 to have that same concern on the other
22 workgroups' reports as well. Why? Because one,

1 it's not just about cost. It's about
2 accountability, transparency, equity, fraud,
3 waste and abuse. And I think that concern ought
4 to be laced by this group onto all the other
5 ones.
6 No. 2, at the end you talk about the
7 removal criteria. And then I look at the removal
8 criteria on the other two workgroup reports. I
9 don't know why they should be different. We're
10 supposed to be about alignment and harmonization.
11 And whether we remove it from PAC or hospitals or
12 clinician, we remove it. What's the difference?
13 I think -- and I think it was best written again
14 in the clinician report, so I would encourage us
15 to think about that.
16 The third part of my diatribe at this
17 point is saying that here we are since 2011 into
18 alignment and harmonization, and what's
19 frustrating to me is that for example today we're
20 doing 22 items on MIPS, a program that MedPAC has
21 said is essentially dead in their books. So what
22 are we going to do when they pronounce it and it

1 doesn't resurrect? Well, then we're going to
2 either can that or we're going to have to wait
3 until the next program comes out, go through the
4 process again because that's what law requires,
5 and do the same work again.
6 The count that we had on this
7 particular meeting was 32 measures across the
8 board, but when you actually sit and count the
9 chart, it's 37, and the reason being there is
10 duplicity across some of the programs. That's
11 not alignment. That's not harmonization.
12 In my own situation -- so I've got
13 somewhat controlled diabetes and my hemoglobin
14 A1c is 6.5 last time and this morning my blood
15 sugar, fasting blood sugar was 109. That's all
16 that counts. I don't care whether it was
17 Medicare Advantage or a model home or whatever
18 you want to call it, or MIPS or MSSP, et cetera.
19 We should be aligning, not trying to cater to
20 separate different programs the same blessed
21 measures. And I'll go through that diatribe over
22 and over again. But our initial charge from 2011

1 is align and harmonize, not create more gaps and
2 more distinct differences. End of story. Thank
3 you.
4 CO-CHAIR KAHN: Okay. Other comments?
5 (No audible response.)
6 CO-CHAIR KAHN: Okay. So we've got
7 certain measures that have been, in quotes,
8 "pulled," which we'll go through. We then I
9 guess create a list, which is the ones that were
10 pulled and then any that the Committee here would
11 like to add to that pull. Then we will I guess
12 have a discussion on each, and when we discuss
13 each of the ones that were pulled, a member of
14 the Committee can choose to do a motion to change
15 the status of whatever it is.
16 In terms of the measures that remain
17 on the consent calendar that have not been pulled
18 either by someone for this meeting or -- I mean,
19 in an way, then when we finally vote on the total
20 package, the presumption is that those will be
21 the ones we're voting to approve, unless we've
22 changed the status of any that I -- as I

1 described. I think I've gotten our process down.
2 And we have John Bott and Derek
3 Robinson and Carl to be discussants. And then
4 obviously Bruce is on the phone, and staff is
5 here.
6 So when we go through the list, I
7 guess you, John, will describe sort of the basic
8 circumstances about why it was pulled and if a
9 change was made why there was a change made.
10 But to create a complete list, does
11 anyone around the room want to pull any beyond
12 the ones that we know are pulled, or do we need
13 to go through that so everybody -- everybody
14 needs to go through it?
15 Okay. Let's go through the list that
16 have been pulled and if anyone wants to pull
17 others, they can do it.
18 MR. BERNOT: Sure, no problem. So
19 I'll give just some very quick stats on the --
20 what the status of the measures are. I will list
21 the ones that have already been pulled. I will
22 start with the MIPS Program, but I do want to let

1 you know they are all on one consent calendar, so
2 whatever is left there that is not pulled off
3 would be for both programs. There is not a MIPS
4 consent calendar and a separate MSSP consent
5 calendar. What is left would be for both
6 programs. So if there's any questions, we'll
7 keep going on with the voting and help out.
8 But for the MIPS Program, as we
9 mentioned, we had 22 measures. They had 3 that
10 were support, 8 with -- 18 with conditional
11 support and 1 that had refine and resubmit.
12 Seven of those have been pulled, and I will read
13 those seven right now.
14 The first one is the continuity of
15 pharmacotherapy for opioid use disorder. We will
16 have the chance to talk about each one of these,
17 so I'll just list the ones that have been pulled
18 so you know, if there's anybody who wants to pull
19 other measures.
20 The next one is the optimal diabetes
21 care, which is -- I should give you the number
22 also -- which is MUC17-181, optimal diabetes

1 care. Next is MUC17-194, optimal vascular care.
2 Next is MUC17-215, which is diabetes A1c control
3 less than 8.0. Next, MUC17-234, ischemic
4 vascular disease, use of aspirin or antiplatelet
5 medication. MUC17-262, STE-elevation myocardial
6 infarction, STEMIs for percutaneous coronary
7 intervention. And lastly for the MIPS Program is
8 the MUC17-363, intracranial hemorrhage or
9 cerebral infarction. So those are the MIPS
10 measures that have been pulled.
11 I guess at this point perhaps we
12 should see if anyone from the MIPS would like to
13 pull, and then I will go over the MSSP.
14 CO-CHAIR KAHN: Yes, is -- any other
15 -- anybody that would like to pull from MIPS?
16 Amir?
17 MEMBER QASEEM: I just want to make
18 sure that I'm -- there might be some repeats, so
19 I wanted to have 181, 215, 194, 210. I'm trying
20 to figure out how many should I pull. Sorry.
21 Three-sixty-three was pulled. Three-sixty-seven.
22 Did I already say 310?

1 CO-CHAIR KAHN: Yes.
2 MEMBER QASEEM: Three-ten as well.
3 Three-one-zero.
4 MR. BERNOT: So for the ones that
5 you're proposing to pull that have not already
6 been pulled do you want to pull them for
7 discussion or do you want to pull them for a
8 different motion?
9 MEMBER QASEEM: Well, I'll actually
10 probably have a different motion.
11 MR. BERNOT: Okay.
12 MEMBER QASEEM: Because my problem is
13 that conditional support has always worried me
14 actually. Conditional support ends up getting
15 implemented. That's the bottom line, right? So
16 any of the conditional supports -- many of them
17 actually are conditional support. Conditional
18 support -- and maybe you guys can educate me
19 again. Conditional support measures end up
20 getting implemented. And that's why I'm being a
21 little bit more stricter on that one.
22 So actually most of them are

1 conditional support and that's why I actually
2 have a different motion, unless I can get some
3 sort of another point of view that conditional
4 support does not mean that they're going to get
5 implemented.
6 CO-CHAIR KAHN: Okay. So to deal with
7 this in an ordered way, and since -- I don't know
8 if everyone has all the paper. Can -- how many
9 do we have total?
10 MR. BERNOT: That would be two more.
11 I don't -- I think -- did you mean 310 when you
12 said 210? I don't believe there is a 210.
13 CO-CHAIR KAHN: I think --
14 (Simultaneous speaking.)
15 MR. BERNOT: Okay. Right. Yes, I had
16 210 and 310. Did I miss it?
17 MS. BUCHANAN: That's in the hospital.
18 MR. BERNOT: So there would be two
19 additional measures. That would be Measure 310
20 and 367, both which would need a motion as to
21 what the new motion would be.
22 CO-CHAIR KAHN: Okay. And how many

1 were pulled total?

2 MR. BERNOT: Prior to that we had

3 seven pulled, so this puts it to nine.

4 CO-CHAIR PINCUS: Okay. So I suppose

5 if the Committee will allow us then, why don't --

6 I guess we should go one by one from -- I mean,

7 by the numbers, and discuss each one and then

8 just make sure with each one whether there's just

9 interest in discussion or -- but let's just --

10 let's sort of -- so what's the first one?

11 Oh, I'm sorry. Did I skip anybody who

12 had any to add? I'm sorry. Bruce?

13 MEMBER HALL: Well, I have more of a

14 question than wanting to push forward one

15 measure, but procedurally then if we don't pull

16 -- like of these 22 or whatever we've pulled 9.

17 There's 10 or 11 others that are also recommended

18 for conditional. If we don't pull them, we are

19 saying we agree with the conditional comments

20 that the prior committee entered.

21 CO-CHAIR KAHN: Yes, anything that's

22 on the consent calendar, and the consent calendar

1 is now made up of all the recommendations of the
2 Task Force, that are not pulled, they will be
3 voted on in the end as they are in the calendar.
4 So if you want to have discussion and possible
5 action on any of them, any of the measures that
6 are not already on the list for discussion, then
7 we'd have to pull it to change it. Otherwise, it
8 will be considered in the final vote.
9 Now the final vote is a vote, so --
10 but presumably by the time we get there, we'll
11 have sufficient votes. We'll have to wait and
12 see.
13 MEMBER HALL: Okay. So some of the
14 conditional comments though are nebulous.
15 CO-CHAIR KAHN: Well, let me add this,
16 that as we said in the introduction that if you
17 want to pull a measure, that doesn't mean that we
18 have to take action on it. We could just have a
19 discussion on it so that if there's a measure
20 that you think you don't want to fight city hall
21 on the conditional, but you think it requires a
22 little more discussion and at least some comment

1 which would then go along with it as we pass
2 things off to CMS, then that would be a reason to
3 pull it. You don't have to have a motion on it.
4 So I leave it to you to decide whether
5 there are any --
6 MEMBER HALL: I'm just trying to get
7 the procedure straight. So like I'm just reading
8 one example where it looks like the comments have
9 already been put into our perspective, the
10 comments saying MAP recognized, MAP did this, MAP
11 did that. And that is meant to reflect that we
12 did --
13 CO-CHAIR KAHN: Right the Coordinating
14 Committee, both to simplify our process and allow
15 us to come to a conclusion -- and actually the
16 Task Forces have a base to work from, the consent
17 calendar. The consent calendar was created
18 initially by the staff taking the measures
19 through the algorithms and coming up with a draft
20 recommendation based on the algorithms. The Task
21 Force then can change that recommendation, and in
22 some cases it does.

1 And then it comes to us. And then we
2 have the prerogative -- well first others can
3 pull prior to here that we have the prerogative,
4 the Committee members, to pull others, but we
5 only consider either for discussion and/or for
6 action -- further discussion and/or for action
7 the item is pulled. That's the procedure.
8 MEMBER HALL: All right. I'm sorry.
9 I misunderstood. I had sort of assumed that
10 anything that was conditional we would at least
11 review the language around that, but that's not
12 the case.
13 CO-CHAIR KAHN: Well, no, no. We can
14 review the language, but you got to pull it to --
15 MEMBER HALL: I understand.
16 CO-CHAIR KAHN: -- have a discussion.
17 That's what I'm saying.
18 MEMBER HALL: Okay.
19 MEMBER ROBINSON: Just for final
20 clarification on the procedures, so if the
21 consent calendar says that we're going --
22 recommendation is for resubmission and we vote to

1 approve it, those that are voted for approval
2 would be approved. Those that were voted for or
3 recommended for resubmission, would be for
4 resubmission. Is that correct?
5 CO-CHAIR KAHN: Correct.
6 MEMBER ROBINSON: Okay.
7 CO-CHAIR KAHN: So that the --
8 whatever is on the consent calendar when we vote
9 at the end, we'll be voting on that unless it's
10 pulled. If it's pulled, there can be two things
11 happen: One, we can just have a discussion which
12 would go into the record on it, and then whatever
13 the recommendation of the Task Force is would go
14 in the -- back into the consent calendar. Or if
15 people want to change the recommendation, then we
16 can have a motion, have discussion and have a
17 vote and see if the recommendation would be
18 something different than was made previously. So
19 we're putting together a package basically that's
20 been already prepared for us.
21 John?
22 MR. BERNOT: Sure. So unless there

1 was anything else, any other -- we had two more
2 measures from MIPS pulled. I'll just very
3 quickly go over the MSSP measures, which is a
4 little bit easier. Again, three measures on
5 here. They all received conditional support. So
6 far two of them have been pulled of the three
7 measures. The remaining measure that has not
8 been pulled from MSSP is the MUC17-234. Yes,
9 that was pulled by MIPS, but it has not been
10 pulled for discussion for MSSP yet. And they
11 would need a separate vote for each program. So
12 if --
13 PARTICIPANT: I'm sorry. Those two
14 measures are -- it's the --
15 MR. BERNOT: It's the same measure for
16 two different programs, correct. The one pulled
17 for MIPS was pulled by -- pre-pulled by Bill
18 Kramer, but the one from -- but it only lists the
19 MIPS. It does not list the MSSP as having been
20 pre-pulled.
21 CO-CHAIR KAHN: You mean it is
22 identical?

1 MR. BERNOT: It is identical. I don't
2 know if there was a reason that he only wanted it
3 in one program or not.
4 PARTICIPANT: Yes, there is a reason.
5 I have to know the reason. He does not --
6 CO-CHAIR KAHN: Then I'll pull it.
7 MR. BERNOT: Sure. All right. So --
8 PARTICIPANT: We do have a reason.
9 CO-CHAIR KAHN: Then when we consider
10 it, we consider it for both programs at the same
11 time.
12 MR. BERNOT: We would talk about --
13 the way we had done it the clinician program, we
14 talked about it in one discussion and then took
15 two votes. After that discussion, is there
16 anything that would change your mind on -- that
17 it belongs in one program versus the other?
18 CO-CHAIR KAHN: Okay. Well, I'll --
19 it's pulled, so --
20 MR. BERNOT: Okay. So it is pulled.
21 So that means all three of the MSSP measures are
22 now pulled.

1 CO-CHAIR KAHN: Now let's proceed in
2 an orderly way and -- hopefully, and we'll go to
3 the first measure that was pulled.
4 MS. MOYER: This is Amy. Can I --
5 sorry, it's hard to raise my hand virtually.
6 CO-CHAIR KAHN: Oh, sure. Just speak
7 up, Amy. Thanks.
8 MS. MOYER: As I hear the measures
9 being pulled and some of the discussion around
10 that, I know something that we struggled with in
11 our workgroup and I've heard that other
12 workgroups struggled with was what exactly
13 conditional support meant versus revise and
14 resubmit. And so I'm wondering; and I apologize
15 because I came in at the clinician portion, has
16 there been a discussion of the one status versus
17 the other with this group to make sure that the
18 questions are stemming from disagreement and not
19 from misunderstanding or a lack of clarity?
20 CO-CHAIR KAHN: Let me do this:
21 First, we'll have discussion tomorrow about --
22 not that it helps us right now, but about how we

1 go forward in the future on these items. In
2 order for consistency with this, I'm going to
3 look at the staff and ask them to provide us with
4 their perception at the Task Force level of what
5 the meaning of those two categories were because
6 they were at each of the levels and I wasn't. So
7 I'd prefer them to explain.
8 And then let me just say we could have
9 discussion on it right now, but my view would be
10 and my hope would be that the Committee will just
11 go with whatever the staff definition is, because
12 otherwise we're just going to go around in
13 circles.
14 So would the staff provide their
15 working perception for the purposes this
16 afternoon of conditional versus -- of the
17 categories?
18 MS. O'ROURKE: Sure. So in the
19 algorithm that staff used to make our preliminary
20 recommendations we really use if a measure has
21 been fully tested as the line in the sand for if
22 the algorithm gives it a conditional support or

1 it a refine and resubmit, so the preliminary
2 analysis the workgroup received based off of
3 that. If it was not tested, it went into this
4 refine category.
5 The workgroup's operationalized the
6 refine and resubmit as a category to reflect when
7 a measure needed a significant change. They
8 wanted to see testing completed. They had
9 concerns that it was tested at one level, but not
10 at the level of the program that was being under
11 -- being considered for. So they wanted to
12 reflect that. Any other sort of significant
13 change they would like to see the measure have
14 made before it goes into the program.
15 Conditional support was more of a
16 minor thing, if you will, usually around gaining
17 NQF endorsement. Refine and resubmit they
18 operationalized as something more significant
19 that would perhaps require the measure to go back
20 to the developer and have something re-specified.
21 CO-CHAIR KAHN: Let me ask a question.
22 How many times was conditional support given for

1 reasons other than it lacking endorsement, and
2 what were those reasons?
3 MS. O'ROURKE: So I don't have a hard
4 number off the top of my head.
5 CO-CHAIR KAHN: Oh, just roughly.
6 MS. O'ROURKE: Maybe there were 5 out
7 of the 35 total where they attached a different
8 condition other than NQF endorsement. Some that
9 come to mind were for some of the hospital
10 measures that you'll review this afternoon, a
11 recommendation that it be considered by the NQF
12 Methods Panel even though it may be closer to a
13 process measure than an outcome measure, some
14 concerns about examining the need for say SES
15 adjustment some -- during the endorsement review.
16 So any kind of special consideration about the
17 measure.
18 CO-CHAIR KAHN: Pierre?
19 DR. YONG: Well, I was wondering
20 whether -- and I don't mean to put Harold on the
21 spot, but -- because this discussion did happen
22 at the webinar discussion about how to use refine

1 and resubmit in terms of guidance for the
2 workgroup committees, which I think, Harold, as I
3 recall you were the one that sort of verbalized
4 that. But Harold also had the benefit of
5 actually sitting in on the Clinician Workgroup,
6 and so how they sort of operationlized and
7 applied that sort of guidance. I was wondering
8 -- it's up to you, but I thought it may be
9 helpful for folks to hear from you.
10 CO-CHAIR PINCUS: Well, I mean, the
11 way I conceptualize it; and it may not be the way
12 it's intended to, is conditional support, if
13 there's a very specific condition that needs to
14 be met and if that condition is met, they would
15 support it. So the modal version of that is NQF
16 endorsement. There may be some other potential
17 little things that are very specific to a
18 particular measure that might -- are in the
19 potential in the short term to be fixed in some
20 way, but that was it.
21 Anything that needs more work
22 basically that has sort of multiple issues or

1 needs more work in general would be refine and
2 resubmit. That's the way I've been interpreting
3 it.
4 CO-CHAIR KAHN: And I'm going to give
5 it back to Amy in a second, but -- and the
6 problem actually with both of them I think is for
7 some people to say; well, and for me, too, is the
8 feedback loop, because in both cases there's a --
9 there's something -- the action needs to be, at
10 least from the view of the Task Force and/or the
11 Coordinating Committee, action needs to be taken
12 on that. And I guess the dilemma for some around
13 the table is that we obviously can eliminate
14 recommendations, but CMS will choose to go
15 forward with them sometimes regardless. But
16 that's where we are.
17 Amy, do you have more to add?
18 MS. MOYER: I was just going to add
19 that an additional reason that for a couple of
20 these we used conditional support was that there
21 are existing measures in the program that are
22 competing measures. And our understanding from

1 CMS was that those other measures will be being
2 removed from the program, so there won't actually
3 be duplications, but we wanted to kind of
4 formally capture that in our recommendation. So
5 other than NQF endorsement that was also a theme
6 in our conditional support.
7 CO-CHAIR KAHN: Okay. That's actually
8 -- how many times do you think that happened?
9 MR. BERNOT: So in terms of this,
10 looking -- the condition being that we wanted to
11 ensure that there was no duplication. And that
12 was considered. It happened on I believe three
13 measures. It would be the optimal -- both the
14 optimal vascular and optimal diabetes, the A1c
15 and the antiplatelet. So I think that's four
16 measures of which some of those were duplicate in
17 MSSP and MIPS.
18 CO-CHAIR PINCUS: To fit the criteria
19 I'd put forward that this is a very specific
20 thing. And if that were done, then it would be
21 supported.
22 CO-CHAIR KAHN: Okay. At least to

1 proceed, is there then a general understanding of
2 what these different categories mean? We can
3 deal tomorrow with the results I think in terms
4 of conditional and refine and resubmit as to what
5 we would like CMS to interpret them to mean. We
6 can talk about that tomorrow.
7 I'm sorry, Bruce. I didn't mean --
8 MEMBER HALL: So just final
9 clarification then. Several of these definitely
10 say conditional pending NQF approval. And then
11 they go on to say when it's in the endorsement
12 process MAP would request the following things be
13 examined. But regardless, if the NQF endorsement
14 did not happen, the conditional is taken away,
15 this is communicated again, or how is it handled?
16 CO-CHAIR KAHN: I'll look at the staff
17 and ask them what they do.
18 MS. O'ROURKE: So that's an excellent
19 point. So the way the MAP process is currently
20 set up it's really only looked at once. I think
21 if the measure were to have that happen where MAP
22 conditionally supported it and then it failed the

1 endorsement process, that feedback would go to
2 CMS and they would need to address it when
3 proposing the measure, that it was not ultimately
4 endorsed. But I think we don't really have a
5 process for adjudicating that kind of disparity
6 between CDP and MAP, but I think that's perhaps
7 something we could put on the feedback loop
8 conversation for tomorrow as how we check that
9 and what that means.
10 CO-CHAIR KAHN: Yes, I think that we
11 really ought to think about that. We will have
12 an opportunity to talk about that tomorrow. And
13 if -- and obviously our recommendations go over
14 with the conditional language and -- but then if
15 things are put in place in April, or I guess
16 whichever month you do the other -- the
17 regulations for the clinicians, and it's there
18 and it still hasn't been endorsed, I think we do
19 need to figure out at what point the Coordinating
20 Committee or somebody sends a letter to CMS of
21 either concern or question as to why something
22 hasn't happened.

1 I mean, maybe we need to do that.
2 Because in some ways you could say it's maybe
3 partly incumbent upon us when we're doing
4 something conditionally to at least have a notion
5 of some length of time and then to go back,
6 because CMS could argue, well, it's in the
7 process. We have to -- we have our regulation.
8 It's -- we got to meet our deadlines. And we're
9 in the endorsement line and we can't wait. I
10 mean, and there's no argument because the HHS
11 Secretary has the power to do these, whatever we
12 recommend.
13 So I think we need -- I think it's
14 incumbent upon NQF to come up with some process
15 to at least come back and query or set something
16 in motion so we could bring something back to the
17 Coordinating Committee. And I mean, obviously
18 CMS can do what they decided to do. But we -- I
19 think this is a -- in some ways I guess it's our
20 fault. I think that we don't have the feedback
21 loop that we ought to.
22 MEMBER ROBINSON: Mr. Chairman, I

1 agree with your comments.
2 And to the staff, is it possible to
3 let the Task Force know what the approximate date
4 of the NQF endorsement process -- when that would
5 actually occur and be considered for the measure
6 relative to the regulatory process just so that
7 the recommendation can be offered with a little
8 bit more certainty. So if we anticipate that we
9 won't know what the endorsement outcome is prior
10 to the regulatory decision in summary we
11 recommend that you go forward with it versus not?
12 MS. O'ROURKE: So I think we don't
13 necessarily know what you're -- CMS is
14 considering a measure for or when they would be
15 wanting to propose a measure, so there's a little
16 bit of uncertainty. But I think we could look at
17 what you're saying especially with our redesigned
18 CDP process where we have consistent calls in the
19 spring and the fall of each year and perhaps
20 highlight when there may be opportunities to
21 submit a measure.
22 I know the workgroups were questioning

1 that a bit more as they realized the changes to
2 the CDP process, and I think we're asking the
3 developers some more pointed questions over when
4 exactly will you be bringing this in now that the
5 endorsement is consistent, when there would be
6 the opportunity to submit rather than having to
7 wait for a call.
8 So I think that's a great point,
9 Derek. We can try to work that into how our
10 calendars map with the rulemaking calendars and
11 what information could potentially be available
12 and try to deal with some of that nebulousness
13 that -- about the timing.
14 CO-CHAIR KAHN: I think presumably a
15 measure that gets conditional is ready for prime
16 time other than it may not have endorsement or it
17 may be duplicative, but it's a measure that's
18 ready to go. And we don't know that CMS would
19 put it in the next cycle, but if it's ready to
20 go, presumably they probably would in most cases,
21 whereas the other category is quite different if
22 it's not fully tested or whatever.

1 Okay. Any other discussion?
2 PARTICIPANT: Elisa has housekeeping,
3 some disclosures.
4 MS. MUNTHALI: Yes. Yes.
5 CO-CHAIR KAHN: Okay.
6 MS. MUNTHALI: So we do have two new
7 members that have joined us, and before we
8 continue discussion and vote we wanted them to
9 orally disclose. So Mary Barton from NCQA and
10 Mary Beth from the American Nurses Association.
11 We'll start with Mary Barton.
12 MEMBER BARTON: Thanks. This is Mary
13 Barton. I'm the Vice President for Performance
14 Measurement at the National Committee for Quality
15 Assurance. NCQA is a measure developer and we
16 design measures that principally are used in
17 health plan evaluation, which we do because we
18 accredit health plans, both Medicare, commercial
19 and Medicaid. Thanks.
20 MEMBER BRESCH WHITE: Mary Beth Bresch
21 White, Director of Health Policy at ANA. I have
22 nothing to disclose.

1 CO-CHAIR KAHN: Okay. Are we ready?
2 (No audible response.)
3 CO-CHAIR KAHN: Okay. So now we're
4 going to go down and with each one John will lay
5 it out. Comment. We have commenters who can
6 comment. Bruce can comment. And I guess then
7 it's incumbent upon the people that had --
8 whoever had a problem with it to either discuss
9 it further or make a motion.
10 MR. BERNOT: Great. Thank you, Chip.
11 And I know that was a little bit confusing. We
12 -- I do believe we have everything that we need.
13 We'll be able to walk through this in an
14 organized manner now that we know which measures
15 we're looking at. I'll do my best to let you
16 know what the workgroup had -- was thinking in
17 their thoughts, what the motion is if we have a
18 motion. Or if we need a motion, we'll lay that
19 out. And then we can have the discussion.
20 So the first measure to discuss is
21 MUC17-139, top of the list here. This is the
22 continuation of the pharmacotherapy for opioid

1 use disorder. The workgroup discussed this and
2 gave it a recommendation of conditional support
3 for rulemaking with the condition that it's
4 tested and endorsed at the clinician and
5 clinician group level.
6 They encourage the Relevance Standing
7 Committee to specifically evaluate the
8 attribution method, reliability and validity of
9 this measure at the individual clinician and
10 practice level. The reason for that was that
11 this measure was not tested previously at the
12 clinician level.
13 So the motion -- this was -- this
14 measure was pulled by Carl and it -- the motion
15 that was on the table was to change the
16 conditional support to a refine and resubmit
17 category. Rationale was that it's only been
18 specified tested and endorsed at the health plan
19 level. Because it's not yet developed and tested
20 at the clinician or practice level, we do not
21 believe it should receive conditional support.
22 CO-CHAIR KAHN: Okay. Discussion?

1 MEMBER SIRIO: Well, I mean, you in
2 part articulated the argument that I gave you
3 guys in an email, which is you have the same
4 discussion. This is consistent I think with
5 Amir's conversation, which is if it's not quite
6 ready for prime time, it's not conditionally
7 approved. I mean, it should be -- we should take
8 a step back. So I'm making the motion that we
9 refine and resubmit rather than conditional
10 support.
11 CO-CHAIR KAHN: John?
12 MEMBER BOTT: Yes, what Carl is
13 suggesting makes sense to me. And it gets into
14 this -- again, just to articulate what my
15 understanding of this definition of "conditional"
16 and "refine" means, it's not simply resubmitting
17 to -- submitting it to NQF, getting it tested and
18 getting it endorsed. It needs to be refined so
19 that attribution can be appropriately conducted
20 at the physician or group level.
21 I've been involved in measurement at
22 the medical group level and at the health plan

1 level, and it's a whole other kettle of fish to
2 come up with attribution for the physician or
3 group level than the health plan level. So it's
4 not as simple as send it to NQF, get it endorsed
5 with testing because it has to be reconfigured to
6 make it work at that level. So that -- I'm just
7 expressing that's my understanding of the
8 definition of particularly the word "refine,"
9 because it does need to be refined, not just
10 simply sent to NQF with testing done. So it's --
11 so right now I support Carl with that
12 understanding on some of those words.
13 CO-CHAIR KAHN: Okay. Are there any
14 other comments?
15 MR. BERNOT: Just to your point, I
16 just wanted to -- one thing I did not mention was
17 even though this did not happen frequently, this
18 is one where the staff preliminary assessment was
19 refine and resubmit. Due to the importance of
20 the epidemic is the reason -- was part of the
21 discussion for the Committee to change it to a
22 conditional support. Just wanted to state that.

1 CO-CHAIR KAHN: Good. Okay. So --
2 CO-CHAIR PINCUS: Just -- I'm sorry.
3 Just one clarification. And this is an endorsed
4 measure, correct?
5 MR. BERNOT: At the health plan level.
6 PARTICIPANT: Not at the health plan
7 level.
8 CO-CHAIR PINCUS: No, no, but it is an
9 endorsed -- it's an endorsed measure so that it
10 wouldn't make sense to re-endorse it in a sense,
11 but you'd want to -- but, no, it just needs to be
12 refined. It just -- it needs to be refined to
13 apply it at a -- not at the health plan level.
14 DR. AMIN: Right, I just want to be
15 clear that the endorsement is for the measure
16 specifications at the health plan level. So we
17 wouldn't -- I mean, to state that it's endorsed
18 is accurate, but it's endorsed at the health plan
19 level. It's --
20 CO-CHAIR KAHN: Right, but I think
21 that's an important point, that one can have a
22 conditional to -- for it to be endorsed even

1 though it has been endorsed for something else,
2 but endorse it for this particular purpose.
3 MR. BERNOT: I mean, it fits for
4 purpose here.
5 CO-CHAIR PINCUS: Right.
6 CO-CHAIR KAHN: Derek, do you have a
7 comment?
8 MEMBER ROBINSON: I concur with the
9 comments that were made as a discussant on this
10 particular measure.
11 CO-CHAIR KAHN: Okay. So, Carl had
12 made a motion. I need a second. Do I hear a
13 second?
14 PARTICIPANT: Second.
15 CO-CHAIR KAHN: Is there any more
16 discussion?
17 (No audible response.)
18 CO-CHAIR KAHN: The motion is to move
19 this to the resubmit category. I guess does our
20 -- do our machine work? Do we need a test?
21 MS. OGUNGBEMI: We could do another
22 test.

1 CO-CHAIR KAHN: Well, let's just --
2 MS. OGUNGBEMI: It works for me, so
3 hopefully --
4 CO-CHAIR KAHN: Let's take -- this
5 vote will be a test. So I'm going to pass it off
6 to the staff to give us instructions on the vote.
7 And those on the phone, they should -- they know
8 how to submit by email.
9 Are we ready for a vote?
10 (No audible response.)
11 MS. OGUNGBEMI: And we're just going
12 to have it displayed also. It's on the back.
13 And people participating via phone, please email
14 your vote in.
15 Mira, I just received yours. Thank
16 you.
17 CO-CHAIR KAHN: Okay. You ready?
18 MS. OGUNGBEMI: It should come up in
19 a moment. Hold on one second.
20 CO-CHAIR KAHN: Okay. We're going to
21 give it 10 seconds and then -- okay.
22 (Pause.)

1 CO-CHAIR KAHN: Okay. Does it look
2 good?
3 MS. OGUNGBEMI: Hold on. This is the
4 test. This is a test.
5 CO-CHAIR KAHN: Okay.
6 MS. OGUNGBEMI: Okay.
7 CO-CHAIR KAHN: Everybody, you ready?
8 MS. OGUNGBEMI: Hold on. Hold on.
9 Let this clear out.
10 Okay. Here we go. Polling is open.
11 CO-CHAIR KAHN: Okay. One is yes; two
12 is no.
13 MS. O'ROURKE: And, Maureen, we also
14 received yours. Thank you.
15 MS. KAHN: Good to know.
16 CO-CHAIR KAHN: Did it work?
17 MS. O'ROURKE: So it looks like we're
18 waiting for a couple more people to come in. So
19 it would be -- we're looking for 25.
20 CO-CHAIR KAHN: We're waiting for
21 people on the Internet or people here?
22 MS. O'ROURKE: I think we're waiting

1 for patient population here. I have Mira and
2 Maureen's from on the phone. We also have
3 Stephanie Glier substituting for Bill Kramer.
4 She sent in a no vote.
5 CO-CHAIR KAHN: Okay. So that
6 wouldn't be here, though?
7 MS. OGUNGBEMI: So she needs to --
8 Stephanie, could you please email
9 mapcoordinatingcommittee@qualityforum.org?
10 MS. GLIER: Yes, thanks.
11 CO-CHAIR KAHN: Okay. How are we
12 doing?
13 MS. OGUNGBEMI: We're doing great. We
14 have 24, waiting for one more.
15 CO-CHAIR PINCUS: One more here or one
16 more --
17 MS. OGUNGBEMI: No, just --
18 PARTICIPANT: Remotely.
19 CO-CHAIR PINCUS: Remotely?
20 CO-CHAIR KAHN: Well, going back to --
21 it's 24 with the ones -- there you are, you're
22 25.

1 MS. O'ROURKE: We got it.
2 CO-CHAIR KAHN: Okay.
3 MS. O'ROURKE: So we're working now.
4 CO-CHAIR KAHN: And so what's the
5 vote?
6 MS. O'ROURKE: So this was just a
7 test.
8 CO-CHAIR KAHN: I thought we were
9 testing by the vote. Okay. Well, let's -- I
10 understand. Let's hurry this up. We got a lot
11 to do this afternoon. If this is going to work,
12 it's got to work now or we're going to vote by
13 hand.
14 MEMBER QASEEM: So it's -- we are
15 voting refine and resubmit, to support refine and
16 resubmit?
17 CO-CHAIR KAHN: Right. Right.
18 MEMBER QASEEM: So I vote yes, that
19 means --
20 (Simultaneous speaking.)
21 CO-CHAIR KAHN: A yes vote is in favor
22 of the motion to change the categorization for

1 this to the refine and -- revise and resubmit
2 rather than conditional. That's what the vote is
3 about.
4 MS. OGUNGBEMI: Okay. We are voting
5 on MUC17-139. The motion is refine and resubmit.
6 Yes to refine and resubmit; not to not support
7 that motion.
8 CO-CHAIR KAHN: Okay. Great.
9 MS. OGUNGBEMI: Voting is open.
10 (Voting.)
11 CO-CHAIR KAHN: Let's see what the
12 result is.
13 PARTICIPANT: We'll vote until we get
14 it right.
15 CO-CHAIR KAHN: Yes.
16 (Laughter.)
17 CO-CHAIR KAHN: We got the 25. Oh,
18 okay. And we got --
19 MS. O'ROURKE: So our N is 25.
20 CO-CHAIR KAHN: What happened to it?
21 Well, I saw 80 percent, and 80 percent is more 60
22 percent.

1 MS. O'ROURKE: Okay. Eighty percent
2 yes to support refine and resubmit.
3 CO-CHAIR KAHN: So we have a consensus
4 by Bill Kramer's definition, or anybody's
5 definition. So let's go to the next one.
6 MS. BUCHANAN: And this is Kate
7 Buchanan. Just a quick housekeeping
8 announcement. People on the teleconference are
9 having a very challenging time hearing people, so
10 please make sure to speak very loudly into your
11 microphones so that everyone can participate.
12 Thank you.
13 CO-CHAIR KAHN: Yes, make sure you're
14 always putting your red button on. Maybe that's
15 a problem, too. And then make sure you turn it
16 off when you finish. Probably only allows so
17 many at a given time.
18 Okay. John, let's go.
19 MR. BERNOT: All right. One down.
20 So we are on -- moving to MUC17-181.
21 This is the optimal diabetes care measure. It
22 has been pulled for both MIPS and MSSP. I will

1 give you the quick read of the Committee's
2 recommendations, and they are very similar
3 between the two programs.
4 So the recommendation for this is
5 conditional support for rulemaking. And I'm
6 going over the MIPS recommendation. The
7 condition is that there are no competing measures
8 in the program and that the measure is updated to
9 the most current clinical guidelines. And that
10 is in reference to the fact that there's a blood
11 pressure reading in the composite measure.
12 That's the MIPS.
13 For the MSSP it is the exact same
14 recommendation, conditional support with the same
15 condition.
16 So as a matter of process we'll have
17 one discussion, but we will need to have two
18 votes on this. And I will tell you why this was
19 pulled. This was also pulled by Carl for further
20 discussion. And since Carl's here, I'll just in
21 the interest of time allow you to state your --
22 (Simultaneous speaking.)

1 MEMBER SIRIO: Yes, so real briefly.
2 I'm not suggesting we change the motion on this
3 for either of the programs. The concern
4 basically is -- and I think Sam alluded to it in
5 his personal commentary with respect to his
6 capacity to manage his diabetes.
7 I mean, there are going to be
8 sociodemographic factors and other health factors
9 that are going to play into the capacity of an
10 individual to in fact hit targets, so what we're
11 advocating for is that when CMS does this, it
12 takes a hard look at actually appropriately re-
13 stratifying the folks that in fact are being
14 measured.
15 CO-CHAIR KAHN: I'm sorry,
16 stratifying --
17 MEMBER SIRIO: The re-stratification
18 issue, which is not clearly addressed. It's a
19 comment basically that it probably warrants a
20 discussion if CMS is going to move forward. I'm
21 not going to change the recommendation. It's
22 just a comment on the specification of the

1 measure.
2 CO-CHAIR KAHN: John, or any of the
3 other commenters have any other comment? Amir?
4 MEMBER QASEEM: So I actually -- I
5 agree what you said, but I'm more leaning towards
6 actually changing the vote on this as well,
7 because I just pulled a slide, a CMS slide,
8 Medicare beneficiaries, a record of under-
9 treatment versus over-treatment for diabetic
10 patients. Hyperglycemia admissions decreased by
11 39 percent for the period of past -- since 1999
12 until 2014 and hypoglycemic events admissions
13 increased 33 percent.
14 So you can see there's an issue with
15 this. The bottom line is that eight is not an
16 absolute number. It might be okay for certain
17 younger patient population. Actually you
18 probably want to go lower. But for certain other
19 aging populations you would go higher. And this,
20 the CMS Medicare data is showing that there is a
21 difference that under -- actually hyperglycemic
22 events decrease, but hypoglycemic events

1 increase, and hypoglycemia is more dangerous if
2 you look at any of the new research.
3 So I'm more leaning for -- that this
4 measure is again -- I think it's going to cause
5 more harm than benefit over here. So I'm
6 actually have a motion that we need to change
7 this as well to revise and resubmit, or
8 something --
9 (Simultaneous speaking.)
10 CO-CHAIR KAHN: Okay. So let's --
11 well, actually just to make it clean, so Amir's
12 made a motion. Is there a second to the motion?
13 MEMBER MULLINS: Second.
14 PARTICIPANT: I would agree. I
15 support it.
16 CO-CHAIR KAHN: Okay. So now we're in
17 discussion around the motion, which would be to
18 actually go beyond simply a comment from us to
19 actually changing its status.
20 So, Amy, will you --
21 MS. MOYER: Yes, I agree with Amir.
22 When you look at this measure, you have to

1 realize this is not just Type 2 diabetes. This
2 is also Type 1 diabetes. And they are treating
3 to an A1c of less than eight with -- in patients
4 up to age 74. And I think that that is dangerous
5 and I think that the evidence is out on that. I
6 don't think it should be incorporated into a
7 composite measure.
8 And then you look at the
9 administrative burden associated with this sort
10 of composite measure, and that goes against
11 everything we're trying to accomplish in reduced
12 administrative burden on clinicians. And so the
13 measurement process around this measure is
14 extremely complicated. So if it's in the MIPS
15 Program, that's one thing. You don't have to
16 choose it. You wouldn't, because why would you?
17 But if it's in MSSP, you might be stuck with
18 that, and that is unacceptable.
19 CO-CHAIR KAHN: Carl?
20 MEMBER SIRIO: One other comment --
21 CO-CHAIR KAHN: Sure.
22 MEMBER SIRIO: -- which is I'm not

1 sure how you want to handle this procedurally,
2 but the comments I was going to make on 194,
3 which was the change it to -- change that one to
4 conditional support. Conceptually they're
5 linked. So it would seem to me just as a prelude
6 to the comments I'll make in a few moments,
7 whatever we do for this one intellectually makes
8 sense to make -- do it for the second one.
9 CO-CHAIR KAHN: Okay. Chris?
10 MEMBER QUERAM: Thank you. I want to
11 speak in favor of this measure and actually am
12 inclined to opposed the motion that's been made,
13 and depending on the outcome of the vote would
14 propose that we change the recommendation to
15 support for rulemaking.
16 We've been reporting this measure, and
17 for that matter we've been reporting the optimal
18 vascular care measure for seven, almost eight
19 years now. It's been in use. We have not
20 encountered the type of problems that we've heard
21 from the previous speakers in terms of the burden
22 or how cumbersome it is to collect the data. We

1 adopted it for precisely the reasons that are
2 cited elsewhere in various narratives about the
3 complexity of identifying an accountable
4 physician.
5 The reason that we adopted this was
6 because it forces a higher standard of care in
7 care coordination and care communication across
8 multiple disciplines that are involved in caring
9 for these patients.
10 I would even go so far as to say I
11 think for purposes of MIPS we should remove the
12 duplicate component measures and put all of our
13 emphasis on the composite.
14 CO-CHAIR KAHN: Okay. The --
15 DR. BAGLEY: Chip, my hand's up.
16 CO-CHAIR KAHN: Okay. Is that Bruce?
17 Would you speak?
18 DR. BAGLEY: It is, yes. I would
19 concur with those comments. And I have a couple
20 of other things that might help.
21 With -- especially with MSSP there is
22 an individual clinician component or

1 responsibility, but there's also an
2 organizational component, a responsibility to
3 make sure that there are systems in place that
4 all of these things happen. So I'd be far more
5 in favor of this as an MSSP measure. And we
6 could talk more about whether it should be MIPS
7 as well.
8 The second thing that I would say is
9 that with any measure that we have ever
10 considered the outcome is a bell-shaped curve and
11 a physician's brain immediately goes to the most
12 -- the sickest patient they've ever seen. Oh, my
13 God, how am I going to get that person under
14 eight? And that's just not the way it works.
15 Biology is not that way.
16 So we don't know what the optimal
17 outcome for a particular individual clinician
18 might be, but it isn't 100 percent. It's, you
19 know, 90 percent. But unless we measure that,
20 we'll never know what optimal outcome is.
21 The final comment I'll make is that
22 this clearly is a composite measure which is all

1 or nothing. And if there are four components to
2 it and you average the four components; in other
3 words, you take individual measures and average
4 them, then you'll get -- like let's say for each
5 of the four components you've got a 75 percent.
6 If you average them, of course the average is 75
7 percent, but in an all or nothing measure the
8 answer is 0.75 times 0.75 times 0.75 times 0.75,
9 which actually is about 32 percent.
10 So what happens is in order to do well
11 on a composite all or nothing measure it forces
12 the organization and the clinician and the
13 practice to have a systematic way to get all four
14 of these things done every time. It really is
15 something that drives quality improvement that's
16 not true of an individual measure.
17 CO-CHAIR KAHN: Okay. Raj?
18 MEMBER DAVDA: Thanks. I know we
19 speak a lot about MSSP and CMS here, but my job
20 is really to represent the health plans and
21 commercial side of the business as well. And we
22 frequently pick up on what's done here and use

1 the same measures to reduce the burden for
2 physicians.
3 So in this one, in addition to 215, I
4 think the -- I agree with the comments that were
5 in support of this. I would agree to support it,
6 again because there are -- there's a larger
7 population also at stake here that has diabetes,
8 and it's not just the CMS population.
9 So from a health plans perspective A1c
10 less than eight is clearly appropriate for our
11 commercial population in general. And we were
12 forced really to use an A1c greater than nine,
13 and it really doesn't hold true for our
14 population, so I would also support this.
15 CO-CHAIR KAHN: When you say
16 "support," you mean support the initial one?
17 MEMBER DAVDA: Yes.
18 CO-CHAIR KAHN: Okay. Marissa?
19 MEMBER SCHLAIFER: So I'm not going to
20 comment on the clinical argument speak, but just
21 looking at a little more process. And going back
22 to -- I guess I'm a little uncomfortable with us

1 questioning -- I'm very uncomfortable with us
2 questioning the appropriateness of the measure
3 that's been NQF endorsed.
4 And there is an opportunity to click
5 on -- because staff's done such a great job of
6 putting this together, to go back and look at the
7 NQF endorsement review from 2015. A lot of the
8 things being said right now are in the discussion
9 and in the comments that were taken in that the
10 NQF Endorsement Committee took into consideration
11 and then endorsed the measure.
12 So I think as a MAP our responsibility
13 is to say whether it's appropriate to be used in
14 this program, not to question -- not to revisit
15 the endorsement process. So I just want to make
16 sure that we're kind of staying within our charge
17 of work. And it sounds like we're trying to
18 rethink the endorsement process.
19 CO-CHAIR KAHN: Any other comments?
20 Oh, Amy?
21 MEMBER MULLINS: So thinking about
22 which program it should go into; and I want to

1 kind of dovetail off of what you said, if you put
2 a measure like these diabetes composites into
3 MIPS and you take out all the other diabetes
4 measures, what's going to happen is no one's
5 going to measure diabetes anymore, because you're
6 not going to pick this measure because it's too
7 hard, it's too many components in one measure.
8 You get credit for one measure, but you're doing
9 four or five at one time. So what you're going
10 to see in effect is no one's going to be
11 measuring diabetes, because why would you?
12 I mean, you just have to think
13 realistically about what six measures are you
14 going to pick? Are you going to pick one measure
15 that's four different things plus five others?
16 Are you going -- you're just not going to do
17 that. You're an overworked clinician. This is
18 administratively burdensome. And so you're going
19 to quit measuring diabetes. That's not good for
20 anyone.
21 And this A1c less than eight, this is
22 new and it really hasn't -- the evidence right

1 now is debatable on this six to nine range versus
2 over nine. So to hold physicians accountable for
3 this less than eight, especially in older
4 populations and Type 1 diabetics I think is
5 questionable.
6 And then also this -- you have to make
7 sure all of your diabetic patients are now non-
8 tobacco users. If you visited the states where I
9 used to practice, that is sometimes completely
10 outside of your control. And that's part of this
11 composite measure as well.
12 So I mean, I seconded the refine and
13 resubmit. My initial thing was don't support at
14 all, but I would be fine with refine and
15 resubmit.
16 CO-CHAIR KAHN: Okay. Any other
17 comments from the phone?
18 MS. GLIER: Yes, this is Stephanie
19 Glier from PBGH. Can you guys hear me okay?
20 CO-CHAIR KAHN: Sure. Yes.
21 MS. GLIER: Thanks. I want to follow
22 up on a couple of the comments that were just

1 made. I totally agree that MAP's job is not re-
2 endorse a measure, or to re-adjudicate the
3 endorsement of a measure. And I think this is an
4 endorsed measure. The population has been
5 clearly specified. If the guidelines change for
6 A1c levels, then I think that's something that we
7 would want to consider or that CMS would
8 consider, but until that's true I think it's
9 appropriate to move forward with an endorsed
10 measure.
11 The second piece to Amy's point that
12 she just made, I think this is actually a program
13 design issue, so a comment to CMS. If you're
14 going to continue with a measure that allows
15 clinicians the opportunity to pick and choose the
16 measures that they're most likely to succeed on,
17 I think that's a flaw in the program. I don't
18 think MAP should be keeping good high-value
19 measures out of the program because we're
20 concerned that people will game the program or
21 choose the measures that are easier to report.
22 Instead, back to what Chris had said

1 earlier; maybe it was Bruce that said it earlier,
2 I think MAP's job is to keep the high-value
3 measures in the program and to remove the lower-
4 value measures so we're pushing people to report
5 the things that matter more to patients.
6 MEMBER QASEEM: Okay. So just a
7 couple of things. We're not going to go dive
8 into the evidence in this one, but I mean, at any
9 point in time I can give you a quick summary of
10 this.
11 The newer evidence is actually
12 pointing towards individualized decision making.
13 If you look at any of the new guideline
14 recommendations that have come out, they do say
15 that you target, talk to the patient and it's a
16 joint decision making. No one is saying anywhere
17 seven to eight at this point because of the newer
18 evidence. And if you look at even the VA
19 guidelines that just came out last year, right,
20 they also said individualized decision making,
21 just one thing.
22 The second thing is you can already

1 see there's enough -- we're not agreeing on a
2 measure. Generally speaking, and again looking
3 at you, Kate, I mean, if there is -- there's
4 plenty of low-hanging fruit. First we need to
5 improve quality of care versus start targeting
6 where we are not agreeing on something. I mean,
7 that's to begin with should not be used for
8 accountability as a fundamental principle.
9 That's just a personal opinion.
10 CO-CHAIR KAHN: Okay.
11 MEMBER QASEEM: There is a motion.
12 CO-CHAIR KAHN: Oh, wait. No, is
13 there any other comments?
14 (No audible response.)
15 CO-CHAIR KAHN: Okay. Let's have a
16 vote on this.
17 PARTICIPANT: Which one.
18 CO-CHAIR KAHN: I know.
19 PARTICIPANT: There's only one.
20 CO-CHAIR KAHN: On this vote, just
21 remind people, we have two separate measures -- I
22 mean, two separate measures or -- well, one

1 measure that is used in two separate programs.
2 And if you allow me, I will package this so that
3 -- because I think if we're going to -- if you're
4 going to vote one way, you're going to vote one
5 way on both.
6 So if it's agreeable, I'm going to
7 package this into one motion, but the motion
8 would affect both programs. And the issue is
9 moving this diabetic -- diabetes measure from
10 conditional to refine and resubmit. That's what
11 the motion is. I'm -- Carl?
12 MEMBER SIRIO: No, I was going to let
13 you finish. Go ahead.
14 CO-CHAIR KAHN: And that's what we
15 would be voting on, if it's acceptable to the
16 group, because I'm repacking it a bit just for
17 simplicity.
18 Yes?
19 PARTICIPANT: For process we need
20 individual votes, so --
21 CO-CHAIR KAHN: Okay.
22 PARTICIPANT: -- we have to do it

1 twice.

2 CO-CHAIR KAHN: Then we will vote

3 twice.

4 MEMBER SIRIO: Actually, look, I don't

5 want to get real crazy, but this is getting a

6 little much. We don't need two votes. If in

7 fact the Committee wants to split it -- but if we

8 want to split it, basically what you're saying is

9 the motion includes both. Someone around this

10 table could say split the thing, otherwise you

11 get one vote. I mean, we're spending 20 minutes

12 worrying about a clicker.

13 Let me get to my point. So the point

14 that Chris made earlier, which is what happens if

15 this motion fails.

16 Chris, the motion as I understood it

17 would revert to where we are, which is

18 conditional support for rulemaking, which would

19 -- I don't think you need a motion for. And I

20 would just like to make sure that the comments

21 that were made with respect to some of the

22 stratification issues go forward. That's all.

1 CO-CHAIR KAHN: I was going to -- what
2 I was going to do -- well, let me -- I'm going to
3 make an alternative suggestion then. Let's vote
4 -- one, let's have the vote and then I think we
5 can look around the table and revert back to the
6 comments going over if the vote fails.
7 Let me -- MIPS -- why don't we do MIPS
8 first. Where is Amir?
9 MEMBER SIRIO: Why don't we do this by
10 hand then? We're wasting way too much time.
11 CO-CHAIR KAHN: No, no, I understand,
12 but let me offer -- let me make clear people need
13 to know what they're voting on. We'll vote on
14 MIPS, and frankly my argument would be if the
15 vote is clear one way or the other, then I'm
16 happy to have a vote on the second item, but I
17 don't -- but it's only going to be clear if the
18 motion carries that it's worth having a second
19 vote.
20 So we'll have one vote and then we'll
21 see whether Amir who offered the motion wants to
22 have a second vote, because he's got to win the

1 first one to have the second one.
2 Chris?
3 MEMBER QUERAM: Chip, just to be
4 clear, then, Carl, on your motion you're not
5 recommending -- or the motion doesn't propose
6 changing the workgroup's recommendation, but
7 adding the requirement that the measure be risk-
8 adjusted or stratified?
9 MEMBER SIRIO: I'm just suggesting
10 that -- I'm asking that the commentary go along.
11 I'm not even going so far as to propose that the
12 measure change. So I think what it would revert
13 to is the -- is Bruce Bagley's committee's
14 report, which was conditional support with a memo
15 going over to CMS with some additional
16 commentary.
17 CO-CHAIR KAHN: Yes, actually -- well,
18 let's get through the motion and then we'll --
19 MEMBER SCHLAIFER: I was just going to
20 mention that as was brought up earlier, it might
21 not influence the vote, but a reason for two
22 votes is MIPS is -- it's -- you get to use it as

1 a voluntary measure, where for MSSP it's a
2 mandatory measure. So there is -- there could be
3 a difference in voting. I don't think there
4 would be, but I mean as far as just wanted --
5 CO-CHAIR KAHN: Okay. MIPS. Are we
6 ready to use this thing?
7 MS. OGUNGBEMI: Yes. No, we're voting
8 with clicker.
9 CO-CHAIR KAHN: I'm willing to use it
10 if we do it fast.
11 MS. OGUNGBEMI: So we're voting for
12 the recommendation for MIPS, optimal diabetes
13 care, MUC17-181, refine and resubmit. This is
14 for MIPS. Yes or no voting is open.
15 CO-CHAIR KAHN: Okay.
16 (Voting.)
17 MS. BUCHANAN: And I have Mira's.
18 Steve, I don't know if you are able to vote, but
19 if you are, please email. Stephanie, Bill is
20 back, so he is voting. And so -- but I just have
21 Mira's right now.
22 Okay. Maureen, I have yours.

1 Okay.
2 CO-CHAIR KAHN: Okay. And the vote is
3 overwhelming no by a consensus amount, so that
4 the motion fails.
5 So, Amir, the question do you want to
6 bring it up for a vote on the other program?
7 (No audible response.)
8 CO-CHAIR KAHN: Okay. Now, but to be
9 clear in terms of Carl's comments, is -- let me
10 just ask. We're not going to vote, but is it
11 sort of generally around the table a feeling that
12 it's fine that as one of the conditions to ask
13 that CMS consider some stratification? I don't
14 think you defined exactly what it was.
15 We're not voting on the second one
16 because we're going to revert back to the consent
17 calendar. Yes.
18 MS. OGUNGBEMI: And for the record we
19 have 32 percent yes and 68 percent no.
20 CO-CHAIR KAHN: Right. Okay. We're
21 going to go forward with the comments that Carl
22 made. And the vote's the vote. So now let's go

1 to the next item.
2 MS. O'ROURKE: Procedurally John
3 pointed out that now that we took a motion, that
4 is off of the consent calendar. So we would need
5 to now take a vote for the conditional support.
6 CO-CHAIR KAHN: Well, wait a minute.
7 Wait a minute. It reverts back to the consent
8 calendar. Why do we need to have another vote?
9 MS. O'ROURKE: This came up in
10 clinician; and I would ask Bruce to correct me if
11 I'm wrong, but per parliamentary procedure once
12 you take it off a consent calendar, it can't go
13 back on. Is that correct, or can --
14 DR. BAGLEY: That's correct. You have
15 to vote on it.
16 PARTICIPANT: So moved.
17 CO-CHAIR KAHN: Okay. Let's vote.
18 We're voting on -- we're now voting on whether or
19 not we make a conditional recommendation
20 including Carl's comments, on the measure on MIPS
21 regarding diabetes.
22 So one is yes and two is no.

1 Actually, can we have a show of hands
2 in terms of it being conditional?
3 (Show of hands.)
4 CO-CHAIR KAHN: This is the MIPS. We
5 have to vote on MIPS again because we -- since it
6 is now off the consent calendar because we had a
7 motion. So it's clear that we have consent.
8 MS. BUCHANAN: And so I have two
9 people on the phone who said yes. Four, five,
10 six, seven, eight, nine, ten, eleven, twelve,
11 thirteen, fourteen, fifteen, sixteen, seventeen,
12 eighteen, nineteen, twenty, twenty-one, twenty-
13 two, twenty-three. Twenty-four, because Maureen
14 just said yes. So we have 24 for yes.
15 CO-CHAIR KAHN: Okay. And I assume we
16 have one no? Right.
17 Okay. Now -- and we didn't -- and
18 since on the other we didn't vote on the motion,
19 it remains on the consent calendar, on the second
20 item. You made a motion but we -- it was
21 withdrawn, so --
22 MS. O'ROURKE: Okay.

1 CO-CHAIR KAHN: -- it remains on the
2 consent calendar.
3 CO-CHAIR KAHN: So to clarify, optimal
4 diabetes care remains on the consent calendar for
5 MSSP.
6 CO-CHAIR KAHN: Right, because there
7 was no motion voted on by the body.
8 Okay. Let's move to the next one,
9 please.
10 MR. BERNOT: Sure. Hurry, hurry,
11 hurry.
12 So we will go to the next one, which
13 is MUC17-194. And this particular measure was
14 pulled for both -- or sorry, for the MIPS
15 Program. The preliminary recommendation from the
16 workgroup was support for rulemaking, and the
17 preliminary assessment from the staff was
18 conditional support with the condition that the
19 -- that there's no duplicate measures.
20 At the meeting CMS had said that they
21 would just be swapping this measure with a
22 preexisting measure. The motion was subsequently

1 changed to support, so the workgroup
2 recommendation is support for rulemaking. This
3 particular measure was pulled again by Carl.
4 CO-CHAIR KAHN: Carl? No, this is
5 what we're supposed to be doing.
6 MEMBER SIRIO: No, no, no. I mean, in
7 terms of the voting and all that good stuff.
8 CO-CHAIR KAHN: No, no. Move forward.
9 MEMBER SIRIO: So on this one actually
10 I'm encouraged on the one hand to hear that the
11 staff recommendation is the same thing that I'm
12 actually asking us to revert to.
13 It's interesting; and I don't know if
14 it's worth a conversation, this will be the
15 second time in 20 minutes where in fact the staff
16 recommendation and the Committee recommendations
17 were different in terms of their conversation and
18 we're reverting back to the staff. So I think
19 there's some signal in there that we should talk
20 about maybe tomorrow.
21 But that having been said, my comment
22 really is to align the two measures. If the one

1 that we just discussed is conditional and these
2 are in essence linked in terms of the care of the
3 diabetic patient, that this should be conditional
4 also. So all I'm now suggesting is the motion
5 would be to revert to the staff recommendation,
6 which is to support conditional.
7 CO-CHAIR KAHN: Okay. So themotion is
8 to make this conditional. Do I have a second?
9 (No audible response.)
10 CO-CHAIR KAHN: I need a second.
11 MEMBER QASEEM: Second.
12 CO-CHAIR KAHN: Okay. Amir. Well,
13 it's for the person offering the motion to
14 explain what the condition is.
15 MEMBER SIRIO: Sure. So there's a
16 couple of points: The first is that there --
17 it's consistency in terms of the care of the
18 diabetic. And secondly, there is some -- there
19 are some blood pressure guidelines that need to
20 be accounted for. So one would at least need to
21 look at the newer guidelines to make sure that
22 the measure is consistent with current science.

1 MS. MOYER: Hi, this is Amy. I don't
2 know if the measure developer is on the line, but
3 they are --
4 (Simultaneous speaking.)
5 MEMBER SIRIO: To assess whether the
6 measure is consistent with best practice, and if
7 it's not, to align with best practice. So it
8 would be to tweak it in a way that actually would
9 be making the measure current.
10 CO-CHAIR KAHN: I'm sorry. Is this an
11 endorsed measure?
12 MR. BERNOT: Yes, it is.
13 MS. MOYER: And this is Amy. It's
14 currently undergoing revision to address
15 compliance with that guideline.
16 CO-CHAIR KAHN: Oh, okay.
17 MEMBER QASEEM: So but then it
18 shouldn't be conditional. So that measure is
19 going through revision. It's not even ready yet,
20 so how can we -- shouldn't it be refine and
21 resubmit and you look at the new measure?
22 CO-CHAIR KAHN: Well, Marissa --

1 MEMBER SIRIO: Well, Amir, I'm going
2 to suggest for political purposes that is likely
3 to fail again in terms of where we're going.
4 CO-CHAIR KAHN: Well, Marissa, what
5 were you going to --
6 (Simultaneous speaking.)
7 MEMBER SIRIO: So my only point is
8 that if it's already endorsed and it's a tweak on
9 one part of it, it probably doesn't need to be
10 tested all over again.
11 MEMBER SCHLAIFER: I'm fine with the
12 recommendation, but I think I disagree with the
13 fact of saying that it's not really out there
14 because it's being -- I mean, updated. It's
15 still -- there is a measure out there that is
16 NQF-endorsed until the revision comes forward.
17 So I'm not opposed to the discussion. I just
18 want to make sure that we get that right.
19 MS. MUNTHALI: I just wanted to
20 clarify. It's going through a maintenance
21 review, so it isn't currently endorsed, but it is
22 being reassessed after -- per our process after

1 three years, yes.
2 CO-CHAIR KAHN: Well, let me ask a --
3 but technically -- well, it is endorsed, but
4 there is a likelihood that it would be revised in
5 this technical -- I mean, in this technical
6 review or --
7 MS. MUNTHALI: I think this is
8 included in the revisions, so this would be a
9 significant revision to the measure. But is
10 under review right now. It is currently an
11 endorsed measure. It's going through its
12 maintenance process.
13 CO-CHAIR KAHN: So when something's
14 going through a maintenance process, it will come
15 back for re-endorsement?
16 MS. MUNTHALI: If it's re-endorsed, it
17 will be endorsed again for three years.
18 CO-CHAIR KAHN: Well, it is different
19 than the other measure that was just endorsed.
20 Marissa?
21 MEMBER SCHLAIFER: This is just a
22 process question. When you -- when a measure

1 gets revised through the normal -- and goes
2 through the normal NQF process, does CMS
3 automatically revise that, or how does that work?
4 MEMBER GOODRICH: So we always want to
5 use the most updated form of the measure. As
6 that relates to the MAP though, the answer is it
7 depends as to whether it comes back here. It
8 comes back here to the MAP if the revision is
9 determined to be a significant revision, and
10 there are parameters around what "significant"
11 means. If it's a minor insignificant revision,
12 like a few codes are added for new drugs that
13 came on the market or something like that, we
14 don't bring it back.
15 MEMBER SCHLAIFER: You would update
16 it?
17 MEMBER GOODRICH: We would update it,
18 yes. We always in our regular ongoing process of
19 updating measures would use the updated measure,
20 yes.
21 CO-CHAIR KAHN: But it does say that
22 doing conditional would be recognized. They're

1 going to recognize it in a sense by what they're
2 going to do.
3 I guess does anyone -- Stuart's on the
4 phone. Does he or she -- who is it?
5 PARTICIPANT: Colleen.
6 CO-CHAIR KAHN: Colleen, do you have
7 any comment?
8 MS. PITZEN: Hi, this is Collette
9 Pitzen --
10 CO-CHAIR KAHN: Oh, Collette. I'm
11 sorry.
12 MS. PITZEN: -- from the Minnesota
13 Community Measurement. As these measures were
14 submitted for the call for measures in June the
15 new guidelines had not yet come out. They were
16 fairly recent the end of 2017. And we are taking
17 action to review those to connect with the
18 Measure Development Workgroup and determine what
19 we are going to do with the guidelines and some
20 of the controversy around them. And we will have
21 an answer before this comes back to MAP review
22 again.

1 CO-CHAIR KAHN: Okay. That was -- oh,
2 Chris?
3 MEMBER QUERAM: Thank you, Chip. my
4 comments on this measure are similar to the ones
5 that I made on the optimal diabetes care. We've
6 been reporting this as well. It's an accepted
7 measure. It has been well embraced by the
8 clinical community in our state. I come from
9 Wisconsin. Run a quality collaborative in our
10 state. I know the same is true in Minnesota.
11 I oppose the motion that would change
12 this to conditional support and prefer that we
13 maintain the recommendation from the workgroup
14 that it be supported for rulemaking.
15 CO-CHAIR KAHN: Okay. Carl, anything
16 else?
17 MEMBER SIRIO: No.
18 CO-CHAIR KAHN: Okay. Any other
19 comments? I'm sorry. Leah?
20 MEMBER BINDER: Yes, I would support
21 Chris' recommendation. I just also want to make
22 a process point that I don't think we have any of

1 us months to sit on this committee and re-
2 litigate all of the endorsement protocols that
3 have already happened. I'm just concerned that
4 we won't even get through this agenda if we keep
5 re-litigating the endorsement process, which I
6 think we all know. So we put so much time into
7 that process. It's a thorough process and I
8 think we should have some confidence in it.
9 CO-CHAIR KAHN: Okay. I think we've
10 heard the points. Anybody else? Any other --
11 oh, I'm sorry.
12 MEMBER KRAMER: I also think that we
13 ought to be careful about how we -- what kind of
14 conditions we put on. If something is lacking
15 NQF endorsement and needs to go through the
16 endorsement process, that seems to be an
17 appropriate condition. I think a simple updating
18 for updated clinical guidelines is more like a
19 maintenance kind of function which would be done
20 automatically. This is already an endorsed
21 measure. I don't think it warrants applying a
22 condition. So I would not support -- I recommend

1 that we not support this motion.
2 CO-CHAIR KAHN: Okay. So let's then
3 on this measure -- I guess the committee approved
4 it, or recommended that it be sent forward with
5 approval. And the motion is to change that to
6 conditional. And so a yes would be for
7 conditional; a no would be for the Task Force's
8 recommendation that it be recommended to CMS.
9 So with that, is everybody ready? You
10 ready?
11 MS. OGUNGBEMI: Yes.
12 CO-CHAIR KAHN: Okay. Let's -- one is
13 yes and two is no.
14 MS. OGUNGBEMI: Yes, we're voting on
15 a recommendation for MIPS, optimal vascular care,
16 MUC17-194, conditional support. One is yes; two
17 is no. Voting is open.
18 (Voting.)
19 MS. BUCHANAN: I'm still waiting to
20 hear from people participating through the phone.
21 MEMBER SIRIO: -- general comment?
22 CO-CHAIR KAHN: Yes.

1 MEMBER SIRIO: It does strike me as
2 worthy of a discussion at some point that we've
3 had now two episodes of stuff that gets pulled
4 where we've had discord between the staff and the
5 committee.
6 And for this group to understand that,
7 in terms of being the final adjudicator of the
8 recommendations that go forward, we need some
9 mechanism I think to understand when that
10 disconnect or that discord happens between the
11 staff assessment and the workgroup, you know,
12 what, a little bit more background in terms of
13 the whys and the wherefores.
14 It's in here, but I think an explicit
15 discussion might be warranted insofar as it would
16 maybe inform this conversation a bit better.
17 CO-CHAIR KAHN: Well, I think, so if
18 we, if this happens, we're going to discuss more
19 of them, then, one, we know from the discussion
20 this morning that the staff follows this
21 algorithm to come to its conclusion.
22 So, if you could, when you describe,

1 explain why you think the task force made a
2 different recommendation than was in your draft
3 based on the algorithm, they can explain it.
4 Well, you explain it.
5 Okay. So do we have the vote? Are we
6 at 25? We have 24. So, if that's sufficient,
7 let's go ahead and close it.
8 MS. BUCHANAN: I apologize. I think
9 we'll have to scrap the voting as far as again.
10 So I think moving forward we won't be doing that
11 anymore, so many apologies. I think we're going
12 to have to handle it. It did not capture.
13 CO-CHAIR KAHN: Okay. All of those in
14 favor of the motion to move this measure from
15 recommend to conditional recommendation, please
16 vote aye and raise your hand if you're for it,
17 the motion.
18 (Show of hands.)
19 CO-CHAIR KAHN: Okay. And now,
20 everyone who is opposed to the motion, please
21 raise their hands.
22 (Show of hands.)

1 CO-CHAIR KAHN: Okay. So the motion
2 fails, and we voted. So let's go to the next
3 measure, please.
4 MR. BERNOT: Sure thing. So the next
5 measure is MUC17-215. This is the diabetes A1C
6 control less than 8.0. It has been pulled for
7 both MIPS and MSSP. It was identified for MIPS
8 by Bill Kramer. I will let him go over his
9 rationale. And it was pulled by Carl for both
10 MIPS and MSSP.
11 CO-CHAIR KAHN: Okay. I'm sorry. So
12 we have two people pulling it for different
13 reasons presumably. Okay. So who pulled it
14 first?
15 (Off-microphone comments.)
16 CO-CHAIR KAHN: No, no, no, seriously,
17 because we have to, I mean, we got to stack this
18 linearly, or I'll just choose.
19 MR. BERNOT: Bill's was first on the
20 list.
21 CO-CHAIR KAHN: Who?
22 MR. BERNOT: Bill Kramer's was first

1 on the list.
2 CO-CHAIR KAHN: Okay. So Bill is
3 first. And I hope we can maybe even get a
4 motion, if there is one from Bill, unless it's
5 just a comment. So we can then get going through
6 it.
7 MEMBER KRAMER: Yes, okay. The
8 recommendation applies from -- the reason I asked
9 for this to be pulled and reconsidered and would
10 ask for a revote is with regard to the use of
11 this measure in MIPS, not MSSP.
12 CO-CHAIR KAHN: Okay.
13 MEMBER KRAMER: So it's just one piece
14 of this. The rationale is that this is a
15 voluntary -- two parts, it's a part of a larger
16 composite measure. It's one component of a
17 composite measure.
18 Second, it exists in a program, MIPS,
19 being proposed here for a program, MIPS, which
20 there is voluntary reporting. In other words,
21 clinicians can choose to report on this or
22 something else.

1 So this, while the measure itself
2 seems like a fine measure, the danger is that in
3 the use of this measure in MIPS, it might be
4 chosen by clinicians instead of the composite
5 measure, in which case we, the stakeholders in
6 healthcare, consumers, purchasers, and
7 clinicians, would lose information about what is
8 happening with the optimal care.
9 So, because of the risk of how it
10 would be used in MIPS, displacing a more valuable
11 composite measure, I recommend that it not be
12 approved for use in MIPS so that the information
13 that will be gathered will be on the composite
14 measure.
15 CO-CHAIR KAHN: Okay. So, I'm sorry,
16 so your recommendation is that it be removed from
17 MIPS. Is that --
18 MEMBER KRAMER: That it not be, that
19 we would recommend, or that the -- I would move
20 that MAP recommend that it not -- to CMS -- that
21 it not be used, this measure not be used in MIPS.
22 CO-CHAIR KAHN: I'm sorry, in --

1 MEMBER KRAMER: That this measure
2 would not be used in MIPS.
3 CO-CHAIR KAHN: MIPS, okay. So it
4 would be removal. He's recommending to remove
5 it. Okay. So you've made a motion. Can the
6 staff sort of describe anything else about this,
7 who our expert is?
8 MR. BERNOT: Sure, sure. So the
9 discussions around this -- and, Bruce and Amy,
10 feel free to jump in if I missed anything. But
11 they said that, even though the composite was,
12 that this was discussed with the workgroup, that
13 there was a composite and a subcomponent of the
14 composite.
15 And they did talk about the tension
16 between, that there was some folks who felt there
17 was still value in this particular measure for
18 several reasons. It was part of some programs,
19 part of things that people were tracking.
20 Also the attribution of the composite
21 was a concern to the workgroup that they may not
22 be, fully be able to affect all of the

1 components, but this would be a way for them to
2 track diabetes. That's my very quick summary
3 unless, Bruce or Amy, you have other
4 recollection.
5 DR. BAGLEY: No other comments.
6 CO-CHAIR KAHN: Okay. Are there
7 comments around the table? Thoughts? Chris?
8 MEMBER QUERAM: Do you need a second
9 for the motion?
10 CO-CHAIR KAHN: Oh, yes, actually.
11 Thanks.
12 MEMBER QUERAM: Second.
13 CO-CHAIR KAHN: Yes. Thank you. I
14 apologize. Any other comments?
15 MEMBER SIRIO: So my only comment
16 would be I don't think I would get as draconian
17 as withdrawing this. I think the ask that I was
18 going to make for both of these was the same as
19 earlier. It's just that we look at the issue as
20 a recommendation to Kate and her team with
21 respect to appropriate risk stratification. It's
22 not even risk adjustment; it's risk

1 stratification.
2 So I won't support it, not because I
3 don't think that the argument's got merit. But I
4 think that there's value in the communication.
5 CO-CHAIR KAHN: Yes, I think --
6 MS. PITZEN: This is Collette from
7 Minnesota. May I make an additional comment --
8 CO-CHAIR KAHN: Oh, sure, yes, please.
9 MS. PITZEN: Yes, we had proposed
10 putting forward this component. Believe me, we
11 are big believers in the composite. The purpose
12 of this was to replace the poor control A1C
13 greater than 9 measure that's currently existing
14 in programs, because when you're looking at poor
15 control, there's the unintended consequences that
16 anything less than 9 is good control. And that's
17 simply not true and not evidence-based for
18 diabetes care. Thank you.
19 CO-CHAIR KAHN: Continue other
20 discussion? Bill, do you have anything else to
21 say?
22 MEMBER KRAMER: I'll say this. We're

1 not opposed to the measure, per se. Just to
2 clarify, this isn't a complicated argument I'm
3 making, that the problem is how the measure is
4 used in MIPS. So I fully support it being used
5 in MSSP, where it is a required measure. The
6 problem is how it's used in MIPS has the -- would
7 have the unintended effect of crowding out a more
8 valuable measure, the diabetes composite measure.
9 CO-CHAIR KAHN: It's really a
10 structural argument. Chris?
11 MEMBER QUERAM: And I just build on
12 Bill's comments a little bit and some of my
13 earlier observations. What animates my thinking
14 about this motion is that we need to begin to
15 take steps, however measured or however big they
16 may be, to up the bar a bit in terms of what it
17 is we expect of clinicians in these programs.
18 A gentleman made the comment earlier
19 that there's lots of low hanging fruit out there,
20 and we should be focused on that. Many of us
21 have been around these tables for a lot of years,
22 and we keep talking about low hanging fruit.

1 When are we going to move to higher hanging
2 fruit? And I think this is a good example of
3 taking a measured step in that direction.
4 CO-CHAIR KAHN: Good. Okay. Any
5 other comments?
6 MEMBER O'BRIEN: I think the way that
7 CMS would describe the whole point of the choice
8 within MIPS is that, so you can, a clinician can
9 find the measures that are the best fit for their
10 practice.
11 When talking about a component of a
12 composite measure, I think unless there's a
13 pretty clearly articulated and valid reason why
14 the composite measure itself isn't a -- wouldn't
15 generally be a good fit, I think there is a -- to
16 me, there only seems to be downside to including
17 a component measure. And the downside is the
18 risk of someone choosing the component measure,
19 not so much because it's the best fit for their
20 practice, but it's going to -- they know they're
21 going to do well on it. It's going to put their
22 practice in the best light.

1 So I don't see any upside to including
2 this, only downside, when it comes to MIPS
3 itself.
4 CO-CHAIR KAHN: Okay. Enough
5 comments. Let's just -- we're going to vote by
6 hands? Yes, please. Okay. The motion --
7 MS. MUNTHALI: Sorry, we have one more
8 voter who's joined us. Rich Antonelli's on the
9 phone. Rich, can you introduce yourself? And
10 let us know if you have anything to disclose.
11 MEMBER ANTONELLI: Dr. Richard
12 Antonelli, Medical Director of Integrated Care,
13 Boston Children's Hospital. And I'm representing
14 the hospital. And I don't have any disclosures.
15 CO-CHAIR KAHN: Rich, I'm happy to
16 have you. Okay. So the motion is to remove this
17 measure. And we've had discussion.
18 (Off-microphone comments.)
19 CO-CHAIR KAHN: Oh, I'm sorry. I
20 thought remove and not support was the same
21 thing. Or not support this measure or recommend
22 not to support. So a yes vote is supporting the

1 motion not to support. A no vote is to maintain
2 the current recommendation.
3 MS. BUCHANAN: Not to support for
4 MIPS.
5 CO-CHAIR KAHN: Not to support for
6 MIPS, I'm sorry. Yes, it's for MIPS. It doesn't
7 affect the other; only voting on MIPS. Okay.
8 All those in favor of the motion please raise
9 their hands, and on the phone, you can vote yes
10 or no now by email. Okay, here.
11 (Show of hands.)
12 MS. BUCHANAN: One, two, three, four,
13 five, six, seven, eight, nine, and then I have,
14 on the phone, I have Maureen, Steve, and Mira's
15 votes. I don't -- Rich, I don't know if you're
16 connected to the, your email right now. If
17 you're not, if you just wouldn't mind verbally
18 saying yes or no.
19 MEMBER ANTONELLI: Actually, I just
20 clicked send. Could you just confirm that you
21 receive it in the next five seconds?
22 MS. BUCHANAN: So --

1 MEMBER ANTONELLI: The vote is in the
2 subject line.
3 MS. BUCHANAN: So I didn't -- did you
4 send it to mapcoordinatingcommittee@qualityforum
5 .org?
6 MEMBER ANTONELLI: Yes.
7 MS. BUCHANAN: I did not receive it.
8 MEMBER ANTONELLI: I'll send it again.
9 MS. BUCHANAN: Okay. Rich, I still
10 haven't received anything. So maybe just
11 verbally --
12 MEMBER ANTONELLI: Okay.
13 MS. BUCHANAN: Oh, I got it. Thank
14 you.
15 MEMBER ANTONELLI: Yes.
16 CO-CHAIR KAHN: Okay.
17 MS. BUCHANAN: And then yes, you need
18 yeses.
19 CO-CHAIR KAHN: And then we vote no.
20 MS. BUCHANAN: So we voted no. We
21 have 11 noes. And now for yeses.
22 CO-CHAIR KAHN: How many?

1 MS. BUCHANAN: 11 noes. So for yeses
2 --
3 CO-CHAIR KAHN: But we didn't vote no.
4 We didn't do the votes for no.
5 MS. BUCHANAN: Sorry, we have 11 for
6 yes. We have not done the noes.
7 CO-CHAIR KAHN: That's what I thought.
8 Okay. So can we have the votes for noes?
9 MS. BUCHANAN: One, two, three, four,
10 five, six, seven, eight, nine, nine, and then we
11 have three. So that's 12. Okay.
12 CO-CHAIR KAHN: So what -- do you have
13 a --
14 MS. BUCHANAN: I do. I do not have 25
15 people, though.
16 CO-CHAIR KAHN: Yes, Mira's not --
17 actually, do you have enough to have to meet the
18 quorum test?
19 MS. BUCHANAN: We do have enough for
20 quorum.
21 CO-CHAIR KAHN: Then, if you're not at
22 the table, you don't get a vote. If we have a

1 quorum, that's it.
2 MS. BUCHANAN: Okay. So we had 10 for
3 yes, 12 for no, which gives us --
4 (Off-microphone comments.)
5 MS. BUCHANAN: No, we have 10. I was
6 wrong the first time.
7 CO-CHAIR KAHN: We have to get to 60-
8 plus --
9 MS. BUCHANAN: And so we're at 45
10 percent. So the motion does not pass.
11 CO-CHAIR KAHN: Okay. So the
12 recommendation goes forward as made by the task
13 force. Let's go to the next one.
14 Oh, do we have to vote again?
15 MS. BUCHANAN: Yes.
16 MR. BERNOT: For MIPS.
17 MS. BUCHANAN: For MIPS. So this is
18 a vote for MIPS to conditional support.
19 CO-CHAIR KAHN: But what if it doesn't
20 get the 60-plus? Okay. So everybody vote now.
21 MS. BUCHANAN: So, to clarify for the
22 record, this is the diabetes A1C control measure.

1 And you are voting yes to conditional support.
2 No is a disagree with conditional support.
3 CO-CHAIR KAHN: Any noes? I think we
4 made it.
5 MS. BUCHANAN: We did. I just want to
6 make sure, because I just wanted to capture our
7 online people who are voting in as well.
8 CO-CHAIR KAHN: While you're capturing
9 those --
10 MR. BERNOT: Sure thing. Next one is
11 MUC17-234. This is the ischemic vascular disease
12 use of aspirin or anti-platelet medication. The
13 workgroup came up with a recommendation of
14 conditional support for rulemaking. And the
15 conditional was that there's no competing
16 measures within the program or that is rectified.
17 That's for MIPS.
18 They also had a similar recommendation
19 for MSSP conditional support, with the condition
20 that there are no competing measures in the
21 program, exact same thing.
22 So this was originally pulled by Bill

1 Kramer for discussion for MIPS only I believe,
2 Bill. And then, Chip, you had pulled it for MSSP
3 to have a discussion.
4 MEMBER KRAMER: Which measure are we
5 on? Sorry, I thought we were still on the A1C.
6 MR. BERNOT: 234.
7 MEMBER KRAMER: Okay. I thought --
8 didn't Carl also pull -- okay, okay. So we're
9 not reconsidering the A1C for MSSP and MIPS. I
10 understand. Okay. Sorry. I was --
11 CO-CHAIR KAHN: Can you repeat --
12 MR. BERNOT: Absolutely, yes. So the
13 measure is MUC17-234, ischemic vascular disease
14 use of aspirin or anti-platelet medication. And
15 this was pulled for MIPS by Bill Kramer.
16 MEMBER KRAMER: The rationale for this
17 recommendation is similar to the one we just went
18 through, which is that the aspirin use is a
19 component of the optimal vascular care composite.
20 Again, if it is used in the MIPS
21 program, it has the risk that it will crowd out a
22 more valuable composite measure. So it's

1 basically the same rationale as on the previous
2 measure. So my recommendation is that we do not
3 support for use in MIPS.
4 MR. BERNOT: Correct. This was a
5 conditional support that there was no -- that it
6 was rectified with competing measures within the
7 program.
8 CO-CHAIR KAHN: That was, that's what
9 the staff --
10 MR. BERNOT: That was both staff as
11 well as the workgroup.
12 MEMBER MACKAY: I support Bill's
13 recommendation to not include it in the MIPS
14 program. I'm seconding his motion.
15 MEMBER ROBINSON: Yes, I just wanted
16 to offer a comment. I think if, I think we have
17 to be careful about the assumption that if we
18 take out the component measures that are in the
19 composite measures that it will sufficiently
20 shrink the pool of other measures such that
21 providers have no choice but to pick the
22 composite measure. I don't know that the math

1 necessarily equates with that.
2 I mean, like in the end you could end
3 up with no individual component measures selected
4 because we pull them out. The composite measure
5 isn't selected because the provider chooses not
6 to select that one. And they select a universe
7 of other measures.
8 I think if the rationale is that there
9 are ten measures and we have to choose six and
10 are going to pull out three or four, and so that
11 means you by default have to choose the
12 composite, then I think, you know, it maybe seems
13 more rational.
14 MEMBER KRAMER: You're right there.
15 That might be the case in some cases. That might
16 be the case. And we're talking about the, you
17 know, problem we all know exists, the structure
18 of MIPS on the choice of measures.
19 I think the net effect will be, if
20 this component measure stays in, there will be
21 less reporting of the composite measure. And if
22 we take it out, there will be more reporting of

1 the composite measure.
2 But you're right. It won't be --
3 there will be some cases in which they choose not
4 to report the composite measure. But I think the
5 net effect will be, there will be -- we'll get
6 better information for patients, for consumers,
7 purchasers, and clinicians, and taxpayers about
8 how the, like the quality of care is just being
9 delivered.
10 MEMBER ROBINSON: This is a quick
11 follow up. Are there any other examples where
12 this has happened that, you know, can serve as a
13 model for us? I mean, it's sort of an assumption
14 versus having seen this happen in two or three
15 other cases, and it's substantial enough to
16 inform our decision.
17 MEMBER KRAMER: I'm not aware of any
18 evidence relying on kind of our, it's, how human
19 nature would work. But the -- I will say, too,
20 as just an additional point, we've been talking
21 about trying to remove the clutter in our
22 measurement system. There are too many measures.

1 This kind of goes along the point that
2 Chris was making earlier that we should be moving
3 toward better measurements and removing measures
4 that are of lower value. This is a lower value
5 measure because it's a component. We have a
6 better measure, the composite. Let's support
7 that. Let's get rid of the clutter, the low
8 value measures.
9 CO-CHAIR KAHN: And there is some
10 discussion. I mean, I've heard discussion about
11 that, I mean, that if you don't like MIPS, you
12 can play the minimums. So I don't, I think it is
13 possible. But, Leah?
14 MEMBER BINDER: Actually, I agree with
15 everything Bill said.
16 CO-CHAIR KAHN: Shaun?
17 MEMBER O'BRIEN: Yes, I just wanted to
18 amplify Bill's response to Derek. One of the
19 things we do know is that consultants advise
20 clinicians, you know, to, I'll use the pejorative
21 term, game the system, but, you know, to select
22 those measures that they already do, they know

1 they already do well on. And that's the risk
2 here when you have a component of a composite,
3 and they're both in the same set.
4 And so, you know, look, in my mind,
5 having, you know, a component and a composite
6 undermines the credibility of the system. And,
7 yes, there's a structural problem here, but I
8 just don't think CMS should be feeding that
9 structure. I think that's what this does.
10 MEMBER MULLINS: Raise your hand if
11 you've ever had to actually report a measure.
12 Okay. It is hard to do. And by doing composite
13 measures, you're not reducing the number of
14 measures. You're packaging measures together.
15 But the same number of measures still exist.
16 You can't just start removing
17 component measures and assume people are going to
18 report composites. As an overworked clinician,
19 it's not going to happen. And until the systems
20 we have support them and make it easier to report
21 measures, people are not going to report
22 composite measures. They just don't have the

1 time and the energy and the resources to do it.
2 As a rural clinician with one, you
3 know, support staff in your office that's
4 typically maybe your MA or your, you know, spouse
5 that's running your office to report all these
6 measures, I mean, just isn't -- it's not feasible
7 to have a set of MIPS measures that are a bunch
8 of composite measures that now six measures are
9 now 24.
10 You just can't take away all the
11 component measures. You just -- the system is
12 not set up to support that at this time. Maybe
13 at some point; not right now.
14 MEMBER DAVDA: One other point I would
15 bring up to keeping individual measures is really
16 the data collection issue. A lot of the
17 composite components tend to be hybrid data. And
18 there is truly a data collection and burden issue
19 that at least our health plan and many of the
20 health plans face because of the lack of
21 interoperability. So, and it is a very manual
22 process.

