COMM PARTNERS

Moderator: n\a
April 18, 2017
11:13 a.m. ET

OPERATOR: This is Conference #: Miranda.

(Off-Mic)

Female: OK.

Male: Yes, we're OK.

(Off-Mic)

Female: OK.

Male: And some of us (getting) behavioral …

Male: Yes.

Male: … and then behavioral course.

Male: Yes.

Male: Yes, yes, right.

Male: I will make sure this going to get you …

(Off-Mic)

Female: Yes, I think some folks definitely will …

(Off-Mic)

Female: (Miranda)?

(Miranda): Hi, (Shawnn).

(Shawnn): Hi. I have your streaming already set and you're recording as well. So you're all good to go to start your meeting whenever you're ready.

(Miranda): All right, thank you very much.

(Shawnn): Thank you and I'll be dropping off the line, but I do see you in the chat if you need something.

(Miranda): OK. Thank you very much.

(Off-Mic)

(Miranda): So, I guess and then I believe we'll …

Male: NQF.

(Miranda): … NQF yet.

(Off-Mic)

(Miranda): So people get started in about for minutes. Has had everyone had a chance to meet one another. I have not met all of you. My name is (Miranda). (Peg) and I will be here for the remainder of the next two days on …

(Off-Mic)

(Miranda): We're really excited about this.

Female: And are we going to go to through …

(Off-Mic)

Female: Yes.

(Off-Mic)

(Miranda): OK. So I know that – as you know within (Inaudible) today with the most updated discussion guide. If you'd like to pull that up, we'll be using that as a resource …

(Off-Mic)

(Miranda): Yes.

(Off-Mic)

Male: So are we going to start with 19?

(Off-Mic)

(Miranda): Yes, we will be starting with 19.

Male: Thank you.

Female: Yes.

(Miranda): She's already there. And we'll go – I believe the discussion …

(Off-Mic)

Female: And I just want to say …

(Off-Mic)

Female: … really you are the expert, so.

(Off-Mic)

Female: We have our guidelines.

Male: Is this the discussion guides?

(Miranda): That is not the discussion guides. The discussion guide is the (inaudible) file that was sent out this morning. I can also resend it to you if you'd like.

(Off-Mic)

(Miranda): It's a 105 pages.

(Off-Mic)

Male: What is the password to the WiFi?

(Miranda): NQF (guest).

(Off-Mic)

Male: No.

Female: Yes, it's a little faddy.

(Off-Mic)

Female: Oh nothing at all.

Male: All right. Is that a normal?

(Miranda): Typically, that is abnormal but it is set that the username and password when you add in the credentials.

Male: (Inaudible) the phone.

(Miranda): Oh you came up – let's try to access the WiFi because that might help?

(Off-Mic)

(Miranda): Yes.

(Off-Mic)

Male: So you sent it this morning?

Female: We can do a little …

(Off-Mic)

Male: Yes, numbers and the discussion (inaudible) (19, 1726).

(Off-Mic)

(Crosstalk)

Male: Rock on, OK, great.

(Miranda): So yes. So, what we did …

(Crosstalk)

(Miranda): … for logistical purposes …

Male: OK. Yes, yes. OK, cool.

(Miranda): Yes.

(Crosstalk)

(Off-Mic)

(Miranda): Oh OK. Well, I will …

Female: He has – you have it …

(Miranda): So hopefully we can …

(Crosstalk)

(Off-Mic)

Female: She's got it.

Female: Oh you're good to go, yes.

Female: So here is …

Male: I would prefer.

(Off-Mic)

Male: I prefer paper.

Female: Yes. I think that would great.

Female: Yes, OK. Yes, we have somebody do that.

Female: Yes.

(Off-Mic)

Female: Is that helpful?

Female: Yes, absolutely.

Female: (Miranda)?

(Miranda): Yes.

Female: I'm going to see if somebody can make her (inaudible)?

(Miranda): Sure …

(Off-Mic)

(Miranda): Sure. I can go (around) and do it.

Female: But, I could do it.

Female: Fine.

Female: OK.

Female: And this is the meeting …

(Off-Mic)

Female: OK. Yes.

Female: So we should get started in a few minutes.

(Miranda): Yes. I think to get everyone acquainted with the discussion guide. We can do a quick overview on that. So (David) brought up a really good point, a new item on here or components are these numbers that are …

(Miranda): … each measure. You should think of that as an assignment system and not an orderly linking system. And that's for our purposes as project staff when we review the transcript and we file …

(Off-Mic)

(Crosstalk)

(Miranda): … statements provided during the meeting. We are going to look for the measures number and measure title.