1 So I don't know where the motion is,
2 but I would support keeping the individual
3 measures.
4 MEMBER ROBINSON: I'd echo Raj's
5 comments. And the other question is whether this
6 is the right mechanism for addressing the
7 opportunity to better employ the use of composite
8 measures.
9 I mean, should another tactic be
10 looking at increased weighting of composite
11 measures in the program versus the individual
12 measures as a mechanism for incentivizing
13 providers to select the composite measure? Just
14 trying to think about, you know, different ways
15 we can use this forum versus other forums to get
16 to that end goal.
17 MS. BUCHANAN: Microphone.
18 CO-CHAIR KAHN: What?
19 MS. BUCHANAN: Microphone, if you
20 wouldn't mind.
21 CO-CHAIR KAHN: -- kind of vote as the
22 previous one, which is to recommend against a

1 measure, if I've worded it properly, going
2 forward. And so let's -- we're going to vote by
3 hand.
4 So those voting in favor of the motion
5 would be to recommend that this measure be
6 removed, this measure not be recommended. Okay.
7 So all those voting in favor of the motion,
8 please raise their hands.
9 (Show of hands.)
10 CO-CHAIR KAHN: And on the phone,
11 please vote by email. Those voting against the
12 motion here in the NQF offices, please raise your
13 hand.
14 (Show of hands.)
15 CO-CHAIR KAHN: Okay. I can just tell
16 we didn't get to 60-plus percent. So did we make
17 it?
18 MS. BUCHANAN: We did not. So we had
19 10 for yes, do not recommend, and we had 12 for
20 no, to oppose the measure.
21 CO-CHAIR KAHN: And we made 22 votes.
22 MS. BUCHANAN: We made 22 so far.

1 CO-CHAIR KAHN: So we had enough
2 votes. Okay. Let's go to the next one, please.
3 MR. BERNOT: So we just have to go --
4 I'm sorry. But we just go back and --
5 CO-CHAIR KAHN: Oh, I'm sorry.
6 MR. BERNOT: -- the staff conditional
7 support --
8 CO-CHAIR KAHN: So now we have to vote
9 in support of, in a motion. Do we have to offer
10 a motion for that, or can the Chair just --
11 MS. BUCHANAN: If there's no other
12 motions, you can go forward. Then we vote on the
13 staff.
14 CO-CHAIR KAHN: Okay. So, now we're
15 going to re-vote on the recommendation of the
16 task force actually. So all those in favor of
17 the recommendation of the task force, please
18 raise their hands.
19 (Show of hands.)
20 CO-CHAIR KAHN: And on the phone,
21 please vote by email. All those opposed to the
22 recommendation of the task force, please raise

1 their hands.

2 (Show of hands.)

3 CO-CHAIR KAHN: And as long as we get

4 to 22, I sense we've gotten the 60-plus percent.

5 MS. BUCHANAN: That is correct.

6 CO-CHAIR KAHN: Okay.

7 MS. BUCHANAN: We have -- yes.

8 CO-CHAIR KAHN: So now let's move to

9 the next --

10 CO-CHAIR PINCUS: Actually, can I call

11 a point of order --

12 CO-CHAIR KAHN: Sure, yes.

13 CO-CHAIR PINCUS: -- to get

14 parliamentary?

15 CO-CHAIR KAHN: Sure.

16 CO-CHAIR PINCUS: Okay. Could we make

17 a general procedural motion that in the case

18 where a motion has failed to pass to override the

19 workgroup recommendation and that there's no

20 other motion on the floor, that automatically the

21 workgroup motion goes ahead, so we don't have to

22 keep doing this over and over again?

1 CO-CHAIR KAHN: So Harold has
2 suggested that we vote on a -- well, he would
3 like to make a motion --
4 CO-CHAIR PINCUS: Right. I would like
5 to make a motion.
6 CO-CHAIR KAHN: -- that in cases where
7 the motion to change the task force
8 recommendation fails that --
9 CO-CHAIR PINCUS: And there's no other
10 motion on the table.
11 CO-CHAIR KAHN: -- and there was no
12 other motion on the table, that we would
13 automatically support the task force position,
14 and thus we wouldn't have to vote twice. Is that
15 acceptable to the legal opinion of the staff?
16 CO-CHAIR PINCUS: I believe according
17 to parliamentary, Robert's Rules of Order, you
18 can do that.
19 CO-CHAIR KAHN: Okay.
20 DR. AMIN: So the voting procedure
21 that we've agree to is not that. However,
22 recognizing that the committee is trying to move

1 things along, and we are trying not to just have
2 arbitrary sort of rules of procedure, we can
3 agree to move forward with that.
4 CO-CHAIR KAHN: Okay. So all in
5 favor, then, of a blanket reversion -- do you
6 have a --
7 MEMBER HALL: Well, then is it
8 portrayed as a unanimous decision?
9 DR. AMIN: That's how -- because, yes,
10 that's the only thing that we have to work with.
11 CO-CHAIR KAHN: Well, that would be
12 the case. Well, actually, let's do this. You've
13 made a motion. I second the motion. Now let's
14 have a discussion. No, we have to have a
15 discussion of it because -- and the discussion
16 just began. And the point is, the question is
17 whether it would be considered unanimous, I
18 guess.
19 MS. O'ROURKE: So we don't actually
20 have unanimous decisions at MAP. The vote is
21 really just to get to a decision category. We
22 don't pass along that 24 people voted, 18 voted

1 conditional support, the others disagreed with
2 that motion. So we just say that MAP
3 conditionally supported the measure. MAP members
4 said X, Y, and Z. However, others raised
5 concerns about A, B, C. So there's not --
6 CO-CHAIR KAHN: That's true. But
7 people have been -- we haven't gotten a unanimous
8 vote on any of this really. So, Bill, do you
9 have a comment?
10 MEMBER KRAMER: I'll just make the
11 observation that this will inform our discussion
12 tomorrow about voting rules and voting process
13 and consensus.
14 I remember earlier that there's just
15 a comment made that sometimes consensus takes a
16 long time. And it's difficult to achieve and
17 measure. And voting can be more efficient. I
18 think we've seen a situation which voting
19 actually makes it less efficient right now.
20 I think we could actually say,
21 modifying Harold's suggestion, that we could say
22 that we have a consensus that when a proposal has

1 failed to move forward, in other words there's
2 not consensus, that the measure will revert, that
3 if there's consensus, it will revert. We don't
4 have to have a vote. We can say, we can agree by
5 consensus that that's what we will do.
6 So I just, I don't want to get us
7 overly tangled up, but just an observation and a
8 suggestion about we could make a better use of
9 consensus --
10 CO-CHAIR KAHN: Well, I would like to
11 accept that as an amendment. But I'm not sure
12 that will pass muster with the staff because, in
13 terms of their advice to us.
14 MS. MUNTHALI: Yes, I think we should
15 take a five-minute break here because we want to
16 make sure that we're not making this painful for
17 you. But we also want to make sure we're being
18 consistent and not changing rules midstream. We
19 understand tomorrow we're going to discuss this
20 further. So we need to --
21 CO-CHAIR KAHN: Well, before we do
22 that --

1 MS. MUNTHALI: Yes.
2 CO-CHAIR KAHN: -- I just want to go
3 back to Bruce and ask, do you -- or let me ask
4 the broad question. The staff will make a
5 determination whether we can or can't do it. But
6 assuming we can, is there an objection to this by
7 anybody? I mean, I just -- do you object to this
8 approach?
9 MEMBER HALL: Well, I would just
10 highlight the second part of Harold's statement.
11 And that is that if this group confirms that
12 there's no alternate motion, then I would be
13 willing to accept that everyone is therefore
14 saying. But I think there does have to be a
15 confirmation that after one motion is voted and
16 rejected, that there needs to be confirmation at
17 that point that no one else wants to raise a
18 motion.
19 CO-CHAIR KAHN: Well, yes, well,
20 first, let me say two things. One, I think that
21 is accepted. We have only gone to the
22 reaffirmation when there were no more motions on

1 the floor. So I don't even think we -- I mean,
2 that, procedurally, if anybody else had made a
3 motion, we would have accepted it.
4 CO-CHAIR PINCUS: Yes, that's explicit
5 in my motion.
6 CO-CHAIR KAHN: Yes, that's explicit.
7 MEMBER SCHLAIFER: I just have one
8 comment and one --
9 MEMBER HALL: Yes --
10 MEMBER SCHLAIFER: -- possible
11 alternate suggestion.
12 CO-CHAIR KAHN: Marissa was going to
13 go. Then --
14 MEMBER SCHLAIFER: I'm sorry.
15 CO-CHAIR KAHN: -- I'll recognize.
16 MEMBER SCHLAIFER: Well, one, just as
17 a reminder, as Bill said, we've got a thorough
18 discussion about this tomorrow. So I think if we
19 do anything today, it should be kind of a
20 temporary until we have time to --
21 CO-CHAIR KAHN: Right.
22 MEMBER SCHLAIFER: -- thoroughly

1 discuss this tomorrow.
2 And the other thing is I think what we
3 said, I think what you were saying was that if we
4 vote down the modified recommendation but then we
5 accept that the committee recommendation passes,
6 I'm wondering, just for staff discussion in the
7 five-minute break, if it makes sense just to say
8 it goes back on the consent calendar because then
9 we still --
10 CO-CHAIR KAHN: No, no, they said we
11 couldn't do that. That's the reason we --
12 MEMBER SCHLAIFER: Well, they
13 originally said that. But I think that would at
14 least allow, there would be a vote. Otherwise,
15 there's no vote. And so I just, that's just, was
16 going to throw that out there just for
17 consideration.
18 CO-CHAIR KAHN: Okay. I'm sorry. On
19 the phone, was it -- I don't know who it was.
20 DR. BAGLEY: Yes, this is Bruce
21 Bagley. Let me make this suggestion that if a
22 motion is made and fails, procedurally you revert

1 to the motion on the table. And what you could
2 do is at that point just say is there any
3 objection to accepting the motion on the table.
4 And then you only get, basically you're getting
5 only the no votes.
6 CO-CHAIR KAHN: Okay.
7 DR. BAGLEY: So --
8 CO-CHAIR KAHN: Well, actually, that's
9 the best way to go.
10 DR. BAGLEY: -- that might speed
11 things along.
12 CO-CHAIR KAHN: Okay.
13 DR. BAGLEY: So, in essence, you're
14 voting on the motion --
15 CO-CHAIR KAHN: Okay. So --
16 DR. BAGLEY: -- but you're only asking
17 for objections.
18 CO-CHAIR KAHN: Well, procedurally, we
19 can do that.
20 MS. BUCHANAN: We can do that, yes.
21 DR. BAGLEY: Yes.
22 CO-CHAIR KAHN: Okay. Well, I think

1 you just solved the problem. And we just spent
2 15 minutes figuring it out. I hate to take a
3 break because -- let's just keep rolling because
4 -- what's the next one?
5 MR. BERNOT: The next measure is
6 MUC17-262. That's the ST-elevation myocardial
7 infarction with percutaneous coronary
8 intervention. This is for the MIPS program.
9 The workgroup recommendation was
10 conditional support for rulemaking. The
11 condition was that this was pending NQF
12 endorsement, with even some further guidance
13 saying during the NQF endorsement review, the MAP
14 encouraged Cost and Resource Use Standing
15 Committee to specifically consider the
16 appropriateness of risk adjustment model to
17 ensure clinical and social risk factors are
18 reviewed and included when appropriate.
19 They also expressed concern over the
20 precision of the cohort definition, whether it
21 was sufficiently large cost performance
22 distribution within the measure.

1 This was pulled by -- identified by
2 Carl with a new motion to refine and resubmit.
3 Koryn, are you stepping -- okay.
4 MS. RUBIN: I'm handling it in his
5 absence. So the AMA put forward a motion to
6 change the decision category to refine and
7 resubmit based on some of the comments that were
8 made by the American Heart Association and
9 American Stroke Association in terms of the
10 emerging evidence that's expected to change the
11 way that patients with STEMI will receive care.
12 And it doesn't appear it's captured in
13 this cost measure. And so it will have
14 implications moving forward and does not appear
15 this measure is ready to move forward.
16 I would just want to highlight that
17 CMS did engage in a pretty collaborative process
18 as they were developing these cost measures. And
19 we thank them for that. But with this cost
20 measure, we don't feel comfortable moving
21 forward.
22 CO-CHAIR KAHN: Okay. Did staff and

1 the task force agree?

2 MR. BERNOT: The staff recommendation

3 on this was a conditional support. That is also

4 what the workgroup came up with.

5 CO-CHAIR KAHN: Okay. Other comments?

6 Leah?

7 MEMBER BINDER: Just a question, if

8 the developer can --

9 CO-CHAIR KAHN: Is the --

10 MEMBER BINDER: -- insight on this?

11 CO-CHAIR KAHN: Oh --

12 DR. NAGAVARAPU: Yes, we're online.

13 This is Sri Nagavarapu from Acumen. And I'm

14 joined by Dr. Do from Acumen --

15 CO-CHAIR KAHN: Great, thanks. Leah

16 has a question.

17 MEMBER BINDER: If they could comment

18 on the objection raised by AMA.

19 CO-CHAIR KAHN: Yes, would you all

20 comment on the objection raised by AMA in terms

21 of the status of the measure for use?

22 DR. NAGAVARAPU: Sure. We'd be glad

1 to. So we think this is related to a concern
2 expressed in the public comments regarding
3 emerging recent evidence for multi-vessel PCI in
4 selected STEMI patients.
5 We do have an approach. So multi-
6 vessel PCI was considered during the measure
7 development process. As was mentioned, the
8 measure development process included a clinical
9 subcommittee with over 30 members from an array
10 of specialty societies. And Dr. Do can walk
11 through those.
12 So we did think about multi-vessel
13 PCIs there in order to address it as carefully as
14 possible. We came up with the specific approach
15 that Dr. Do can talk about to both address issues
16 with staged procedures, as well as in cases where
17 there's multi-vessel PCI performed during the
18 triggering event, the inpatient stay.
19 The cost measure does reflect
20 potential savings from reduced adverse events
21 from that performance. So that is included in
22 the cost measure.

1 Going forward, as evidence continues
2 to emerge from ongoing clinical trials, I think
3 the clinical subcommittee has expertise that
4 makes it really well-positioned to continue
5 monitoring that evidence and make adjustments
6 going forward as needed.
7 But I'll turn it over to Dr. Do. He's
8 a cardiologist on our team that's worked with
9 this. So --
10 DR. DO: Yes, thank you, Sri. This is
11 Rose Do. I'm a cardiologist. And I had the
12 opportunity to work with the 40-plus members
13 represented, ACC/AHA, Society for Cardiovascular
14 Angiography and Intervention.
15 I do know that during the
16 conversations we did talk about multi-vessel PCI.
17 We understand the data that is out there with
18 PRAMI, culprit, the Danish study with AMI and,
19 therefore, did talk about staged PCI.
20 I also want to note that we are aware
21 that there is new evidence emerging. The
22 guidelines so far for 2015 in the ESC and AHA/ACC

1 guidelines state that a multi-vessel PCI for
2 STEMI is still Grade IIb, classification raised
3 from Grade III, Class III a few years prior.
4 So I think there's still some
5 development to be occurring in the clinical
6 community in terms of consensus for stating
7 whether PCI, multi-vessel PCI should happen on
8 the trigger date.
9 That said, I do want to reiterate what
10 Dr. Nagavarapu said, which is that we do account
11 for staged PCI in some of the service assignment
12 rules that we have. So once we have the trigger,
13 we are assigning a revascularization only if
14 there are some diagnoses that are present such as
15 a repeat STEMI or new angina, a new chronic
16 disease that's found within the claims. So we
17 tried very hard to be restrictive when that did
18 occur.
19 And then I would say at this time that
20 the measure does capture, you know, potential
21 cost savings. So, if a clinician does decide to
22 do a multi-vessel PCI, and they do have some

1 savings in the sense that there's fewer
2 admissions for angina or revascularization needs,
3 then that will be seen at this time.
4 We also have ways of measuring, just
5 kind of following people, because I think at this
6 time at least in the clinical community, we want
7 to gather more data. And we do have that
8 capability with our measure now.
9 We have some upcoming meetings with
10 the clinical subcommittee. And we're going to be
11 addressing these comments and then talking about
12 service assignments and risk adjustments. So
13 those are things that we can tweak.
14 I think also our process allows for us
15 to consider new data as it's coming. I would say
16 there are some meta-analyses in the last two
17 months or so that have come about to bring
18 discussion into mind.
19 And so I think our process does allow
20 for us to kind of think how strong the data is,
21 has it been widely accepted by the community, is
22 it in the guidelines, is there something that we

1 should be accounting for.

2 Well, I'll pause right there to see if

3 anybody has any other comments or questions.

4 CO-CHAIR KAHN: Comments?

5 MS. RUBIN: Yes, just to speak also

6 just a little bit further is this is one of the

7 measures that the public hasn't seen the testing

8 data. And I'm not sure if the specs have been

9 updated. I do -- you know, and to what regard,

10 because there was an additional clinician

11 subcommittee meeting after the clinical workgroup

12 met.

13 And so we're talking about something

14 that's, you know, we're talking about stroke,

15 pretty complex disease. And the public have not

16 had access to the most updated specs or the

17 testing data to really evaluate and then confirm

18 what's being stated.

19 CO-CHAIR KAHN: Are there any other --

20 I mean, anything else from the developers?

21 DR. NAGAVARAPU: Yes, this is Sri

22 Nagavarapu from Acumen. Just quickly on that, so

1 we did go through a field testing process in
2 which all attributed clinicians with at least ten
3 cases received field testing reports on these
4 measures.
5 Shortly after that time, we created a
6 national summary data report on these measures
7 that were published online so that people could
8 get a sense of what the cost distributions were
9 like and so on and compare them to their own
10 field testing reports.
11 As the commenter noted, in December
12 there was a round of measure refinement
13 activities to discuss substantive aspects of the
14 measure and ensure that the clinical
15 subcommittees felt comfortable with them.
16 Those refinements were submitted to
17 our team here. And we worked with them and
18 incorporated them. We'll be sharing an updated
19 national summary data report with the clinical
20 subcommittee members before we talk to them in
21 the upcoming refinement webinars that will
22 hopefully share the sort of information that was

1 being requested there.
2 I will say that we did compute updated
3 reliability metrics based on the changes that
4 were recommended in December that have now been
5 fully incorporated into the measures. And the
6 reliability at the team level for the STEMI with
7 PCI measure is at least .75, at a case minimum of
8 30. And so that surpasses the usual standard for
9 high reliability.
10 And we'll be sharing these sorts of
11 numbers with the clinical subcommittees soon and
12 can talk with you on that about sharing updated
13 numbers when we've got them.
14 CO-CHAIR KAHN: Okay. Let's go to
15 Bill and then over there. And then let's call it
16 a day. Bill.
17 MEMBER KRAMER: I have just a process
18 question. I'm not a clinical expert to be able
19 to judge or comment on these things, but a
20 question for staff and maybe other experts.
21 It sounds like these are the kind of
22 issues that will be discussed and resolved in the

1 endorsement process. And my understanding is
2 that we're not trying to second guess endorsement
3 or other -- or judge the measures in that way.
4 There are clinical experts and others who will be
5 doing that.
6 So our recommendation here is, my
7 understanding it came from the workgroup, was
8 conditional support based on the condition of NQF
9 endorsement and which -- and if it passes through
10 endorsement and it addresses these concerns, then
11 it seems to me that's, that works from the MAP's
12 perspective.
13 I don't think this is the place to re-
14 litigate whether something should be endorsed or
15 not. We don't have the expertise. We're not
16 charged with that. And so I'm comfortable with
17 the -- but I may be misunderstanding. So I look
18 for anyone --
19 CO-CHAIR KAHN: Let me just --
20 MEMBER KRAMER: -- to clarify that for
21 me.
22 CO-CHAIR KAHN: Where is this in the

1 endorsement process?

2 MS. O'ROURKE: So this has not been

3 submitted for NQF endorsement, still in

4 development from what we just understood.

5 But I think to your point, Bill, we

6 can certainly pass all of these, MAP's input and

7 concerns, along to the endorsement subcommittee.

8 We can also make sure that the reports from that

9 reflect the concerns raised by the AMA. But it's

10 obviously to the committee if you feel this is a

11 conditional support or a refine and resubmit.

12 Well, it already is conditional.

13 MS. O'ROURKE: Like if agree with the

14 AMA's motion to refine rather than the

15 workgroup's standing --

16 CO-CHAIR KAHN: So this is not an

17 issue of endorsement. It hasn't gone through the

18 endorsement process yet.

19 MEMBER KRAMER: Right. The condition,

20 though, the recommendation from the workgroup was

21 that it be approved, conditional upon NQF

22 endorsement. Is that correct? So it hasn't gone

1 through NQF endorsement. Is that right? But if
2 it is, does go through endorsement and addresses
3 these concerns, then the question is are we okay
4 with that. That's --
5 CO-CHAIR KAHN: Well, okay.
6 MEMBER KRAMER: Because it just seems
7 to me these are the questions that will be
8 addressed in the endorsement process, and we're
9 not trying to second guess that.
10 CO-CHAIR KAHN: Okay. I don't know.
11 Did I get a second on the motion? I'm not sure I
12 did. So where are we? Do you want to do a
13 motion? We need to do the --
14 MS. RUBIN: Yes, I would like to make
15 a motion to move to refine and resubmit.
16 CO-CHAIR KAHN: Okay. Is there a
17 second?
18 MEMBER QASEEM: Guys, this is Amir on
19 the phone now. I second it.
20 CO-CHAIR KAHN: Okay. Amir seconds.
21 Is there any -- oh, I'm sorry. Bruce, I didn't
22 see -- I was going to ask --

1 MEMBER HALL: Yes, this is the same
2 question I asked earlier. So it looks to me like
3 13 of these 22 measures are not NQF-endorsed.
4 This is one. And for all 13 of the 22, we're
5 saying we approve it if it gets endorsed. But
6 we've been told earlier in the day there's really
7 no feedback loop to take that information back to
8 CMS. So that makes me really --
9 CO-CHAIR KAHN: But wait, wait, wait.
10 No, I don't think -- it's not a question of
11 feedback loop. CMS will get a recommendation
12 from us that we are only recommending, we're
13 conditionally approving it based on the notion
14 that it's got to be endorsed.
15 The feedback loop is then to us and us
16 taking action as to whether or not CMS ignored
17 with our recommendation and went on and made it,
18 you know, required it anyway.
19 MEMBER HALL: Right.
20 CO-CHAIR KAHN: And then the question
21 is: what do we do about it?
22 MEMBER HALL: Which is their

1 prerogative, right?
2 CO-CHAIR KAHN: Yes.
3 MEMBER HALL: So they would be acting
4 on the assumption that we've conditionally
5 endorsed, when in fact this measure's not even
6 submitted for endorsement. And they --
7 CO-CHAIR KAHN: Well, no, no, we are
8 --
9 MEMBER HALL: They will move forward
10 with the work.
11 CO-CHAIR KAHN: No, in defense of us,
12 we're only recommending conditionally that it go
13 forward based on it becoming endorsed. If they
14 choose to go forward with it, then that's their
15 prerogative because they have authority to do
16 that.
17 What I think we'll discuss tomorrow
18 is, when they do that and let's say it doesn't
19 get endorsed, but when they do that, what do we
20 do. I mean, do we stand on our hands, or do we
21 go back to them and start some process and
22 complain and do whatever we can? Obviously, we

1 can only jawbone. But we haven't done that in
2 the past.
3 MEMBER HALL: Yes, this feels to me
4 like we're --
5 (Simultaneous speaking.)
6 CO-CHAIR PINCUS: -- CMS doing it in
7 the absence of it being endorsed, or if it goes
8 ahead and gets endorsed and gets implemented, you
9 know, are we comfortable with that?
10 MEMBER HALL: Yes, I don't have a
11 problem with these ultimately getting endorsed.
12 I wish that were going to be true of all of them.
13 I think what we're doing is we're
14 actually taking a stand on something that's not
15 specified. That's how I see it, because, in
16 fact, the conditional statements on 10 of these
17 13 ask for very specific issues to be addressed.
18 And all we're doing is saying we hope that
19 happens someday. In the meantime, we're going to
20 let it move forward.
21 CO-CHAIR KAHN: Well, we're --
22 MEMBER QASEEM: And another problem

1 that I raised when I was at the meeting is, well,
2 I think that that's important. And in this case,
3 I'm really strongly pushing for that we need to
4 just -- the measure is we don't even have the
5 full information if the measure is ready for
6 prime time. And whether the measure developer
7 decides to submit it to NQF for an endorsement,
8 that's their decision to make.
9 But at this point, the information
10 that we have in front of us, what I'm hearing
11 from the commission workgroup is that they were
12 unable to make that decision, because they didn't
13 even probably have the expertise. And they want
14 NQF to look into this measure, decide whether
15 it's a good measure or not.
16 And in that case, the measure
17 developer needs to make a judgment call whether
18 they go through the NQF process or not. But our
19 decision needs to be is whether this measure is
20 ready to be used for accountability.
21 At this point, what is presented in
22 front of us and that's what I think Horan and AMA

1 has been saying is there is not enough
2 information for us to be able to make that
3 judgment call.
4 I don't think we need to get into this
5 issue of what the measure developer does, what
6 process they follow. We need to make the
7 decision based on the information that's in front
8 of us.
9 Can we make, do we have enough
10 information that we can say this measure should
11 be used for physician accountability and we
12 firmly believe it's going to improve the patient
13 outcome?
14 If you feel like that, we should give
15 it a thumbs-up. If you don't feel like that and
16 go with what the clinician subgroup is saying
17 that we don't know and NQF needs to review this
18 measure in detail, then it's a revise and
19 resubmit.
20 CO-CHAIR KAHN: Okay. Let me -- and
21 I know I need to go to Leah. But let me go to
22 Kate, and then I'll recognize Leah, to sort of

1 have CMS response so we have some sense of --
2 MEMBER GOODRICH: Yes, I do feel like
3 we have this conversation every year just for the
4 record. But, anyway, glad to have it again.
5 So what I do want people to just, as
6 a point of information for the committee, this
7 measure, while, yes, we're sort of in the final
8 stages of testing the measure as the developer --
9 actually, it's done, right? We just have to get
10 all the information out there.
11 Just I do want to say the measure is
12 specified. This is a specified measure. It is
13 not unspecified. This is not just a concept. So
14 I want to be really clear with everybody how far
15 along this measure is.
16 The other thing just for the committee
17 to know, and many of you know this but some of
18 you who are newer may not, at CMS every single
19 measure that we develop -- and we are the
20 stewards of this measure. Acumen is our
21 contractor. Every single measure we develop we
22 put through NQF endorsement pretty much. I mean,

1 there's been one or two here or there that are
2 not used in accountability programs that we
3 haven't.
4 But that's our practice, because we
5 are required by law for our programs to use NQF-
6 endorsed measures except where there isn't an
7 NQF-endorsed measure for a particular quality
8 area.
9 And so I just want folks to know that
10 it is not -- I think Amir was saying we can
11 decide, the developer can decide whether or not
12 they want to. That is, of course, technically
13 true. But we always put ours through
14 endorsement. And this one will be put through
15 endorsement.
16 CO-CHAIR KAHN: Leah.
17 MEMBER QASEEM: And, Kate, if you're
18 saying that it's a revise and resubmit, it will
19 be perfectly fine to bring it back the next year.
20 That's right. I mean, for this year's deadline
21 the measure is not there yet. I absolutely
22 agree. It might be in the final stages, but the

1 deadline was missed.

2 CO-CHAIR KAHN: Well, Amir, I'm going

3 to let Leah comment. And then I'll come back,

4 and I'll ask a question of Kate. Leah.

5 MEMBER BINDER: Well, from my

6 understanding and I'm not a clinician either, but

7 my understanding is that the objection was that

8 there is some new science that has not been

9 considered in the measure.

10 I was actually reassured by the

11 comments of the measure developers that they have

12 considered it. And they are continuing to evolve

13 the measure. And then I am certain that the

14 process of endorsement would also go over those

15 same issues once again, and I think in a thorough

16 way with all of the stakeholders.

17 So I would think from that point of

18 view this would be -- that the recommendation of

19 the workgroup would make the most sense.

20 And I will add that the measure is

21 important, and that I would not want to see it

22 delayed. I think this is a critical issue of

1 cost, resource use, and quality. This is a very
2 high-stakes issue for purchasers and consumers.
3 So I would very -- unless there's some major,
4 major issue, I would not like to see it delayed.
5 CO-CHAIR KAHN: So let me ask a
6 question of CMS then. Okay. So, if we go
7 forward with the recommendation, it says
8 conditional based on endorsement. Knowing, I
9 mean, endorsement takes a while, and the measure
10 is not quite ready to go to the endorsement
11 process it sounds like.
12 So which cycle -- maybe you can't
13 answer the question. But in an ideal world,
14 which cycle is this measure in, going back to
15 Amir's issue of is this going to go, you know,
16 forward in the current cycle, or is it a year
17 away because of the development process? I mean,
18 what's the -- how much can you tell us?
19 MEMBER GOODRICH: So what I can say
20 is, again, this issue does come up every year,
21 which I think is one that NQF is trying very hard
22 to resolve in partnership with a lot of us here

1 around the difficulties of the timelines between
2 endorsement and MAP process.
3 In an ideal world, we would be able to
4 have only endorsed measures come through the MAP
5 process. We are not in that ideal world,
6 although I am very optimistic about the progress
7 that is being made. So we do take the
8 recommendations of the MAP very seriously.
9 It is true. We could decide because
10 this is a gap area, because it's really
11 important, whatever we decide, that we want to
12 propose it in rulemaking this year.
13 We also could decide that, based upon
14 input from the MAP, that we want to wait another
15 year. That is at the Secretary's discretion for
16 us to do.
17 You are right. I cannot tell you
18 exactly what we're going to do. I'm not allowed
19 to do that.
20 CO-CHAIR KAHN: Well, let me say that
21 at least as a matter of course, a recommendation
22 that's conditioned on endorsement is making a

1 statement from us that it's not ready for this
2 year, I mean, basically, I mean, in a sense.
3 Now, that doesn't mean you can't go
4 ahead and do it. As you say, you have authority,
5 and it depends on -- you're making decisions for
6 a lot of reasons.
7 But there's no way it's going to get
8 endorsed, you know, in time for this year's
9 regulatory process even if endorsement was, you
10 know, only a three or four-month process, because
11 there's just not time. So, and as you say, you
12 can't tell us what you're going to do. And you
13 may not even really know yet what you're going to
14 do.
15 But, you know, we are recommending in
16 a sense against going forward with it without
17 endorsement. Bill.
18 MEMBER KRAMER: Yes, and just to put
19 it another way, I think by recommending to move
20 forward conditioned upon endorsement sends a
21 sense of the MAP Coordinating Committee that this
22 is an important measure, fills an important gap.

1 It needs to be endorsed soon and put in place as
2 soon as feasible and appropriate.
3 Saying that we should revise and
4 replace and send it back -- it's not repeal and
5 replace, is it?
6 (Simultaneous speaking.)
7 MEMBER KRAMER: That would send a
8 different message that we think a lot more work
9 needs to be done on this. It's not, the concept
10 isn't right. It's not, or maybe it's not
11 important, doesn't meet our selection criteria.
12 And it would probably delay it for at least
13 another year.
14 And so I think we -- there is a
15 difference between support with conditions versus
16 -- what is the other category? Revise and
17 resubmit.
18 CO-CHAIR KAHN: Okay.
19 MEMBER KRAMER: So I would recommend
20 that we support. I'll also say a lot of this was
21 discussed and I understand happened in the
22 clinician workgroup already.

1 CO-CHAIR KAHN: Right.
2 MEMBER KRAMER: And they've hammered
3 it out and came out with this conditional
4 support. Unless there's a compelling reason to
5 overturn the workgroup's recommendation, then I
6 think we ought to stick with the workgroup's
7 recommendation.
8 CO-CHAIR KAHN: Okay. So we have on
9 the table a motion to revise and resubmit this
10 rather than the recommendation of the task force,
11 which was conditional on endorsement. We're
12 going to have a vote now. All those in favor of
13 the motion raise your hands. You can vote for
14 the AMA.
15 (Off-microphone comments.)
16 CO-CHAIR KAHN: The motion was refine
17 and resubmit, yes. Okay. So all those in favor.
18 Okay. All those opposed.
19 (Show of hands.)
20 CO-CHAIR KAHN: And please vote on the
21 phone. Okay. Clearly --
22 MS. BUCHANAN: Yes, so, for the motion

1 of refine and resubmit for MUC262, we have 1 yes
2 and 24 no.
3 CO-CHAIR KAHN: Okay. And if there's
4 no objection, then we will consider reverting
5 back to the consent calendar. And seeing anybody
6 object?
7 MS. RUBIN: Yes, I'd then like to add
8 a condition, to make a motion to add a condition
9 that, as the evidence emerges in terms of
10 changing with how STEMI is treated, that the
11 measure is looked at for and incorporate, looked
12 at whether the latest procedures are
13 incorporated. I'm trying better --
14 CO-CHAIR KAHN: Okay. Is there --
15 MS. RUBIN: -- phrase that.
16 CO-CHAIR PINCUS: That's an
17 assumption. I mean, that's really an assumption.
18 That's what the endorsement process looks at.
19 CO-CHAIR KAHN: Yes, but she --
20 CO-CHAIR PINCUS: Yes.
21 CO-CHAIR KAHN: -- offered a motion.
22 CO-CHAIR PINCUS: Okay.

1 CO-CHAIR KAHN: I mean, I --
2 CO-CHAIR PINCUS: Okay.
3 CO-CHAIR KAHN: Is there a second to
4 the motion? Okay. There's no -- any second on
5 the phone? Okay. There's no second to the
6 motion. Is there any objection to go forward?
7 Okay. We'll go forward. Let's go to the next
8 one.
9 MR. BERNOT: Okay. So we are going to
10 MUC17-310. I'll give you a bit of history from
11 this one. The workgroup recommendation was
12 conditional support for rulemaking with the
13 condition of NQF endorsement and that it's
14 updated to reflect the most current clinical
15 guidelines.
16 The discussion of the workgroup
17 revolved around the fact that there is a current
18 vaccine with evolving guidelines that may propose
19 a different vaccine with a different age group.
20 So this was pulled not previously, but
21 just in the discussion by Amir. And you did not
22 have a motion yet. Or are we just going to

1 discuss this?
2 CO-CHAIR KAHN: I'm sorry --
3 MR. BERNOT: It's to Amir, sorry.
4 CO-CHAIR KAHN: Amir, are you on the
5 phone?
6 MEMBER QASEEM: Yes, I am.
7 CO-CHAIR KAHN: And do you want to --
8 I'm sorry. First, the recommendation was
9 conditional --
10 MR. BERNOT: Conditional support for
11 NQF endorsement.
12 CO-CHAIR KAHN: And was the staff
13 algorithm the same?
14 MR. BERNOT: Yes.
15 CO-CHAIR KAHN: Okay. Amir, how do
16 you want to proceed? Do you want to make a
17 motion, or do you just want to --
18 MEMBER QASEEM: Yes, just quickly, I
19 just wanted to hear the conditions from the
20 staff. What are they asking for with these
21 things?
22 CO-CHAIR KAHN: I'm sorry?

1 CO-CHAIR PINCUS: What were the
2 conditions?
3 MEMBER QASEEM: What are the
4 conditions you guys are asking to put in place --
5 CO-CHAIR KAHN: What is the condition
6 --
7 MEMBER QUERAM: -- from the staff
8 perspective?
9 CO-CHAIR KAHN: Yes. What is the
10 condition that's placed on this by the task
11 force?
12 MR. BERNOT: The condition was NQF
13 endorsement and inherently at that point that
14 it's updated to reflect the most current clinical
15 guidelines. But that was specified in the
16 condition.
17 CO-CHAIR KAHN: Okay, so it's
18 conditional based on endorsement which presumes
19 that it will be updated, I guess, to the latest
20 form of vaccination, is that correct?
21 MEMBER QASEEM: So, no, I won't really
22 make a motion to revise it. I just I wanted to

1 add some conditions there and just want to make
2 sure that, you know, the medical exclusions are
3 just not even listed in this one.
4 There's so many examples and even in
5 a compromise, you can't really give this vaccine.
6 It's a very expensive vaccine, guys. I mean, you
7 can keep it in mind what you're asking for.
8 And, this does not even follow the CDC
9 recommendations. It's not even consistent based
10 on what CDC says.
11 They even talk about allergies, being
12 a compromise and all that.
13 So, essentially, this measure needs to
14 be revised. I can live with it, keep it under
15 conditional, but I just want to add the condition
16 that at least reflect what CDC is saying.
17 CO-CHAIR KAHN: Does -- do we know,
18 are the developers available for this? Do we
19 know what kind of stratification they've done on
20 this measure?
21 MR. BERNOT: We did not, but more of
22 the discussion was the fact that there is a

1 potentially evolving change, significant change
2 to the vaccination guidelines and that's why the
3 workgroup had recommended --
4 CO-CHAIR KAHN: But the guidelines,
5 because of what the proper vaccination is or
6 because of the issues that Amir's raising?
7 MR. BERNOT: It was about really about
8 the proper vaccination was the discussion.
9 CO-CHAIR KAHN: Because he's really --
10 he's raising the issue that, you know, there's
11 certain circumstances you wouldn't provide --
12 that you wouldn't choose to give the shot. Which
13 means that's not --
14 CO-CHAIR PINCUS: But, is the measure
15 fully specified at this point? Does that include
16 the exclusions?
17 CO-CHAIR KAHN: I don't -- let me look
18 at CMS and ask the question. Pierre, do you know
19 anything?
20 DR. YONG: Yes, I believe it is fully
21 specified, but it does need to be updated. But,
22 let me check on the phone, I know there's CMS

1 staff there. Do you know, is the developer on
2 the line?
3 MS. ERDE: Hi, this is Susan Erde, I
4 believe the developer was supposed to be on the
5 line. But the measure itself is fully developed.
6 The situation is one of where the Zostrix vaccine
7 is coming out. And, I believe that the developer
8 wants to make sure that's incorporated into the
9 new measure guidelines or measure specifications.
10 CO-CHAIR KAHN: The issue that Amir's
11 raising really --
12 (Simultaneous speaking.)
13 MEMBER QASEEM: Yes, and so
14 essentially we need to have the CDC
15 recommendation or the exclusion who shouldn't be
16 given this vaccine.
17 And then, generally, just for the
18 group to think about, you know, it's an expensive
19 vaccine. A lot of hospitals are giving it to
20 underserved population, no insurance. I am not
21 really sure, but I won't really get into the
22 operational issue.

1 At the least, we should be following
2 what the current guideline by the government
3 says.
4 DR. AMIN: It might be helpful just to
5 clarify, the specifications that we have doesn't
6 include any exclusions.
7 So, what we can do is we could just
8 add this into the narrative, all of Amir's sort
9 of points of just clarification as elements that
10 the endorsement committee should review when it
11 goes through endorsement.
12 So, we could just add that to the
13 discussion.
14 CO-CHAIR KAHN: Okay. Would that be
15 acceptable, Amir? We'll add in your concerns.
16 MEMBER QASEEM: Yes, that's fine.
17 CO-CHAIR KAHN: Okay, good.
18 MEMBER QASEEM: I'm nicer over the
19 phone than I am in person, I guess.
20 CO-CHAIR KAHN: We love you in any
21 form.
22 Okay, let's move on to the next one.

1 DR. BERNOT: Sure.
2 So, the next one is MUC17-363. This
3 is the intracranial hemorrhage or cerebral
4 infarction. This is for the MIPS program.
5 The workgroup recommendation for this
6 was conditional support for rulemaking similar to
7 the STEMI measure, this was for NQF endorsement
8 with the same specific considered appropriateness
9 of clinical cohorts defining the measures.
10 That meaning that there was two
11 clinical cohorts. There was the ischemic stroke
12 as well as the hemorrhagic stroke where the two
13 clinical cohorts that were brought up in the
14 discussion.
15 And, that the appropriateness of the
16 risk adjustment model for both the clinical and
17 social risk factors.
18 The other thing that -- the point that
19 was raised was the need to ensure that the
20 measure appropriately handles transfers from
21 tertiary medical centers, that they may receive
22 transfer patients without -- with a more severe

1 presentation that may not be reflected in the
2 administrative data.
3 That was all part of the conditions,
4 a long condition. NQF endorsement considering
5 then with some guidance of what things they
6 should be considering.
7 CO-CHAIR KAHN: Okay. And, then who
8 --
9 MS. RUBIN: The AMA pulled this.
10 CO-CHAIR KAHN: The AMA, okay.
11 MS. RUBIN: Yes, we pulled this and
12 made a motion for refine and resubmit.
13 The conditions placed on this measure
14 are structural issues and potentially will change
15 the intent. As highlighted in the comments the
16 MAP received and then in the Clinician Workgroup
17 discussion, there's many questions that need to
18 be answered and further examined, including the
19 appropriateness of including the two conditions
20 within one cost measure.
21 And, each requires treatment from
22 different specialties. And, you're including it

1 all in one measure.
2 And then, also, the lack of precision
3 of the coding to capture patient severity.
4 So, also, to, you know, ensure that
5 there is really the appropriate risk adjustment
6 in there.
7 CO-CHAIR KAHN: I'm sorry, this is up
8 for endorsement or this has been endorsed?
9 MR. BERNOT: This is the exact same
10 thing as the STEMI, so it will -- the CMS had
11 stated that this will go through the endorsement
12 process.
13 CO-CHAIR KAHN: Okay. Has anything
14 that's been said not, I mean, not included in the
15 comments that are going? I mean the comments --
16 okay, do you want to have a motion?
17 MS. RUBIN: Yes, to me, the type of
18 the -- the comments that were made and the
19 conditions placed on it warrant refine and
20 resubmit. We're looking at potentially a whole
21 different measure in the end.
22 CO-CHAIR KAHN: Okay, but, so there's

1 a motion to refine and resubmit.

2 Is there a second for this?

3 Okay, sorry, no second and there is a

4 recognition of all your comments in the

5 conditional. So, let's go forward with the next

6 one.

7 MR. BERNOT: Okay. Do we need to make

8 sure there's no objections from any --

9 CO-CHAIR KAHN: No, no, but there was

10 no motion. I mean, the motion -- but the motion

11 wasn't seconded. So, there's no real motion.

12 MR. BERNOT: My error, my error.

13 CO-CHAIR KAHN: Unless -- I'm sorry,

14 Derek?

15 MEMBER ROBINSON: Yes, I just had a

16 question in terms of, I mean, I share some of the

17 concerns around the, you know, the cohorts and

18 how management of those cohorts can vary quite

19 substantially.

20 When we look at the total cost, and

21 this may be a little bit more down in the weeds,

22 but does this include like air ambulance

1 transport and all the things associated with the
2 cost for these patients?
3 DR. YONG: Sri, are you still on the
4 line?
5 DR. NAGAVARAPU: Yes, I'm here.
6 So, this is Sri Nagavarapu from
7 Acumen.
8 One thing we wanted to clarify is that
9 we think there is an important misunderstanding
10 in the comments that were received by the MAP
11 about these two conditions.
12 This was actually an issue that the
13 clinical subcommittee, when they started
14 deliberating on this early last summer, was
15 sensitive to.
16 And, what they did was they subgrouped
17 the two conditions separately. So, what this
18 means is that observed spending for ICH episodes
19 are compared only to expected spending for ICH
20 episodes and observed spending for stroke is
21 compared only to expected spending for stroke
22 episodes.

1 So, the way that's accomplished in the
2 measure, the way subgrouping is implemented is
3 that there's entirely separate risk adjustment
4 models estimated for each case.
5 So, ICH is only compared to ICH and
6 stroke is only compared to stroke. So, the
7 result of that is that no clinician or clinician
8 group is penalized or rewarded simply if they're
9 focusing ICH cases or only on stroke cases.
10 And, this is something the clinical
11 subcommittee chose to do specifically for the
12 types of concerns that were raised in the cost.
13 After the subgroup calculations are
14 performed, they're brought together in one
15 measure. The clinical subcommittee chose to do
16 this for several reasons.
17 One is that the subgrouping approach
18 that we kind of just ran through directed the
19 clinical condition concern.
20 The second is that often the same sets
21 of clinicians may be involved in both types of
22 cases. It may also be the case that several of

1 the included services that are assigned such as
2 adverse events and complications may be common
3 across the two cases.
4 And, then ICH cases were perceived as
5 extremely important to address and not segment
6 them off.
7 The final point is that Medicare does
8 consolidate these cases into a single set of
9 DRGs.
10 In terms of the inclusion of certain
11 costs, the clinical subcommittee did decide to
12 include certain types of costs like ambulance and
13 air transport and exclude other costs that they
14 felt were not in control of the attributed
15 clinician.
16 There's also several other issues that
17 were brought up regarding risk adjustment. This
18 is dealt with by --
19 CO-CHAIR KAHN: I think we got the
20 picture.
21 DR. NAGAVARAPU: Okay.
22 CO-CHAIR KAHN: That was very helpful,

1 though.

2 So, where are we? Where are we?

3 MS. O'ROURKE: So, I believe it was

4 one -- Amir had pulled the HIV screening measure,

5 MUC17-367. Everything else was still on the

6 consent calendar.

7 MR. BERNOT: Correct. So, I can go

8 through the 17-367. This is the HIV screening.

9 The workgroup recommendation for this was

10 conditional support for rulemaking.

11 They requested the standing committee

12 review the patient cohort definition how

13 community is handled in the endorsement process

14 with the --

15 So, this would be a recommendation for

16 NQF endorsement with a very particular requests.

17 And, this was pulled by Amir, again.

18 So, we do not have a motion. So, Amir, it would

19 be up to you whether this is for discussion or --

20 CO-CHAIR KAHN: Amir, on the HIV, do

21 you want to -- what are your concerns? I mean,

22 do you want to express concerns or have a motion?

1 MEMBER QASEEM: So, yes, and I'll just
2 express concerns and then that makes me feel
3 better. I'll leave it.
4 As you do know, all of you are in
5 primary care, one-time screening in a lifetime,
6 it just doesn't make sense. That has no evidence
7 that shows that one time screening is going to
8 have a better clinical outcome.
9 And this, I mean sure that we have
10 actually we had discussed also, I don't actually
11 -- so, they are in our population health
12 committee, this keeps on coming up.
13 And, for whatever the reason, on the
14 back for years, then we come in here and the
15 measure is going to get revised and nothing get
16 revised.
17 And, the reason I wanted to pull this
18 measure and want to bring this issue up is, many
19 of these conditions supports and all that and we
20 had asked for changes from the measure
21 developers.
22 The reality of things is, many of

1 these measures don't change. We hope they will,
2 and they don't. And, that's my little spiel
3 based on the evidence.
4 So, it's a one time screening in a
5 lifetime doesn't make sense.
6 CO-CHAIR KAHN: If I can ask CMS, so,
7 I mean, just logic, why was this included?
8 MEMBER GOODRICH: This is a measure
9 from the CDC, is that correct? And, obviously,
10 HIV screening is important.
11 I think for the issues that Amir
12 raises, I'm not going to speak to them clinically
13 except to say that, those are exactly the kind of
14 issues that, through the development of the
15 measure and the endorsement process would
16 definitely come up.
17 So, you know, I think sometimes things
18 that come up at the MAP may or may not get
19 addressed in the measure because of the MAP
20 process, but they may get addressed because of
21 the endorsement process.
22 But, I don't know the answer, Amir, to

1 your question about why that particular choice
2 was made for this measure. I would have to defer
3 to the CDC.
4 CO-CHAIR KAHN: And, this measure --
5 so, it hasn't gone through -- is it --
6 MR. BERNOT: It is not NQF endorsed.
7 PARTICIPANT: And, this is the CDC
8 here. I can speak to some --
9 CO-CHAIR KAHN: Oh, yes, thanks.
10 PARTICIPANT: -- of the concerns.
11 CO-CHAIR KAHN: Yes, please respond.
12 PARTICIPANT: So, whether -- you could
13 -- I assume that there are individual concerns
14 with the once ever screening, but it's not valid
15 to say that there's no evidence for that because
16 there is evidence for that, it is not just the
17 CDC recommendation, it is also a USPSTF
18 recommendation with a Grade A assigned to it.
19 And the USPSTF is reviewing that and
20 is expected to re-endorse it again with a Grade
21 A.
22 So, the evidence for this

1 recommendation is solid, that it does have
2 meaningful individual and public health
3 ramifications.
4 In terms of not making any changes to
5 the measure, this measure did go before the
6 Population Health Committee with NQF and, based
7 on some concerns about how we had defined the
8 denominator, the measure was reconfigured to
9 expressly address those particular concerns
10 around the denominator which is why it didn't
11 move forward with that review.
12 So, I think it would be fair to say
13 that we do take concerns when expressed very,
14 very seriously and we have tried to make changes.
15 So, this measure has gone through
16 changes in response to specific feedback we have
17 received including from previous iteration when
18 we visited it at NQF.
19 CO-CHAIR KAHN: Okay, so it's in the
20 endorsement process? It's been --
21 MS. MUNTHALI: It came through the
22 process but it was not successful. It sounds

1 like the developer took that feedback, is
2 revising the measure. It's not back through the
3 process yet. But, we expect -- it sounds like
4 it's coming back through the process.
5 CO-CHAIR KAHN: Okay, we have
6 questions.
7 Sam?
8 MEMBER LIN: Thank you, Chip.
9 I'm looking at the specs on this and
10 it says review for scientific acceptability.
11 The measure failed to meet the
12 scientific acceptability criteria, et cetera, et
13 cetera, and it explains why.
14 While the committee -- review
15 committee was generously supportive of the
16 measure, several concerns were raised about the
17 numerator and denominator. Ultimately, the
18 measure failed the reliability criterion.
19 So, for what that's worth.
20 PARTICIPANT: Which is this from?
21 MEMBER LIN: This is from the spec
22 sheets for the coordinating committee here.

1 Let's see, as to that particular -- it's the
2 summary of the NQF endorsement review in 2016.
3 MEMBER QASEEM: So, it's for -- would
4 it be possible that we just put this measure
5 through NQF process first without getting into
6 the debate about the evidence and all that,
7 right?
8 I think this measure needs to be taken
9 a look at and especially if it's going to go
10 through this process. Unless they --- then are
11 we going to see it? It's probably going to
12 population health first, right?
13 CO-CHAIR KAHN: Yes, I think it's
14 already gone to population -- I think you said it
15 had gone to population health.
16 MS. MUNTHALI: It failed, yes.
17 CO-CHAIR KAHN: And that concerns were
18 raised and that they're having to adjust the
19 measure.
20 I think --
21 MEMBER QASEEM: No, but I thought that
22 I heard that they had revised the measure based

1 on the feedback and they're going to resubmit.
2 CO-CHAIR KAHN: Yes, yes, well, yes.
3 PARTICIPANT: Yes.
4 CO-CHAIR KAHN: Yes. But, you're
5 raising a fundamental issue, I think, that --
6 let's continue with the points here and we'll see
7 where we get.
8 Mary?
9 MEMBER HALL: Thank you.
10 I actually was on a technical panel
11 for this measure. And so, I am going to recuse
12 myself from any voting.
13 But, I wanted to just add that, one of
14 the very often problems as someone who has over
15 80 measure NQF endorsed, speaking from NCQA's
16 point of view, is the difficulty in mapping a
17 guideline with great precision to a measure.
18 And, while, of course, Amir, you would
19 expect that in practicing in primary care, you
20 would assess somebody's risk factors routinely
21 and you would re-screen them every time they had
22 had a potential new exposure.

1 When you're creating a -- and that's
2 what a guideline would support.
3 But, when you're creating a measure,
4 you have to aim, unfortunately, for the, I don't
5 want to say the floor, but, you know, the most
6 common set of scenarios.
7 And, without the capacity using claims
8 to assess risk level, you can't make a measure
9 that's risk appropriate. You have to just make
10 the measure that would apply to the whole
11 population without regard to understanding each
12 person's risk status.
13 And so, that's the argument for the
14 validity of a measure that is of -- and, I
15 believe that this is a first HIV screening
16 measure to be used in federal programs that the
17 point of starting here is to say, everybody
18 should at least be screened once and that's the
19 starting point.
20 MEMBER QASEEM: But, they have better
21 measure that, again, are being reviewed in NQF
22 that gets into the whole treatment because we

1 haven't had that just one time screening is not
2 going to help. You have to follow it through.
3 So, that's one thing.
4 And so to respond to your comment, I
5 absolutely agree that this is the floor, but if
6 that's the logic we're going to follow, we need
7 to apply it consistently across all the measures
8 we have reviewed today.
9 We can't say that this one is okay for
10 this one, but the others we have gone through,
11 which I am not too sure if they were.
12 CO-CHAIR KAHN: You know, Mary, I
13 haven't studied much of this stuff, but I did
14 study when I was in graduate school, we looked at
15 the old guaiac stool study and it really, you
16 know, it wasn't worth doing them.
17 And, this one, I don't know, it sort
18 of raises -- because you're basically saying we
19 need, you know, you can't see it all the time so
20 we ought to at least do one time everybody, if I
21 understood what you said.
22 Okay, Bruce?

1 MEMBER HALL: Well, I think some of my
2 questions may have been resolved. But, I'm just
3 trying to clarify what we're looking at here, so
4 this was a measure that was previously submitted
5 for endorsement and failed.
6 The developer says that, I think the
7 developer said that what we're looking at now has
8 been revised. But, I don't know whether that
9 means it's going to be in the endorsement process
10 in a timely fashion because our comments as
11 recorded talk about the standing committee
12 reviewing the cohort definition and so on and so
13 forth.
14 So, are we looking at something that
15 is going to be re-submitted for endorsement and
16 is that more than a year away then?
17 CO-CHAIR KAHN: Well, my sense is it
18 either has or will be re-submitted for
19 endorsement, right? Do we know? Can CDC tell
20 us?
21 PARTICIPANT: Yes, yes, it will be
22 revised and re-submitted. In fact, I thought

1 that was part of the message that you get from
2 the conditional endorsement.
3 We condition it on further review
4 under the appropriate NQF subcommittee.
5 MS. O'ROURKE: So, just to clarify,
6 MAP does not grant NQF endorsement as to just be
7 precise with language.
8 But, I think just to clarify, the
9 conditional support is pending on re-submission
10 for NQF endorsement.
11 CO-CHAIR KAHN: Yes, we understand
12 that.
13 MS. O'ROURKE: Okay.
14 CO-CHAIR KAHN: The issue is --
15 PARTICIPANT: Yes.
16 CO-CHAIR KAHN: -- that our
17 conditional support is based on endorsement. It
18 may be endorsed, it may -- if it doesn't get
19 endorsed then that answers the question.
20 If it gets endorsed, then it would
21 meet our conditions.
22 MS. MUNTHALI: And, I just wanted to

1 ask the CDC, so it sounds like you did make those
2 revisions to what the MAP is looking at now.
3 And, if that's the case, would you be ready to
4 submit this year to NQF?
5 PARTICIPANT: Yes, so, the previous
6 time we went through NQF, we didn't actually get
7 to the validity and reliability data because
8 there was a conceptual concern about how we had
9 constructed the measure.
10 We redid the measure and have gone
11 through all of the testing process with
12 Mathematica, policy research according to CMS's
13 Blueprint version, what, 13 or whatever.
14 So, at this point, we are in the final
15 stages of developing all of the materials that
16 would be needed to take it back to NQF.
17 MS. MUNTHALI: Okay, that's helpful,
18 thanks.
19 CO-CHAIR KAHN: Okay, John?
20 MEMBER BOTT: Yes, just because it
21 seems like there's a lot of gray area for when
22 something would fall the conditional support and

1 refine and re-submit, I just thought I'd go back
2 to, you know, these seven assessment criteria.
3 And, Sam made a good point when he
4 read, and correct me if I'm wrong, that it didn't
5 test out as being reliable and valid.
6 So, the way these, you know, somebody
7 put a lot thought into these criteria and the
8 seven components. So, if it fails that
9 assessment number six, then it falls to refine
10 and re-submit. So, it seems like until it's been
11 tested and reliable and valid, it -- we can't go
12 -- it can't graduate to conditional support.
13 So, it sounds like it falls in the
14 refine and re-submit bucket.
15 CO-CHAIR KAHN: I'm sorry, so you said
16 --
17 PARTICIPANT: This is Abigail, can NQF
18 speak to that? Because what we got from them was
19 that it did pass all of those. And, Mathematica
20 is also on the line to discuss the validity and
21 reliability.
22 I did hear the person that brought

1 that up reference 2016, which wouldn't be the
2 current version of the measure.
3 MR. BERNOT: Sure, yes. I can address
4 that.
5 So, the preliminary assessment that we
6 had had information on the testing. We had it
7 looked at by a number of different individuals,
8 including our Chief Methodologist and others.
9 And, there is, admittedly, a need to
10 go through the endorsement process. That was not
11 supposed to be there. They thought there was
12 enough information that it is quite conceivable
13 that it was going to get through the endorsement
14 process on the reliability and validity.
15 So, we did not, obviously, have their
16 endorsement data, but it was looked at internally
17 to see if it appeared to be sufficient to get to
18 that point on a quick glance based on the
19 information and it did.
20 So, that's where -- that's why we were
21 able, in our preliminary assessment, to pass it
22 as saying that it appeared to be valid and

1 reliable.
2 I will admit this is an unusual
3 situation where the data was close like that.
4 And, that's why we went through the extra steps
5 including at the actual Clinician Workgroup,
6 Helen Burstin was the lead discussant on there
7 also had looked at the data herself.
8 And we had this discussion. But it
9 was close, but that's why we wanted the
10 endorsement process and that's what the workgroup
11 set as a condition.
12 CO-CHAIR KAHN: Okay. So, let me ask
13 this question. There really are two issues here.
14 I mean, I think, one, that everyone's brought up
15 now which is just questioning the measure.
16 There is the more fundamental issue,
17 I think, from Amir, which is, is this the right
18 approach and should this measure be in here?
19 So, let me first as Amir, do you want
20 to offer a motion? You were the one that pulled
21 it.
22 I'm not getting any --

1 DR. AMIN: Amir, are you on the line?
2 CO-CHAIR KAHN: Amir, are you on the
3 line?
4 Well, okay. So then --
5 DR. AMIN: Operator? Let me just make
6 sure. Operator, can you just verify that Amir's
7 line is open and is he on the line?
8 OPERATOR: Amir has actually
9 disconnected.
10 CO-CHAIR KAHN: Okay. So, that solves
11 that.
12 So, let's go to the second issue that
13 Bruce and others have raised.
14 Is there any interest in any kind of
15 motion from the room to change the status from
16 conditional with the proviso about endorsement
17 and the other issues that have been raised to
18 revise and re-submit? Okay, going once, going
19 twice.
20 (No audible response.)
21 CO-CHAIR KAHN: Okay, so we had our
22 discussion and clearly it's not ready for prime

1 time, but hopefully it will become so in the
2 process.
3 DR. AMIN: We'll clarify, we'll add
4 all this commentary.
5 CO-CHAIR KAHN: Okay. And so, is --
6 are there any other measures for consideration?
7 MR. BERNOT: There are no other
8 measures. So, everything else would have --
9 would be on the consent calendar that would just
10 need to be accepted.
11 CO-CHAIR KAHN: Do I have motion to
12 accept the consent calendar?
13 PARTICIPANT: So moved.
14 CO-CHAIR KAHN: Do I have a second?
15 Okay, we have a second.
16 All those in favor of proceeding with
17 the consent calendar. And, please vote on the
18 phone by email.
19 MS. BUCHANAN: And, we're just getting
20 in some of our phone ones.
21 CO-CHAIR KAHN: Okay. While they're
22 doing the tabulation, let me say, I'd like to

1 take a ten minute break. The Chairs have to
2 confer about -- with the staff about how we
3 proceed with the agenda.
4 So, we'll determine what we do for the
5 rest of the afternoon.
6 DR. AMIN: Can I just clarify?
7 CO-CHAIR KAHN: Yes.
8 DR. AMIN: Can I just clarify one
9 thing? There was a measure, that optimal
10 vascular measure for the MIPS program was pulled.
11 And, the motion did not pass. We're assuming
12 that that went on to the consent calendar that
13 was just voted on. Just want to confirm that
14 there's --
15 CO-CHAIR KAHN: That one -- was that
16 the one where we made the transition to asking if
17 there was an objection?
18 DR. AMIN: Yes.
19 MS. BUCHANAN: Yes.
20 DR. AMIN: Right, it was before that.
21 So, I just want to confirm that the consent
22 calendar has been --

1 CO-CHAIR KAHN: There wasn't any where
2 we didn't vote on them but until we changed the
3 policy.
4 DR. AMIN: Okay, just wanted to
5 confirm.
6 CO-CHAIR KAHN: Yes.
7 DR. AMIN: For the record, that's what
8 it is.
9 CO-CHAIR KAHN: For the record, there
10 was no objection. We proceeded.
11 DR. AMIN: Thank you.
12 CO-CHAIR KAHN: Okay. And the vote?
13 MS. BUCHANAN: Yes. So, we have 26
14 yeses to support the clinician consent calendar.
15 CO-CHAIR KAHN: Okay, it's passed.
16 Sorry this took so long, but this is
17 what our process is.
18 So, we're going to take a ten minute
19 break and then reconvene.
20 PARTICIPANT: Then we'll get to the
21 hard stuff.
22 CO-CHAIR KAHN: Right.

1 (Whereupon, the above-entitled matter
2 went off the record at 3:41 p.m. and resumed at
3 3:56 p.m.)
4 CO-CHAIR PINCUS: Okay, so, we're
5 about to approach the report from the Hospital
6 Workgroup. And so, if everybody can take their
7 seats?
8 MS. O'ROURKE: And, do we have Ron
9 Walters and Cristie Travis on the phone?
10 DR. WALTERS: I am.
11 MS. TRAVIS: Yes, I'm here.
12 MS. O'ROURKE: Okay, excellent, I just
13 wanted to be sure.
14 MS. TRAVIS: Yes, we're both here.
15 MS. O'ROURKE: Be sure we had you guys
16 and your lines were open.
17 CO-CHAIR PINCUS: So, before we get
18 the report from the Hospital Workgroup, is there
19 anybody in the room from the public who wants to
20 make a comment?
21 (No audible response.)
22 CO-CHAIR PINCUS: Seeing nobody, what

1 about on the phone? Anybody on the phone that
2 wishes to make a comment about hospital programs?
3 MS. O'ROURKE: Bridget or Kathy, could
4 you open the line up for public comments?
5 OPERATOR: If you'd like to make a
6 public comment, please press star, one on your
7 telephone keypad. That's star, one to make a
8 public comment.
9 And there are no public comments.
10 CO-CHAIR PINCUS: Okay.
11 MS. MARINELARENA: Great, thank you.
12 Hi, my name is Melissa Marinelarena. I'm the
13 Senior Director. I'm working on the MAP Hospital
14 Workgroup. I want to thank you for hanging in
15 there this afternoon. We've got an hour and
16 hopefully we can get through this.
17 And it's kind of refreshing to see
18 that we weren't the only ones that had voting
19 issues. I think my colleagues will agree with
20 that.
21 I'm just going to turn it over to my
22 colleague, Kate, it's been a long day, Kate.

1 She's going to provide just an overview of the
2 themes that our workgroup discovered.
3 And then, turn it over to our co-
4 chairs to give an overview of the
5 recommendations.
6 And then, we're here to answer any
7 specific questions that you have on the
8 workgroup's recommendations.
9 MS. MCQUESTON: Great, thank you. So,
10 we promise to make the introduction very quick.
11 This year, there were nine measure for
12 five of the hospital and setting specific
13 programs.
14 Four of the programs in the Hospital
15 Workgroup purview did not have measures under
16 consideration for this year. And those are the
17 hospital acquired condition reduction program,
18 the hospital readmissions reduction program, the
19 inpatient psychiatric facility quality reporting
20 program and the value-based purchasing program
21 had no measures.
22 This is just a quick overview of the

1 meeting themes that were discussed during the
2 hospital in person meeting.
3 The first major theme was the need to
4 promote alignment and harmonization to reduce
5 provider burden and provide better information to
6 patients.
7 The workgroup discussed the need to
8 balance costs and quality issues with measure
9 burden that's placed on clinicians and providers
10 as well, also remaining aware of measurement
11 resource issues.
12 So, this discussion fell into four
13 main buckets.
14 The first is alignment across payers.
15 They noted that it's important to align measures
16 across CMS programs and public and private sector
17 payers.
18 The next area was harmonizing similar
19 constructs. They noted there was a need for
20 increased harmonization of measures that evaluate
21 similar constructs across setting and programs.
22 This, in particular, was discussed in

1 relation to MUC17-176, the dialysis facility
2 medication reconciliation measure where the
3 workgroup discussed opportunities to improve
4 alignment of med rec measures across programs.
5 Next is the MAP role in advising on
6 harmonization. They noted the importance of
7 considering parsimony alignment and measure
8 harmonization at MAP.
9 And, noted that there should be an
10 active MAP role in examining measures used in CMS
11 programs more broadly. And, this would include
12 assessing opportunities across current programs
13 and measure sets.
14 And, finally, discussed patient and
15 family engagement and the importance of engaging
16 these groups to improve measure harmonization.
17 The next item was balancing the need
18 to address quality concerns with the need to
19 ensure fair measurement. And we won't go too
20 much into this because this has been discussed in
21 depth today.
22 But they noted a lot of the same

1 issues that have been discussed previously in
2 terms of balancing, driving improvements in key
3 outcome areas with the need to ensure that
4 there's fair attribution for providers that use
5 measures and that the use of measures is reliable
6 and valid.
7 And, they also stressed the importance
8 of NQF endorsement as a mechanism to ensure that
9 the measure is evidence-based, reliable and
10 valid.
11 And, in particular, there looked at,
12 you know, some of the issues with timing
13 challenges, that measures are brought to -- that
14 some measures are currently under development and
15 have been reviewed for NQF endorsement when
16 they're brought to the MAP.
17 And, that there were some concerns
18 with the status of measure development where MAP
19 struggled with balancing quality issues and
20 patient outcomes with ensuring that there was the
21 right information to evaluate if a measure is
22 reliable, valid or actionable for providers.

1 So now we'll quickly go through the
2 discussion for each of the specific programs.
3 So, I'll pass it to Cristie to summarize the
4 discussion of the ESRD program.
5 MS. TRAVIS: Thank you, Kate. This is
6 Cristie Travis and I'm one of the co-chairs for
7 the Hospital Workgroup.
8 And so, we had measures that we looked
9 under the end stage renal disease quality
10 incentive program.
11 One which the workgroup supported was
12 the medication reconciliation for patients
13 receiving care at dialysis facilities, that
14 there's an NQF endorsed measure.
15 There were two wait list measures and
16 the workgroup had a robust discussion around
17 these measures. The decision was to
18 conditionally support both of them based upon NQF
19 endorsement, they have not yet gone through the
20 endorsement process.
21 From the commenter standpoint, it was
22 broad support among stakeholders for the

1 medication reconciliation measure.
2 There were quite a few comments that
3 came in on both of the wait list measures. And,
4 I would say that the committee itself, our
5 workgroup, also worked through a lot of these
6 same issues.
7 Perhaps the one to single out is the
8 issue of attribution to dialysis facilities
9 because, clearly, the transplant centers are also
10 a key player in whether or not patients are able
11 to successfully get wait listed.
12 So, that was one of the major concerns
13 both discussed at the workgroup and with the
14 commentators.
15 So, I'll turn it over to Ron for the
16 next one.
17 DR. WALTERS: You want me to do the
18 PCHQR, right?
19 MS. MCQUESTON: Yes, that's right,
20 Ron.
21 DR. WALTERS: Yes. So, the advanced
22 cancer center program had one measure which was a

1 readmission measure proposed by the exempt cancer
2 centers because the all-cause readmission measure
3 did not cover cancer patients.
4 This is an endorsed measure and was
5 supported by the exempt cancer group. The
6 Hospital Workgroup accepted that NQF endorsement
7 and recommended that it be approved. And we're
8 not taking individual questions, right?
9 The AFC quality reporting program also
10 had one measure which was supported
11 conditionally. That's a theme you're going to
12 hear recurrent through this and was discussed
13 extensively in your previous concerns.
14 The condition was that of NQF
15 endorsement, I would say that the workgroup, in
16 general, was very supportive of the rigorous
17 review that the committee, sustaining committees
18 perform for the endorsement process.
19 And therefore, recommended the measure
20 of the hospital visits following an AFC procedure
21 for conditional support pending that review.
22 There was, obviously, some discussion

1 regarding attribution and it was felt that the
2 review process would take that into
3 consideration.
4 MS. TRAVIS: Thank you. In the
5 hospital outpatient quality reporting committee
6 there was one measure under consideration. It's
7 lumbar spine imagining for low back pain and the
8 committee -- the workgroup did not support moving
9 this forward.
10 This measure was not recommended for
11 continued endorsement by the NQF musculoskeletal
12 standing committee in 2017.
13 I think you can see on the slide what
14 the major concerns were from the standing
15 committee. There was significant concern that it
16 did not pass the validity standard.
17 There was one comment that was
18 received and they supported the workgroup's
19 recommendation.
20 DR. WALTERS: Okay, and then came the
21 inpatient quality reporting. And, again, there
22 was two risk-adjusted mortality measures. And,

1 those were extensively discussed and also an
2 opioid-related adverse respiratory event was
3 extensively discussed.
4 There was a lot of discussion and,
5 again, it was felt that for the risk standardized
6 mortality measure, the best recommendation was
7 conditional support.
8 There were many conditions placed on
9 that.
10 The mortality measure was conditional
11 support and the opioid measure was refine an re-
12 submit.
13 There was a lot of discussion about
14 whether or not that was adequately defined at the
15 present time to even take to the standing
16 committee.
17 MS. MARINELARENA: Okay, thank you,
18 Ron and Cristie.
19 So, that's an overview of the measures
20 that the Hospital Workgroup reviewed. And I
21 think that there was one measure that was pulled
22 off of the consent calendar.

1 CO-CHAIR PINCUS: I thought there were
2 several.
3 MS. MARINELARENA: So, there was one.
4 John Bott had pulled two, but I understand that
5 there is a conflict so those go back on the
6 consent calendar unless somebody else wants to
7 pull them.
8 So, as of right now, we have MUC17-
9 241, percentage of prevalent patients wait listed
10 for the end stage renal disease quality incentive
11 program.
12 MS. O'ROURKE: And, John, just to
13 confirm, he had pulled the two mortality measures
14 but he participated in the development, so he
15 declined -- rescinded his pull, if you will,
16 because of that recusal.
17 CO-CHAIR PINCUS: So we only have one?
18 So, there's only one measure that has been
19 formally pulled out?
20 MS. O'ROURKE: Yes.
21 CO-CHAIR PINCUS: Well, showed me up.
22 (Laughter.)

1 CO-CHAIR PINCUS: Well, now, but you
2 know, that -- is there any -- you know, from --
3 are any other measures sort of that are being
4 proposed by the committee to be pulled for
5 discussion?
6 (No audible response.)
7 CO-CHAIR PINCUS: If not, then we'll
8 proceed with the discussion of measure 241, is
9 it?
10 So, Bill, you were the --
11 MEMBER KRAMER: I was scheduled to be
12 a lead discussant, so maybe I'll be both the lead
13 discussant and a measure puller at the same time.
14 (Laughter.)
15 MEMBER KRAMER: So, I think in my
16 general comments first. First of all, I thought
17 it was very encouraging to see that, on the MUC
18 list, there were a number of very important
19 outcomes measures. And, that's the direction
20 we're trying to move.
21 The ASC measure, the mortality
22 measures and the readmissions for cancer

1 patients, I think are all good, important outcome
2 measures.
3 And the Hospital Workgroup recommended
4 full support or conditional support pending NQF
5 endorsement for most of these measures which is
6 also encouraging given the complex nature,
7 attribution issues and so on for all of these.
8 And, I think, in particular, the ASC
9 and the readmission for cancer patients measures
10 fill important gaps in our current measure set.
11 So, I think there's -- this is a good set of
12 measures to advance.
13 I do think the ESRD measures warrant
14 further discussion and I suggest that we pull the
15 17-241, the percentage of prevalent patients wait
16 listed, PPPW, for discussion, but I'm not
17 recommending a re-vote just because I think
18 there's some important issues raised in the --
19 what this measure is and how it's discussed in
20 the workgroup.
21 And, may be some useful information
22 that gets captured in the discussion that would

1 be useful for CMS and its decision on whether and
2 how to use this.
3 Before I go on, though, to that
4 specific thing, were there other discussants?
5 Lead discussants who want to give some general
6 comments? I don't want to jump ahead to the
7 specific thing if there are some other folks who
8 want to make general comments.
9 MEMBER KAHN: Hi, Bill, this is
10 Maureen Kahn and I think I was your partner as
11 one of the discussants on the hospital measures.
12 And --
13 MEMBER KRAMER: And, I think Rich
14 Antonelli also. Rich, are you on now?
15 MEMBER ANTONELLI: I'm on and I'm
16 fine. Why don't we let Maureen go and then I'll
17 bat third in this lineup.
18 MEMBER KRAMER: Okay, that's fine.
19 MEMBER KAHN: You know, I would agree
20 in the whole general comment, Bill, that you made
21 on the measures, you know, that it is good to see
22 some strong outcome measures.

1 And, I certainly have some reservation
2 for the wait list thing, putting a lot of
3 accountability in one place and how do we take it
4 across to the transplant centers who make those
5 final determinations of who gets onto the list?
6 And, you know, and I share John Bott's
7 when I look at all of our concerns on hospital
8 mortality measures.
9 You know, running a hospital, we track
10 our mortality measures and, you know, as you all
11 do, looking at specific diseases.
12 But, broad categories, I want to make
13 sure that we get actionable data to make change
14 and not just collect a lot of data.
15 Anyhow, those are my only comments on
16 the measures. You know, I thought that a lot of
17 them were well -- the discussions and the
18 feedback that was given, I think was on target.
19 MEMBER ANTONELLI: Yes, this is Rich
20 Antonelli.
21 So, I'll just weigh in. Basically,
22 they pretty much mirror what Maureen had said. I

1 had some concerns about the approach to the
2 mortality measures.
3 The ESRD, I agree to the extent that
4 attribution to the dialysis centers causes an
5 opportunity, in fact, to fragment the types of
6 accountability.
7 I do want to open this up to
8 conversation because I think that it's one thing
9 to measure -- to put a measure in place at one
10 point in the system, but it's another to
11 misinterpret that there is a malaligned
12 accountability in that place.
13 So, I would like to hear some
14 discussion about the ESRD wait list.
15 CO-CHAIR PINCUS: So, in the
16 discussion at the Hospital Workgroup, were there
17 specific strategies or alternatives that were
18 suggested as a way to fix some of those problems?
19 It sounds like there wasn't a general
20 discussion of sort of moving to a lower category
21 because nobody's proposing that.
22 But, are there some particular

1 recommendations that were made or that came up in
2 the Hospital Workgroup with regard to particular
3 issues that should be addressed during the
4 endorsement process?
5 MS. MCQUESTON: This is Kate speaking.
6 Yes, so, I can read the list of
7 conditions.
8 So, it includes NQF review and
9 endorsement, also the workgroup recommended that
10 the measure be reviewed by the scientific methods
11 panel and the renal standing committee.
12 In particular, they asked that the
13 endorsement process look at the validity of the
14 measure, particularly, the risk-adjustment model,
15 ensuring that it appropriately accounts for
16 social risk.
17 And then, finally, the workgroup noted
18 the need for the attribution expert panel to
19 provide further guidance on the attribution model
20 as well as the disparity standing committee to
21 provide guidance on potential health equity
22 concerns.

1 CO-CHAIR PINCUS: Why don't we open it
2 up for discussion here and see who wants to
3 discuss it.
4 So, I see Raj is raised his hand.
5 That's good, we'll start with Raj.
6 MEMBER DAVDA: So, thank you.
7 As a former nephrologist and a
8 transplant physician, I've got to say, I am so
9 glad to see this on the MUC list.
10 I can't tell you how much disparity
11 and variation in care there is for patients
12 getting on the transplant list and for patients
13 maintaining on the transplant list and the number
14 of living related transplants we do.
15 Dialysis, at least on the commercial
16 side, is probably one of the most expensive
17 therapies we offer.
18 Transplant, I've tried to push many
19 ways and, really, there weren't any ways of
20 making anybody take accountability.
21 I do think accountability, as a former
22 practitioner in this area, does rest with the

1 nephrologist and does rest with the dialysis
2 facility.
3 They are the primary care givers of
4 these patients in that sense. Most primary care
5 physicians and other subspecialists will give up
6 control of these patients.
7 The other thing I would say is that,
8 and as Nancy said, I don't believe there's a risk
9 of fragmentation, but a risk of more coordination
10 of care.
11 When I was running the transplant
12 program at two different places, it was very
13 important when we had questionable patients to
14 put on the transplant list if the nephrologist
15 participated in the committee meetings.
16 And the nephrologists rarely came into
17 the committee meetings to participate. And, a
18 lot of times, we made blind decisions because we
19 didn't know.
20 By putting the percentage of prevalent
21 patients on the wait list, at least it allows the
22 accountability and promotes nephrologists who

1 don't meet that criteria to go to the transplant
2 committee meetings and support and advocate their
3 patients and at least provide information.
4 They may not have the final decision
5 but they can certainly influence the process and
6 they can certainly ask for a vote.
7 All dialysis centers, by network
8 rules, are aligned to a transplant center. And
9 the nephrologist has to sign off on their thing
10 every year. It has been just a paper push for
11 many years.
12 And, patients are disadvantaged by
13 that so I'm wholly in support of this and I'm
14 very glad this was on the MUC list.
15 Thanks.
16 CO-CHAIR PINCUS: Bill?
17 MEMBER KRAMER: Raj, I really
18 appreciate your sharing that because I had pulled
19 this list for a lot of those same reasons, but
20 not being a clinician, I'm glad you went first
21 and could describe it, what the situation is.
22 But, that's what we understand from

1 our perspective. There's -- there are issues
2 around all the care provided by dialysis centers
3 and the coordination, or lack thereof,
4 fragmentation of care for people who need
5 transplants.
6 And, the scary thing is, from what I
7 can tell, we are lacking good measures of quality
8 for ESRD patients and that this is -- moves in
9 the right direction.
10 Is this -- are there questions about
11 is this the right measure, the only measure? I
12 don't think it is. I think it would be important
13 for the MAP coordinating committee to send a send
14 of the group to CMS and other measure developers
15 that this is a gap that needs to be filled and
16 needs to be -- an issue that needs to be
17 addressed.
18 So, the question, I think, for us is,
19 is this a measure that we think is good enough?
20 Is indicative of measure of quality? That it
21 warrants moving forward conditionally on the
22 endorsement, of course?

1 But, I think it is, but I also know
2 it's a tough issue. And, since it's not a slam
3 dunk from my perspective, but I was very
4 encouraged to hear what you said, Raj, about the
5 need for this from a clinician's perspective and
6 it mirrors the perspectives we have.
7 CO-CHAIR PINCUS: I'm confused. So,
8 why was there a vote like there was at the
9 workgroup on this? This was not what you heard.
10 I mean, the feedback I got was this is
11 not what you heard at the workgroup. What you
12 heard at the workgroup was that a question as to
13 whether this was the right place to be doing
14 this, that the nephrologist is the keystone and
15 that they don't even put them on the list.
16 So, they're going to have to, I guess
17 you could say, aspirationally, it'll push the
18 centers to push the nephrologists, I suppose.
19 But, you had a 60 percent vote. I
20 mean, if it had been -- if one more person had
21 switched, it would have been -- it would have
22 passed to remove. So, it was one vote away from

1 removal and we have kumbaya here. So, what's
2 going on?
3 (Laughter.)
4 CO-CHAIR PINCUS: No, I want an
5 explanation.
6 MS. O'ROURKE: No, I mean, I think
7 that's a great point. I think there were a lot
8 of very strong feelings about this measure at the
9 Hospital Workgroup.
10 And some very difficult issues that
11 came up about this. I think it was a -- people
12 were trying to balance attribution concerns and
13 who actually makes the decision about putting a
14 patient on the wait list.
15 We did not have anyone, I think, to
16 represent the perspective Raj just brought up of
17 the transplant center. Rather, we had
18 representatives from dialysis facilities and I
19 think a nephrologist, but not at a transplant
20 center.
21 I just want to represent people's
22 credentials correctly.

1 There were, I think, a lot of concerns
2 about the potential disparities on the other side
3 of who is -- to your concerns about who actually
4 gets put on the wait list and that kidney
5 transplants may not be equitably allocated and
6 that there's issues there.
7 I think we also heard some strongly
8 held concerns that dialysis facilities may be
9 putting patients -- or profits over what might be
10 best for their patient. And, I think that caused
11 some alarm from some of the provider community
12 that they were offended by that perspective.
13 And, I think it was a very challenging
14 conversation working through some of these issues
15 around disparities and potential social issues
16 and conversation that I think people felt maybe
17 insulted their professionalism and that whether
18 they put their patients' best interests at heart.
19 So, I think there were quite a lot of
20 things that came out on the table and the long
21 list of conditions that Kate read reflects trying
22 to broker a compromise of how we look at the

1 methodological challenges to this measure and
2 ensure that it's valid and fairly attributed with
3 some of the concerns that Raj and Bill just
4 raised, that we need to drive progress in this
5 area and make sure that we're addressing equity
6 issues.
7 But, I think Melissa, Kate, Jesse,
8 anything that I missed from the conversation?
9 DR. ROACH: No, I think -- I'm Jesse
10 Roach, I'm a nephrologist at CMS.
11 And, I think you captured the
12 contentiousness of the discussion.
13 I think one of the things you
14 mentioned about whether it was fair to attribute
15 this to the dialysis facilities, and I think that
16 was -- I think that was one of the main issues
17 that people had.
18 We brought up the point that, one,
19 that this is sort of a shared attribution model.
20 So, while the transplant facilities do have some
21 responsibility, there is some responsibility on
22 the part of the dialysis facilities to get

1 patients wait listed and to keep them healthy
2 enough and get the education enough to keep them
3 maintained on the wait list.
4 I think it's the same model that we
5 have the readmission measure, for instance, where
6 there's a shared accountability between the
7 hospital and the dialysis facilities and
8 encourages coordination of care.
9 The other point that I wanted to bring
10 up is that the TEP, we had a TEP of experts that
11 agreed that this was -- the dialysis facilities
12 did have some accountability to keep these
13 patients on the transplant list and getting them
14 transplanted.
15 And, the -- and, a lot of this is
16 education of the patient to have their options
17 available to them so that they push for it and
18 then maintain the whole status.
19 And then, lastly, from a patient
20 perspective, this is very popular with patients.
21 Patients want to be encouraged to transplant --
22 get transplants. Patients want transplants once

1 they found out about it.
2 And, there are lots of disparities
3 between who gets transplanted and who doesn't get
4 transplanted.
5 DR. AMIN: If you don't mind, can I
6 just add a few additional comments?
7 There were extensive public comments
8 on this measure that I just wanted to make sure
9 were accurately represented. And, we essentially
10 have them in the room today.
11 But, Casey P. has provided extensive
12 comments on the measure expressing concern
13 primarily related, and I'd point everybody to
14 these comments in the discussion guide, but a lot
15 of it was related to the attribution model,
16 specifically pointing out that there were social
17 factors that significantly affect patients length
18 and influence waiting list placement and wanted
19 to make sure that that was included in the model.
20 And then, also, specifically pointed
21 out concerns related to the reliability of the
22 measure with an overall C statistic of .72.