When you go to the (Inaudible), you can click on the top right hand corner or in your case, you can just click through on the agenda at the bottom, there is a listed measure slated for discussion. And also categorized by domain that is how we're going to reviewing all of the measures. So we're going to start up with care coordination. And measure number 19 follow up after hospitalization from mental illness.

Male: I have a quick question.

(Miranda): Yes.

Male: What's the interest on the overall score? We got all of the …

Male: … on the spreadsheet that was sent out, some of the scores were a little bit different, were they updated?

(Miranda): So they may have been updated as of middle this week, last week. When you hold your discussion guide right now, what is the (boarding) number on the top left hand corner?

(Off-Mic)

Male: OK.

(Miranda): OK, that should be the most updated information but that is something that we can talk about when that measure is up for discussion is …

(Off-Mic)

Female: I don't think anything that was on the change in terms of reaching on …

(Off-Mic)

Female: … were low, if they change anything, right. No measures – except for the measures that were pulled out on members and said let's move this one.

Male: Right.

(Off-Mic)

Male: OK.

(Off-Mic)

Female: Right.

Male: It still had a higher score but …

(Crosstalk)

Female: Right.

Male: But it doesn't really matter.

Female: It doesn't matter. It's there. We didn't – we want (Vicky).

(Off-Mic)

Female: You might have to defend it but.

Male: Yes. So hopefully …

(Off-Mic)

Female: So which one are we starting with?

Male: 19.

(Miranda): We're going to start with 19.

Female: OK, I put that in here.

(Crosstalk)

(Andrea): What I have – what we're going to hand up to everybody and unfortunately, I didn't send out in advance is this article that one of our C.P. committee members (inaudible) shared with us. And it's really about the complexity in a way – yes, and how do you define it. Somebody talked about that. And they had some good tables and one looks that readmission before the Medicaid population which is helpful, non-Medicare says none-elderly. That's good. And it just talks about three types of populations that, you know, that seem to fit that category. And then it's not consistent from year to year all the time.

You know, some people have a major illness and (my thoughts) next year not so high. Some people have consistently have high, and then can deal with (a) cancer it's an end stage type of situation, which has put …

(Off-Mic)

(Andrea): … high again. So, you know, it's just a way to think that and coming up with the definition BCN. Apparently, there's a whole group that (listened) and had trouble with that, is that true, (John)?

(John Shaw): They looked at it, they came up with some generics guidelines. They pretty much at the time were focused on the Medicare population but did put a footnote in that in the Medicaid population, it was critical to incorporate behavioral health and substance into the process.

And in our work in New York in trying to figure out who the BCN population we were targeting was, we did find that actually the mental and substance indicators are hugely predictive of being part of the …

Female: Thank you.

(John Shaw): … the same class.

Male: We've found the same thing.

(John Shaw): Yes.

Male: Yes.

(John Shaw): So, a couple of things I had suggested is – thank you – trying to perhaps – try to – guideline, OK. Yes. In here, page six of the study which was done and released in 2015 looking across and looking at some of the identifying characteristics and then – let's see – I simplified it a little bit.

(Off-Mic)

(John Shaw): Right.

Female: It's complicated.

(John Shaw): It's complicated. Usually, there's some degree of the admission. So they had suggested using (Camden) and some of the other ones, two plus non-OB admissions in the last year, priority of one within the last six months.

Six plus, ED visits in the last year and then in the Medicaid population presence of the alcohol, drug use disorders or severe metal illness. And then that was sort of generic level and then fine tuning that happens typically at a local level gets into pulling things in from the EHR having community – what's really a priority in our community and so on.

But that uniform, it would be nice to have a multistate benchmark capability with the common set of goals just really looking at claims data and looking for the readmissions and ED visits flags.

Female: Thank you. Thank you. Just want to make sure this is on the …

(Off-Mic)

(Miranda): We are live. And just was a reminder already …

(Off-Mic)

(Miranda): So at the end of the domain that we assess, we're going to out for a couple of comments and members of the public will have an opportunity to weigh in.

Female: (Inaudible) of course at the same time.

(Off-Mic)

Female: OK.

(Miranda): We have an ambitious schedule.

Male: Yes.

Female: So shall we dive in?

Female: Let's go.

Male: Let’s do it.