1 And then, HA also sort of raised some
2 significant questions related to attribution
3 around whether or not the dialysis facilities can
4 meaningfully influence patient include on wait
5 lists enough to provide measure -- provide
6 responsibility for this measure.
7 I just don't want to -- I just wanted
8 to make sure we don't downplay the fact that this
9 took up a significant amount of the Hospital
10 Workgroup's deliberations and there were
11 significant representation and sort of concerns
12 that were raised along these lines.
13 DR. WALTERS: This is Ron.
14 If I could say, I think you've heard
15 exactly the answer to your question.
16 This was a very difficult one. I
17 think it took us about an hour and a half or an
18 hour and 45 minutes to get to conditional
19 support.
20 There were views all across the
21 spectrum on this one.
22 MS. MCQUESTON: And, just to recap,

1 because you mentioned the voting earlier.
2 So, there was a motion for do not
3 support that came in very close, almost 50/50.
4 There was a second motion for refine and re-
5 submit also along those lines.
6 But, ultimately, the final vote for
7 conditional endorsement was 23 yes, yes for
8 conditional support -- oh, sorry apologies --
9 conditional support was 23 yes, three for no.
10 CO-CHAIR PINCUS: Jesse, you had
11 mentioned the fact that there was a kind of
12 shared accountability modeling this.
13 Can you explain? Because, what I'm
14 hearing is that there was a concern that too much
15 of the accountability was on the dialysis
16 centers, not enough on the transplant centers.
17 And, just say a little bit more about how the
18 accountability model actually worked?
19 DR. ROACH: So, I'll use the example
20 of the readmission measure where, if you get
21 admitted to the hospital, it's partially the
22 responsibility of the hospital that discharges

1 you to make sure that the patient doesn't come
2 back.
3 But, it's also the responsibility of
4 the dialysis facility to follow up with that
5 patient and to make sure that they are taken care
6 of so that they don't end up readmitted to the
7 hospital.
8 And, it's the same sort of idea with
9 this measure where, yes, the transplant facility
10 makes the ultimate decision as to whether to list
11 someone, but a lot of things have to happen
12 before they make that decision, before they even
13 see that patient.
14 They have to have a patient that's
15 educated about the transplant process. They have
16 to have a patient that's healthy enough to do
17 that. And, they have to have a patient that is
18 sort of stabilized from a health perspective.
19 And, most of that is on the -- is
20 under the purview of the dialysis facility.
21 So, both of these things -- so wait
22 listing someone and getting the transplant labs

1 and doing -- that's the responsibility of the
2 transplant center. But, getting the patient to a
3 health status where they're able to be
4 transplanted is the responsibility of the
5 dialysis facility.
6 Furthermore, in the conditions for
7 coverage, there are requirements that the
8 dialysis facilities encourage referrals to
9 transplant centers that they facilitate education
10 of the patient so that they can be prepared to do
11 the things for -- to ready themselves for
12 transplant.
13 So, I think that it's pretty clear
14 that some of the responsibility lies with the
15 dialysis facility being the, for the most part,
16 the primary provider of health for these
17 patients.
18 CO-CHAIR PINCUS: So, what I am
19 hearing, then, is this is not really a wait list.
20 I mean, wait list is not a functional thing you
21 just sign somebody up.
22 They have to meet certain standards

1 with the patients that are set by the centers and
2 there's not a cap on age or anything.
3 And so, and there's still going to be
4 a predominance of real Medicare patients. So,
5 and so, is this really sensitively --
6 I mean, so here, the stratification
7 really makes a big difference. I mean, you could
8 be a center that has a lot of 75-year-olds
9 because of where you're located and, you know,
10 you could be doing -- you could stand on your
11 head and you're not going to get them to a
12 condition that could really justify a bypass.
13 Is this going to be --
14 DR. ROACH: So, they're adjusted for
15 age on the measures. And, the SWR, so, the
16 initial wait list one is adjusted for certain
17 comorbidities that would -- that we would expect
18 to be increased mortality and make it less likely
19 for you to listed on a transplant list. So that
20 is taken into account.
21 And, also, one of the things that
22 people brought up were that some facilities were

1 more served -- some transplant centers were more
2 stringent when -- than others.
3 And so, at some facilities would be
4 penalized for having -- for living -- or for
5 being near a transplant center that was -- that
6 didn't list people as well.
7 And so, they actually looked at that
8 and I don't want to give you the exact number.
9 When they tried -- when they
10 controlled for regional transplant center rates,
11 the reliability just went from 0.82 to 0.79 when
12 they adjusted for the regional differences in the
13 transplant centers.
14 So, it wasn't a significant factor.
15 CO-CHAIR PINCUS: So, I have Derek and
16 then Raj.
17 MEMBER ROBINSON: I just wanted to
18 rise in support of the measure. I think that
19 it's important to have that accountability as has
20 already been described.
21 And then, also just acknowledge that
22 there are substantial disparities in access to

1 transplants for kidneys.
2 And, I think while the -- some of the
3 concerns expressed by the facilities regarding
4 the attribution were noted, I think, also as
5 something that's important.
6 And, I think any of you who drive
7 through any impoverished communities today, one
8 of the thriving enterprises and new buildings
9 that, at least I see in the metropolitan area
10 where I live, are dialysis centers everywhere.
11 So, we need to ensure that there's good
12 visibility and to provide the right support
13 system within the healthcare delivery system for
14 an individual to be prepared for transplants.
15 And, I think everybody needs to play
16 their role.
17 MEMBER DAVDA: Well, thanks.
18 You know, the other way to sort of
19 think about this is that we worked for so many
20 years, and CMS in particular, and I give them a
21 lot of credit for setting up the ESRD QIP.
22 And, starting to make people

1 understand that this is a continuum of care for
2 those patients.
3 That -- and so, the transplant
4 centers, we tend to think of them as separate,
5 but really, it's not. The patients don't think
6 of them as separate, they think of them as
7 continuum of care.
8 The second thing I would say is that
9 for patients, transparency is very important.
10 Right now, they have no way of knowing which
11 centers are doing a lot of transplants for the
12 wait list and which centers are encouraging them.
13 And, you have to be aware that, even
14 in today's age, there are still nephrologists out
15 there that will tell a patient that they need to
16 be on dialysis for a year before they can get
17 transplanted or be referred for transplantation,
18 which is just not true. It's countered and we
19 have evidence based medicine, we know.
20 And so, although I agree that
21 attribution is an issue, but I'm not really
22 certain that attribution itself is an issue, it's

1 who should take responsibility for those patients
2 and who should advocate for that patient in the
3 healthcare system.
4 And, whether the dialysis centers want
5 it or not, they are the people who advocate and
6 should be advocating as CO's and CEC's the value-
7 based care is along that same line, they are the
8 ones responsible for advocating.
9 So, I think this measure, although --
10 and, I understand the resistance of attribution
11 from the facilities and not wanting any more
12 responsibility, but I think it's fully beneficial
13 to patients and I think it is a move forward
14 towards having a full continuum and continuity of
15 care for those patients.
16 CO-CHAIR PINCUS: Yes?
17 MEMBER GIFFORD: It's a little bit of
18 an example of our earlier stretch over
19 attribution dialogue.
20 I might suggest, and I would endorse
21 the previous two comments on this measure, the
22 importance.

1 It might be helpful in these
2 attribution things to add a recommendation or
3 think about recommendations to CMS on how are you
4 measuring the impact these measures unintended
5 effects on access to care or shifts in care or
6 stinting of care or, you know, denying care, you
7 know?
8 Because, you can start to game some of
9 these measures in ways that we never intended
10 even though it was helpful out there.
11 And so, I don't think it underscores
12 the importance of using the measure and going
13 forward, but it's the advice to CMS in
14 rulemaking, how they might think about using the
15 measure, other consequences around it and
16 measuring it.
17 CO-CHAIR PINCUS: I think Rich --
18 PARTICIPANT: Oh, sorry.
19 CO-CHAIR PINCUS: I think --
20 DR. ROACH: That's just part -- I was
21 just going to say that that would be part of our
22 regular maintenance of our measures to look at

1 unintended consequences.

2 For instance, with the transfusion

3 measure, we noticed that there were regional

4 differences in coding and that was affecting how

5 the measure was being implemented.

6 And so, they made changes and last

7 year, it was brought in.

8 So, we regularly monitor those things.

9 MEMBER GIFFORD: No, I appreciate

10 that. I think I'm just taking another step

11 forward. As you write rules for the program,

12 it's in -- it's not just on when you come back,

13 but thinking about how that program design is.

14 This is not, as we've talked about

15 here, this is not about endorsing the measure or

16 this measure spec, this is about how you're going

17 to use it in rules.

18 CO-CHAIR PINCUS: I think Rich

19 Antonelli on the phone had a comment, question.

20 MEMBER ANTONELLI: Yes, thank you.

21 Harold, it's sort of is related to the

22 point that you raised and I'm hoping that Raj is

1 still on the line.
2 In my brain, I'm trying to think about
3 how this measure, you know, where it would fit in
4 say to a logic model and that we could actually
5 say that this measure would move us away from
6 fragmentation to integration.
7 So, I'm obviously asking that question
8 because that's what I'd love to see this measure
9 do.
10 My concern is that, you know, if it's
11 interpreted about where the air quotes now
12 accountability lies, what would be the drivers,
13 you know, what's in it for the nephrologists, for
14 example, to reduce fragmentation and move toward
15 integration?
16 Could you speak a little bit about how
17 this measure would strategically support
18 integration?
19 MEMBER DAVDA: Yes, thanks for asking.
20 So, I think it particularly helps in
21 the C models and the actual models. And, I -- it
22 clearly depends on how those value-based cares

1 are arranged and how the incentives are arranged
2 within those value-based care.
3 But, I think this gives -- by
4 including it in the QIP, it gives CMS some
5 flexibility to be able to do that.
6 So, for example, if a dialysis
7 facility was not meeting whatever the benchmark
8 is set at, this would be an opportunity for them
9 to engage their nephrologists, their -- the
10 medical director of the facility and engage with
11 the transplant center to see what are the
12 particular issues.
13 And, we may -- and it's not, you know,
14 I know we kind of tend to think about it as it's
15 a -- the patient was too sick and couldn't be
16 wait listed. But, a lot of it is, and a majority
17 of it is really coordination of care.
18 You know, the patient didn't come to
19 that one CT that they needed or they didn't come
20 to the one appointment they needed. These are
21 areas where really the facility who coordinates
22 their care, which is the dialysis center can help

1 out and work with the transplant center to see
2 what the issues are to try to resolve.
3 In terms of non-value-based care, I
4 think it proves a fair amount of transparency but
5 we're moving very quickly in the dialysis world
6 toward value-based care.
7 And, I see this as, again, a micro
8 step forward, although I would love to see one
9 thing, is the transplant center part of the
10 dialysis facility but it moves us closer to that
11 continuous care, you know, for that patient.
12 So, that's where I see the benefits of
13 this coming forward.
14 CO-CHAIR PINCUS: Any other comments
15 on this measure?
16 (No audible response.)
17 CO-CHAIR PINCUS: Okay, and nobody's
18 interested in putting it forward another motion?
19 (No audible response.)
20 CO-CHAIR PINCUS: Good.
21 So, we have a little bit of time and,
22 you know, a number of concerns have been raised

1 about the mortality measures. And, I just want
2 to give people an opportunity that, if they do
3 have any comments on the mortality measures to be
4 able to discuss them now, if they -- the hospital
5 mortality measures, if they do have any comments
6 just to be able to open that up since there were
7 some concerns and issues that were raised in the
8 workgroup.
9 (No audible response.)
10 CO-CHAIR PINCUS: I guess everybody's
11 tired out.
12 Melissa, did you want to make any
13 other comments about the mortality measures in
14 terms of just the concerns or issues that you
15 think need to be addressed?
16 DR. AMIN: Harold, I think -- sorry to
17 just jump in there.
18 Just, I think there is the question
19 around the lack of variability that was raised in
20 the comments before. I think we can just -- we
21 can at least incorporate some of that into the
22 current dialogue that we have for the measure.

1 So, I want to make sure that those
2 comments that were submitted before are
3 addressed.
4 CO-CHAIR PINCUS: Okay. So, any other
5 comments on any other issues pertaining to the
6 Hospital Workgroup?
7 (No audible response.)
8 CO-CHAIR PINCUS: Okay. So, I think
9 we're ready for public comment at the end of the
10 day.
11 MEMBER GIFFORD: Don't we have to vote
12 on the --
13 CO-CHAIR PINCUS: Oh, we've got to --
14 you're right.
15 Everything went so easy.
16 MEMBER GIFFORD: I think this will be
17 an easy vote.
18 CO-CHAIR PINCUS: Yes. I couldn't
19 hear you. Turn on your --
20 MEMBER GIFFORD: I may have missed
21 what the public comment was on. Shouldn't we get
22 the vote -- comments before we vote?

1 CO-CHAIR PINCUS: No, we've got public
2 comment before we voted.
3 MEMBER GIFFORD: Oh, sorry.
4 CO-CHAIR PINCUS: The very beginning
5 was public comment. Yes, at the end of the day,
6 we have public comments on the whole day.
7 So, okay, we have a motion to accept
8 the consent calendar? Second? Okay.
9 And vote by hand? Everybody in favor
10 of the consent calendar? And people on the
11 phone, phone people, send in yours.
12 MS. BUCHANAN: We have 22 in the room
13 and they are coming in on the phone.
14 Okay, great, so, we have for the
15 hospital consent calendar, we have 26 yeses.
16 CO-CHAIR PINCUS: Great.
17 Anybody opposed?
18 MS. BUCHANAN: And no oppositions.
19 CO-CHAIR PINCUS: Okay. Now, any
20 public comment from room about anything that was
21 discussed today?
22 (No audible response.)

1 CO-CHAIR PINCUS: Seeing none, any
2 public comment on the phone?
3 OPERATOR: If you would like to make
4 a public comment, please press star, one. That's
5 star, one on your telephone keypad to make a
6 public comment.
7 And there are no public comments at
8 this time.
9 CO-CHAIR PINCUS: Okay. Well, I guess
10 we're adjourned for the day unless you guys have
11 some final things that you want to --
12 MS. O'ROURKE: Kate has one final
13 announcement, just to clarify about the PAC/LTC
14 vote.
15 But before that, I just want to thank
16 everyone for sticking with us for today. I know
17 it was a lot of votes and a lot of good
18 discussion.
19 Thank you for bearing with us as we
20 worked through some of the process concerns and
21 hopefully it was some good case studies for
22 tomorrow when we can put everything out on the

1 table and get your input about what we could do
2 better next year.
3 You know, I think we want your
4 feedback on everything, the voting process, the
5 algorithm, the decision categories. So, if you
6 have some time tonight to think it through, we're
7 hoping to get all of your input on how we can do
8 this better next year.
9 And, thank you for bearing with us
10 through some of those challenging votes and re-
11 votes and a special thank you to Chip and Harold
12 for expertly guiding us through all of that.
13 CO-CHAIR PINCUS: Chip did the heavy
14 lifting.
15 Bill?
16 MEMBER KRAMER: Just a question about
17 since we did address or discussed the attribution
18 model, or issues earlier today, we're going to
19 come back to that again tomorrow or remodify the
20 agenda?
21 CO-CHAIR PINCUS: No, modify the
22 agenda so that we both have to do that.

1 MEMBER KRAMER: Okay, so how is it
2 being modified? Maybe I missed that earlier.
3 CO-CHAIR PINCUS: Well, part of it.
4 Do you have more that you want to talk about?
5 MEMBER KRAMER: No.
6 CO-CHAIR PINCUS: I mean, it would
7 shorten the day.
8 MS. O'ROURKE: Yes, I think we're
9 going to see if our colleagues from the Rural
10 Health Workgroup could come earlier and give
11 their presentation in the morning and then
12 transition to the conversation about process
13 concerns and then if that wraps up early, just
14 let everyone head out.
15 CO-CHAIR PINCUS: Okay, so it's moving
16 rural health up earlier in the morning where the
17 attribution slot was and then continuing on with
18 the other ones around the voting process and the
19 decision algorithms as originally scheduled?
20 MS. O'ROURKE: And giving, yes, giving
21 more time to that and then if that doesn't take
22 the whole day, letting people go early and --

1 MS. BUCHANAN: And thank you, Erin.
2 And I just wanted to clarify, for the record's
3 sake, for the PAC/LTC consent calendar, CoreQ
4 short start discharge measure, MUC17-258, we had
5 23 voting yes, zero voting no and one abstaining.
6 I just wanted to get those numbers on the record.
7 And I wanted to ask my colleague to do
8 a quick announcement regarding the dinner.
9 (Whereupon, the above-entitled matter
10 went off the record at 4:45 p.m.)
11
12
13
14
15
16
17
18
19
20
21
22

A

a.m 1:8 5:2 70:7 71:6 95:16 105:19,20
A1c 188:14 192:2 208:14 231:3 236:9 236:12 238:21 240:6 264:5 269:12 276:22 278:5,9
AAFP 137:13
Abigail 351:17
ability 108:4 111:7 112:4 124:22 157:16 157:18
able 19:13 26:1,11 51:5 60:7 78:20 91:8 111:21,22 112:17 119:16 123:6,17 124:4 129:6 136:20 137:1,2 171:7 179:12 179:14 181:7 182:17 215:13 247:18 267:22 306:18 314:2 319:3 352:21 365:10 389:3 398:5 400:4,6
ABMS 13:19
above-entitled 105:18 163:2 358:1 406:9
absence 298:5 312:7
absolute 32:18 229:16
absolutely 22:19 110:4 113:12 172:6 173:11 278:12 316:21 347:5
abstain 96:1
abstained 102:13
abstaining 49:12 54:13 61:6 98:16 165:9 166:5 406:5
abstention 102:20
abstentions 49:10 61:4 64:10 165:8,13 166:3 166:6
abstraction 142:9
abuse 93:11 187:3
Academy 2:5,9 10:12 12:15
ACC/AHA 301:13
accept 48:2 292:11 293:13 295:5 355:12 402:7
acceptability 343:10,12
acceptable 159:3 171:7 243:15 289:15 330:15
accepted 137:14 259:6 293:21 294:3 303:21 355:10 366:6
accepting 58:7,12 296:3
access 7:13 55:21 110:3 134:17 304:16 391:22 395:5
accessing 7:7
accommodate 78:10
accomplish 231:11
accomplished 336:1
account 302:10 390:20
accountability 74:6,17 108:12,19 114:5,21 116:22 117:7 119:9 119:21 120:22 121:17 124:10 130:19 131:7 131:11 132:16 134:3 187:2 242:8 313:20 314:11 316:2 373:3 374:6,12 376:20,21 377:22 384:6,12 387:12,15,18 391:19 397:12
accountable 116:12 118:17 121:2 123:5,7 123:16 124:3 155:6 156:15 158:22 159:9 233:3 239:2
accounted 253:20
accounting 304:1
accounts 12:4 375:15
accredit 214:18
accumulation 42:1
accuracy 114:16
accurate 122:2 124:11 124:14 219:18
accurately 114:20 385:9
achieve 120:14 127:15 127:15 128:3 150:10 164:15 291:16
achieved 119:17
achieves 61:2
achieving 127:17 130:10 140:20 141:3
acknowledge 27:8 77:11 113:14 391:21
acknowledged 146:11
ACO 95:1 123:14
ACOs 94:11
acquire 84:9
acquired 360:17
Act 73:5 76:5 97:8 107:12
acting 3:5 18:2 311:3
action 151:6 196:5,18 198:6,6 207:9,11 258:17 310:16
actionability 114:16
actionable 160:2 161:14 363:22 373:13
actions 89:16
active 362:10
activities 14:18 62:3 161:2 305:13
actual 49:2 56:12 62:13 81:7 103:13 353:5 397:21
Acumen 3:10,13 299:13 299:14 304:22 315:20 335:7
acute 96:17 147:4
acute- 132:13
acute-care 133:2
adaption 73:7
add 20:22 31:6 77:8 79:5 151:3 155:3 161:3,16 183:16 189:11 195:12 196:15 207:17,18 317:20 323:7,8 327:1,15 330:8,12,15 345:13 355:3 385:6 395:2
added 157:1 257:12
adding 246:7
addition 33:11 45:18 140:9 155:4 181:7 236:3
additional 19:9 61:21 125:18 126:18 158:14 183:16 194:19 207:19 246:15 269:7 281:20 304:10 385:6
Additionally 98:21 111:19
address 33:3,20 73:17 112:13 210:2 254:14 300:13,15 337:5 342:9 352:3 362:18 404:17
addressed 35:18 38:10 47:14 228:18 309:8 312:17 340:19,20 375:3 379:17 400:15 401:3
addresses 34:10 76:12 307:10 309:2
addressing 38:5 75:12 285:6 303:11 383:5
adequate 121:20 124:5
adequately 368:14
adhered 46:3
Adjourn 4:22
adjourned 403:10
adjudicating 210:5
adjudication 124:17
adjudicator 262:7
adjunct 16:5
adjust 344:18
adjusted 246:8 390:14 390:16 391:12
adjustment 121:22 124:7 205:15 268:22 297:16 331:16 333:5 336:3 337:17
adjustments 301:5 303:12
ADL 75:21
administration 27:10 27:13 30:11 83:9 84:10 86:4
administrative 157:8 231:9,12 332:2
administratively 238:18
admissions 229:10,12 303:2
admit 353:2
admitted 387:21
admittedly 352:9
adopted 50:6 233:1,5
advance 173:3 371:12
advanced 74:15,19 126:1 178:1,2 365:21
advancing 113:22
Advantage 188:17
adverse 300:20 337:2 368:2
advice 292:13 395:13
advise 282:19
advising 362:5
advisory 16:8 166:22 166:22 167:17
advocate 378:2 394:2,5
advocating 228:11 394:6,8
AFC 366:9,20
affect 135:14 243:8 267:22 273:7 385:17
AFL-CIO 2:6 11:9
afternoon 105:15 179:6 203:16 205:10 224:11 356:5 359:15
age 231:4 324:19 390:2 390:15 393:14
agencies 28:1
Agency 2:17
agenda 22:21 260:4 356:3 404:20,22
aggressive 48:11
aging 229:19
ago 51:8
agree 5:20 41:6 44:1 195:19 212:1 229:5 230:14,21 236:4,5 240:1 282:14 289:21 290:3 292:4 299:1 308:13 316:22 347:5

359:19 372:19 374:3 393:20
agreeable 243:6
agreed 41:6 42:18 384:11
agreeing 242:1,6
agreement 51:22 53:15
agrees 59:14
AHA/ACC 301:22
AHCA 91:19
ahead 69:10 71:19 78:12 108:20 183:14 243:13 263:7 288:21 312:8 320:4 372:6
AHIP 12:19
AHRQ 2:18
aid 163:15
ailment 135:8
ailments 154:21
aim 346:4
aims 33:4
air 334:22 337:13 397:11
AL 83:21
Alan 91:7
alarm 382:11
algorithm 32:3,5 36:13 37:3,10,12,16 39:18 39:20 40:5,8,14 57:22 119:2 134:21 161:7 161:10,16,22 203:19 203:22 262:21 263:3 325:13 404:5
algorithmic 39:1
algorithmically 37:21
algorithms 38:11 197:19,20 405:19
align 115:9 185:13 189:1 252:22 254:7 361:15
aligned 378:8
aligning 188:19
alignment 33:5,21 73:12 185:20 187:10 187:18 188:11 361:4 361:14 362:4,7
all-cause 366:2
allergies 327:11
Alliance 1:19 11:1
allocated 382:5
allotted 22:20
allow 34:4 112:18,20 121:22 124:19 195:5 197:14 227:21 243:2 295:14 303:19
allowed 55:1 319:18
allowing 5:15
allows 122:10 226:16
240:14 303:14 377:21
alluded 139:4 228:4
alternate 12:2 293:12 294:11
alternative 45:16 108:14 245:3
alternatives 374:17
AMA 171:21 298:5 299:18,20 308:9 313:22 322:14 332:9 332:10
AMA's 308:14
ambulance 334:22 337:12
amendment 292:11
America's 1:15
American 1:14,17,18 1:19,21 2:3,5,6,10 3:16 10:11,17,18 11:16 12:12 13:2,16 13:18 15:19 16:6 79:17 169:15 214:10 298:8,9
AMGA 10:4
AMI 301:18
AMIN 3:2 36:20 37:4,8 39:14 103:1 106:11 106:14 110:4,9 111:11 115:11 128:9 133:11 146:2 155:15 159:14 219:14 289:20 290:9 330:4 354:1,5 355:3 356:6,8,18,20 357:4,7,11 385:5 400:16
Amir 2:6 13:2 147:21 159:15 160:6 161:13 171:21 174:16 192:16 229:3 230:21 245:8 245:21 248:5 253:12 255:1 309:18,20 316:10 317:2 324:21 325:3,4,15 330:15 338:4,17,18,20 340:11,22 345:18 353:17,19 354:1,2,8
Amir's 217:5 230:11 318:15 328:6 329:10 330:8 354:6
AMJ 144:18
amount 29:19 46:7 175:1,20 248:3 386:9 399:4
ample 71:20
amplify 282:18
Amy 2:5 3:12 10:11 148:1 179:11,12,15 183:2,15 202:4,7
207:5,17 230:20 237:20 254:1,13 267:9 268:3
Amy's 135:18 153:11 240:11
ANA 214:21
analysis 30:22 31:19,21 32:5 118:4,8 127:10 128:5 133:2 160:17 161:7 204:2
Analyst 3:6
Analytics 3:8
analyze 141:12
and/or 22:5 198:5,6 207:10
Andy 109:10 131:14
angina 302:15 303:2
Angiography 301:14
animates 270:13
announce 59:3 61:6 98:2,3,19 103:6,6 104:21
announcement 226:8 403:13 406:8
announcements 7:5
answer 20:18 91:8 92:8 108:22 154:20,22 183:6 235:8 257:6 258:21 318:13 340:22 360:6 386:15
answered 332:18
answers 349:19
Anthony 2:15 17:11,11 141:19
anti-platelet 277:12 278:14
anticipate 212:8
antiplatelet 192:4 208:15
Antonelli 1:12 9:9 16:11 272:11,12 273:19 274:1,6,8,12 274:15 372:14,15 373:19,20 396:19,20
Antonelli's 272:8
anxious 162:11
anybody 15:5 89:18 191:18 192:15 195:11 260:10 293:7 294:2 304:3 323:5 358:19 359:1 376:20 402:17
anybody's 226:4
anymore 152:1 238:5 263:11
anyway 81:20 101:9 186:11 310:18 315:4
anyways 22:7
APCAPM 137:13
APM 126:1
apologies 70:2 163:14 263:11 387:8
apologize 56:17 202:14 263:8 268:14
appeal 112:9 124:19
appear 51:22 298:12,14
appeared 352:17,22
appears 13:14
applaud 144:21
apples 39:3
applicability 63:12
applicable 152:18
APPLICATIONS 1:3
applied 52:15 115:8 119:6 148:14 149:2 169:19 206:7
applies 265:8
apply 127:13 219:13 346:10 347:7
applying 149:12 260:21
appointment 398:20
appreciate 81:21 144:5 157:21 162:8 186:17 378:18 396:9
appreciated 30:10
approach 4:6 17:21 18:4 27:7 30:21,21 67:8 130:10 293:8 300:5,14 336:17 353:18 358:5 374:1
approaches 110:15 120:12
appropriate 118:9 120:13 185:2 236:10 237:13 240:9 260:17 268:21 297:18 321:2 333:5 346:9 349:4
appropriately 121:21 128:2 145:13 181:14 217:19 228:12 331:20 375:15
appropriateness 63:3 237:2 297:16 331:8 331:15 332:19
approval 199:1 209:10 261:5
approve 50:2 189:21 199:1 310:5
approved 41:3 49:18 199:2 217:7 261:3 266:12 308:21 366:7
approving 310:13
approximate 212:3
April 210:15
arbitrary 290:2
area 15:22 88:21 95:8 113:5 122:9 125:19

126:19 139:11 142:1 142:2,6 162:21 316:8 319:10 350:21 361:18 376:22 383:5 392:9
areas 27:17 28:5,15 59:5 63:7,19,22 77:18 78:5,19 97:20 126:13 363:3 398:21
argue 211:6
argument 145:5 211:10 217:2 236:20 245:14 270:2,10 346:13
argument's 269:3
arranged 143:16 398:1 398:1
array 20:8 38:22 300:9
article 143:12
articulate 217:14
articulated 124:2 217:2 271:13
ASC 370:21 371:8
asked 8:21 9:1 14:17 61:17 87:1,13 103:15 160:20 265:8 310:2 339:20 375:12
asking 29:6 36:21 37:9 94:3 111:16 134:14 134:20 213:2 246:10 252:12 296:16 325:20 326:4 327:7 356:16 397:7,19
asks 160:16
aspect 47:17 151:14 181:7,8 184:7
aspects 305:13
aspirational 117:6 119:20 151:14
aspirationally 380:17
aspirations 152:6
aspirin 192:4 277:12 278:14,18
assess 108:2 135:16 254:5 345:20 346:8
assessing 362:12
assessment 73:7 218:18 251:17 262:11 351:2,9 352:5,21
assessments 38:1,2
assign 108:8 112:12 114:20 122:22
assigned 119:1 337:1 341:18
assigning 302:13
assignment 145:7 302:11
assignments 303:12
assist 32:13
associated 32:15 231:9 335:1
Association 1:15,17,20 2:2,3,10 3:16 11:16 12:12,22 79:18 169:16 214:10 298:8 298:9
Associations 16:7
assume 19:20 83:14 176:18 250:15 283:17 341:13
assumed 198:9
assuming 135:7 145:20 293:6 356:11
assumption 279:17 281:13 311:4 323:17 323:17
Assurance 214:15
attached 205:7
attended 186:15
attitude 152:8
attributable 159:1
attribute 116:18 122:12 122:19 137:18 157:13 383:14
attributed 112:9 118:9 124:21 134:11 138:3 149:2 305:2 337:14 383:2
attributes 134:4
attributing 126:8 133:19 135:21,21,22 136:5 139:2
audible 168:22 171:15 171:19 178:11 189:5 215:2 220:17 221:10 242:14 248:7 253:9 354:20 358:21 370:6 399:16,19 400:9 401:7 402:22
August 171:6
authority 34:20 311:15 320:4
authors 112:7
automatically 257:3 260:20 288:20 289:13
available 55:16 57:21 61:11 113:18 115:2 170:21 171:4,6 213:11 327:18 384:17
average 235:2,3,6,6
avoid 163:18
aware 84:11 92:8 94:14 103:7 281:17 301:20 361:10 393:13
aye 263:16

B

B 291:5
back 14:2 18:16,17 24:14 27:6 29:3 34:18 37:18 41:4,17 42:3,7 42:9 50:2 53:1 66:9 67:2,3 91:6 95:16 99:3 100:18 105:6 106:2 113:11 114:8 115:12 116:10 125:4 128:18 144:2 155:16 157:9,21 161:21 162:10,14 169:11,11 175:2 179:6 199:14 204:19 207:5 211:5 211:15,16 217:8 221:12 223:20 236:21 237:6 240:22 245:5 247:20 248:16 249:7 249:13 252:18 256:15 257:7,8,14 258:21 287:4 293:3 295:8 310:7 311:21 316:19 317:3 318:14 321:4 323:5 339:14 343:2,4 350:16 351:1 367:7 369:5 388:2 396:12 404:19
background 37:14 262:12
Bagley 3:10 174:8,18 174:19 175:15 179:10 183:5 233:15,18 249:14 268:5 295:20 295:21 296:7,10,13 296:16,21
Bagley's 246:13
Baker 1:13 10:13,13
balance 50:17 81:14 159:5,11 173:5 361:8 381:12
balancing 362:17 363:2 363:19
ball 45:20
bar 270:16
Barton 2:17 214:9,11 214:12,13
base 67:5 112:22 176:7 197:16
baseball 141:6
based 51:19 121:14 126:19 139:4,19 170:4 174:9 197:20 204:2 263:3 298:7 306:3 307:8 310:13 311:13 314:7 318:8 319:13 326:18 327:9 340:3 342:6 344:22 349:17 352:18 364:18 393:19 394:7
basic 160:18 190:7
basically 52:14 88:8 108:22 109:5,16 116:10,12,17 144:2 199:19 206:22 228:4 228:19 244:8 279:1 296:4 320:2 347:18 373:21
basis 147:10 182:1
bat 372:17
batter 141:8
bearing 403:19 404:9
becoming 311:13
began 115:15 290:16
beginning 21:19 42:2 78:15 97:8 147:10 402:4
behavioral 16:8 75:13 90:5 92:11,15 93:6,12 130:17
behavioral- 92:5
behavioral-health 90:13
believe 50:4 64:1,21 83:7 84:6 150:14 194:12 208:12 215:12 216:21 269:10 278:1 289:16 314:12 328:20 329:4,7 338:3 346:15 377:8
believers 269:11
bell-shaped 234:10
belongs 136:18 138:5,6 201:17
benchmark 398:7
benchmarks 94:20
beneficial 394:12
beneficiaries 94:17 96:21 229:8
benefit 206:4 230:5
benefits 399:12
bereavement 76:7
Bernot 3:2 177:17 179:4,7,17,20 183:11 183:14,17 190:18 193:4,11 194:10,15 194:18 195:2 199:22 200:15 201:1,7,12,20 208:9 215:10 218:15 219:5 220:3 226:19 251:10 254:12 264:4 264:19,22 267:8 276:16 277:10 278:6 278:12 279:4,10 287:3,6 297:5 299:2 324:9 325:3,10,14 326:12 327:21 328:7 331:1 333:9 334:7,12

338:7 341:6 352:3 355:7
best 44:12 51:3 67:19 99:13 109:5 110:12 112:1 122:12,16 141:3 167:22 187:13 215:15 254:6,7 271:9 271:19,22 296:9 368:6 382:10,18
Beth 1:14 214:10,20
better 28:22 34:10 44:8 53:10 174:12 262:16 281:6 282:3,6 285:7 292:8 323:13 339:3,8 346:20 361:5 404:2,8
beyond 74:3,5 94:15 190:11 230:18
biased 18:3
big 28:6 74:7 94:14 96:22 158:5 175:9 269:11 270:15 390:7
bigger 75:14
bill 10:8 66:1 88:13 200:17 223:3 226:4 247:19 264:8,22 265:2,4 269:20 277:22 278:2,15 282:15 291:8 294:17 306:15,16 308:5 320:17 370:10 372:9 372:20 378:16 383:3 404:15
Bill's 67:14 264:19 270:12 279:12 282:18
binary 98:11
Binder 1:13 11:10,10 88:16 140:8 259:20 282:14 299:7,10,17 317:5
binding 47:12,13,17 48:8
Biology 234:15
bit 23:22 27:6 44:21 46:1 72:16 73:9 79:8 96:12 106:18 111:17 128:18 134:22 138:16 149:4 157:1,6 172:4 174:6 180:2 193:21 200:4 212:8,16 213:1 215:11 243:16 262:12 262:16 270:12,16 304:6 324:10 334:21 387:17 394:17 397:16 399:21
BJC 10:20
blanket 290:5
blessed 188:20
Blessing 1:20 13:22
blind 377:18
blood 153:13 154:1,4,6 154:8,11 188:14,15 227:10 253:19
blue 60:12 98:6
Blueprint 350:13
board 1:21 13:16,18 29:5 188:8
body 251:7
books 187:21
Boston 272:13
bother 153:7
Bott 1:14 11:3,3 166:16 167:6,8,11,15,19 168:3,5,8,11,17 190:2 217:12 350:20 369:4
Bott's 373:6
bottom 193:15 229:15
boundaries 159:21
bounds 173:8
box 132:20 133:10
Boy 18:21
brain 234:11 397:2
break 95:15 100:18 151:16 152:9 164:6 167:20 168:2 292:15 295:7 297:3 356:1 357:19
breakdown 109:14 178:8
Bresch 1:14 214:20,20
Bridget 359:3
brief 179:21
briefly 228:1
bring 21:11 22:17 42:9 66:21 70:1 78:16 125:2 142:22 143:8 161:8,11,21 171:7 172:19 211:16 248:6 257:14 284:15 303:17 316:19 339:18 384:9
bringing 20:14 26:21 43:7 67:1 109:22 172:1 177:18 213:4
brings 41:17
broad 50:13 51:22 176:6 293:4 364:22 373:12
broader 49:19 72:5 91:12
broadly 72:20 119:6 169:20 362:11
broker 382:22
brought 25:20 29:11 34:18 50:1 70:13 148:10 153:4 156:13 184:17 185:20 246:20 331:13 336:14 337:17
351:22 353:14 363:13 363:16 381:16 383:18 390:22 396:7
Bruce 1:18 3:10 10:16 138:9 148:1,10 157:3 159:15 160:18 174:18 179:10 183:2 190:4 195:12 209:7 215:6 233:16 241:1 246:13 249:10 267:9 268:3 293:3 295:20 309:21 347:22 354:13
Bruce's 142:18 159:6
Buchanan 3:3 30:15,17 35:8 36:7,14 40:17 49:3,16,21 54:10 64:18 65:1,5 102:7 103:20 194:17 226:6 226:7 247:17 250:8 261:19 263:8 273:3 273:12,22 274:3,7,9 274:13,17,20 275:1,5 275:9,14,19 276:2,5,9 276:15,17,21 277:5 285:17,19 286:18,22 287:11 288:5,7 296:20 322:22 355:19 356:19 357:13 402:12 402:18 406:1
bucket 351:14
buckets 361:13
build 44:14 112:4 270:11
building 23:4 135:20
buildings 392:8
built 108:19 110:14 119:5 122:6 157:7
bunch 141:11 284:7
bundles 94:11
burden 28:10,11,17,21 76:18 81:5 88:19 89:1 231:9,12 232:21 236:1 284:18 361:5,9
burdensome 238:18
Burstin 353:6
business 2:1,11 3:16 10:9 14:5,8 235:21
busy 42:13
button 100:22 226:14
buy-in 112:19
bypass 390:12

C

C 291:5 385:22 397:21
C-O-N-T-E-N-T-S 4:1
CAHP 76:13
CAHPS 80:14,16 86:3 88:7 90:17,19 91:1,14 92:1,6
calculate 54:14 98:18
calculation 64:19
calculations 336:13
calendar 21:15 31:17 36:11 37:6 54:19 58:6 58:9,11 62:2 67:6 95:10 97:21 101:11 101:13 102:21 186:4 186:8 189:17 191:1,4 191:5 195:22,22 196:3 197:17,17 198:21 199:8,14 248:17 249:4,8,12 250:6,19 251:2,4 295:8 323:5 338:6 355:9,12,17 356:12 356:22 357:14 368:22 369:6 402:8,10,15 406:3
calendars 213:10,10
call 13:13 84:17,20 131:13 188:18 213:7 258:14 288:10 306:15 313:17 314:3
called 18:14
calling 105:2 161:18
calls 212:18
cancer 63:13 365:22 366:1,3,5 370:22 371:9
cap 390:2
capability 75:21 303:8
capable 85:13
capacity 228:6,9 346:7
capture 68:4 69:2 99:13 181:7 182:8 208:4 263:12 277:6 302:20 333:3
captured 298:12 371:22 383:11
captures 98:7
capturing 277:8
cardiologist 153:14 154:13 301:8,11
Cardiovascular 301:13
care 1:17 2:9,10 6:4 12:15 19:17 27:18 63:19,19,20 73:22 74:2,4,5,6 76:15 79:11 80:17,21 90:4 90:17 93:8 118:12 122:19,20 123:10,15 126:8 130:17 132:13 132:14 136:12,15,16 143:14 144:3 174:3 178:2 182:9 188:16 191:21 192:1,1

226:21 232:18 233:6 233:7,7 242:5 247:13 251:4 253:2,17 259:5 261:15 266:8 269:18 272:12 278:19 281:8 298:11 339:5 345:19 364:13 376:11 377:3 377:4,10 379:2,4 384:8 388:5 393:1,7 394:7,15 395:5,5,6,6 398:2,17,22 399:3,6 399:11
careful 135:3 260:13 279:17
carefully 300:13
caregiver 76:6
Caregiving 1:19 11:1
cares 397:22
caring 233:8
Carl 2:10 12:11 43:20 44:17 190:3 216:14 217:12 218:11 220:11 227:19 231:19 243:11 246:4 248:21 252:3,4 259:15 264:9 278:8 298:2
Carl's 227:20 248:9 249:20
carries 245:18
carry 150:20
case 12:3 103:10 114:13 198:12 266:5 280:15,16 288:17 290:12 306:7 313:2 313:16 336:4,22 350:3 403:21
case-volume 63:10,17
cases 125:21,22 155:7 155:11 197:22 207:8 213:20 280:15 281:3 281:15 289:6 300:16 305:3 336:9,9,22 337:3,4,8
Casey 385:11
catch 78:14
categories 6:12 31:13 33:14 37:19 38:7 39:1 40:13 45:7 66:6 203:5 203:17 209:2 373:12 404:5
categorization 224:22
category 34:14,16 35:1 35:20 66:10 145:19 204:4,6 213:21 216:17 220:19 290:21 298:6 321:16 374:20
cater 188:19
caught 18:21
causal 130:13
cause 230:4
caused 382:10
causes 374:4
caution 144:1
cautions 181:12
CC 55:2,13
CDC 327:8,10,16 329:14 340:9 341:3,7 341:17 348:19 350:1
CDP 50:6,20 107:7 115:18 156:8 160:3 163:21 210:6 212:18 213:2
CEC's 394:6
center 1:13 10:14 16:22 73:6 86:20 365:22 378:8 381:17,20 389:2 390:8 391:5,10 398:11,22 399:1,9
centers 2:19 3:15,19 16:19 331:21 365:9 366:2 373:4 374:4 378:7 379:2 380:18 387:16,16 389:9 390:1 391:1,13 392:10 393:4,11,12 394:4
central 33:1 142:15
centric 97:10
cerebral 192:9 331:3
certain 117:1 148:12 155:9 189:7 229:16 229:18 317:13 328:11 337:10,12 389:22 390:16 393:22
certainly 28:10 50:14 88:6 92:1 138:10,13 147:14 186:17 308:6 373:1 378:5,6
certainty 212:8
cetera 188:18 343:12 343:13
chain 10:20
chair 3:11,13 179:11 287:10
Chairman 211:22
chairs 5:6 17:21 56:20 60:21 356:1 360:4
challenge 63:10,17 172:18
challenges 108:6 111:13,19 112:13 113:15 158:5 182:12 182:20 363:13 383:1
challenging 63:13 102:16 112:4 226:9 382:13 404:10
chance 14:1 175:4 191:16
change 35:21 41:7 57:22 65:17 102:14 103:2 104:4,7,9 113:17 130:9 139:5,6 143:20 156:3 165:13 165:16 168:21,21 173:13 182:17 189:14 190:9,9 196:7 197:21 199:15 201:16 204:7 204:13 216:15 218:21 224:22 228:2,21 230:6 232:3,3,14 240:5 246:12 259:11 261:5 289:7 298:6,10 328:1,1 332:14 340:1 354:15 373:13
changed 39:18 40:2 42:22,22 92:3 189:22 252:1 357:2
changes 35:2 103:2 127:14 151:22 213:1 306:3 339:20 342:4 342:14,16 396:6
changing 20:21 159:9 229:6 230:19 246:6 292:18 323:10
chaos 176:9
characteristics 32:14 109:17,18
characterized 109:15
characterizes 109:16
charge 69:15 74:4 188:22 237:16
charged 307:16
Charles 1:9,11
chart 142:8 188:9
chat 99:9
CHCQM 2:8
check 42:19,19 55:20 210:8 328:22
CHF 143:13
Chief 16:21 352:8
Children's 272:13
Chip 5:21 9:9,12 15:17 24:14 46:5 56:20 64:2 64:3 68:4 151:8 174:8 174:18 176:2 215:10 233:15 246:3 259:3 278:2 343:8 404:11 404:13
Chip's 68:18 159:13
choice 98:9 120:16 137:12 271:7 279:21 280:18 341:1
choices 115:2
choose 165:10,11 189:14 207:14 231:16 240:15,21 264:18 265:21 280:9,11 281:3 311:14 328:12
chooses 280:5
choosing 271:18
chose 336:11,15
chosen 266:4
Chris 2:7 11:5 232:9 240:22 244:14,16 246:2 259:2 268:7 270:10 282:2
Chris' 259:21
chronic 147:4 302:15
Cigna 12:19
circles 203:13
circumstance 116:3
circumstances 190:8 328:11
cited 75:12 76:5 233:2
city 196:20
claim 147:1
claims 134:16 146:20 157:8 302:16 346:7
clarification 64:7 83:4 102:8 176:3 198:20 209:9 219:3 330:9
clarify 21:15 36:1 57:9 59:2 65:10 66:5 103:7 105:9 116:1 123:2 163:8,17 251:3 255:20 270:2 276:21 307:20 330:5 335:8 348:3 349:5,8 355:3 356:6,8 403:13 406:2
clarifying 20:20 57:12
clarity 87:13 202:19
Class 302:3
classification 302:2
clean 230:11
clear 47:10 86:22 98:4 103:11 104:22 136:4 156:9 160:18 168:18 219:15 222:9 245:12 245:15,17 246:4 248:9 250:7 315:14 389:13
clearer 131:16
clearly 20:2 21:18 48:9 124:2 128:21 129:16 143:3 228:18 234:22 236:10 240:5 271:13 322:21 354:22 365:9 397:22
click 237:4
clicked 273:20
clicker 60:13 244:12 247:8

clickers 60:12 69:18 70:10
Cliff 101:5,6 151:10,15 153:4
clinic 167:11
clinical 16:22 227:9 236:20 259:8 260:18 297:17 300:8 301:2,3 302:5 303:6,10 304:11 305:14,19 306:11,18 307:4 324:14 326:14 331:9 331:11,13,16 335:13 336:10,15,19 337:11 339:8
clinically 340:12
clinically-oriented 143:9
clinician 3:10,12 4:11 4:14 6:4 37:14 55:19 62:9 118:6 138:6 162:16,18 163:6 168:7 169:4,6,9,18,21 170:2,2,4,9,10 172:8 174:19 175:2,6,17 176:3,20 177:6,9 178:7 179:8,22 181:2 182:17 187:12,14 201:13 202:15 206:5 216:4,5,9,12,20 233:22 234:17 235:12 238:17 249:10 271:8 283:18 284:2 302:21 304:10 314:16 317:6 321:22 332:16 336:7 336:7 337:15 353:5 357:14 378:20
clinician's 380:5
clinicians 29:6 108:10 134:8 135:22 137:1 147:11 148:4 149:1 157:14 172:8,14,17 172:20 175:21 177:20 210:17 231:12 240:15 265:21 266:4,7 270:17 281:7 282:20 305:2 336:21 361:9
clockwise 9:18
close 125:9 147:4 263:7 353:3,9 387:3
closed 98:19 101:20
closely 76:20
closer 46:10 138:16 205:12 399:10
clutter 281:21 282:7
CMS 2:20 3:15,19 5:14 17:6 20:17 22:14 23:15 25:3 26:2 27:11 29:18 39:17,22 41:5 41:16 42:8,18 43:1 45:4,14 47:19 48:1,9 48:21 62:6 67:11 68:10,17 72:22 81:10 83:15 84:19 89:3 90:1 90:18 91:3 96:16 97:14 125:16 145:22 166:18 170:17 171:7 171:20 183:21 185:6 197:2 207:14 208:1 209:5 210:2,20 211:6 211:18 212:13 213:18 228:11,20 229:7,20 235:19 236:8 240:7 240:13 246:15 248:13 251:20 257:2 261:8 266:20 271:7 283:8 298:17 310:8,11,16 312:6 315:1,18 318:6 328:18,22 333:10 340:6 361:16 362:10 372:1 379:14 383:10 392:20 395:3,13 398:4
CMS' 185:1
CMS's 132:12 350:12
CO's 394:6
co- 3:11,12 56:19 60:20 360:3
co-chairs 1:9 14:14 18:4 19:2,7 55:11 56:15 57:3,8 72:11 77:5 92:22 179:9 364:6
codes 146:18,19 257:12
coding 333:3 396:4
cohort 297:20 338:12 348:12
cohorts 331:9,11,13 334:17,18
collaborate 42:8
collaborating 123:8
collaborative 185:15 259:9 298:17
collaboratively 30:7
colleague 60:11 131:4 359:22 406:7
colleagues 18:2,8 48:21 109:9 125:15 126:2 359:19 405:9
collect 28:17 147:9 232:22 373:14
collected 140:12
collecting 94:15
collection 97:11 126:10 284:16,18
collectively 158:4
Colleen 258:5,6
College 1:18 2:7 10:17 10:19 13:3
Collette 3:14 258:8,10 269:6
Columbia 16:3
column 39:10
columns 42:16
combine 8:10
come 8:19 14:2 17:21 25:10 26:17 42:7 50:5 54:1,4 71:6 93:1 95:15 100:18 107:7 122:11 137:15 146:3 150:18 155:10 158:1 162:10,14 164:12 166:16 197:15 205:9 211:14,15 218:2 221:18 222:18 241:14 256:14 258:15 259:8 262:21 303:17 317:3 318:20 319:4 339:14 340:16,18 388:1 396:12 398:18,19 404:19 405:10
comes 94:9 147:12 150:17 155:8 164:14 188:3 198:1 255:16 257:7,8 258:21 272:2
comfort 46:2
comfortable 50:18 70:10 166:14 298:20 305:15 307:16 312:9
coming 5:8 11:19 62:4 66:14 84:7 87:1 147:16 173:1 184:16 197:19 303:15 329:7 339:12 343:4 399:13 402:13
comment 4:7,10,16 24:3 61:15 69:12 70:6 70:17,19,21 71:13 76:19 83:14,18 87:14 88:17,17,18 89:15,17 89:21 90:15 94:1 105:13 146:18 151:8 157:10 162:16 163:7 163:13 169:4 170:1,8 177:18 178:15 196:22 215:5,6,6 220:7 228:19,22 229:3 230:18 231:20 234:21 236:20 240:13 252:21 258:7 261:21 265:5 268:15 269:7 270:18 279:16 291:9,15 294:8 299:17,20 306:19 317:3 347:4 358:20 359:2,6,8 367:17 372:20 396:19 401:9,21 402:2,5,20 403:2,4,6
commentary 228:5 246:10,16 355:4
commentators 365:14
commenter 305:11 364:21
commenters 61:17 215:5 229:3
commenting 61:9,11 61:22 167:2
commercial 214:18 235:21 236:11 376:15
commission 1:16 12:9 109:20 110:3,10 112:7 114:9 313:11
committed 27:11 44:11
committee's 118:1 227:1 246:13
committees 23:8 24:8 24:12 29:13 52:16 206:2 366:17
common 337:2 346:6
communicated 209:15
communication 91:18 233:7 269:4
communities 63:4 392:7
community 3:14 134:8 258:13 259:8 302:6 303:6,21 338:13 382:11
comorbidities 390:17
compare 124:7 305:9
compared 335:19,21 336:5,6
comparing 40:9
comparisons 111:21 122:1
compelling 322:4
competing 33:6 168:14 207:22 227:7 277:15 277:20 279:6
complain 311:22
complaints 145:15
complement 32:21
complete 88:12 190:10
completed 93:18 107:3 204:8
completely 101:6 239:9
complex 113:14 126:8 170:12 304:15 371:6
complexity 87:21 233:3
compliance 254:15
complicated 52:9

136:22 137:6,6 144:22 231:14 270:2
complications 337:2
component 233:12,22 234:2 265:16 269:10 271:11,17,18 278:19 279:18 280:3,20 282:5 283:2,5,17 284:11
components 107:11 182:16,18 235:1,2,5 238:7 268:1 284:17 351:8
composite 182:5,13,18 182:20 183:7,9,9 184:18 227:11 231:7 231:10 233:13 234:22 235:11 239:11 265:16 265:17 266:4,11,13 267:11,13,14,20 269:11 270:8 271:12 271:14 278:19,22 279:19,22 280:4,12 280:21 281:1,4 282:6 283:2,5,12,22 284:8 284:17 285:7,10,13
composites 185:19 238:2 283:18
comprehensive 41:22 182:10
compromise 327:5,12 382:22
compute 306:2
computer 85:15
conceivable 352:12
concept 34:5 35:16 106:22 108:7 109:1 131:10 156:2 315:13 321:9
concepts 106:6
conceptual 118:16 128:8 130:9 350:8
conceptualize 206:11
Conceptually 232:4
concern 90:10 169:22 186:21 187:3 210:21 228:3 267:21 297:19 300:1 336:19 350:8 367:15 385:12 387:14 397:10
concerned 67:18,22 78:19 172:7 240:20 260:3
concerning 174:6
concerns 34:13 35:14 68:21 79:21 163:19 181:10,12 204:9 205:14 291:5 307:10 308:7,9 309:3 330:15 334:17 336:12 338:21 338:22 339:2 341:10 341:13 342:7,9,13 343:16 344:17 362:18 363:17 365:12 366:13 367:14 373:7 374:1 375:22 381:12 382:1 382:3,8 383:3 385:21 386:11 392:3 399:22 400:7,14 403:20 405:13
concluded 98:1
conclusion 197:15 262:21
conclusions 117:15,18
concrete 131:18,19
concur 220:8 233:19
condition 47:6 205:8 206:13,14 208:10 216:3 227:7,15 251:18 253:14 260:17 260:22 277:19 297:11 307:8 308:19 323:8,8 324:13 326:5,10,12 326:16 327:15 332:4 336:19 349:3 353:11 360:17 366:14 390:12
conditionally 33:22 209:22 211:4 217:6 291:3 310:13 311:4 311:12 364:18 366:11 379:21
conditioned 319:22 320:20
conditions 47:5 59:3 60:6 248:12 260:14 321:15 325:19 326:2 326:4 327:1 332:3,13 332:19 333:19 335:11 335:17 339:19 349:21 368:8 375:7 382:21 389:6
conduct 7:1 109:10
conducted 31:19 217:19
conducting 86:3
confer 356:2
Conference 1:8
confidence 260:8
confirm 172:16 173:9 273:20 304:17 356:13 356:21 357:5 369:13
confirmation 293:15,16
confirms 293:11
conflict 15:14 17:3,18 18:2 47:22 139:21 165:1,6 166:19 167:1 167:5 369:5
conflicted 11:17 167:18
conflicts 10:5,10,12,15 10:20 11:2,4,7,9,11 11:14 12:7,10,13,20 13:1,5,10,20 14:9 16:15 18:6,17 140:5
confused 21:2 380:7
confusing 50:20 215:11
confusion 163:17 183:8
congratulate 89:11
Congress 47:19,20 48:3,11
connect 258:17
connected 273:16
connecting 146:15
connection 117:21
consensus 6:17,20,20 48:15 49:8 50:5 51:4 51:18,22 52:6 53:2,11 53:13 54:5 55:7 66:14 67:15 102:2 122:11 145:8 164:2,5 165:19 166:1,2 226:3 248:3 291:13,15,22 292:2,3 292:5,9 302:6
consensus- 51:11 107:7
consent 21:14 31:17 36:11 37:6 54:19 58:6 58:9,11 67:5 95:10 97:21 101:11,13 102:21 186:4 189:17 191:1,4,4 195:22,22 197:16,17 198:21 199:8,14 248:16 249:4,7,12 250:6,7,19 251:2,4 295:8 323:5 338:6 355:9,12,17 356:12,21 357:14 368:22 369:6 402:8 402:10,15 406:3
consequences 121:12 126:11 269:15 395:15 396:1
consider 6:6 38:8 50:10 109:6 116:19 126:5 126:21 133:7 142:21 157:21 158:11 198:5 201:9,10 240:7,8 248:13 297:15 303:15 323:4
considerable 44:22
consideration 29:22 31:5,9,20 41:18 54:17 54:22 56:22 62:18 72:14 73:14 75:3,4 76:10 161:12 170:19 176:12 205:16 237:10 295:17 355:6 360:16 367:3,6
considerations 74:12 129:10
considered 20:10 115:2 117:2 139:9 170:7 196:8 204:11 205:11 208:12 212:5 234:10 290:17 300:6 317:9 317:12 331:8
considering 34:21 50:9 63:9 121:5 185:3 212:14 332:4,6 362:7
considers 37:6
consistency 31:14 112:3 170:16 203:2 253:17
consistent 73:14 139:14 212:18 213:5 217:4 253:22 254:6 292:18 327:9
consistently 115:7 347:7
consolidate 337:8
constant 6:16 182:1
constituted 173:2
constructed 350:9
constructs 361:19,21
consultant 3:2 16:6
consultants 282:19
Consumer 11:3
consumers 1:14 266:6 281:6 318:2
contentiousness 383:12
context 40:4 51:6 52:22 77:16 79:6 94:6 116:21 117:9 119:8 120:17 132:22 133:19
continuation 90:16,19 215:22
continue 73:17 103:1 123:10 125:18 126:18 148:20 150:3 183:17 214:8 240:14 269:19 301:4 345:6
continued 73:12 107:13 367:11
continues 26:18 148:15 301:1
continuing 55:5 126:14 317:12 405:17
continuity 191:14 394:14
continuous 30:8 399:11
continuum 74:6 393:1

393:7 394:14
contracting 25:12
contractor 315:21
contracts 25:7
contrary 45:13
contribute 33:12
contributed 157:1
control 123:3,18 192:2 239:10 264:6 269:12 269:15,16 276:22 337:14 377:6
controlled 188:13 391:10
controversy 258:20
convened 112:14
conversation 59:12 82:3 105:11 112:1 117:17 146:3 156:5 156:14,21 157:4,22 158:1 160:11 161:5 210:8 217:5 252:14 252:17 262:16 315:3 374:8 382:14,16 383:8 405:12
conversations 156:10 156:12 301:16
coordinate 72:8 82:2
coordinates 398:21
coordinating 1:3 5:9 7:12,17 15:2 19:8,17 19:22 21:20 30:19 34:15,22 35:12 38:8 50:1 56:19 69:5 99:10 99:15 101:14 125:5 127:2 161:15 162:4 164:10 174:20 175:7 197:13 207:11 210:19 211:17 320:21 343:22 379:13
coordination 233:7 377:9 379:3 384:8 398:17
Coordinator 2:15 17:13
Core 185:14
CoreQ 72:15 73:14 76:9 80:19 84:13 88:6 100:9 406:3
corner 98:8
coronary 192:6 297:7
Corporation 2:9 11:13
correct 37:8 50:4 83:7 135:8 146:2 175:15 199:4,5 200:16 219:4 249:10,13,14 279:4 288:5 308:22 326:20 338:7 340:9 351:4
correcting 20:20
correctly 145:12 381:22
correlate 94:16
cost 107:15 132:14,15 132:17 134:10,18 147:19 171:9 180:22 181:1,7,11 184:21 186:19 187:1 297:14 297:21 298:13,18,19 300:19,22 302:21 305:8 318:1 332:20 334:20 335:2 336:12
costs 96:22 133:7 155:9 337:11,12,13 361:8
Counsel 16:7
count 49:11 61:5 101:17 104:18 188:6 188:8
counter-discussion 184:17
countered 393:18
counts 101:5 188:16
couple 15:3 23:18 24:13 26:20 30:20 54:16 127:5 150:22 154:21 178:22 186:11 186:14,18 207:19 222:18 233:19 239:22 241:7 253:16
course 22:12 36:7 39:3 43:6 57:14 67:9 73:4 74:8,20 84:14 150:7 235:6 316:12 319:21 345:18 379:22
cover 19:13 366:3
coverage 389:7
covered 76:4 134:22 151:11
covers 183:6
CPHQ 1:16
crazy 244:5
create 46:21,22 112:16 182:22 189:1,9 190:10
created 34:16 175:17 197:17 305:5
creating 346:1,3
credentials 177:22 178:7 381:22
credibility 283:6
credit 25:16 144:8 238:8 392:21
Cristie 3:17 358:9 364:3 364:6 368:18
criteria 32:4,6,12,13,18 33:8 90:13 114:15 117:13 123:22 149:18 150:7 180:2 187:7,8 208:18 321:11 343:12
351:2,7 378:1
criterion 343:18
critical 33:4 114:1 317:22
critically 78:13 82:16
Croix 2:2 12:21,21
cross- 97:6
crowd 278:21
crowding 270:7
crucial 114:12
CT 398:19
culprit 301:18
cumbersome 232:22
curious 90:9
current 31:3,12 35:6 61:19 71:3 119:15 122:6 144:12 152:9 169:9 227:9 253:22 254:9 273:2 318:16 324:14,17 326:14 330:2 352:2 362:12 371:10 400:22
currently 38:12 83:11 122:21 125:11 142:4 209:19 254:14 255:21 256:10 269:13 363:14
curve 234:10
cutting 97:7
CVS 12:16,17
cycle 62:4 72:14 213:19 318:12,14,16
cycles 25:12 35:3 55:4

D

D.C 1:8
danger 266:2
dangerous 230:1 231:4
Danish 301:18
data 3:7 28:17 73:7 94:16 97:11 113:17 115:3 119:1 122:1 124:11,14 126:9,10 134:15,16 140:11,17 147:10,12,15,16 157:5,8,11 170:17,20 171:4,8,11 229:20 232:22 284:16,17,18 301:17 303:7,15,20 304:8,17 305:6,19 332:2 350:7 352:16 353:3,7 373:13,14
date 22:18 212:3 302:8
Davda 1:15 12:18,18 235:18 236:17 284:14 376:6 392:17 397:19
Dave 144:15
David 1:17,19 10:1,4 11:15 93:19 147:15
David's 95:7
day 62:1 67:17 103:3 165:4 306:16 310:6 359:22 401:10 402:5 402:6 403:10 405:7 405:22
days 24:15 87:18 132:15 133:18 134:10 134:19 135:5 143:15
dead 187:21
deadline 316:20 317:1
deadlines 211:8
deal 144:18 145:5 151:12 153:10 157:22 194:6 209:3 213:12
dealing 93:3
dealt 121:21 173:19 337:18
debatable 239:1
debate 150:7 344:6
December 31:10,11 54:20 56:16 62:22 77:13 180:21 186:16 305:11 306:4
decide 13:4 35:2 41:5 197:4 302:21 313:14 316:11,11 319:9,11 319:13 337:11
decided 27:5 211:18
decides 313:7
decision 31:8,13,15 33:14 35:1,16 37:19 45:12 51:13 54:18,21 56:8 68:13 69:6 181:21 212:10 241:12 241:16,20 281:16 290:8,21 298:6 313:8 313:12,19 314:7 364:17 372:1 378:4 381:13 388:10,12 404:5 405:19
decision-making 51:17
decisionmaking 46:16 51:14,17 52:8
decisions 32:20 53:5 55:1,12 56:1 172:21 290:20 320:5 377:18
declined 369:15
decrease 229:22
decreased 229:10
default 280:11
defense 311:11
defer 341:2
deficit 80:9
define 67:15 109:5 116:11,13 128:14 164:22
defined 108:8 164:1

248:14 342:7 368:14
defines 163:22
defining 331:9
definitely 23:17 44:10 184:15 209:9 340:16
definition 51:3 109:2 110:22 116:18 152:20 152:21 203:11 217:15 218:8 226:4,5 297:20 338:12 348:12
degree 121:9,13
delay 321:12
delayed 317:22 318:4
deliberating 335:14
deliberations 56:9 79:9 79:13 80:5 81:2 138:21 386:10
delivered 89:9 139:8 281:9
delivery 392:13
delve 40:13
demonstrated 107:13
demonstrates 121:19 124:11,13
denominator 49:11 61:5 64:7 96:2 103:2 103:13 164:20 165:7 165:9 166:2,3 342:8 342:10 343:17
denying 395:6
depending 113:17 120:13 232:13
depends 257:7 320:5 397:22
deploy 126:12,21
deployed 146:6
deploying 129:4
depression 75:14
depth 170:4 362:21
Derek 2:8 11:12 190:2 213:9 220:6 282:18 334:14 391:15
describe 58:19 190:7 262:22 267:6 271:7 378:21
described 50:10 66:2 165:3 190:1 391:20
describing 125:10
design 115:1,3 159:2 214:16 240:13 396:13
designation 32:10 34:17
designing 114:11
desire 115:16,21,22
desperately 137:4
detail 93:9 314:18
details 84:14,15 119:2 134:21 175:3,9
determinants 75:17
determination 293:5
determinations 373:5
determine 32:6 122:16 258:18 356:4
determined 110:14 257:9
determines 57:15
develop 25:7 60:21 112:14,22 125:18 159:21 315:19,21
developed 32:3 51:11 90:6 97:4 118:7 122:10 126:18 133:1 146:19 216:19 329:5
developer 166:21 204:20 214:15 254:2 299:8 313:6,17 314:5 315:8 316:11 329:1,4 329:7 343:1 348:6,7
developers 120:19 213:3 304:20 317:11 327:18 339:21 379:14
developing 110:13 116:19 119:6 155:13 166:22 298:18 350:15
development 24:1 25:13 26:3,18 27:21 28:4 41:20 48:12 51:7 51:12 53:2 73:1 79:19 92:15 107:8 109:6 110:16 114:22 116:6 139:14,18 140:6 165:2 167:17 182:22 258:18 300:7,8 302:5 308:4 318:17 340:14 363:14,18 369:14
developmental 113:6
device 98:7
devolved 52:13
diabetes 63:19 130:22 131:3,6,7 188:13 191:20,22 192:2 208:14 226:21 228:6 231:1,2 236:7 238:2,3 238:5,11,19 243:9 247:12 249:21 251:4 259:5 264:5 268:2 269:18 270:8 276:22
diabetic 229:9 239:7 243:9 253:3,18
diabetics 239:4
diabetologist 131:5
diagnoses 302:14
dialog 45:12
dialogue 157:1 394:19 400:22
dialysis 29:7 362:1
364:13 365:8 374:4 376:15 377:1 378:7 379:2 381:18 382:8 383:15,22 384:7,11 386:3 387:15 388:4 388:20 389:5,8,15 392:10 393:16 394:4 398:6,22 399:5,10
diatribe 187:16 188:21
dictated 120:17
did-not- 43:18
difference 153:2 157:12 187:12 229:21 247:3 321:15 390:7
differences 189:2 391:12 396:4
different 6:11 27:6 34:10 39:4 59:5 65:12 66:10 67:10 87:19 93:15 102:6 120:12 125:21 128:6 130:12 136:3 139:7 140:20 148:15 156:17 157:15 172:10,20 177:5 181:16 183:10 184:5 187:9 188:20 193:8 193:10 194:2 199:18 200:16 205:7 209:2 213:21 238:15 252:17 256:18 263:2 264:12 285:14 321:8 324:19 324:19 332:22 333:21 352:7 377:12
differs 58:20
difficult 68:1 135:15 152:16 154:15 155:1 182:21 291:16 381:10 386:16
difficulties 56:3 319:1
difficulty 345:16
dilemma 87:6 151:13 176:18 207:12
dinner 406:8
directed 92:21,22 336:18
direction 27:2,17 86:8 271:3 370:19 379:9
directives 74:19
directly 17:22 123:7,18 153:7
director 3:2,3,4,7 16:21 179:8 214:21 272:12 359:13 398:10
Directors 2:2 13:1
disadvantaged 378:12
disagree 21:4 87:9 98:13 255:12 277:2
disagreed 68:15 291:1
disagreement 20:3,5 20:12,15 202:18
disagrees 57:20
disappeared 148:7
discharge 72:15 73:3 82:18 100:10 132:19 143:19 406:4
discharges 143:13 387:22
disciplines 233:8
disclose 15:13 17:1,4 17:14 214:9,22 272:10
disclosed 18:7
disclosing 16:14
Disclosure 14:16
disclosures 4:3 7:2 8:1 8:10 13:4 15:7 17:5,7 18:22 214:3 272:14
disconnect 262:10
disconnected 18:14 354:9
discord 262:4,10
discouraged 61:4
discovered 360:2
discretion 319:15
discuss 6:8 53:22 55:3 56:22 58:5 72:3 81:5 167:21 179:3 189:12 195:7 215:8,20 262:18 292:19 295:1 305:13 311:17 325:1 351:20 376:3 400:4
discussant 220:9 353:6 370:12,13
discussants 59:5,11,17 72:2 82:11 190:3 372:4,5,11
discussed 22:5 33:13 82:8 99:6 170:3,14 174:14 184:14 216:1 253:1 267:12 306:22 321:21 339:10 361:1 361:7,22 362:3,14,20 363:1 365:13 366:12 368:1,3 371:19 402:21 404:17
discussing 132:4
discussions 6:11 11:18 32:2 55:12 77:19 182:19 185:21 267:9 373:17
disease 192:4 277:11 278:13 302:16 304:15 364:9 369:10
diseases 373:11
disorder 191:15 216:1
disparities 382:2,15

385:2 391:22
disparity 210:5 375:20 376:10
displacing 266:10
displayed 221:12
dissatisfied 95:2
dissidence 54:5,6
dissonance 134:9
distance 152:15
distinct 189:2
distinction 90:9
distinguish 21:11
distribution 297:22
distributions 305:8
dive 72:18 241:7
divided 104:1
do- 32:9
do-not- 37:10 45:8
do-not-support 33:17 37:21 38:13
do-not-supports 36:12
doctor 147:6
doctors 154:19
document 68:11 144:17
doing 23:17 29:5 39:8 43:9 45:14 47:1 55:9 60:10 95:14 113:1 129:7 144:7,18 159:16 187:20 211:3 223:12,13 238:8 252:5 257:22 263:10 283:12 288:22 307:5 312:6,13,18 347:16 355:22 380:13 389:1 390:10 393:11
domains 184:6
dominant 144:11
dovetail 238:1
downplay 386:8
downside 271:16,17 272:2
dozen 178:1
Dr 25:17 36:20 37:4,8 39:14 79:1 88:1,5 103:1 106:11,14 110:4,9 111:11 115:11 128:9 133:11 146:2,16 155:15 159:14 174:8,18 175:15 183:5 205:19 219:14 233:15,18 249:14 268:5 272:11 289:20 290:9 295:20 296:7,10,13,16,21 299:12,14,22 300:10 300:15 301:7,10 302:10 304:21 328:20 330:4 331:1 335:3,5 337:21 354:1,5 355:3 356:6,8,18,20 357:4,7 357:11 358:10 365:17 365:21 367:20 383:9 385:5 386:13 387:19 390:14 395:20 400:16
draconian 268:16
draft 197:19 263:2
draw 117:15,18,21
DRG 135:7,8,8
DRGs 337:9
drill-down 93:8
drill-downs 93:15
drive 28:18 29:8 97:14 107:14 119:20 141:1 159:4 383:4 392:6
driven 134:7
driver 96:22
drivers 397:12
drives 235:15
driving 142:15 363:2
drop 96:2 165:16
drugs 257:12
due 171:3 218:19
dumb 53:3
dunk 380:3
duplicate 180:14 208:16 233:12 251:19
duplication 208:11
duplications 208:3
duplicative 184:8 185:17 213:17
duplicity 188:10

E

eager 86:7
earlier 21:1 44:6 61:6 62:12 68:18 162:20 241:1,1 244:14 246:20 268:19 270:13 270:18 282:2 291:14 310:2,6 387:1 394:18 404:18 405:2,10,16
early 175:22 335:14 405:13,22
easier 9:7 50:19 99:8 148:3 200:4 240:21 283:20
easily 38:19,19,21
easy 52:11 162:20 401:15,17
echo 68:3 82:15 86:14 285:4
ECQMs 142:7
educate 193:18
educated 154:13 388:15
education 384:2,16
389:9
effect 139:5 182:17 238:10 270:7 280:19 281:5
effectively 81:3
effects 395:5
efficiency 107:20 184:21
efficient 52:10 291:17 291:19
effort 5:9,12 43:12,13 67:19 77:15 176:11
efforts 150:15
EHR 83:9
EHRs 78:10,14
eight 181:1 229:15 231:3 232:18 234:14 236:10 238:21 239:3 241:17 250:10 273:13 275:10
eighteen 250:12
Eighty 226:1
either 51:14 54:18 55:14 59:9 61:15 85:9 85:19 98:10,11 121:21 123:7 160:2 188:2 189:18 198:5 210:21 215:8 228:3 317:6 348:18
electronic 142:7
element 117:22
elements 109:4 111:1 111:14 116:11,16,19 117:2,12,19 128:14 128:20 129:15 130:2 157:12 160:18 330:9
eleven 250:10
eligible 102:1 118:16 163:22 164:3,11,13 164:14,22 165:7,21
eliminate 207:13
Elisa 3:5 7:1,6,22 8:4 165:3 214:2
Elliott 1:16 12:8,9
email 7:16,17 56:3 60:15 99:7,10 158:9 177:10 217:3 221:8 221:13 223:8 247:19 273:10,16 286:11 287:21 355:18
embraced 259:7
emerge 301:2
emerged 19:6 113:4
emerges 323:9
emerging 298:10 300:3 301:21
emphasis 47:15 233:13
emphasize 19:15 23:11 23:15 60:3 63:9 120:16 123:15
emphasized 48:22 73:21 120:11 121:18 122:13
emphasizing 115:6
employ 285:7
employed 12:18 16:3
employee 12:16 13:19
employer 15:5
encountered 232:20
encourage 94:13 97:3 187:14 216:6 389:8
encouraged 73:12 252:10 297:14 380:4 384:21
encourages 384:8
encouraging 370:17 371:6 393:12
end-of-life 74:5
end-point 52:7
ended 43:17
endorse 220:2 240:2 394:20
endorsed 76:14 80:18 81:19 133:3 175:12 210:4,18 216:4,18 217:18 218:4 219:3,9 219:9,17,18,22 220:1 237:3,11 240:4,9 254:11 255:8,21 256:3,11,17,19 260:20 307:14 310:5 310:14 311:5,13,19 312:7,8,11 316:6 319:4 320:8 321:1 333:8 341:6 345:15 349:18,19,20 364:14 366:4
endorsing 396:15
ends 80:21 193:14
energy 284:1
engage 127:20 298:17 398:9,10
engaged 63:1 109:8
engagement 362:15
engaging 82:3 362:15
enhanced 157:19
enhancement 140:9
enjoyed 138:13
ensure 181:13 208:11 297:17 305:14 331:19 333:4 362:19 363:3,8 383:2 392:11
ensuring 50:17 363:20 375:15
enter 163:6
entered 195:20

enterprises 392:8
entirely 25:16 148:16 149:19 183:21 336:3
entities 116:12 118:14 122:19 128:3 134:4 157:15
entity 9:2 121:2 123:1,5 123:16 124:4,20 151:17 155:6
environmental 109:8 109:11 119:11 148:18
epidemic 218:20
episode 132:15 134:18 135:5
episodes 144:3 262:3 335:18,20,22
episodic-care 97:16
equates 280:1
equitably 382:5
equity 187:2 375:21 383:5
Erde 329:3,3
Erin 2:4 3:7 8:2 13:8 36:17 44:11 49:21 77:14 113:9 115:11 120:1 127:8 128:9 146:2 161:3 163:9,10 406:1
error 334:12,12
ESC 301:22
especially 23:11 102:17 108:18 140:18 174:21 183:7 212:17 233:21 239:3 344:9
ESRD 364:4 371:13 374:3,14 379:8 392:21
essence 253:2 296:13
essential 114:22
essentially 42:1 65:13 111:15 174:2 187:21 327:13 329:14 385:9
establish 49:7 108:11
established 62:21
establishing 55:7
estimated 336:4
et 188:18 343:12,12
evaluate 31:5 32:4 111:7 120:9 155:13 155:17 216:7 304:17 361:20 363:21
evaluated 19:3 119:11 170:3
evaluating 33:9 87:22 174:3
evaluation 112:20 129:19 171:12 175:22 214:17
event 300:18 368:2
events 63:20 229:12,22 229:22 300:20 337:2
everybody 5:5,7 30:4 53:20 69:20 82:2 86:2 106:2 162:22 190:13 190:13 222:7 261:9 276:20 315:14 346:17 347:20 358:6 385:13 392:15 402:9
everybody's 81:14 87:10 162:8,11 400:10
everyone's 47:10 353:14
evidence 112:3,4,22 116:5 120:18 122:7 231:5 238:22 241:8 241:11,18 281:18 298:10 300:3 301:1,5 301:21 323:9 339:6 340:3 341:15,16,22 344:6 393:19
evidence-based 117:6 269:17 363:9
evolution 47:9
evolve 45:21 97:12 317:12
evolved 51:8
evolving 141:15 324:18 328:1
exact 227:13 277:21 333:9 391:8
exactly 44:3 131:22 150:1 164:7 202:12 213:4 248:14 319:18 340:13 386:15
examine 147:12
examined 209:13 332:18
examining 132:18 205:14 362:10
example 15:12 35:20 63:12 118:11 130:20 132:1,3,7 134:16 135:3,17 140:19 143:11 170:9 187:19 197:8 271:2 387:19 394:18 397:14 398:6
examples 281:11 327:4
excellent 46:15 54:10 209:18 358:12
excess 65:18
exchange 78:7
excited 23:9 81:14
exclude 337:13
excluded 124:6
exclusion 329:15
exclusions 121:22 327:2 328:16 330:6
exempt 366:1,5
exist 53:16 283:15
existing 34:9 110:14 143:2 207:21 269:13
exists 151:5 265:18 280:17
expand 125:11
expect 8:19 127:16 133:22 270:17 343:3 345:19 390:17
expected 298:10 335:19,21 341:20
expecting 156:3,9
expensive 327:6 329:18 376:16
experience 6:16 78:13 79:11 80:17,21 81:16 87:17 91:15
experiences 25:18
experimented 26:20
expert 1:12 9:14 14:14 113:14 129:11 267:7 306:18 375:18
expertise 170:2,13 172:12 301:3 307:15 313:13
expertly 404:12
experts 8:15 9:8,21 14:12 19:16 306:20 307:4 384:10
explain 52:11 203:7 253:14 263:1,3,4 387:13
explains 343:13
explanation 95:11 136:2 381:5
explicit 262:14 294:4,6
explore 55:4 126:14 146:13
explored 110:17
exposure 345:22
express 19:18 34:4 68:8 338:22 339:2
expressed 51:10 297:19 300:2 342:13 392:3
expressing 218:7 385:12
expressly 342:9
extensive 385:7,11
extensively 366:13 368:1,3
extent 374:3
extra 46:22,22 353:4
extract 128:13
extremely 11:17 144:17 144:20 231:14 337:5

F

FAAFP 2:5
FAAN 3:11
face 82:4 151:15 284:20
face-to- 82:4
FACEP 2:8
facilitate 31:17 64:2 142:4 389:9
facilities 29:7 75:4 123:11 364:13 365:8 381:18 382:8 383:15 383:20,22 384:7,11 386:3 389:8 390:22 391:3 392:3 394:11
facility 29:7 138:7 360:19 362:1 377:2 388:4,9,20 389:5,15 398:7,10,21 399:10
facility-level 133:1
FACP 2:6 3:12
FACS 1:18
fact 45:10,15 46:3 51:12 91:16 116:4 125:3,5 164:18 227:10 228:10,13 244:7 252:15 255:13 311:5 312:16 324:17 327:22 348:22 374:5 386:8 387:11
factor 181:15 391:14
factors 120:2,9 228:8,8 297:17 331:17 345:20 385:17
fail 37:22 255:3
failed 209:22 288:18 292:1 343:11,18 344:16 348:5
fails 38:2 244:15 245:6 248:4 264:2 289:8 295:22 351:8
fair 46:7 117:15,18 121:22 123:5 133:6 153:8 173:22 175:20 342:12 362:19 363:4 383:14 399:4
fairly 79:22 80:6 114:20 124:7 258:16 383:2
fairness 114:16 152:3
fall 34:12 41:15 51:2 109:14 212:19 350:22
falling 184:22
falls 351:9,13
familiar 88:20,21 146:17
families 2:4 13:9 148:4
family 2:5 10:12 11:22

86:4 362:15
family-reported 80:11
Fantastic 88:14
far 26:10,22 84:9 144:1 145:22 160:19 200:6 233:10 234:4 246:11 247:4 263:9 286:22 301:22 315:14
fashion 348:10
fast 247:10
fasting 188:15
father's 85:12
fault 211:20
favor 101:9,12,16 224:21 232:11 234:5 263:14 273:8 286:4,7 287:16 290:5 322:12 322:17 355:16 402:9
feasibility 78:9
feasible 284:6 321:2
February 62:6,12,14
fed 164:12
federal 2:13 6:3 9:22 16:16 17:10 98:21 99:2 103:22 164:10 164:21 346:16
Federation 15:19
fee-for- 95:2
fee-for-service 108:14
feedback 41:9,14,16 44:11 45:9 46:2 50:15 51:1 62:18 85:5,6 89:7 96:15 126:19 127:2 207:8 210:1,7 211:20 310:7,11,15 342:16 343:1 345:1 373:18 380:10 404:4
feeding 283:8
feel 18:1 42:20 43:4 46:9 52:3 68:7 124:22 128:9 158:10 165:5,6 174:12 267:10 298:20 308:10 314:14,15 315:2 339:2
feeling 162:19 248:11
feelings 381:8
feels 312:3
fell 38:22 361:12
felt 26:19 27:4 78:11 113:7 267:16 305:15 337:14 367:1 368:5 382:16
fewer 24:10 25:1,11,15 303:1
field 78:3,12,21 119:22 181:18 305:1,3,10
fifteen 166:7 250:11
fight 196:20
figure 9:13 41:8 48:1 53:19 54:8 106:11 153:9 192:20 210:19
figuring 43:8 44:12 297:2
fill 33:4 81:15 371:10
filled 379:15
fills 320:22
final 120:4 150:13 178:4 196:8,9 198:19 209:8 234:21 262:7 315:7 316:22 337:7 350:14 373:5 378:4 387:6 403:11,12
finality 44:21
finalize 6:2 72:4,5
finalized 43:18
finally 14:5 29:16 30:2 73:22 75:11 76:3,7 112:5 123:19 124:16 134:13 189:19 362:14 375:17
financial 94:20
find 42:6 88:12 94:2 271:9
findings 109:21 110:11 185:18
fine 40:8 45:21 154:9 239:14 248:12 255:11 266:2 316:19 330:16 372:16,18
finish 226:16 243:13
finite 173:7
firm 147:16
firmly 139:13 140:5 141:20 314:12
first 9:5,19 10:2 22:22 23:18 25:3 27:9 31:2 38:1,2 56:14 59:6 74:13 94:1 107:3 110:12 116:21 120:5 120:7 125:12 129:1 129:12 132:20 137:16 138:14 146:4,9 150:8 154:11 156:2 168:7 169:21 186:3 191:14 195:10 198:2 202:3 202:21 215:20 242:4 245:8 246:1 253:16 264:14,19,22 265:3 276:6 293:20 325:8 344:5,12 346:15 353:19 361:3,14 370:16,16 378:20
fish 218:1
fit 45:5 77:20 115:19 121:10 208:18 271:9 271:15,19 397:3
fits 23:18 220:3
five 83:21 87:17 238:9 238:15 250:9 273:13 273:21 275:10 360:12
five-minute 292:15 295:7
five-star 84:3
fix 155:8 374:18
fixed 206:19
fixing 101:2 166:12
flaw 240:17
flexibility 398:5
flip 181:10 185:3
floor 1:8 66:20 171:14 178:10 288:20 294:1 346:5 347:5
flow 46:16
focus 22:3,4 27:17 33:1 57:12 58:1 107:13
focused 119:12 270:20
focusing 20:11 28:4 336:9
folder 7:11
folks 9:20 23:12 86:7 146:16 206:9 228:13 267:16 316:9 372:7
follow 149:22 164:17 239:21 281:11 314:6 327:8 347:2,6 388:4
follow-up 143:14 172:3
following 24:8 45:11 59:16 62:5 106:15 150:3 209:12 303:5 330:1 366:20
follows 262:20
force 67:4 169:5 196:2 197:21 199:13 203:4 207:10 212:3 263:1 276:13 287:16,17,22 289:7,13 299:1 322:10 326:11
Force's 261:7
forced 236:12
forces 176:18,19,21 197:16 233:6 235:11
forget 24:15 143:9
form 14:16,17 257:5 326:20 330:21
formal 12:16 66:2
formally 138:15 163:7 208:4 369:19
former 376:7,21
forms 90:19
forth 29:8 57:17,19 58:15 59:10 79:16 84:17,19 166:8 348:13
forum 1:1,8 8:7 285:15
forums 285:15
forward 11:19 24:11 25:21 26:21 29:13,15 40:1 47:3 48:3 52:19 61:1 68:15 77:17 78:3 78:21 79:17 84:7 89:12 101:13 119:3 119:22 142:16 144:9 150:6 161:2 163:19 170:14 171:8 173:1 195:14 203:1 207:15 208:19 212:11 228:20 240:9 244:22 248:21 252:8 255:16 261:4 262:8 263:10 269:10 276:12 286:2 287:12 290:3 292:1 298:5,14 298:15,21 301:1,6 311:9,13,14 312:20 318:7,16 320:16,20 324:6,7 334:5 342:11 367:9 379:21 394:13 395:13 396:11 399:8 399:13,18
found 27:3 85:22 111:17 302:16 385:1
four 33:14 87:19 88:8 99:17 103:22 164:10 170:10 172:8,13 177:19,19 178:5 208:15 235:1,2,5,13 238:9,15 250:9 273:12 275:9 280:10 360:14 361:12
four-month 320:10
fourteen 250:11
fragment 374:5
fragmentation 377:9 379:4 397:6,14
framed 80:3
Framework 26:4 27:16
frameworks 128:8
frankly 53:19 151:12 153:22 245:14
fraud 187:2
free 68:7 128:9 158:10 267:10
frequently 68:1 218:17 235:22
front 9:3 14:19 23:8 60:13 162:5 167:13 313:10,22 314:7
fronts 28:10
fruit 242:4 270:19,22 271:2
frustrating 187:19
full 22:20 103:13 162:17 313:5 371:4

394:14
fully 203:21 213:22 267:22 270:4 306:5 328:15,20 329:5 394:12
fun 23:5
function 260:19
functional 76:8 78:16 389:20
fundamental 115:3 242:8 345:5 353:16
funding 173:6
further 55:4,14 57:1,9 57:12 59:9 156:1 168:4 179:3 198:6 215:9 227:19 292:20 297:12 304:6 332:18 349:3 371:14 375:19
Furthermore 389:6
future 28:3 55:4 72:22 85:2 112:21 119:17 146:12 160:12 161:1 203:1

G

Gail 1:19 10:22 72:1 82:14
gaining 204:16
game 141:7 240:20 282:21 395:8
games 141:12
gap 33:20 77:17 78:19 80:12 81:15 319:10 320:22 379:15
gaps 33:4 77:16 189:1 371:10
gather 303:7
gathered 266:13
general 32:19 84:20 95:7 96:4 106:6 130:17 169:16 176:11 186:6,10 207:1 209:1 236:11 261:21 288:17 366:16 370:16 372:5 372:8,20 374:19
generally 19:20 37:22 90:2 115:17 143:8 176:15 242:2 248:11 271:15 329:17
generate 117:16
generic 145:10
generously 343:15
gentleman 270:18
genuinely 26:7
Gerri 3:11 72:12 77:5,9 79:1,3,7 80:8 81:4 82:1 93:2
getting 7:15 24:4 30:4 42:20 87:11 148:11 148:14,22 149:2 193:14,20 217:17,18 244:5 296:4 312:11 344:5 353:22 355:19 376:12 384:13 388:22 389:2
Giff 91:18 142:17 156:13
Gifford 1:17 11:15,15 47:8 83:11,17 85:9 95:20 96:4,13 142:18 158:15 394:17 396:9 401:11,16,20 402:3
give 5:17 27:22 39:5 40:12 72:22 99:2 100:17 106:20 144:8 190:19 191:21 207:4 221:6,21 227:1 241:9 314:14 324:10 327:5 328:12 360:4 372:5 377:5 391:8 392:20 400:2 405:10
given 41:22 46:3 116:3 129:12 141:3 204:22 226:17 329:16 371:6 373:18
givers 377:3
gives 41:19 46:2 104:1 109:13 203:22 276:3 398:3,4
giving 96:16 329:19 405:20,20
glad 150:3 183:6 299:22 315:4 376:9 378:14,20
glance 352:18
Glier 3:16 223:3,10 239:18,19,21
global 61:22
goal 116:8,22 130:14 132:13 285:16
goals 114:2,12 115:10 117:5 127:15,18 128:3
God 234:13
gold 114:10 120:11 122:7 138:19 139:3
goodness 121:10
Goodrich 2:19 16:18,19 22:13,19 24:19 43:22 44:7 85:17 90:21 91:11,14 92:7,17 257:4,17 315:2 318:19 340:8
gotten 190:1 288:4 291:7
government 2:13 330:2
Grade 302:2,3 341:18 341:20
graduate 347:14 351:12
grant 349:6
gray 350:21
greater 49:8 50:11,11 54:11 60:18,20 61:2 75:18 111:20 112:18 119:21 164:2,5 165:20 236:12 269:13
gremlins 100:21
grey 139:15
grounded 113:21
groundwork 112:21
group 1:13,19 2:1,3,11 3:16 10:9 11:11 14:6 14:8 15:4 34:1 43:11 53:11 68:11 109:10 113:7 115:22 119:14 126:17 171:17 172:6 172:14,17 174:15 178:5,6 180:20 187:4 202:17 216:5 217:20 217:22 218:3 243:16 262:6 293:11 324:19 329:18 336:8 366:5 379:14
groups 123:8 128:2 150:17 151:4 173:3 175:17 177:5 362:16
guaiac 347:15
guess 6:19,22 15:21 40:6 49:18 65:16 71:21 82:7 83:4 85:7 95:6 101:17 153:4 154:17,17 162:14,15 163:10 177:2 178:21 186:6 189:9,11 190:7 192:11 195:6 207:12 210:15 211:19 215:6 220:19 236:22 258:3 261:3 290:18 307:2 309:9 326:19 330:19 380:16 400:10 403:9
guidance 32:20 35:11 72:5,22 125:18 126:6 126:18 148:6 206:1,7 297:12 332:5 375:19 375:21
guide 55:16,22 56:6 61:12 112:16 115:14 116:9 120:8 125:20 126:5 385:14
guided 184:2
guideline 241:13 254:15 330:2 345:17 346:2
guidelines 61:9 70:20 227:9 240:5 241:19 253:19,21 258:15,19 260:18 301:22 302:1 303:22 324:15,18 326:15 328:2,4 329:9
guides 73:7
guiding 56:1 112:15 113:3,8 114:19 149:8 404:12
gut 153:5

H

HA 386:1
half 107:2 386:17
hall 1:18 10:16,16 64:6 102:4 103:11 104:6 104:10 138:10,18 195:13 196:13,20 197:6 198:8,15,18 209:8 290:7 293:9 294:9 310:1,19,22 311:3,9 312:3,10 345:9 348:1
hammered 322:2
hand 21:7 53:9,12 63:15 152:12 202:5 224:13 245:10 252:10 263:16 283:10 286:3 286:13 376:4 402:9
hand's 174:8 233:15
handle 156:18 232:1 263:12
handled 209:15 338:13
handles 331:20
handling 298:4
hands 101:4,16,18 250:1,3 263:18,21,22 272:6 273:9,11 286:8 286:9,14 287:18,19 288:1,2 311:20 322:13,19
hanging 270:19,22 271:1 359:14
happen 36:17 70:3 148:21 149:15 180:14 199:11 205:21 209:14 209:21 218:17 234:4 238:4 281:14 283:19 302:7 388:11
happened 41:5 80:14 81:22 132:18 146:13 149:20 208:8,12 210:22 225:20 260:3 281:12 321:21
happening 105:15 148:12 150:16 266:8
happens 41:1 43:6,12 46:13 235:10 244:14

262:10,18 312:19
happy 245:16 272:15
hard 22:1 25:18 44:15 81:11 152:17 202:5 205:3 228:12 238:7 283:12 302:17 318:21 357:21
harkening 24:14
harm 230:5
harmonization 150:14 187:10,18 188:11 361:4,20 362:6,8,16
harmonize 189:1
harmonized 137:9
harmonizing 361:18
Harold 1:9,11 5:5 9:9 16:2 22:6 46:5 56:20 64:2 68:4 89:14,17,20 111:12 113:2 128:17 139:4 205:20 206:2,4 289:1 396:21 400:16 404:11
Harold's 116:10 291:21 293:10
hat 141:20
hate 150:18 297:2
HCAHPS 85:8
head 36:16 205:4 390:11 405:14
health 1:15,17,20 2:1,8 2:11,16 3:17 10:9 12:16,17 13:22 14:6,9 16:8 17:13 62:17,20 63:1,8 74:11 75:13,16 75:18 90:5,8 92:11,13 93:6,6,10,12 108:18 126:2 130:16,17 142:1,5 214:17,18,21 216:18 217:22 218:3 219:5,6,13,16,18 228:8 235:20 236:9 284:19,20 339:11 342:2,6 344:12,15 375:21 388:18 389:3 389:16 405:10,16
health- 92:15
health-plan 149:1
health-specific 92:6
healthcare 2:8,17 10:19 10:20 11:7,13,16 12:6 12:19 79:18 88:22 96:21 97:13 114:2 143:2 151:5 266:6 392:13 394:3
healthcare's 141:5
healthy 384:1 388:16
hear 83:2 118:5 136:2 148:20 149:4 179:14 179:16 180:18 202:8 206:9 220:12 239:19 252:10 261:20 325:19 351:22 366:12 374:13 380:4 401:19
heard 26:5 28:7 69:8 78:15 81:4 179:10 184:3 202:11 232:20 260:10 282:10 344:22 380:9,11,12 382:7 386:14
hearing 18:6 136:2 172:7 226:9 313:10 387:14 389:19
hears 41:4
heart 298:8 382:18
heavier 166:13
heavily 68:19 79:14
heavy 404:13
held 107:19 118:21 123:7 134:12 156:15 382:8
Helen 353:6
hello 179:13
help 28:18 33:21 39:5 54:14 56:5 86:12 87:20 90:22 97:14 103:7 108:10 172:21 191:7 233:20 347:2 398:22
helped 82:2 159:4
helpful 35:11 44:1,16 48:14 97:13 133:13 206:9 330:4 337:22 350:17 395:1,10
helping 77:16
helps 49:13 202:22 397:20
hemoglobin 188:13
hemorrhage 192:8 331:3
hemorrhagic 331:12
heterogeneity 129:13
heterogeneous 181:16
HHS 6:2 34:20 211:10
hi 12:11 14:7 16:2,18 17:6 30:16 179:15 254:1 258:8 329:3 359:12 372:9
hierarchy 177:3
high 92:2 101:18 140:19 149:10 306:9
high-acuity 96:19
high-cost 96:19
high-level 63:2
high-priority 184:6
high-quality 33:2
high-stakes 318:2
high-value 72:21 240:18 241:2
higher 121:15 135:12 229:19 233:6 271:1
highlight 121:13 180:19 212:20 293:10 298:16
highlighted 75:17 80:9 114:9,14 120:19 123:9 124:1 332:15
historical 52:22
history 53:10 139:16 324:10
hit 141:8 165:22 228:10
HIV 63:20 338:4,8,20 340:10 346:15
hold 159:8 221:19 222:3,8,8 236:13 239:2
holding 121:2 158:21
holistic 182:9
home 75:16 80:14,16 90:8 92:13 93:10 96:21 154:6,8 188:17
homes 91:17
honing 27:20
hope 112:17 203:10 265:3 312:18 340:1
hopefully 112:22 155:18 163:18 169:17 202:2 221:3 305:22 355:1 359:16 403:21
hoping 71:6 149:22 396:22 404:7
Horan 313:22
hospice 76:3 90:8 92:14
hospital 3:17,18 4:17 4:20 6:4 10:19 16:4 55:19 62:10 66:13 82:20 87:17,18 90:4 93:9 132:10,15,17 133:2,5,18,19,20 134:5,12 135:13 143:11 151:17 156:15 166:17 167:9 168:10 194:17 205:9 272:13 272:14 358:5,18 359:2,13 360:12,14 360:17,18 361:2 364:7 366:6,20 367:5 368:20 371:3 372:11 373:7,9 374:16 375:2 381:9 384:7 386:9 387:21,22 388:7 400:4 401:6 402:15
hospital's 135:7
hospital-wide 166:18
hospitalization 63:21
hospitalizations 143:19
hospitals 15:19,20 74:9 74:17 86:19 132:14 135:22 143:16,17 187:11 329:19
hour 5:4 105:5 359:15 386:17,18
hours 145:15
housekeeping 7:5 214:2 226:7
hovers 106:9
human 281:18
hundreds 24:20
Hunt 1:19 10:22,22 72:1 82:14,14
hurry 224:10 251:10,10 251:11
hybrid 54:1 284:17
Hyperglycemia 229:10
hyperglycemic 229:21
hypoglycemia 230:1
hypoglycemic 229:12 229:22

I

ICH 335:18,19 336:5,5,9 337:4
idea 12:5 39:8 44:9 46:15 127:9 144:3 388:8
ideal 32:15 119:17 318:13 319:3,5
identical 185:18 200:22 201:1
identified 56:21 57:4,6 57:11 58:18 59:10,21 63:18 264:7 298:1
identifies 59:8
identify 19:7 20:2 57:2 57:7 108:10 124:3 141:2 146:22 169:13
identifying 32:14 55:13 128:2 233:3
ignored 310:16
IIb 302:2
III 1:9,11 302:3,3
illness 135:5
imagining 367:7
immediately 234:11
immunization 158:16 158:19 159:4
impact 73:5,18 75:18 76:5 77:21 97:8 107:12 130:14 141:13 395:4
implement 41:16 81:3 81:11 107:16 160:7
implementation 24:2

34:7,18 77:2 89:4 115:1 122:14
implemented 34:4 193:15,20 194:5 312:8 336:2 396:5
implementing 54:12 113:15 119:7
implications 298:14
importance 23:15 38:4 63:9 75:17 94:6 119:19 181:6,8 184:21 218:19 362:6 362:15 363:7 394:22 395:12
important 5:16 15:1 20:16 21:10,18 23:22 24:6 28:15 32:17 34:19 35:4,9 43:11 47:4 49:1,1 56:1,10 56:18 67:15 76:12 78:13 80:12,21 82:16 82:22 86:16 89:6,11 90:12,12 91:15 108:17 110:11 115:14 126:7 130:5 138:19 142:19 144:20 151:11 153:12 160:17 219:21 313:2 317:21 319:11 320:22,22 321:11 335:9 337:5 340:10 361:15 370:18 371:1 371:10,18 377:13 379:12 391:19 392:5 393:9
importantly 49:10 110:18 142:2 157:14
impossible 42:2
impoverished 392:7
improve 61:18 71:3 132:13 136:11 169:9 242:5 314:12 362:3 362:16
improved 28:18
improvement 2:8 11:7 29:9 30:8 76:1 80:4 121:1,16 136:10,14 136:21 137:3 141:2 157:18 184:9 235:15
improvements 6:8 107:14 363:2
improving 169:17
in-person 54:20 55:8 56:16
inadvertently 143:1
inappropriate 185:4
inbox 99:11
incentive 180:7 364:10 369:10
incentives 107:15 127:19 398:1
incentivizing 285:12
incidence 75:9
inclined 232:12
include 68:20 147:17 279:13 328:15 330:6 334:22 337:12 362:11 386:4
included 80:5 130:8 138:20 146:20 165:8 256:8 297:18 300:8 300:21 333:14 337:1 340:7 385:19
includes 74:16 244:9 375:8
including 19:5 24:2 33:19 76:6 185:13 249:20 271:16 272:1 332:18,19,22 342:17 352:8 353:5 398:4
inclusion 337:10
inclusion/exclusion 117:13
income 10:18
incorporate 323:11 400:21
incorporated 181:21 231:6 305:18 306:5 323:13 329:8
incorrect 83:10
increase 33:5 230:1
increased 229:13 285:10 361:20 390:18
increasingly 108:2
incredible 29:19
incumbent 211:3,14 215:7
indicative 379:20
individual 1:12 8:22 15:4 19:10 33:11 118:9 140:1 158:18 159:8 185:12 216:9 228:10 233:22 234:17 235:3,16 243:20 280:3 284:15 285:2 285:11 341:13 342:2 366:8 392:14
individualized 241:12 241:20
individually 54:18
individuals 117:15,18 158:22 352:7
induce 127:20
industry 79:17
inevitably 144:22
infarction 192:6,9 297:7 331:4
infection 75:7
inflated 24:16
influence 118:19 121:1 122:20 123:3,6,17 124:4 125:1 133:6 246:21 378:5 385:18 386:4
influenced 79:14
influenza 158:20
inform 60:7 89:7 119:13 262:16 281:16 291:11
information 2:16 17:13 26:11 27:5 37:20 40:12 41:17 42:6 57:21 73:22 75:2 78:6 213:11 266:7,12 281:6 305:22 310:7 313:5,9 314:2,7,10 315:6,10 352:6,12,19 361:5 363:21 371:21 378:3
informed 26:1
inherently 326:13
initial 19:19 108:20 156:12 162:5 188:22 236:16 239:13 390:16
initially 197:18
initiative 28:6,9 121:9
innovate 132:17 142:6
inpatient 134:18 300:18 360:19 367:21
input 23:20 24:4,5 26:22 41:13,20 46:3 50:15 59:16 67:11,20 68:5,19 125:8,13 162:8 170:13 175:2 176:14 308:6 319:14 404:1,7
inputs 39:16
insane 24:21
insight 299:10
insights 51:7
insignificant 257:11
insofar 262:15
instance 138:22 384:5 396:2
instances 58:14,17 171:1,9
institutional 140:3
institutions 85:14
instructions 36:4 40:19 49:5 221:6
instrument 83:6
insulted 382:17
insurance 1:15 329:20
integral 23:21
integrated 123:11 272:12
integration 130:16 397:6,15,18
integrity 29:1 126:9
intellectually 232:7
intelligently 145:12
intended 31:21 32:13 51:13,16,18 52:7 119:6 139:17 206:12 395:9
intending 21:13
intent 21:6 22:9 35:15 332:15
inter-operability 74:10
interact 6:9
interest 4:3 7:2 8:11 9:1 10:21 11:2,4 14:16 15:8,14 16:15 18:7 59:19 63:22 125:13 165:1 195:9 227:21 354:14
interested 15:7 50:15 144:17 146:5 399:18
interesting 109:21 148:19 252:13
interests 382:18
intermediate 46:11 51:20
internal 121:16
internally 42:9 352:16
Internet 222:21
internist 131:5 153:15
interoperability 284:21
interpret 209:5
interpreted 35:7 397:11
interpreting 207:2
interrupt 111:8
intervention 192:7 297:8 301:14
intracranial 192:8 331:3
Introcaso 1:19 10:3,4 93:20 144:16
introduce 10:4 16:16 22:10 272:9
introduces 76:18
introducing 125:4
introduction 196:16 360:10
introductions 4:3 8:11
invariably 144:22
invested 12:6
involved 12:1 28:7 217:21 233:8 336:21
involvement 168:16
IRF 74:22 75:3,8 93:8 93:10
Irons 1:21 13:17,17
ischemic 192:3 277:11

278:13 331:11
issue 19:14 20:6 35:18 55:2 81:1,5 83:18 92:12 103:15 106:8 108:15 142:19 148:11 148:20 152:3,13 154:9 177:2 228:18 229:14 240:13 243:8 268:19 284:16,18 308:17 314:5 317:22 318:2,4,15,20 328:10 329:10,22 335:12 339:18 345:5 349:14 353:16 354:12 365:8 379:16 380:2 393:21 393:22
issues 5:16 6:7,14 15:20 19:5 22:3 38:9 46:18 77:22 78:17 84:8 118:19 125:6 127:6,9 128:1 130:5 130:18 143:2 155:10 161:19 163:9 172:2 206:22 244:22 300:15 306:22 312:17 317:15 328:6 332:14 337:16 340:11,14 353:13 354:17 359:19 361:8 361:11 363:1,12,19 365:6 371:7,18 375:3 379:1 381:10 382:6 382:14,15 383:6,16 398:12 399:2 400:7 400:14 401:5 404:18
it'll 39:4 40:11 43:6 150:8 380:17
item 198:7 245:16 249:1 250:20 362:17
items 170:6 187:20 203:1
iterate 51:1
iteration 342:17

J

JANUARY 1:6
jawbone 312:1
JD 2:6
Jean-Luc 3:7 70:4 72:8 72:10 77:10,14 78:4 79:7 80:8 81:4
Jenk's 143:12
Jesse 3:15 383:7,9 387:10
job 30:4 149:8 235:19 237:5 240:1 241:2
Joe 1:13 10:13
John 1:14 3:2 11:3 37:13 166:15 177:16 178:21 179:7 186:15 190:2,7 199:21 215:4 217:11 226:18 229:2 249:2 350:19 369:4 369:12 373:6
JOHNSON 3:3
joined 16:13 64:19 72:10 214:7 272:8 299:14
joint 1:16 12:9 241:16
judge 107:20 108:4 306:19 307:3
judgment 152:16 313:17 314:3
judiciously 35:20
July 171:3
jump 113:10 115:11 128:10 133:11 267:10 372:6 400:17
June 258:14
justify 390:12

K

KAREN 3:3
Kate 2:19 3:5 16:17,18 17:7 22:13,17 30:13 30:17 43:20 48:21 64:15 68:5 83:17 90:15 103:2 110:9 146:14 226:6 242:3 268:20 314:22 316:17 317:4 359:22,22 364:5 375:5 382:21 383:7 403:12
Kate's 94:13
KATHRYN 3:3
Kathy 359:3
Katie 37:18
keep 40:3 63:6 101:1 138:11 164:4 191:7 241:2 260:4 270:22 288:22 297:3 327:7 327:14 384:1,2,12
keeping 172:12 184:10 240:18 284:15 285:2
keeps 105:1 339:12
kept 184:16
kettle 218:1
key 28:4 49:6 72:3 78:5 78:5 114:14 122:8 150:2 155:21 184:20 363:2 365:10
keypad 359:7 403:5
keystone 380:14
kick 127:4
kidney 382:4
kidneys 392:1
kinds 25:20 155:9
knew 25:8
knowing 107:18 318:8 393:10
known 23:2 31:6 98:17
knows 69:18 175:3
Koryn 3:16 169:15 172:1 177:19 298:3
Kramer 2:1 10:8,8 51:5 200:18 223:3 260:12 264:8 265:7,13 266:18 267:1 269:22 278:1,4,7,15,16 280:14 281:17 291:10 306:17 307:20 308:19 309:6 320:18 321:7 321:19 322:2 370:11 370:15 372:13,18 378:17 404:16 405:1 405:5
Kramer's 226:4 264:22
kumbaya 381:1

L

La 2:2 12:21,21
labs 388:22
laced 187:4
lack 67:18 111:5 112:8 122:7 170:1 202:19 284:20 333:2 379:3 400:19
lacked 171:8
lacking 205:1 260:14 379:7
laid 127:22 128:21 129:9
Lamb 3:11 72:12 77:9 77:10 93:2
landed 111:18 116:4,17 129:12
language 184:1 198:11 198:14 210:14 349:7
large 143:14 297:21
largely 110:14 145:3
larger 236:6 265:15
lastly 192:7 384:19
latest 323:12 326:19
Laughter 9:15 13:7 104:15 153:19 225:16 369:22 370:14 381:3
launch 141:17
launched 143:12
law 188:4 316:5
lay 112:21 113:8 129:15 215:4,18
laying 129:21
lead 22:14 53:1 59:4,11 59:16 72:1 82:11 127:17 163:10 353:6 370:12,12 372:5
leadership 53:19
Leah 1:13 11:10 72:1 88:15 140:7 259:19 282:13 299:6,15 314:21,22 316:16 317:3,4
leaning 229:5 230:3
Leapfrog 1:13 11:11
learning 23:19 151:6
leave 17:16,16 100:14 101:18 105:7 197:4 339:3
leaving 164:12
led 26:13 112:6
left 9:19 25:16 191:2,5
legal 289:15
legislation 107:11
lend 144:6
length 184:14 211:5 385:17
lengthier 14:15
lens 26:8
let's 42:15 52:2 66:18 70:14 100:8 101:2,3 135:4 155:5 159:20 162:10 190:15 195:9 195:10 202:1 221:1,4 224:9,10 225:11 226:5,18 230:10 235:4 242:15 245:3,4 246:18 248:22 249:17 251:8 261:2,12 263:7 264:2 272:5 276:13 282:6,7 286:2 287:2 288:8 290:12,13 297:3 306:14,15 311:18 324:7 330:22 334:5 344:1 345:6 354:12
letter 210:20
letting 405:22
level 89:1 97:17 121:1 124:9 138:6,7,8 139:20 140:1 144:2 148:13,15 149:1,10 160:16 174:15 181:18 203:4 204:9,10 216:5 216:10,12,19,20 217:20,22 218:1,3,3,6 219:5,7,13,16,19 306:6 346:8
levels 93:3 118:3,8 203:6 240:6
Levitt 91:7,10
Liaison 99:2
liaisons 2:13 17:10 98:21 103:22 164:11

164:21
liar 104:3
liberties 132:6
lies 389:14 397:12
life 74:3
lifecycle 24:2 25:4
lifecycles 25:11,22
lifetime 339:5 340:5
lifting 404:14
light 172:10 271:22
likelihood 256:4
Likewise 18:1
limit 57:6 61:20 70:21 70:22 169:5,7
limited 85:7 106:4 112:2
limits 111:7
LIN 2:3 176:2 186:10,14 343:8,21
line 7:15,19 77:6 155:10 175:5 179:11,13 184:22 193:15 203:21 211:9 229:15 254:2 274:2 329:2,5 335:4 351:20 354:1,3,7,7 359:4 394:7 397:1
linear 66:15
linearly 264:18
lines 358:16 386:12 387:5
lineup 372:17
linked 61:12 232:5 253:2
list 22:16 24:11 26:14 29:11,12,14,22 42:3 44:5 47:1 60:5 63:2 63:11 79:10 84:18 169:8 170:19 171:2 182:6 185:6 189:9 190:6,10,15,20 191:17 196:6 200:19 215:21 264:20 265:1 364:15 365:3 370:18 373:2,5 374:14 375:6 376:9,12,13 377:14 377:21 378:14,19 380:15 381:14 382:4 382:21 384:3,13 385:18 388:10 389:19 389:20 390:16,19 391:6 393:12
listed 327:3 365:11 369:9 371:16 384:1 390:19 398:16
listen 20:17
listing 388:22
lists 41:19 200:18 386:5
literally 24:20
literature 184:8
litigate 260:2 307:14
little 7:11 9:7 27:6 42:2 44:21 46:9 70:7 72:16 73:9 79:8 96:12 102:16 105:3 106:18 111:17 123:3 128:18 134:22 138:16 149:4 157:1 172:4,7 174:6 175:9 180:2 182:9 193:21 196:22 200:4 206:17 212:7,15 215:11 236:21,22 244:6 262:12 270:12 304:6 334:21 340:2 387:17 394:17 397:16 399:21
live 327:14 392:10
lived 86:17
lively 52:17
living 376:14 391:4
loading 66:5
located 390:9
logic 340:7 347:6 397:4
logistical 167:21
long 23:13 85:21 91:3 94:3 96:14 100:14 147:11 154:7 288:3 291:16 332:4 357:16 359:22 382:20
long-stay 83:21,22 84:2
long-term 6:4 90:4,17 93:8 147:7
longer 52:10 80:18 84:8
longer-term 82:19
look 23:1 29:4,10,12 37:17 40:4,13 45:16 77:16 110:5 117:11 119:3 129:18 133:14 133:15 142:10 148:8 161:6,21 169:11 172:9 175:4 176:15 187:7 203:3 209:16 212:16 222:1 228:12 230:2,22 231:8 237:6 241:13,18 244:4 245:5 253:21 254:21 268:19 283:4 307:17 313:14 328:17 334:20 344:9 373:7 375:13 382:22 395:22
looked 26:8 108:22 126:1 128:11 145:21 149:6 175:18 209:20 323:11,11 347:14 352:7,16 353:7 363:11 364:8 391:7
looking 37:13 40:7 42:12 74:12 78:2 93:11 125:8 140:17 141:4 142:12 143:13 165:19 174:10 175:8 177:21 184:9 208:10 215:15 222:19 236:21 242:2 269:14 285:10 333:20 343:9 348:3,7 348:14 350:2 373:11
looks 177:22 197:8 222:17 310:2 323:18
loop 41:14 44:12 45:10 151:7 207:8 210:7 211:21 310:7,11,15
loosely 112:11
lose 64:10 266:7
lost 46:1 91:5
lot 6:10 25:5 26:15 28:8 39:21 40:15 41:2 43:9 43:9 45:19 53:13,17 77:15 78:2,15 79:5 84:14,15 86:15 87:3 91:18 96:18 118:5 125:12 127:22 130:16 144:8 150:15 154:19 158:22 170:6 180:20 181:3 182:4 184:3 185:8 224:10 235:19 237:7 270:21 284:16 318:22 320:6 321:8 321:20 329:19 350:21 351:7 362:22 365:5 368:4,13 373:2,14,16 377:18 378:19 381:7 382:1,19 384:15 385:14 388:11 390:8 392:21 393:11 398:16 403:17,17
lots 78:19 80:4 174:1 270:19 385:2
loudly 226:10
love 330:20 397:8 399:8
low 63:9,17 75:8 270:19 270:22 282:7 367:7
low-hanging 242:4
lower 229:18 282:4,4 374:20
lower- 241:3
LTEC 75:11
lumbar 367:7
lunch 158:14 162:12,13 162:22 179:6

M

M.D.s 178:1
MA 1:13 2:11 284:4
machine 220:20
Mackay 2:4 13:8,8 279:12
MACRA 77:21 107:12 145:21
MACRA's 145:18
magic 165:14
mail 83:6,9,12,14 85:10
mailings 81:6
main 25:2,14 126:16 361:13 383:16
maintain 105:12 259:13 273:1 384:18
maintained 384:3
maintaining 76:2 376:13
maintenance 75:21 255:20 256:12,14 260:19 395:22
major 15:22 183:3 318:3,4 361:3 365:12 367:14
majority 65:21 176:20 178:6 180:9 398:16
makeup 53:19
making 29:5 59:2 65:11 72:21 114:1 120:10 149:13 160:18 162:5 175:21 217:8 241:12 241:16,20 254:9 270:3 282:2 292:16 319:22 320:5 342:4 376:20
malaligned 374:11
man's 6:19
manage 228:6
Managed 2:9 12:15
management 74:1 76:6 334:18
Manager 3:3,5,7 30:18
managing 106:12
mandated 47:20,21
mandatory 121:17 123:20 149:16 247:2
manner 18:3 215:14
manual 284:21
map 4:6 6:7 7:11,12,16 19:1,7 20:10 23:12 24:9 25:22 26:22 27:9 30:21 31:8,10,21 32:1 32:4,12,14 33:18,22 34:4,8,18 40:1 42:17 44:2 49:7,19 50:7,8 50:18,21 52:16,21 54:8 55:13 62:4,17,19 62:20 63:8 68:15 73:16 74:22 92:18,20 107:9 108:1 109:22 115:18 125:5 156:7 160:3 161:14 163:21

163:21 164:9 169:17 170:15 179:9 197:10 197:10,10 209:12,19 209:21 210:6 213:10 237:12 240:18 257:6 257:8 258:21 266:20 290:20 291:2,3 297:13 319:2,4,8,14 320:21 332:16 335:10 340:18,19 349:6 350:2 359:13 362:5,8 362:10 363:16,18 379:13
MAP's 31:17 34:21 41:20 51:15,17 240:1 241:2 307:11 308:6
mapcoordinatingco... 274:4
mapcoordinatingco... 56:4 60:16 99:12 223:9
mapping 345:16
March 62:10
Marinelarena 3:4 359:11,12 368:17 369:3
Marissa 2:9 12:14 43:21 44:18 46:20 236:18 254:22 255:4 256:20 294:12
market 257:13
Mary 1:14 2:17 214:9 214:10,11,12,20 345:8 347:12
matches 66:14
materials 7:8,9,13 350:15
math 279:22
Mathematica 16:6 350:12 351:19
matrix 39:9 148:7
matter 1:12 14:14 27:18 48:18 105:18 163:2 175:6 227:16 232:17 241:5 319:21 358:1 406:9
matters 53:14,16
Maureen 1:20 14:1 18:11,19 86:14 222:13 247:22 250:13 273:14 372:10,16 373:22
Maureen's 223:2
MBA 1:14,16,18 2:1,3,8 3:18
McQUESTON 3:5 360:9 365:19 375:5 386:22
MD 1:11,12,15,17,18,21 2:3,5,6,8,10,17,19 3:10,10,12,15,18,19
mean 6:15 13:3 15:13 27:19 41:8 53:9 67:21 74:8 83:20 92:10 97:20 111:9 137:19 140:2 150:1 168:19 168:20 177:4 184:2 186:5 189:18 194:4 194:11 195:6 196:17 200:21 205:20 206:10 209:2,5,7 211:1,10,17 217:1,7 219:17 220:3 228:7 236:16 238:12 239:12 241:8 242:3,6 242:22 244:11 247:4 252:6 255:14 256:5 264:17 280:2 281:13 282:10,11 284:6 285:9 293:7 294:1 304:20 311:20 315:22 316:20 318:9,17 320:2,2,3 323:17 324:1 327:6 333:14 333:15 334:10,16 338:21 339:9 340:7 353:14 380:10,20 381:6 389:20 390:6,7 405:6
meaning 39:19,21 203:5 331:10
meaningful 26:4,12 27:16 28:16 47:7 123:5 124:19 148:4 157:12 342:2
meaningfully 118:19 124:4 386:4
means 131:9 201:21 210:9 217:16 224:19 257:11 280:11 328:13 335:18 348:9
meant 23:20 32:19 74:4 85:3 197:11 202:13
measure's 311:5
measure-developer 124:12 138:14
measure-developers 27:22 117:3
measure-development 25:4
measure-selection 32:4,12,13,18,20 33:8
measure-specification 117:12
measured 124:5,10,20 228:14 270:15 271:3
measurement 3:6,14 8:6 17:3 23:7 28:11 33:4 48:12 74:14 107:1 113:5 125:19 142:7,13 180:22 214:14 217:21 231:13 258:13 281:22 361:10 362:19
measurements 143:5 282:3
measuring 28:2 94:14 121:3 185:13 238:11 238:19 303:4 395:4 395:16
mechanism 117:7 120:22 262:9 285:6 285:12 363:8
med 362:4
Medicaid 2:2,20 3:15 3:19 12:1 13:1 16:19 214:19
Medicaid-related 11:22
medical 1:19,21 2:3,10 3:16 12:12 13:16,18 16:21 130:17 169:16 217:22 272:12 327:2 331:21 398:10
medically 181:14
Medicare 1:13 2:19 3:15,19 10:14 16:19 96:20 180:1,8,11,15 185:7,21 188:17 214:18 229:8,20 337:7 390:4
Medicare- 132:8
medication 74:1 76:6 192:5 277:12 278:14 362:2 364:12 365:1
medicine 393:19
MedPAC 187:20
meet 123:21 149:18 211:8 275:17 321:11 343:11 349:21 378:1 389:22
meeting 4:3 7:10 17:19 27:9 35:13 41:15 44:6 55:8 62:5 63:1 72:4 78:18 81:22 82:4 104:18 132:8 188:7 189:18 251:20 304:11 313:1 361:1,2 398:7
meetings 19:6 29:20 34:13 54:21 56:16 184:20 303:9 377:15 377:17 378:2
meets 88:13
Melissa 3:4 359:12 383:7 400:12
members 8:13,16,17 9:6,12,17,21 13:12 19:9 31:22 34:13 38:7 56:21 57:2,5 59:4 60:14 63:8,18 99:5,14 103:16,17,18,21 164:9 172:13 173:20 173:20 198:4 214:7 291:3 300:9 301:12 305:20
memo 246:14
mental 75:12 93:6 130:16
mention 183:4 218:16 246:20
mentioned 97:5 131:17 147:15 180:6 183:19 184:19,20 191:9 300:7 383:14 387:1 387:11
merit 269:3
merit-based 180:7
message 87:11 321:8 349:1
met 1:7 31:10 36:22 37:1 47:5,6 206:14,14 304:12
meta-analyses 303:16
method 216:8
methodological 383:1
methodologies 147:18
Methodologist 352:8
methodology 108:8 119:2
methods 124:3 205:12 375:10
metrics 306:3
metropolitan 392:9
MGA 1:13
MHA 1:20 2:6 3:18
MHS 2:19
mic 29:17 36:18 73:10 138:17
Michigan 109:10
micro 399:7
Microphone 285:17,19
microphones 226:11
mics 163:11,12
middle 17:19 125:11
midstream 292:18
miff 145:1
mind 24:17 40:3 63:7 70:13 146:14 150:17 161:12 164:4 172:12 184:10 201:16 205:9 273:17 283:4 285:20 303:18 327:7 385:5
mindset 142:22 143:7
minimal 160:4
minimum 116:11,13

123:22 150:6 306:7
minimums 282:12
Minnesota 3:14 126:3 258:12 259:10 269:7
minor 64:6 204:16 257:11
minority 68:14
minute 95:15 111:9 249:6,7 356:1 357:18
minutes 22:20 30:20 61:21 69:10 71:1 169:7 244:11 252:15 297:2 386:18
MIP's 145:18
MIPs 105:13 179:22 180:6,10,11,13 181:20,22 182:11 185:6,11,20 187:20 188:18 190:22 191:3 191:8 192:7,9,12,15 200:2,9,17,19 208:17 226:22 227:6,12 231:14 233:11 234:6 238:3 245:7,7,14 246:22 247:5,12,14 249:20 250:4,5 251:14 261:15 264:7 264:7,10 265:11,18 265:19 266:3,10,12 266:17,21 267:2,3 270:4,6 271:8 272:2 273:4,6,6,7 276:16,17 276:18 277:17 278:1 278:9,15,20 279:3,13 280:18 282:11 284:7 297:8 331:4 356:10
Mira 1:21 13:17,21 221:15 223:1
Mira's 247:17,21 273:14 275:16
Miranda 77:14
mirror 373:22
mirrored 76:20
mirrors 380:6
misinterpret 374:11
misperception 48:7
missed 40:21 138:2 267:10 317:1 383:8 401:20 405:2
misspoke 163:20
misunderstanding 95:21 202:19 307:17 335:9
misunderstood 198:9
mixed 176:21,22
modal 206:15
mode 85:19
model 94:17 111:2,4,10 112:10,16 113:16 114:11,15,20 115:4,9 115:13 116:9,14,18 116:20 120:3,8,15,16 121:18 122:14,17 123:4 124:8,10,15 125:20 126:5 127:11 129:4 130:2 136:17 137:15,17 140:9,10 141:1,14 142:4 150:11 188:17 281:13 297:16 331:16 375:14 375:19 383:19 384:4 385:15,19 387:18 397:4 404:18
modeled 142:8
modeling 387:12
models 97:2 108:15 109:7,11,16,17 110:13,14,17,20 111:1,6,22 112:21 113:16 114:21 115:5 115:6,19 116:2 119:4 119:7,18,20 121:7,8 122:4,19,22 123:15 123:20 124:18 126:1 126:12 128:15 137:5 143:4 148:3 149:15 157:7 336:4 397:21 397:21
modes 83:8
modifications 34:6
modified 295:4 405:2
modify 404:21
modifying 291:21
moment 30:16 58:3 80:22 95:12 163:11 221:19
momentarily 163:15
moments 232:6
money 152:2
monitor 103:3 104:21 396:8
monitored 126:11
monitoring 140:10 301:5
month 210:16
months 260:1 303:17
morning 8:4 11:5,12 12:8,11 45:2 72:9 77:9 105:11 163:18 165:3 188:14 262:20 405:11,16
mortality 166:18 367:22 368:6,10 369:13 370:21 373:8,10 374:2 390:18 400:1,3 400:5,13
mother 154:21
mother's 85:12
motions 66:18 67:2,10 287:12 293:22
motivating 128:2
mouth 132:12
move 27:12 48:3 72:21 73:3 77:17 78:3,20 86:7 96:12 105:10 107:10 108:13,18,21 109:19 119:22 123:10 141:21 142:16 163:17 175:5 176:16 220:18 228:20 240:9 251:8 252:8 263:14 266:19 271:1 288:8 289:22 290:3 292:1 298:15 309:15 311:9 312:20 320:19 330:22 342:11 370:20 394:13 397:5 397:14
moved 45:20 105:3 108:20 249:16 355:13
moves 379:8 399:10
moving 78:12 101:2 106:5,17 123:14 156:16 226:20 243:9 263:10 282:2 298:14 298:20 367:8 374:20 379:21 399:5 405:15
Moyer 3:12 179:11,15 179:19 183:13,15 202:4,8 207:18 230:21 254:1,13
MPA 2:3
MPH 1:11,17 2:4 3:2,5 3:16,19
MSN 1:20 3:14
MSSP 145:4 188:18 191:4 192:13 200:3,8 200:10,19 201:21 208:17 226:22 227:13 231:17 233:21 234:5 235:19 247:1 251:5 264:7,10 265:11 270:5 277:19 278:2,9
MSSW 1:14
MUC 22:16 42:2,3 44:5 63:2,11 78:1,8 79:10 84:18 100:9 169:8 171:2 173:2,3 182:6 370:17 376:9 378:14
MUC17- 369:8
MUC17-139 215:21 225:5
MUC17-176 362:1
MUC17-181 191:22 226:20 247:13
MUC17-194 192:1 251:13 261:16
MUC17-215 192:2 264:5
MUC17-234 192:3 200:8 277:11 278:13
MUC17-258 406:4
MUC17-262 192:5 297:6
MUC17-310 324:10
MUC17-363 192:8 331:2
MUC17-367 338:5
MUC262 323:1
MUCs 31:6,12 34:17 58:8 61:18 71:2
Mulhausen 3:12 72:12 79:1,2 88:1,2,5
Mullins 2:5 10:11,11 135:19 230:13 237:21 283:10
multi- 113:6 122:4,15 300:5
multi-dimensional 113:15
multi-stakeholder 24:5 112:14,19
Multi-stakeholder's 172:5
multi-stakeholders 172:19
multi-vessel 300:3,12 300:17 301:16 302:1 302:7,22
multi-year 25:7
multiple 24:20 118:20 138:15 142:11,11 156:17 182:16 206:22 233:8
Munthali 3:5 8:2,5 9:16 10:6 13:11,21 14:10 16:10 17:9,15 18:15 18:18 103:4 167:4,7 167:10,12,16 168:1,4 168:12 172:15 173:13 214:4,6 255:19 256:7 256:16 272:7 292:14 293:1 342:21 344:16 349:22 350:17
musculoskeletal 367:11
muster 292:12
myocardial 192:5 297:6

N

N 98:15,18 100:16 102:13 104:5 165:16 225:19

N.W 1:8
Nagavarapu 3:13 299:12,13,22 302:10 304:21,22 335:5,6 337:21
name 8:4 13:13 30:17 179:7 359:12
Nancy 377:8
narrative 330:8
narratives 233:2
national 1:1,7,19 2:2,4 2:11,15 8:6 11:1 12:22 13:9 14:5,8 17:12 33:3 78:17 113:19 214:14 305:6 305:19
nature 25:11 97:10 143:2 281:19 371:6
NCQA 16:8 17:2 214:9 214:15
NCQA's 345:15
near 391:5
nebulous 196:14
nebulousness 213:12
necessarily 53:18 123:17 132:11 142:14 156:8 160:9,19 175:13 212:13 280:1
needed 25:22 113:8 145:16 164:15 204:7 301:6 350:16 398:19 398:20
needs 34:2,6,11 35:21 86:10 90:22 107:17 108:15 123:5 127:17 130:8 140:10 149:5 170:21 183:22 185:1 185:7,12 190:14 206:13,21 207:1,9,11 217:18 219:11,12 223:7 260:15 293:16 303:2 313:17,19 314:17 321:1,9 327:13 344:8 379:15 379:16,16 392:15
nephrologist 376:7 377:1,14 378:9 380:14 381:19 383:10
nephrologists 377:16 377:22 380:18 393:14 397:13 398:9
nervous 154:3
net 280:19 281:5
network 2:7 11:6 151:6 378:7
never 70:13 91:5 124:21 234:20 395:9
new 16:4 23:12 27:9,10 27:13,13 55:15 57:11 57:16,17,19,21 58:15 58:15,18 59:10 62:20 73:8 74:14 97:2 142:12 146:4,12,19 194:21 214:6 230:2 238:22 241:13 254:21 257:12 258:15 298:2 301:21 302:15,15 303:15 317:8 329:9 345:22 392:8
newer 181:20 241:11 241:17 253:21 315:18
nicer 330:18
nine 103:16 195:3 236:12 239:1,2 250:10 273:13 275:10 275:10 360:11
nineteen 165:14 250:12
no-longer 90:16
nobody's 374:21 399:17
noes 102:1 274:21 275:1,6,8 277:3
nominated 15:6
non- 239:7
non-provider 176:20
non-value-based 399:3
non-voting 2:13 98:22 99:18
normal 135:12 257:1,2
north 113:20
not-support 32:10
note 32:17 34:19 35:5 58:1 73:16 76:17 94:6 180:12 301:20
noted 35:22 63:15 75:20 77:1 112:8 305:11 361:15,19 362:6,9,22 375:17 392:4
notes 75:1
noticed 90:3 107:22 396:3
noting 113:5 122:7
notion 211:4 310:13
notions 152:6
November 35:13
NQF 3:1 5:13 6:16 7:8 17:22 19:1 30:3 31:18 34:2 42:8 50:2,13,16 51:4,7 52:16,21 77:11 80:18 81:18 82:2 91:5 91:5 125:15 138:15 139:11 140:4 150:14 150:18 163:22 172:4 174:22 204:17 205:8 205:11 206:15 208:5 209:10,13 211:14 212:4 217:17 218:4 218:10 237:3,7,10 257:2 260:15 286:12 297:11,13 307:8 308:3,21 309:1 313:7 313:14,18 314:17 315:22 318:21 324:13 325:11 326:12 331:7 332:4 338:16 341:6 342:6,18 344:2,5 345:15 346:21 349:4 349:6,10 350:4,6,16 351:17 363:8,15 364:14,18 366:6,14 367:11 371:4 375:8
NQF's 51:14,16 177:12
NQF- 316:5
NQF-endorsed 79:15 255:16 310:3 316:7
NQS 113:22
nuanced 69:5
number 20:7 26:5,14,17 29:11 33:19 36:15 38:22 39:17,19 48:5 52:16 57:7 64:20 66:20 71:14 74:14 102:6 103:15 117:17 127:14,16,19 165:13 165:15 172:16,16 173:7,10,18 177:21 178:16 191:21 205:4 229:16 283:13,15 351:9 352:7 370:18 376:13 391:8 399:22
numbers 64:15 104:21 164:7 178:4 195:7 306:11,13 406:6
numerator 343:17
nurse 178:3
Nurses 1:14 214:10
nursing 80:14,16 91:17
nursing-home 91:1 143:22

O

O'Brien 2:6 11:8,8 65:9 66:4 67:7 271:6 282:17
O'ROURKE 3:7 7:4 37:13 41:12 43:14 49:22 50:14 64:14 68:3 69:11,17,22 82:10 83:7 104:13,20 105:9,21 113:12 120:4 132:5 134:2 161:4 163:14 177:8 203:18 205:3,6 209:18 212:12 222:13 222:17,22 224:1,3,6 225:19 226:1 249:2,9 250:22 290:19 308:2 308:13 338:3 349:5 349:13 358:8,12,15 359:3 369:12,20 381:6 403:12 405:8 405:20
object 293:7 323:6
objection 58:7 293:6 296:3 299:18,20 317:7 323:4 324:6 356:17 357:10
objections 296:17 334:8
objective 6:1
objectives 4:4 5:18 6:1
observation 79:14 81:18 88:2 291:11 292:7
observations 63:5 80:5 270:13
observed 335:18,20
obviously 20:11,17 22:2 27:9 71:5 82:18 94:18 101:15 125:6 125:14 134:4 157:19 157:22 166:11 190:4 207:13 210:13 211:17 308:10 311:22 340:9 352:15 366:22 397:7
occasional 79:20
occupies 142:1
occupy 142:2
occur 212:5 302:18
occurring 302:5
occurs 46:16 183:8
Off-microphone 264:15 272:18 276:4 322:15
offended 382:12
offer 51:6 121:8 157:14 245:12 279:16 287:9 353:20 376:17
offered 212:7 245:21 323:21
offering 253:13
office 2:15 17:12 284:3 284:5
Officer 16:21
offices 86:19 286:12
official 149:21
OGUNGBEMI 3:6 97:22 99:17,21 100:16 220:21 221:2,11,18 222:3,6,8 223:7,13,17 225:4,9 247:7,11 248:18 261:11,14

old 23:4 347:15
old-fashioned 101:3
older 239:3
ONC 2:16 141:20
once 58:4 98:5,17 140:11 141:11 147:15 149:12 151:21 158:7 182:7 209:20 249:11 302:12 317:15 341:14 346:18 354:18 384:22
one's 82:10 238:4,10
one-time 339:5
ones 41:21 174:22 187:5 189:9,13,21 190:12,21 191:17 193:4 223:21 259:4 355:20 359:18 394:8 405:18
ongoing 28:3 89:8 169:22 257:18 301:2
online 277:7 299:12 305:7
open 7:15,19 57:5 59:11,17 66:21 98:5 98:17 100:12,15 124:18 142:12 162:15 163:11,12 179:11,13 222:10 225:9 247:14 261:17 354:7 358:16 359:4 374:7 376:1 400:6
opened 98:2
opening 162:9 186:19
openness 15:16
operational 329:22
operationalize 51:3
operationalized 204:5 204:18
operationlized 206:6
operations 89:8
operator 7:18 71:12,16 178:14,18 354:5,6,8 359:5 403:3
operator's 71:11
opinion 39:22 69:1 242:9 289:15
opinions 68:8,12,15
opioid 75:3 78:17 191:15 215:22 368:11
opioid- 63:19
opioid-related 368:2
opportunities 61:18 71:2 73:17 74:14 169:8 184:10 212:20 362:3,12
opportunity 4:7,10,16 29:3 61:14 62:16 71:20 81:21 158:8 163:7 179:2 210:12 213:6 237:4 240:15 285:7 301:12 374:5 398:8 400:2
oppose 259:11 286:20
opposed 46:10 232:12 255:17 263:20 270:1 287:21 322:18 402:17
oppositions 402:18
optimal 191:20,22 192:1 208:13,14,14 226:21 232:17 234:16 234:20 247:12 251:3 259:5 261:15 266:8 278:19 356:9
optimally 33:2
optimistic 319:6
option 60:1
options 155:14 384:16
oral 171:10
orally 214:9
oranges 39:4
order 101:1 111:20 119:20 203:2 235:10 288:11 289:17 300:13
ordered 194:7
orderly 202:2
org 274:5
organization 8:18 235:12
organizational 8:14,16 8:17,21 9:6,12,17,20 10:2 13:12 18:19 234:2
organizations 89:9 175:18
organized 55:17 215:14
orientation 106:21
original 61:3
originally 277:22 295:13 405:19
ought 186:20 187:3 210:11 211:21 260:13 322:6 347:20
outcome 73:20 76:13 83:2 108:2 118:19,21 121:3 140:15,21,21 141:3 184:4,15 185:18 205:13 212:9 232:13 234:10,17,20 314:13 339:8 363:3 371:1 372:22
outcomes 28:19,22 90:20 108:5,9,16 117:4 122:20 123:4,6 124:5 125:1 131:1,2,7 131:8 141:4 363:20 370:19
outliers 121:20 124:6
outline 19:2
outpatient 367:5
outside 21:14 239:10
over-treatment 229:9
overall 72:18 141:1 385:22
overlaps 34:9
overlooked 170:6
overly 292:7
overnight 53:8 161:20
override 288:18
oversees 179:22
overturn 322:5
overview 31:3 55:6,12 78:4 179:21 180:3 186:1 360:1,4,22 368:19
overwhelmed 86:18
overwhelming 248:3
overworked 238:17 283:18

P

P 385:11
P-for-P 94:9,17,18 145:3
P-for-V 94:10
P-R-O-C-E-E-D-I-N-G-S 5:1
p.m 163:1,3,4 358:2,3 406:10
PAC 69:12 73:4,6 123:13 187:11
PAC/LTC 3:11,12 4:7,9 55:19 62:10 70:4,15 70:17,19,22 71:3,22 72:11 74:9 102:21 106:4 403:13 406:3
Pacific 2:1 3:16 10:9
package 189:20 199:19 243:2,7
packaging 283:14
Page 4:2
paid 15:8 135:7 139:1,8
pain 367:7
painful 292:16
pairs 150:21
panel 110:5 113:14,19 114:19 121:18 122:6 122:13,21 123:9,19 124:16 129:11 205:12 345:10 375:11,18
Panels 138:15
paper 109:20 110:3,11 112:8 114:9 138:13 146:9 150:5 158:8 194:8 378:10
paperwork 28:8,21 166:20
paragraph 186:18
parameters 257:10
parent 86:17,18
parliamentary 249:11 288:14 289:17
parsimony 362:7
part 20:2,19 23:21 26:15 28:15 51:6,11 54:19 81:12 113:4,13 114:22 133:15 141:16 142:15 146:20 147:17 151:13 152:4 160:10 170:7,18 187:16 217:2 218:20 239:10 255:9 265:15 267:18 267:19 293:10 332:3 349:1 383:22 389:15 395:20,21 399:9 405:3
partially 387:21
PARTICIPANT 176:22 200:13 201:4,8 214:2 219:6 220:14 223:18 225:13 230:14 242:17 242:19 243:19,22 249:16 258:5 341:7 341:10,12 343:20 345:3 348:21 349:15 350:5 351:17 355:13 357:20 395:18
participants 99:1,18
participate 104:14 127:17 226:11 377:17
participated 165:1 167:16 369:14 377:15
participating 60:14 102:17 221:13 261:20
participation 141:10
particular 8:18 75:22 80:22 83:5 88:6,21 93:18 139:20 140:19 188:7 206:18 220:2 220:10 234:17 251:13 252:3 267:17 316:7 338:16 341:1 342:9 344:1 361:22 363:11 371:8 374:22 375:2 375:12 392:20 398:12
particularly 75:13 94:21 171:9 218:8 375:14 397:20
partly 211:3
partner 372:10
partnering 132:18
partners 9:22 16:16 126:2

partnership 1:3 2:4 13:9 318:22
partnerships 74:8
parts 8:12 56:18 265:15
pass 22:6 49:9 60:19 66:8 68:10 154:1 164:1 165:20 166:6 197:1 221:5 276:10 288:18 290:22 292:12 308:6 351:19 352:21 356:11 364:3 367:16
passed 357:15 380:22
passes 295:5 307:9
passing 173:18
pathway 130:14
patient 28:18,22,22 73:7 78:12 79:11 80:17 81:16 85:6 89:7 91:15 97:15 108:10 108:16 124:21 130:21 132:19 137:12,17 138:2 145:18 146:17 146:22 147:8 153:3 154:14 157:17 223:1 229:17 234:12 241:15 253:3 314:12 333:3 338:12 362:14 363:20 381:14 382:10 384:16 384:19 386:4 388:1,5 388:13,14,16,17 389:2,10 393:15 394:2 398:15,18 399:11
patient's 80:20 123:4 137:21 148:4 182:9
patient- 83:1 90:19
patient-centered 87:7,8
patient-reported 73:20 76:13 80:10 82:17
patients 28:8,20 29:9 63:4 94:22 95:1,2 108:9 114:4 119:21 126:8 136:9,11 229:10 231:3 233:9 239:7 241:5 281:6 298:11 300:4 331:22 335:2 361:6 364:12 365:10 366:3 369:9 371:1,9,15 376:11,12 377:4,6,13,21 378:3 378:12 379:8 382:9 384:1,13,20,21,22 385:17 389:17 390:1 390:4 393:2,5,9 394:1 394:13,15
patients' 382:18
Paul 3:12 72:12 77:5 78:22 79:2 82:6 88:1
pause 166:9,14 178:17 221:22 304:2
pay-for- 94:10
pay-for-performance 107:17
pay-for-value 145:11
payers 137:9 361:14,17
paying 27:12
payment 32:16 97:2 108:14 121:15 123:21 143:4,5 144:6 149:16 151:6 180:7
PBGH 239:19
PCHQR 365:18
PCI 300:3,6,17 301:16 301:19 302:1,7,7,11 302:22 306:7
PCIs 300:13
PCPI 150:17,19 151:4
peer-reviewed 184:7
pejorative 282:20
penalized 336:8 391:4
pending 209:10 297:11 349:9 366:21 371:4
people 5:14 20:13 21:2 27:4 53:7 54:13 59:10 59:19 64:12 67:1 68:12 71:20 78:11 79:22 80:6 82:19 85:13 96:19 98:15 99:7 101:8 102:9,11 102:17,19 104:13 145:1,1 152:6,11 159:3 164:14 165:16 165:17,22 166:5,7,10 166:14 173:7 175:8 199:15 207:7 215:7 221:13 222:18,21,21 226:8,9 240:20 241:4 242:21 245:12 250:9 261:20 264:12 267:19 275:15 277:7 283:17 283:21 290:22 291:7 303:5 305:7 315:5 379:4 381:11 382:16 383:17 390:22 391:6 392:22 394:5 400:2 402:10,11 405:22
people's 381:21
perceived 337:4
percent 42:21 49:8,20 50:1,3 51:12,19 52:4 53:4 54:4,11 60:19,20 61:2 65:19 66:19 69:4 80:1 96:20 103:4,12 104:2,11 163:22 164:2,4,5,13 165:20 165:22 173:19 225:21 225:21,22 226:1 229:11,13 234:18,19 235:5,7,9 248:19,19 276:10 286:16 288:4 380:19
percentage 42:20 369:9 371:15 377:20
perception 203:4,15
percutaneous 192:6 297:7
Perfect 10:6
perfectly 316:19
perform 79:22 80:6 366:18
performance 3:3 17:2 76:2 78:16 94:11 107:21 114:6 121:4 122:12 133:18 134:12 182:10 214:13 297:21 300:21
performed 118:22 134:14 300:17 336:14
performer 140:19
period 61:22 70:6 133:6 229:11
periods 61:10,11
perplexing 157:6
person 25:16 92:11 94:14 102:12 104:17 137:18 234:13 253:13 330:19 351:22 361:2 380:20
person's 6:20 346:12
Person-and-Family-... 76:15
personal 52:20 228:5 242:9
personally 12:2 29:3 30:10
persons 6:21,21
perspective 8:18 58:19 63:3 172:20 182:22 197:9 236:9 307:12 326:8 379:1 380:3,5 381:16 382:12 384:20 388:18
perspectives 122:8 380:6
persuade 45:15
pertaining 401:5
pharmacotherapy 191:15 215:22
Pharmacy 2:10 12:16
phase 107:3,4 112:6 117:20 120:6 125:3 125:10,17 126:14,21 146:4,12 158:12 161:1
phases 107:2
PhD 1:18,19 2:2,3,6 3:2 3:11,13
phenomenon 141:15
philosophical 85:18
phone 6:11 7:14 9:10 9:20 13:13 14:2,3,15 16:11,12 18:11 60:15 61:16 64:13,17 72:11 81:21 85:15 91:8 99:5 101:21 102:9,11 169:3 174:17 178:13 179:10 190:4 221:7 221:13 223:2 239:17 250:9 258:4 261:20 272:9 273:9,14 286:10 287:20 295:19 309:19 322:21 324:5 325:5 328:22 330:19 355:18,20 358:9 359:1,1 396:19 402:11,11,13 403:2
phones 71:10 162:15
phrase 323:15
physician 86:19 137:18 137:21,22 145:2 147:5 170:5,13 171:1 217:20 218:2 233:4 314:11 376:8
physician's 234:11
physicians 2:5,7 10:12 13:3 136:8 145:14 157:15 176:5,12 236:2 239:2 377:5
pick 69:21 93:21 235:22 238:6,14,14 240:15 279:21
picture 175:9 337:20
piece 125:12 129:1,12 240:11 265:13
Pierre 3:19 17:6 25:17 26:6 29:18 90:21 146:14 205:18 328:18
Pitzen 3:14 258:8,9,12 269:6,9
place 100:21 130:13 141:20 150:12 170:22 210:15 234:3 307:13 321:1 326:4 373:3 374:9,12 380:13
placed 170:19 326:10 332:13 333:19 361:9 368:8
placement 385:18
places 177:2 377:12
plan 214:17 216:18 217:22 218:3 219:5,6 219:13,16,18 284:19

plans 1:16 214:18 235:20 236:9 284:20
platform 99:9
play 118:13 228:9 282:12 392:15
played 132:7 165:12
player 365:10
playing 166:4 181:18
plays 114:1
please 7:15,20 17:19 54:14 56:3 58:1 61:6 68:7,19 71:13 99:2 165:5 178:15 180:5 182:3 221:13 223:8 226:10 247:19 251:9 263:15,20 264:3 269:8 272:6 273:8 286:8,11,12 287:2,17 287:21,22 322:20 341:11 355:17 359:6 403:4
pleasure 79:3
plenty 242:4
plus 132:15 134:18 182:7 238:15 276:8
PMP 2:2
pneumonia 63:21
point 21:21 32:1 38:11 39:16 43:3 44:20 45:19 59:13 67:15 68:18 77:4 80:13 87:5 98:6 112:6 141:10 142:19 145:10 150:13 151:2 153:11 155:18 158:14 159:6,14 160:6 161:13 169:14 176:3 187:17 192:11 194:3 209:19 210:19 213:8 218:15 219:21 240:11 241:9,17 244:13,13 255:7 259:22 262:2 271:7 281:20 282:1 284:13 284:14 288:11 290:16 293:17 296:2 308:5 313:9,21 315:6 317:17 326:13 328:15 331:18 337:7 345:16 346:17,19 350:14 351:3 352:18 374:10 381:7 383:18 384:9 385:13 396:22
pointed 96:17 213:3 249:3 385:20
pointing 241:12 385:16
points 59:20 78:5 123:12 130:5 148:1 155:2 253:16 260:10 330:9 345:6
policies 124:12
policy 115:1 152:6 214:21 350:12 357:3
political 255:2
Polling 222:10
pool 279:20
poor 269:12,14
popular 384:20
populated 19:16
population 157:17 158:17,20 159:7 223:1 229:17 236:7,8 236:11,14 240:4 329:20 339:11 342:6 344:12,14,15 346:11
populations 126:9 181:16,17 229:19 239:4
portion 202:15
portrayed 290:8
posed 108:6
position 47:19 152:5 159:8 289:13
possibility 76:18
possible 38:17 71:1 196:4 212:2 282:13 294:10 300:14 344:4
possibly 95:1
post 95:15 135:12
post- 96:16
post-acute 6:4 77:20 93:4 94:8,12 96:5,18 134:7 151:18 162:21
post-discharge 133:4,6
potential 6:8 53:15 66:6 88:19 114:12 120:21 121:11 146:11 147:14 158:17 206:16,19 300:20 302:20 345:22 375:21 382:2,15
potentially 20:20 35:17 45:11,15 110:18 147:17,19 161:1 213:11 328:1 332:14 333:20
power 50:9,12 211:11
PPPW 371:16
practice 143:20 144:12 178:2 216:10,20 235:13 239:9 254:6,7 271:10,20,22 316:4
practices 109:5 110:12 112:1 141:3
practicing 345:19
practitioner 376:22
practitioners 178:3
PRAMI 301:18
pre- 71:21
pre-pulled 19:8 200:17 200:20
pre-rulemaking 4:6,8 4:13,19 6:9 19:6 30:21
pre-work 57:1
preamble 113:13
precise 349:7
precisely 233:1
precision 39:22 297:20 333:2 345:17
predominance 390:4
preexisting 251:22
prefer 203:7 259:12
preference 19:18 52:20
preferences 73:22 74:2 74:5
preliminary 31:19,21 32:5 36:21 161:7 203:19 204:1 218:18 251:15,17 352:5,21
prelude 232:5
prepare 161:22
prepared 199:20 389:10 392:14
preparing 29:20,22
prerogative 198:2,3 311:1,15
Presbyterian 16:4
present 1:10 3:9,22 56:15 95:18 104:17 131:19 186:3 302:14 368:15
presentation 70:4 332:1 405:11
presented 26:6 44:5 313:21
President 3:6 8:5 214:13
presiding 1:9
press 71:13 178:15 359:6 403:4
pressed 100:22
pressing 98:9
pressure 153:13 154:1 154:4,7,8,11 227:11 253:19
pressure-test 125:19 126:4
presumably 74:3 196:10 213:14,20 264:13
presumes 326:18
presumption 189:20
pretend 88:22
pretty 140:4 271:13 298:17 304:15 315:22 373:22 389:13
prevalent 369:9 371:15 377:20
previous 43:16 232:21 279:1 285:22 342:17 350:5 366:13 394:21
previously 33:13 57:4 199:18 216:11 324:20 348:4 363:1
previously-identified 33:20
previously-used 110:15
primarily 73:19 81:17 385:13
primary 6:1 72:1 147:6 339:5 345:19 377:3,4 389:16
prime 213:15 217:6 313:6 354:22
principally 145:3 214:16
principle 242:8
principles 49:7 52:21 54:16 73:15 112:15 113:3,8,21 114:19 119:5 148:6 149:8
prior 32:9 33:16 41:18 61:16 195:2,20 198:3 212:9 302:3
priorities 27:10,14 33:6 183:22 185:1,7,12
priority 90:5 92:2,19 93:13
private 122:15 170:21 361:16
private-sector 119:8,12 125:21
probably 6:18 24:16 39:8 46:22 67:19 97:19 137:20 161:5 169:19 174:14 193:10 213:20 226:16 228:19 229:18 255:9 313:13 321:12 344:11 376:16
problem 18:17 19:15 38:5 65:8 75:14 103:16 131:19 148:16 152:5 190:18 193:12 207:6 215:8 226:15 270:3,6 280:17 283:7 297:1 312:11,22
problems 54:3 66:12 232:20 345:14 374:18
procedural 288:17
procedurally 195:15 232:1 249:2 294:2 295:22 296:18

procedure 56:11 197:7 198:7 249:11 289:20 290:2 366:20
procedures 198:20 300:16 323:12
proceed 150:9 169:2 178:21 202:1 209:1 325:16 356:3 370:8
proceeded 357:10
proceeding 355:16
processes 40:15 54:3 81:9 160:12
produced 37:11
product 120:5
productive 77:12
products 112:17
professional 14:18
professionalism 382:17
profile 31:22
profits 382:9
profound 151:10
program 27:20 29:1 31:2,7 33:10,21 34:11 59:5 63:7 74:21 76:4 76:4,4 84:13 90:4 91:13 102:21 109:17 115:1,10 116:22 117:5,5,7 121:15,18 132:10,13 133:20 134:1,4,11 147:20 180:1,1,7,9,11,12,15 181:6,22 182:11 185:8,12 187:20 188:3 190:22 191:8 192:7 200:11 201:3 201:13,17 204:10,14 207:21 208:2 227:8 231:15 237:14,22 240:12,17,19,20 241:3 248:6 251:15 265:18,19 277:16,21 278:21 279:7,14 285:11 297:8 331:4 356:10 360:17,18,20 360:20 364:4,10 365:22 366:9 369:11 377:12 396:11,13
program-implementer 124:13
program-implemente... 117:3 120:20
program-specific 32:21
programs 4:7,9,11,14 4:17,20 6:3 19:3 23:7 24:6 31:4,15 32:16 62:11 70:19 73:1,5,8 74:13 94:11 105:13 107:17 118:6 119:9 119:13 121:9 123:21 128:7,12,13,22 129:8 129:14 131:19 145:3 149:17 158:3 162:16 162:18 169:4,6 179:21 180:6 184:1 185:22 186:2 188:10 188:20 191:3,6 200:16 201:10 227:3 228:3 243:1,8 267:18 269:14 270:17 316:2 316:5 346:16 359:2 360:13,14 361:16,21 362:4,11,12 364:2
progress 114:2 144:13 319:6 383:4
project 3:3,5,6,7 30:18 107:1 108:21 141:22 150:4 159:18
promise 360:10
promote 33:21 361:4
promotes 377:22
pronounce 187:22
proper 328:5,8
properly 286:1
properties 121:4
proportion 143:14
proportionality 135:4 135:10
proposal 137:14 170:22 291:22
propose 34:20 84:9 212:15 232:14 246:5 246:11 319:12 324:18
proposed 43:17 109:12 110:21 265:19 269:9 366:1 370:4
proposing 170:18 171:1 193:5 210:3 374:21
prospective 145:6 157:11
prospectively 157:17
prostate 63:20
protocols 260:2
proverbial 6:15
proves 399:4
provide 30:6 31:2,21 32:19 55:6,11 73:6 102:8 203:3,14 328:11 360:1 361:5 375:19,21 378:3 386:5,5 392:12
provided 31:15 166:21 171:10 174:3 184:11 379:2 385:11
provider 97:17 146:21 280:5 361:5 382:11 389:16
provider- 97:9
provider-centric 97:2
providers 29:6 63:10 63:13 73:6 74:9,10 94:19 108:9 118:10 123:2 134:7 157:14 158:22 178:2,2 279:21 285:13 361:9 363:4,22
proviso 354:16
proxy-voting 99:4
psychiatric 16:7 360:19
psychiatrist 130:21 153:18
PTAC 137:14
public 4:7,10,16 7:9 24:3 32:16 61:10,11 61:15,22 69:12 70:6 70:17,18,20 71:16 76:19 84:21 88:17 105:12,14 117:22 119:8 121:14 122:15 123:20 124:18 125:13 146:18 149:16 162:16 163:7,13 169:3 170:8 171:12,13 173:19,20 178:13,18 180:18 300:2 304:7,15 342:2 358:19 359:4,6,8,9 361:16 385:7 401:9 401:21 402:1,5,6,20 403:2,4,6,7
public-sector 125:22
public.qualityforum.... 7:10 55:17 56:2
published 305:7
pull 20:1 21:2,4,8 22:8 22:9 30:16 39:14 57:6 95:6 110:10 144:2 177:8,13 189:11 190:11,16 191:18 192:13,15,20 193:5,6 193:7 195:15,18 196:7,17 197:3 198:3 198:4,14 201:6 278:8 280:4,10 339:17 369:7,15 371:14
pulled 19:10 22:4 65:10 82:10 189:8,10,13,17 190:8,12,16,21 191:2 191:12,17 192:10,21 193:6 195:1,3,16 196:2 198:7 199:10 199:10 200:2,6,8,9,10 200:16,17 201:19,20 201:22 202:3,9 216:14 226:22 227:19 227:19 229:7 251:14 252:3 262:3 264:6,9 264:13 265:9 277:22 278:2,15 298:1 324:20 332:9,11 338:4,17 353:20 356:10 368:21 369:4 369:13,19 370:4 378:18
puller 370:13
pulling 21:4 57:9 163:15 174:11 264:12
pulse 55:20
punt 64:14
purchasers 266:6 281:7 318:2
purchasing 107:14 132:10 133:20 360:20
purpose 113:17 115:10 115:19 125:4 220:2,4 269:11
purposes 114:5 122:17 203:15 233:11 255:2
purview 360:15 388:20
push 195:14 376:18 378:10 380:17,18 384:17
pushing 241:4 313:3
put 5:9 23:7 37:5 42:5 44:20 47:15 57:17,19 58:15 59:9 61:1 68:15 68:16 70:2 77:15 79:16,17 83:22 84:3,6 84:11,17,20,22 120:5 132:11 149:21 170:14 170:21 179:2 183:22 197:9 205:20 208:19 210:7,15 213:19 233:12 238:1 260:6 260:14 271:21 298:5 315:22 316:13,14 320:18 321:1 326:4 344:4 351:7 374:9 377:14 380:15 382:4 382:18 403:22
puts 66:18 84:19 185:6 195:3
putting 22:15,15 24:2 40:1 85:2 89:12 199:19 226:14 237:6 269:10 373:2 377:20 381:13 382:9 399:18

Q

Qaseem 2:6 13:2,2 40:20 42:11 147:22 171:22 173:11,15

174:9 192:17 193:2,9 193:12 224:14,18 229:4 241:6 242:11 253:11 254:17 309:18 312:22 316:17 325:6 325:18 326:3,21 329:13 330:16,18 339:1 344:3,21 346:20
QIP 392:21 398:4
QRP 72:15 74:22 75:11 75:16 100:2,7
quality 1:1,7 2:18 3:6 8:6,6 16:7,22 27:18 28:11,13 33:3 38:5 73:17 89:8 107:14,19 108:2,9 113:19 121:8 121:16 136:10,11,13 136:20 137:3 141:2 147:19 157:18 181:8 185:14 214:14 235:15 242:5 259:9 281:8 316:7 318:1 360:19 361:8 362:18 363:19 364:9 366:9 367:5,21 369:10 379:7,20
quality- 81:12
qualityforum.org 7:17
Queram 2:7 11:5,6 232:10 246:3 259:3 268:8,12 270:11 326:7
query 211:15
question 8:22 19:14 20:7,12,15 21:8 36:5 36:15,20 40:7,21 49:14 65:6 80:15 90:14 91:8 99:20 102:3,22 104:17 111:15 113:2 116:10 126:17 129:17 133:4 134:3 139:2 145:20 154:20 156:17 159:16 160:16 175:11 186:7 195:14 204:21 210:21 237:14 248:5 256:22 285:5 290:16 293:4 299:7,16 306:18,20 309:3 310:2,10,20 317:4 318:6,13 328:18 334:16 341:1 349:19 353:13 379:18 380:12 386:15 396:19 397:7 400:18 404:16
questionable 239:5 377:13
questioning 173:15 212:22 237:1,2 353:15
questions 7:1 18:8 20:18 38:4 57:13 62:15 64:4 69:10 87:2 88:8 90:1 109:1 128:16 133:9 134:14 134:20 135:18 144:15 151:1 162:1 166:10 172:4 183:6 191:6 202:18 213:3 304:3 309:7 332:17 343:6 348:2 360:7 366:8 379:10 386:2
quick 36:20 40:20 55:20 60:11 62:16 64:18 87:4 130:5 180:3 190:19 226:7 227:1 241:9 268:2 281:10 352:18 360:10 360:22 406:8
quickly 39:16 148:8 200:3 304:22 325:18 364:1 399:5
quit 238:19
quite 88:12 137:19 157:6 173:22 183:10 184:22 213:21 217:5 318:10 334:18 352:12 365:2 382:19
quorum 64:8,9 65:4,7 99:20,20 103:6,9 104:2,6,19 163:21,22 164:4,15,16 165:9,13 165:14,18 275:18,20 276:1
quorum's 65:8
quote 22:8 112:10
quotes 189:7 397:11

R

Rachel 2:2 12:21
raise 101:16,18 202:5 263:16,21 273:8 283:10 286:8,12 287:18,22 293:17 322:13
raised 34:13 35:14 67:14 79:21 126:17 181:9 182:12 291:4 299:18,20 302:2 308:9 313:1 331:19 336:12 343:16 344:18 354:13,17 371:18 376:4 383:4 386:1,12 396:22 399:22 400:7 400:19
raises 340:12 347:18
raising 127:5 128:17 328:6,10 329:11 345:5
Raj 12:18 235:17 376:4 376:5 378:17 380:4 381:16 383:3 391:16 396:22
Raj's 285:4
RAJESH 1:15
ramifications 342:3
ran 120:8 336:18
RAND 16:5
range 239:1
ranges 147:3
ranging 88:9
rarely 377:16
rate 75:9 86:13
rates 86:11 159:4 391:10
ratification 19:11
ratified 20:10
rational 280:13
rationale 31:16 118:17 216:17 264:9 265:14 278:16 279:1 280:8
re- 98:17 143:18 228:12 240:1 260:1 307:13 368:11 387:4 404:10
re-adjudicate 240:2
re-endorse 219:10 341:20
re-endorsed 256:16
re-endorsement 256:15
re-examined 75:10
re-litigating 260:5
re-look 45:10
re-screen 345:21
re-specified 204:20
re-stratification 228:17
re-submission 349:9
re-submit 351:1,10,14 354:18
re-submitted 348:15,18 348:22
re-vote 21:9,13 287:15 371:17
reach 31:8 52:4,6 54:21
reached 102:2
reaching 48:15
reacting 85:7
reaction 35:13 153:6
reactors 59:7
read 144:16 166:20 183:20 185:9 191:12 227:1 351:4 375:6 382:21
reading 197:7 227:11
readmission 63:14 135:6,6,11 156:16 366:1,2 371:9 384:5 387:20
readmissions 132:1 156:13,19 360:18 370:22
readmitted 388:6
ready 26:16 30:4 34:1 69:13 177:16 213:15 213:18,19 215:1 217:6 221:9,17 222:7 247:6 254:19 261:9 261:10 298:15 313:5 313:20 318:10 320:1 350:3 354:22 389:11 401:9
reaffirmation 293:22
real 17:20 47:18 228:1 244:5 334:11 390:4
realigning 107:15
realistic 152:7 154:9
realistically 156:15 238:13
reality 152:10 339:22
realize 142:14 231:1
realized 213:1
realizing 47:11
reason 25:1,13,14 148:17 160:10 165:11 188:9 197:2 201:2,4,5 201:8 207:19 216:10 218:20 233:5 246:21 265:8 271:13 295:11 322:4 339:13,17
reasonably 108:5 133:5
reasons 24:13,22 25:2 33:19 57:18 205:1,2 233:1 264:13 267:18 320:6 336:16 378:19
reassessed 255:22
reassure 178:5
reassured 317:10
rec 362:4
recall 206:3
recap 386:22
receive 60:20 152:1,2 216:21 273:21 274:7 298:11 331:21
received 14:15 76:20 87:19 88:18 118:1 125:12 200:5 204:2 221:15 222:14 274:10 305:3 332:16 335:10 342:17 367:18
receives 32:7 54:18 60:18
receiving 34:17 118:15 364:13
recite 14:20

recognition 28:14 334:4
recognize 35:17 114:3 119:15 140:17 258:1 294:15 314:22
recognized 73:13 113:22 122:21 197:10 257:22
recognizing 113:16 289:22
recollection 268:4
recommend 35:2 211:12 212:11 260:22 263:15 266:11,19,20 272:21 285:22 286:5 286:19 321:19
recommendation 19:12 20:3 26:1 32:7 57:20 58:8,21 59:15 61:3 65:12,18 67:4 76:21 89:3 90:8 92:14,17 100:2,7 120:10 121:6 122:3,18 197:20,21 198:22 199:13,15,17 205:11 208:4 212:7 216:2 227:4,6,14 228:21 232:14 246:6 247:12 249:19 251:15 252:2,11,16 253:5 255:12 259:13,21 261:8,15 263:2,15 265:8 266:16 268:20 273:2 276:12 277:13 277:18 278:17 279:2 279:13 287:15,17,22 288:19 289:8 295:4,5 297:9 299:2 307:6 308:20 310:11,17 317:18 318:7 319:21 322:5,7,10 324:11 325:8 329:15 331:5 338:9,15 341:17,18 342:1 367:19 368:6 395:2
recommendations 4:8 4:13,19 6:2 19:19 20:8 34:21 36:9,12,22 43:5 45:3,4 46:12 47:2,11,21 48:8,16,19 56:15 60:6 62:6,13 66:6 70:22 71:22 72:6 93:3 101:14 112:15 119:4,5 120:6 162:6 162:18 169:6 172:10 185:14 196:1 203:20 207:14 210:13 227:2 241:14 252:16 262:8 319:8 327:9 360:5,8 375:1 395:3
recommended 45:13 90:5 122:9 123:19 124:16 195:17 199:3 261:4,8 286:6 306:4 328:3 366:7,19 367:10 371:3 375:9
recommending 39:22 246:5 267:4 310:12 311:12 320:15,19 371:17
reconciliation 362:2 364:12 365:1
reconfigured 218:5 342:8
reconsidered 265:9
reconsidering 278:9
reconvene 105:4 162:15 163:1 357:19
record 73:2 105:19 163:3 199:12 229:8 248:18 276:22 315:4 357:7,9 358:2 406:6 406:10
record's 406:2
recorded 348:11
rectified 277:16 279:6
recurrent 366:12
recusal 104:17 369:16
recusals 165:15 166:1
recuse 11:18 12:1 101:6,6 104:19 164:19 167:5 345:11
recused 165:7
red 226:14
redesigned 212:17
redid 350:10
reduce 236:1 361:4 397:14
reduced 231:11 300:20
reducing 28:9 283:13
reduction 28:21 184:21 360:17,18
reevaluated 182:1
reference 33:9 145:18 227:10 352:1
referrals 389:8
referred 393:17
referring 147:5
refers 114:3
refine 32:9 33:16 34:3 34:14 191:11 204:1,4 204:6,17 205:22 207:1 209:4 216:16 217:9,16 218:8,19 224:15,15 225:1,5,6 226:2 239:12,14 243:10 247:13 254:20 298:2,6 308:11,14 309:15 322:16 323:1 332:12 333:19 334:1 351:1,9,14 368:11 387:4
refine-and- 60:4
refine-and-resubmit 59:1
refined 45:8 217:18 218:9 219:12,12
refinement 305:12,21
refinements 36:1 59:3 305:16
reflect 69:1 79:8 123:16 152:10 197:11 204:6 204:12 300:19 308:9 324:14 326:14 327:16
reflected 27:15 29:14 332:1
reflection 80:20
reflects 382:21
refrain 59:19
refreshing 359:17
regard 145:16 265:10 304:9 346:11 375:2
regarding 6:14 169:4 249:21 300:2 337:17 367:1 392:3 406:8
regardless 59:14 207:15 209:13
regards 92:5
regional 2:7 11:6 391:10,12 396:3
regular 257:18 395:22
regularly 115:5 396:8
regulation 211:7
regulations 210:17
regulatory 32:22 212:6 212:10 320:9
rehab 87:17,18
reinforce 143:1 144:12
reinforced 157:3
reiterate 119:10 142:18 148:1 302:9
reiterated 35:15
rejected 171:3 293:16
relate 117:9 132:21 134:1 155:22
related 9:2 28:11 63:20 78:6 84:5 92:16 107:12 115:20 117:4 117:12 118:2,5 125:6 126:7 133:17 169:17 300:1 376:14 385:13 385:15,21 386:2 396:21
relates 94:7,10 126:6 257:6
relating 126:22
relation 151:3 362:1
relationship 108:11 145:19 146:17,22 147:7,7
relative 33:9 75:9 88:7 145:8 212:6
relatively 75:8 76:2 106:4 154:13
released 62:10,11,13 138:14 171:11 173:4
releasing 62:7
relevance 184:4 216:6
relevancy 63:22
relevant 14:19 15:1 19:16 109:21 125:7
reliability 140:1 148:12 216:8 306:3,6,9 343:18 350:7 351:21 352:14 385:21 391:11
reliable 351:5,11 353:1 363:5,9,22
relying 281:18
remain 189:16
remaining 58:8 200:7 361:10
remains 27:11 250:19 251:1,4
Remarks 4:5
remember 17:18 21:18 44:7,8 49:17 70:20 291:14
remind 15:12 17:17 41:1 169:2 174:20 242:21
reminded 45:2
reminder 18:19 35:11 294:17
reminders 15:3
remodify 404:19
remote 98:6 99:1
remotely 102:17 223:18 223:19
remotes 98:22
removal 46:19 187:7,7 267:4 381:1
remove 66:19 166:3 187:11,12 233:11 241:3 267:4 272:16 272:20 281:21 380:22
removed 58:5,10 164:20 166:2 208:2 266:16 286:6
removing 282:3 283:16
renal 364:9 369:10 375:11
rep 18:20
repacking 243:16

repeal 321:4
repeat 22:4 278:11 302:15
repeating 59:20
repeats 192:18
replace 269:12 321:4,5
report 10:10 28:12 62:11 68:11,16,20 69:6 186:19 187:14 240:21 241:4 246:14 265:21 281:4 283:11 283:18,20,21 284:5 305:6,19 358:5,18
reported 83:2 90:20
reporting 32:16 81:13 121:15 123:21 149:16 232:16,17 259:6 265:20 280:21,22 360:19 366:9 367:5 367:21
reports 11:4 62:8 68:5 186:22 187:8 305:3 305:10 308:8
represent 8:17 15:5,20 83:1 235:20 381:16 381:21
representation 386:11
representative 13:15 13:22
representatives 8:14 381:18
represented 170:11 173:6,17 177:6 301:13 385:9
representing 10:9,14 10:16,22 11:6,9,16 12:9,15,19,22 13:8,18 14:8 17:12 272:13
represents 176:5
reproducible 124:2
request 209:12
requested 57:1 306:1 338:11
requests 338:16
require 160:8 170:18,20 204:19
required 28:12 270:5 310:18 316:5
requirement 160:13 246:7
requirements 32:22 389:7
requires 73:6 188:4 196:21 332:21
rescinded 369:15
research 2:18 230:2 350:12
reservation 373:1
reservations 81:17
resident's 80:20
resident-reported 80:10
resistance 394:10
resistant 63:17
resolve 318:22 399:2
resolved 306:22 348:2
resource 297:14 318:1 361:11
resources 284:1
respect 45:12 70:5 228:5 244:21 268:21
respiratory 368:2
respond 44:1 341:11 347:4
response 85:4 86:11,13 168:22 171:15,19 178:11 189:5 215:2 220:17 221:10 242:14 248:7 253:9 282:18 315:1 342:16 354:20 358:21 370:6 399:16 399:19 400:9 401:7 402:22
responsibility 112:12 130:19 131:6 234:1,2 237:12 383:21,21 386:6 387:22 388:3 389:1,4,14 394:1,12
responsible 107:19 108:5,17 131:1 134:10 140:14 141:7 151:19,21 153:16 154:10 394:8
rest 24:1 165:4 356:5 376:22 377:1
restrictions 85:18,19
restrictive 302:17
resubmission 198:22 199:3,4
resubmit 32:9 33:16 34:3,14 60:5 191:11 202:14 204:1,6,17 206:1 207:2 209:4 216:16 217:9 218:19 220:19 224:15,16 225:1,5,6 226:2 230:7 239:13,15 243:10 247:13 254:21 298:2 298:7 308:11 309:15 314:19 316:18 321:17 322:9,17 323:1 332:12 333:20 334:1 345:1
resubmitting 217:16
result 25:6 46:10 98:20 225:12 336:7
results 81:6 107:19 112:9,10 114:6 117:4 123:1 124:7 180:4 209:3
resume 60:21
resumed 105:19 163:3 358:2
resumes 14:21
resurrect 188:1
rethink 237:18
retirement 12:4
retrospective 145:6 157:7,11
revascularization 302:13 303:2
reversion 290:5
revert 244:17 245:5 246:12 248:16 252:12 253:5 292:2,3 295:22
reverting 252:18 323:4
reverts 67:2,3 249:7
review 4:3 5:22 7:3 25:9 30:20 31:3,12 35:1,11 40:18 49:4 72:4,5 85:1 120:2 122:5,16 158:8 163:6 198:11 198:14 205:10,15 237:7 255:21 256:6 256:10 258:17,21 297:13 314:17 330:10 338:12 342:11 343:10 343:14 344:2 349:3 366:17,21 367:2 375:8
reviewed 115:6 297:18 346:21 347:8 363:15 368:20 375:10
reviewing 36:10 341:19 348:12
revise 46:8 202:13 225:1 230:7 257:3 314:18 316:18 321:3 321:16 322:9 326:22 354:18
revised 256:4 257:1 327:14 339:15,16 344:22 348:8,22
revising 20:21 343:2
revision 254:14,19 255:16 256:9 257:8,9 257:11
revisions 256:8 350:2
revisit 237:14
revolved 324:17
revote 265:10
rewarded 336:8
Rich 9:9 14:3,14 16:11 16:11 64:16 65:1 272:8,9,15 273:15 274:9 372:13,14 373:19 395:17 396:18
Richard 1:12 272:11
Rick 64:19
rid 282:7
Rights 1:13 10:14
rigor 121:11 124:9
rigorous 86:1,6 366:16
rise 391:18
risk 121:22 124:7 181:15 266:9 268:21 268:22,22 271:18 278:21 283:1 297:16 297:17 303:12 331:16 331:17 333:5 336:3 337:17 345:20 346:8 346:9,12 368:5 375:16 377:8,9
risk- 246:7
risk-adjusted 181:14 367:22
risk-adjustment 375:14
RN 1:20 3:11,14
Roach 3:15 383:9,10 387:19 390:14 395:20
road 145:22
Rob 2:15 17:11 141:18
Robert's 66:17 289:17
Robinson 2:8 11:12,13 190:3 198:19 199:6 211:22 220:8 279:15 281:10 285:4 334:15 391:17
robust 26:1 53:2 77:13 82:3 112:22 182:4 186:16 364:16
role 92:10 114:1 127:20 141:13,22 162:1 166:22 167:18 362:5 362:10 392:16
roll 84:16
rolling 81:12 297:3
Ron 3:18 358:8 365:15 365:20 368:18 386:13
rookie 79:3
room 1:8 9:19 13:12 17:10 23:2,3 61:15 71:8,10 80:4 101:7 102:10,12 120:22 154:4 164:16 169:2 169:12 177:14 190:11 354:15 358:19 385:10 402:12,20
root 136:19
Rose 3:10 301:11
roster 13:14 177:9,22
roughly 205:5

round 305:12
routinely 345:20
RPh 2:9
Rubin 3:16 169:15,15 298:4 304:5 309:14 323:7,15 332:9,11 333:17
rule 49:18,19,19 50:13 51:11,13 52:13 84:1,3 84:4,6 176:19
rulemaking 32:8,8,9 33:15,16,17,17,19 34:2,9 38:13 71:22 83:18 84:12 85:2 213:10 216:3 227:5 232:15 244:18 251:16 252:2 259:14 277:14 297:10 319:12 324:12 331:6 338:10 395:14
rules 32:19 43:16 47:14 66:17 83:15 116:6 163:20 168:20 289:17 290:2 291:12 292:18 302:12 378:8 396:11 396:17
run 37:3 55:5 141:9 259:9
run-through 60:11
running 70:7 284:5 373:9 377:11
rural 62:17,19 63:1,8,10 63:12,22 284:2 405:9 405:16
Ryan 109:10