Female: All right. Is …

(Off-Mic)

(Andrea): Well, you're handing it over to me. We're going to get right into the measures, is that correct?

(Miranda): That's right. We're going to get into the measures, yes.

(Andrea): So we're turning with measure 19, which is a follow-up after hospitalization for mental illness and it's a measure that's very commonly in use.

(Miranda): Yes. And, you know, I can provide an overview of the …

Female: Yes.

(Miranda): … that would help.

Female: First, I think she gave us some general guidelines.

Female: Yes, sure.

Female: And then as to how well …

(Off-Mic)

Female: … to the measure.

(Miranda): No problem. So again, some of these slides starting with slide number four are a repeat of what we talked about at …

(Off-Mic)

(Miranda): And I think that there's a lot of discussion about the role of TEP versus the role of the (CCE). And I think it's just important …

(Off-Mic)

(Miranda): … designed is …

(Off-Mic)

(Miranda): … assessed and a measure on its individual merits. And then these coordinating committee will come in, in two months and then look at the program area as a whole in across program areas.

So, you know each measure is going to go through the decision logic that we've created. And we don't want to emphasize the duplicative nature of

some of the measures that we have in this set because we know that there are lot of very similar readmissions measures for example. Take each one through on its individual merits.

And for that (set), I think we want to focus on alignment across program areas specifically federal program areas.

So as we mentioned before, each measure we'll discuss on the core criteria, feasibility, usability and …

(Off-Mic)

(Miranda): … and it was given an overall measures score and all measures and measure concepts were assessed. And we took the mean of all those scores and that was the measure threshold. So on measures that met or exceeded that number were automatically slated for discussion during this meeting. And that is highlighted in the top blue box.

Then all measures that fell below that measure score, we ask you all to review them to identify any measures that you thought were promising. And you wanted to discuss during this meeting. You all had an opportunity to save up to three measures. So we have within those measures and we will discuss them during this time.

To provide you with, you know, (novel) landscape of the BCN measure areas. We looked at about 75 different sources, 17 of which came from the state. We found 69 measures and measure concepts that were related to BCN. And majority almost 15 percent fell under the safety category which his largely readmissions and utilization measures.

The next part of category making up almost a third was care coordination. That was, you know, follow-up measures and the like.

The next was population health intervention followed by patient and caregiver experience. And then by …

(Off-Mic)

(Miranda): … I'm sorry, it went to our clinician, clinical care, population health and prevention.

(Crosstalk)

(Miranda): And then patient and caregiver experience. And we did not identify any access measures for benefit …

(Off-Mic)

(Miranda): So moving on to the next slide, as I mentioned before …

Female: Can I just interrupt for just one minute. So, if you look at the pie chart?

Female: Yes.

Female: So there are a no access measures.

Female: Right, correct.

Female: OK.

(Miranda): That is correct. So, you know, there are six possible domains to evaluate but we will only be evaluating five. As I mentioned before, our mean is at 1.71. So there were 69 core measure assessed, 50 of which were measures and 19 were measure concepts.

We had a lot of variation obviously measures are always developed and so they had a higher overall mean score than the measure concept. Based on our means, 38 measures or measure concepts met or exceeded the threshold score that was 38, but with the (inaudible) measures that you all provided. That measure – I'm sorry that number jumps up to 43 measures on measure concepts.

And this next slide, is just a really high level overview of the measures that we will be assessing today.

Here's another look at that decision logic. And each measure and measure concept will be assessed under this parameters. The only (DDHN) is on step number four is this measure – or measure concepts ready for immediate use? That's where it would (BDA) and it would run under two parallel courses. Would either be including as a measure, included as a measure concept or excluded altogether.

And just a little bit of a, you know, housekeeping. We require four individuals to be present at every vote to achieve quorum. And we need 60 percent agreement on a measure for the measure and measure concept to move forward so that's three votes.

We will be utilizing hand votes. And for each measure, I'll note the measure allowed and record the number of votes that were taken in the room for (inaudible) the transcript.

I do want to reiterate the importance of providing a rationale for every statement that you make or arguments that you make and just seeking (inaudible) that this is just one component of the overall project that the coordinating committees will convene in June and it's really important for us for that purpose to provide a rationale.

Individuals who submitted measures to be retained will serve as lead discussants and again, you know, please provide a rationale during that time.

One other thing, we have mikes throughout the table or all along the tables. Please speak into the when you can. And please identify yourself for the transcript (involved) as possible. So with that, I think we can get started.