S

S 73:6
safety 28:22 76:7
sake 406:3
Sam 176:1 177:16 186:9 228:4 343:7 351:3
sample 117:14 118:3 118:20 121:20 124:6
SAMUEL 2:3
sand 203:21
satisfaction 80:2 88:9
satisfied 88:10
save 94:19
savings 94:12 132:17 180:1,8,11,15 185:8 185:21 300:20 302:21 303:1
saw 185:11 225:21
saying 42:21 43:15 68:4 102:5 114:8 136:3 187:17 195:19 197:10 198:17 212:17 241:16 244:8 255:13 273:18 293:14 295:3 297:13 310:5 312:18 314:1,16 316:10,18 321:3 327:16 347:18 352:22
says 5:21 73:2 198:21 318:7 327:10 330:3 343:10 348:6
scan 109:8,11 148:19
scary 379:6
scenarios 165:12 166:4 346:6
schedule 71:19
scheduled 370:11 405:19
schizophrenia 130:21 131:2,8
Schlaifer 2:9 12:14,14 46:21 236:19 246:19 255:11 256:21 257:15 294:7,10,14,16,22 295:12
school 347:14
science 107:1 113:6 115:20 119:16 139:19 253:22 317:8
scientific 121:4,11 124:9 343:10,12 375:10
score 80:2
scores 54:15
scoring 94:17
scrap 263:9
screen 70:21 100:13 177:14
screened 346:18
screening 63:20,21 338:4,8 339:5,7 340:4 340:10 341:14 346:15 347:1
screw 152:9,15 155:4
screwed 152:21
screwing 159:12
se 270:1
seat 5:5 170:5
seats 106:2 358:7
second 11:21 31:3 39:10 56:19 69:22 90:14 100:17 107:4 112:6 117:8,20 121:6 125:3,10,17 126:14 133:10 138:10 170:16 207:5 220:12,13,14 221:19 230:12,13 232:8 234:8 240:11 241:22 245:16,18,22 246:1 248:15 250:19 252:15 253:8,10,11 265:18 268:8,12 290:13 293:10 307:2 309:9,11,17,19 324:3 324:4,5 334:2,3 336:20 354:12 355:14 355:15 387:4 393:8 402:8
seconded 239:12 334:11
seconding 279:14
secondly 253:18
seconds 186:11 221:21 273:21 309:20
Secretary 34:20 47:12 47:17 211:11
Secretary's 319:15
sector 170:21 361:16
sectors 122:15
seeing 23:3 25:15 50:16 71:9 84:8 129:13 143:21 184:7 323:5 358:22 403:1
seen 48:4,10 118:12 124:21 234:12 281:14 291:18 303:3 304:7
sees 45:5
segment 337:5
select 280:6,6 282:21 285:13
selected 280:3,5 300:4
selecting 114:11,15 119:7
selection 30:22 33:2 112:16 115:13 116:9 120:8 122:14 125:20 126:5 180:2 321:11
selects 120:3
self- 146:21
send 81:6 101:22 110:4 158:10 177:5 218:4 273:20 274:4,8 321:4 321:7 379:13,13 402:11
sends 210:20 320:20
senior 3:2,3,4,5,7,7 8:5 30:18 154:17,18 179:8 359:13
seniors 154:16
sense 15:21 39:2,5 46:15 65:22 90:18 147:16 149:13 217:13 219:10,10 232:8 258:1 288:4 295:7 303:1 305:8 315:1 317:19 320:2,16,21 339:6 340:5 348:17 377:4
sensitive 335:15
sensitively 390:5
sent 62:6 177:10 218:10 223:4 261:4
separate 188:20 191:4 200:11 242:21,22 243:1 336:3 393:4,6
separately 153:15 335:17
series 29:20 32:6 62:7 120:6
seriously 264:16 319:8 342:14
serve 32:1 281:12
served 391:1
service 2:9 11:13 28:21 95:3 139:1,8,9 147:2 302:11 303:12
services 2:20 3:15,19 16:20 93:5 119:1 134:18 337:1
serving 8:9 15:11 138:15
SES 205:14
session 17:17 166:11 167:9
set 31:7 33:10,12 56:5 61:19 71:3 98:2,13,14 115:22 123:21 146:19 169:10 209:20 211:15 283:3 284:7,12 337:8 346:6 353:11 371:10 371:11 390:1 398:8
sets 32:15 184:9 336:20 362:13
setting 75:15,19,22 77:3,15 91:22 96:18 97:20 156:18 360:12 361:21 392:21
setting- 61:16
setting-specific 55:18 62:8 75:2
settings 6:5 19:17 73:18 75:8,9 96:17 118:12 142:12 143:22 156:17
seven 23:3 24:10 191:12,13 195:3 232:18 241:17 250:10 273:13 275:10 351:2 351:8
seventeen 250:11
seventh 23:16
severe 331:22
severity 333:3
share 68:19 81:22 305:22 334:16 373:6
shared 74:6,16 79:6

108:19 116:12 130:18 130:19 131:12 132:16 180:1,8,11,15 185:7 185:21 383:19 384:6 387:12
shared-savings 105:13
SharePoint 7:9
sharing 8:19 305:18 306:10,12 378:18
sharper 44:21
Shaun 2:6 11:8 282:16
sheets 343:22
Sheila 177:10
shifts 395:5
shingles 63:16
short 138:12 206:19 406:4
short- 84:5 94:22
short-stay 72:15 73:2 82:18 88:20 100:9
short-term 147:6
shorten 405:7
Shortly 305:5
shot 328:12
show 101:3 250:1,3 263:18,22 273:11 286:9,14 287:19 288:2 322:19
showed 369:21
showing 143:13 229:20
shown 57:16
shows 139:22 184:12 339:7
shrink 279:20
shy 20:13
sick 96:19 398:15
sickest 234:12
side 50:6,7,8 94:12 127:6 181:10 182:7 185:3 235:21 376:16 382:2
sign 378:9 389:21
signal 252:19
signals 27:21
significant 16:1 26:13 35:17 204:7,12,18 256:9 257:9,10 328:1 367:15 386:2,9,11 391:14
significantly 385:17
silent 95:22 96:8
siloed 97:10 143:2,4,6
similar 44:20 75:1 185:5,9 227:2 259:4 277:18 278:17 331:6 361:18,21
similarly 165:2
simple 42:12 63:21 88:6,12 137:8,19 218:4 260:17
simple-minded 131:21
simplicity 243:17
simplify 197:14
simplistic 52:13
simply 217:16 218:10 230:18 269:17 336:8
Simultaneous 194:14 224:20 227:22 230:9 254:4 255:6 312:5 321:6 329:12
single 26:8 150:20 173:16 176:6 315:18 315:21 337:8 365:7
Sirio 2:10 12:11,12 44:19 217:1 228:1,17 231:20,22 243:12 244:4 245:9 246:9 252:6,9 253:15 254:5 255:1,7 259:17 261:21 262:1 268:15
sit 15:3 29:3 38:14 154:7 188:8 260:1
site 7:9 177:12
sitting 173:21 206:5
situation 120:13 188:12 291:18 329:6 353:3 378:21
situations 152:18
six 23:2 238:13 239:1 250:10 273:13 275:10 280:9 284:8 351:9
sixteen 250:11
sixth 23:16
sixty 164:5
Sixty-six 164:4
size 117:14 118:3,20 121:20 124:6
skill 53:13
skip 14:4 70:12 195:11
slam 380:2
slated 106:18
slice 40:7
slide 32:11 37:18 56:17 70:1 72:17 100:6 105:22 106:16 107:10 108:21 109:19 114:18 149:14 150:1 180:5 180:16 182:3 183:1 183:20 184:12 229:7 229:7 367:13
slides 30:16 106:12,16 113:11
slot 405:17
slow 89:3
SME 14:4
SNF 72:14 74:13 76:19 95:2 96:21 100:2,7
social 75:17 181:15 297:17 331:17 375:16 382:15 385:16
societies 176:6,8 300:10
Society 301:13
sociodemographic 228:8
software 100:20 101:2
solid 342:1
solution 155:12
solved 297:1
solves 354:10
somebody 22:14 66:9 66:18,21 100:21 159:12 210:20 351:6 369:6 389:21
somebody's 345:20
someday 312:19
something's 256:13
somewhat 188:13
soon 64:20 77:2 143:17 306:11 321:1,2
sorely 145:16
sorry 9:12 18:15 39:13 43:22 64:3 93:19 95:20 96:13 101:4 102:3,4 135:16 144:15 183:14,15 192:20 195:11,12 198:8 200:13 202:5 209:7 219:2 228:15 251:14 254:10 258:11 259:19 260:11 264:11 266:15,22 272:7,19 273:6 275:5 278:5,10 287:4,5 294:14 295:18 309:21 325:2 325:3,8,22 333:7 334:3,13 351:15 357:16 387:8 395:18 400:16 402:3
sort 22:17 25:21 27:5 39:9 40:1 66:17 79:2 81:1,5 85:7 87:6 90:1 90:15 97:6,10 106:9 107:4 109:13 111:3 113:3 115:21 116:1,9 116:16 117:21 118:13 119:10 120:2 125:2 125:22 128:17 129:11 129:18,22 131:21 133:21 146:5 155:9 155:10 157:3,16 159:19 160:15,21 176:10 190:7 194:3 195:10 198:9 204:12 206:3,6,7,22 231:9 248:11 267:6 281:13 290:2 305:22 314:22 315:7 330:8 347:17 370:3 374:20 383:19 386:1,11 388:8,18 392:18 396:21
sorts 306:10
sought 146:18
sound 18:9 172:6
sounds 67:7 237:17 306:21 318:11 342:22 343:3 350:1 351:13 374:19
source 122:1 146:11
sources 124:11
span 6:7
speak 17:19 18:3 141:20 150:19 202:6 226:10 232:11 233:17 235:19 236:20 304:5 340:12 341:8 351:18 397:16
speaker 169:12
speakers 232:21
speaking 7:21 72:20 180:20 194:14 224:20 227:22 230:9 242:2 254:4 255:6 312:5 321:6 329:12 345:15 375:5
spec 343:21 396:16
special 75:4 126:8 205:16 404:11
specialized 175:1
specialties 1:22 13:16 13:19 170:11 171:1 173:5 177:19 184:5 332:22
specialty 170:5 175:18 176:6,8,14 178:7 300:10
specific 38:9 61:17 74:13 92:14 93:5 169:18 206:13,17 208:19 300:14 312:17 331:8 342:16 360:7 360:12 364:2 372:4,7 373:11 374:17
specifically 91:10 92:13 216:7 297:15 336:11 385:16,20
specification 228:22
specifications 56:7 111:4 116:13 130:1 219:16 329:9 330:5
specifics 176:13
specified 129:16

216:18 240:5 312:15 315:12,12 326:15 328:15,21
specs 159:9 304:8,16 343:9
spectacular 30:4
spectrum 386:21
speed 296:10
spend 43:12 44:22 45:19 46:7 85:14 135:10,12
spending 43:9 94:7,19 133:15 134:6 244:11 335:18,19,20,21
spending-for-benefic... 132:9
spent 66:11 78:2 180:20 297:1
spiel 340:2
spine 367:7
spirit 15:15 30:8
spirt 93:21
split 55:1 244:7,8,10
sport 141:6
spot 70:3 205:21
spouse 284:4
spring 212:19
Sri 3:13 299:13 301:10 304:21 335:3,6
ST-elevation 297:6
stabilized 388:18
stack 264:17
staff 3:1 16:5 17:22,22 18:5 19:1 29:18,21 30:3 31:18 32:3 36:9 36:21 55:6,10 56:14 95:18 101:19 146:15 161:11,18 163:8 190:4 197:18 203:3 203:11,14,19 209:16 212:2 218:18 221:6 251:17 252:11,15,18 253:5 262:4,11,20 267:6 279:9,10 284:3 287:6,13 289:15 292:12 293:4 295:6 298:22 299:2 306:20 325:12,20 326:7 329:1 356:2
staff's 237:5
stage 364:9 369:10
staged 300:16 301:19 302:11
stages 140:11 315:8 316:22 350:15
stake 236:7
stakeholder 113:7 122:5,8,16
stakeholders 115:16 116:1 122:10 125:15 266:5 317:16 364:22
stakes 121:14
stand 38:12 61:3 119:11 139:13 140:4 311:20 312:14 390:10
standard 50:20 110:22 114:10 120:11 122:8 139:3 233:6 306:8 367:16
standardization 111:6 111:20 112:18
standardized 31:14 368:5
standards 16:22 138:19 389:22
standing 76:15 216:6 297:14 308:15 338:11 348:11 367:12,14 368:15 375:11,20
standpoint 53:22 364:21
star 71:13 113:20 178:15 359:6,7 403:4 403:5
start 5:4 8:15 9:5,11,17 15:16 16:17 42:20 43:2,8 55:7 57:3 69:12 70:6 89:6 107:16 113:10 141:12 142:10 149:12 153:1 190:22 214:11 242:5 283:16 311:21 376:5 395:8 406:4
started 44:13 143:19 149:13 156:20 158:21 335:13
starting 32:1 107:4 143:18 147:9 160:1 180:18 346:17,19 392:22
starts 23:18
startup 155:9
state 35:7 59:13 119:16 119:17 218:22 219:17 227:21 259:8,10 302:1
stated 115:10 304:18 333:11
statement 149:21 293:10 320:1
statements 31:16 312:16
states 239:8
stating 139:16 302:6
statistic 385:22
stats 190:19
status 8:20 76:8 189:15 189:22 190:20 202:16 230:19 299:21 346:12 354:15 363:18 384:18 389:3
statutory 32:21 34:20
stay 84:6 95:1 300:18
staying 95:22 96:8 237:16
stays 280:20
STE-elevation 192:5
STEMI 298:11 300:4 302:2,15 306:6 323:10 331:7 333:10
STEMIs 192:6
stemming 202:18
step 12:3 27:6 46:11 102:17 137:16 138:1 150:9 155:16 156:1 217:8 271:3 396:10 399:8
Stephanie 3:16 223:3,8 239:18 247:19
stepped 102:12
stepping 298:3
steps 56:12 130:12 270:15 353:4
Steve 2:11 14:7 143:12 247:18 273:14
steward 11:19
stewards 315:20
stick 322:6
sticking 403:16
stinting 395:6
stints 74:17
stipulate 34:6
stock 12:17
stool 347:15
stop 67:1 127:1 131:13
story 189:2
straight 197:7
strategic 6:6 19:5
strategically 397:17
strategies 374:17
strategy 113:20
strategy's 33:3
stratification 244:22 248:13 268:21 269:1 327:19 390:6
stratified 246:8
stratifying 228:13,16
straw 52:1,2 53:3
Street 1:8
strengths 33:9
stress 119:19
stressed 363:7
stretch 152:13,14,16 155:4 156:10 394:18
stretching 159:12
strict 139:12
stricter 193:21
strike 262:1
stringent 391:2
striving 160:22
stroke 298:9 304:14 331:11,12 335:20,21 336:6,6,9
strong 19:18 303:20 372:22 381:8
strongly 89:12 94:4 113:7 313:3 382:7
structural 108:3 270:10 283:7 332:14
structure 280:17 283:9
struggled 202:10,12 363:19
Stuart's 258:3
stuck 231:17
studied 347:13
studies 403:21
study 301:18 347:14,15
stuff 46:12 252:7 262:3 347:13 357:21
style 181:20
sub- 117:1
sub-specialty 173:16
subcategories 126:7
subcommittee 300:9 301:3 303:10 304:11 305:20 308:7 335:13 336:11,15 337:11 349:4
subcommittees 305:15 306:11
subcomponent 267:13
subgroup 314:16 336:13
subgrouped 335:16
subgrouping 336:2,17
subject 1:12 121:9,19 122:4 144:20 274:2
subject- 14:13
subject-matter 8:15 9:8 9:13,21 14:11
subjective 129:19
submission 146:20
submit 55:15 57:10 99:8 212:21 213:6 221:8 313:7 350:4 368:12 387:5
submitted 74:21 137:13 147:1 258:14 305:16 308:3 311:6 348:4 401:2
submitting 217:17
subsequently 251:22

subset 93:11
subspecialists 377:5
substance 93:11
substantial 281:15 391:22
substantially 334:19
substantive 35:21 67:20 305:13
substituting 223:3
succeed 240:16
successful 342:22
successfully 365:11
succinct 31:22
sufficient 78:14 86:12 117:17 118:3 124:8 196:11 263:6 352:17
sufficiently 122:2 124:14 279:19 297:21
sugar 188:15,15
suggest 59:3 95:13 140:8 255:2 371:14 394:20
suggested 35:19 36:1 289:2 374:18
suggesting 217:13 228:2 246:9 253:4
suggestion 245:3 291:21 292:8 294:11 295:21
suite 83:20
summarize 155:20 364:3
summarizes 72:17
summary 56:8 212:10 241:9 268:2 305:6,19 344:2
summer 171:2 335:14
super-majority 52:14 53:4 65:22
supply 14:18
supported 43:18 68:12 76:11,22 120:18 208:21 209:22 259:14 291:3 364:11 366:5 366:10 367:18
supporting 272:22
supportive 82:22 91:20 94:5 185:10 343:15 366:16
supports 37:11 41:3 127:20 193:16 339:19
suppose 64:10 195:4 380:18
supposed 52:22 71:11 175:8 187:10 252:5 329:4 352:11
Surgeons 1:18 10:17 10:19
surmise 140:14
surpasses 306:8
surprise 185:17
surprising 172:5
surprisingly 185:6
survey 79:10,11,12 81:6,9 86:17 88:6,9
SurveyMonkey 164:17
surveys 85:20 86:4,19 87:4,19 88:7
Susan 329:3
sustaining 366:17
swapping 251:21
swayed 81:17
switched 380:21
SWR 390:15
system 1:21 14:1 81:13 88:22 97:13 108:13 108:18 137:3 151:16 151:17 152:9 155:8 180:8 281:22 282:21 283:6 284:11 374:10 392:13,13 394:3
systematic 155:14 235:13
systems 142:11 143:10 144:3,6 234:3 283:19

T

table 8:19 9:5 38:15 42:5 51:1 143:8 165:18 170:5 173:21 178:22 179:2,3 207:13 216:15 244:10 245:5 248:11 268:7 275:22 289:10,12 296:1,3 322:9 382:20 404:1
tables 270:21
tabulation 355:22
tactic 285:9
taken 22:14 41:21 207:11 209:14 237:9 344:8 388:5 390:20
takes 52:10 53:13 87:3 228:12 291:15 318:9
talk 23:10 26:5 28:8 30:8 41:10,11 48:14 58:13 61:9 62:17 67:13 73:9 92:9 130:1 131:9 153:15 154:2 168:4 176:8 184:3 187:6 191:16 201:12 209:6 210:12 234:6 241:15 252:19 267:15 300:15 301:16,19 305:20 306:12 327:11 348:11 405:4
talked 79:12 97:6 130:18 145:21 153:17 182:13 201:14 396:14
talking 23:6 44:15 66:12 72:20 110:6 128:7,8 151:15 159:20,21 172:13 270:22 271:11 280:16 281:20 303:11 304:13 304:14
tally 60:17
tallying 60:9
tangled 292:7
tapped 59:4
target 241:15 373:18
targeting 242:5
targets 228:10
Taroon 120:8 127:8
TAROOQ 3:2
task 19:4 67:4 169:4 176:18,19,21 196:2 197:16,20 199:13 203:4 207:10 212:3 261:7 263:1 276:12 287:16,17,22 289:7 289:13 299:1 322:10 326:10
Taskforce 66:13
taskforces 50:5 53:17
taxpayers 281:7
team 25:17 29:18 30:7 77:11 91:19 141:6,6,9 268:20 301:8 305:17 306:6
team-based 123:10,15 126:7
tease 138:3
technical 104:16 173:22 182:20 256:5 256:5 345:10
technically 256:3 316:12
technology 2:16 17:13 74:11
teleconference 3:22 226:8
telephone 83:12,15 85:10 359:7 403:5
tell 40:10 145:14 227:18 286:15 318:18 319:17 320:12 348:19 376:10 379:7 393:15
tells 40:15 101:19 136:17
temporary 294:20
ten 105:5,7 250:10 280:9 305:2 356:1 357:18
ten- 95:14
tend 284:17 393:4 398:14
tension 47:18 115:16 143:3 159:11 267:15
TEP 166:17,21 384:10 384:10
TEPs 166:19
term 21:2 147:11 206:19 282:21
terminology 159:13
terms 36:8 37:10 49:19 66:15 78:9 85:3,5 88:11 90:13,18 93:1 95:19 99:19 103:18 125:13 127:11,13 128:1 129:14 130:10 130:13 131:11 132:4 135:2 146:5 149:14 151:13 169:21 170:17 186:6 189:16 206:1 208:9 209:3 232:21 248:9 250:2 252:7,17 253:2,17 255:3 262:7 262:12 270:16 292:13 298:9 299:20 302:6 323:9 334:16 337:10 342:4 363:2 399:3 400:14
tertiary 331:21
test 69:12,13,15,16 70:8,12 100:1,3,4,5 101:10 220:20,22 221:5 222:4,4 224:7 275:18 351:5
tested 85:21 121:7 140:6 148:22 203:21 204:3,9 213:22 216:4 216:11,18,19 217:17 255:10 351:11
testing 34:7 79:18 81:8 83:5 86:1,3,6,22 100:4 117:19 121:10 121:19 124:8 137:14 139:18,22 142:19 170:17,20 171:4,8,11 204:8 218:5,10 224:9 304:7,17 305:1,3,10 315:8 350:11 352:6
text 67:21 68:16
text-heavy 56:17
thank 5:7,8,11,14 8:2,8 13:11,21 14:10 16:10 16:14 17:8,15 18:9,18 18:20 29:18 30:2,12 35:8 40:17 49:3 65:15 82:1,5 93:16,20 95:4 99:3 100:17 106:14

109:20 110:10 135:1 158:13 169:14 171:12 179:4,17,19 186:14 189:2 215:10 221:15 222:14 226:12 232:10 259:3 268:13 269:18 274:13 298:19 301:10 343:8 345:9 357:11 359:11,14 360:9 364:5 367:4 368:17 376:6 396:20 403:15 403:19 404:9,11 406:1
thanks 40:16 77:10 79:1 81:20 82:6 115:11 168:5,11,17 172:1 174:16 176:2 179:5 202:7 214:12 214:19 223:10 235:18 239:21 268:11 299:15 341:9 350:18 378:15 392:17 397:19
theme 74:7 208:5 361:3 366:11
themes 72:3,18 97:7 180:17 183:3 184:20 186:6,10 360:2 361:1
themotion 253:7
theoretical 141:16
theoretically 130:14 140:13
theory 130:9 139:5 156:3
therapies 376:17
thereof 379:3
they'd 38:9 77:8
things 15:8 28:1 39:15 77:7 101:1 115:14 121:10 129:5 132:20 136:3 137:11 142:20 155:21 157:20 161:10 163:12 167:21 179:1 179:2 186:14,18 197:2 199:10 206:17 209:12 210:15 233:20 234:4 235:14 237:8 238:15 241:5,7 267:19 282:19 290:1 293:20 296:11 303:13 306:19 325:21 332:5 335:1 339:22 340:17 382:20 383:13 388:11 388:21 389:11 390:21 395:2 396:8 403:11
thinks 34:1
third 31:4 118:14 122:3 134:3 155:5 187:16 372:17
thirdly 119:15
thirteen 250:11
thorough 260:7 294:17 317:15
thoroughly 294:22
thought 25:18 34:16 35:10 40:15 46:4 70:8 75:6,10 97:14 151:9 153:11 184:13 206:8 224:8 272:20 275:7 278:5,7 344:21 348:22 351:1,7 352:11 369:1 370:16 373:16
thoughtful 144:9
thoughtfulness 29:21 30:5
thoughts 171:18,21 215:17 268:7
three 9:8 24:12 25:6 29:13 33:3 38:1,2,7 45:7 63:7 102:11 127:19 136:3 166:7 180:12,13,14 185:16 200:4,6 201:21 208:12 256:1,17 273:12 275:9,11 280:10 281:14 320:10 387:9
Three-one-zero 193:3
Three-sixty-seven 192:21
Three-sixty-three 192:21
three-step 31:1
Three-ten 193:2
threshold 52:5 103:1 103:19 164:13 166:1 173:18
thresholds 160:5 164:3
thriving 392:8
throw 158:6 295:16
throws 135:6
thumbs-up 314:15
THURSDAY 1:5
ties 50:2 69:22
Tilly 3:7 72:9,10 73:11
time-limited 81:9
timelines 319:1
timely 124:19 348:10
times 25:21 26:5 48:5 100:22 102:18 107:7 137:10 156:6 159:15 182:2 204:22 208:8 235:8,8,8 377:18
timing 77:1 96:12 213:13 363:12
tired 400:11
Title 145:21
tobacco 239:8
today 5:6 6:1 9:4,7 11:18 19:5,21 23:10 29:12 35:5 54:12 55:5 56:10 72:10 81:21 102:9 162:10,20 168:21 171:11 174:13 187:19 294:19 347:8 362:21 385:10 392:7 402:21 403:16 404:18
today's 7:10 393:14
told 70:5 102:6 171:6 310:6
tomorrow 30:9 34:22 37:17 38:15,18 41:14 42:5 45:1 46:6,17 50:10 52:17 53:7,21 54:9 55:3 67:13 95:18 105:11 106:19 161:5 161:21 162:9 166:12 202:21 209:3,6 210:8 210:12 252:20 291:12 292:19 294:18 295:1 311:17 403:22 404:19
tomorrow's 48:13 106:5
tonight 404:6
top 19:5 36:16 164:12 205:4 215:21
topic 63:18 158:6 161:8 181:4 182:3 184:19
topics 184:3,13 185:4
topped-out 184:10
total 64:7,13 135:10 189:19 194:9 195:1 205:7 334:20
totally 5:20 53:9 139:7 240:1
tough 380:2
track 42:9 268:2 373:9
tracking 43:17 164:7 267:19
tradeoffs 110:16 120:21
traditionally 83:22 151:18
transfer 73:21 74:18 75:1 331:22
transfers 331:20
transfusion 396:2
transition 70:14 78:6 356:16 405:12
transitions 97:7
transparency 15:16 43:7,7 112:8,19 114:17 187:2 393:9 399:4
transparent 110:19 111:14 115:7 116:15 120:20 124:2 129:3 129:16 130:3 155:17 156:4,22 159:22
transplant 365:9 373:4 376:8,12,13,18 377:11,14 378:1,8 381:17,19 383:20 384:13,21 387:16 388:9,15,22 389:2,9 389:12 390:19 391:1 391:5,10,13 393:3 398:11 399:1,9
transplantation 393:17
transplanted 384:14 385:3,4 389:4 393:17
transplants 376:14 379:5 382:5 384:22 384:22 392:1,14 393:11
transport 335:1 337:13
Travis 3:17 358:9,11,14 364:5,6 367:4
treated 49:20 323:10
treating 131:5 231:2
treatment 229:9 332:21 346:22
tremendous 29:3 175:1
trials 301:2
Tricia 1:16 12:8
tried 26:19 148:8 302:17 342:14 376:18 391:9
trigger 302:8,12
triggered 97:16 117:20
triggering 300:18
trouble 7:7,15,21 53:12 53:14 131:22 152:4
troubles 153:5
true 37:4 97:19 235:16 236:13 240:8 259:10 269:17 291:6 312:12 316:13 319:9 393:18
truly 26:10 69:1 284:18
try 39:14 52:6 132:16 155:20 173:4 180:19 181:17 213:9,12 399:2
trying 9:12 41:8 72:22 94:19 106:11 120:14 123:14 128:13 137:4 150:10 156:9 172:16 172:18 173:8,9 188:19 192:19 197:6 231:11 237:17 281:21 285:14 289:22 290:1 307:2 309:9 318:21

323:13 348:3 370:20 381:12 382:21 397:2
turn 6:22 7:22 36:18 64:1 72:19 74:13 77:4 186:2 226:15 301:7 359:21 360:3 365:15 401:19
turning 7:6 72:7 74:22 76:9
tweak 254:8 255:8 303:13
twelve 250:10
twenty 250:12
twenty- 250:12
Twenty-four 250:13
twenty-one 250:12
twenty-three 250:13
twice 244:1,3 289:14 354:19
two 8:12,12 21:3 25:2,6 42:16 45:14 46:1 61:21 71:1 89:22 93:3 98:10 107:2 127:16 130:5 148:1 155:2 159:6 166:6 169:7,16 179:9,21 180:6 183:3 186:1 187:8 194:10 194:18 199:10 200:1 200:6,13,16 201:15 203:5 214:6 222:11 227:3,17 242:21,22 243:1 244:6 246:21 249:22 250:8,13 252:22 261:13,16 262:3 264:12 265:15 273:12 275:9 281:14 293:20 303:16 316:1 331:10,12 332:19 335:11,17 337:3 353:13 364:15 367:22 369:4,13 377:12 394:21
type 132:19 133:8 161:11 231:1,2 232:20 239:4 333:17
types 8:13 21:3 29:7 336:12,21 337:12 374:5
typically 284:4

U

ultimate 388:10
ultimately 45:3 108:16 111:18 147:11 210:3 312:11 343:17 387:6
unable 313:12
unacceptable 231:18
unanimous 290:8,17,20 291:7
uncertainty 212:16
uncomfortable 236:22 237:1
uncommon 130:22
under- 229:8
undergoing 254:14
undergone 124:8
undermines 283:6
underscores 395:11
underserved 329:20
understand 37:7 45:14 53:9,10,11 65:17 66:1 85:16 87:15 114:12 127:10 129:7 137:1,6 141:13 144:5 157:17 198:15 224:10 245:11 262:6,9 278:10 292:19 301:17 321:21 349:11 369:4 378:22 393:1 394:10
understandable 50:19
understanding 43:15 84:18 181:5 207:22 209:1 217:15 218:7 218:12 307:1,7 317:6 317:7 346:11
understands 70:9
understood 148:3 244:16 308:4 347:21
undertook 29:21
unfairly 122:22
unfortunately 346:4
unintended 121:11 126:10 269:15 270:7 395:4 396:1
Union 1:14
unique 180:13
unit 118:17 127:10 128:4
units 118:15,20
universe 280:6
University 16:3 109:9
unpaid 15:8
unquote 112:11
unsatisfied 88:9
unspecified 315:13
unusual 353:2
upcoming 35:3 303:9 305:21
update 41:19 102:15 140:22 171:10 257:15 257:17
updated 115:6 227:8 255:14 257:5,19 260:18 304:9,16 305:18 306:2,12 324:14 326:14,19 328:21
updating 257:19 260:17
upside 272:1
urgent 89:5
use 6:3 20:6 23:20 50:3 52:19 53:3 58:20 69:19 75:3 78:17 96:21 109:12,12 112:11 114:13 120:7 121:5 122:15 125:21 125:22 132:8,14 137:7 139:13,17 140:2,5 147:15,18 185:2,4 191:15 192:4 203:20 205:22 216:1 232:19 235:22 236:12 246:22 247:6,9 257:5 257:19 265:10 266:3 266:12 277:12 278:14 278:18 279:3 282:20 285:7,15 292:8 297:14 299:21 316:5 318:1 363:4,5 372:2 387:19 396:17
use-agnostic 160:15
useful 38:18 371:21 372:1
users 239:8
uses 32:6
USPSTF 341:17,19
usual 30:3 306:8
usually 44:4,5 204:16
utilize 137:2

V

VA 241:18
vaccination 63:16 326:20 328:2,5,8
vaccine 324:18,19 327:5,6 329:6,16,19
valid 271:13 341:14 351:5,11 352:22 363:6,10,22 383:2
validated 85:22 86:11
validation 81:8 83:5
validity 148:12 216:8 346:14 350:7 351:20 352:14 367:16 375:13
valuable 42:6 266:10 270:8 278:22
value 27:12 75:22 94:15 152:16 241:4 267:17 269:4 282:4,4,8
value- 394:6
value-based 107:13 132:10 133:20 181:6 360:20 397:22 398:2 399:6
variability 400:19
variation 94:7 133:16 140:18 141:4 376:11
variety 28:10 147:19
various 68:5 102:18 107:11,17 118:3 157:15 158:2 233:2
vary 121:13 334:18
varying 25:21
vascular 63:19 192:1,4 208:14 232:18 261:15 277:11 278:13,19 356:10
vast 178:6 180:9
vehicles 85:6
verbalized 206:3
verbally 273:17 274:11
verify 354:6
verifying 177:20
version 206:15 350:13 352:2
versus 21:15 133:18 134:10 145:6 172:10 201:17 202:13,16 203:16 212:11 229:9 239:1 242:5 281:14 285:11,15 321:15
vessel 300:6
Vice 3:5 8:5 214:13
vice-versa 140:3
view 59:14 144:11 182:9,10 194:3 203:9 207:10 317:18 345:16
viewed 46:11
viewpoint 82:17
views 8:20 386:20
virtually 202:5
visibility 392:12
vision 87:21
visited 239:8 342:18
visits 366:20
visual 163:15
visualizing 131:22
voice 150:20
voluntary 147:10 247:1 265:15,20
volunteered 15:9
vote's 248:22
voted 22:5 101:8 196:3 199:1,2 251:7 264:2 274:20 290:22,22 293:15 356:13 402:2
voter 272:8
voters 164:1,3,11,13,14 165:7,21
votes 54:13 60:9 98:7 99:7,13 100:20 102:5 103:12 163:17 196:11

201:15 227:18 243:20 244:6 246:22 273:15 275:4,8 286:21 287:2 296:5 403:17 404:10 404:11
voting 31:18 33:14 36:4 40:18 49:2,4,6 51:10 51:13,19 52:13 53:3,4 56:11,12 57:19 60:10 64:5 68:22 69:11,15 69:15 93:22 95:11,15 96:1 98:2,4,5,12,16 98:17,19 100:7,12,19 101:19 102:19 103:16 103:17,18,20 163:9 166:13 168:19 172:11 189:21 191:7 199:9 224:15 225:4,9,10 243:15 245:13 247:3 247:7,11,14,16,20 248:15 249:18,18 252:7 261:14,17,18 263:9 273:7 277:1,7 286:4,7,11 289:20 291:12,12,17,18 296:14 345:12 359:18 387:1 404:4 405:18 406:5,5

W

wait 65:16 188:2 196:11 211:9 213:7 242:12 249:6,7 310:9,9,9 319:14 364:15 365:3 365:11 369:9 371:15 373:2 374:14 377:21 381:14 382:4 384:1,3 386:4 388:21 389:19 389:20 390:16 393:12 398:16
waiting 222:18,20,22 223:14 261:19 385:18
walk 30:14 56:12 132:3 215:13 300:10
walking 113:10
walkthrough 131:18
Walters 3:18 358:9,10 365:17,21 367:20 386:13
wanted 15:12 17:17 30:20 65:9 66:4 82:21 88:16 99:22 113:14 119:10 125:2,9 129:14 135:16 141:19 161:8 163:8,16 164:6 192:19 201:2 204:8 204:11 208:3,10 214:8 218:16,22 247:4 255:19 277:6 279:15 282:17 325:19 326:22 335:8 339:17 345:13 349:22 353:9 357:4 358:13 384:9 385:8,18 386:7 391:17 406:2,6,7
wanting 21:15 195:14 212:15 394:11
wants 58:14 66:10 95:6 177:13 190:16 191:18 244:7 245:21 293:17 329:8 358:19 369:6 376:2
warrant 333:19 371:13
warranted 262:15
warrants 228:19 260:21 379:21
Washington 1:8
wasn't 92:21 93:13 111:16 143:15 166:20 203:6 334:11 347:16 357:1 374:19 391:14
waste 187:3
wasting 245:10
wavelength 53:20
way 6:8 7:13 13:6 26:12 34:4 35:6 44:12 45:10 45:16 46:8 47:15 48:22 49:20 53:3,5 70:9 83:15 89:4 99:13 101:3 112:9 122:12 128:19 131:11 140:20 141:1 142:5,8 155:7 155:13,14 159:3,18 166:19 175:2 189:19 194:7 201:13 202:2 206:11,11,20 207:2 209:19 234:14,15 235:13 243:4,5 245:10,15 254:8 268:1 271:6 296:9 298:11 307:3 317:16 320:7,19 336:1,2 351:6 374:18 392:18 393:10
ways 17:5 21:3 48:17 52:12 90:11 127:21 142:12 161:10 211:2 211:19 285:14 303:4 376:19,19 395:9
weaknesses 33:10
web 41:15 62:22 99:9 177:12
web-based 86:4
webchat 7:16
webinar 26:6 205:22
webinars 305:21
website 7:8
weeds 334:21
weigh 26:11 68:19 122:10 373:21
weighed 33:7
weight 135:9 150:21
weighting 285:10
welcome 4:5 8:3,8 9:22 127:1 158:7 179:6
well-defined 111:16
well-positioned 301:4
well-suited 182:8
well-vetted 81:18
went 21:21 24:11 25:9 47:3 68:6 87:16 93:4 93:7,9,14 105:19 156:14 163:3 204:3 278:17 310:17 350:6 353:4 356:12 358:2 378:20 391:11 401:15 406:10
weren't 26:16,21 66:5 359:18 376:19
wherefores 262:13
whichever 210:16
white 1:14 150:5 214:20 214:21
wholly 378:13
whys 262:13
widely 303:21
wife 105:1,2
WILLIAM 2:1
willing 247:9 293:13
willingness 144:21
win 94:19 245:22
window 133:4
winning 141:7,8
Wisconsin 259:9
wish 312:12
wishes 359:2
witching 5:3
withdraw 60:2
withdrawing 268:17
withdrawn 250:21
Wojcik 2:11 14:7,8
Women 2:4 13:9
wonder 80:13
wonderful 49:3 186:20
wondering 202:14 205:19 206:7 295:6
word 20:5,6 123:1 218:8
worded 286:1
words 132:12 218:12 235:3 265:20 292:1
work 5:11,14,15 7:18 9:3 14:19 15:1,18 17:7 23:15,21 24:9 28:12 29:19 43:9 46:4 46:22,22 50:3,16 51:7 52:22 53:17 69:15 84:16 107:2,3,5,8 112:7 113:1,4 115:15 117:20 118:2 119:13 120:6 125:3,7,10,12 125:17 126:2,15,20 126:22 129:2,12 130:16 136:10 137:2 137:3,12 138:4,19 145:16 146:4,13 150:15 158:12 161:1 168:20 175:20 186:17 188:5 197:16 206:21 207:1 213:9 218:6 220:20 222:16 224:11 224:12 237:17 257:3 281:19 290:10 301:12 311:10 321:8 399:1
worked 301:8 305:17 365:5 387:18 392:19 403:20
workers 162:4
workgroup's 41:15 57:20 61:3 204:5 246:6 308:15 322:5,6 360:8 367:18 386:10
workgroups 5:10,11 6:7,13 19:3,16 20:9 31:8,10,19 35:22 36:22 37:1,2 39:11 42:10 54:21 55:10 62:9 169:20 173:7 202:12 212:22
workgroups' 19:19 186:22
working 30:6,19 31:18 40:5 69:18 87:20 100:20 106:22 137:11 203:15 224:3 359:13 382:14
works 40:8 51:2 151:16 221:2 234:14 307:11
world 123:14 145:2 318:13 319:3,5 399:5
worried 193:13
worrying 244:12
worth 28:16 96:16 245:18 252:14 343:19 347:16
worthwhile 52:17
worthy 85:2 262:2
wouldn't 146:14 219:10 219:17 223:6 231:16 271:14 273:17 285:20 289:14 328:11,12 352:1

wow 167:15
wraps 405:13
write 396:11
written 187:13
wrong 50:4 83:8 146:3 175:14 249:11 276:6 351:4
wrongly 112:11

X

X 291:4

Y

Y 291:4
year 23:6,16 24:7,12,20 25:1,15 26:7,15,18 30:1 31:11,11 43:16 44:3,14 45:11 46:1 51:2 62:21 65:10,13 107:2 182:6 183:21 212:19 241:19 315:3 316:19 318:16,20 319:12,15 320:2 321:13 348:16 350:4 360:11,16 378:10 393:16 396:7 404:2,8
year's 19:6 316:20 320:8
years 23:3,18 24:10 25:6,20 26:20 40:2 51:8 232:19 256:1,17 270:21 302:3 339:14 378:11 392:20
yeses 274:18,21 275:1 357:14 402:15
Yetunde 3:6 60:11 64:15 70:2
Yong 3:19 17:6,6 25:17 146:16 205:19 328:20 335:3
York 16:4
younger 229:17

Z

Z 291:4
zero 102:20 406:5
Zostrix 329:6

0

0.75 235:8,8,8,8
0.79 391:11
0.82 391:11

1

10 195:17 221:21 276:2 276:5 286:19 312:16
10,000 9:2
10,000-foot 159:18
10:30 70:7 71:6
10:55 105:19
100 234:18
100,000-foot 149:10
1030 1:8
109 188:15
11 195:17 274:21 275:1 275:5
11:00 95:16
11:12 105:20
12 275:11 276:3 286:19
12:05 163:3
12:30 162:12,14 163:1
12:37 163:4
13 176:4 310:3,4 312:17 350:13
130 137:5
15 22:20 69:10 297:2
15th 1:8 62:10,12
16 166:7
160 128:6,22 129:2
163 109:11
169 4:11
17 100:9 165:22 166:5
17-241 371:15
17-367 338:8
179 4:14
18 149:14 165:17 191:10 290:22
181 192:19
19 164:14
194 192:19 232:2
1999 229:11
1st 62:7,14

2

2 187:6 231:1
20 244:11 252:15
2011 187:17 188:22
2014 229:12
2015 237:7 301:22
2016 344:2 352:1
2017 31:11 34:12 35:13 56:16 62:22 76:14 258:16 367:12
2018 1:6 147:10
2019 77:2
210 192:19 194:12,12 194:16
215 192:19 236:3
22 4:5 102:5,9,13,19,20 103:11 104:1,6,13 180:10,13 187:20 191:9 195:16 286:21 286:22 288:4 310:3,4 402:12
23 387:7,9 406:5
234 278:6
24 223:14,21 250:14 263:6 284:9 290:22 323:2
241 369:9 370:8
25 1:6 222:19 223:22 225:17,19 263:6 275:14
258 100:9
26 102:8 357:13 402:15
27 165:17
28 98:15 164:13 165:17 165:21
29 103:21 104:4

3

3 176:5 180:11 191:9
3:41 358:2
3:56 358:3
30 4:6 42:15 132:15 133:17 134:10,19 135:5 143:15 300:9 306:8
30-day 133:4,15
300 24:18
30th 35:13
310 192:22 194:11,16 194:19
32 65:2 164:9 188:7 235:9 248:19
33 99:14 229:13
35 205:7
358 4:17
359 4:20
367 194:20
37 188:9
39 100:20 229:11

4

4 102:9 176:5
4:45 406:10
40 96:20
40-plus 301:12
401Ks 12:5
406 4:22
45 276:9 386:18

5

5 4:4 205:6
50/50 387:3
500 24:15
59 66:19

6

6.5 188:14
60 49:8,20 50:1,3,11,11 51:12,19 52:4 53:4 54:4,11 60:18,20 61:2 65:18 66:20 67:3,5 68:2 104:10 164:2 165:20,22 173:19 225:21 380:19
60- 276:7
60-plus 276:20 286:16 288:4
61 69:4
66 163:22 164:13
68 248:19

7

70 4:7
71 4:9
72 385:22
74 231:4
75 103:4,12 104:2 235:5 235:6 306:7
75-year-olds 390:8

8

8 191:10
8.0 192:3 264:6
80 80:1 225:21,21 345:15
83 106:16

9

9 195:16 269:13,16
9:00 1:8
9:15 5:4
9:16 5:2
90 234:19
91 85:12
92 85:12
9th 1:8

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership Coordinating Committee Meeting

Before: NQF

Date: 01-25-18

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.

Court Reporter

NATIONAL QUALITY FORUM

+ + + + +

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE

+ + + + +

FRIDAY
JANUARY 26, 2018

The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Charles Kahn III and Harold Pincus, Co-Chairs, presiding.

PRESENT:
CHARLES KAHN III, MPH, Co-Chair
HAROLD PINCUS, MD, Co-Chair
RICHARD ANTONELLI, MD, MS, Individual Subject Matter Expert*
JOE BAKER, Medicare Rights Center
LEAH BINDER, MA, MGA, The Leapfrog Group
JOHN BOTT, MSSW, MBA, Consumers Union
MARY BETH BRESCH WHITE, American Nurses Association
RAJESH DAVDA, MD, America's Health Insurance Plans
TRICIA ELLIOTT, MBA, CPHQ, The Joint Commission
DAVID GIFFORD, MD, MPH, American HealthCare Association
BRUCE HALL, MD, PhD, MBA, FACS, American College of Surgeons
GAIL HUNT, National Alliance for Caregiving
MAUREEN KAHN, RN, MHA, MSN, Blessing Health System*
MIRA IRONS, MD, American Board of Medical Specialties*
WILLIAM KRAMER, MBA, Pacific Business Group on Health*

RACHEL LA CROIX, PhD, PMP, National Association of Medicaid Directors
SAMUEL LIN, MD, PhD, MBA, MPA, MS, American Medical Group Association
ERIN MACKAY, MPH, National Partnership for Women & Families
AMY MULLINS, MD, FAAFP, American Academy of Family Physicians
SHAUN O'BRIEN, JD, AFL-CIO
AMIR QASEEM, MD, PhD, MHA, FACP, American College of Physicians*
CHRIS QUERAM, MS, Network for Regional Healthcare Improvement
DEREK ROBINSON, MD, MBA, FACEP, CHCQM, Health Care Service Corporation
MARISSA SCHLAIFER, MS, RPh, Academy of Managed Care Pharmacy

CARL SIRIO, MD, American Medical Association

STEVE WOJCIK, MA, National Business Group on Health

FEDERAL GOVERNMENT LIAISONS (NON-VOTING):

MARY BARTON, MD, National Committee for Quality Assurance

KATE GOODRICH, MD, MHS, Centers for Medicare and Medicaid Services (CMS)

NQF STAFF:

TAROON AMIN, PhD, MPH, Consultant

JOHN BERNOT, Senior Director

KATHRYN BUCHANAN, Project Manager

KAREN JOHNSON, MS, Senior Director, Performance Measures

ELISA MUNTHALI, MPH, Acting Senior Vice President, Quality Measurement

YETUNDE OGUNGBEMI, Project Analyst

ERIN O'ROURKE, Senior Director

ALSO PRESENT:

PIERRE YONG, MD, MPH, MS, Centers for Medicare and Medicaid Services (CMS)

* present by teleconference

C-O-N-T-E-N-T-S

Page

Input on Measure Removal Criteria. 5

Potential Improvements to the Pre-
Rulemaking Process: Voting Process 39

Opportunity for Public Comment 164

MAP Rural Health Presentation. 165

Pre-Rulemaking Cross-Cutting Issues:
Attribution. 136

Potential Improvements to the Pre-
Rulemaking Process: Voting Decision
Categories 112

Opportunity for Public Comment 207

Closing Remarks and Next Steps 207

Adjourn. 210

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

2 (9:09 a.m.)

3 CO-CHAIR KAHN: Okay, let's bring the
4 group to order. And we're going to start as soon
5 as Pierre gets his food. We're going to start
6 with him on the input on measure removal
7 criteria.

8 So, for those of you who are looking
9 at your agenda, we're going to start with the
10 12:45 item, which is Pierre, because I think he
11 might have to leave this morning. So, we want to
12 cover first.

13 And then I guess will we do rural
14 next?

15 MS. O'ROURKE: We'll do the process
16 improvement and then rural.

17 CO-CHAIR KAHN: Okay.

18 MS. O'ROURKE: Process improvement.

19 CO-CHAIR KAHN: Okay. So we'll then
20 go to process improvement and then rural. So,
21 we've got people on the phone. And whatever
22 points you think appropriate on the phone, please

1 don't be shy to ask questions or make comments,
2 if you have them.
3 And also, we will have points during
4 the day, I guess where we have opportunity for
5 public comment. Will they come at the same time,
6 is there only one time today or is there a few
7 times?
8 MS. O'ROURKE: We'll have one before
9 lunch and then one before we conclude for the
10 day.
11 CO-CHAIR KAHN: Okay. Okay, so
12 without further ado, Pierre, you have the floor.
13 DR. YONG: Thanks. Thank you very
14 much, Chip, I appreciate it.
15 And so, good morning to everybody.
16 Very happy that today is our last official day of
17 the MAP in-person meeting since I've been here a
18 number of days, but it has been great this year.
19 I think this year, as you've noticed,
20 we have taken a little bit of a different
21 approach to the MUC list as you've noticed. The
22 MUC list is quite smaller than it has been in the

1 past years.

2 As Kate mentioned yesterday, we've

3 launched a new initiative called meaningful

4 measures. Hopefully you have heard that

5 presentation.

6 We've done a number of them across the

7 MAP workgroups on the webinars as well as the in-

8 person December meetings. And thought you

9 probably have had a chance to hear it so I didn't

10 want to repeat it here.

11 But in that sort of context, we've

12 been thinking about that framework and applying

13 it to our work in multiple different ways. So

14 it's not just about what kinds of measures we

15 have in our programs, but it's also about measure

16 development, it's also about thinking about the

17 current measure sets and what really makes sense

18 to keep in those measure sets, what might be

19 right for removal in the context of the criteria

20 we have laid out.

21 So in that sort of framing, we thought

22 it would be a great opportunity to take those in-

1 person meetings and get some feedback across the
2 work MAP workgroups about some potential removal
3 criteria for us to consider as we look at our
4 existing measure sets.
5 And so we did these, they did this
6 session or this agenda across those workgroups,
7 and wanted to actually bring some of that
8 discussion to the Coordinating Committee as well.
9 And so have wanted to bring this forward.
10 So, if you'd move to the next slide.
11 The question, which I have already said but, is,
12 what criteria should CMS consider as it reviews
13 its measure sets across its programs for its
14 quality reporting and value-based purchasing
15 programs?
16 So, in the next couple of slides, if
17 you advance to the next slide please, outlines
18 some high-level criteria that we put forward to
19 the different workgroups and would love your
20 feedback on those.
21 The first is that the measures are
22 meaningful to patients and providers. That they

1 really are patient-centered, that they focus on
2 the high priority quality areas that we've
3 identified in the framework, and that they are
4 current with clinical guidelines. And we had
5 some discussion around guidelines yesterday.
6 Of note, sometimes we do have
7 statutory specifics, statutory requirements that
8 we need to meet with particular programs and have
9 to develop particular measures for programs, so
10 we need to consider that as well.
11 Measure type is actually something
12 that we have had lots of discussion across the
13 MAP workgroups as well as in the endorsement side
14 as well, but really do prefer this movement
15 towards outcome measures. That doesn't mean that
16 there isn't a role or place for process measures.
17 Sometimes there aren't outcome
18 measures available in particular quality areas,
19 and so, in that certain situations process
20 measures can be very valuable. Particularly if
21 they're proximal really and tied to the outcome
22 of interest.

1 Given that we are moving increasingly
2 towards value-based purchasing programs where
3 payment is tied to performance on quality
4 measures, I really do want to look at the
5 variation in performance across a particular
6 metric. And so that's another consideration we
7 identified.
8 If you move to the next slide please.
9 Performance trends, some of these measures have
10 been in these programs for many years now, so one
11 of the things we want to look at is looking at
12 the trends and performance burden.
13 Kate mentioned the patients over
14 paperwork initiative that we have been working on
15 at CMS to really focus on decreasing the amount
16 of burden placed on providers and clinicians.
17 And so the amount of burden associated with
18 recording a measure, reviewing measure.
19 Also, it's a burden related to any
20 particular measures is another consideration for
21 us.
22 Unintended consequences is something

1 that's come up yesterday. We talked a little bit
2 about that with the A1C measure and the diabetes
3 composite, but certainly want to consider
4 unintended, potential unintended consequences
5 that have arisen from the use of any particular
6 issue.
7 We also at CMS have significant
8 operational considerations that come into play
9 when we consider both implementing a measure, but
10 also if there are challenges that may influence
11 whether or not we decide to keep a measure in the
12 program.
13 If you'd move to the next slide.
14 Alignment is something we heard a lot about
15 yesterday as well. These are, I think, all these
16 sorts of elements are things that are surprising
17 to anybody, but alignment of similar measures
18 across, not just our programs within CMS but also
19 with private pairs.
20 This also ties back to the burden
21 issue that I mentioned on the prior slide.
22 De-duplication. So we want to try and

1 minimize unnecessary duplication of measures and
2 measure concepts within measure sets to really
3 focus on measures at the measure set, and they're
4 individual measures, on particular high impact
5 quality areas.
6 Quality improvement. So, the ability
7 of a particular measure to drive quality
8 improvement is ultimately what we want to see
9 happen.
10 If you move to the next slide. And
11 this is the last slide. Consideration of that
12 measure and the context of the overall measure
13 set.
14 So, certainly if you remove a measure,
15 is that going to leave a huge gap in the measure
16 set that's going to be creating an important gap
17 that we don't want to create or will there be
18 other measures that sort of remain that are more
19 important to the overall measure sets.
20 So those are some overall initial
21 draft considerations that we discussed across the
22 individual workgroups. We got a lot of great

1 feedback.

2 Some of its reflected here in the

3 slides I just went over, but would welcome any

4 sort of feedback or reactions or comments based

5 on what we presented. And I don't know if Erin

6 or anybody else from Staff want to comment about

7 certain discussions we had in December.

8 MS. O'ROURKE: Sure. So, to reiterate

9 what Pierre said, this is something we've brought

10 to each of the individual workgroups to get their

11 input on.

12 I think overall people agreed with

13 what Pierre put forward here. Some suggestions

14 on additional areas to look at, ways to refine.

15 So I think we want to get your input.

16 We know measure removal is a topic MAP has wanted

17 to take up.

18 We may not necessarily have the

19 statutory charge to do that right now at a

20 measure-by-measure level, so we wanted to bring

21 you, when we were discussing this with our

22 colleagues at CMS, at least a chance to weigh in

1 on the input that they are using to make these
2 decisions.
3 So, again, this is our chance to
4 inform what CMS will be, how they'll be thinking
5 about measure removal and what they'll be doing.
6 And I think overall agreement at the workgroup
7 level with some minor refinements. So we, I
8 think, welcome any thoughts the Coordinating
9 Committee has.
10 CO-CHAIR KAHN: I have a question.
11 When the measure developer, and this may be a
12 naive question, maybe I should know the answer
13 already but I don't think I do, when the measure
14 developers make a presentation to you of whatever
15 their thing is, do they, do you require any
16 quantification of burden?
17 Obviously it's different, depending on
18 which, the claims are different then obviously
19 claims versus IT versus something that requires
20 to be done by hand, and then obviously it varies
21 from setting-to-setting too, but is that, is
22 there any attempt to quantify that?

1 I mean, this has been a constant
2 discussion about burden since we've been doing
3 this thing. Sort of going into the input.
4 And then the output is, I mean, into
5 the trail would be looking at measures to see
6 whether, gee, we've discovered over the time that
7 the burden may not be worth the price of what we
8 get out of it.
9 DR. YONG: Yes, thanks, Chip, it's a
10 great question. I think when we consider any
11 measure for any of our, both the MUC list and
12 potentially for any other programs, we look at
13 multiple aspects of any measure, right?
14 It's not just whether or not the
15 measure is a good measure, has it been fully
16 developed and tested and specified and reliable
17 and all that kind of statistical testing, but we
18 also consider things like the burden of that
19 measure and whether we can operationally feasibly
20 implement such a measure.
21 And in our regulations, when we
22 proposed a measure, we actually do need to assess

1 the estimated burden of implementing any sort of
2 change. And so -- and that we do quantify, both
3 in hours and then dollars impact, the estimated
4 impact of that measure.
5 So, I don't know, Kate, if you want to
6 add anything.
7 MEMBER GOODRICH: The only thing I'll
8 add is, I mean, it's impossible to be able to,
9 with great precision, right, estimate the burden
10 going in. We do our best based upon what we hear
11 from stakeholders, based upon now our number of
12 years of experience and implementation of
13 measures.
14 With this being such a priority for
15 this administration, one of the things that
16 Pierre and his team has undertaken is trying to
17 get at that issue with a little bit more detail
18 so that we can have a better understanding of
19 what the actual burden is for, for example, a
20 chart-abstracted EHR registry measure.
21 So we have plans to sort of go out in
22 the field to understand that a little bit better.

1 So I think our understanding of burden will
2 increase over time.
3 And what's very important about that
4 though, to be very clear, is to understand what
5 you mentioned Chip, which is that tradeoff
6 between burden and the importance of the measure
7 to clinicians and patients.
8 Because one of the things we have
9 absolutely heard from, I would say in particular
10 the clinician community, is that when it's a
11 measure that's actually helping me to improve
12 care for my patients, the burden may be worth it.
13 And so, it really is about
14 understanding that tradeoff from, I would say,
15 certainly from the provider's perspective but
16 also from the patient's perspective.
17 CO-CHAIR KAHN: One more question. I
18 guess, this question of funding of NQFs activity
19 in this area, is there anything authority wise
20 that would prevent you from starting a project
21 where our process could begin to wash through
22 these existing, particularly the more aged

1 measures and make recommendations in terms of
2 whether they still are relevant or meet the kind
3 of, in how they compare with the criteria you
4 have listed for removal?
5 DR. YONG: So I can certainly start,
6 and maybe, Kate, you might want to add in. So, I
7 think we'd have to go back to actually look at
8 the statutory language, I don't know it off the
9 top of my head.
10 But my recollection of the intent or
11 the language that sort of created the, the MAP
12 essentially, was to make recommendations about
13 measures before they get implemented into
14 programs. And that was assumed to be the focus,
15 but we'd have to go look back at the exact
16 language to be sure.
17 MEMBER GOODRICH: Yes, exactly right.
18 And the only thing I would add to that is, for
19 this contract in particular, because the
20 activities are required by statute, unlike a lot
21 of our other contracting activities, it goes
22 through a fairly significant, our scope of work,

1 goes through a fairly significant review by
2 lawyers and OMB and people like that to make sure
3 that we are doing what is within the statutory
4 purview. So it would require all that.
5 So the answer is not definitely yes or
6 definitely no, we'd really have to go back and
7 understand that better.
8 CO-CHAIR KAHN: I guess I want to sort
9 of, I want to broaden your thinking. Which is
10 that I don't, I mean, the MAP is an entity that
11 works with you based on the contracting based on
12 the law, but that doesn't mean there are other
13 authorities within CMS that wouldn't allow you to
14 contract with NQF.
15 And if this is a priority of the
16 administration then it seems to me that, and some
17 of the issues that come up here really relate to
18 this issue of what's the feedback loop. And it
19 seems to me that if we were creative in looking,
20 I mean, there are different things you can
21 contract for.
22 So I just want to open your mind a

1 little bit to that.
2 MEMBER GOODRICH: No, you're right
3 about that. And not to get too into weedy
4 government contracting stuff, it has to do with
5 the funding source, right?
6 So if our lawyers, and we were to feel
7 like we could not use the current contract,
8 you're right, we could compete another contract
9 for that work under a different funding source.
10 So, I don't want to get into the details.
11 So that is something we absolutely
12 could think about. We probably couldn't do it
13 under the existing contractual structure, but we
14 certainly could think about that through another
15 stream.
16 CO-CHAIR KAHN: Well, at least from my
17 standpoint I wish you would.
18 MEMBER MULLINS: So, I want to preface
19 some of my comments with some survey results we
20 recently had. We recently surveyed our
21 membership about value-based payment contracts
22 and found some interesting results.

1 And one of the reasons I spoke so
2 passionately yesterday about burden reduction was
3 because of some of this.
4 So, 37 percent of our members have ten
5 or more payers that they report to and 60 percent
6 of them have at least seven payers they report
7 to. So that's a lot of reporting and a lot of
8 burden placed on them.
9 In that same survey, we found out that
10 62 percent of our members don't believe that
11 quality measure and quality measurement improves
12 patient care at all. So, we have a huge gap in
13 what we're doing and what we're asking them to do
14 and what they believe that does for these
15 patients.
16 So, as we're trying to improve
17 measurement and move measures in and out of
18 programs, we need to be very cautious that we do
19 it intentionally and we do it with plenty of
20 warning to clinicians. So you can't just have a
21 measure there one year and take it away the next,
22 because the infrastructure it takes to report

1 that measure is timely and costly.
2 And so you build it up, you build the
3 process up, you get your EHR ready to do it and
4 then the next year that measure is gone. And
5 that is like pulling the rug out from under the
6 clinicians that are doing that work.
7 So I would caution against that.
8 There is the process, you know this, Pierre,
9 there is a process in MIPS to remove topped-out
10 measures over a four year process.
11 So that is probably a good time frame
12 and a good process. I don't know if that could
13 be applied to other programs, but the measure
14 removal process in MIPS is the topped out
15 process. So perhaps that could be something that
16 could be applied across other programs.
17 MEMBER BOTT: Yes, so a couple
18 questions. So, I noticed patient-centered was at
19 the top of your list, so how are you planning to
20 ascertain if a measure is patient-centered?
21 And a follow-up question. I noticed,
22 again, it was at the top of the list, is there

1 any formal or informal prioritization amongst
2 these criteria and measure selection/removal?
3 DR. YONG: So, maybe I'll answer both.
4 Or I want to respond to Amy and then I'll answer
5 John's questions as well.
6 So, taking John's questions first. I
7 mean I think, yes, certainly in terms of patient-
8 centered we do think in all of our sort of
9 thinking, and that's reflected, I think in our
10 materials as well, the patient is always is at
11 the center of what we do.
12 In terms of sort obtaining feedback
13 about measures that we might want to put into
14 preference, I think we can get input in multiple
15 different ways. Certainly, we've had lots of
16 input, at least in our development process, we
17 actually explicitly incorporate patient
18 perspectives and care giver and family
19 perspectives as part of the measure development
20 process from the very beginning, as we develop
21 measures.
22 We also make sure, and we work with

1 NQF to make sure there is explicit representation
2 of patients and consumers across the MAP
3 workgroup so that we get that perspective.
4 That's reflected in both the, and across all the
5 workgroups at the workgroup levels as a
6 coordinating committee level.
7 And then certainly we actually, as we
8 put through all of our proposals they go through
9 a notice and comment rulemaking process. And so
10 do actively look for the comments submitted from
11 patient and consumer groups as part of that
12 process in addition to the rest of the
13 stakeholders that we work with.
14 In terms of the overall criteria,
15 they're not in any explicit order. Certainly if
16 you have suggestions about things that are more,
17 you think are higher priority for us to consider
18 we'd welcome that sort of feedback on that.
19 And on Amy's comment about sort of
20 timing and not wanting to, like, that it takes
21 time to build infrastructure and not being
22 careful and cognizant about the impacts of

1 pulling measures away, once that infrastructure
2 is created we certainly are aware of that.
3 And certainly as we go through our
4 processes, you know we, to remove any measures
5 generally we go through this notice and comment
6 rulemaking that is usually forecast out at least
7 a few years. And so it's not usually immediate
8 in terms of impact.
9 There are times when we suspend a
10 measure immediately, but that's usually for
11 safety concerns or some, you know, that we've
12 done that. I remember a case where we did that
13 where we had a diabetes, a post-op glycemic
14 measure that we started to hear concerns of
15 overtreatment or under-treatment of the patients
16 because in order to maintain their glycemic
17 control post-op we suspended that measure
18 immediately.
19 But that's usually the only case, at
20 least in recent recollection, that we immediately
21 suspended a measure. Usually there is some
22 forecasting out a few years.

1 MEMBER GIFFORD: A quick clarifying
2 question. This is, we're looking at criteria for
3 CMS to use not criteria that we would adopt and
4 use with individuals. The --
5 CO-CHAIR KAHN: We have no role in
6 removal, although I guess I'm suggesting that
7 maybe we should have a role if we could work it
8 out.
9 MEMBER GIFFORD: Yes. I guess then
10 some feedback on it. And it may sound unique to
11 the PAC setting, but on the burden side often
12 I've seen a discussion around measures that have
13 high performance, low burden and they should be
14 dropped.
15 But even when they have an average
16 high performance, take some of the immunization
17 measures, or, in our setting restraint measures,
18 you have still a significant number, several
19 hundred or a thousand providers, who are
20 performing really poorly on that measure.
21 And so what you may want to think
22 about in this programs is how you weight the

1 measures. So a low burden measure that meets all
2 the other criteria you may not want to get rid of
3 because they're also, they have other benefits
4 outside the program, they are used by other
5 individuals.
6 So even though doctors have multiple
7 people, they often are using the same measures.
8 Hopefully. Not always.
9 But, there may be more innovative ways
10 to do that. And certainly I think, in any of the
11 programs, you may want to know how you weight the
12 measures. Because you really often do a
13 disservice to the measures by equally weighting
14 in almost all the programs.
15 And then the other thing is you're
16 talking, I think, just to add in a clarification
17 point on alignment with the programs, in several
18 settings, particularly the PAC settings, there is
19 a number of other measurement reporting programs
20 or measuring programs that are not coming through
21 the MAP at all that have similar measures that
22 are specified differently than what's in the MAP

1 program.

2 And so there is a value to starting to

3 think about how you align, not just there but

4 across the board and other programs that don't

5 come through the MAP that are not statutorily

6 required.

7 CO-CHAIR KAHN: Carl.

8 MEMBER SIRIO: Yes, just a couple

9 comments. So the first is, and, Kate, this goes

10 go to the conversation we had about a couple

11 measures yesterday where it looked like things

12 over the course of the next 12 months might

13 change in terms of the guidelines that underpin

14 the measures.

15 And I was struck by your comment that

16 you've got a process where you can suspend things

17 relatively quickly. It just seems to me that,

18 and if you have it, I apologize for not knowing

19 about it, there needs to be a process where if in

20 midstream, in the middle of a year, that in fact

21 the world changes in terms of a new set of

22 guidelines, that there's an internal process to

1 in fact determine whether or not, whether
2 suspension is the right word or not, but some
3 process to basically, to take a pause on whether
4 or not there's enough concordance with what's
5 currently going on when compared to what's
6 changing in the world in terms of new guidelines.
7 It's just a thought in terms of being
8 a little bit more speedy or timely given the fact
9 you have to change the battleship with all your
10 rules in terms of process.
11 You know, picking up on some of the
12 things that Amy and you have said, and in
13 particular I'm struck by the discordance between
14 what people believe is actual helpful or not, I
15 think there is value in thinking about
16 maintaining measures even if there is an
17 intuitive sense that you can take it away because
18 performance is high in two spaces.
19 One is certainly the public health
20 space around tobacco cessation and the like,
21 screening for alcoholism. Because those are just
22 important things to do.

1 And there is I think pretty good
2 evidence among human beings. It's not just the
3 medicine, that if you take your eye off the ball
4 you're apt to start to have decrements in your
5 performance.
6 So I think there are some baseline
7 things that you just want to kind of keep your
8 eye on.
9 But the other thing is, as you start
10 to remove measures, in particular if in fact the
11 data, or the survey data suggests that people
12 actually don't believe this helpful, is that as
13 you take things away to see what the change over
14 time is, because if people don't believe this is
15 actually helping, they may not be doing it other
16 than for checking a box. Which is actually not
17 the intent obviously.
18 So my only plea would be that as you
19 remove things, keep the high priority things in
20 place because they're just the right thing to do.
21 And secondly, make sure that we have some process
22 to actually measure decrements in performance

1 over time. I'll probably have some other stuff
2 to say but I'll think about it.
3 CO-CHAIR KAHN: What's the volume of
4 measures that have been removed? I'm mean, sort
5 of how many?
6 I mean, is it a lot, a little, a few,
7 I mean, is it a few, many?
8 DR. YONG: I don't know the answer to
9 that. I mean, every year we make proposals to
10 remove measures in programs.
11 It's usually on the scale probably
12 between, for most part on average, it's probably
13 between like, I'm going to guess, between like
14 three and six maybe per program, per year. And
15 this number measures per program varies.
16 As I know for IQR it's a 50 but for
17 PAC it's, I think they're nine measures or seven
18 measures. So it really varies.
19 CO-CHAIR KAHN: Okay.
20 CO-CHAIR PINCUS: I guess this follows
21 up a little -- so, I mean, this follows a little
22 bit of, I think in terms of thinking about how

1 the process of removal could inform our process
2 so that we begin to learn what things have either
3 haven't worked or have developed some problems,
4 it would be useful if we actually got some kind
5 of feedback so that when you're removing stuff
6 like, so we know how many measures were removed
7 and the reasons why.
8 I presume that you have some way of
9 gathering data on all these criteria, and so if
10 there is some way that we could also share in
11 that information so that it gets fed back to us
12 in some kind of report or some discussion sort of
13 early in our process, hey, here's what we've
14 learned about things that haven't worked or that
15 things have worked for a while but no longer
16 work, that would, I think, help inform our
17 process.
18 CO-CHAIR KAHN: Erin. Sorry.
19 MEMBER MACKAY: Yes, I wanted to pick
20 up on John's point about patient-centeredness and
21 suggest that as we are thinking creatively about
22 whether and how to leverage this group to provide

1 input or to help quantify burden, that we're
2 similarly leveraging the patient and consumer
3 reps that, Pierre, you mentioned are integrated,
4 not only on this committee but in the workgroups,
5 to provide that perspective about the value from
6 the patient and care giver perspective, to be
7 able to inform your decision making around this
8 balanced point that you referenced.
9 Because it may be that there is a
10 delta between measures that providers don't think
11 are useful to patients and families and measures
12 that patients and family themselves prioritize.
13 I'm sure there is much overlap but I
14 think it's important to just to be making sure
15 we're having both perspectives represented.
16 CO-CHAIR KAHN: Kate.
17 MEMBER GOODRICH: I think --
18 MEMBER KAHN: Hi, this is Maureen.
19 MEMBER GOODRICH: -- be helpful for
20 us, and one thing for the NQF Staff to ask,
21 because I just don't remember, in the reports
22 that come out, about all of these deliberations,

1 as you mentioned, you do say the committee
2 supported conditional, whatever the determination
3 is, some members said this, some members said
4 that.
5 What I don't remember is if it is
6 outlined where the stakeholder perspective came
7 from for members who said this and members who
8 said that. I know there have definitely been
9 times, internally for us when we're considering a
10 measure for proposal, where we wanted to
11 understand better who said what, I don't mean the
12 person's name but the perspective, and I think we
13 maybe didn't have that.
14 And that would have been helpful for
15 us in sort of crafting our justification for
16 proposed lever measure or internally for us to
17 not propose a measure. That can be really
18 helpful for us for our rulemaking process
19 actually.
20 So to the extent that's able to be
21 captured, that would be really, really great.
22 CO-CHAIR KAHN: And I'm sorry, now

1 I'll go to the phone. So anyone on the phone
2 have comments or questions?
3 MEMBER KAHN: This is Maureen. I
4 would tell you I echo a lot of the comments that
5 have been said and really, it's very positive to
6 see the work that's going on.
7 I would just suggest, and I'm sure CMS
8 has seen this, as I sit on a regional policy
9 board, the AHA has done a lot of work looking at
10 the cost of collecting quality data and the
11 administrative burden that came in there.
12 And if I recall it correctly, I think
13 when they did their study it was about, the
14 average hospital spent about $700,000 a year just
15 in collecting the data. Not even acting on the
16 data, and taking it to make improvements.
17 And the larger institutions certainly
18 exceeded the millions of dollars to collect the
19 data. So I would say, I'm pleased to look at
20 ways of how we're, you know, you're looking at
21 making better alignment in the quality and even
22 eliminating some of the measures that may not

1 have value.
2 But I do believe, as the last two
3 speakers mentioned, the voice of the consumer in
4 quality indicators and data, I think it's
5 important and we shouldn't lose sight of that.
6 CO-CHAIR KAHN: Thanks, Maureen. Any
7 other comments on the phone?
8 MEMBER QASEEM: Yes. Hi, this is
9 Amir. Very nice presentation, Pierre, I enjoyed
10 your criteria.
11 And there is not much to add to the
12 criteria but more of a comment that you
13 mentioned, that there are a certain number of
14 measures that are getting removed. And I think
15 it will be very helpful if, again, I'm a very
16 visual person, something simple that you can, if
17 you would be able to share, here's the list of
18 measures and here is the criteria and this
19 measure was removed because, a simple checkmark
20 yes or no that this criteria, it said this
21 measure failed on this criteria.
22 I think that's going to help not only

1 the MAP committee thinking but, for example, if I
2 bring it back to ACP member physicians I can say,
3 look, CMS is listening and this is why this
4 measure was removed. And this information might
5 be there, probably, because it should be public
6 knowledge anyways.
7 And if it's not if you can help us,
8 like he said, identify where this information is
9 located and if not, if you can ask your staff to
10 create something similar that will be, I will
11 find it very helpful.
12 CO-CHAIR KAHN: Great, thank you,
13 Amir. And then Tricia.
14 MEMBER ELLIOTT: Yes, thank you. Good
15 morning. One, first, a comment. I know there is
16 work obviously outside of NQF and there is work
17 being done.
18 I sit on a committee that's looking at
19 the blueprint and incorporating the patient
20 perspective. We just met last week. So that's
21 been really informative.
22 Just so others are aware, that looking

1 at the whole measurement development process and
2 how do you get that voice of the patient, voice
3 of the care giver into that process. So that's
4 been very enlightening and eye opening to work
5 with that group.
6 Second is just a clarifying question.
7 I notice that you mentioned in your kind of list
8 of criteria a burden but then you call out
9 operational issues separately.
10 From the joint commission's
11 perspective, we have always kind of thought of
12 those part in parcels so I'm just kind of
13 curious, from a clarifying, why you felt to pull
14 out that operational piece separate from burden
15 instead of using the umbrella term of burden.
16 DR. YONG: I guess one way to think
17 about, I guess I am sort of thinking about it a
18 little bit sort of external versus internal. One
19 way to think about it, so burden may be more
20 external. Sort of the burden placed on the
21 provider or the patient to fill out the survey
22 for example or to administer a survey or to

1 collect data.

2 Operational concerns I think primarily

3 is more, the way I'm thinking about it, is more

4 internal sort of consideration. Do we have the

5 ability to collect, to receive the data, to

6 calculate the rates to, whatever it is internally

7 or there budgetary concerns with, you know, are

8 there updates that need to be made to the system,

9 can we make them in time in order to collect the

10 data, those are the kinds of concerns when I

11 refer to operational considerations.

12 MEMBER ELLIOTT: Excellent. Thank

13 you.

14 CO-CHAIR KAHN: Other questions on the

15 phone?

16 MEMBER SIRIO: Actually, I was chewing

17 over what Amy had said earlier and I think that

18 it warrants some restatement in terms of the

19 stability of the systems over time. If there's

20 stuff that's changing you got to take it out, if

21 it's something that's not helpful it's not taken

22 out, but to the degree that there is some

1 consistency year-to-year.
2 As I think about helping to run a
3 health system, the cost associated with actually
4 changing the IT systems alone, never mind re-
5 enculturating folks as to what's important from
6 the perspective of the organization, the patient
7 and the country in terms of your measures I think
8 cannot be overstated. So I would just suggest
9 that stability is really helpful.
10 CO-CHAIR KAHN: Great. Any other
11 comments, thoughts? Going once, going twice.
12 Okay.
13 Now, I guess we're going to move to
14 the, what's on your agenda is the 10:15, which is
15 potential improvements to the pre-rulemaking
16 process and our voting process. And I guess, are
17 you going to say anything?
18 MS. O'ROURKE: Yes. Can I say --
19 CO-CHAIR KAHN: And I'm going to turn
20 it over to Erin and then David, Sam and Marissa
21 will be lead discussants here on this --
22 MS. O'ROURKE: Okay. So I've got a

1 few slides to go through but I just wanted to
2 provide a little bit of context about what we're
3 doing, how we've gotten here.
4 I think every year we want to make
5 this a better process for you all and make sure
6 that you're feeling that your voices are heard
7 and we're doing this in the most efficient way,
8 but in a way that allows you to express your
9 opinion and feel we truly came to consensus.
10 I'll kind of harken back to some of
11 Bill's comments yesterday about the best way to
12 do that and how to ensure that the conversation
13 is heard.
14 From our perspective, we have made
15 this more structured over time. I think some of
16 you have been on MAP since year one.
17 I do remember when we did not take
18 formal votes and it was a purely conversation
19 based process. We did hear some concerns that
20 that led to the chance for people's opinions to
21 be misrepresented.
22 People could have a, hear the same

1 conversation and have a different determination
2 of what the consensus position was. So we
3 implemented this voting process to ensure that
4 we, everyone was clear on what the recommendation
5 would be how we got there.
6 I think we also want to emphasize, we
7 don't actually send the vote counts in the report
8 that Kate was referencing to CMS, it's just what
9 the decision was and the rationale.
10 We also try to capture any dissenting
11 opinions, minority opinions. Make sure that's
12 all in the document too so that the CMS Staff has
13 the breadth of what MAP had to say and can
14 consider all of those points when they're making
15 their rules. Not just we conditionally supported
16 this measure and they don't actually see any of
17 the counts of the votes and things like that. So
18 I did want to clarify some of that.
19 So if we'd go to the next slide I just
20 want to briefly go over some of the ideas we had
21 about how we can make this better.
22 We want to avoid some of the

1 frustration that perhaps people felt yesterday
2 when the processing to be hampering the
3 conversation you all wanted to have but ensure
4 that we're coming to clear consistent decisions
5 and that everyone is in agreement of about how
6 the meeting proceeded.
7 So, some ideas that we had. We'd love
8 to get your thoughts.
9 We don't want to force you to come to
10 any decisions today, this is something we're
11 going to continue to iterate on but we just want
12 to get all of your ideas out on the table. And
13 we can work through the off season, if you will,
14 to bring back something when we bring you all
15 back together next fall.
16 So there is no need to feel like we
17 need to make decisions today, we just want to get
18 all of your ideas.
19 So for the voting process, some things
20 we thought about. We could revise the process to
21 more closely follow Robert's Rules of Order.
22 Some things we did this year was to

1 add a vote to accept the consent calendar rather
2 than just letting everyone know that it would be
3 accepted. So we did have that affirmation from
4 the committee that you accepted the calendar and
5 there were no concerns with what was going
6 through on that.
7 We also did want to clarify. The idea
8 of how many motions to handle at one time and the
9 role of the lead discussant isn't necessarily to
10 put forward an alternative motion rather to share
11 their thoughts, react to what the conversation
12 is, their feelings on the measure, but making
13 sure that we're handling things one motion at a
14 time so that it's clear to everyone what is on
15 the table.
16 We also thought we could, we heard
17 that people do want a larger staff role and for
18 us to be more active in the conversation, helping
19 to clarify how we got to the results of the
20 preliminary analysis, if people have questions,
21 have the chance to ask us why we, or what we did
22 or what lead us to that decision. As well as to

1 jump in and help our co-chairs theme your
2 conversation more so that we're, people can know
3 what the threads are, what type if input we're
4 going to put into the report.
5 We also want to address the technical
6 issues. I apologize again for the frustration of
7 the voting clickers, I think we want to have a
8 voting conversation there.
9 Do people like voting anonymously, are
10 you comfortable voting publicly. Also, would you
11 be comfortable moving to a system where perhaps
12 you vote, we had a little app on your phone or
13 through the web that you could vote that way
14 rather than our big clunky blue clickers. So if
15 people could share some thoughts on that topic
16 too.
17 We want your thoughts on, should there
18 be a default position. So for the workgroups,
19 this year we used the Staff preliminary analysis
20 decision that if people couldn't come to
21 consensus that would be what would come through
22 to the Coordinating Committee.

1 For the coordinating committee, we
2 used the workgroups recommendation. And the idea
3 yesterday was you needed a 60 percent majority to
4 overturn that.
5 Or do people want to keep voting until
6 there is consensus on a decision category. And
7 then similarly for the Coordinating Committee,
8 are you comfortable with split decisions coming
9 to you all. We worked to try to eliminate that
10 on some input from this committee in the past
11 that you did want a solid recommendation from the
12 workgroup to react to.
13 We also heard some feedback that we
14 should clarify abstentions prior to each vote.
15 So, Bruce, to some of your concerns about what's
16 our quorum number, what are we looking for here
17 so that the math is clear to everyone of how
18 we're getting to what we're getting to.
19 So, next slide. So, this is just the
20 first bucket of topics that I've got for you, but
21 we wanted to break them a part. First think
22 about the voting, next we're going to transition

1 and think about the decision categories.
2 And then finally, we had had it on
3 your agenda as the algorithm, but I actually hope
4 you would indulge me a little and we could
5 broaden it to think about what kind of
6 information MAP needs generally.
7 We started to have some conversation
8 about the feedback loops, what type of analytics
9 you like about what happened the prior year, what
10 measures are currently in the program, how what
11 CMS did track with MAPs recommendation, as well
12 as any input you have on how we could change the
13 algorithm to make sure that we're bringing the
14 workgroups the information you all think they
15 need to have.
16 Also, if you've got any thoughts on
17 our measure selection criteria. We haven't
18 really changed those since year one so anything
19 to freshen that up.
20 But just to keep things manageable.
21 If we could start maybe talking about the voting
22 process and what you would think about some of

1 the changes on the prior side, are there
2 additional changes you suggest, your thoughts on
3 a structured voting process rather than a more
4 loose consensus driven process.
5 And then finally, this is something
6 our Co-Chairs asked us to put on the discussion
7 items, started to come up yesterday, is, how
8 should we define consensus. It's currently
9 greater than 60 percent, and that's something we
10 did to align across NQF, but we want thoughts on,
11 is that right benchmark, what does the
12 Coordinating Committee think?
13 CO-CHAIR PINCUS: I just want to
14 clarify a few things. One is that, after this
15 discussion we're going to have a discussion about
16 the voting categories. So this is the voting
17 process focus.
18 And secondly, with regard to your
19 first question, how are those suggestions that
20 you proposed different from what we involved to
21 over the course of yesterday?
22 MS. O'ROURKE: So, that's a good

1 point. Some of them are things we've actually
2 implemented with the Coordinating Committee that
3 came out of the workgroup discussions this year
4 that we heard people wanted, the workgroups
5 wanted that vote on the consent calendar.
6 They did want some more input --
7 CO-CHAIR PINCUS: Maybe I want to go
8 back to the next slide.
9 MS. O'ROURKE: So if you want to go
10 back, yes. So, some of these we have started. I
11 think we'd still like some guidance on what you
12 all see as a good role for this Staff and how
13 you'd like us to use that preliminary analysis
14 that we put together.
15 Right now it's really for the
16 workgroups information to inform their
17 conversations. If you want a larger role for a
18 chance to question the Staff on how we got there,
19 what you would like us to do as far as theming.
20 And then obviously the whole bucket of IT
21 technical issues we'd love some input on.
22 CO-CHAIR PINCUS: And, Marissa, do you

1 want to hold up Robert's Rules of Order?
2 (Laughter)
3 CO-CHAIR KAHN: Amy.
4 MEMBER MULLINS: So, I know that, you
5 know, when I give lectures a lot there is
6 technology built into the lecture that you can
7 actually ask questions and people can answer
8 their phone and it registers on the screen and
9 it's really easy. So, there's an app for that.
10 (Laughter)
11 MEMBER MULLINS: That can be so much
12 easier than the point and click clicker. So, I
13 think that that's an easy fix. Just download the
14 app. I don't know what it's called but everybody
15 has it.
16 (Laughter)
17 MEMBER MULLINS: So I think that can
18 be an easy thing to do. And then I think it's
19 interesting, this question about should we ask
20 the workgroups to come to a decision or should
21 they come to us with a split decision.
22 I think some of the things we talked

1 about yesterday would of almost been easier to
2 discuss if we had known how split the decision in
3 the workgroup was to begin with.
4 So I think maybe coming to us with a
5 split decision wouldn't be bad. Because knowing
6 how much controversy the workgroup had may have
7 helped frame our discussion instead of thinking,
8 well, they said this, they must have really
9 believed that it was okay or it was not.
10 Knowing that they struggled with it
11 and they couldn't come to a decision may have
12 helped us not just flounder in our discussion for
13 so long thinking, well, why did they think that
14 we should do revise and resubmit, or whatever it
15 was, if they just come to us with no decision at
16 all then we could have started from there and
17 then work to a better conclusion. Just my
18 opinion.
19 CO-CHAIR KAHN: It seems to me that we
20 need, and one of the keys to conditional I mean
21 is this endorsement. And so we really need, I
22 think, information about pathway on endorsement

1 when we're talking about measures that have not
2 been endorsed or measures that started through
3 the process and then got sent back.
4 I mean, I just was always struck by
5 every time this issue came up there was a
6 vagueness about where it was in the process and
7 what the implications of that conditional work
8 really was. And so I think we need a little bit
9 more information about that up front. And I
10 think it would save us some time in our
11 discussions frankly.
12 CO-CHAIR PINCUS: Can I just add to
13 your point about endorsement?
14 I mean, we'll talk more about this
15 under the categories discussion, but it's also
16 unclear how many of us around the table have had
17 the experience or direct knowledge of what the
18 endorsement process is. In terms of
19 participating in it and sort of understanding
20 both the process and the timing and the criteria.
21 CO-CHAIR KAHN: Bruce.
22 CO-CHAIR PINCUS: So therefore we

1 should probably have some more orientation about
2 that.
3 CO-CHAIR KAHN: I think that actually
4 we could do that and then have everything
5 systematized so that on each of the measures
6 where that's an issue, we'd sort of like see the
7 timeline. Where it falls in the timeline. Okay,
8 Bruce.
9 MEMBER HALL: I think for those of us
10 who have sat on committees and standing
11 committees before, we're used to the vote tallies
12 that you see coming out of those committees. You
13 know, eight high, five medium. And so that's
14 probably built into our mind set of expecting a
15 vote where we actually formally vote and see what
16 the numbers are.
17 I do think that, again, if you've sat
18 on committees and done the endorsement process
19 before, I think you also realize that it's not a
20 linear or a straightforward and a given. And
21 that's why I repeatedly raised my concern that I
22 think yesterday a preponderance of the measures

1 that we move forward under conditional have not
2 been NQF approved. A preponderance of them.
3 And so for someone who has sat on the
4 endorsement committee process before, I'm not
5 sure that those are going to go through unrevised
6 or they're going to go through at all. And I
7 feel like we are kind of advocating a
8 responsibility, in a sense, by just saying, if
9 someone else says this is okay, we'll say it's
10 okay.
11 And again, I would just emphasize that
12 even for measures that have entered that
13 endorsement process and are specified at some
14 level in that endorsement process, we're not sure
15 if there will be a request to revise those
16 specifications during that process.
17 And again, for a preponderance of our
18 decisions that just, I feel like I'm not
19 expressing this very eloquently but it feels like
20 we've missed a beat somehow there.
21 On quorum, you only have to establish
22 a quorum for the meeting and then that's it, your

1 quorum is established and then you just adhere to
2 your voting process. So, the NQF pending,
3 endorsement pending issue was what caused me the
4 most the concern.
5 CO-CHAIR KAHN: Bruce, could you say
6 that again, I didn't hear it very well. The last
7 point.
8 MEMBER HALL: Us moving forward on a
9 preponderance of measures that are pending
10 endorsement was what caused me the most concern.
11 CO-CHAIR KAHN: Leah.
12 MEMBER BINDER: I was actually
13 interested in having an opportunity for us to
14 say, when we wanted something to have a high
15 priority endorsement or a high priority on the
16 calendar for endorsement, I really think this
17 group should not be replicating the endorsement
18 process, I think that we should be relying on it.
19 But I do think that there were some
20 measures that came up that were, to my mind, just
21 urgent issues for which there is a major gap in
22 measures. Example being ambulatory surgical

1 center, whatever, readmissions to the hospital,
2 revisits to the hospital. To me that's an urgent
3 issue.
4 Because there is virtually, there is
5 no data right now. There is just virtually no
6 information on safety and quality in ambulatory
7 surgical centers, and this is the kind of data
8 CMS can get that others cannot.
9 So, anyway, that, for me, was a very
10 high priority. I would have liked to be able to
11 say, well, let's say that we want that one to be
12 on the top of the calendar for endorsements. So,
13 I would like that opportunity.
14 And the second issue I have though, is
15 just a general issue, is perhaps NQF could have a
16 parliamentarian or something. I feel like the
17 chairs are put in some very difficult spots in
18 many cases where they have to sort of referee and
19 say, well, this is the rule and that's it and
20 we're, you know, it sounds like we're kind of
21 making it up as we go along, which I don't think
22 is all that useful.

1 And especially when there is
2 contentious issues that can be just very awkward,
3 and I don't think it's fair to the chairs. So I
4 would say, if you could get somebody who can say,
5 well, this is it.
6 I mean, I've been to plenty of
7 committees where you just have a parliamentary or
8 you have somebody who is the rule, this is the
9 referee and he says here's how it's going to go.
10 I think that would really help to move things
11 along and I think make us all a little bit more
12 comfortable about knowing where the lines are
13 drawn in terms of our arguments.
14 CO-CHAIR KAHN: Okay, Cliff.
15 MEMBER GIFFORD: So, I'd say in
16 general I think we put too much emphasis on this
17 voting process because it's not really binding on
18 CMS in any way and it's more the recommendation.
19 But I do think having different -- but I don't
20 think we should throw the baby out with the
21 bathwater.
22 And I do think having different

1 categories in voting does help with that. But
2 it's really the recommendations that sort of go
3 along with it.
4 Building a little bit on what Bruce
5 has says, I see too often, both in the MAP and
6 the workgroups and even in the endorsement
7 process, difference to the timelines that CMS is
8 put under, put under themselves, put under the
9 process or put under by Congress, in the voting
10 process.
11 I don't think that should be a factor
12 in our voting. We are charged with saying
13 whether it's ready for rulemaking. If it's not
14 ready for rulemaking but CMS has to issue it next
15 month in a rule to comply with Congress, then CMS
16 will issue it next month in a rule and they will
17 say, we are doing it against MAPs purpose.
18 But I don't think we should say, oh
19 well, you have to do it. And Congress says you
20 have to do it, we don't really like the measure,
21 go ahead and do it.
22 And I've seen that happen a number of

1 times over the years. Both in the endorsement
2 side and the other side. So I would agree with
3 you, Bruce, on this side of how that.
4 And there is going to be measures that
5 are going to be put forth that are not NQF
6 endorsed and I think we should comment on that.
7 But, we spend too much time on the measure
8 specifications.
9 Both in the workgroup, the coming up
10 to us. I usually sit in and listen on a couple
11 of them and they just get way down.
12 And even in our own group we use the
13 word endorsement when we're talking about this.
14 And we're not endorsing these measures. There is
15 another process for that.
16 So to that leads me to, I think, Erin,
17 your point. I would love to see you guys more
18 involved and more emphasis on some of the
19 criteria that are about the role and rulemaking.
20 Because you've really thought them through.
21 And there is no one measure that's
22 going to mean all the things. And so I think we

1 have that.
2 So otherwise we do sort of, I think
3 Amy you started to say, well, okay, I actually
4 think the voting would be better if we had the,
5 whatever categories we had where we just, down
6 those apps, we just pick what they are.
7 And then you, CMS sees what the spread
8 is and they'll say whether they're, you know,
9 what it is. Because it's really about feedback
10 to the secretary for their use.
11 And I was struck by the conversation
12 yesterday, I think in the afternoon, I was coming
13 in and out when I had the calls about, well, if
14 we vote it, will they have to bring it back or
15 anything. Once it goes, once they put it on the
16 list, it doesn't matter what we do we're
17 advisory.
18 I mean, Kate and CMS and the team
19 really are good. I don't mean to minimize it but
20 we just need to realize what the process is. We
21 could vote no and bring it back and they don't
22 have to bring it back.

1 We can vote yes on a QRP program and
2 they could use it in the VBP program in the
3 future. Once it's on the MUC list it's free to
4 use sort of whenever they want.
5 Now, Kate I think has been really good
6 about that process. So I think, to me I think we
7 need to think about how that voting process is.
8 And so the 60 percent and everything
9 that helps provide the meaningful feedback to
10 CMS. And then they have to justify why they are
11 going to do something different than that.
12 And I think the guidance needs to be,
13 we need to think more about how we give the
14 guidance around the recommendations. Because I
15 don't think it's sufficient with just the
16 categories and then hear all the comments.
17 Because, frankly, there is some wacky comments
18 out there. Including some of my own.
19 (Laughter)
20 MEMBER GIFFORD: No. So I don't think
21 that there is, there is a binding nature to how
22 they have to respond to all of these in the

1 process. And I don't think that's a good use of
2 CMS's time and everyone else's time on that.
3 And so, just like you are saying on
4 how to prioritize, I don't think we should get
5 into a voting of it all, I don't think we should
6 be writing the comments because we would never
7 get done. That would be like a five week meeting
8 here.
9 But I think there's got to be a better
10 way to address those comments.
11 CO-CHAIR KAHN: I think this point
12 about the voting is this dilemma. I guess, if
13 you just, let's say whatever categories we have,
14 if we just had all the categories, you're not
15 ever going to get the 60 unless it's something
16 that's just pretty clear cut. So, it's going to
17 be confusing.
18 On the other hand, if you went to this
19 app based voting, I mean, it would be pretty
20 simple, you could do it. Part of the problem is
21 we don't have a sophisticated way of doing voting
22 so it's sort of a mess if we try to do anything

1 other than be linear.
2 MEMBER GIFFORD: The app program, you
3 have four categories. We all pick which one it
4 is and we see the distribution here, we can then
5 do a little a modify Delphi and decide whether
6 we're going to talk about it.
7 But then it gives some -- and frankly,
8 the top three right now, I think the four we have
9 are pretty reasonable. The top three basically
10 say to CMS, go forward. The bottom one says no.
11 And then they really have to justify if they
12 wrote forward why it is.
13 And it's really, the other two just
14 sort of give, the other two, the top one is go
15 and don't bother, the bottom is, you got to
16 really figure it out. The middle two are, you
17 guys got to do something more and they have to
18 justify it.
19 Which gets into a monitor discussion.
20 I think you and Harold were talking about how do
21 we monitor and track that and I think we should
22 be, I think that is a bigger role that we should

1 take on now that we've gotten further down the
2 path in the measures that are out there.
3 CO-CHAIR KAHN: Carl.
4 MEMBER SIRIO: So, I'm going to give
5 you a potpourri of comments that I think touch on
6 a lot of the questions you asked. First of all,
7 I would strongly urge us not to get too rule
8 bound with the Robert's thing, right.
9 I mean, you guys aren't, whoever is
10 sitting in those chairs are not experts in
11 programs or procedure. And I've come to learn
12 through some governance process with another
13 organization, actually a misconception I think I
14 had but many people probably have is that you
15 don't necessarily need to be bound by it, right.
16 I mean, you use rules of order to help you with a
17 process not become hidebound to them.
18 So, again, I think that the more fluid
19 the conversation could be the better. And it's
20 really up to good chairs to manage the meeting
21 not throw in some other person to adjudicate
22 fights. I could not support that notion.

1 I want to come back to actually a
2 comment Kate made yesterday, as I was getting a
3 little prickly, and that was that we needed votes
4 and we needed counts.
5 And I was struck by the comment that
6 was made this morning that said that we started
7 this process without that. So I think that even
8 that we need some clarification on what CMS
9 really needs to in fact feel comfortable that
10 what we're doing is a true recommendation as
11 opposed to kind of just a bunch of smart people
12 talking about it.
13 Because if we've done it differently,
14 it suggests to me that it's not clear as to
15 what's required, what's needed or what would be
16 helpful.
17 I am particularly struck by the number
18 of times that we heard yesterday that the
19 Committee has overrode the Staff recommendation.
20 Look, the Staff puts a lot of time and a lot of
21 thought into and frankly our general experts, in
22 terms of living with this material every day, and

1 I think that we need to have a better process of
2 understanding.
3 And I think it's reflective in some of
4 the comments, if a decision was changed with
5 respect to recommendation, how, why and what was
6 the discontent with the Staff recommendation so
7 that we can actually be the arbitrators of that.
8 Which leads to a sense that we don't
9 need to, the Committee shouldn't be forced to
10 come up with a decision. If they can't come up
11 with a decision, that's our job. I mean, we're
12 advisory and they're advisory to us.
13 I think that, my sense is that the
14 committees need to, to the point about not re-
15 validating endorsed measures or not need to think
16 about the appropriateness of the measure on
17 balance with criteria and reliability issues so
18 that in fact we get a better sense of a more
19 robust and broader conversation.
20 I'm ambivalent on the issue of public
21 versus electronic voting. I'm not sure how we
22 evolved to a point we're afraid to see each other

1 raise our hands. But that, to me, implies a
2 level of trust that needs to be questioned as a
3 fundamental point of the group.
4 If we have disagreements, that's okay.
5 I mean, that's what the process is for. We
6 shouldn't be ashamed of them we should be proud
7 of the fact that we can celebrate our differences
8 and move on.
9 I'm concerned that there's
10 inconsistency based on the conversations we had
11 yesterday and how the workgroups are approaching
12 their work and/or their decision making.
13 So, again, I'm not sure what the right
14 place is, whether it's with the chairs of the
15 committees or with the staff in terms of kind of
16 giving a little speech ahead of time. But I
17 think we, as a MAP, need to have some sense that
18 the work that they're doing on behalf of us or as
19 the prelude to us, is actually this consistent,
20 internally consistent among them, so that we have
21 some sense that we're getting kind of the same
22 materials to look at with the same kind of

1 thought process.
2 We're going to talk about the
3 categories because I've got some significant
4 issues with respect to how we seem to be confused
5 by them yesterday.
6 And lastly, again, it seems to me that
7 the notion of a consensus at 60 percent is
8 somewhat historical. You know, we spent a lot of
9 time yammering about quorums and whatnot
10 yesterday to the point, once you got a quorum,
11 you got a quorum.
12 But to the degree that this is not
13 decision making this is advisory, it seems to me
14 if you got 51 percent, or 50 plus one you win.
15 And that's the recommendation.
16 I'm not sure that 60 percent is any
17 more logical than 67 or 75 in terms of the super
18 majority, so I would suggest that we look
19 strongly at actually just saying, if you've got a
20 majority, the thing moves forward.
21 CO-CHAIR KAHN: Marissa.
22 MEMBER SCHLAIFER: Okay. And some of

1 comments, I was asked to look at this as a lead
2 discussant ahead of time, so some of my comments
3 have kind of been trumped by some of the
4 discussion yesterday and today.
5 But first, I think what's most
6 important is that, and I think we've evolved a
7 lot from year one in that knowing what we're
8 voting on. And so I just want to, once again,
9 thank Staff for the background information in
10 making sure that we're very well guided.
11 And so I think that's always been a
12 little confusion on what are we voting on right
13 now, what really does this vote mean. So that's
14 good.
15 My thought was, one of the things is,
16 I see this, and I think it's not necessarily that
17 the way I see it is correct but it's worthy of
18 discussion from the wider group, of what we're
19 doing is endorsing a workgroup decision.
20 And I think it did me some good this
21 year, something I've said I was going to do every
22 year and had never done until required to, but

1 sit in on all of the workgroup discussions and
2 listen to those discussions.
3 And while I don't think all of us have
4 three days to put into that every year, I think
5 everyone on the Coordinating Committee really
6 should, at least one time, listen to the
7 workgroup discussions. Because it's given me a
8 lot of respect for the workgroup.
9 You know, maybe they're not always
10 right, but it really has made me think about that
11 when we're voting we're voting, in my mind, to
12 endorse or not endorse the workgroup discussion.
13 One of the things that came up in one
14 of the workgroups, and I think it was the
15 hospital workgroup but I'm not, they all started
16 running together, was that horrible up and down
17 vote that I'm sure Staff has nightmares about
18 still. Where they couldn't come to one.
19 They couldn't reach 60 percent on one
20 and went through, I think, all four before they
21 finally got to something. But there was a lot of
22 discussion right then about, if we can't decide

1 should we just go with the Staff recommendation.
2 Which I think in some ways has a lot of merit.
3 As Carl mentioned, the Staff has
4 really thought this through. What came out of
5 that discussion was someone else on the workgroup
6 saying, if Congress and CMS wanted Staff to be
7 making decisions, they wouldn't have convened all
8 of us around the table and said that these are
9 the experts that should be making the decision
10 and Staff as a recommendation.
11 So, whichever way we go I think that's
12 something that we really need to think about,
13 where we've said, let's put more weight on the
14 Staff recommendation. I think we need to know if
15 that's CMS, if that jives with what CMS is
16 thinking or CMS really wants to see that it's the
17 people around the tables decision.
18 I think, and I don't know that I know
19 the answer but I think it's something we really
20 need to think about. One of the things, and Carl
21 and I kind of, the whole move from raising our
22 hand to anonymous voting through the clicker, I

1 think we made the move because of technology and
2 thinking that the technology was easier.
3 Without that real discussion, at least
4 to my knowledge, about it being anonymous voting,
5 I don't care whether we vote anonymously or not,
6 but I think that's a significant change that
7 either hopefully Staff and CMS had discussions
8 about that or we need to have discussions about
9 that to make sure it's not just a technology
10 change it is an anonymous decision.
11 And then back to the 50 percent. If
12 we are truly, something was said earlier in this
13 discussion, I just want to make sure that we've
14 captured it because I hadn't thought about it,
15 someone said at 60 percent to overturn a
16 workgroup discussion.
17 And if it's just a 60 percent vote,
18 but 60 percent is what NQF does, or we could go
19 to 50 percent, or are we saying that because
20 we're overturning a decision then we need more
21 than a, we need a steeper majority, if we're
22 supporting a decision we only need a majority. I

1 think we need to make sure that we hammer that
2 out.
3 CO-CHAIR KAHN: Let me, I think that
4 the basic operating procedure here is there has
5 to be, and that's why Bill brought it up
6 yesterday, a consensus. So part of the problem
7 is that this consensus thing is a little
8 nebulous.
9 And if you listened to Bill yesterday,
10 and I wish Bill was here today, he sort of said -
11 -
12 MEMBER KRAMER: I'm actually on the
13 line.
14 CO-CHAIR KAHN: -- at key. The key
15 was getting to the consensus. But the trouble
16 is, but, Bill, you could speak for yourself, if
17 you're able.
18 MEMBER KRAMER: Sure. Thanks for
19 letting me join in. Sorry, everybody, that I am
20 not able to be there in person today. I came
21 down with a bad bug when I woke up this morning.
22 First, my understanding is that

1 Measures Applications Partnership is supposed to
2 be a consensus organization similar to the
3 National Quality Forum.
4 It's a multi-stakeholder group in
5 which stakeholders appeal from all different
6 parts of the healthcare industry and the
7 healthcare sectors expect to come together and
8 work out a consensus.
9 No one said this could be easy, but I
10 think it was felt that that was the appropriate
11 way for decisions to made. Consensus, we need to
12 be very sharp and clear what our definition is
13 and I think there are a number of working
14 definitions around there that we could use.
15 What happened, expanding a little bit
16 on the discussion yesterday that I brought this
17 up in the morning, this issue, the NQF Forum
18 wrestled with this issue several years ago, and
19 Chip and maybe some others may have been a part
20 of that conversation, we formed an ad hoc
21 workgroup to look at the consensus development
22 process for decisionmaking at NQF, not just at

1 the board, but at CSAC and various committees as
2 well, with the understanding that the goal was to
3 find a way to reach consensus.
4 We struggled, frankly, and, you know,
5 as part of that workgroup, I feel that, I'll say
6 our work product was, though I was 100 percent
7 satisfied with, but it got us past some sticking
8 points.
9 One of the mechanisms that was in
10 there to help move the process along was to say
11 if there seemed to be, a consensus was not
12 clearly emerging from some group discussion that
13 there would be a pause and then a straw vote
14 taken and if it was more than 60 percent then the
15 group would say like, well, you know, it does
16 seem like there is a pretty strong majority here,
17 let's hear from the folks who are still, you
18 know, opposed to the direction we're headed here,
19 the minority, let's see if we can convince you,
20 modify the motion, or figure out a solution here
21 that could get a broader consensus.
22 Not that this would be your first

1 choice of the way we should go, but it would be
2 acceptable to you and you would support it, or if
3 it fell below 60 percent then you say, oh, it
4 looks like we've got some pretty serious
5 conflicts here, we clearly don't have consensus,
6 this needs a lot more work, and then it could go
7 either direction.
8 But, again, the goal is to get, give
9 everybody a chance to hear what the issue is and
10 be heard on their point of view, listen to each
11 other, try to convince each other but also being
12 open to being convinced, and in the end find a
13 solution that works good enough.
14 Again, it might not be the first
15 preference or first choice for everyone, but it
16 would be acceptable to the folks in the room, and
17 people would also come into this knowing that
18 they would not exercise their veto power to block
19 consensus except in extreme circumstances.
20 So that -- What unfortunately happened
21 after that was despite a verbal commitment to a
22 consensus things kind of devolved, and I think

1 particularly we have seen this here in the MAP
2 process over the last couple of years, in which
3 the search for consensus was kind of not
4 emphasized.
5 Instead we started using the 60
6 percent guidance as an indicator of whether
7 consensus existed as the final decision making
8 process and then we came up with all these fairly
9 rigid voting rules and, you know, what's the
10 denominator and what's the quorum and all that
11 kind of stuff. It was never intended to be used
12 that way.
13 Now MAP could decide to use that if
14 they wanted to. I, frankly, it would be hard to
15 get me to participate in a consensus decision
16 around that, but I think in the spirit of
17 formation of the Measures Application
18 Partnership, in the spirit of NQF, and I think in
19 the spirit of most people in the room that we are
20 trying to, we have a common goal here.
21 We do not have necessarily a
22 bipartisan or -- I'm sorry. We do not have zero

1 some kind of interests. This is unlike another
2 institution up on Capitol Hill.
3 Here we have the interest of trying to
4 improve quality and affordability,
5 appropriateness, the care, and the patient
6 experience, and so on, and make it work for all
7 stakeholders, and I think that in that spirit
8 that is possible and preferable to try to achieve
9 consensus.
10 It is harder work. It takes training
11 by the staff, it takes training and hard work by
12 a leadership large groups or small groups, and it
13 takes a training of the participants and a strong
14 commitment to make it work.
15 And it won't always work but I think
16 in most cases it's preferable and I would argue
17 when it is done well it can be more efficient
18 than voting.
19 In the end more people will support
20 the direction that's been achieved because people
21 have had a chance to have their say, listen to
22 others, be influenced by others, and more likely

1 to have a solid front within our organization, or
2 our committee, and to the outer world.
3 So those are my thoughts and I hope
4 those are helpful in the session today.
5 CO-CHAIR KAHN: Bill, they are,
6 although they are troubling to me because clearly
7 when you describe that we have taken it doesn't
8 comply with what you were trying to accomplish on
9 the one hand.
10 On the other hand I think that we are
11 balancing a lot of things and we are also, this
12 each stakeholder, and we can call it interest,
13 but we could also call it, I mean there are
14 different world views, and particularly now that
15 we are dealing with payment programs it's one
16 thing, you know, not to just be dealing with
17 professionalism, but we're dealing with payment
18 programs, boy, the notion of -- I mean I guess
19 the question, if you look back at yesterday on
20 the decisions that were made based on votes in my
21 mind I don't think we got to a consensus.
22 I think that one side won and one side

1 lost and I don't know how many hours we would
2 have had to spend, I don't think it would have
3 been physically possible.
4 I think everybody agrees with the
5 process there, you know, and you paid your money
6 and you take your chances, but I guess I am
7 little concerned.
8 I don't know, I guess I'm just not
9 sure, we have the time and it's necessarily
10 realistic frankly to be thinking about consensus
11 versus, you know, sort of general view.
12 I don't know, let's go around the
13 table. Marissa?
14 MEMBER SCHLAIFER: I think, and I am
15 sure even the people who did not get their way --
16 I would not want to portray it as one side won
17 and one side lost only because I think one thing
18 we did see yesterday, whether people were excited
19 about it or not, but when we took a vote and it
20 failed to reach 60 percent, when we took the vote
21 the next time to go to either the higher or lower
22 pretty much more or less we got to 90 percent of

1 the people changing their vote and going along
2 with the group I think to show that this was a
3 successful consensus process.
4 So I think where people lost or didn't
5 get their way they still indicated that, okay, I
6 want to go along, show we have a consensus, and
7 let this move forward.
8 It didn't happen every time but it did
9 happen every vote I remember yesterday, and that
10 was something that maybe I was a little surprised
11 to see, but I think we need to be careful not to
12 say it was won or lost.
13 CO-CHAIR KAHN: I guess, and I think
14 we need to be careful with our words, maybe I
15 shouldn't have said won or lost on the one hand.
16 On the other hand I think people buy in to the
17 process.
18 MEMBER SCHLAIFER: Yes.
19 CO-CHAIR KAHN: Saying people buy in
20 to the process is not saying they have a
21 consensus, because I think when you have the
22 votes at the end I think if you went back and

1 looked at the people they weren't necessarily, I
2 mean that were --
3 MEMBER SCHLAIFER: If we measured how
4 excited they were.
5 CO-CHAIR KAHN: Yes. I mean, to me,
6 consensus is actually, as Bill is defining it, is
7 spending the time to bringing everybody to yes,
8 and I guess what I saw yesterday was, you know,
9 on the ones that were controversial disagreements
10 and then at the end acquiescence to the process.
11 That's not bringing everybody to yes
12 in my view. Now that is my perception and I am
13 interested in other people's view, but I would
14 say, and I don't want to name names, but I could
15 name a couple of names that I think would
16 probably, you know, voted yes, I mean voted at
17 the end but they, I don't think that they
18 consider it a consensus, I think they just
19 acquiesced. I don't know.
20 CO-CHAIR PINCUS: Just to apply some
21 broader technology, we could attach brain scans
22 to everybody and determine whether they were

1 excited or not, but the problem is it is hard to
2 differentiate between excitement and anger.
3 CO-CHAIR KAHN: Yes. Carl?
4 MEMBER SIRIO: So, Chip, I think you
5 put your finger on the difference between, and we
6 were having a little sidebar here, between
7 consensus and acquiescence, right.
8 I mean, I think you are right. I mean
9 to the degree that there were positions that were
10 supported or not, I won't say won or lost, but to
11 the degree that we are time limited, we are
12 process driven, and we can't spend hours
13 adjudicating all of these, different process,
14 different methods, we might get to a consensus.
15 But that is why I would advocate just
16 go with a 51 percent because at the end of the
17 day it is not an consensus in terms of -- It's
18 consensus with a process, not with the outcome.
19 So I would submit that 60 percent is
20 as random a number as any other number north of
21 50 percent.
22 CO-CHAIR KAHN: Giff?

1 MEMBER GIFFORD: If I was Kate I would
2 be chuckling over there at this discussion
3 because I mean not to make our vote irrelevant
4 but in many ways the vote doesn't matter.
5 I mean I read the rules on everything
6 that comes out of this and, you know, whether --
7 The vote categories aren't what drives this.
8 What drives it is their need to meet the programs
9 in the rules and whether it is statutory or not
10 and what they have to go forward for.
11 And unless we just say no it's -- I
12 have yet to see something that hasn't come
13 through not show up in a rule and it gets
14 imposed.
15 And so there is just way too much over
16 emphasis on what this voting is and it's more
17 about the guidance and I think -- Now with that
18 said CMS, and Kate has been very good about
19 trying to honor these and you will see stuff show
20 up in the rules as to why they are trying to
21 explain it all the time, but it's not -- Well,
22 I'm not Kate, I am chuckling at the conversation

1 because I mean, yes, I really don't care what the
2 vote is.
3 I mean to me it is what is the
4 feedback and the wealth of the discussion. I
5 have heard Kate say it multiple times over the
6 years, it is the discussion that they find really
7 valuable.
8 The question is how do we capture that
9 discussion and get it in there and I think the
10 vote is, this is why I say don't throw the baby
11 out with the bath water, the vote does help with
12 that, but we've got to think about it that way
13 and that I think will help easier get to the
14 consensus sort of view out there.
15 But to try to get to 60 percent I
16 think is not, it's missing the point of what our
17 role is and how CMS uses the results from that
18 and I think when we start looking at the actual
19 data of how they use this you'll see it.
20 I can't recall a single time that
21 anyone has ever said bring a measure back that
22 it's actually come back to the MAP. I have seen

1 them say it should get NQF endorsement, I have
2 seen it shown up as an NQF endorsement later on,
3 but I have never seen a measure come back to us,
4 ever.
5 Kate is about to prove me wrong, but
6 they are scratching their heads, too. I'm not
7 saying that we have to have had measures come
8 back, I am just saying I haven't seen them come
9 back. We act like they are something --
10 MEMBER GOODRICH: You're good if you
11 can remember every measure --
12 (Simultaneous speaking)
13 MEMBER GIFFORD: I'm just saying we're
14 acting, overemphasizing something that doesn't
15 matter as much and we are missing our point on
16 there and I think that is the message I am trying
17 to deliver to you.
18 And so to me whether it's 59 percent,
19 60 percent, 51 percent, I don't really care on
20 it. I think our role is to, if you look at the
21 statute, is to give feedback to CMS on what to do
22 and I think Kate and CMS takes that very

1 seriously and has done a really good job with
2 that, but I think that, you know, we spend too
3 much time hung up on it.
4 Did you remember, Kate, when we
5 brought back --
6 (Simultaneous speaking)
7 MEMBER GOODRICH: The only thing I am
8 trying remember there was a measure that we
9 brought back as part of the feedback loop pilot,
10 but it didn't go back on the muck list but it
11 came back for discussion. I think that's what I
12 was just trying to clarify with Pierre.
13 And we have talked about trying to do
14 more of that so that there can be feedback to the
15 MAP about decisions we have made, et cetera,
16 that's all.
17 CO-CHAIR KAHN: Leah?
18 MEMBER BINDER: Well I think one other
19 role, to be very blunt, is political cover. I
20 mean I think so. When we have a strong -- I
21 think really our biggest role is going to come
22 when we have strong feelings one way or the other

1 about a particular measure.
2 So if this group really feels strongly
3 that a measure should not be in rulemaking and
4 then CMS puts it in rulemaking, they have, you
5 know, it's very difficult for them to politically
6 put it into the final rule because it will
7 immediately come back, well, you know, the MAP
8 strongly did not, you know, approve of this.
9 So I think we have a real impact
10 again, but I do think it's on the outliers when
11 we have strong feeling one way or another. So
12 that gets to the point of the 60 percent being
13 probably a good metric to give CMS a real
14 indicator that this is a strong feeling, or
15 strong enough feeling on the MAP that it's
16 relevant for them to take into consideration from
17 a political point of view as well as substantive
18 point of view. So that's why I would support
19 that.
20 I just wanted to make one clarifying
21 remark about what I said earlier about the role
22 of the Chair as sort of a parliamentarian or

1 somebody who is kind of a referee.
2 I don't mean that the Chair should not
3 actually oversee the discussion and controversy,
4 those things are all valuable and I think healthy
5 and important for the Chair to oversee and for
6 the conversation to take place.
7 So I in no way mean to say the Chair
8 should have no role in that by no means, but I do
9 think that one of the things we get caught up in
10 is like the procedural voting issue, you know, do
11 we take a vote on that or do we, you know, do we
12 need a second, or when does the discussion take
13 place, when does a motion happen.
14 Those kinds of things I think can
15 really trip us up and that's when, and it just
16 doesn't, I don't think it's healthy for the group
17 or the conversation to have the Chair kind of
18 caught up in those kinds of procedural issues
19 where I do see a role for, a staff role to really
20 have somebody there that can just clarify it, to
21 move on, and not get us caught up in things that
22 take on a life of their own and derail the

1 conversation in a way that is not healthy.

2 MEMBER QASEEM: Hi, Chip and Harold,

3 this is Amir. Can I just say a couple of things?

4 CO-CHAIR KAHN: Yes, we're going

5 around the table here, but why don't you speak.

6 MEMBER QASEEM: Sure. So the issues

7 with Measures I think what I am hearing is that

8 it is an accountability. They are being used for

9 accountability, it's a high stakes environment,

10 right, and my worry is that yesterday what

11 happened and many measures that came through that

12 were not NQF endorsed.

13 So either we believe in NQF's process

14 or we don't believe in NQF's process and if we

15 believe in NQF's process the way to simplify

16 things if a measure hasn't been endorsed by NQF

17 we need to come up with a set of rules that then

18 need to be just exceptional circumstances that we

19 really need to look at this measure.

20 Yes, there are many urgent emerging

21 issues, there are tons of them in clinical care,

22 but will it be okay if we wait another year since

1 we have waited for 20 years to address that issue
2 and let a measure go through the NQF process, at
3 least we start feeling comfortable that some
4 smart people around the table have spent enough
5 time looking at the measure making sure it is a
6 good measure or a not so good measure.
7 Many times yesterday I think, at least
8 I felt like is we didn't have enough chance to
9 dig deep into whether this is a good enough
10 measure and if it can be used for accountability
11 purposes or it's just for quality improvement,
12 and those two are different issues, right.
13 NQF endorsement what is happening in
14 clinical, you all know, Carl mentioned yesterday
15 about the who attribution issue.
16 We are endorsing measures at the
17 health plan level but they are being applied at
18 clinician levels without any evidence whether it
19 should be or if it works out or not.
20 We are all aware of those issues. I
21 think there is some fundamental process issues
22 that till they get resolved, and I have seen

1 deviation over the years.
2 I think when MAP started out we used
3 to rely more on NQF endorsement and now we are
4 slowly moving completely away from NQF
5 endorsements.
6 And I think to be honest we don't have
7 enough time at MAP meetings to go through
8 reviewing and figuring it out whether a measure
9 is a good enough measure one just general comment
10 I think we need to start thinking about it.
11 Otherwise, I am not really sure what
12 are we doing. As I said yesterday there is a lot
13 of smart people, we are spending a lot of time,
14 but I had rubber-stamping things as well.
15 The second thing is I think the
16 voting, the votes do matter, but I am not a big
17 fan of the 60 percent/50 percent number. I think
18 what CMS will benefit more is to see the spread
19 and there are various ways to convey that and you
20 can use RAND process, you can do whatever
21 process, but if they are, they are a certain
22 percent -- Like use the example of that A1C

1 measure.

2 If the spread is 64 versus 36 percent

3 we should automatically categorize a measure like

4 that as a condition measure. What if the measure

5 is getting 90 percent, then it should be fully

6 endorsed.

7 I mean there are ways to address that.

8 A lot of people have done research on this and

9 more scientific, what does this random 60

10 percent, at least I feel like that we are using

11 to overturn the committee's decision, which I do

12 value a lot as well, and I think that is exactly

13 the spread that we should also be seeing.

14 But what happened in the clinician

15 subgroup? What was the spread or help us make

16 that decision. But I think some of these process

17 issues, is MAP's coordinating committee's

18 function is to look into the evidence and look

19 into the quality of the measure or are we going

20 to rely on someone else who has spent enough time

21 to go about doing that and that brings me to the

22 discussion.

1 I mean I value NQF's staff
2 recommendation a lot. They have very smart
3 people and I think we need to take those into
4 consideration as well as the NQF endorsement
5 process and I feel like that CMS might have a
6 deadline but we are gathered around that table
7 with a different function that we wholeheartedly
8 believe the measure is a good measure.
9 And if you believe it is not a good
10 measure, to be frank, I don't care what happens
11 with what Congress is saying and what -- My
12 obligation is to my patients and that's what we
13 should all care about clinicians were sitting
14 around the table, as well as the patients who
15 should worry about what kind of care they are
16 getting.
17 (Simultaneous speaking)
18 MEMBER GIFFORD: Kate, I don't want to
19 put you on the spot, is feedback of whether it's
20 an absolute yes or no a black and white vote or
21 the distribution, because you have heard, I think
22 there has several that suggested, what is more

1 helpful for you guys?
2 MEMBER GOODRICH: Like I said before,
3 it's really helpful to us, and Pierre should also
4 weigh in, I mean the yes or no in the
5 distribution in terms of numbers does matter less
6 than what the actual comments were and by which
7 kinds of stakeholders.
8 That's much more useful information to
9 us. I don't quite know how to resolve this
10 dilemma, but I will say at the end of the day
11 that's what we want to be able to use when we are
12 justifying why we are proposing a measure, or
13 internally for ourselves to make a decision about
14 when not to propose a measure as well.
15 CO-CHAIR KAHN: It strikes me, too,
16 that we do play a role that reinforces in the
17 endorsement process, because if MAP didn't exist
18 and you just had the endorsement process, not
19 that CMS wouldn't worry about the endorsement
20 process, but it wouldn't, there wouldn't be any
21 transparency -- I mean you could look at a
22 measure that was in a reg and see whether it was

1 endorsed or not on the NQF list, but it wouldn't
2 have been part of a process and I think that's
3 important.
4 To me that is important because there
5 is a synergy there, I mean, you know, people are
6 talking about it. If people weren't talking
7 about it, if the MAP wasn't here, and I think
8 that is your point, Giff, it really does make a,
9 it probably does make a difference and without
10 the endorsement process we don't have what Amir
11 is talking about.
12 MEMBER GIFFORD: When we get into a
13 later of discussion about the steps and the
14 criteria for review we are evaluating the
15 measures --
16 CO-CHAIR KAHN: Well speak into your
17 mic just because the people on the phone.
18 MEMBER GIFFORD: Well when we get into
19 the discussion later on this morning or this
20 afternoon on the criteria for the review we are
21 looking at the measures form a different vantage
22 point than the endorsement process.

1 CO-CHAIR KAHN: Yes.
2 MEMBER GIFFORD: Endorsement is
3 looking for liability, validity, and all the
4 other stuff. We're looking at is it ready for a
5 rulemaking and the rulemaking process.
6 And if you look at the criteria that
7 are there, that's why I think the staff have gone
8 through it, it would be helpful to give us more
9 input on that because that's I think --
10 CO-CHAIR KAHN: Right.
11 MEMBER GIFFORD: I would like to see
12 more of the discussion on that than on the
13 reliability, validity, or even the burden. I
14 mean the burden is important part of the rule,
15 but we don't talk about a lot of those other
16 things at all when we are talking about the
17 measures.
18 CO-CHAIR KAHN: Chris, did you want to
19 say something
20 MEMBER QUERAM: Chip, I think we might
21 be nearing that point in the meeting where
22 everything that can be said on this topic has

1 been said but not everybody has said it.
2 (Laughter)
3 CO-CHAIR KAHN: Yes, Chris.
4 MEMBER QUERAM: I find myself agreeing
5 with comments you made probably 20 minutes ago in
6 response to Bill's articulation, a very
7 thoughtful articulation of the consensus process
8 of the NQF, and I would just say that I think
9 that approach to decision making is designed for
10 a different type of structure than we have here.
11 It works well with workgroups, it
12 works well with the board. Groups that have a
13 frequency and a duration to their interaction
14 with one another where trust, not that trust
15 isn't important here, but where trust is critical
16 to ensure commitment to an outcome.
17 And I think we have to balance
18 expediency with good process because we are here
19 for a day. We consider a tremendous amount of
20 work that has gone into the preparation for a
21 voting process and there just isn't time to be
22 able to follow faithfully the approach that Bill

1 so nicely articulated for us.
2 I worry about Kate's comment about
3 relying more on people's contributions and
4 comments than on the outcome of a voting process.
5 I have very little faith that there is a good
6 recording, a good capture, of the points of view.
7 It is too subjective, it's too
8 ephemeral. I just don't see the -- I mean I hear
9 you, I accept it, and I think you are being
10 genuine in your comment, but I, it's a thin reed
11 for me to feel we should rely that CMS is going
12 to take to heart the comments that they have
13 heard from people.
14 So I do think some type of a voting
15 procedure is important. Boards have requirements
16 to protect changes to bylaws that necessitate
17 super majorities or some higher level.
18 I don't agree with Carl's comment that
19 it should be 50 percent plus one, I think that is
20 too casual. I don't know that there is any magic
21 with 60 percent. I would actually like to see a
22 little higher number so that there is some

1 confidence that a strong plurality of people
2 around the table agree with a particular point of
3 view. So those are my comments.
4 CO-CHAIR KAHN: Kate?
5 MEMBER GOODRICH: Yes, I think for us
6 the good thing is for the majority, I think, of
7 measures the MAP is pretty clear, there is a
8 pretty good consensus on whether the measure
9 should be support, conditional support, or do not
10 support.
11 So we are talking about, in my mind,
12 a minority of measures, or if I harken back to
13 internally when we are trying to make decisions
14 about whether or not to propose a measure that
15 got one, you know, ruling, if you will, or
16 another.
17 We talked a lot about, well, so what
18 was the discussion, because I think for us when
19 we are putting something out into a proposed rule
20 for a measure where there is not consensus
21 really.
22 I mean maybe it got voted in one

1 direction but we know from the conversations that
2 there wasn't consensus. What can helpful to
3 elicit helpful public comment in a proposed rule
4 is to be able to say here is measure x, we want
5 to propose it for this reason, it went to the
6 MAP, it got, you know, conditional support, or
7 whatever, and, you know, some of the viewpoints
8 were this and some were that, you, public, tell
9 us what you think.
10 So it is in those situations which
11 thankfully are a minority of situations where I
12 do think that especially having that richer
13 detail would be helpful because then we can say
14 to the public here is what we have already heard,
15 tell us what you think, and that can then, I
16 think, engender more specific and more helpful
17 public comment for us.
18 CO-CHAIR KAHN: Sam, I was going to
19 hit Joe and then --
20 MEMBER LIN: Well --
21 CO-CHAIR KAHN: Well you may leave.
22 Yes, why don't you go.

1 PARTICIPANT: You haven't spoken for
2 a day and a half.
3 (Laughter)
4 MEMBER LIN: Thank you. Well, I had
5 written Leah, Giff, Carl, and Marissa's remarks.
6 Following Chris's new rule for the group here, do
7 not repeat what has been repeated, I will try to
8 say something new.
9 I am thinking, you know, Giff had the
10 comment about the discussions and whether it is
11 important and I certainly buy in to that except I
12 have to think back to yesterday where we spent
13 time needing to count the numbers for two
14 different programs because the numbers had to be
15 there.
16 That's not following just the
17 discussion, that's spending more time on numbers.
18 So, you know, with English as a second language I
19 always go to Wikipedia as my source of
20 information.
21 So what is a consensus decision making
22 process, and this may give us either help or more

1 headaches. Consensus decision making is a group,
2 a group, decision making process in which group
3 members develop and agree to support a decision
4 in the best interest of the whole, a decision in
5 the best interest of the whole.
6 Consensus may be defined
7 professionally as an acceptable resolution, one
8 that could be supported even if not the favorite
9 of each individual.
10 So if what we are trying to do, and I
11 am following Bill's lead at this point about
12 consensus, is that we take our vote. We find the
13 vote is six to four, whatever that is, fine.
14 So then we have to decide whether or
15 not we are going to go into a consensus and
16 whether or not the four can agree as part of the
17 group, because it's this group thing, to be
18 supportive.
19 They don't have to support, but they
20 have to be supportive of the other six. We come
21 up with a consensus of ten out of ten. Now I
22 know all that is very simplified, but that's, if

1 we are going to do consensus or we shouldn't be
2 talking about consensus, we ought to just be
3 talking about rule of law or something.
4 CO-CHAIR KAHN: Joe?
5 MEMBER KRAMER: This is Bill, if I
6 could jump in maybe with a process suggestion. I
7 appreciate the last person who spoke. I couldn't
8 quite recognize who it was, but it is consistent
9 with my thinking.
10 CO-CHAIR KAHN: Sam.
11 MEMBER KRAMER: But listening to the
12 conversation I think it's pretty clear, my
13 observation is that we don't have consensus yet
14 in the Coordinating Committee about what decision
15 making process we should use.
16 It warrants further discussion. We
17 actually don't have to resolve this until, before
18 next year, the next cycle. This is in some sense
19 the beginning of the next annual cycle.
20 I suggest that leadership of the
21 Coordinating Committee and maybe a small ad hoc
22 group work with the NQF staff and maybe others at

1 NQF maybe on the, you might want to bring in a
2 board here that has been doing some work on this,
3 to try to look at the range of options and see if
4 that workgroup can come back with a consensus
5 about the appropriate decisionmaking process.
6 It may be that it is the classic
7 consensus, it may be the opposite voting, it may
8 be a hybrid where we seek consensus and resorts
9 are voting only as a last resort.
10 But the suggestion is that we work on
11 this over the next six, nine months, so as we go
12 into the next cycle we are more clear of how we
13 are going to make decisions and do the
14 preparatory work so that people understand what
15 the process is going to be at the workgroup level
16 as well as in the Coordinating Committee.
17 CO-CHAIR KAHN: Thanks. Let me go to
18 Joe and then I'll come back to Sam.
19 MEMBER BAKER: Thank you. I guess,
20 and I certainly -- and this my first meeting so I
21 have more questions than answers and I agree with
22 Chris that a lot has been discussed and I agree

1 with I think we have reached a consensus and
2 agree with what Bill just said.
3 A few observations from the newbie as
4 it were. One is I think the technology of voting
5 certainly frustrated us yesterday and was part of
6 the problem and people, you know, whether that
7 frustration was real or just displaced
8 frustration because they couldn't be frustrated
9 with the measure itself or other processes making
10 the voting easier by hand or by technology I
11 certainly endorse. It should be as smooth of a
12 process as it can be given the importance and the
13 feelings involved.
14 I mean secondly I do think that there
15 is this gap between endorsed and non-endorsed and
16 that creates a lot of, you know, discomfort it
17 seems for some folks and for others there is a
18 feeling like we need to get this out and we need
19 to get it out quickly and we trust the
20 endorsement process.
21 It seems to me the cycles are
22 misaligned and that's never maybe going to

1 resolved. So on some level we can't -- and it
2 seems like this discussion has been had before,
3 so we either have to say we had that discussion
4 in 1962 and we are done, you know, yes, thank you
5 new person, this is a rule, you can't talk about
6 this anymore, you know, because I'm not going to,
7 okay.
8 I don't really care, okay. Others
9 care about this issue, maybe I don't, or I'm not
10 going to care about it now because it doesn't
11 look like it's going to change, and that's maybe,
12 you know, there is not only a parliamentarian, as
13 Leah has, you know, recommended, but there is
14 also like, no, here is the rule keeper, you know,
15 you can't discuss that part.
16 And then, three, I have a question,
17 or, you know, I also saw this idea that I need to
18 pull a measure in order to make a comment about
19 it, right.
20 So all of a sudden right then I am
21 like, everybody is like, oh, you know, it's been
22 pulled, that's a thing, you know.

1 And then you've got to do a lot of
2 explaining, as Carl did yesterday in some
3 instances, that I am not pulling because I hate
4 this or because I think it's all wrong or because
5 I am a communist or, you know, I am a radical.
6 MEMBER SIRIO: But I am.
7 MEMBER BAKER: Well you are, okay.
8 But, you know, you're not doing it because you
9 are a communist, you're doing it because you have
10 other concerns.
11 You know, it creates this
12 contentiousness and this confusion, right, around
13 that. So maybe there could be more briefing up
14 front about why some thing is being polled so we
15 know up front here is the things that are being
16 polled so the discussion can be had and here is
17 the things being pulled because a nuclear option
18 is being debated, you know, or because there is a
19 -- and then we are prepared.
20 Like, okay, there is nine pulls, but
21 six of them are really just so people can discuss
22 it and three of them are, you know, really to

1 kind of drill down into some of these issues
2 because, for me, I would certainly need that to
3 get those three things in my brain as a consumer
4 advocate and I think it would all focus our
5 attention and calm us down on the other pulls, if
6 you will.
7 So those are my observations and
8 ideas.
9 CO-CHAIR KAHN: I think one of the
10 solutions I mean here is we could -- I didn't
11 like it yesterday, we don't need to use the word
12 "pull." I mean we can just use identification of
13 -- I mean we don't want to discuss every one on
14 there because some we don't have to discuss.
15 So you need to find another word. You
16 don't need to find it now that just talks about
17 raising it. And the trouble is you don't know
18 necessarily, some may be pulled, well, may be
19 identified for discussion that could end up with
20 a motion or it may not end up with a motion.
21 They can't necessarily predict that.
22 I mean in some cases, you know, Amir maybe had

1 his list that he wanted motions on, but that
2 could have changed in the discussion, but I think
3 we do need some nomenclature there that's a
4 little bit more neutral.
5 So we are almost at that point, I'm
6 going to let Harold close out, summarize, and
7 then -- I'm going to pass the baton to him as
8 chair.
9 CO-CHAIR PINCUS: So it sounds that
10 there has been a lot of discussion about this and
11 from my point of view I think it's hard to,
12 number one it is hard to distinguish the process
13 from the decision categories and I think we are
14 going to come to that after the break.
15 But I think that there is a kind of
16 back and forth between adjusting the process to
17 the decision categories and the discussion
18 categories to the process, and so we need to sort
19 of think about them on both tracks.
20 But my inclination is very similar to
21 Giff's in the sense that the main purpose of this
22 is to give advice and whether the advice is

1 dichotomous advice, you know, yes, no, or whether
2 the advice is more qualitative, or both.
3 And so the issue for me for process is
4 what process will provide the most useful advice
5 and to think through that and I think some of the
6 suggestions that we made I think make a lot of
7 sense in terms of, you know, maybe we should, you
8 know, I think being more clear about, you know,
9 what pull means and how to distinguish between
10 clarifications and questions as compared to I
11 really have a disagreement with the proposal that
12 has been given to us by the workgroup, so to
13 clarify that I think can help to do that.
14 I think achieving a consensus is not
15 necessarily the purpose of this because we don't
16 have the time or the, you know, the time or
17 really the resources to go through a whole RAND
18 Delphi process.
19 I do that a lot and it's a lot of
20 work. And so it's really not a process to
21 achieve a consensus but it's a process, again, to
22 provide advice and I think we can talk about

1 what's the best one, but I think, you know,
2 giving -- My own view is that I think coming to
3 some kind of vote puts people to the test of
4 actually having to collect their thoughts and
5 decide how they want to go and then provide some
6 justification for that.
7 And that process does provide more
8 qualitative as well as kind of a more categorical
9 response. So we are going to take a break, okay.
10 CO-CHAIR KAHN: Let me just say one
11 more thing. This was my idea, this whole thing,
12 and when the Hospital Quality Alliance had run
13 its course, and Chris was on the Hospital Quality
14 Alliance, and we needed something that was multi-
15 stakeholder and met all the criteria and to me,
16 and to sort of to bolster what Harold said, the
17 one thing about this idea that has worked is that
18 they are sitting here and they sat here through
19 the whole process and they hear everything that
20 we talk about, and so at the end of the day, you
21 know, I don't want the perfect to be the enemy of
22 the good, I think we do accomplish that.

1 Now whether or not we actually move
2 them on all the things and sometimes, you know,
3 we may not be, you know, maybe it's not possible,
4 but I think we do accomplish that we have their
5 ear, which I think we lost in the Hospital
6 Quality Alliance for a whole set of reasons that
7 were as much process as anything else.
8 CO-CHAIR PINCUS: So we're going to
9 take a break. Let's get back together at ten
10 after 11, okay.
11 (Whereupon, the above-entitled matter
12 went off the record at 10:52 a.m. and resumed at
13 11:09 a.m.)
14 CO-CHAIR KAHN: So the categories that
15 we have had as voting categories have kind of
16 evolved over time and there is various
17 interpretations, even as they have evolved.
18 Even as the categories have been
19 stable there is different interpretations of what
20 they mean has kind of evolved over time and, you
21 know, I think some of the issues that we have
22 dealt with have really came to light yesterday in

1 terms of thinking through and people being clear
2 about what they were voting on.
3 Let me just sort of set this up just
4 to give you sort my way of thinking about this.
5 I think in some ways we have been confusing
6 several different issues as we deal with the
7 categories.
8 Number one I think we have been
9 confusing content and process in some ways, so
10 that we have one category that clearly is a
11 process category of conditional typically for
12 some condition being met most typically in
13 endorsement and then we have more of a content
14 category of refinement and resubmission, which is
15 more about, you know, particular issues that need
16 to be dealt with, and I think there is some
17 confusion about that.
18 And then even when we talk about some
19 of the content issues we have some confusion
20 about that also. Some of it has to do with
21 issues around the nature of the measure itself,
22 some content issues pertaining to the nature of

1 the measure, for example, the measure needing
2 risk adjustment as being something that the
3 people have put forth.
4 And in some cases it has to do with
5 the nature of the measure as it applies to the
6 program in which it's being placed that it hasn't
7 been, it's been attested and endorsed at a health
8 plan level but not at a provider level, and so we
9 have some confusion about that.
10 And from my point of view I think
11 that, again, going back to our discussion that we
12 just had in terms of really what we really want
13 to get at is what is the best way to provide
14 clear advice is that we need to clarify these,
15 the distinctions, especially between the two
16 middle categories.
17 And it seems to me that we have two
18 options. One is to simply go with three
19 categories that we support, we don't support, and
20 something needs to be fixed in the middle, or we
21 make some clearer distinction between the two
22 categories about conditionally support and revise

1 and resubmit and really clarify the distinctions
2 between them in a much more effective way.
3 But ultimately what we want to come
4 out of this is that for those, whether it's one
5 or two middle categories, that we are more
6 specific about what we expect.
7 So why don't I turn it over to the
8 staff to go through sort of their initial
9 thinking about that.
10 MS. O'ROURKE: Sure. If you could go
11 to the next slide. So Harold went through these,
12 but just to reorient everyone to our current
13 decision categories.
14 Right now we have support for
15 rulemaking, conditional support for rulemaking,
16 refine and resubmit for rulemaking, and do not
17 support for rulemaking.
18 And then in the second category, I
19 know it's a little hard to read, it's basically
20 just to our decision algorithm how everything
21 maps to show that at least for the staff
22 assessment when something doesn't hit one of the

1 assessments that we do where it would fall down
2 in the algorithm, if you will, or how we got to
3 the decisions that staff put forward for the
4 workgroup's consideration.
5 So that's maybe not necessarily where
6 we need to focus for this conversation. I think
7 on the next one we could maybe talk about that
8 algorithm and what information people need, but I
9 think Harold already really laid out, if you go
10 to the next slide, some of the concerns we have
11 heard and at least some ideas we had of how we
12 could potentially improve.
13 I think we wanted to get peoples
14 thoughts on is there value in preserving this
15 refine and resubmit category. I think to kind of
16 echo Harold's thoughts of I think the intent is
17 that it signifies there is a larger change
18 needed, do we want to keep that and clarify some
19 of the language, and I think certainly one of our
20 ideas is to change the name.
21 We were thinking something around
22 support continued development or -- that's

1 obviously not anything we are wed to, but an idea
2 is it just in the naming of this resubmit, is
3 that the word that is causing problems, or have
4 we just created differences without distinctions,
5 if you will, and we should just go back to the
6 three category system where there was support,
7 conditional support, and do not support.
8 So I think we just really -- Again,
9 nothing we need to decide on today, but we want
10 to get your thoughts about what you think would
11 work and what's the most valuable for you, do you
12 like the four categories, three categories, so if
13 we could just get everyone's ideas on the tables
14 like we did for the voting we'll bring it back in
15 the fall.
16 (Off-microphone comments)
17 MEMBER GOODRICH: So I have said this
18 before, refine and resubmit, and I will say even
19 the former, support continued development,
20 because we had on like that at one point, I
21 think, or encourage continued developed.
22 MS. O'ROURKE: It was a two-measure

1 pathway and then we collapsed the two pathways
2 into the four.
3 MEMBER GOODRICH: Yes, right. I will
4 say for us at CMS it was, kind of plagued us a
5 little bit, and that was nobody's fault. We were
6 trying it, right.
7 So one of the thoughts that I have
8 around this in terms of just thinking about what
9 would be helpful for us, too many categories gets
10 just challenging I think for lots of reasons.
11 However I think there does need to be
12 something that the MAP can say to us when --
13 There is a significant, you know, right
14 direction, but there is a significant concern
15 that you really need to address.
16 Part of the way we have tried to
17 address that is by not bringing measures forward
18 or not very many anyway unless they are like a
19 significant public health priority like the
20 opioid measure from before that are too early in
21 their development process.
22 So they really wouldn't be ready for

1 rulemaking next year anyway because they haven't
2 even gone through testing or what have your,
3 right, so hopefully there will be fewer of those
4 kinds of things.
5 What I think could be helpful to us,
6 and I think just as a general comment for the
7 conditional support category anyway, is I think
8 the refine and resubmit my personal view is we
9 shouldn't have it.
10 However, because there is still a role
11 for substantive comments that currently may be
12 under refine and resubmit what I might suggest
13 that MAP to consider is some more precision
14 around the conditions in conditional support.
15 Because refine and resubmit or support
16 continued development really has meant we support
17 the direction of this, we think the concept is
18 important, it fills the gap at whatever,
19 whatever, but here is some problems.
20 So we always think of conditional
21 support as being conditional on NQF endorsement
22 because that is the biggest bucket of things that

1 it is conditional on, but there is no reason that
2 it couldn't also be conditional and you got to
3 test this at the clinician level, it's only at
4 the health plan level now.
5 So until you have tested it at the
6 clinician level and it passes muster, you know,
7 that's our condition, or that's just one example,
8 but that is an example of where a measure has
9 gone to refine and resubmit in the past but could
10 just as easily be a condition.
11 And I think that, from my perspective,
12 and you should weigh in, Pierre, if you disagree
13 or think differently or whatever, I think that
14 could be a helpful way to resolve this a little
15 bit more easily, at least when I think about what
16 we talk about and think about internally as we
17 are going through the MAP recommendations prior
18 to rulemaking.
19 CO-CHAIR PINCUS: So it sounds like
20 one of the things you are suggesting is rather
21 than making the conditional one be a process
22 recommendation to make it more of a content

1 recommendation?

2 MEMBER GOODRICH: Yes.

3 MEMBER MULLINS: So I am going to take

4 your suggestion one step further. I think that

5 we should have two categories, support or do not

6 support.

7 I think anything else we do gets

8 really into the endorsement process. Either the

9 measure is ready for rulemaking or the measure is

10 not ready for rulemaking and I feel like that is

11 what our charge here is, is is this measure to be

12 ready in the rule or not.

13 I think that you could scale it after

14 that. So if the measure is -- If you support it

15 I think maybe what would be helpful for you guys

16 would be could we support on a scale of one to

17 ten and then you could some sort of feel from the

18 group of how supportive we are of that, because

19 really the support with conditions, we have

20 talked about it for the last day and a half, it

21 doesn't matter, they're going to put it in the

22 rule or not.

1 What matters is the comments and the
2 discussion around it. So either we don't support
3 it or we do and whatever condition or category we
4 put it in, unless it was a do not support, it's
5 probably going to end up in a rule somewhere.
6 So we either support it or we don't
7 and if we support it how supportive are we and
8 what are our comments around that measure.
9 CO-CHAIR PINCUS: Okay. So I know
10 people put their cards down, but, Giff?
11 MEMBER GIFFORD: I would just sort of
12 add that I think the one thing that gets us hung
13 up is when CMS brings a measure that has not been
14 NQF endorsed and whether -- I don't think our
15 role, it struggles because at that point how do
16 we discuss whether it's ready for rulemaking if
17 it's not been NQF endorsed, and some of us were
18 offline should we just blanket it and say it's
19 not ready for a rulemaking do that.
20 I think that's probably a little bit
21 Draconian, but we almost want to have a default
22 recommendation and I think that's almost where

1 you may want to have some sort of subcategory
2 which is, yes, we understand it has to go forward
3 with rulemaking, yes, I think we buy it, but you
4 better get, you really need to get NQF
5 endorsement and what Leah is saying is it's a
6 high priority out there.
7 But I would agree with you, Amy. I
8 think it's how do we communicate that, and I
9 don't think this third category in the list is
10 adequate communication there, a resubmit or
11 anything else because then it gets into this
12 whole thing.
13 It's just -- We need to have that
14 rulemaking, or that category. And a better way
15 of capturing our support and our endorsement, but
16 you're right in the end it's really black and
17 white.
18 CO-CHAIR PINCUS: Carl?
19 MEMBER SIRIO: Yes, I actually am
20 persuaded also that kind of an up or down is
21 probably the wisest thing, but I think I need
22 some affirmation of my institutional memory.

1 We got to this place if I recall
2 because of the fact CMS was in fact considering
3 materials that were not NQF endorsed so we kind
4 of jerry-rigged this process to create some
5 criteria.
6 So my sense is that going to an up or
7 down it takes the onus off of us in terms of
8 worrying about NQF endorsement or not because we
9 can factor that in but this work around in my
10 view was a construct of the fact that measures
11 were coming forth that didn't have NQF
12 endorsement.
13 It seems to me that we can have the up
14 or down vote and then probably a conversation
15 around measures that are worthy of continued
16 development but I would be reluctant in terms of
17 the comments that were made about support
18 continued development because it's really support
19 continued development as a code word for don't
20 pass along, right.
21 So there is positive verbiage but it's
22 really a negative vote. So I would just be

1 careful that whatever you come up with in terms
2 of the next iteration, whether it's an up or down
3 or a three category thing, that it's pretty clear
4 unless you get an affirmative yes moving forward
5 everything else is a no.
6 CO-CHAIR PINCUS: Marissa?
7 MEMBER SCHLAIFER: I'm going to leave
8 any conversation about the conditional support to
9 Sam, my other lead discussant, and I think he's
10 going to make some comments there. I will just
11 say I agree with him.
12 On refine and resubmit I think both
13 some comments here and I agree what Giff just
14 said about this being confusing but it was
15 something that he said earlier that was going to
16 cause me to disagree.
17 Earlier he said there is three levels
18 of support and one do not support and I very much
19 see refine and resubmit as saying this isn't
20 ready for prime time therefore we don't support
21 it, however we like the concept, we like where
22 you are going, we want you to continue going in

1 that direction, but we don't support this going
2 forward for rulemaking now.
3 And, you know, maybe we will in the
4 future, maybe we won't in the future, we don't
5 know for sure because we are not seeing enough.
6 So whatever this turns out to be I would not use
7 the word "support" in any way in that, you know,
8 I think we talked about encourage.
9 Because when Giff said earlier there
10 is three levels of support I think that showed
11 the level of how we all interpret this
12 differently and I think it needs to be really
13 clear that we are saying we don't want you to go
14 forward, we like what you are doing, but we don't
15 want you to go forward, and I think that needs to
16 be really clear assuming we continue with this.
17 CO-CHAIR PINCUS: Sam, did you have a
18 comment?
19 MEMBER LIN: Agree, agree, agree.
20 Well, I agree with Amy's suggestion, but since we
21 are still under the old rubric I will stick with
22 that.

1 A point of ignorance, other than
2 pending NQF endorsement what other conditional
3 support have we labeled, like it has to rain
4 tomorrow or it has to snow next week, I mean what
5 the conditional other than NQF support?
6 Now I am not trying to be totally
7 facetious because I am still thinking of Amir's
8 concern yesterday relative to the clinical
9 workgroup and his understanding at that time of
10 the composite.
11 Before Marissa and I started attending
12 some of these workgroups I would listen in on the
13 webinar and I remember one time, and I think the
14 numbers are accurate, it's been five, six years
15 at least, where there was like some 28 people on
16 a clinical workgroup and there was some 20 folks
17 in attendance for that particular webinar.
18 And so there was a neurology issue
19 and, you know, there was no neurologist on the
20 thing so they voted for it anyway. That's not a
21 criticism, that's simply how our workgroups
22 cannot include every single specialty, otherwise

1 we would be and CMSS right now.
2 On the other hand, when NQF does their
3 endorsement if it's a neurology issue the
4 neurologist are hot into it, you know. If it's a
5 rheumatology issue the rheumatologists are hot
6 into it, so that the scientific evidence base
7 should be pretty clean, pretty clear, and I think
8 we probably, Amir would accept that.
9 What is our capacity then? I think
10 our capacity is not the evidence base but the
11 experience base, which is all this other context
12 that we have to deal with.
13 We accept the evidence base because we
14 are not the neurologist, but then we look at the
15 other issues that are involved and
16 recommendations to CMS that has to deal with the
17 politics that maybe we can help on or hinder,
18 depending on where we come out.
19 So I need some clarification on what
20 other than NQF support, or endorsement, what
21 conditional support would mean. I think the
22 up/down, vote down, you know, again, I go with

1 Giff saying we are advisory. Again, HHS will do
2 what it thinks is necessary.
3 I will go with what Leah said the last
4 hour that where there is an emergency issue as in
5 all cases in emergency issues we deal with them
6 on a case-by-case basis as needed, as necessary,
7 they already fall out of the normal run of
8 things.
9 CO-CHAIR PINCUS: I mean I can
10 imagine, and Kate or Pierre maybe wants to
11 comment on this, I mean to even now we have had
12 cases where there has been an already endorsed
13 measure but it hasn't been endorsed in a way that
14 would fit with the program. So that is one
15 example where, you know.
16 There also may be reasons for which we
17 want the endorsement committees and CMS and the
18 measure developers to be prepared for, you know,
19 critical issues that we think will come up in the
20 endorsement process that we want to have
21 addressed because of the nature in which CMS, the
22 program in which CMS is proposing to use this.

1 So there may be different types of
2 comments that we want to make and explicitly call
3 out that may be relevant to or, you know, the
4 endorsement process.
5 MEMBER LIN: If I can follow up.
6 Thank you for the --
7 (Simultaneous speaking)
8 CO-CHAIR PINCUS: These guys may have
9 some other ideas about that also.
10 MEMBER LIN: Well, thank you for that
11 clarification. My concern then is if we have
12 those hangars on when we send it forward what if
13 the hangars on are not accepted, are we still
14 supporting it conditionally or do we say all bets
15 are off?
16 CO-CHAIR PINCUS: Well, I mean one
17 thought is to, you know, have this so-called
18 middle category not be support, conditionally
19 support, but to say that, you know, that it
20 really needs to be, and these issues need to be
21 taken into consideration specifically.
22 MEMBER GOODRICH: With that, which I

1 think is fine, the one thing that this committee
2 will have to manage is the issue we were talking
3 about before of getting too deep into the weeds
4 and recreating the endorsement process.
5 I just think that's going to be true
6 not matter what, but just to highlight that as
7 well.
8 CO-CHAIR PINCUS: One of the things,
9 actually if you go back to the slide before this,
10 so -- Actually, the slide before that. So if you
11 read that, you know, actually, right here it
12 talks about the program measure set is adequately
13 addressing the needs of the program, these
14 responses to the program, and sometimes we kind
15 of lose sight of the linkage of the measures to
16 the program.
17 And I think that that's, you know, and
18 that's really in some ways the heart of what we
19 are addressing, more than the sort of endorsement
20 criteria, but the way in which it is intended to
21 be used.
22 And so that's something that we need

1 to sort of, you know, think about as we do that,
2 and that's part of the issue and that's
3 irrespective of whether it's endorsed or not.
4 Pierre, did you want to say something
5 about that or --
6 DR. YONG: No, I think that's a fair
7 point. I mean, something that we also included
8 as part of one of the draft criteria when we
9 talked about measure removal criteria, was sort
10 of, as we think about measures, they are for an
11 entity, whether it's a facility or a clinician,
12 it's part of an entire sort of reporting program.
13 So, I think it's a fair point about
14 that we -- at least based on the couple years of
15 the MAP that I've been able to attend -- have
16 really been thinking more about the MUC list as
17 individual measures, as opposed in the context of
18 the entirety of the set.
19 CO-CHAIR PINCUS: So, let's go around.
20 John?
21 MEMBER BOTT: Yes, I like Amy's initial
22 suggestion of vote a measure up or down, just

1 binary basically. And if it's not yet NQF
2 endorsed and we've been presented with adequate
3 information to vote it up, so be it.
4 The way it's currently written, it
5 doesn't have to be NQF endorsed for us to support
6 for rulemaking. If we don't feel we have enough
7 information or we feel it's inadequate, then we
8 vote it down.
9 I like the idea of providing those
10 supplementary comments with do not support to
11 explain why we can't support it at this time.
12 So, I vote for simplifying our voting that way.
13 CO-CHAIR PINCUS: Leah?
14 MEMBER BINDER: I would like to see
15 some way for us to vote for fast-tracking for
16 endorsement, because there are issues that do
17 merge, and there will be more.
18 So, opioid would be a good example of
19 something that's just a real emergency, and we
20 need to not wait two years to get this through
21 endorsement or something, because then it takes
22 time after rulemaking and everything else.

1 So, I think that there are going to be
2 emergent issues -- or maybe not emergent, but
3 urgent issues or areas where there's an urgent
4 gap.
5 Again, I would reiterate my point
6 about the ambulatory surgical center safety and
7 quality measures, for which there is an urgent
8 gap. We don't have enough measures for that, and
9 60 percent of surgeries are being done there.
10 So, we have to, I think, have the flexibility to
11 be able to put a sticker on something that's
12 around timing.
13 I actually don't have a problem with
14 refine and resubmit, I think that sounds actually
15 -- that makes sense to me. That makes a lot of
16 sense. I think the conditional, defining that,
17 and -- but again, adding something where we can
18 ask for an urgent process to put through
19 endorsement.
20 CO-CHAIR PINCUS: We have Rich
21 Antonelli on the phone, who I think wants to make
22 a comment. Rich?

1 MEMBER ANTONELLI: Yes, thank you. I
2 want to sort of raise an issue that I often start
3 my own team around QI, is: what's the problem
4 we're trying to fix?
5 So, a lot of the really interesting
6 observations and good ideas and comments that
7 I've heard are reflective -- are self-reflective
8 of MAP members. But I'm wondering, other than
9 for us feeling like there is a more harmonized,
10 synchronized approach across our processing, are
11 we missing something?
12 And I'd like to just sort of put two
13 comments on the table for our consideration, to
14 think of what we would measure success at the end
15 of this conversation.
16 One, and I don't know if he's still in
17 the room, but Sam, I think, had such a good point
18 yesterday, when we were looking at one of the
19 measures where it actually failed under
20 scientific reliability. And I was thinking
21 about, okay, well, we just spent of time talking
22 about that.

1 And two, both here in Massachusetts
2 and other conversations, this is kind of in line
3 with the comment about the opioids, there are
4 times where there is a strategic gap that is very
5 time-sensitive when we're going to advance
6 something. And so, I think there will be times
7 where we're going to have to frame shift and do
8 that.
9 So, I guess, that would be the
10 question I'd like to raise is, what's the problem
11 we're trying to fix? Because then, the solution
12 to these conversations around process may be
13 better aligned.
14 CO-CHAIR PINCUS: Thank you, Rich.
15 Giff?
16 MEMBER GIFFORD: Thanks. So, let me
17 ask Sam and then -- so, a couple of examples of
18 where things were not ready, even though they
19 were NQF-endorsed. The main one, I think, as
20 Bruce's point has been, they've not been tested
21 in the other setting.
22 The other is, the discussion we had

1 there, they may have been tested in the setting,
2 but it's an attribution issue. And so, for the
3 program, attribution is important, but for NQF
4 endorsement, it was not important.
5 The other, as we talked a little bit
6 before, the infrastructure may not exist or the
7 time it takes. So, it might be that we endorse
8 it for rulemaking, but it needs to be one or two
9 years out to build the infrastructure.
10 Because we've had some rules go
11 through where it relies on MDS items that CMS has
12 tested in a pilot, but has not been rolled out
13 yet. And so, there's just no way you could -- I
14 mean, as you point out, there's a huge cost to
15 changing infrastructure and going forward.
16 And then, I think the other is the
17 unintended impact the measures might have in the
18 program, and that that should be addressed in the
19 rulemaking. So, it's more about, not whether the
20 measure -- some of it's the measure itself, but
21 how it's used in the measure set in the broader
22 issue.

1 I think the problem we're trying --
2 one of the problems I think we're trying to
3 identify, having been through this now is,
4 particularly when measures come through that are
5 not NQF-endorsed, it causes great angst. And it
6 really confuses our roles with the endorsement
7 process out there.
8 And while I agree with Amy's point,
9 the one thing I worry about is that, in the past,
10 if we endorse it not ready for rulemaking, that
11 -- as you point out, Leah -- that makes it
12 politically really hard for CMS to go forward.
13 They have, but it makes it really hard
14 for them to go forward. And I wouldn't want it
15 to be an absolute that, just because there's not
16 been endorsement, we should vote it down. It
17 should be, if there's no endorsement, it's just
18 so early, it can't go forward.
19 But I think, you almost want to have
20 in each of those categories why you're voting
21 that, because I think if we went back to just
22 two, it wouldn't -- the problem we were always

1 trying to address was this anxiety of both, not
2 that or that, yes, we understand the measure's
3 not quite ready for rulemaking, but we think this
4 rule and the direction and the measure concept is
5 good, but you need to address attribution and
6 other things.
7 And then, CMS will either address it
8 in that rule, I've seen them delay and it'll come
9 out a year or two years later, and they have done
10 the homework to address it. So, I think just a
11 straight up and down vote might lose that -- will
12 bring us back to that anxiety.
13 And we ended up having trouble voting
14 on some of the things because of the labels. So,
15 I think we are looking for a softer label to say,
16 yes, you can use it in a rule, but make sure you
17 address these topics.
18 CO-CHAIR PINCUS: Rachel? And then
19 Bruce.
20 MEMBER LA CROIX: I think this follows
21 along with what a few folks have been talking
22 about, and I understand the desire of wanting to

1 go to just a support or do not support.
2 One thing that I was thinking about,
3 and this might be too soft of a third potential
4 category, but the workgroups all identified
5 basically priority gap areas, areas where they
6 want to find new measures and keep working on.
7 And I don't know that that's something we discuss
8 in here, as the Coordinating Committee at all.
9 But a potential third area would be
10 for those measures or areas that don't seem quite
11 ready or that are missing a key piece for us to
12 fully support them, would be either to set those
13 up as important priority gap areas that we think
14 should be addressed moving forward or to help
15 support just some of those other ideas that
16 aren't ready yet or where we don't have measures.
17 And maybe that would be a third
18 category to provide food for thought moving
19 forward.
20 CO-CHAIR PINCUS: Bruce?
21 MEMBER HALL: I don't want everybody to
22 think I'm a one-trick pony here, but I want to

1 build on two comments by Giff and my esteemed
2 colleague, John.
3 I think that we are not a committee
4 that is structured or capable of doing a
5 technical review, so I disagree that if it's not
6 an NQF measure, we can just look at the technical
7 specs and move it on or not move it on.
8 I don't think we're equipped to do
9 that in any way, shape, or form. Having done it
10 on the NQF side, where I think it's very
11 valuable.
12 So, I would ask, then, for a measure
13 that's not NQF-endorsed, is it in the endorsement
14 process and what is the expected date of
15 completion?
16 If it's not in an NQF endorsement
17 process, where we agree not everything has to be,
18 then who is the technical review body that's
19 vouching for that? And if that's not complete,
20 when will it be complete?
21 And perhaps that's the other category
22 we need, to say, this is in the NQF endorsement

1 process with the following expected date, or this
2 technical review is performed by someone else,
3 who is that?
4 And then, that becomes another
5 category that we can say, we would move it
6 forward, but we can't vouch for that technical
7 review; that technical review was performed by
8 someone else.
9 CO-CHAIR PINCUS: So, you're thinking
10 -- talking about essentially having a third
11 category that's focused on a process item?
12 MEMBER HALL: I think, yes, in that
13 sense. I think calling out that category that
14 we're now confused where to put it in the middle,
15 calling it out for what it is and saying, this is
16 not yet NQF endorsed, but it's expected on the
17 following date, or this technical endorsement is
18 by someone else, and that's what needs to be
19 represented to CMS.
20 CO-CHAIR PINCUS: Sam?
21 MEMBER LIN: Thank you, Harold.
22 Following up on both Giff and Bruce at this

1 point, this may be an anathema in the current
2 market, but I'm sort of old-fashioned, I still
3 believe in science. And so, I think the first
4 thing is that the scientific basis is the first
5 item that's got to come out of the shoot.
6 What we do, and this follows up with
7 Bruce, is: we are not the scientific experts,
8 we're the socialization experts -- if I can use
9 that term -- which is the world or the context in
10 which that science-based evidence is going to be
11 used.
12 So, that's sort of where I go back to
13 my earlier question about what other than NQF
14 endorsed, what does conditional mean?
15 If it comes in in a clean usual format
16 of being evidence-based, scientifically-endorsed,
17 then we can sort of look at the wrap-around and
18 the packaging, and I'm not trying to demean our
19 role, but that's sort of what we do, the rest of
20 the world that this fits into, and then, decide
21 if that fits in with that and then, whether or
22 not we can, by consensus, support it.

1 So, I mean, I think we're sort of
2 getting to some area of changes. I'm still, I
3 don't know, I'm still supporting the up or down,
4 because it's pretty clear, at that point,
5 regardless of what the vote numbers are, if we
6 think about consensus, then it's pretty clear
7 that the group is moving on to the next measure,
8 rather than continuing to drill down.
9 Before I forget, since we've non-voted
10 the up or down, could we go to that next slide?
11 Because there's one thing that this -- Item 4,
12 it's just hit me yesterday, the definition of do
13 not support for rulemaking.
14 The definition or the criteria, sorry,
15 is that the measure under consideration does not
16 meet one or more of the assessments. I think
17 it's better stated, the measure does not meet any
18 of the assessments.
19 If it meets, for example, refine and
20 resubmit, that is sort of a conditional support.
21 It's not a do not support, it's a conditional
22 support requiring refine and resubmit. If it

1 goes under conditional support, that's not a do
2 not support; it's a conditional support.
3 So, I think, hopefully we're going to
4 change this, but if we don't, I would suggest
5 that we might clarify that criteria to say that
6 the measure under consideration does not meet any
7 of the Assessments 1 through 3. That's all.
8 CO-CHAIR PINCUS: Sam, I appreciate
9 your comments about science and evidence-based.
10 Last year, I published a paper in Lancet
11 Psychiatry on evidence-based science policy in a
12 post-truth era.
13 MEMBER LIN: Post what?
14 CO-CHAIR PINCUS: Post-truth era.
15 Leah?
16 MEMBER BINDER: I want to pick up on
17 something that Bruce just said that was kind of a
18 bingo. You mentioned setting a timeline, saying
19 we want it endorsed -- or when is it going to be
20 endorsed, by what date?
21 What if we said that the conditional
22 category was actually very specific -- that it is

1 to be endorsed within one year, period -- go
2 through endorsement within one year or six
3 months? That we were specific about what the
4 condition was and a timeline for it?
5 And then, it should be brought back to
6 MAP by X. And say, we want it back. Because
7 we've all talked about that, like what happens to
8 these things? So, that we're like -- so,
9 conditional support is specific and time-bound.
10 And getting to my point, that gives us
11 a little bit more of an ability to say when
12 something is urgent as opposed to non-urgent.
13 CO-CHAIR PINCUS: Giff?
14 MEMBER GIFFORD: It would be almost
15 helpful, and this gets into the next thing about
16 the criteria review, what are -- to Sam's point
17 -- what are the conditions that would, if they
18 don't pass, would lead us to all vote, don't
19 support in rulemaking?
20 And, clearly, endorsement is one, but
21 not an absolute. But I think attribution would
22 be another, tested in -- we could come up with a

1 set, and then guidance from the workgroups and
2 guidance from the staff would help us in
3 determining the decision out here, and take us
4 away from the discussion about measurement
5 specification.
6 Burden would be one, another category
7 that I think we spend a lot of time on. But
8 there is sort of a finite number of things that
9 should lead us, as a MAP for rulemaking
10 decisions, not about the endorsement.
11 And then, it takes that focus of our
12 discussion on that piece rather than on the
13 measure specs.
14 CO-CHAIR PINCUS: Okay. Elisa?
15 MS. MUNTHALI: I just wanted to clarify
16 a couple of things related to the endorsement
17 process. In the old process, there was
18 significant wait time, and so there were -- it
19 was about a two or three year lag time between
20 projects.
21 In our redesign -- which Erin
22 mentioned yesterday -- we're offering submission

1 times twice yearly. And so, developers can come
2 in any topic twice to us, and that process takes
3 about seven months. So, it is not two to three
4 years.
5 And that's why yesterday, during our
6 dialogue, we did the redesign in very close
7 collaboration with CMS and, in fact, they funded
8 it.
9 So, we were trying to the best of our
10 ability to build in a pipeline, so we can
11 understand what measures CMS needed to come
12 through the endorsement process, but other
13 developers as well.
14 And so, I'm -- as you've heard, it's
15 really hard to kind of coordinate that timing,
16 but we're still working on it. And so there are
17 more opportunities than there were in the past to
18 come to NQF.
19 CO-CHAIR PINCUS: Leah?
20 MEMBER BINDER: Can time be carved out
21 on the next cycle or the next meeting, to launch
22 the endorsement process, that's just for what

1 comes out of the MAP as -- that should be started
2 on endorsement right away?
3 So, in other words, if we see a
4 measure come up that we know needs to be
5 endorsed, that we see as a priority, it's coming
6 from CMS for rulemaking, that we as a MAP can
7 say, well, we would like it put into the high-
8 priority endorsement, and then it's reserved.
9 So, it's not like they have to wait
10 even six months; it's just the next meeting it
11 gets started. In other words, so that we can
12 have some capacity to identify those measures
13 that need that very quick turn.
14 Because, by the way, rulemaking itself
15 takes another year and then, it takes another
16 three years beyond that to even get the data.
17 So, no matter what, we're talking about very long
18 lag times for some of these urgent issues.
19 So, I would like to see if we would
20 have the capacity, really, right now to say, you
21 have a meeting coming up in three months, even
22 though it's not normal that it be that short of

1 time -- turnaround to get something in, that for
2 that measure, we could say we want it to be put
3 in.
4 CO-CHAIR PINCUS: I mean, it seems to
5 me that what could be done is to actually put
6 together a small group with staff to actually
7 come up with some proposals that would be brought
8 up at the next meeting.
9 And I think that that makes a lot of
10 sense. I think there's a lot that came up in
11 this discussion where I think there's some
12 reasonable consensus on, in terms of, number one,
13 we need to clarify these four categories and make
14 some changes and reduce the number of categories.
15 Number two, we want to make sure that
16 we're able to give very clear, specific
17 instructions to CMS about what needs to be done
18 for measures that we don't support.
19 Number three, that we need to be very
20 clear that there are measures that we support,
21 and the other measures we don't support, to
22 distinguish that.