Female: Didn’t we have a slide with each measure?

(Miranda): Yes. So we're going to start out with care coordination.

Female: Just so we all know, how many measures that we're going to be looking at did not make the cuts so to speaking and were retain because TEP members thought they should be.

(Miranda): Right. So TEP members retained six measures. One of the measure actually met the threshold score but that individual wanted to discuss it and that they said that that, so there were really five measures and measure concepts that were …

(Off-Mic)

Female: OK.

Female: OK. So your (inaudible) measures we'll be discussing today.

Female: And we don't have each measure – thinking up, if you go to the – your discussion guide, we can see details on that measure.

(Miranda): All the measures specifications and preliminary review are located on this measure guide.

Female: And we – if necessary, we could set up, we have a computer if you want to …

(Off-Mic)

Female: Great, great, OK. Perfect.

(Crosstalk)

Female: So with each measures as we go through it, there will be you know discussed measure …

(Off-Mic)

Female: … decision logic in here. Additional questions to help with the discussion. I just want to point that out.

(Off-Mic)

Female: We're just putting …

(Off-Mic)

Female: And so, the question – the additional questions are to what extent those as measure address critical quality objectives have the same as quality measurement domain? To what extent will this measure address an opportunity for improvement or significant variation in care? And to what extent does this measure, demonstrate efficient use of measurement being closer?

Female: So the additional question, so that's the main question with the ratings below it. Underneath it and if you all to take this form, we just send it out in case – on the second page are the decision logic questions with the initial questions just for discussion.

Female: I see what you're saying.

(Off-Mic)

Female: Yes.

Female: So a if you wanted to get started on the first measure.

(Off-Mic)

Female: (Peg), when was that doc handed?

(Peg): This one here …

(Off-Mic)

Female: Sure.

(Off-Mic)

Female: So (Miranda), are you going to be presenting?

(Miranda): Yes, we do present the measure and I'll address with the vote.

(Off-Mic)

Female: And everybody who is asked to vote in this measure …

(Off-Mic)

Female: … they may have some familiarity with the measure. So what I would do is just, you know, unless people want to have a deep discussion, I would just …

(Andrea): Yes, follow-up measure 19, follow-up that the hospitalization for mental illness.

(Crosstalk)

(Andrea): The overall measures were 2.7, so this received (five rating). And it's the same measure specification as needed …

(Off-Mic)

Female: … measure that is …

(Off-Mic)

(Jim Bosch): So I had just two questions about this. It doesn't really quite follow because I don't know when we can throw those out. I had two concerns regarding this measure. Because they talked about hospitalization, but that does not include PRTF, psychiatric residential treatment facilities. And we have had significant problems with kids who are discharge from a PRTF without adequate discharge planning.

So do – are they including just acute psychiatric hospitalization or they including – and this is (Jim Bosch) for the record or are they also including discharge from acute site and PRTF? That's question number one.

And question number two is they talk about follow up visit with the mental health practitioner. And our entire state is a mental health professional shortage area and so a lot of follow-up has to be performed or forced by primary care physicians, pediatricians, family physicians. So those are my few concerns for frontier state like mine, this will be extremely challenging and would miss a large part of the population.

(Howard Chaps): Oh that's why we have the measure there as well. So if you don't have an adequate behavioral health network and not to pick on my own, pick on Kentucky or – this is (Howard Chaps) by the way, to pick on Iowa and maybe it sends a message as well to whomever that, you know, there is an issue that need to be address.

Male: Yes.

(Howard Chaps): And I know these are said and done but nonetheless …

(Crosstalk)

Male: … recruiting into Wyoming.

(Howard Chaps): Not me but it's – I hear you. And I have (inaudible) that you have. But I think it's a valid measure in the fact that we need to see what's happening in all of our states for me for a care perspective. And if this was a tough measure, I cringe …

(Off-Mic)

(Howard Chaps): … in a perfect world. And it's hard to, you know, some states (inaudible) do very well but I think there's some best practices out there where you have some gaps.

(Andrea): This is (Andrea) speaking. And I believe that it's going to be a tougher measure because NCQA, the bridge visits …

Male: Yes …

(Off-Mic)

(Andrea): … are going away, have gone away for this current year collection. So the individual needs to be seen, I think primary care physician counts. Doesn't it or does that between mental health?

(Off-Mic)

(Howard Chaps): A code …

(Andrea): I think it's a license.