1 We need to also, I think, make sure
2 that we get more feedback about the process, in
3 terms of what's happened after our
4 recommendations, so that we're informed by that
5 and we can learn from the kind of recommendations
6 that are most helpful.
7 And I think also, the notion of
8 specificity in our recommendations, both in terms
9 of content and in terms of process, would be
10 important.
11 But I think -- which I think bodes
12 well for a small group to actually get together
13 and come up with how to take that into a specific
14 set of recommendations. Is that something that
15 you think could be done?
16 MS. O'ROURKE: Yes. So, I think in the
17 last bucket of information, we actually already
18 started having that conversation.
19 So, if we could bring up the
20 algorithm, I think this is something, the last
21 thing we really wanted to get some input, because
22 I think we already started having a conversation

1 about this type of information that you all need
2 to support your decision-making.
3 And based on what you were talking
4 about yesterday, I think we would also like to
5 hear, not just about this algorithm, but this
6 feedback loop process, what other information you
7 would like to come back through other channels.
8 But to support some of the
9 conversation you were just having about the fit-
10 for-purpose, and that was one of the things we
11 heard with this algorithm, is that it drives a
12 little too much back to revisiting endorsement
13 decisions or starting to do the work of the
14 endorsement committees.
15 And to Bruce's point, we're not
16 necessarily constituted that way. So, I think,
17 Giff, you had some great suggestions about how we
18 focus more on the fit-for-purpose of the program.
19 So, I think any other suggestions people have
20 there would be great.
21 MS. BUCHANAN: And, Erin, if I could
22 just add? So, everyone received a link to the

1 MAP Member Guidebook and that is on -- Page 27 is
2 what we're looking at, so if you want to pull it
3 up on your own computer or if you're
4 participating through the phone, it's Page 27 of
5 the MAP Member Guidebook.
6 MS. O'ROURKE: Yes, so any input people
7 have about what should be in the algorithm,
8 different assessments you'd like to see to make
9 sure that the workgroups are getting the type of
10 information that you want them to have.
11 And then, similarly, I think we'd love
12 any information that you'd like to see through
13 the feedback loop process or analytics that the
14 staff could perform on what went into the rules
15 this year in concordance with MAP's decision-
16 making, what would be valuable to you as a
17 Coordinating Committee.
18 DR. AMIN: So, just to potentially get
19 the conversation started, there's a few themes
20 that we've already discussed that we can sort of
21 discuss right now.
22 I think one of the discussions that

1 we've heard a lot about, in terms of additional
2 data, is what happens with the MAP
3 recommendations over time? So, I think this sort
4 of concordance-type analysis would be helpful,
5 Erin.
6 And I think the other thing that we've
7 talked about is related to a little bit of the
8 endorsement pathway and also, the endorsement
9 experience for the measure. The way that it's
10 currently represented in the discussion guide is
11 sort of an absolute yes or no, whether the
12 measure's been endorsed.
13 But it doesn't get to the nuances
14 related to the level of analysis, of whether it's
15 tested at the clinician level, for example. Or
16 whether it's been resubmitted, which version of
17 the measure. Or, to Leah's point as well, what's
18 the pathway for endorsement, in terms of when the
19 developers would be ready to submit that
20 information to an upcoming cycle?
21 So, those are, I think, some
22 recommendations that we've heard already, which

1 are pretty significant in themselves. But at
2 least to get the conversation started.
3 CO-CHAIR PINCUS: Comments?
4 Suggestions?
5 CO-CHAIR KAHN: So, I think it's a hard
6 one to slice. I mean, I almost wonder whether we
7 should ask the group to come back, if they feel
8 like -- I mean, with written comments on the -- I
9 mean, because we could discuss it, but to me,
10 it's a little difficult. Or if you want to set a
11 few people to look at it and come back with
12 recommendations.
13 CO-CHAIR PINCUS: Yes, I think it would
14 be good to -- I mean, and either way, I think
15 that we should assign a small group to work with
16 staff that would be charged to review sort of the
17 process criteria and decision algorithm.
18 MS. O'ROURKE: Okay.
19 CO-CHAIR PINCUS: And to -- as a
20 package, because it's really hard to separate
21 them out.
22 MS. O'ROURKE: Yes.

1 CO-CHAIR PINCUS: And to come back with
2 a set of recommendations, or even options.
3 MEMBER GIFFORD: Yes, I think that's a
4 good idea. And if you're going to do that, it
5 would seem to me, part of the charge to the group
6 is how the information is presented to us, how
7 the material -- what the decision-making process
8 was ahead of time.
9 But given the very tight time lines
10 we're under, to the degree to which we can figure
11 out a way to make the process of our review of
12 the material, I'm not sure easier is the right
13 word, but a bit more streamlined, since getting
14 this morass of stuff a couple of days before the
15 meeting is almost impossible to go through with
16 any clarity of thought.
17 How we incorporate public commentary
18 and how in fact we either use ahead of time in
19 the agenda books or following, written commentary
20 that might actually make some of the
21 conversations a bit more succinct.
22 So, it's a lot of process questions,

1 Harold and Chip, but I think that we really need
2 to look at the way we do our work and how we get
3 input into the whole process.
4 Because right now, I think there's a
5 sense, and it gets to, I think, comments you
6 made, Chip, is that, without meeting frequently
7 enough and without having the ability to actually
8 spend the time to actually ponder some of these
9 questions, they're almost done on the, I'm not
10 meaning to be pejorative, but it's almost like
11 you're doing them on the fly, because it's just
12 so much stuff that comes at you, like in a week.
13 CO-CHAIR PINCUS: Marissa?
14 MEMBER SCHLAIFER: The one question,
15 one comment I had when I reviewed this in advance
16 may have been kind of overridden by some of the
17 comments we've had over the last couple of days,
18 but I think one of the -- with one of the
19 questions being, can you combine the
20 reliability/validity criteria with the NQF
21 endorsement process?
22 I think it's really clear when we're

1 talking about using a measure in the population
2 for which it was NQF endorsed. And then, you
3 could combine them.
4 But we did have at least one measure
5 where it may be NQF-endorsed, but we were looking
6 at it -- but it was endorsed at the health plans
7 level and we were talking about it at a provider
8 level.
9 And in that case, you do need to pull
10 out, pull apart the reliability, is this reliable
11 and valid, from the NQF endorsement process. So,
12 I think, yes, sometimes, but, no, other times.
13 CO-CHAIR PINCUS: Any comments from
14 people on the phone?
15 MEMBER KAHN: Hi, this is Maureen. And
16 I will tell you, as a first-time attendee, this
17 is my first meeting, I'm overwhelmed with all the
18 comments on this. So, I'm hanging in there.
19 (Laughter.)
20 CO-CHAIR PINCUS: We all are. Giff?
21 MEMBER GIFFORD: Just to follow up on
22 --

1 MEMBER KAHN: I can't see everybody's
2 faces, but it's been a -- I've appreciated the
3 conversation and the dialogue. And -- because I
4 read the 236 pages and had a couple of sleepless
5 nights to be prepared for the meeting, and the
6 book, and I take this very seriously. And so, I
7 do value the comments that I've heard.
8 CO-CHAIR PINCUS: Giff, you had a
9 comment?
10 MEMBER GIFFORD: Yes, I was just going
11 to say, to Marissa's point, it has implications
12 for, I think, CMS providing information on the
13 MUC list to the workgroups, and then to us, to
14 figure out how to do the vote.
15 Because I think, if it's NQF-endorsed,
16 we don't need to know all the other stuff. What
17 we really want to know is attribution, other
18 stuff. If it's not NQF-endorsed, I think Bruce
19 laid out really nicely what we want.
20 And then, that information will
21 expedite our ability to read through the 200-odd
22 pages, and I think get more robust feedback from

1 the workgroups to us as well.
2 CO-CHAIR PINCUS: Okay. Other comments
3 from the phone or here? So, and thanks, Giff
4 sent us some of the ideas for different
5 categorical kind of the issues that might come up
6 and I think this could be useful in the
7 discussion around the smaller group that we put
8 together.
9 MEMBER GIFFORD: Question, and this is
10 just my own ignorance, I could go back and look,
11 but are there any members of this Coordinating
12 Committee on any of the four workgroups?
13 MS. O'ROURKE: Back in the day, there
14 were. I think we purposefully tried to limit it,
15 so that as many stakeholders could participate in
16 MAP --
17 MEMBER GIFFORD: I understand; the
18 answer is no. So, what I'm getting at actually,
19 from the perspective of the memory of this group,
20 and also the trust that we have in the work, I'm
21 not suggesting we put people from this group on
22 it, I would suggest that we think about creating

1 a liaison, where in fact there's an expectation,
2 one, that all of us actually at least go to one
3 or participate on the phone in one in their first
4 year of membership, so we know what the devil
5 they're doing.
6 And secondly, that in fact there be a
7 liaison so that when in this room, recognizing we
8 have the Chairs on the phone, but to the degree
9 that there's a little bit of a cross-check,
10 especially when there's discontinuity between the
11 staff and the decision, that we've got a voice
12 from this room that at least understands the
13 dialogues.
14 Just, again, as you're thinking about
15 process, another suggestion.
16 CO-CHAIR PINCUS: I mean, there was a
17 little bit of that, Marissa and I and Rich, we're
18 sort of hanging around the workgroups, in our
19 roles with the Medicaid Task Force.
20 MEMBER SCHLAIFER: Yes, to follow what
21 Harold said, we were required to sit in on it,
22 because of trying to get a Medicaid tie, but it

1 was trying to get a Medicaid tie, not trying to
2 get a tie to this group. Although, it did serve
3 that --
4 CO-CHAIR PINCUS: Yes.
5 MEMBER SCHLAIFER: -- purpose. So, I
6 guess, we can dual --
7 CO-CHAIR PINCUS: Yes, no, but I think
8 your point, I think you made a very good point
9 about, as almost part of the orientation process,
10 and sort of understanding what's going on.
11 And I would add, it is important also,
12 I think, because -- how many of you have actually
13 been involved in the endorsement process? So,
14 almost -- about 60 percent.
15 MEMBER SCHLAIFER: We should get our
16 clickers out.
17 (Laughter.)
18 CO-CHAIR PINCUS: But some of you
19 haven't, and I think it would be actually
20 important to also give people some experience and
21 also some more background on the endorsement
22 process, so they know what's entailed with that.

1 Sam?

2 MEMBER LIN: I just remembered Frank

3 Opelka, remember when he was the Chair --

4 MEMBER SCHLAIFER: Yes.

5 MEMBER LIN: -- of the Hospital and he

6 was --

7 MEMBER SCHLAIFER: Yes, he was on --

8 MEMBER LIN: -- on the actual -- I

9 mean, that was --

10 CO-CHAIR PINCUS: Yes, and originally,

11 there were people who were on -- in fact, it was

12 almost, I think, required that the Chairs be

13 members of this.

14 MEMBER GIFFORD: I would second Carl,

15 I've always gone to the PAC group, and it's both

16 reassuring and not reassuring.

17 (Laughter.)

18 MEMBER SCHLAIFER: Yes, I can say I

19 learned so much this year sitting in on it.

20 MEMBER HALL: I want to say, I replaced

21 Frank Opelka, and I know I'm not as good looking

22 as he was, but I'll tell him you were remembering

1 him fondly.

2 CO-CHAIR PINCUS: Okay. So, we will
3 sort of convene with the staff and sort of come
4 up with a small group to look at this and look at
5 these issues. Are we going now to the Rural
6 Workgroup?

7 MS. O'ROURKE: Yes. So, I think we
8 should do a public comment; we haven't done one
9 yet this morning.

10 CO-CHAIR PINCUS: Okay.

11 MS. O'ROURKE: And then, Amy and Chris
12 are our lead discussants, and I think they both
13 need to leave in a few minutes, so if they can
14 make their comments and then, do Karen's
15 presentation, if that's okay? Just so we let
16 them catch their flights on time.

17 (Laughter.)

18 CO-CHAIR PINCUS: Okay.

19 MS. O'ROURKE: But, if we could open
20 for comment first.

21 CO-CHAIR PINCUS: Okay. Anybody from
22 the room wish to make a comment? Okay. Anybody

1 on the phone? Can we open up the phones for
2 public comment?
3 OPERATOR: Yes, sir. At this time, if
4 you would like to make a comment, please press
5 star, then the number 1. There are no comments
6 at this time.
7 CO-CHAIR PINCUS: Okay. So, let's
8 proceed to the Rural.
9 MS. O'ROURKE: Great. Amy, Chris,
10 would you mind giving your thoughts? I just want
11 to make sure we get your --
12 MEMBER MULLINS: Yes, so, as I was
13 looking through the slides for this presentation,
14 one of the things that struck me is, I was very
15 happy to see a Rural Workgroup. The Chair is
16 actually an AAFP member, and another member of
17 the workgroup is also an AAFP member, so I think
18 it's very important that family medicine is
19 represented in that capacity.
20 One of the things that I just wanted
21 to comment on, and I'm sure that there would be
22 more explanation if I could actually see the

1 whole presentation, but one of the things it said
2 was that making rural participants a mandatory
3 participation in CMS quality measurements and QI
4 programs, that was on one of the slides.
5 So, in MIPS specifically, there is a
6 low-volume threshold that has been set forth that
7 is going to exclude, and actually, if you read
8 the rule -- which I've had the pleasure of doing
9 a couple of times -- it actually was set to
10 exclude rural physicians.
11 That was actually in the verbiage; it
12 was actually set higher the second year to
13 exclude more small and rural physicians. So,
14 just saying you want to make participation
15 mandatory in CMS quality programs can't just
16 happen. That would have to go through a
17 rulemaking process.
18 What we would ask for, and actually
19 what the Academy asked for, because of this
20 higher low-volume threshold, which we actually
21 liked in some ways and didn't like in others,
22 because as the second year participation comes

1 around, some physicians are going to be kicked
2 out of the program that were once participants
3 and maybe wanted to participate. Some people are
4 going to be happy about it, because they once
5 participated and didn't want to ever participate.
6 So, what we asked for and didn't get,
7 and Pierre knows this, we've had this
8 conversation, but is an opt-in. We wanted an
9 opt-in, so if you wanted to participate, but you
10 were kicked out because of the low-volume
11 threshold, that you could opt-in to the program
12 and report if you chose to. So, if we could
13 maybe align our messages to CMS along that vein,
14 that would be helpful.
15 CO-CHAIR PINCUS: Chris?
16 MEMBER QUERAM: Thank you. Just a
17 couple of comments. Just for context, in our
18 state -- I come from Wisconsin -- about 50
19 percent of the hospitals are rural or Critical
20 Access Hospitals.
21 So, it's a significant part of the
22 landscape in our state, as I'm sure it is in

1 Amy's state as well. And one of the formidable
2 advocates in our state is a member of this
3 workgroup, Tim Size, who is the executive
4 director of the Rural Wisconsin Health
5 Cooperative.
6 And in talking with Tim a little bit
7 about this workgroup and invited him to help
8 influence how I might characterize a perspective
9 on this, words that he uses are "stigma" and
10 "backwater."
11 He's very concerned that on behalf of
12 the constituency that he represents, that fact
13 that rural hospitals are not eligible to
14 participate or find it difficult to participate
15 in CMS's programs, payment programs, perpetuates
16 a stigma that rural hospitals, Critical Access
17 Hospitals, are backwaters -- clinical backwaters.
18 And to provide another context for
19 this, a political science professor at the
20 University of Wisconsin, Kathleen Cramer,
21 Katherine Cramer wrote a book called The Politics
22 of Resentment. It's gotten some publicity here

1 in Washington, because it coincidentally captures
2 some of the themes that emerged in the 2016
3 presidential election.
4 She actually did an ethnography model
5 or study of attitudes, beliefs, values, in the
6 State of Wisconsin, based on a longitudinal
7 series of interviews that were done in about 30
8 different communities in the state, and over a
9 period of 2010 to 2015.
10 So, predating some of what emerged
11 more forcefully at a national level. And
12 uncovered just a tremendous amount of resentment
13 in rural areas towards elites and how they make
14 decisions and how they allocate resources.
15 And the takeaway theme from that book
16 was that there's a fundamental distrust that
17 politicians, and maybe I'd reframe that as the
18 establishment -- in this case, CMS acting on
19 behalf of the administration -- any
20 administration, not this particular one
21 necessarily -- will fail to recognize the
22 distinct identities and values of their

1 communities and fail to allocate resources on
2 their behalf.
3 So, as we think about the work of this
4 workgroup, I'd put it in that context -- that
5 this is critically important work to counteract
6 some of the burgeoning attitudes, the rural/urban
7 divide that we are experiencing in Wisconsin, and
8 restore some faith in the ability of these
9 facilities to participate in as full and an equal
10 manner in the CMS programs as possible.
11 CO-CHAIR PINCUS: Thank you. So,
12 Karen, you want to give your presentation now?
13 MS. JOHNSON: Sure, and thank you. And
14 Kate, are you going to start us off or have you
15 already done the first bit? Apologies.
16 MS. BUCHANAN: So, I did an overview of
17 the feedback that the MAP Rural provided on the
18 MUC list, but that's -- so there is familiarity
19 with that.
20 MS. JOHNSON: Okay, apologies for not
21 having my ducks in a row there. So, my name is
22 Karen Johnson, I'm one of the Senior Directors

1 here at NQF. Thank you, Lisa. I should know
2 better by now. And I have the privilege,
3 actually, of leading this work.
4 It's very exciting for me personally,
5 because I'm from Central Appalachia, so it's a
6 very rural area, so this topic is near and dear
7 to my heart. And Kate is also one of the folks
8 that are on the team with me.
9 So, what I wanted to do today is three
10 things. One, give you the background of how we
11 got here today, tell you a little bit about what
12 we're doing in this current project with the MAP.
13 And then, get some feedback from you guys.
14 So, I hope -- how much time do I have?
15 I have 45 minutes or I know, I'm in-between you
16 and lunch and that's a dangerous place to be.
17 (Laughter.)
18 MS. JOHNSON: Okay. All right. I'll
19 try to talk fast. So, back in 2015, CMS, in
20 cooperation with HRSA, asked NQF to do some work
21 on rural. And basically, what they wanted from
22 us was to provide multi-stakeholder information

1 and guidance on performance measurement and
2 challenges for rural providers.
3 And it was really in the context of
4 CMS payment programs. So, that was the context
5 that we were working under. And they wanted us
6 to make recommendations about measures that would
7 be appropriate for these kinds of programs, make
8 recommendations to help mitigate some challenges
9 that we know about, and also to identify gaps in
10 measurement.
11 And that project was limited in scope,
12 somewhat. We were looking mainly at ambulatory
13 and hospital settings, so we didn't really get
14 into the post-acute world. But what was really
15 interesting was that we weren't just thinking
16 about the rural providers who were paid through
17 the PPS system.
18 It also, by design, included Critical
19 Access Hospitals, rural health centers, and rural
20 FQHCs. And the latter two are paid in a
21 different way and don't actually come under PPS
22 rules.

1 So, that was interesting, because
2 especially the last two groups pretty much don't
3 participate in the programs that we're all used
4 to talking about and thinking about. And
5 Critical Access Hospitals do participate in some
6 of the programs, but only on a voluntary basis.
7 So, this project was meant to really
8 understand some of the challenges of those
9 groups, but also small rural hospitals and small
10 clinician practices that do participate in PPS.
11 So, two different groups, some who actually do
12 participate, others that have never, and trying
13 to bring those two things together.
14 It was a great group, meeting Tim was
15 great, and he's on the current one. He was on
16 that last one in 2015. We had a lot of people
17 from these different groups that we don't
18 normally get to talk to and a lot of on-the-
19 ground providers as well. So, do I -- I guess
20 this -- yes, there we go.
21 So, some of the key issues and
22 challenges in terms of measurement, we

1 articulated in this work. And I'm not going to
2 go into major detail about these. They are
3 clearly related, but they are kind of different
4 concepts.
5 The idea of isolation that is true of
6 some, but not all rural providers. And that gets
7 into the ideas of having specialists who may or
8 may not be available, having transportation
9 issues, IT challenges, perhaps, other kinds of
10 limited support.
11 And all these things, again, the idea
12 here was how do these things impact measurement
13 and how do we think about it? Small practice
14 size, where we were getting at with the small
15 practice size really was this idea of limited
16 staff time.
17 So, one of my favorite stories was,
18 actually our Co-Chair of this project, who talked
19 about not only being the MD of his rural health
20 clinic and working in a CAH associated with it,
21 but also being the IT guy and the plumber when
22 they needed those services. Really small and

1 tiny.

2 And when it comes to measurement,

3 having very few people, it makes it difficult to

4 collect data for measurement and to do QI

5 activities.

6 In terms of heterogeneity, we really

7 talked a lot about differences in rural

8 residents. So, where I'm from, Central

9 Appalachia, is a different animal than the Deep

10 South, and that's different than Alaska and maybe

11 the Western states in terms of social factors and

12 those sorts of things, cultural attitudes.

13 All those things come into play when

14 you start thinking about risk adjustment, for

15 example. So, heterogeneity, really big. And

16 also, heterogeneity in the types of services that

17 are done in rural hospitals and clinics.

18 So, especially thinking about small

19 hospitals, and I actually never really thought

20 about this, not all of them do surgery, not all

21 of them delivery babies, or at least maybe only

22 on an emergency kind of situation.

1 So, when you start thinking about
2 measures and measures that are used in programs,
3 some measures just don't apply. And then, you
4 get into the low case volume problem.
5 That really gets to reliability of
6 measurement and being able to -- when you have a
7 set of measures that you're looking at in
8 programs, if a particular provider can't report
9 on a few of the measures, that means really more
10 weight is hanging on others.
11 And that may be good or not so good,
12 but it can be a problem. So, with all of that --
13 and the other thing is, not all of these things,
14 of course, are rural-only.
15 As a matter of fact, we were quite
16 challenged to come up with things, probably other
17 than the isolation piece, that was really a
18 rural-only problem. But it was really -- it
19 exacerbated the measurement issues for rural
20 providers, maybe in ways that it wouldn't for
21 other providers in suburban or urban areas.
22 So, the overarching recommendation,

1 and Amy has already talked about this, was that
2 eventually we'd like to make -- and when I say,
3 we, I mean, they, the committee at the time --
4 would like to make participation in CMS quality
5 programs mandatory for all rural providers.
6 So, this is not just the ones under
7 PPS, they were talking much more broadly than
8 that. But also, understanding that, given the
9 experience, a phased approach of some sort would
10 be needed. And you'd have to explicitly think
11 about the low case volume challenge.
12 So, with that -- and it was
13 interesting, it was, honestly, for me, a bit of a
14 surprising recommendation, but it was one that
15 had full consensus around our table, as well as
16 consensus from our commenters on the report.
17 So, this is something, and it goes
18 back to what Chris had mentioned that Tim really
19 was talking about, which is, by being left out,
20 and that was their phrase, being left out of
21 these programs, they're kind of left behind, as
22 it were.

1 So, they don't have the opportunity to
2 maybe understand their quality as well as others.
3 They don't have the opportunity to participate in
4 bonus payments, potentially. They don't have the
5 opportunity to publicize how good they can be in
6 providing care.
7 So, those were some of the ideas that
8 we talked about and that underlie -- I don't know
9 what the right word is right now -- that
10 underpinned the overarching recommendation.
11 They also provided many other
12 recommendations to help support a potential
13 transition to participation for all rural
14 providers. And many of these recommendations had
15 to do with development of rural-relevant
16 measures, alignment of measurement efforts.
17 Interestingly enough, that wasn't just
18 about alignment of measures, but also about
19 alignment of data collection efforts and
20 alignment of informational resources and TA,
21 technical assistance, kinds of opportunities.
22 And they also had some recommendations around

1 payment considerations.
2 But for today, I want to highlight the
3 recommendations they provided in terms of
4 thinking about measure selection for programs for
5 CMS.
6 So, I have these on the board, I'm not
7 going to read them word-by-word, but really, they
8 wanted to use guiding principles, and they
9 articled some guiding principles to be used when
10 it's time to select measures that would work for
11 rural providers.
12 They suggested identifying a core set
13 of measures, as well as an optional set. So,
14 have core and optional in these kinds of
15 programs.
16 They wanted us to be sure not to
17 forget PCMH models and the measures that are used
18 in those systems. And they also suggested or
19 recommended creating a MAP workgroup to advise
20 CMS.
21 So, fast-forwarding two years, I'm
22 sitting here today to tell you, we're really

1 excited that CMS took us up on that
2 recommendation and we just have seated our MAP
3 Workgroup for Rural Health.
4 The objectives of this year's work is
5 listed here. Basically, we want to articulate a
6 set of criteria for selecting measures. So, two
7 years ago, we had guiding principles, now we're
8 getting a little bit more concrete, what are the
9 criteria?
10 We're actually going to identify a
11 core set of measures, rural-relevant measures to
12 address the needs of the rural population. For
13 this year, we are concentrating on the hospital
14 inpatient and the ambulatory settings. So,
15 again, pushing off post-acute care for now.
16 We, as usual for MAP work, will talk
17 about gaps in measurement, provide
18 recommendations around alignment. And also, kind
19 of an interesting piece that we're going to be
20 doing is addressing a measurement topic area
21 relevant to individuals and measurements for
22 rural residents.

1 And we actually just yesterday got
2 consensus, I think, from the group, so we think
3 we know where we're going on that. And I'll talk
4 about that a little bit more very soon.
5 In terms of our interaction with you
6 guys and the other workgroups, we kind of did a
7 meet-and-greet with all the other workgroups,
8 back in November/December. We're telling you a
9 little bit more about us today, the Coordinating
10 Committee.
11 And in our last call with them, we did
12 have a chance, a very small chance, to look at
13 the MUC list and offer some high level input,
14 that I know Kate has already shared with you.
15 And then, finally, in August, you guys
16 will have the opportunity to look at what we've
17 done over the year and, hopefully, approve what
18 we come up with.
19 So, our progress to date, just so you
20 know kind of where we are, we -- this is moving
21 fast for us. We put out our call for noms for
22 this workgroup at the end of September. We had

1 seated this workgroup by mid-November.
2 Had our first webinar with them at the
3 end of November. And a second one in the middle
4 of December. And then, our third one yesterday.
5 So, it's moving right along, roughly about once a
6 month, we're contacting everybody.
7 We're doing it all via webinar and the
8 thinking there was, we don't want to pull some of
9 these rural providers who are really busy on-the-
10 ground providers of care and have them travel to
11 D.C. for a couple of days, so we're doing
12 everything virtually. So, that's been
13 interesting, but it's worked so far.
14 So, what we have done so far is obtain
15 guidance from our workgroup on the criteria. So,
16 I mentioned we want to articulate our selection
17 criteria in order to identify core sets of
18 measures.
19 So, our criteria to date are that we
20 want to pick from NQF endorsed measures. And
21 what that does is it hits several of the guiding
22 principles that the committee from two years ago

1 outlined, because NQF endorsement guarantees
2 evidence-based measurement, room for improvement,
3 feasibility, scientific acceptability, that sort
4 of thing.
5 So, they checked off several of those
6 principles by saying, let's focus on NQF endorsed
7 measures. For this core set, we also are really
8 interested in finding measures that address low
9 case volume.
10 Address probably isn't quite the right
11 word, but basically, it's the idea of, you don't
12 want measures that a lot of rural providers won't
13 have enough cases to report. Cross-cutting
14 measures is another thing that seemed really
15 important.
16 So, and cross-cutting and addressing
17 low case volume are related. They're not
18 necessarily mutually exclusive, but if you have
19 cross-cutting measures, often that will mean you
20 also may not have to worry quite so much about
21 low case volume.
22 They also mentioned several, what I'm

1 calling right now, must-have topic areas or
2 conditions. So, the ones that have come up are
3 things like mental health and substance use,
4 medication reconciliation, transitions, moving
5 from one setting to another, diabetes, high blood
6 pressure, COPD.
7 Also of interest has been at least
8 considering measures of readmission and thinking
9 about how and when to bring in measures around
10 perinatal care and pediatric care.
11 So, yesterday on our call, we
12 presented a draft core set that we came up with
13 by applying these criteria. And we basically
14 provided the Committee a strawman set of core
15 measures, we came up with 44 of them to cover the
16 inpatient and ambulatory settings.
17 And over the next week, we're going to
18 continue to obtain feedback from them. There may
19 be more than 44 that they want to think about and
20 then, we'll start winnowing down that 44-plus to
21 something that's reasonable for a core set.
22 And just so you know, our thinking in

1 terms of what would be a reasonable core set
2 would be probably ten to 20 measures per set.
3 So, certainly not -- other things could
4 potentially go in optional sets, if we are funded
5 at some point to do that work.
6 So, that is my kind of lecture part.
7 So, discussion questions. Let me just throw
8 those out for you and we can go in whatever
9 direction you would like to go. But are there
10 key measurement or programmatic issues that we
11 should keep in mind when identifying our core
12 sets?
13 What are your reaction to the criteria
14 that I discussed? Again, cross-cutting,
15 addressing low case volume, and certain
16 conditions. And just so you know, the conditions
17 that were brought up were ones that are really
18 quite prevalent overall and particularly in rural
19 areas.
20 Do you have any advice in terms of
21 what would be important to emphasize as we try to
22 explain our results? We're going to be writing a

1 report, like we always do here at NQF, and we
2 want to make sure that it's a useful document.
3 Going forward, what information or
4 input or guidance from them to you would be of
5 help? So, what can we bring back to you?
6 And then, finally, I didn't put it on
7 this list, but after yesterday and in a lot of
8 our discussions, the idea of access to care was
9 really, really huge. And that's a different way
10 of thinking about measurement and access is not
11 the same as quality measures, right?
12 So, they're different animals. And
13 so, we are thinking that that will probably be
14 our measurement topic area. So, if you have any
15 ideas on how we could scope that down, because
16 access to care is a really huge topic and we
17 would need to really scope that down.
18 We were thinking it might be something
19 along the lines of very foundational, almost
20 thinking piece, what are the types of access?
21 Looking at it through a rural lens, what would be
22 important to consider? What are the pros and

1 cons? What are the things to be aware of? That
2 sort of thing.
3 Again, none of that is yet set in
4 stone, but if you have any ideas, we'd be very
5 much appreciative. So, with that, I'm going to
6 stop and, I guess, hand it back. Or I can
7 facilitate, however you want to do it.
8 CO-CHAIR PINCUS: I think, right now,
9 we're going to open it up for discussion on some
10 of these sort of key issues. And so, one
11 question I had, well, a couple of questions I
12 had, just to kick things off, was in one of the
13 earlier slides, you mentioned using some of the
14 Patient-Centered Medical Home measures.
15 So, are you including structural kind
16 of measures in here too, in terms of the thinking
17 about this? Is it specific though to the thing
18 that CMS is doing? And also, when you're looking
19 at, asking about suggestions around measures, are
20 you talking about actual endorsed measures or are
21 you thinking about measure concepts?
22 MS. JOHNSON: So, your second question

1 first, measures right now, because if we
2 identified a core set, it would be ones that we
3 conceivably could put in use immediately. We
4 could certainly, and we did a couple years ago,
5 talk a little bit more about concepts.
6 And I think we would get there more in
7 our gaps discussions that we would have. In
8 terms of PCH kinds of measures, right now, we
9 have limited to NQF endorsed. But we certainly
10 are open to structural measures.
11 MEMBER BINDER: Thank you. I'm really
12 pleased to hear about this work and I
13 congratulate you on it. I actually, myself,
14 worked in a rural hospital for eight years and
15 came from Maine, so I have some familiarity and
16 am excited about this.
17 I have a couple things to recommend.
18 One is the framing of it, around the concept that
19 rural people deserve the same quality of
20 healthcare as anybody else. I think that's just
21 an important kind of framework for it as opposed
22 to saying, we're going to come up with a whole

1 set of measures that are different for rural
2 communities than urban.
3 They're people and we want them all to
4 get high quality care. And I would say, in terms
5 of measure selection, to try to avoid saying, we
6 have a separate set of criteria for rural
7 populations than we do for urban.
8 I would just say, there are certain
9 measures that have to be adapted, because of the
10 small numbers. But otherwise, we select measures
11 according to the same criteria we use for
12 everything else.
13 That would be my suggestion, simply
14 because, otherwise, I don't understand why we're
15 pulling them out with different criteria, that
16 doesn't make any sense.
17 Other than, of course, that key issue
18 of the small numbers in terms of the calculations
19 and needing to adapt and come up with measures
20 that might be acceptable, given that the small
21 numbers don't allow for certain outcomes to be
22 tracked.

1 So, to somebody else's point about
2 structural measures, are often a substitute or
3 something like that. So, I would suggest
4 thinking of it as an adaptation of current
5 measures.
6 And then, the other thing that I think
7 might be worthwhile for the workgroup to think
8 about too is, how rural communities can actually
9 do things better?
10 I don't know that that's come up in
11 your group, but we, in the rural community that I
12 was part of, we did some very interesting
13 projects that would have been impossible in urban
14 settings. And they were instructive.
15 So, an example would be, we decided we
16 needed to address domestic violence in a more
17 coordinated way, so we had one meeting and we
18 pulled together the sheriff's office, a judge
19 came, the emergency room department director for
20 the only hospital, and physicians, the shelter
21 staff.
22 It was like everybody who had

1 something touched the lives of victims of
2 domestic violence, and the victims themselves
3 came. You can't do that in an urban community.
4 You can't bring in kind of all the key people all
5 at once, usually.
6 But we could and they did some very
7 interesting changes. And it really, really had a
8 significant impact, I think, on the well-being of
9 the victims.
10 So, I mean, and that's just one
11 example, but I think that there's ways that you
12 can look, especially when looking at population
13 health as it intersects with acute care, where I
14 think rural communities have done some
15 extraordinary work and there may be areas to
16 build on those strengths.
17 MEMBER MACKAY: Karen, I just wanted to
18 say, thank you so much for this work. I echo
19 previous comments that it's exciting to see rural
20 communities being brought into this shift towards
21 value.
22 It's understandable why a lot of times

1 these providers have been excluded from some of
2 the programs that we've discussed in previous
3 days.
4 It's hard to live in these communities
5 often, it's difficult to practice medicine, but I
6 do think that we may have been missing some
7 opportunities, particularly because rural
8 providers are oftentimes more familiar with or
9 better at coordinating care and doing some of
10 these more innovative community-gathering
11 exercises or initiatives, like Leah mentioned.
12 So, it's just great to see. A couple
13 of things that I wanted to mention as you're
14 thinking about measure selection, is just getting
15 more data in the pipeline, that will eventually -
16 - about the quality of care provided and provider
17 performance, that will eventually trickle down to
18 patients and families in these communities.
19 I think easily accessible information
20 for rural residents, even in cases where they
21 might not be able to use that information to shop
22 for care, is nonetheless important and it is a

1 critical part of their ability to successfully
2 and meaningfully partner with their providers in
3 care and achieve the outcomes that we're all
4 looking for.
5 I also think that, sort of echoing
6 what Chris mentioned earlier, lack of information
7 about the quality of care that is often provided
8 in these areas may contribute to the incorrect
9 assumption that -- or I screwed up that first
10 part.
11 But not having enough data sometimes
12 leads us to the incorrect conclusion that high
13 quality care is not being provided. I think that
14 can be dangerous and could drive a further out-
15 migration of patients, because they think that
16 their local providers -- or they aren't aware of
17 the care that their local providers are
18 providing.
19 And then, lastly, just that, it's my
20 understanding that healthcare providers are often
21 economic engines of these rural communities and
22 they mean a lot more to the residents of the

1 communities than just the ability to access care.
2 And so, I think that underscores our
3 need to be selecting measures that are reflective
4 of the things that these providers do so well,
5 like care coordination. So, thank you very much.
6 CO-CHAIR PINCUS: Carl?
7 MEMBER SIRIO: Yes, I think, just to
8 build on Leah's comments, and that is, as I drive
9 across Route 80, I would like to think that the
10 care I got in Cleveland than it might be in
11 Topeka, Kansas and in some rural community in-
12 between, if I got into a car wreck. But I think
13 we all know that it wouldn't be.
14 That having been said, it seems to me
15 that some of the issues you've raised, Karen,
16 with respect to the problems around small sample
17 size are not generic to just the smaller
18 populations, right?
19 So, my point is, to the degree that
20 what you do and what you learn cross-fertilizes
21 what I think has been a perennial question, and
22 to some extent, a perennial pushback on the part

1 of at least the clinical community is the issue
2 of sample size and, therefore, robust validity of
3 the outcomes that are being assessed through
4 measurement.
5 So, I think that the Task Force is a
6 great idea, but I think it can actually help
7 inform thinking that's actually broader than just
8 the impacts on smaller communities.
9 CO-CHAIR PINCUS: Giff?
10 MEMBER GIFFORD: Yes, there's, I think,
11 over 80 percent of the counties in the country
12 have a nursing home. So, we have a lot of small
13 -- and even in larger, so we have a small sample
14 size. And I -- they always want to be involved
15 in the programs and everything, until they get
16 involved in the programs.
17 One thing, and it's a little bit in
18 the weeds, as you think about the small sample
19 size, don't -- we've suggested a few times to CMS
20 that they just expand the time window for the
21 measures, but they don't feel that they can have
22 measure specs for the same group with different

1 specifications.
2 I -- you think about -- you may have
3 to do that. And I know there's -- it depends on
4 what OGC says about statutory issues and
5 everything.
6 Second, your burden issue becomes very
7 different. So, we've calculated in some of the
8 VBP programs that our rural people really want to
9 get involved with, they discover that, just
10 through sensitivity analysis, you're talking
11 about either losing $50 or getting $500, if they
12 play in the program.
13 And it doesn't require much burden to
14 suddenly make participation in that program more
15 expensive than $500. And that's all they're
16 going to get by playing in the program.
17 So, I didn't hear the burden aspect in
18 that and so, you may want to think about that
19 burden, help point that out. Because when we
20 point that out to them, they suddenly are not as
21 eager to be in the programs any more.
22 CO-CHAIR PINCUS: I just might add,

1 given Chris's comments earlier, you might want to
2 add to your slide about specific issues, the
3 issue of stigma to that as well. Sam?
4 MEMBER LIN: Thank you, Harold. And,
5 Karen, thank you so much for your presentation.
6 I heard you three times in December and I have to
7 say, just your presentation alone has advanced in
8 the last month. So, thank you.
9 My contribution to the, I was rural
10 when rural wasn't cool, was my time with Indian
11 Health Service, 100 miles from Spokane. And talk
12 about rural and isolated.
13 That sort of leads to my question, you
14 indicated you had three federal liaisons and
15 these are supposed to be publicly reported
16 programs, and I'm wondering, if you don't, you
17 might think about having someone from Indian
18 Health Service there, for Indian Health Service's
19 sake, not for anybody else's in all honesty,
20 because they still have the problems of access,
21 the problems -- et cetera, et cetera.
22 The issue of, what do we do about the

1 rural, goes back to a story, at least I recall,
2 about a former Army Surgeon General years back,
3 when he was asked what he thought about this
4 whole issue of maldistribution of physicians in
5 this country and he says, what maldistribution?
6 And they said, well, sir, you obvious
7 know about the lack of physicians in this
8 country. He said, there's no maldistribution of
9 physicians, if those farmers would move to the
10 cities, we'd be okay.
11 (Laughter.)
12 MEMBER LIN: So, anyway, they're not
13 going to move the city, so therefore, we do have
14 to put them in high consideration. But I really
15 think Indian Health Service needs a lot of help
16 and this is at least a start to get them included
17 in what we'll call the diversity in disadvantaged
18 activity that we here have been pushing for the
19 last two years.
20 CO-CHAIR PINCUS: Do we have any
21 comments from people on the phone?
22 MEMBER ANTONELLI: Harold, Rich

1 Antonelli would like to get in the queue please.
2 CO-CHAIR PINCUS: Okay. Sure, Rich.
3 MEMBER ANTONELLI: Is it okay to jump
4 in?
5 CO-CHAIR PINCUS: Yes, speak up, Rich.
6 MEMBER ANTONELLI: Okay. So, Karen,
7 this is Rich Antonelli, Medical Director of
8 Integrated Care in the rural place otherwise
9 known as Boston, but I just, first of all, want
10 to applaud your approach.
11 Second, a lot of the work we're doing
12 nationally in integrated care and care
13 coordination, and be mindful that that work is
14 embedded in other workgroups, is actually
15 strongly focused on quality measures, including
16 experience and the A-word, access, for rural
17 areas.
18 Some of our most profound work,
19 actually, is being done right now up in Alaska,
20 leveraging the pretty precious resources of
21 community health workers.
22 So, that said, my suggestion is as

1 follows. Every quality measure that we look at
2 across the MAP and across the workgroups, as far
3 as I'm concerned, somebody should make the
4 argument why it wouldn't be appropriate for rural
5 populations.
6 Second, I think that what I would find
7 would be a tremendous value-add from the folks
8 thinking about rural health are the folks
9 thinking about, okay, what would be some of those
10 unique challenges?
11 I also think there are access issues
12 in urban environments that would be different
13 logistically and tactically than rural
14 environments, but the access measures, so
15 utilization of telemedicine, for example, care
16 coordination and implementation, et cetera.
17 So, I guess I would encourage your
18 workgroup to try as hard as you possibly can to
19 think about the core measures at the broadest
20 level, and really challenging to make the case
21 for why we would need any additional measures for
22 this going forward. So, thank you for your

1 commentary, I look forward to hearing what comes
2 from your workgroup.
3 CO-CHAIR PINCUS: Other comments on the
4 phone? Derek?
5 MEMBER ROBINSON: I was just going to
6 make a brief comment. I appreciate the work that
7 Karen and the workgroup is doing.
8 I think it's very important and
9 certainly, I echo some of the comments around the
10 importance of individuals in rural communities
11 having access to the same high quality care as
12 other areas. And I think it's important to have
13 good transparency, as well, from a quality
14 performance perspective.
15 My perception, that historically, the
16 challenges that come into play when quality and
17 performance is tied to reimbursement and the risk
18 for penalization or, perhaps, disruption of other
19 supplemental payments that may be going to those
20 providers. And so, I think that's something
21 that's important for the workgroup to consider.
22 I think the, my perception, I think

1 the excitement about getting engaged in this,
2 having been not part of much of the value-based
3 payment arena or progress over the last few
4 years, is very positive to hear.
5 But I think also, as we get into tying
6 that performance to payment, is really sort of
7 where the rubber hits the road and whether we're
8 able to keep that momentum in a way that folks
9 feel is equitable and fair.
10 CO-CHAIR PINCUS: So, I had a comment,
11 a couple of comments. One is, probably among the
12 biggest issues into the areas in terms of access
13 in rural areas is access to behavioral health
14 services. And it's something that I think is
15 important for the group, obviously, to look at.
16 But it also raises the issue of
17 attribution, because there are very few
18 psychiatrists/psychologists. I can't remember,
19 there's some statistic about something like 50
20 percent of rural healthcare areas have no
21 psychiatrist or psychologist available at all.
22 And so, who's responsible for that?

1 It's -- and that's going to come, not just in
2 behavioral health, but it's something to think
3 about in terms of sort of attribution for access
4 in those situations.
5 And just one other thing is just that,
6 we have a Harkness Fellow in my office who is
7 funded by the Commonwealth Fund, fellows coming
8 from other countries, soon to be career people.
9 And we have one from France who's
10 actually doing a paper, one of her projects is
11 doing a paper on comparing access to behavioral
12 health services in France versus the U.S. And
13 so, she might be somebody worth talking to.
14 Other comments, questions?
15 MS. BUCHANAN: Harold, we received one
16 chat question, asking how geographic isolation is
17 being handled by the workgroup?
18 MS. JOHNSON: So, I'll answer the
19 question about geographic isolation. I think, in
20 terms of what we're doing in this particular
21 project, in terms of core measures, we're
22 definitely thinking about geographic isolation,

1 since it is a huge challenge.
2 We'll have to think about that, when
3 they identify the core measures. So, that will
4 just be one of the things that we think about.
5 Probably, it'll come in a little bit more -- like
6 one of -- what we did yesterday is basically give
7 a list of measures. Here's a strawman, here's a
8 first cut at core measures.
9 What we're asking the workgroup to do
10 over the next few days is to look much more
11 critically at that first cut and tell us things
12 about, okay, based on your perceptions, is this
13 really feasible to collect these data used for
14 these measures in rural areas? And if not, then
15 maybe it doesn't belong on a core set.
16 Other things like, are there
17 unintended consequences that this measure may
18 have from a rural viewpoint? And I think that
19 might be a place where the isolation comes in.
20 And eventually, once we come to a
21 pretty good set of core measures, we need to look
22 at the set itself as a whole and start thinking

1 about, does that really reflect quality for rural
2 providers, as well as we can, knowing that there
3 would probably be optional measures later on that
4 would come in.
5 But I think looking at things kind of
6 more as a set will also be helpful, but that
7 comes a little bit later in the process.
8 Just a couple of things that I wanted
9 to mention, and I probably won't hit everything,
10 but part of the idea of a core set, and I
11 apologize if I've given the impression, the core
12 set of measures for rural providers, if it's ever
13 taken up by CMS and used, the idea isn't
14 necessarily that it would be a completely
15 different set of measures used by everybody else.
16 As a matter of fact, the ideas of
17 alignment with other programs and with other
18 providers is really very important, because you
19 want to be able to compare, if you can, rural
20 quality to their non-rural counterparts. Again,
21 many are very proud of the quality that they
22 provide.

1 And so, the core set hopefully would
2 be something that there would be a lot of
3 intersections. It might not be complete overlap,
4 but there would be a lot of intersections.
5 Going back to the idea of the access
6 measures, I think attribution is absolutely
7 something that we're going to have to hit head-
8 on. A lot of access measures really are more
9 population-based measure.
10 So, if you think about, okay, what
11 does that do? Does that put our community into a
12 -- can we really -- is our core community, or our
13 whatever, fill-in-the-blank community, is that a
14 reasonable thing to do that you might hold
15 somebody accountable for?
16 Those are very important issues that
17 we're going to have to address, I think. There
18 were probably a few other things, and I
19 apologize, that I've kind of lost. But I'm happy
20 to take any questions or any advice that you have
21 going forward.
22 CO-CHAIR PINCUS: Well, thank you. So,

1 I guess that concludes our agenda. So, we'll
2 just hear from the public?
3 MS. O'ROURKE: I think, yes, if we
4 could do one more public comment.
5 CO-CHAIR PINCUS: So, anybody in the
6 room from the public wish to make a comment? I
7 don't see anybody. So, anybody on the phone wish
8 to make a public comment?
9 OPERATOR: At this time, if you would
10 like to make a comment, please press star, then
11 the number 1. And there are no public comments
12 at this time.
13 CO-CHAIR PINCUS: So, I guess we're
14 ready to adjourn? We have lunch there.
15 Let me just really thank and really
16 express my appreciation to Chip, my partner in
17 this. And to NQF staff and the CMS staff and,
18 certainly, to everybody on the MAP Coordinating
19 Committee. So, thank you all.
20 MS. O'ROURKE: Yes, thank you. A
21 special thank you to Harold and Chip for all of
22 your leadership, not just over the past two days,

1 but all the work we do to get here. To Kate and
2 her team for all their partnership and working
3 with us through this.
4 And to all of you for bearing with us
5 for the past two days and all the homework that I
6 know we send you and the short time to prepare,
7 we really appreciate it. Thank you especially
8 for all the feedback on what we could do better
9 next year.
10 I think we'll be following up about
11 how we can make that happen and if we can convene
12 a small group of you or if people want to send
13 thoughts offline, if anything comes to you on the
14 plane ride home, we'd love to hear it.
15 I did just want to briefly cover some,
16 just what we'll do to wrap up pre-rulemaking. We
17 will start issuing the reports of MAP's
18 recommendations in the next few days, really.
19 So, February 1, the spreadsheet of all the
20 individual measures under consideration and MAP's
21 recommendation will be published.
22 February 15, I will release the

1 guidance for hospital and PAC LTC programs. And
2 then, March 15 will be the guidance for clinician
3 programs.
4 I did want to highlight, we will be
5 back in touch in the coming months. There will
6 be a web meeting in August of the Coordinating
7 Committee to review the input from the Medicaid
8 and Rural Task Forces. So, keep an eye out on
9 that and we'll be getting that on your calendars
10 in the coming weeks. Giff?
11 MEMBER GIFFORD: Follow-up for Harold
12 and Chip, I think yesterday it was suggested
13 tracking historically stuff that's come through
14 the MUC, whether it got in rules and what --
15 would that -- how does that fit in that time
16 line? I mean, it's not urgent, but do we wait to
17 August to have that?
18 CO-CHAIR PINCUS: I think our next
19 official meeting is a webinar in August. But
20 there is certainly the possibility of being a
21 communication before then. And certainly, the
22 idea of this sort process workgroup would

1 probably be some phone calls before that.
2 MS. O'ROURKE: Yes. And I think that's
3 something, if you have thoughts about what
4 information is useful or would be helpful, what
5 intervals and formats you'd like us to provide
6 that information, let us know. Because I think
7 that's on our list of how we can bring you better
8 information for next year.
9 So, if you have ideas, let us know and
10 we can follow up on that. Otherwise, again,
11 thank you for all of your time over these past
12 weeks and past two days. We know they were long
13 meetings, so thank you. And we look forward to
14 seeing you virtually in August. So, thank you
15 very much, everyone.
16 (Whereupon, the above-entitled matter
17 went off the record at 12:46 p.m.)
18
19
20
21
22

A

A-word 200:16
a.m 1:8 5:2 113:12,13
A1C 11:2 92:22
AAFP 166:16,17
ability 12:6 39:5 147:11 149:10 158:7 160:21 171:8 194:1 195:1
able 16:8 33:7 34:20 36:17 56:10 73:17,20 95:11 98:22 101:4 133:15 135:11 151:16 177:6 193:21 203:8 206:19
above-entitled 113:11 211:16
absolute 94:20 139:15 147:21 155:11
absolutely 17:9 20:11 207:6
abstentions 46:14
Academy 2:4,8 167:19
accept 44:1 99:9 129:8 129:13
acceptability 184:3
acceptable 76:2,16 103:7 190:20
accepted 44:3,4 131:13
access 168:20 169:16 173:19 174:5 187:8 187:10,16,20 195:1 198:20 200:16 201:11 201:14 202:11 203:12 203:13 204:3,11 207:5,8
accessible 193:19
accomplish 79:8 112:22 113:4
accountability 90:8,9 91:10
accountable 207:15
accurate 128:14
achieve 78:8 111:21 194:3
achieved 78:20
achieving 111:14
ACP 37:2
acquiesced 82:19
acquiescence 82:10 83:7
act 86:9
acting 3:11 35:15 86:14 170:18
active 44:18
actively 24:10
activities 18:20,21 176:5
activity 17:18 199:18
actual 16:19 29:14 85:18 95:6 164:8 188:20
acute 192:13
ad 74:20 104:21
adapt 190:19
adaptation 191:4
adapted 190:9
add 16:6,8 18:6,18 27:16 36:11 44:1 52:12 123:12 153:22 163:11 197:22 198:2
adding 135:17
addition 24:12
additional 13:14 48:2 155:1 201:21
address 45:5 62:10 91:1 93:7 119:15,17 140:1,5,7,10,17 181:12 184:8,10 191:16 207:17
addressed 130:21 138:18 141:14
addressing 132:13,19 181:20 184:16 186:15
adequate 124:10 134:2
adequately 132:12
adhere 55:1
adjourn 4:22 208:14
adjudicate 64:21
adjudicating 83:13
adjusting 110:16
adjustment 115:2 176:14
administer 38:22
administration 16:15 19:16 170:19,20
administrative 35:11
ado 6:12
adopt 26:3
advance 8:17 137:5 158:15
advanced 198:7
advice 110:22,22 111:1 111:2,4,22 115:14 186:20 207:20
advise 180:19
advisory 60:17 66:12 66:12 68:13 130:1
advocate 83:15 109:4
advocates 169:2
advocating 54:7
affirmation 44:3 124:22
affirmative 126:4
affordability 78:4
AFL-CIO 2:5
afraid 66:22
afternoon 60:12 96:20
aged 17:22
agenda 5:9 8:6 40:14 47:3 157:19 208:1
ago 74:18 98:5 181:7 183:22 189:4
agree 59:2 99:18 100:2 103:3,16 105:21,22 106:2 124:7 126:11 126:13 127:19,19,19 127:20 139:8 142:17
agreed 13:12
agreeing 98:4
agreement 14:6 43:5
agrees 80:4
AHA 35:9
ahead 58:21 67:16 69:2 157:8,18
Alaska 176:10 200:19
alcoholism 29:21
algorithm 47:3,13 116:20 117:2,8 152:20 153:5,11 154:7 156:17
align 28:3 48:10 168:13
aligned 137:13
alignment 11:14,17 27:17 35:21 179:16 179:18,19,20 181:18 206:17
Alliance 1:19 112:12,14 113:6
allocate 170:14 171:1
allow 19:13 190:21
allows 41:8
alternative 44:10
ambivalent 66:20
ambulatory 55:22 56:6 135:6 173:12 181:14 185:16
America's 1:15
American 1:14,17,18 1:20 2:2,4,5,10
AMIN 3:6 154:18
Amir 2:5 36:9 37:13 90:3 96:10 109:22 129:8
Amir's 128:7
amount 10:15,17 98:19 170:12
Amy 2:4 23:4 29:12 39:17 50:3 60:3 124:7 165:11 166:9 178:1
Amy's 24:19 127:20 133:21 139:8 169:1
analysis 44:20 45:19 49:13 155:4,14 197:10
Analyst 3:13
analytics 47:8 154:13
anathema 144:1
and/or 67:12
anger 83:2
angst 139:5
animal 176:9
animals 187:12
annual 104:19
anonymous 71:22 72:4 72:10
anonymously 45:9 72:5
answer 14:12 19:5 23:3 23:4 31:8 50:7 71:19 161:18 204:18
answers 105:21
Antonelli 1:12 135:21 136:1 199:22 200:1,3 200:6,7
anxiety 140:1,12
anybody 11:17 13:6 165:21,22 189:20 198:19 208:5,7,7
anymore 107:6
anyway 56:9 119:18 120:1,7 128:20 199:12
anyways 37:6
apart 159:10
apologies 171:15,20
apologize 28:18 45:6 206:11 207:19
app 45:12 50:9,14 62:19 63:2
Appalachia 172:5 176:9
appeal 74:5
applaud 200:10
Application 77:17
Applications 1:3 74:1
applied 22:13,16 91:17
applies 115:5
apply 82:20 177:3
applying 7:12 185:13
appreciate 6:14 104:7 146:8 202:6 209:7
appreciated 160:2
appreciation 208:16
appreciative 188:5
approach 6:21 98:9,22 136:10 178:9 200:10
approaching 67:11
appropriate 5:22 74:10 105:5 173:7 201:4
appropriateness 66:16 78:5
approve 88:8 182:17
approved 54:2
apps 60:6
apt 30:4

arbitrators 66:7
area 17:19 141:9 145:2 172:6 181:20 187:14
areas 9:2,18 12:5 13:14 135:3 141:5,5,10,13 170:13 177:21 185:1 186:19 192:15 194:8 200:17 202:12 203:12 203:13,20 205:14
arena 203:3
argue 78:16
argument 201:4
arguments 57:13
arisen 11:5
Army 199:2
articled 180:9
articulate 181:5 183:16
articulated 99:1 175:1
articulation 98:6,7
ascertain 22:20
ashamed 67:6
asked 48:6 64:6 69:1 167:19 168:6 172:20 199:3
asking 21:13 188:19 204:16 205:9
aspect 197:17
aspects 15:13
assess 15:22
assessed 196:3
assessment 116:22
assessments 117:1 145:16,18 146:7 154:8
assign 156:15
assistance 179:21
associated 10:17 40:3 175:20
Association 1:15,17 2:1,2,10
assumed 18:14
assuming 127:16
assumption 194:9
Assurance 2:17
attach 82:21
attempt 14:22
attend 133:15
attendance 128:17
attendee 159:16
attending 128:11
attention 109:5
attested 115:7
attitudes 170:5 171:6 176:12
attribution 4:12 91:15 138:2,3 140:5 147:21 160:17 203:17 204:3 207:6
August 182:15 210:6 210:17,19 211:14
authorities 19:13
authority 17:19
automatically 93:3
available 9:18 175:8 203:21
average 26:15 31:12 35:14
avoid 42:22 190:5
aware 25:2 37:22 91:20 188:1 194:16
awkward 57:2

B

babies 176:21
baby 57:20 85:10
back 11:20 18:7,15 19:6 32:11 37:2 41:10 43:14,15 49:8,10 52:3 60:14,21,22 65:1 72:11 79:19 81:22 85:21,22 86:3,8,9 87:5,9,10,11 88:7 100:12 102:12 105:4 105:18 110:16 113:9 115:11 118:5,14 132:9 139:21 140:12 144:12 147:5,6 153:7 153:12 156:7,11 157:1 161:10,13 172:19 178:18 182:8 187:5 188:6 199:1,2 207:5 210:5
background 69:9 163:21 172:10
backwater 169:10
backwaters 169:17,17
bad 51:5 73:21
BAKER 1:13 105:19 108:7
balance 66:17 98:17
balanced 33:8
balancing 79:11
ball 30:3
BARTON 2:16
base 129:6,10,11,13
based 13:4 16:10,11 19:11,11 41:19 62:19 67:10 79:20 133:14 153:3 170:6 205:12
baseline 30:6
basic 73:4
basically 29:3 63:9 116:19 134:1 141:5 172:21 181:5 184:11 185:13 205:6
basis 130:6 144:4 174:6
bath 85:11
bathwater 57:21
baton 110:7
battleship 29:9
bearing 209:4
beat 54:20
beginning 23:20 104:19
behalf 67:18 169:11 170:19 171:2
behavioral 203:13 204:2,11
beings 30:2
beliefs 170:5
believe 21:10,14 29:14 30:12,14 36:2 90:13 90:14,15 94:8,9 144:3
believed 51:9
belong 205:15
benchmark 48:11
benefit 92:18
benefits 27:3
BERNOT 3:7
best 16:10 41:11 103:4 103:5 112:1 115:13 149:9
BETH 1:14
bets 131:14
better 16:18,22 19:7 34:11 35:21 41:5 42:21 51:17 60:4 62:9 64:19 66:1,18 124:4 124:14 137:13 145:17 172:2 191:9 193:9 209:8 211:7
beyond 150:16
big 45:14 92:16 176:15
bigger 63:22
biggest 87:21 120:22 203:12
Bill 73:5,9,10,16 79:5 82:6 98:22 104:5 106:2
Bill's 41:11 98:6 103:11
binary 134:1
BINDER 1:13 55:12 87:18 134:14 146:16 149:20 189:11
binding 57:17 61:21
bingo 146:18
bipartisan 77:22
bit 6:20 11:1 16:17,22 20:1 29:8 31:22 38:18 41:2 52:8 57:11 58:4 74:15 110:4 119:5 121:15 123:20 138:5 147:11 155:7 157:13 157:21 162:9,17 169:6 171:15 172:11 178:13 181:8 182:4,9 189:5 196:17 205:5 206:7
black 94:20 124:16
blanket 123:18
Blessing 1:19
block 76:18
blood 185:5
blue 45:14
blueprint 37:19
blunt 87:19
board 1:20 28:4 35:9 75:1 98:12 105:2 180:6
Boards 99:15
bodes 152:11
body 142:18
bolster 112:16
bonus 179:4
book 160:6 169:21 170:15
books 157:19
Boston 200:9
bother 63:15
BOTT 1:14 22:17 133:21
bottom 63:10,15
bound 64:8,15
box 30:16
boy 79:18
brain 82:21 109:3
breadth 42:13
break 46:21 110:14 112:9 113:9
BRESCH 1:14
brief 202:6
briefing 108:13
briefly 42:20 209:15
bring 5:3 8:7,9 13:20 37:2 43:14,14 60:14 60:21,22 85:21 105:1 118:14 140:12 152:19 174:13 185:9 187:5 192:4 211:7
bringing 47:13 82:7,11 119:17
brings 93:21 123:13
broaden 19:9 47:5
broader 66:19 75:21 82:21 138:21 196:7
broadest 201:19
broadly 178:7
brought 13:9 73:5 74:16 87:5,9 147:5 151:7 186:17 192:20
Bruce 1:18 46:15 52:21 53:8 55:5 58:4 59:3 140:19 141:20 143:22

144:7 146:17 160:18
Bruce's 137:20 153:15
BUCHANAN 3:8 153:21 171:16 204:15
bucket 46:20 49:20 120:22 152:17
budgetary 39:7
bug 73:21
build 22:2,2 24:21 138:9 142:1 149:10 192:16 195:8
Building 58:4
built 50:6 53:14
bunch 65:11
burden 10:12,16,17,19 11:20 14:16 15:2,7,18 16:1,9,19 17:1,6,12 21:2,8 26:11,13 27:1 33:1 35:11 38:8,14,15 38:19,20 97:13,14 148:6 197:6,13,17,19
burgeoning 171:6
Business 1:21 2:11
busy 183:9
buy 81:16,19 102:11 124:3
bylaws 99:16

C

C-O-N-T-E-N-T-S 4:1
CAH 175:20
calculate 39:6
calculated 197:7
calculations 190:18
calendar 44:1,4 49:5 55:16 56:12
calendars 210:9
call 38:8 79:12,13 131:2 182:11,21 185:11 199:17
called 7:3 50:14 169:21
calling 143:13,15 185:1
calls 60:13 211:1
calm 109:5
capable 142:4
capacity 129:9,10 150:12,20 166:19
Capitol 78:2
capture 42:10 85:8 99:6
captured 34:21 72:14
captures 170:1
capturing 124:15
car 195:12
cards 123:10
care 2:8,9 17:12 21:12 23:18 33:6 38:3 72:5 78:5 85:1 86:19 90:21 94:10,13,15 107:8,9 107:10 179:6 181:15 183:10 185:10,10 187:8,16 190:4 192:13 193:9,16,22 194:3,7,13,17 195:1,5 195:10 200:8,12,12 201:15 202:11
career 204:8
careful 24:22 81:11,14 126:1
Caregiving 1:19
Carl 2:10 28:7 64:3 71:3 71:20 83:3 91:14 102:5 108:2 124:18 164:14 195:6
Carl's 99:18
carved 149:20
case 25:12,19 159:9 170:18 177:4 178:11 184:9,17,21 186:15 201:20
case-by-case 130:6
cases 56:18 78:16 109:22 115:4 130:5 130:12 184:13 193:20
casual 99:20
catch 165:16
categorical 112:8 161:5
categories 4:16 47:1 48:16 52:15 58:1 60:5 61:16 62:13,14 63:3 68:3 84:7 110:13,17 110:18 113:14,15,18 114:7 115:16,19,22 116:5,13 118:12,12 119:9 122:5 139:20 151:13,14
categorize 93:3
category 46:6 114:10 114:11,14 116:18 117:15 118:6 120:7 123:3 124:9,14 126:3 131:18 141:4,18 142:21 143:5,11,13 146:22 148:6
caught 89:9,18,21
cause 126:16
caused 55:3,10
causes 139:5
causing 118:3
caution 22:7
cautious 21:18
celebrate 67:7
center 1:13 23:11 56:1 135:6
centered 23:8
centers 2:18 3:18 56:7 173:19
Central 172:5 176:8
certain 9:19 13:7 36:13 92:21 186:15 190:8 190:21
certainly 11:3 12:14 17:15 18:5 20:14 23:7 23:15 24:7,15 25:2,3 27:10 29:19 35:17 102:11 105:20 106:5 106:11 109:2 117:19 186:3 189:4,9 202:9 208:18 210:20,21
cessation 29:20
cetera 87:15 198:21,21 201:16
chair 88:22 89:2,5,7,17 110:8 164:3 166:15
chairs 56:17 57:3 64:10 64:20 67:14 162:8 164:12
challenge 178:11 205:1
challenged 177:16
challenges 11:10 173:2 173:8 174:8,22 175:9 201:10 202:16
challenging 119:10 201:20
chance 7:9 13:22 14:3 41:20 44:21 49:18 76:9 78:21 91:8 182:12,12
chances 80:6
change 16:2 28:13 29:9 30:13 47:12 72:6,10 107:11 117:17,20 146:4
changed 47:18 66:4 110:2
changes 28:21 48:1,2 99:16 145:2 151:14 192:7
changing 29:6 39:20 40:4 81:1 138:15
channels 153:7
characterize 169:8
charge 13:19 122:11 157:5
charged 58:12 156:16
Charles 1:9,11
chart-abstracted 16:20
chat 204:16
CHCQM 2:7
checked 184:5
checking 30:16
checkmark 36:19
chewing 39:16
Chip 6:14 15:9 17:5 74:19 83:4 90:2 97:20 158:1,6 208:16,21 210:12
choice 76:1,15
chose 168:12
Chris 2:6 97:18 98:3 105:22 112:13 165:11 166:9 168:15 178:18 194:6
Chris's 102:6 198:1
chuckling 84:2,22
circumstances 76:19 90:18
cities 199:10
city 199:13
claims 14:18,19
clarification 27:16 65:8 129:19 131:11
clarifications 111:10
clarify 42:18 44:7,19 46:14 48:14 87:12 89:20 111:13 115:14 116:1 117:18 146:5 148:15 151:13
clarifying 26:1 38:6,13 88:20
clarity 157:16
classic 105:6
clean 129:7 144:15
clear 17:4 42:4 43:4 44:14 46:17 62:16 65:14 74:12 100:7 104:12 105:12 111:8 114:1 115:14 126:3 127:13,16 129:7 145:4,6 151:16,20 158:22
clearer 115:21
clearly 75:12 76:5 79:6 114:10 147:20 175:3
Cleveland 195:10
click 50:12
clicker 50:12 71:22
clickers 45:7,14 163:16
Cliff 57:14
clinic 175:20
clinical 9:4 90:21 91:14 128:8,16 169:17 196:1
clinician 17:10 91:18 93:14 121:3,6 133:11 155:15 174:10 210:2
clinicians 10:16 17:7 21:20 22:6 94:13
clinics 176:17
close 110:6 149:6
closely 43:21
Closing 4:20
clunky 45:14

CMS 2:19 3:19 8:12 10:15 11:7,18 13:22 14:4 19:13 26:3 35:7 37:3 42:8,12 47:11 56:8 57:18 58:7,14,15 60:7,18 61:10 63:10 65:8 71:6,15,15,16 72:7 84:18 85:17 86:21,22 88:4,13 92:18 94:5 95:19 99:11 119:4 123:13 125:2 129:16 130:17 130:21,22 138:11 139:12 140:7 143:19 149:7,11 150:6 151:17 160:12 167:3 167:15 168:13 170:18 171:10 172:19 173:4 178:4 180:5,20 181:1 188:18 196:19 206:13 208:17
CMS's 62:2 169:15
CMSS 129:1
co-chairs 1:9 45:1 48:6
code 125:19
cognizant 24:22
coincidentally 170:1
collaboration 149:7
collapsed 119:1
colleague 142:2
colleagues 13:22
collect 35:18 39:1,5,9 112:4 176:4 205:13
collecting 35:10,15
collection 179:19
College 1:18 2:6
combine 158:19 159:3
come 6:5 11:1,8 19:17 28:5 33:22 43:9 45:20 45:21 48:7 50:20,21 51:11,15 64:11 65:1 66:10,10 70:18 74:7 76:17 84:12 85:22 86:3,7,8 87:21 88:7 90:17 103:20 105:4 105:18 110:14 116:3 126:1 129:18 130:19 139:4 140:8 144:5 147:22 149:1,11,18 150:4 151:7 152:13 153:7 156:7,11 157:1 161:5 165:3 168:18 173:21 176:13 177:16 182:18 185:2 189:22 190:19 191:10 202:16 204:1 205:5,20 206:4 210:13
comes 84:6 144:15 150:1 158:12 167:22 176:2 202:1 205:19 206:7 209:13
comfortable 45:10,11 46:8 57:12 65:9 91:3
coming 27:20 43:4 46:8 51:4 53:12 59:9 60:12 112:2 125:11 150:5 150:21 204:7 210:5 210:10
comment 4:7,18 6:5 13:6 24:9,19 25:5 28:15 36:12 37:15 59:6 65:2,5 92:9 99:2 99:10,18 101:3,17 102:10 107:18 120:6 127:18 130:11 135:22 137:3 158:15 160:9 165:8,20,22 166:2,4 166:21 202:6 203:10 208:4,6,8,10
commentary 157:17,19 202:1
commenters 178:16
comments 6:1 13:4 20:19 24:10 28:9 35:2 35:4 36:7 40:11 41:11 61:16,17 62:6,10 64:5 66:4 69:1,2 95:6 98:5 99:4,12 100:3 118:16 120:11 123:1,8 125:17 126:10,13 131:2 134:10 136:6 136:13 142:1 146:9 156:3,8 158:5,17 159:13,18 160:7 161:2 165:14 166:5 168:17 192:19 195:8 198:1 199:21 202:3,9 203:11 204:14 208:11
Commission 1:16
commission's 38:10
commitment 76:21 78:14 98:16
committee 1:3,7 2:16 8:8 14:9 24:6 33:4 34:1 37:1,18 44:4 45:22 46:1,7,10 48:12 49:2 54:4 65:19 66:9 70:5 79:2 104:14,21 105:16 132:1 141:8 142:3 154:17 161:12 178:3 182:10 183:22 185:14 208:19 210:7
committee's 93:11,17
committees 53:10,11 53:12,18 57:7 66:14 67:15 75:1 130:17 153:14
common 77:20
Commonwealth 204:7
communicate 124:8
communication 124:10 210:21
communist 108:5,9
communities 170:8 171:1 190:2 191:8 192:14,20 193:4,18 194:21 195:1 196:8 202:10
community 17:10 191:11 192:3 195:11 196:1 200:21 207:11 207:12,13
community-gathering 193:10
compare 18:3 206:19
compared 29:5 111:10
comparing 204:11
compete 20:8
complete 142:19,20 207:3
completely 92:4 206:14
completion 142:15
comply 58:15 79:8
composite 11:3 128:10
computer 154:3
conceivably 189:3
concentrating 181:13
concept 120:17 126:21 140:4 189:18
concepts 12:2 175:4 188:21 189:5
concern 53:21 55:4,10 119:14 128:8 131:11
concerned 67:9 80:7 169:11 201:3
concerns 25:11,14 39:2 39:7,10 41:19 44:5 46:15 108:10 117:10
conclude 6:9
concludes 208:1
conclusion 51:17 194:12
concordance 29:4 154:15
concordance-type 155:4
concrete 181:8
condition 93:4 114:12 121:7,10 123:3 147:4
conditional 34:2 51:20 52:7 54:1 100:9 101:6 114:11 116:15 118:7 120:7,14,20,21 121:1 121:2,21 126:8 128:2 128:5 129:21 135:16 144:14 145:20,21 146:1,2,21 147:9
conditionally 42:15 115:22 131:14,18
conditions 120:14 122:19 147:17 185:2 186:16,16
Conference 1:8
confidence 100:1
conflicts 76:5
confused 68:4 143:14
confuses 139:6
confusing 62:17 114:5 114:9 126:14
confusion 69:12 108:12 114:17,19 115:9
congratulate 189:13
Congress 58:9,15,19 71:6 94:11
cons 188:1
consensus 41:9 42:2 45:21 46:6 48:4,8 68:7 73:6,7,15 74:2,8 74:11,21 75:3,11,21 76:5,19,22 77:3,7,15 78:9 79:21 80:10 81:3 81:6,21 82:6,18 83:7 83:14,17,18 85:14 98:7 100:8,20 101:2 102:21 103:1,6,12,15 103:21 104:1,2,13 105:4,7,8 106:1 111:14,21 144:22 145:6 151:12 178:15 178:16 182:2
consent 44:1 49:5
consequences 10:22 11:4 205:17
consider 8:3,12 9:10 11:3,9 15:10,18 24:17 42:14 82:18 98:19 120:13 187:22 202:21
consideration 10:6,20 12:11 39:4 88:16 94:4 117:4 131:21 136:13 145:15 146:6 199:14 209:20
considerations 11:8 12:21 39:11 180:1
considering 34:9 125:2 185:8
consistency 40:1
consistent 43:4 67:19 67:20 104:8
constant 15:1
constituency 169:12
constituted 153:16

construct 125:10
Consultant 3:6
consumer 24:11 33:2 36:3 109:3
consumers 1:14 24:2
contacting 183:6
content 114:9,13,19,22 121:22 152:9
contentious 57:2
contentiousness 108:12
context 7:11,19 12:12 41:2 129:11 133:17 144:9 168:17 169:18 171:4 173:3,4
continue 43:11 126:22 127:16 185:18
continued 117:22 118:19,21 120:16 125:15,18,19
continuing 145:8
contract 18:19 19:14,21 20:7,8
contracting 18:21 19:11 20:4
contracts 20:21
contractual 20:13
contribute 194:8
contribution 198:9
contributions 99:3
control 25:17
controversial 82:9
controversy 51:6 89:3
convene 165:3 209:11
convened 71:7
conversation 28:10 41:12,18 42:1 43:3 44:11,18 45:2,8 47:7 60:11 64:19 66:19 74:20 84:22 89:6,17 90:1 104:12 117:6 125:14 126:8 136:15 152:18,22 153:9 154:19 156:2 160:3 168:8
conversations 49:17 67:10 101:1 137:2,12 157:21
convey 92:19
convince 75:19 76:11
convinced 76:12
cool 198:10
cooperation 172:20
Cooperative 169:5
coordinate 149:15
coordinated 191:17
coordinating 1:3 8:8 14:8 24:6 45:22 46:1 46:7 48:12 49:2 70:5 93:17 104:14,21 105:16 141:8 154:17 161:11 182:9 193:9 208:18 210:6
coordination 195:5 200:13 201:16
COPD 185:6
core 180:12,14 181:11 183:17 184:7 185:12 185:14,21 186:1,11 189:2 201:19 204:21 205:3,8,15,21 206:10 206:11 207:1,12
Corporation 2:8
correct 69:17
correctly 35:12
cost 35:10 40:3 138:14
costly 22:1
count 102:13
counteract 171:5
counterparts 206:20
counties 196:11
countries 204:8
country 40:7 196:11 199:5,8
counts 42:7,17 65:4
couple 8:16 22:17 28:8 28:10 59:10 77:2 82:15 90:3 133:14 137:17 148:16 157:14 158:17 160:4 167:9 168:17 183:11 188:11 189:4,17 193:12 203:11 206:8
course 28:12 48:21 112:13 177:14 190:17
cover 5:12 87:19 185:15 209:15
CPHQ 1:16
crafting 34:15
Cramer 169:20,21
create 12:17 37:10 125:4
created 18:11 25:2 118:4
creates 106:16 108:11
creating 12:16 161:22 180:19
creative 19:19
creatively 32:21
criteria 4:3 5:7 7:19 8:3 8:12,18 18:3 23:2 24:14 26:2,3 27:2 32:9 36:10,12,18,20 36:21 38:8 47:17 52:20 59:19 66:17 96:14,20 97:6 112:15 125:5 132:20 133:8,9 145:14 146:5 147:16 156:17 158:20 181:6 181:9 183:15,17,19 185:13 186:13 190:6 190:11,15
critical 98:15 130:19 168:19 169:16 173:18 174:5 194:1
critically 171:5 205:11
criticism 128:21
CROIX 2:1 140:20
cross-check 162:9
cross-cutting 4:11 184:13,16,19 186:14
cross-fertilizes 195:20
CSAC 75:1
cultural 176:12
curious 38:13
current 7:17 9:4 20:7 116:12 144:1 172:12 174:15 191:4
currently 29:5 47:10 48:8 120:11 134:4 155:10
cut 62:16 205:8,11
cycle 104:18,19 105:12 149:21 155:20
cycles 106:21

D

D.C 1:8 183:11
dangerous 172:16 194:14
data 30:11,11 32:9 35:10,15,16,19 36:4 39:1,5,10 56:5,7 85:19 150:16 155:2 176:4 179:19 193:15 194:11 205:13
date 142:14 143:1,17 146:20 182:19 183:19
DAVDA 1:15
David 1:17 40:20
day 6:4,10,16 65:22 83:17 95:10 98:19 102:2 112:20 122:20 161:13
days 6:18 70:4 157:14 158:17 183:11 193:3 205:10 208:22 209:5 209:18 211:12
De-duplication 11:22
deadline 94:6
deal 114:6 129:12,16 130:5
dealing 79:15,16,17
dealt 113:22 114:16
dear 172:6
debated 108:18
December 7:8 13:7 183:4 198:6
decide 11:11 63:5 70:22 77:13 103:14 112:5 118:9 144:20
decided 191:15
decision 4:15 33:7 42:9 44:22 45:20 46:6 47:1 50:20,21 51:2,5,11,15 66:4,10,11 67:12 68:13 69:19 71:9,17 72:10,20,22 77:7,15 93:11,16 95:13 98:9 102:21 103:1,2,3,4 104:14 110:13,17 116:13,20 148:3 156:17 162:11
decision- 154:15
decision-making 153:2 157:7
decisionmaking 74:22 105:5
decisions 14:2 43:4,10 43:17 46:8 54:18 71:7 74:11 79:20 87:15 100:13 105:13 117:3 148:10 153:13 170:14
decreasing 10:15
decrements 30:4,22
deep 91:9 132:3 176:9
default 45:18 123:21
define 48:8
defined 103:6
defining 82:6 135:16
definitely 19:5,6 34:8 204:22
definition 74:12 145:12 145:14
definitions 74:14
degree 39:22 68:12 83:9,11 157:10 162:8 195:19
delay 140:8
deliberations 33:22
deliver 86:17
delivery 176:21
Delphi 63:5 111:18
delta 33:10
demean 144:18
denominator 77:10
department 191:19
depending 14:17 129:18
depends 197:3
derail 89:22
Derek 2:7 202:4

describe 79:7
deserve 189:19
design 173:18
designed 98:9
desire 140:22
despite 76:21
detail 16:17 101:13 175:2
details 20:10
determination 34:2 42:1
determine 29:1 82:22
determining 148:3
develop 9:9 23:20 103:3
developed 15:16 32:3 118:21
developer 14:11
developers 14:14 130:18 149:1,13 155:19
development 7:16 23:16,19 38:1 74:21 117:22 118:19 119:21 120:16 125:16,18,19 179:15
deviation 92:1
devil 162:4
devolved 76:22
diabetes 11:2 25:13 185:5
dialogue 149:6 160:3
dialogues 162:13
dichotomous 111:1
difference 58:7 83:5 96:9
differences 67:7 118:4 176:7
different 6:20 7:13 8:19 14:17,18 19:20 20:9 23:15 42:1 48:20 57:19,22 61:11 74:5 79:14 83:13,14 91:12 94:7 96:21 98:10 102:14 113:19 114:6 131:1 154:8 161:4 170:8 173:21 174:11 174:17 175:3 176:9 176:10 187:9,12 190:1,15 196:22 197:7 201:12 206:15
differentiate 83:2
differently 27:22 65:13 121:13 127:12
difficult 56:17 88:5 156:10 169:14 176:3 193:5
dig 91:9
dilemma 62:12 95:10
direct 52:17
direction 75:18 76:7 78:20 101:1 119:14 120:17 127:1 140:4 186:9
director 3:7,9,14 169:4 191:19 200:7
Directors 2:1 171:22
disadvantaged 199:17
disagree 121:12 126:16 142:5
disagreement 111:11
disagreements 67:4 82:9
discomfort 106:16
discontent 66:6
discontinuity 162:10
discordance 29:13
discover 197:9
discovered 15:6
discuss 51:2 107:15 108:21 109:13,14 123:16 141:7 154:21 156:9
discussant 44:9 69:2 126:9
discussants 40:21 165:12
discussed 12:21 105:22 154:20 186:14 193:2
discussing 13:21
discussion 8:8 9:5,12 15:2 26:12 32:12 48:6 48:15,15 51:7,12 52:15 63:19 69:4,18 70:12,22 71:5 72:3,13 72:16 74:16 75:12 84:2 85:4,6,9 87:11 89:3,12 93:22 96:13 96:19 97:12 100:18 102:17 104:16 107:2 107:3 108:16 109:19 110:2,10,17 115:11 123:2 137:22 148:4 148:12 151:11 155:10 161:7 186:7 188:9
discussions 13:7 49:3 52:11 70:1,2,7 72:7,8 102:10 154:22 187:8 189:7
displaced 106:7
disruption 202:18
dissenting 42:10
disservice 27:13
distinct 170:22
distinction 115:21
distinctions 115:15 116:1 118:4
distinguish 110:12 111:9 151:22
distribution 63:4 94:21 95:5
distrust 170:16
diversity 199:17
divide 171:7
doctors 27:6
document 42:12 187:2
doing 14:5 15:2 19:3 21:13 22:6 30:15 41:3 41:7 58:17 62:21 65:10 67:18 69:19 92:12 93:21 105:2 108:8,9 127:14 142:4 158:11 162:5 167:8 172:12 181:20 183:7 183:11 188:18 193:9 200:11 202:7 204:10 204:11,20
dollars 16:3 35:18
domestic 191:16 192:2
download 50:13
DR 6:13 15:9 18:5 23:3 31:8 38:16 133:6 154:18
Draconian 123:21
draft 12:21 133:8 185:12
drawn 57:13
drill 109:1 145:8
drive 12:7 194:14 195:8
driven 48:4 83:12
drives 84:7,8 153:11
dropped 26:14
dual 163:6
ducks 171:21
duplication 12:1
duration 98:13

E

eager 197:21
ear 113:5
earlier 39:17 72:12 88:21 126:15,17 127:9 144:13 188:13 194:6 198:1
early 32:13 119:20 139:18
easier 50:12 51:1 72:2 85:13 106:10 157:12
easily 121:10,15 193:19
easy 50:9,13,18 74:9
echo 35:4 117:16 192:18 202:9
echoing 194:5
economic 194:21
effective 116:2
efficient 41:7 78:17
efforts 179:16,19
EHR 16:20 22:3
eight 53:13 189:14
either 32:2 72:7 76:7 80:21 90:13 102:22 107:3 122:8 123:2,6 140:7 141:12 156:14 157:18 197:11
election 170:3
electronic 66:21
elements 11:16
elicit 101:3
eligible 169:13
eliminate 46:9
eliminating 35:22
Elisa 3:11 148:14
elites 170:13
ELLIOTT 1:16 37:14 39:12
eloquently 54:19
else's 62:2 191:1 198:19
embedded 200:14
emerged 170:2,10
emergency 130:4,5 134:19 176:22 191:19
emergent 135:2,2
emerging 75:12 90:20
emphasis 57:16 59:18 84:16
emphasize 42:6 54:11 186:21
emphasized 77:4
encourage 118:21 127:8 201:17
enculturating 40:5
ended 140:13
endorse 70:12,12 106:11 138:7 139:10
endorsed 52:2 59:6 66:15 90:12,16 93:6 96:1 106:15 115:7 123:14,17 125:3 130:12,13 133:3 134:2,5 143:16 144:14 146:19,20 147:1 150:5 155:12 159:2,6 183:20 184:6 188:20 189:9
endorsement 9:13 51:21,22 52:13,18 53:18 54:4,13,14 55:3 55:10,15,16,17 58:6 59:1,13 86:1,2 91:13 92:3 94:4 95:17,18,19

96:10,22 97:2 106:20 114:13 120:21 122:8 124:5,15 125:8,12 128:2 129:3,20 130:17,20 131:4 132:4,19 134:16,21 135:19 138:4 139:6 139:16,17 142:13,16 142:22 143:17 147:2 147:20 148:10,16 149:12,22 150:2,8 153:12,14 155:8,8,18 158:21 159:11 163:13 163:21 184:1
endorsements 56:12 92:5
endorsing 59:14 69:19 91:16
enemy 112:21
engaged 203:1
engender 101:16
engines 194:21
English 102:18
enjoyed 36:9
enlightening 38:4
ensure 41:12 42:3 43:3 98:16
entailed 163:22
entered 54:12
entire 133:12
entirety 133:18
entity 19:10 133:11
environment 90:9
environments 201:12 201:14
ephemeral 99:8
equal 171:9
equally 27:13
equipped 142:8
equitable 203:9
era 146:12,14
Erin 2:3 3:14 13:5 32:18 40:20 59:16 148:21 153:21 155:5
especially 57:1 101:12 115:15 162:10 174:2 176:18 192:12 209:7
essentially 18:12 143:10
establish 54:21
established 55:1
establishment 170:18
esteemed 142:1
estimate 16:9
estimated 16:1,3
et 87:15 198:21,21 201:16
ethnography 170:4
evaluating 96:14
eventually 178:2 193:15,17 205:20
everybody 6:15 50:14 73:19 76:9 80:4 82:7 82:11,22 98:1 107:21 141:21 183:6 191:22 206:15 208:18
everybody's 160:1
everyone's 118:13
evidence 30:2 91:18 93:18 129:6,10,13 144:10
evidence-based 144:16 146:9,11 184:2
evolved 66:22 69:6 113:16,17,20
exacerbated 177:19
exact 18:15
exactly 18:17 93:12
example 16:19 37:1 38:22 55:22 92:22 115:1 121:7,8 130:15 134:18 145:19 155:15 176:15 191:15 192:11 201:15
examples 137:17
exceeded 35:18
Excellent 39:12
exceptional 90:18
excited 80:18 82:4 83:1 181:1 189:16
excitement 83:2 203:1
exciting 172:4 192:19
exclude 167:7,10,13
excluded 193:1
exclusive 184:18
executive 169:3
exercise 76:18
exercises 193:11
exist 95:17 138:6
existed 77:7
existing 8:4 17:22 20:13
expand 196:20
expanding 74:15
expect 74:7 116:6
expectation 162:1
expected 142:14 143:1 143:16
expecting 53:14
expediency 98:18
expedite 160:21
expensive 197:15
experience 16:12 52:17 78:6 129:11 155:9 163:20 178:9 200:16
experiencing 171:7
Expert 1:12
experts 64:10 65:21 71:9 144:7,8
explain 84:21 134:11 186:22
explaining 108:2
explanation 166:22
explicit 24:1,15
explicitly 23:17 131:2 178:10
express 41:8 208:16
expressing 54:19
extent 34:20 195:22
external 38:18,20
extraordinary 192:15
extreme 76:19
eye 30:3,8 38:4 210:8

F

FAAFP 2:4
FACEP 2:7
faces 160:2
facetious 128:7
facilitate 188:7
facilities 171:9
facility 133:11
FACP 2:5
FACS 1:18
fact 28:20 29:1,8 30:10 65:9 66:18 67:7 125:2 125:2,10 149:7 157:18 162:1,6 164:11 169:12 177:15 206:16
factor 58:11 125:9
factors 176:11
fail 170:21 171:1
failed 36:21 80:20 136:19
fair 57:3 133:6,13 203:9
fairly 18:22 19:1 77:8
faith 99:5 171:8
faithfully 98:22
fall 43:15 117:1 118:15 130:7
falls 53:7
familiar 193:8
familiarity 171:18 189:15
families 2:3 33:11 193:18
family 2:4 23:18 33:12 166:18
fan 92:17
far 49:19 183:13,14 201:2
farmers 199:9
fast 172:19 182:21
fast-forwarding 180:21
fast-tracking 134:15
fault 119:5
favorite 103:8 175:17
feasibility 184:3
feasible 205:13
feasibly 15:19
February 209:19,22
fed 32:11
federal 2:14 198:14
feedback 8:1,20 13:1,4 19:18 23:12 24:18 26:10 32:5 46:13 47:8 60:9 61:9 85:4 86:21 87:9,14 94:19 152:2 153:6 154:13 160:22 171:17 172:13 185:18 209:8
feel 20:6 41:9 43:16 54:7,18 56:16 65:9 75:5 93:10 94:5 99:11 122:10,17 134:6,7 156:7 196:21 203:9
feeling 41:6 88:11,14 88:15 91:3 106:18 136:9
feelings 44:12 87:22 106:13
feels 54:19 88:2
fell 76:3
Fellow 204:6
fellows 204:7
felt 38:13 43:1 74:10 91:8
fewer 120:3
field 16:22
fights 64:22
figure 63:16 75:20 157:10 160:14
figuring 92:8
fill 38:21
fill-in-the-blank 207:13
fills 120:18
final 77:7 88:6
finally 47:2 48:5 70:21 182:15 187:6
find 37:11 75:3 76:12 85:6 98:4 103:12 109:15,16 141:6 169:14 201:6
finding 184:8
fine 103:13 132:1
finger 83:5
finite 148:8
first 5:12 8:21 23:6 28:9 37:15 46:20,21 48:19 64:6 69:5 73:22 75:22 76:14,15 105:20

144:3,4 159:17 162:3 165:20 171:15 183:2 189:1 194:9 200:9 205:8,11
first-time 159:16
fit 130:14 210:15
fit- 153:9
fit-for-purpose 153:18
fits 144:20,21
five 53:13 62:7 128:14
fix 50:13 136:4 137:11
fixed 115:20
flexibility 135:10
flights 165:16
floor 1:8 6:12
flounder 51:12
fluid 64:18
fly 158:11
focus 9:1 10:15 12:3 18:14 48:17 109:4 117:6 148:11 153:18 184:6
focused 143:11 200:15
folks 40:5 75:17 76:16 106:17 128:16 140:21 172:7 201:7,8 203:8
follow 43:21 98:22 131:5 159:21 162:20 211:10
follow-up 22:21 210:11
following 102:6,16 103:11 143:1,17,22 157:19 209:10
follows 31:20,21 140:20 144:6 201:1
fondly 165:1
food 5:5 141:18
for-purpose 153:10
force 43:9 162:19 196:5
forced 66:9
forcefully 170:11
Forces 210:8
forecast 25:6
forecasting 25:22
forget 145:9 180:17
form 96:21 142:9
formal 23:1 41:18
formally 53:15
format 144:15
formation 77:17
formats 211:5
formed 74:20
former 118:19 199:2
formidable 169:1
forth 59:5 110:16 115:3 125:11 167:6
Forum 1:1,8 74:3,17
forward 8:9,18 13:13 44:10 54:1 55:8 63:10 63:12 68:20 81:7 84:10 117:3 119:17 124:2 126:4 127:2,14 127:15 131:12 138:15 139:12,14,18 141:14 141:19 143:6 187:3 201:22 202:1 207:21 211:13
found 20:22 21:9
foundational 187:19
four 22:10 63:3,8 70:20 103:13,16 118:12 119:2 151:13 161:12
FQHCs 173:20
frame 22:11 51:7 137:7
framework 7:12 9:3 189:21
framing 7:21 189:18
France 204:9,12
frank 94:10 164:2,21
frankly 52:11 61:17 63:7 65:21 75:4 77:14 80:10
free 61:3
frequency 98:13
frequently 158:6
freshen 47:19
FRIDAY 1:5
front 52:9 79:1 108:14 108:15
frustrated 106:5,8
frustration 43:1 45:6 106:7,8
full 171:9 178:15
fully 15:15 93:5 141:12
function 93:18 94:7
Fund 204:7
fundamental 67:3 91:21 170:16
funded 149:7 186:4 204:7
funding 17:18 20:5,9
further 6:12 64:1 104:16 122:4 194:14
future 61:3 127:4,4

G

GAIL 1:19
gap 12:15,16 21:12 55:21 106:15 120:18 135:4,8 137:4 141:5 141:13
gaps 173:9 181:17 189:7
gathered 94:6
gathering 32:9
gee 15:6
general 56:15 57:16 65:21 80:11 92:9 120:6 199:2
generally 25:5 47:6
generic 195:17
genuine 99:10
geographic 204:16,19 204:22
getting 36:14 46:18,18 65:2 67:21 73:15 93:5 94:16 132:3 145:2 147:10 154:9 157:13 161:18 175:14 181:8 193:14 197:11 203:1 210:9
Giff 83:22 96:8 102:5,9 123:10 126:13 127:9 130:1 137:15 142:1 143:22 147:13 153:17 159:20 160:8 161:3 196:9 210:10
Giff's 110:21
GIFFORD 1:17 26:1,9 57:15 61:20 63:2 84:1 86:13 94:18 96:12,18 97:2,11 123:11 137:16 147:14 157:3 159:21 160:10 161:9 161:17 164:14 196:10 210:11
give 50:5 61:13 63:14 64:4 76:8 86:21 88:13 97:8 102:22 110:22 114:4 151:16 163:20 171:12 172:10 205:6
given 10:1 29:8 53:20 70:7 106:12 111:12 157:9 178:8 190:20 198:1 206:11
giver 23:18 33:6 38:3
gives 63:7 147:10
giving 67:16 112:2 166:10
glycemic 25:13,16
goal 75:2 76:8 77:20
GOODRICH 2:18 16:7 18:17 20:2 33:17,19 86:10 87:7 95:2 100:5 118:17 119:3 122:2 131:22
gotten 41:3 64:1 169:22
governance 64:12
government 2:14 20:4
greater 48:9
ground 174:19 183:10
group 1:13,21 2:2,11 5:4 32:22 38:5 55:17 59:12 67:3 69:18 74:4 75:12,15 81:2 88:2 89:16 102:6 103:1,2,2 103:17,17 104:22 122:18 145:7 151:6 152:12 156:7,15 157:5 161:7,19,21 163:2 164:15 165:4 174:14 182:2 191:11 196:22 203:15 209:12
groups 24:11 78:12,12 98:12 174:2,9,11,17
guarantees 184:1
guess 5:13 6:4 17:18 19:8 26:6,9 31:13,20 38:16,17 40:13,16 62:12 79:18 80:6,8 81:13 82:8 105:19 137:9 163:6 174:19 188:6 201:17 208:1 208:13
guidance 49:11 61:12 61:14 77:6 84:17 148:1,2 173:1 183:15 187:4 210:1,2
guide 155:10
Guidebook 154:1,5
guided 69:10
guidelines 9:4,5 28:13 28:22 29:6
guiding 180:8,9 181:7 183:21

H

half 102:2 122:20
HALL 1:18 53:9 55:8 141:21 143:12 164:20
hammer 73:1
hampering 43:2
hand 14:20 62:18 71:22 79:9,10 81:15,16 106:10 129:2 188:6
handle 44:8
handled 204:17
handling 44:13
hands 67:1
hangars 131:12,13
hanging 159:18 162:18 177:10
happen 12:9 58:22 81:8 81:9 89:13 167:16 209:11
happened 47:9 74:15 76:20 90:11 93:14 152:3
happening 91:13
happens 94:10 147:7 155:2
happy 6:16 166:15

168:4 207:19
hard 77:14 78:11 83:1 110:11,12 116:19 139:12,13 149:15 156:5,20 193:4 201:18
harder 78:10
harken 41:10 100:12
Harkness 204:6
harmonized 136:9
Harold 1:9,11 63:20 90:2 110:6 112:16 116:11 117:9 143:21 158:1 162:21 198:4 199:22 204:15 208:21 210:11
Harold's 117:16
hate 108:3
head 18:9
head- 207:7
headaches 103:1
headed 75:18
heads 86:6
health 1:15,19,22 2:7 2:12 4:9 29:19 40:3 91:17 115:7 119:19 121:4 159:6 169:4 173:19 175:19 181:3 185:3 192:13 198:11 198:18,18 199:15 200:21 201:8 203:13 204:2,12
healthcare 1:17 2:7 74:6,7 189:20 194:20 203:20
healthy 89:4,16 90:1
hear 7:9 16:10 25:14 41:19,22 55:6 61:16 75:17 76:9 99:8 112:19 153:5 189:12 197:17 203:4 208:2 209:14
heard 7:4 11:14 17:9 41:6,13 44:16 46:13 49:4 65:18 76:10 85:5 94:21 99:13 101:14 117:11 136:7 149:14 153:11 155:1,22 160:7 198:6
hearing 90:7 202:1
heart 99:12 132:18 172:7
help 32:16 33:1 36:22 37:7 45:1 57:10 58:1 64:16 75:10 85:11,13 93:15 102:22 111:13 129:17 141:14 148:2 169:7 173:8 179:12 187:5 196:6 197:19 199:15
helped 51:7,12
helpful 29:14 30:12 33:19 34:14,18 36:15 37:11 39:21 40:9 65:16 79:4 95:1,3 97:8 101:2,3,13,16 119:9 120:5 121:14 122:15 147:15 152:6 155:4 168:14 206:6 211:4
helping 17:11 30:15 40:2 44:18
helps 61:9
heterogeneity 176:6,15 176:16
hey 32:13
HHS 130:1
Hi 33:18 36:8 90:2 159:15
hidebound 64:17
high 9:2 12:4 26:13,16 29:18 30:19 53:13 55:14,15 56:10 90:9 124:6 182:13 185:5 190:4 194:12 199:14 202:11
high- 150:7
high-level 8:18
higher 24:17 80:21 99:17,22 167:12,20
highlight 132:6 180:2 210:4
Hill 78:2
hinder 129:17
historical 68:8
historically 202:15 210:13
hit 101:19 116:22 145:12 206:9 207:7
hits 183:21 203:7
hoc 74:20 104:21
hold 50:1 207:14
home 188:14 196:12 209:14
homework 140:10 209:5
honest 92:6
honestly 178:13
honesty 198:19
honor 84:19
hope 47:3 79:3 172:14
hopefully 7:4 27:8 72:7 120:3 146:3 182:17 207:1
horrible 70:16
hospital 35:14 56:1,2 70:15 112:12,13 113:5 164:5 173:13 181:13 189:14 191:20 210:1
hospitals 168:19,20 169:13,16,17 173:19 174:5,9 176:17,19
hot 129:4,5
hour 130:4
hours 16:3 80:1 83:12
HRSA 172:20
huge 12:15 21:12 138:14 187:9,16 205:1
human 30:2
hundred 26:19
hung 87:3 123:12
HUNT 1:19
hybrid 105:8

I

idea 44:7 46:2 107:17 112:11,17 118:1 134:9 157:4 175:5,11 175:15 184:11 187:8 196:6 206:10,13 207:5 210:22
ideas 42:20 43:7,12,18 109:8 117:11,20 118:13 131:9 136:6 141:15 161:4 175:7 179:7 187:15 188:4 206:16 211:9
identification 109:12
identified 9:3 10:7 109:19 141:4 189:2
identify 37:8 139:3 150:12 173:9 181:10 183:17 205:3
identifying 180:12 186:11
identities 170:22
ignorance 128:1 161:10
III 1:9,11
imagine 130:10
immediate 25:7
immediately 25:10,18 25:20 88:7 189:3
immunization 26:16
impact 12:4 16:3,4 25:8 88:9 138:17 175:12 192:8
impacts 24:22 196:8
implement 15:20
implementation 16:12 201:16
implemented 18:13 42:3 49:2
implementing 11:9 16:1
implications 52:7 160:11
implies 67:1
importance 17:6 106:12 202:10
important 12:16,19 17:3 29:22 33:14 36:5 40:5 69:6 89:5 96:3,4 97:14 98:15 99:15 102:11 120:18 138:3 138:4 141:13 152:10 163:11,20 166:18 171:5 184:15 186:21 187:22 189:21 193:22 202:8,12,21 203:15 206:18 207:16
imposed 84:14
impossible 16:8 157:15 191:13
impression 206:11
improve 17:11 21:16 78:4 117:12
improvement 2:7 5:16 5:18,20 12:6,8 91:11 184:2
improvements 4:4,14 35:16 40:15
improves 21:11
in- 7:7,22 195:11
in-between 172:15
in-person 6:17
inadequate 134:7
inclination 110:20
include 128:22
included 133:7 173:18 199:16
including 61:18 188:15 200:15
inconsistency 67:10
incorporate 23:17 157:17
incorporating 37:19
incorrect 194:8,12
increase 17:2
increasingly 10:1
Indian 198:10,17,18 199:15
indicated 81:5 198:14
indicator 77:6 88:14
indicators 36:4
individual 1:12 12:4,22 13:10 103:9 133:17 209:20
individuals 26:4 27:5 181:21 202:10
indulge 47:4

industry 74:6
influence 11:10 169:8
influenced 78:22
inform 14:4 32:1,16 33:7 49:16 196:7
informal 23:1
information 32:11 37:4 37:8 47:6,14 49:16 51:22 52:9 56:6 69:9 95:8 102:20 117:8 134:3,7 152:17 153:1 153:6 154:10,12 155:20 157:6 160:12 160:20 172:22 187:3 193:19,21 194:6 211:4,6,8
informational 179:20
informative 37:21
informed 152:4
infrastructure 21:22 24:21 25:1 138:6,9,15
initial 12:20 116:8 133:21
initiative 7:3 10:14
initiatives 193:11
innovative 27:9 193:10
inpatient 181:14 185:16
input 4:3 5:6 13:11,15 14:1 15:3 23:14,16 33:1 45:3 46:10 47:12 49:6,21 97:9 152:21 154:6 158:3 182:13 187:4 210:7
instances 108:3
institution 78:2
institutional 124:22
institutions 35:17
instructions 151:17
instructive 191:14
Insurance 1:15
integrated 33:3 200:8 200:12
intended 77:11 132:20
intent 18:10 30:17 117:16
intentionally 21:19
interaction 98:13 182:5
interest 9:22 78:3 79:12 103:4,5 185:7
interested 55:13 82:13 184:8
interesting 20:22 50:19 136:5 173:15 174:1 178:13 181:19 183:13 191:12 192:7
Interestingly 179:17
interests 78:1
internal 28:22 38:18 39:4
internally 34:9,16 39:6 67:20 95:13 100:13 121:16
interpret 127:11
interpretations 113:17 113:19
intersections 207:3,4
intersects 192:13
intervals 211:5
interviews 170:7
intuitive 29:17
invited 169:7
involved 48:20 59:18 106:13 129:15 163:13 196:14,16 197:9
IQR 31:16
IRONS 1:20
irrelevant 84:3
irrespective 133:3
isolated 198:12
isolation 175:5 177:17 204:16,19,22 205:19
issue 11:6,21 16:17 19:18 52:5 53:6 55:3 56:3,14,15 58:14,16 66:20 74:17,18 76:9 89:10 91:1,15 107:9 111:3 128:18 129:3,5 130:4 132:2 133:2 136:2 138:2,22 190:17 196:1 197:6 198:3,22 199:4 203:16
issues 4:11 19:17 38:9 45:6 49:21 55:21 57:2 66:17 68:4 89:18 90:6 90:21 91:12,20,21 93:17 109:1 113:21 114:6,15,19,21,22 129:15 130:5,19 131:20 134:16 135:2 135:3 150:18 161:5 165:5 174:21 175:9 177:19 186:10 188:10 195:15 197:4 198:2 201:11 203:12 207:16
issuing 209:17
it'll 140:8 205:5
item 5:10 143:11 144:5 145:11
items 48:7 138:11
iterate 43:11
iteration 126:2

J

JANUARY 1:6
JD 2:5
jerry-rigged 125:4
jives 71:15
job 66:11 87:1
Joe 1:13 101:19 104:4 105:18
John 1:14 3:7 133:20 142:2
John's 23:5,6 32:20
Johnson 3:9 171:13,20 171:22 172:18 188:22 204:18
join 73:19
joint 1:16 38:10
judge 191:18
jump 45:1 104:6 200:3
justification 34:15 112:6
justify 61:10 63:11,18
justifying 95:12

K

Kahn 1:9,11,19 5:3,17 5:19 6:11 14:10 17:17 19:8 20:16 26:5 28:7 31:3,19 32:18 33:16 33:18 34:22 35:3 36:6 37:12 39:14 40:10,19 50:3 51:19 52:21 53:3 55:5,11 57:14 62:11 64:3 68:21 73:3,14 79:5 81:13,19 82:5 83:3,22 87:17 90:4 95:15 96:16 97:1,10 97:18 98:3 100:4 101:18,21 104:4,10 105:17 109:9 112:10 113:14 156:5 159:15 160:1
Kansas 195:11
Karen 3:9 171:12,22 192:17 195:15 198:5 200:6 202:7
Karen's 165:14
Kate 2:18 7:2 10:13 16:5 18:6 28:9 33:16 42:8 60:18 61:5 65:2 84:1,18,22 85:5 86:5 86:22 87:4 94:18 100:4 130:10 171:14 172:7 182:14 209:1
Kate's 99:2
Katherine 169:21
Kathleen 169:20
KATHRYN 3:8
keep 7:18 11:11 30:7,19 46:5 47:20 117:18 141:6 186:11 203:8 210:8
keeper 107:14
key 73:14,14 141:11 174:21 186:10 188:10 190:17 192:4
keys 51:20
kick 188:12
kicked 168:1,10
kinds 7:14 39:10 89:14 89:18 95:7 120:4 173:7 175:9 179:21 180:14 189:8
knowing 28:18 51:5,10 57:12 69:7 76:17 206:2
knowledge 37:6 52:17 72:4
known 51:2 200:9
knows 168:7
KRAMER 1:21 73:12,18 104:5,11

L

LA 2:1 140:20
label 140:15
labeled 128:3
labels 140:14
lack 194:6 199:7
lag 148:19 150:18
laid 7:20 117:9 160:19
Lancet 146:10
landscape 168:22
language 18:8,11,16 102:18 117:19
large 78:12
larger 35:17 44:17 49:17 117:17 196:13
lastly 68:6 194:19
Laughter 50:2,10,16 61:19 98:2 102:3 159:19 163:17 164:17 165:17 172:17 199:11
launch 149:21
launched 7:3
law 19:12 104:3
lawyers 19:2 20:6
lead 40:21 44:9,22 69:1 103:11 126:9 147:18 148:9 165:12
leadership 78:12 104:20 208:22
leading 172:3
leads 59:16 66:8 194:12 198:13
Leah 1:13 55:11 87:17 102:5 107:13 124:5 130:3 134:13 139:11 146:15 149:19 193:11
Leah's 155:17 195:8

Leapfrog 1:13
learn 32:2 64:11 152:5 195:20
learned 32:14 164:19
leave 5:11 12:15 101:21 126:7 165:13
lecture 50:6 186:6
lectures 50:5
led 41:20
left 178:19,20,21
lens 187:21
let's 5:3 56:11 62:13 71:13 75:17,19 80:12 113:9 133:19 166:7 184:6
letting 44:2 73:19
level 13:20 14:7 24:6 54:14 67:2 91:17 99:17 105:15 107:1 115:8,8 121:3,4,6 127:11 155:14,15 159:7,8 170:11 182:13 201:20
levels 24:5 91:18 126:17 127:10
lever 34:16
leverage 32:22
leveraging 33:2 200:20
liability 97:3
liaison 162:1,7
liaisons 2:14 198:14
life 89:22
light 113:22
liked 56:10 167:21
limit 161:14
limited 83:11 173:11 175:10,15 189:9
LIN 2:2 101:20 102:4 127:19 131:5,10 143:21 146:13 164:2 164:5,8 198:4 199:12
line 73:13 137:2 210:16
linear 53:20 63:1
lines 57:12 157:9 187:19
link 153:22
linkage 132:15
Lisa 172:1
list 6:21,22 15:11 22:19 22:22 36:17 38:7 60:16 61:3 87:10 96:1 110:1 124:9 133:16 160:13 171:18 182:13 187:7 205:7 211:7
listed 18:4 181:5
listen 59:10 70:2,6 76:10 78:21 128:12
listened 73:9
listening 37:3 104:11
little 6:20 11:1 16:17,22 20:1 29:8 31:6,21,21 38:18 41:2 45:12 47:4 52:8 57:11 58:4 63:5 65:3 67:16 69:12 73:7 74:15 80:7 81:10 83:6 99:5,22 110:4 116:19 119:5 121:14 123:20 138:5 147:11 153:12 155:7 156:10 162:9 162:17 169:6 172:11 181:8 182:4,9 189:5 196:17 205:5 206:7
live 193:4
lives 192:1
living 65:22
local 194:16,17
located 37:9
logical 68:17
logistically 201:13
long 51:13 150:17 211:12
longer 32:15
longitudinal 170:6
look 8:3 10:4,11 13:14 15:12 18:7,15 24:10 35:19 37:3 65:20 67:22 68:18 69:1 74:21 79:19 86:20 90:19 93:18,18 95:21 97:6 105:3 107:11 129:14 142:6 144:17 156:11 158:2 161:10 165:4,4 182:12,16 192:12 201:1 202:1 203:15 205:10,21 211:13
looked 28:11 82:1
looking 5:8 10:11 15:5 19:19 26:2 35:9,20 37:18,22 46:16 85:18 91:5 96:21 97:3,4 136:18 140:15 154:2 159:5 164:21 166:13 173:12 177:7 187:21 188:18 192:12 194:4 206:5
looks 76:4
loop 19:18 87:9 153:6 154:13
loops 47:8
loose 48:4
lose 36:5 132:15 140:11
losing 197:11
lost 80:1,17 81:4,12,15 83:10 113:5 207:19
lot 11:14 12:22 18:20 21:7,7 31:6 35:4,9 50:5 64:6 65:20,20 68:8 69:7 70:8,21 71:2 76:6 79:11 92:12 92:13 93:8,12 94:2 97:15 100:17 105:22 106:16 108:1 110:10 111:6,19,19 135:15 136:5 148:7 151:9,10 155:1 157:22 174:16 174:18 176:7 184:12 187:7 192:22 194:22 196:12 199:15 200:11 207:2,4,8
lots 9:12 23:15 119:10
love 8:19 43:7 49:21 59:17 154:11 209:14
low 26:13 27:1 177:4 178:11 184:8,17,21 186:15
low-volume 167:6,20 168:10
lower 80:21
LTC 210:1
lunch 6:9 172:16 208:14

M

MA 1:13 2:11
MACKAY 2:3 32:19 192:17
magic 99:20
main 110:21 137:19
Maine 189:15
maintain 25:16
maintaining 29:16
major 55:21 175:2
majorities 99:17
majority 46:3 68:18,20 72:21,22 75:16 100:6
making 33:7,14 35:21 42:14 44:12 56:21 67:12 68:13 69:10 71:7,9 77:7 91:5 98:9 102:21 103:1,2 104:15 106:9 121:21 154:16 167:2
maldistribution 199:4,5 199:8
manage 64:20 132:2
manageable 47:20
Managed 2:8
Manager 3:8
mandatory 167:2,15 178:5
manner 171:10
MAP 4:9 6:17 7:7 8:2 9:13 13:16 18:11 19:10 24:2 27:21,22 28:5 37:1 41:16 42:13 47:6 58:5 67:17 77:1 77:13 85:22 87:15 88:7,15 92:2,7 95:17 96:7 100:7 101:6 119:12 120:13 121:17 133:15 136:8 147:6 148:9 150:1,6 154:1,5 155:2 161:16 171:17 172:12 180:19 181:2 181:16 201:2 208:18
MAP's 93:17 154:15 209:17,20
maps 47:11 58:17 116:21
March 210:2
Marissa 2:8 40:20 49:22 68:21 80:13 126:6 128:11 158:13 162:17
Marissa's 102:5 160:11
market 144:2
MARY 1:14 2:16
Massachusetts 137:1
material 65:22 157:7,12
materials 23:10 67:22 125:3
math 46:17
matter 1:12 60:16 84:4 86:15 92:16 95:5 113:11 122:21 132:6 150:17 177:15 206:16 211:16
matters 123:1
Maureen 1:19 33:18 35:3 36:6 159:15
MBA 1:14,16,18,21 2:2 2:7
MD 1:11,12,15,17,18,20 2:2,4,5,7,10,16,18 3:18 175:19
MDS 138:11
mean 9:15 15:1,4 16:8 19:10,12,20 23:7 31:4 31:6,7,9,21 34:11 51:20 52:4,14 57:6 59:22 60:18,19 62:19 64:9,16 66:11 67:5 69:13 79:13,18 82:2,5 82:16 83:8,8 84:3,5 85:1,3 87:20 89:2,7 93:7 94:1 95:4,21 96:5 97:14 99:8 100:22 106:14 109:10 109:12,13,22 113:20 128:4 129:21 130:9 130:11 131:16 133:7

138:14 144:14 145:1 151:4 156:6,8,9,14 162:16 164:9 178:3 184:19 192:10 194:22 210:16
meaning 158:10
meaningful 7:3 8:22 61:9
meaningfully 194:2
means 89:8 111:9 177:9
meant 120:16 174:7
measure's 140:2 155:12
measure-by-measure 13:20
measured 82:3
measurement 3:12 21:11,17 27:19 38:1 148:4 173:1,10 174:22 175:12 176:2 176:4 177:6,19 179:16 181:17,20 184:2 186:10 187:10 187:14 196:4
measurements 167:3 181:21
measuring 27:20
mechanisms 75:9
Medicaid 2:1,19 3:19 162:19,22 163:1 210:7
Medical 1:20 2:2,10 188:14 200:7
Medicare 1:13 2:18 3:18
medication 185:4
medicine 30:3 166:18 193:5
medium 53:13
meet 9:8 18:2 84:8 145:16,17 146:6
meet-and-greet 182:7
meeting 6:17 43:6 54:22 62:7 64:20 97:21 105:20 149:21 150:10,21 151:8 157:15 158:6 159:17 160:5 174:14 191:17 210:6,19
meetings 7:8 8:1 92:7 211:13
meets 27:1 145:19
members 21:4,10 34:3 34:3,7,7 103:3 136:8 161:11 164:13
membership 20:21 162:4
memory 124:22 161:19
mental 185:3
mention 193:13 206:9
mentioned 7:2 10:13 11:21 17:5 33:3 34:1 36:3,13 38:7 71:3 91:14 146:18 148:22 178:18 183:16 184:22 188:13 193:11 194:6
merge 134:17
merit 71:2
mess 62:22
message 86:16
messages 168:13
met 1:7 37:20 112:15 114:12
methods 83:14
metric 10:6 88:13
MGA 1:13
MHA 1:19 2:5
MHS 2:18
mic 96:17
mid-November 183:1
middle 28:20 63:16 115:16,20 116:5 131:18 143:14 183:3
midstream 28:20
migration 194:15
miles 198:11
millions 35:18
mind 19:22 40:4 53:14 55:20 70:11 79:21 100:11 166:10 186:11
mindful 200:13
minimize 12:1 60:19
minor 14:7
minority 42:11 75:19 100:12 101:11
minutes 98:5 165:13 172:15
MIPS 22:9,14 167:5
MIRA 1:20
misaligned 106:22
misconception 64:13
misrepresented 41:21
missed 54:20
missing 85:16 86:15 136:11 141:11 193:6
mitigate 173:8
model 170:4
models 180:17
modify 63:5 75:20
momentum 203:8
money 80:5
monitor 63:19,21
month 58:15,16 183:6 198:8
months 28:12 105:11
147:3 149:3 150:10 150:21 210:5
morass 157:14
morning 5:11 6:15 37:15 65:6 73:21 74:17 96:19 165:9
motion 44:10,13 75:20 89:13 109:20,20
motions 44:8 110:1
move 8:10 10:8 11:13 12:10 21:17 40:13 54:1 57:10 67:8 71:21 72:1 75:10 81:7 89:21 113:1 142:7,7 143:5 199:9,13
movement 9:14
moves 68:20
moving 10:1 45:11 55:8 92:4 126:4 141:14,18 145:7 182:20 183:5 185:4
MPA 2:2
MPH 1:11,17 2:3 3:6,11 3:18
MSN 1:19
MSSW 1:14
MUC 6:21,22 15:11 61:3 133:16 160:13 171:18 182:13 210:14
muck 87:10
MULLINS 2:4 20:18 50:4,11,17 122:3 166:12
multi- 112:14
multi-stakeholder 74:4 172:22
multiple 7:13 15:13 23:14 27:6 85:5
MUNTHALI 3:11 148:15
must-have 185:1
muster 121:6
mutually 184:18

N

N.W 1:8
naive 14:12
name 34:12 82:14,15 117:20 171:21
names 82:14,15
naming 118:2
national 1:1,7,19 2:1,3 2:11,16 74:3 170:11
nationally 200:12
nature 61:21 114:21,22 115:5 130:21
near 172:6
nearing 97:21
nebulous 73:8
necessarily 13:18 44:9 64:15 69:16 77:21 80:9 82:1 109:18,21 111:15 117:5 153:16 170:21 184:18 206:14
necessary 130:2,6
necessitate 99:16
need 9:8,10 15:22 21:18 39:8 43:16,17 47:15 51:20,21 52:8 60:20 61:7,13 64:15 65:8 66:1,9,14,15 67:17 71:12,14,20 72:8,20,21,22 73:1 74:11 81:11,14 84:8 89:12 90:17,18,19 92:10 94:3 106:18,18 107:17 109:2,11,15 109:16 110:3,18 114:15 115:14 117:6 117:8 118:9 119:11 119:15 124:4,13,21 129:19 131:20 132:22 134:20 140:5 142:22 150:13 151:13,19 152:1 153:1 158:1 159:9 160:16 165:13 187:17 195:3 201:21 205:21
needed 46:3 65:3,4,15 112:14 117:18 130:6 149:11 175:22 178:10 191:16
needing 102:13 115:1 190:19
needs 28:19 47:6 61:12 65:9 67:2 76:6 115:20 127:12,15 131:20 132:13 138:8 143:18 150:4 151:17 181:12 199:15
negative 125:22
Network 2:6
neurologist 128:19 129:4,14
neurology 128:18 129:3
neutral 110:4
never 40:4 62:6 69:22 77:11 86:3 106:22 174:12 176:19
new 7:3 28:21 29:6 102:6,8 107:5 141:6
newbie 106:3
nice 36:9
nicely 99:1 160:19
nightmares 70:17
nights 160:5

nine 31:17 105:11 108:20
nobody's 119:5
nomenclature 110:3
noms 182:21
non-endorsed 106:15
non-rural 206:20
non-urgent 147:12
non-voted 145:9
NON-VOTING 2:14
normal 130:7 150:22
normally 174:18
north 83:20
note 9:6
notice 24:9 25:5 38:7
noticed 6:19,21 22:18 22:21
notion 64:22 68:7 79:18 152:7
November 183:3
November/December 182:8
NQF 3:5 19:14 24:1 33:20 37:16 48:10 54:2 55:2 56:15 59:5 72:18 74:17,22 77:18 86:1,2 90:12,16 91:2 91:13 92:3,4 94:4 96:1 98:8 104:22 105:1 120:21 123:14 123:17 124:4 125:3,8 125:11 128:2,5 129:2 129:20 134:1,5 138:3 142:6,10,16,22 143:16 144:13 149:18 158:20 159:2,11 172:1,20 183:20 184:1,6 187:1 189:9 208:17
NQF's 90:13,14,15 94:1
NQF-endorsed 137:19 139:5 142:13 159:5 160:15,18
NQFs 17:18
nuances 155:13
nuclear 108:17
number 6:18 7:6 16:11 26:18 27:19 31:15 36:13 46:16 58:22 65:17 74:13 83:20,20 92:17 99:22 110:12 114:8 148:8 151:12 151:14,15,19 166:5 208:11
numbers 53:16 95:5 102:13,14,17 128:14 145:5 190:10,18,21
Nurses 1:14
nursing 196:12

O

O'BRIEN 2:5
O'ROURKE 3:14 5:15 5:18 6:8 13:8 40:18 40:22 48:22 49:9 116:10 118:22 152:16 154:6 156:18,22 161:13 165:7,11,19 166:9 208:3,20 211:2
objectives 181:4
obligation 94:12
observation 104:13
observations 106:3 109:7 136:6
obtain 183:14 185:18
obtaining 23:12
obvious 199:6
obviously 14:17,18,20 30:17 37:16 49:20 118:1 203:15
Off-microphone 118:16
offer 182:13
offering 148:22
office 191:18 204:6
official 6:16 210:19
offline 123:18 209:13
oftentimes 193:8
OGC 197:4
OGUNGBEMI 3:13
old 127:21 148:17
old-fashioned 144:2
OMB 19:2
on-the- 174:18 183:9
once 25:1 40:11 60:15 60:15 61:3 68:10 69:8 168:2,4 183:5 192:5 205:20
one-trick 141:22
ones 82:9 178:6 185:2 186:17 189:2
onus 125:7
Opelka 164:3,21
open 19:22 76:12 165:19 166:1 188:9 189:10
opening 38:4
operating 73:4
operational 11:8 38:9 38:14 39:2,11
operationally 15:19
OPERATOR 166:3 208:9
opinion 41:9 51:18
opinions 41:20 42:11 42:11
opioid 119:20 134:18
opioids 137:3
opportunities 149:17 179:21 193:7
opportunity 4:7,18 6:4 7:22 55:13 56:13 179:1,3,5 182:16
opposed 65:11 75:18 133:17 147:12 189:21
opposite 105:7
opt-in 168:8,9,11
option 108:17
optional 180:13,14 186:4 206:3
options 105:3 115:18 157:2
order 5:4 24:15 25:16 39:9 43:21 50:1 64:16 107:18 183:17
organization 40:6 64:13 74:2 79:1
orientation 53:1 163:9
originally 164:10
ought 104:2
out- 194:14
outcome 9:15,17,21 83:18 98:16 99:4
outcomes 190:21 194:3 196:3
outer 79:2
outliers 88:10
outlined 34:6 184:1
outlines 8:17
output 15:4
outside 27:4 37:16
overall 12:12,19,20 13:12 14:6 24:14 186:18
overarching 177:22 179:10
overemphasizing 86:14
overlap 33:13 207:3
overridden 158:16
overrode 65:19
oversee 89:3,5
overstated 40:8
overtreatment 25:15
overturn 46:4 72:15 93:11
overturning 72:20
overview 171:16
overwhelmed 159:17

P

P-R-O-C-E-E-D-I-N-G-S 5:1
p.m 211:17
PAC 26:11 27:18 31:17 164:15 210:1
Pacific 1:21
package 156:20
packaging 144:18
Page 4:2 154:1,4
pages 160:4,22
paid 80:5 173:16,20
pairs 11:19
paper 146:10 204:10,11
paperwork 10:14
parcels 38:12
parliamentarian 56:16 88:22 107:12
parliamentary 57:7
part 23:19 24:11 31:12 38:12 46:21 62:20 73:6 74:19 75:5 87:9 96:2 97:14 103:16 106:5 107:15 119:16 133:2,8,12 157:5 163:9 168:21 186:6 191:12 194:1,10 195:22 203:2 206:10
PARTICIPANT 102:1
participants 78:13 167:2 168:2
participate 77:15 161:15 162:3 168:3,5 168:9 169:14,14 171:9 174:3,5,10,12 179:3
participated 168:5
participating 52:19 154:4
participation 167:3,14 167:22 178:4 179:13 197:14
particular 9:8,9,18 10:5 10:20 11:5 12:4,7 17:9 18:19 29:13 30:10 88:1 100:2 114:15 128:17 170:20 177:8 204:20
particularly 9:20 17:22 27:18 65:17 77:1 79:14 139:4 186:18 193:7
partner 194:2 208:16
partnership 1:3 2:3 74:1 77:18 209:2
parts 74:6
pass 110:7 125:20 147:18
passes 121:6
passionately 21:2
path 64:2
pathway 51:22 119:1 155:8,18

pathways 119:1
patient 21:12 23:10,17 24:11 33:2,6 37:19 38:2,21 40:6 78:5
patient's 17:16
patient- 23:7
patient-centered 9:1 22:18,20 188:14
patient-centeredness 32:20
patients 8:22 10:13 17:7,12 21:15 24:2 25:15 33:11,12 94:12 94:14 193:18 194:15
pause 29:3 75:13
payers 21:5,6
payment 10:3 20:21 79:15,17 169:15 173:4 180:1 203:3,6
payments 179:4 202:19
PCH 189:8
PCMH 180:17
pediatric 185:10
pejorative 158:10
penalization 202:18
pending 55:2,3,9 128:2
people 5:21 13:12 19:2 27:7 29:14 30:11,14 41:22 43:1 44:17,20 45:2,9,15,20 46:5 49:4 50:7 64:14 65:11 71:17 76:17 77:19 78:19,20 80:15,18 81:1,4,16,19 82:1 91:4 92:13 93:8 94:3 96:5,6,17 99:13 100:1 105:14 106:6 108:21 112:3 114:1 115:3 117:8 123:10 128:15 153:19 154:6 156:11 159:14 161:21 163:20 164:11 168:3 174:16 176:3 189:19 190:3 192:4 197:8 199:21 204:8 209:12
people's 41:20 82:13 99:3
peoples 117:13
percent 21:4,5,10 46:3 48:9 61:8 68:7,14,16 70:19 72:11,15,17,18 72:19 75:6,14 76:3 77:6 80:20,22 83:16 83:19,21 85:15 86:18 86:19,19 88:12 92:17 92:22 93:2,5,10 99:19 99:21 135:9 163:14 168:19 196:11 203:20
percent/50 92:17
perception 82:12 202:15,22
perceptions 205:12
perennial 195:21,22
perfect 112:21
perform 154:14
performance 3:9 10:3,5 10:9,12 26:13,16 29:18 30:5,22 173:1 193:17 202:14,17 203:6
performed 143:2,7
performing 26:20
perinatal 185:10
period 147:1 170:9
perpetuates 169:15
person 7:8 8:1 36:16 64:21 73:20 104:7 107:5
person's 34:12
personal 120:8
personally 172:4
perspective 17:15,16 24:3 33:5,6 34:6,12 37:20 38:11 40:6 41:14 121:11 161:19 169:8 202:14
perspectives 23:18,19 33:15
persuaded 124:20
pertaining 114:22
Pharmacy 2:9
phased 178:9
PhD 1:18 2:1,2,5 3:6
phone 5:21,22 35:1,1 36:7 39:15 45:12 50:8 96:17 135:21 154:4 159:14 161:3 162:3,8 166:1 199:21 202:4 208:7 211:1
phones 166:1
phrase 178:20
physically 80:3
physicians 2:4,6 37:2 167:10,13 168:1 191:20 199:4,7,9
pick 32:19 60:6 63:3 146:16 183:20
picking 29:11
piece 38:14 141:11 148:12 177:17 181:19 187:20
Pierre 3:18 5:5,10 6:12 13:9,13 16:16 22:8 33:3 36:9 87:12 95:3 121:12 130:10 133:4 168:7
pilot 87:9 138:12
Pincus 1:9,11 31:20 48:13 49:7,22 52:12 52:22 82:20 110:9 113:8 121:19 123:9 124:18 126:6 127:17 130:9 131:8,16 132:8 133:19 134:13 135:20 137:14 140:18 141:20 143:9,20 146:8,14 147:13 148:14 149:19 151:4 156:3,13,19 157:1 158:13 159:13 159:20 160:8 161:2 162:16 163:4,7,18 164:10 165:2,10,18 165:21 166:7 168:15 171:11 188:8 195:6 196:9 197:22 199:20 200:2,5 202:3 203:10 207:22 208:5,13 210:18
pipeline 149:10 193:15
place 9:16 30:20 67:14 89:6,13 125:1 172:16 200:8 205:19
placed 10:16 21:8 38:20 115:6
plagued 119:4
plan 91:17 115:8 121:4
plane 209:14
planning 22:19
plans 1:16 16:21 159:6
play 11:8 95:16 176:13 197:12 202:16
playing 197:16
plea 30:18
please 5:22 8:17 10:8 166:4 200:1 208:10
pleased 35:19 189:12
pleasure 167:8
plenty 21:19 57:6
plumber 175:21
plurality 100:1
plus 68:14 99:19
PMP 2:1
point 27:17 32:20 33:8 49:1 50:12 52:13 55:7 59:17 62:11 66:14,22 67:3 68:10 76:10 85:16 86:15 88:12,17 88:18 96:8,22 97:21 100:2 103:11 110:5 110:11 115:10 118:20 123:15 128:1 133:7 133:13 135:5 136:17 137:20 138:14 139:8 139:11 144:1 145:4 147:10,16 153:15 155:17 160:11 163:8 163:8 186:5 191:1 195:19 197:19,20
points 5:22 6:3 42:14 75:8 99:6
policy 35:8 146:11
political 87:19 88:17 169:19
politically 88:5 139:12
politicians 170:17
politics 129:17 169:21
polled 108:14,16
ponder 158:8
pony 141:22
poorly 26:20
population 159:1 181:12 192:12
population-based 207:9
populations 190:7 195:18 201:5
portray 80:16
position 42:2 45:18
positions 83:9
positive 35:5 125:21 203:4
possibility 210:20
possible 78:8 80:3 113:3 171:10
possibly 201:18
Post 146:13
post-acute 173:14 181:15
post-op 25:13,17
post-truth 146:12,14
potential 4:4,14 8:2 11:4 40:15 141:3,9 179:12
potentially 15:12 117:12 154:18 179:4 186:4
potpourri 64:5
power 76:18
PPS 173:17,21 174:10 178:7
practice 175:13,15 193:5
practices 174:10
Pre- 4:4,14
pre-rulemaking 4:11 40:15 209:16
precious 200:20
precision 16:9 120:13
predating 170:10
predict 109:21
preface 20:18
prefer 9:14

preferable 78:8,16
preference 23:14 76:15
preliminary 44:20 45:19 49:13
prelude 67:19
preparation 98:20
preparatory 105:14
prepare 209:6
prepared 108:19 130:18 160:5
preponderance 53:22 54:2,17 55:9
present 1:10 3:17,22
presentation 4:9 7:5 14:14 36:9 165:15 166:13 167:1 171:12 198:5,7
presented 13:5 134:2 157:6 185:12
preserving 117:14
President 3:12
presidential 170:3
presiding 1:9
press 166:4 208:10
pressure 185:6
presume 32:8
pretty 30:1 62:16,19 63:9 75:16 76:4 80:22 100:7,8 104:12 126:3 129:7,7 145:4,6 156:1 174:2 200:20 205:21
prevalent 186:18
prevent 17:20
previous 192:19 193:2
price 15:7
prickly 65:3
primarily 39:2
prime 126:20
principles 180:8,9 181:7 183:22 184:6
prior 11:21 46:14 47:9 48:1 121:17
prioritization 23:1
prioritize 33:12 62:4
priority 9:2 16:14 19:15 24:17 30:19 55:15,15 56:10 119:19 124:6 141:5,13 150:5,8
private 11:19
privilege 172:2
probably 7:9 20:12 22:11 31:1,11,12 37:5 53:1,14 64:14 82:16 88:13 96:9 98:5 123:5 123:20 124:21 125:14 129:8 177:16 184:10 186:2 187:13 203:11 205:5 206:3,9 207:18
211:1
problem 62:20 73:6 83:1 106:6 135:13 136:3 137:10 139:1 139:22 177:4,12,18
problems 32:3 118:3 120:19 139:2 195:16 198:20,21
procedural 89:10,18
procedure 64:11 73:4 99:15
proceed 166:8
proceeded 43:6
processes 25:4 106:9
processing 43:2 136:10
product 75:6
professionalism 79:17
professionally 103:7
professor 169:19
profound 200:18
program 11:12 27:4 28:1 31:14,15 47:10 61:1,2 63:2 115:6 130:14,22 132:12,13 132:14,16 133:12 138:3,18 153:18 168:2,11 197:12,14 197:16
programmatic 186:10
programs 7:15 8:13,15 9:8,9 10:2,10 11:18 15:12 18:14 21:18 22:13,16 26:22 27:11 27:14,17,19,20 28:4 31:10 64:11 79:15,18 84:8 102:14 167:4,15 169:15,15 171:10 173:4,7 174:3,6 177:2 177:8 178:5,21 180:4 180:15 193:2 196:15 196:16 197:8,21 198:16 206:17 210:1 210:3
progress 182:19 203:3
project 3:8,13 17:20 172:12 173:11 174:7 175:18 204:21
projects 148:20 191:13 204:10
proposal 34:10 111:11
proposals 24:8 31:9 151:7
propose 34:17 95:14 100:14 101:5
proposed 15:22 34:16 48:20 100:19 101:3
proposing 95:12 130:22
pros 187:22
protect 99:16
proud 67:6 206:21
prove 86:5
provide 32:22 33:5 41:2 61:9 111:4,22 112:5,7 115:13 141:18 169:18 172:22 181:17 206:22 211:5
provided 171:17 179:11 180:3 185:14 193:16 194:7,13
provider 38:21 115:8 159:7 177:8 193:16
provider's 17:15
providers 8:22 10:16 26:19 33:10 173:2,16 174:19 175:6 177:20 177:21 178:5 179:14 180:11 183:9,10 184:12 193:1,8 194:2 194:16,17,20 195:4 202:20 206:2,12,18
providing 134:9 160:12 179:6 194:18
proximal 9:21
psychiatrist 203:21
psychiatrists/psycho... 203:18
Psychiatry 146:11
psychologist 203:21
public 4:7,18 6:5 29:19 37:5 66:20 101:3,8,14 101:17 119:19 157:17 165:8 166:2 208:2,4,6 208:8,11
publicity 169:22
publicize 179:5
publicly 45:10 198:15
published 146:10 209:21
pull 38:13 107:18 109:12 111:9 154:2 159:9,10 183:8
pulled 107:22 108:17 109:18 191:18
pulling 22:5 25:1 108:3 190:15
pulls 108:20 109:5
purchasing 8:14 10:2
purely 41:18
purpose 58:17 110:21 111:15 163:5
purposefully 161:14
purposes 91:11
purview 19:4
pushback 195:22
pushing 181:15 199:18
put 8:18 13:13 23:13 24:8 44:10 45:4 48:6 49:14 56:17 57:16 58:8,8,8,9 59:5 60:15 70:4 71:13 83:5 88:6 94:19 115:3 117:3 122:21 123:4,10 135:11,18 136:12 143:14 150:7 151:2,5 161:7,21 171:4 182:21 187:6 189:3 199:14 207:11
puts 65:20 88:4 112:3
putting 100:19

Q

QASEEM 2:5 36:8 90:2 90:6
QI 136:3 167:3 176:4
QRP 61:1
qualitative 111:2 112:8
quality 1:1,7 2:16 3:12 8:14 9:2,18 10:3 12:5 12:6,7 21:11,11 35:10 35:21 36:4 56:6 74:3 78:4 91:11 93:19 112:12,13 113:6 135:7 167:3,15 178:4 179:2 187:11 189:19 190:4 193:16 194:7 194:13 200:15 201:1 202:11,13,16 206:1 206:20,21
quantification 14:16
quantify 14:22 16:2 33:1
QUERAM 2:6 97:20 98:4 168:16
question 8:11 14:10,12 15:10 17:17,18 22:21 26:2 38:6 48:19 49:18 50:19 79:19 85:8 107:16 137:10 144:13 158:14 161:9 188:11 188:22 195:21 198:13 204:16,19
questioned 67:2
questions 6:1 22:18 23:5,6 35:2 39:14 44:20 50:7 64:6 105:21 111:10 157:22 158:9,19 186:7 188:11 204:14 207:20
queue 200:1
quick 26:1 150:13
quickly 28:17 106:19
quite 6:22 95:9 104:8 140:3 141:10 177:15

184:10,20 186:18
quorum 46:16 54:21,22 55:1 68:10,11 77:10
quorums 68:9

R

Rachel 2:1 140:18
radical 108:5
rain 128:3
raise 67:1 136:2 137:10
raised 53:21 195:15
raises 203:16
raising 71:21 109:17
RAJESH 1:15
RAND 92:20 111:17
random 83:20 93:9
range 105:3
rates 39:6
rationale 42:9
re- 40:4 66:14
reach 70:19 75:3 80:20
reached 106:1
react 44:11 46:12
reaction 186:13
reactions 13:4
read 84:5 116:19 132:11 160:4,21 167:7 180:7
readmission 185:8
readmissions 56:1
ready 22:3 58:13,14 97:4 119:22 122:9,10 122:12 123:16,19 126:20 137:18 139:10 140:3 141:11,16 155:19 208:14
real 72:3 88:9,13 106:7 134:19
realistic 80:10
realize 53:19 60:20
reason 101:5 121:1
reasonable 63:9 151:12 185:21 186:1 207:14
reasons 21:1 32:7 113:6 119:10 130:16
reassuring 164:16,16
recall 35:12 85:20 125:1 199:1
receive 39:5
received 153:22 204:15
recognize 104:8 170:21
recognizing 162:7
recollection 18:10 25:20
recommend 189:17
recommendation 42:4 46:2,11 47:11 57:18 65:10,19 66:5,6 68:15 71:1,10,14 94:2 121:22 122:1 123:22 177:22 178:14 179:10 181:2 209:21
recommendations 18:1 18:12 58:2 61:14 121:17 129:16 152:4 152:5,8,14 155:3,22 156:12 157:2 173:6,8 179:12,14,22 180:3 181:18 209:18
recommended 107:13 180:19
reconciliation 185:4
record 113:12 211:17
recording 10:18 99:6
recreating 132:4
redesign 148:21 149:6
reduce 151:14
reduction 21:2
reed 99:10
refer 39:11
referee 56:18 57:9 89:1
referenced 33:8
referencing 42:8
refine 13:14 116:16 117:15 118:18 120:8 120:12,15 121:9 126:12,19 135:14 145:19,22
refinement 114:14
refinements 14:7
reflect 206:1
reflected 13:2 23:9 24:4
reflective 66:3 136:7 195:3
reframe 170:17
reg 95:22
regard 48:18
regardless 145:5
regional 2:6 35:8
registers 50:8
registry 16:20
regulations 15:21
reimbursement 202:17
reinforces 95:16
reiterate 13:8 135:5
relate 19:17
related 10:19 148:16 155:7,14 175:3 184:17
relative 128:8
relatively 28:17
release 209:22
relevant 18:2 88:16 131:3 181:21
reliability 66:17 97:13 136:20 159:10 177:5
reliability/validity 158:20
reliable 15:16 159:10
relies 138:11
reluctant 125:16
rely 92:3 93:20 99:11
relying 55:18 99:3
remain 12:18
remark 88:21
remarks 4:20 102:5
remember 25:12 33:21 34:5 41:17 81:9 86:11 87:4,8 128:13 164:3 203:18
remembered 164:2
remembering 164:22
removal 4:3 5:6 7:19 8:2 13:16 14:5 18:4 22:14 26:6 32:1 133:9
remove 12:14 22:9 25:4 30:10,19 31:10
removed 31:4 32:6 36:14,19 37:4
removing 32:5
reorient 116:12
repeat 7:10 102:7
repeated 102:7
repeatedly 53:21
replaced 164:20
replicating 55:17
report 21:5,6,22 32:12 42:7 45:4 168:12 177:8 178:16 184:13 187:1
reported 198:15
reporting 8:14 21:7 27:19 133:12
reports 33:21 209:17
representation 24:1
represented 33:15 143:19 155:10 166:19
represents 169:12
reps 33:3
request 54:15
require 14:15 19:4 197:13
required 18:20 28:6 65:15 69:22 162:21 164:12
requirements 9:7 99:15
requires 14:19
requiring 145:22
research 93:8
resentment 169:22 170:12
reserved 150:8
residents 176:8 181:22 193:20 194:22
resolution 103:7
resolve 95:9 104:17 121:14
resolved 91:22 107:1
resort 105:9
resorts 105:8
resources 111:17 170:14 171:1 179:20 200:20
respect 66:5 68:4 70:8 195:16
respond 23:4 61:22
response 98:6 112:9
responses 132:14
responsibility 54:8
responsible 203:22
rest 24:12 144:19
restatement 39:18
restore 171:8
restraint 26:17
resubmission 114:14
resubmit 51:14 116:1 116:16 117:15 118:2 118:18 120:8,12,15 121:9 124:10 126:12 126:19 135:14 145:20 145:22
resubmitted 155:16
results 20:19,22 44:19 85:17 186:22
resumed 113:12
review 19:1 96:14,20 142:5,18 143:2,7,7 147:16 156:16 157:11 210:7
reviewed 158:15
reviewing 10:18 92:8
reviews 8:12
revise 43:20 51:14 54:15 115:22
revisiting 153:12
revisits 56:2
rheumatologists 129:5
rheumatology 129:5
Rich 135:20,22 137:14 162:17 199:22 200:2 200:5,7
RICHARD 1:12
richer 101:12
rid 27:2
ride 209:14
Rights 1:13
rigid 77:9
risk 115:2 176:14 202:17
RN 1:19
road 203:7
Robert's 43:21 50:1

64:8
ROBINSON 2:7 202:5
robust 66:19 160:22 196:2
role 9:16 26:5,7 44:9,17 49:12,17 59:19 63:22 85:17 86:20 87:19,21 88:21 89:8,19,19 95:16 120:10 123:15 144:19
roles 139:6 162:19
rolled 138:12
room 1:8 76:16 77:19 136:17 162:7,12 165:22 184:2 191:19 208:6
roughly 183:5
Route 195:9
row 171:21
RPh 2:8
rubber 203:7
rubber-stamping 92:14
rubric 127:21
rug 22:5
rule 56:19 57:8 58:15 58:16 64:7 84:13 88:6 97:14 100:19 101:3 102:6 104:3 107:5,14 122:12,22 123:5 140:4,8,16 167:8
rulemaking 4:5,15 24:9 25:6 34:18 58:13,14 59:19 88:3,4 97:5,5 116:15,15,16,17 120:1 121:18 122:9 122:10 123:16,19 124:3,14 127:2 134:6 134:22 138:8,19 139:10 140:3 145:13 147:19 148:9 150:6 150:14 167:17
rules 29:10 42:15 43:21 50:1 64:16 77:9 84:5 84:9,20 90:17 138:10 154:14 173:22 210:14
ruling 100:15
run 40:2 112:12 130:7
running 70:16
rural 4:9 5:13,16,20 165:5 166:8,15 167:2 167:10,13 168:19 169:4,13,16 170:13 171:17 172:6,21 173:2,16,19,19 174:9 175:6,19 176:7,17 177:19 178:5 179:13 180:11 181:3,12,22 183:9 184:12 186:18 187:21 189:14,19 190:1,6 191:8,11 192:14,19 193:7,20 194:21 195:11 197:8 198:9,10,12 199:1 200:8,16 201:4,8,13 202:10 203:13,20 205:14,18 206:1,12 206:19 210:8
rural-only 177:14,18
rural-relevant 179:15 181:11
rural/urban 171:6

S

safety 25:11 56:6 135:6
sake 198:19
Sam 40:20 101:18 104:10 105:18 126:9 127:17 136:17 137:17 143:20 146:8 164:1 198:3
Sam's 147:16
sample 195:16 196:2 196:13,18
SAMUEL 2:2
sat 53:10,17 54:3 112:18
satisfied 75:7
save 52:10
saw 82:8 107:17
saying 54:8 58:12 62:3 68:19 71:6 72:19 81:19,20 86:7,8,13 94:11 124:5 126:19 127:13 130:1 143:15 146:18 167:14 184:6 189:22 190:5
says 54:9 57:9 58:5,19 63:10 197:4 199:5
scale 31:11 122:13,16
scans 82:21
SCHLAIFER 2:8 68:22 80:14 81:18 82:3 126:7 158:14 162:20 163:5,15 164:4,7,18
science 144:3 146:9,11 169:19
science-based 144:10
scientific 93:9 129:6 136:20 144:4,7 184:3
scientifically-endorsed 144:16
scope 18:22 173:11 187:15,17
scratching 86:6
screen 50:8
screening 29:21
screwed 194:9
search 77:3
season 43:13
seated 181:2 183:1
second 38:6 56:14 89:12 92:15 102:18 116:18 164:14 167:12 167:22 183:3 188:22 197:6 200:11 201:6
secondly 30:21 48:18 106:14 162:6
secretary 60:10
sectors 74:7
seeing 93:13 127:5 211:14
seek 105:8
seen 26:12 35:8 58:22 77:1 85:22 86:2,3,8 91:22 140:8
sees 60:7
select 180:10 190:10
selecting 181:6 195:3
selection 47:17 180:4 183:16 190:5 193:14
selection/removal 23:2
self-reflective 136:7
send 42:7 131:12 209:6 209:12
Senior 3:7,9,11,14 171:22
sense 7:17 29:17 54:8 66:8,13,18 67:17,21 104:18 110:21 111:7 125:6 135:15,16 143:13 151:10 158:5 190:16
sensitivity 197:10
sent 52:3 161:4
separate 38:14 156:20 190:6
separately 38:9
September 182:22
series 170:7
serious 76:4
seriously 87:1 160:6
serve 163:2
Service 2:8 198:11,18 199:15
Service's 198:18
services 2:19 3:19 175:22 176:16 203:14 204:12
session 8:6 79:4
set 12:3,13,16 28:21 53:14 90:17 113:6 114:3 132:12 133:18 138:21 141:12 148:1 152:14 156:10 157:2 167:6,9,12 177:7 180:12,13 181:6,11 184:7 185:12,14,21 186:1,2 188:3 189:2 190:1,6 205:15,21,22 206:6,10,12,15 207:1
sets 7:17,18 8:4,13 12:2 12:19 183:17 186:4 186:12
setting 26:11,17 137:21 138:1 146:18 185:5
setting-to-setting 14:21
settings 27:18,18 173:13 181:14 185:16 191:14
seven 21:6 31:17 149:3
shape 142:9
share 32:10 36:17 44:10 45:15
shared 182:14
sharp 74:12
SHAUN 2:5
shelter 191:20
sheriff's 191:18
shift 137:7 192:20
shoot 144:5
shop 193:21
short 150:22 209:6
show 81:2,6 84:13,19 116:21
showed 127:10
shown 86:2
shy 6:1
side 9:13 26:11 48:1 59:2,2,3 79:22,22 80:16,17 142:10
sidebar 83:6
sight 36:5 132:15
significant 11:7 18:22 19:1 26:18 68:3 72:6 119:13,14,19 148:18 156:1 168:21 192:8
signifies 117:17
similar 11:17 27:21 37:10 74:2 110:20
similarly 33:2 46:7 154:11
simple 36:16,19 62:20
simplified 103:22
simplify 90:15
simplifying 134:12
simply 115:18 128:21 190:13
Simultaneous 86:12 87:6 94:17 131:7
single 85:20 128:22
sir 166:3 199:6

SIRIO 2:10 28:8 39:16 64:4 83:4 108:6 124:19 195:7
sit 35:8 37:18 59:10 70:1 162:21
sitting 64:10 94:13 112:18 164:19 180:22
situation 176:22
situations 9:19 101:10 101:11 204:4
six 31:14 103:13,20 105:11 108:21 128:14 147:2 150:10
size 169:3 175:14,15 195:17 196:2,14,19
sleepless 160:4
slice 156:6
slide 8:10,17 10:8 11:13 11:21 12:10,11 42:19 46:19 49:8 116:11 117:10 132:9,10 145:10 198:2
slides 8:16 13:3 41:1 166:13 167:4 188:13
slowly 92:4
small 78:12 104:21 151:6 152:12 156:15 165:4 167:13 174:9,9 175:13,14,22 176:18 182:12 190:10,18,20 195:16 196:12,13,18 209:12
smaller 6:22 161:7 195:17 196:8
smart 65:11 91:4 92:13 94:2
smooth 106:11
snow 128:4
so-called 131:17
social 176:11
socialization 144:8
soft 141:3
softer 140:15
solid 46:11 79:1
solution 75:20 76:13 137:11
solutions 109:10
somebody 57:4,8 89:1 89:20 191:1 201:3 204:13 207:15
somewhat 68:8 173:12
soon 5:4 182:4 204:8
sophisticated 62:21
sorry 32:18 34:22 73:19 77:22 145:14
sort 7:11,21 12:18 13:4 15:3 16:1,21 18:11 19:8 23:8,12 24:18,19 31:4 32:12 34:15 38:17,18,20 39:4 52:19 53:6 56:18 58:2 60:2 61:4 62:22 63:14 73:10 80:11 85:14 88:22 110:18 112:16 114:3,4 116:8 122:17 123:11 124:1 132:19 133:1,9,12 136:2,12 144:2,12,17,19 145:1 145:20 148:8 154:20 155:3,11 156:16 162:18 163:10 165:3 165:3 178:9 184:3 188:2,10 194:5 198:13 203:6 204:3 210:22
sorts 11:16 176:12
sound 26:10
sounds 56:20 110:9 121:19 135:14
source 20:5,9 102:19
South 176:10
space 29:20
spaces 29:18
speak 73:16 90:5 96:16 200:5
speakers 36:3
speaking 86:12 87:6 94:17 131:7
special 208:21
specialists 175:7
Specialties 1:21
specialty 128:22
specific 101:16 116:6 146:22 147:3,9 151:16 152:13 188:17 198:2
specifically 131:21 167:5
specification 148:5
specifications 54:16 59:8 197:1
specificity 152:8
specifics 9:7
specified 15:16 27:22 54:13
specs 142:7 148:13 196:22
speech 67:16
speedy 29:8
spend 59:7 80:2 83:12 87:2 148:7 158:8
spending 82:7 92:13 102:17
spent 35:14 68:8 91:4 93:20 102:12 136:21
spirit 77:16,18,19 78:7
split 46:8 50:21 51:2,5
Spokane 198:11
spoke 21:1 104:7
spoken 102:1
spot 94:19
spots 56:17
spread 60:7 92:18 93:2 93:13,15
spreadsheet 209:19
stability 39:19 40:9
stable 113:19
staff 3:5 13:6 33:20 37:9 42:12 44:17 45:19 49:12,18 65:19 65:20 66:6 67:15 69:9 70:17 71:1,3,6,10,14 72:7 78:11 89:19 94:1 97:7 104:22 116:8,21 117:3 148:2 151:6 154:14 156:16 162:11 165:3 175:16 191:21 208:17,17
stakeholder 34:6 79:12 112:15
stakeholders 16:11 24:13 74:5 78:7 95:7 161:15
stakes 90:9
standing 53:10
standpoint 20:17
star 166:5 208:10
start 5:4,5,9 18:5 30:4,9 47:21 85:18 91:3 92:10 136:2 171:14 176:14 177:1 185:20 199:16 205:22 209:17
started 25:14 47:7 48:7 49:10 51:16 52:2 60:3 65:6 70:15 77:5 92:2 128:11 150:1,11 152:18,22 154:19 156:2
starting 17:20 28:2 153:13
state 168:18,22 169:1,2 170:6,8
stated 145:17
states 176:11
statistic 203:19
statistical 15:17
statute 18:20 86:21
statutorily 28:5
statutory 9:7,7 13:19 18:8 19:3 84:9 197:4
steeper 72:21
step 122:4
steps 4:20 96:13
STEVE 2:11
stick 127:21
sticker 135:11
sticking 75:7
stigma 169:9,16 198:3
stone 188:4
stop 188:6
stories 175:17
story 199:1
straight 140:11
straightforward 53:20
strategic 137:4
straw 75:13
strawman 185:14 205:7
stream 20:15
streamlined 157:13
Street 1:8
strengths 192:16
strikes 95:15
strong 75:16 78:13 87:20,22 88:11,14,15 100:1
strongly 64:7 68:19 88:2,8 200:15
struck 28:15 29:13 52:4 60:11 65:5,17 166:14
structural 188:15 189:10 191:2
structure 20:13 98:10
structured 41:15 48:3 142:4
struggled 51:10 75:4
struggles 123:15
study 35:13 170:5
stuff 20:4 31:1 32:5 39:20 77:11 84:19 97:4 157:14 158:12 160:16,18 210:13
subcategory 124:1
subgroup 93:15
Subject 1:12
subjective 99:7
submission 148:22
submit 83:19 155:19
submitted 24:10
substance 185:3
substantive 88:17 120:11
substitute 191:2
suburban 177:21
success 136:14
successful 81:3
successfully 194:1
succinct 157:21
sudden 107:20
suddenly 197:14,20
sufficient 61:15
suggest 32:21 35:7 40:8 48:2 68:18

104:20 120:12 146:4 161:22 191:3
suggested 94:22 180:12,18 196:19 210:12
suggesting 26:6 121:20 161:21
suggestion 104:6 105:10 122:4 127:20 133:22 162:15 190:13 200:22
suggestions 13:13 24:16 48:19 111:6 153:17,19 156:4 188:19
suggests 30:11 65:14
summarize 110:6
super 68:17 99:17
supplemental 202:19
supplementary 134:10
support 64:22 76:2 78:19 88:18 100:9,9 100:10 101:6 103:3 103:19 115:19,19,22 116:14,15,17 117:22 118:6,7,7,19 120:7,14 120:15,16,21 122:5,6 122:14,16,19 123:2,4 123:6,7 124:15 125:17,18 126:8,18 126:18,20 127:1,7,10 128:3,5 129:20,21 131:18,19 134:5,10 134:11 141:1,1,12,15 144:22 145:13,20,21 145:22 146:1,2,2 147:9,19 151:18,20 151:21 153:2,8 175:10 179:12
supported 34:2 42:15 83:10 103:8
supporting 72:22 131:14 145:3
supportive 103:18,20 122:18 123:7
supposed 74:1 198:15
Surgeon 199:2
Surgeons 1:18
surgeries 135:9
surgery 176:20
surgical 55:22 56:7 135:6
surprised 81:10
surprising 11:16 178:14
survey 20:19 21:9 30:11 38:21,22
surveyed 20:20
suspend 25:9 28:16
suspended 25:17,21
suspension 29:2
synchronized 136:10
synergy 96:5
system 1:20 39:8 40:3 45:11 118:6 173:17
systematized 53:5
systems 39:19 40:4 180:18

T

TA 179:20
table 43:12 44:15 52:16 71:8 80:13 90:5 91:4 94:6,14 100:2 136:13 178:15
tables 71:17 118:13
tactically 201:13
takeaway 170:15
taken 6:20 39:21 75:14 79:7 131:21 206:13
takes 21:22 24:20 78:10 78:11,13 86:22 125:7 134:21 138:7 148:11 149:2 150:15,15
talk 52:14 63:6 68:2 97:15 107:5 111:22 112:20 114:18 117:7 121:16 172:19 174:18 181:16 182:3 189:5 198:11
talked 11:1 50:22 87:13 100:17 122:20 127:8 133:9 138:5 147:7 155:7 175:18 176:7 178:1 179:8
talking 27:16 47:21 52:1 59:13 63:20 65:12 96:6,6,11 97:16 100:11 104:2,3 132:2 136:21 140:21 143:10 150:17 153:3 159:1,7 169:6 174:4 178:7,19 188:20 197:10 204:13
talks 109:16 132:12
tallies 53:11
TAROON 3:6
Task 162:19 196:5 210:8
team 16:16 60:18 136:3 172:8 209:2
technical 45:5 49:21 142:5,6,18 143:2,6,7 143:17 179:21
technology 50:6 72:1,2 72:9 82:21 106:4,10
teleconference 3:22
telemedicine 201:15
tell 35:4 101:8,15 159:16 164:22 172:11 180:22 205:11
telling 182:8
ten 21:4 103:21,21 113:9 122:17 186:2
term 38:15 144:9
terms 18:1 23:7,12 24:14 25:8 28:13,21 29:6,7,10 31:22 39:18 40:7 52:18 57:13 65:22 67:15 68:17 83:17 95:5 111:7 114:1 115:12 119:8 125:7,16 126:1 151:12 152:3,8,9 155:1,18 174:22 176:6,11 180:3 182:5 186:1,20 188:16 189:8 190:4,18 203:12 204:3,20,21
test 112:3 121:3
tested 15:16 121:5 137:20 138:1,12 147:22 155:15
testing 15:17 120:2
thank 6:13 37:12,14 39:12 69:9 102:4 105:19 107:4 131:6 131:10 136:1 137:14 143:21 168:16 171:11 171:13 172:1 189:11 192:18 195:5 198:4,5 198:8 201:22 207:22 208:15,19,20,21 209:7 211:11,13,14
thankfully 101:11
thanks 6:13 15:9 36:6 73:18 105:17 137:16 161:3
theme 45:1 170:15
themes 154:19 170:2
theming 49:19
thin 99:10
things 10:11 11:16 15:18 16:15 17:8 19:20 24:16 28:11,16 29:12,22 30:7,13,19 30:19 32:2,14,15 42:17 43:19,22 44:13 47:20 48:14 49:1 50:22 57:10 59:22 69:15 70:13 71:20 76:22 79:11 89:4,9,14 89:21 90:3,16 92:14 97:16 108:15,17 109:3 113:2 120:4,22 121:20 130:8 132:8 137:18 140:6,14 147:8 148:8,16 153:10 166:14,20 167:1 172:10 174:13 175:11,12 176:12,13 177:13,16 185:3 186:3 188:1,12 189:17 191:9 193:13 195:4 205:4,11,16 206:5,8 207:18
thinks 130:2
third 124:9 141:3,9,17 143:10 183:4
thought 7:8,21 29:7 38:11 43:20 44:16 59:20 65:21 68:1 69:15 71:4 72:14 131:17 141:18 157:16 176:19 199:3
thoughtful 98:7
thoughts 14:8 40:11 43:8 44:11 45:15,17 47:16 48:2,10 79:3 112:4 117:14,16 118:10 119:7 166:10 209:13 211:3
thousand 26:19
threads 45:3
three 31:14 63:8,9 70:4 107:16 108:22 109:3 115:18 118:6,12 126:3,17 127:10 148:19 149:3 150:16 150:21 151:19 172:9 198:6,14
threshold 167:6,20 168:11
throw 57:20 64:21 85:10 186:7
tie 162:22 163:1,2
tied 9:21 10:3 202:17
ties 11:20
tight 157:9
till 91:22
Tim 169:3,6 174:14 178:18
time-bound 147:9
time-sensitive 137:5
timeline 53:7,7 146:18 147:4
timelines 58:7
timely 22:1 29:8
times 6:7 25:9 34:9 59:1 65:18 85:5 91:7 137:4,6 149:1 150:18 159:12 167:9 192:22 196:19 198:6

timing 24:20 52:20 135:12 149:15
tiny 176:1
tobacco 29:20
today 6:6,16 43:10,17 69:4 73:10,20 79:4 118:9 172:9,11 180:2 180:22 182:9
tomorrow 128:4
tons 90:21
top 18:9 22:19,22 56:12 63:8,9,14
Topeka 195:11
topic 13:16 45:15 97:22 149:2 172:6 181:20 185:1 187:14,16
topics 46:20 140:17
topped 22:14
topped-out 22:9
totally 128:6
touch 64:5 210:5
touched 192:1
track 47:11 63:21
tracked 190:22
tracking 210:13
tracks 110:19
tradeoff 17:5,14
trail 15:5
training 78:10,11,13
transition 46:22 179:13
transitions 185:4
transparency 95:21 202:13
transportation 175:8
travel 183:10
tremendous 98:19 170:12 201:7
trends 10:9,12
Tricia 1:16 37:13
trickle 193:17
tried 119:16 161:14
trip 89:15
trouble 73:15 109:17 140:13
troubling 79:6
true 65:10 132:5 175:5
truly 41:9 72:12
trumped 69:3
trust 67:2 98:14,14,15 106:19 161:20
try 11:22 42:10 46:9 62:22 76:11 78:8 85:15 102:7 105:3 172:19 186:21 190:5 201:18
trying 16:16 21:16 77:20 78:3 79:8 84:19 84:20 86:16 87:8,12 87:13 100:13 103:10 119:6 128:6 136:4 137:11 139:1,2 140:1 144:18 149:9 162:22 163:1,1 174:12
turn 40:19 116:7 150:13
turnaround 151:1
turns 127:6
twice 40:11 149:1,2
two 29:18 36:2 63:13,14 63:16 91:12 102:13 115:15,17,21 116:5 119:1 122:5 134:20 136:12 137:1 138:8 139:22 140:9 142:1 148:19 149:3 151:15 173:20 174:2,11,13 180:21 181:6 183:22 199:19 208:22 209:5 211:12
two-measure 118:22
tying 203:5
type 9:11 45:3 47:8 98:10 99:14 153:1 154:9
types 131:1 176:16 187:20
typically 114:11,12

U

U.S 204:12
ultimately 12:8 116:3
umbrella 38:15
unclear 52:16
uncovered 170:12
under-treatment 25:15
underlie 179:8
underpin 28:13
underpinned 179:10
underscores 195:2
understand 16:22 17:4 19:7 34:11 105:14 124:2 140:2,22 149:11 161:17 174:8 179:2 190:14
understandable 192:22
understanding 16:18 17:1,14 52:19 66:2 73:22 75:2 128:9 163:10 178:8 194:20
understands 162:12
undertaken 16:16
unfortunately 76:20
unintended 10:22 11:4 11:4 138:17 205:17
Union 1:14
unique 26:10 201:10
University 169:20
unnecessary 12:1
unrevised 54:5
up/down 129:22
upcoming 155:20
updates 39:8
urban 177:21 190:2,7 191:13 192:3 201:12
urge 64:7
urgent 55:21 56:2 90:20 135:3,3,7,18 147:12 150:18 210:16
use 11:5 20:7 26:3,4 49:13 59:12 60:10 61:2,4 62:1 64:16 74:14 77:13 85:19 92:20,22 95:11 104:15 109:11,12 127:6 130:22 140:16 144:8 157:18 180:8 185:3 189:3 190:11 193:21
useful 32:4 33:11 56:22 95:8 111:4 161:6 187:2 211:4
uses 85:17 169:9
usual 144:15 181:16
usually 25:6,7,10,19,21 31:11 59:10 192:5
utilization 201:15

V

vagueness 52:6
valid 159:11
validating 66:15
validity 97:3,13 196:2
valuable 9:20 85:7 89:4 118:11 142:11 154:16
value 28:2 29:15 33:5 36:1 93:12 94:1 117:14 160:7 192:21
value-add 201:7
value-based 8:14 10:2 20:21 203:2
values 170:5,22
vantage 96:21
variation 10:5
varies 14:20 31:15,18
various 75:1 92:19 113:16
VBP 61:2 197:8
vein 168:13
verbal 76:21
verbiage 125:21 167:11
version 155:16
versus 14:19,19 38:18 66:21 80:11 93:2 204:12
veto 76:18
Vice 3:11
victims 192:1,2,9
view 76:10 80:11 82:12 82:13 85:14 88:17,18 99:6 100:3 110:11 112:2 115:10 120:8 125:10
viewpoint 205:18
viewpoints 101:7
views 79:14
violence 191:16 192:2
virtually 56:4,5 183:12 211:14
visual 36:16
voice 36:3 38:2,2 162:11
voices 41:6
volume 31:3 177:4 178:11 184:9,17,21 186:15
voluntary 174:6
vote 42:7 44:1 45:12,13 46:14 49:5 53:11,15 53:15 60:14,21 61:1 69:13 70:17 72:5,17 75:13 80:19,20 81:1,9 84:3,4,7 85:2,10,11 89:11 94:20 103:12 103:13 112:3 125:14 125:22 129:22 133:22 134:3,8,12,15 139:16 140:11 145:5 147:18 160:14
voted 82:16,16 100:22 128:20
votes 41:18 42:17 65:3 79:20 81:22 92:16
voting 4:5,15 40:16 42:3 43:19 45:7,8,9 45:10 46:5,22 47:21 48:3,16,16 55:2 57:17 58:1,9,12 60:4 61:7 62:5,12,19,21 66:21 69:8,12 70:11,11 71:22 72:4 77:9 78:18 84:16 89:10 92:16 98:21 99:4,14 105:7,9 106:4,10 113:15 114:2 118:14 134:12 139:20 140:13
vouch 143:6
vouching 142:19

W

wacky 61:17
wait 90:22 134:20 148:18 150:9 210:16
waited 91:1

wanted 8:7,9 13:16,20 32:19 34:10 41:1 43:3 46:21 49:4,5 55:14 71:6 77:14 88:20 110:1 117:13 148:15 152:21 166:20 168:3 168:8,9 172:9,21 173:5 180:8,16 192:17 193:13 206:8
wanting 24:20 140:22
wants 71:16 130:10 135:21
warning 21:20
warrants 39:18 104:16
wash 17:21
Washington 1:8 170:1
wasn't 96:7 101:2 179:17 198:10
water 85:11
way 32:8,10 38:16,19 39:3 41:7,8,11 45:13 57:18 59:11 62:10,21 69:17 71:11 74:11 75:3 76:1 77:12 80:15 81:5 84:15 85:12 87:22 88:11 89:7 90:1 90:15 114:4 115:13 116:2 119:16 121:14 124:14 127:7 130:13 132:20 134:4,12,15 138:13 142:9 150:14 153:16 155:9 156:14 157:11 158:2 173:21 187:9 191:17 203:8
ways 7:13 13:14 23:15 27:9 35:20 71:2 84:4 92:19 93:7 114:5,9 132:18 167:21 177:20 192:11
wealth 85:4
web 45:13 210:6
webinar 128:13,17 183:2,7 210:19
webinars 7:7
wed 118:1
weeds 132:3 196:18
weedy 20:3
week 37:20 62:7 128:4 158:12 185:17
weeks 210:10 211:12
weigh 13:22 95:4 121:12
weight 26:22 27:11 71:13 177:10
weighting 27:13
welcome 13:3 14:8 24:18
well-being 192:8
went 13:3 62:18 70:20 81:22 101:5 113:12 116:11 139:21 154:14 211:17
weren't 82:1 96:6 173:15
Western 176:11
whatnot 68:9
whichever 71:11
white 1:14 94:20 124:17
wholeheartedly 94:7
wider 69:18
Wikipedia 102:19
WILLIAM 1:21
win 68:14
window 196:20
winnowing 185:20
Wisconsin 168:18 169:4,20 170:6 171:7
wise 17:19
wisest 124:21
wish 20:17 73:10 165:22 208:6,7
WOJCIK 2:11
woke 73:21
Women 2:3
won 79:22 80:16 81:12 81:15 83:10
wonder 156:6
wondering 136:8 198:16
word 29:2 59:13 109:11 109:15 118:3 125:19 127:7 157:13 179:9 184:11
word-by-word 180:7
words 81:14 150:3,11 169:9
work 7:13 8:2 18:22 20:9 22:6 23:22 24:13 26:7 32:16 35:6,9 37:16,16 38:4 43:13 51:17 52:7 67:12,18 74:8 75:6 76:6 78:6 78:10,11,14,15 98:20 104:22 105:2,10,14 111:20 118:11 125:9 153:13 156:15 158:2 161:20 171:3,5 172:3 172:20 175:1 180:10 181:4,16 186:5 189:12 192:15,18 200:11,13,18 202:6 209:1
worked 32:3,14,15 46:9 112:17 183:13 189:14
workers 200:21
workgroup 14:6 24:3,5 46:12 49:3 51:3,6 59:9 69:19 70:1,7,8 70:12,15 71:5 72:16 74:21 75:5 105:4,15 111:12 128:9,16 165:6 166:15,17 169:3,7 171:4 180:19 181:3 182:22 183:1 183:15 191:7 201:18 202:2,7,21 204:17 205:9 210:22
workgroup's 117:4
workgroups 7:7 8:2,6 8:19 9:13 12:22 13:10 24:5 33:4 45:18 46:2 47:14 49:4,16 50:20 58:6 67:11 70:14 98:11 128:12,21 141:4 148:1 154:9 160:13 161:1,12 162:18 182:6,7 200:14 201:2
working 10:14 74:13 141:6 149:16 173:5 175:20 209:2
works 19:11 76:13 91:19 98:11,12
world 28:21 29:6 79:2 79:14 144:9,20 173:14
worry 90:10 94:15 95:19 99:2 139:9 184:20
worrying 125:8
worth 15:7 17:12 204:13
worthwhile 191:7
worthy 69:17 125:15
wouldn't 19:13 51:5 71:7 95:19,20,20 96:1 119:22 139:14,22 177:20 195:13 201:4
wrap 209:16
wrap-around 144:17
wreck 195:12
wrestled 74:18
writing 62:6 186:22
written 102:5 134:4 156:8 157:19
wrong 86:5 108:4
wrote 63:12 169:21

X

x 101:4 147:6

Y

yammering 68:9
year 6:18,19 21:21 22:4 22:10 28:20 31:9,14 35:14 41:4,16 43:22 45:19 47:9,18 49:3 69:7,21,22 70:4 90:22 104:18 120:1 140:9 146:10 147:1,2 148:19 150:15 154:15 162:4 164:19 167:12 167:22 181:13 182:17 209:9 211:8
year's 181:4
year-to-year 40:1
yearly 149:1
years 7:1 10:10 16:12 25:7,22 59:1 74:18 77:2 85:6 91:1 92:1 128:14 133:14 134:20 138:9 140:9 149:4 150:16 180:21 181:7 183:22 189:4,14 199:2,19 203:4
yesterday 7:2 9:5 11:1 11:15 21:2 28:11 41:11 43:1 46:3 48:7 48:21 51:1 53:22 60:12 65:2,18 67:11 68:5,10 69:4 73:6,9 74:16 79:19 80:18 81:9 82:8 90:10 91:7 91:14 92:12 102:12 106:5 108:2 109:11 113:22 128:8 136:18 145:12 148:22 149:5 153:4 182:1 183:4 185:11 187:7 205:6 210:12
YETUNDE 3:13
YONG 3:18 6:13 15:9 18:5 23:3 31:8 38:16 133:6

Z

zero 77:22

0

1

10:15 40:14
10:52 113:12
100 75:6 198:11
1030 1:8
11 113:10
11:09 113:13
112 4:16
12 28:12
12:45 5:10
12:46 211:17
136 4:12

15 209:22 210:2
15th 1:8
164 4:7
165 4:9
1962 107:4

2

20 91:1 98:5 128:16 186:2
200-odd 160:21
2010 170:9
2015 170:9 172:19 174:16
2016 170:2
2018 1:6
207 4:18,20
210 4:22
236 160:4
26 1:6
27 154:1,4
28 128:15

3

3 146:7
30 170:7
36 93:2
37 21:4
39 4:5

4

4 145:11
44 185:15,19
44-plus 185:20
45 172:15

5

5 4:3
50 31:16 68:14 72:11,19 83:21 99:19 168:18 197:11 203:19
500 197:11,15
51 68:14 83:16 86:19
59 86:18

6

60 21:5 46:3 48:9 61:8 62:15 68:7,16 70:19 72:15,17,18 75:14 76:3 77:5 80:20 83:19 85:15 86:19 88:12 92:17 93:9 99:21 135:9 163:14
62 21:10
64 93:2
67 68:17

7

700,000 35:14
75 68:17

8

80 195:9 196:11

9

9:00 1:8
9:09 5:2
90 80:22 93:5
9th 1:8

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Coordinating Committee Meeting

Before: NQF

Date: 01-26-18

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.

Court Reporter