(Crosstalk)

(Howard Chaps): Right. I mean I think it could be a code or …

(Off-Mic)

(Howard Chaps): … in order to …

(Off-Mic)

(Howard Chaps): … top of my head.

(Andrea): And I think it's just refer to inpatient hospitalization. Is that correct?

Female: The denominator is acute inpatient as well acute care and psychiatric …

(Off-Mic)

(Jim Bosch): So that would include a …

(Off-Mic)

Female: If that's what an acute care (inaudible) facility is, yes.

Male: OK.

(Howard Chaps): One of things that doesn't count and maybe I'm not up to date on my measure, but when the patient goes from a inpatient facility or PR test to a residential or receiving services, I don't think in my head captures that. It can be captured away but not in the other kind of claim space.

(Off-Mic)

(Andrea): Wouldn't all those residential facility has to have by definition?

(Howard Chaps): Yes.

(Andrea): A license, no?

(Jim Bosch): Not Wyoming, Medicaid actually does have (RTCs).

(Howard Chaps): Yes.

(Off-Mic)

(Jim Bosch): So it's very rare. Most patient go from acute site to PRTF to home and residential treatment facilities tend to be more just behavioral and less mental health disorders.

(Howard Chaps): And maybe, it's not (inaudible) check but I'm almost positive that …

(Off-Mic)

Female: End of it, does it really as rest clinical – the importance of …

(Off-Mic)

Female: Measures we have today are not …

Male: Yes.

Female: Comparatively speaking, I believe that it does and to exclude it would create a critical gap.

(Jim Bosch): So do we vote on high, medium or low for question one?

Female: Yes, yes.

(Jim Bosch): Are we ready to vote?

(Crosstalk)

(Miranda): … ready to vote, we can see the hand vote. So for all those who vote for high for measure number 19 follow-up after hospitalization for mental illness, please raise your hand. We have two – four votes for high. How about

medium? One vote for medium. So the measure will continue on to the next step.

Female: So thank you. The next measure is follow-up after emergency department visit for …

(Jim Bosch): No, we go to decision logic.

Female: Decision logic two, it's hard to get …

(Crosstalk)

(Off-Mic)

(Miranda): So we're going to have this down tomorrow.

(Crosstalk)

(Miranda): We're going to be experts. This is …

(Crosstalk)

Female: Oh so, OK. I apologize.

(Crosstalk)

(Howard Chaps): We need three votes for …

(Off-Mic)

(Miranda): Correct. And that could be for high and medium.

Male: Right.

(Andrea): So now we're on to what extent will this measure address an opportunity for improvement?

Female: Right.

(Andrea): OK. Did you want me to take the vote or we?

(Crosstalk)

(Miranda): Discussion. All right, we can vote then. For measure number 19, follow-up after hospitalization for mental illness, that number key to what extent will this measure define all the committee on the same med? All those who vote high, please raise your hand. We have four votes for high. Medium, one vote for medium.

(Off-Mic)

(Miranda): The measure will continue and the decision logic.

(Andrea): So continuing on, to what extent does this measure demonstrate efficient use for the measurement resources?

(Off-Mic)

(Miranda): For measure number 19, follow-up after hospitalization for mental illness, to what extent does this measure demonstrate efficient use of measurement resources? All those who vote high? Four, five. The measure will continue.

(Andrea): And to what extent is this measure ready for immediate use? Any discussion?

Male: It's in play by …

(Off-Mic)

Male: Yes.

(Crosstalk)

(Off-Mic)

Male: Some Medicaid states are already using this because we aren't.

Female: Multiple states.

(Off-Mic)

Female: We have a majority of Washington state and Colorado.

Female: OK.

(Jim Bosch): Very good.

Female: Florida.

Female: OK.

(Off-Mic)

Female: Are we ready to vote?

Male: Yes.

(Miranda): All right, for measure number 19, follow-up after hospitalization for mental illness, to what extent is this measure ready for immediate use? All those who vote high, pleas raise your hand. Five votes for high.

(Off-Mic)

Female: This was an easy measure.

Female: I know this was an easy measure.

Female: I wanted to point that out.

Female: We're getting the routine down.

(Off-Mic)

Male: Yes.

(Miranda): Yes. And so, at this point, the measure will continue as a measure. So then we'll address the next question related to stakeholders.

(Off-Mic)

(Andrea): To what extent do you think this measure is important to state Medicaid agency?

(Miranda): All right, are we ready for a vote?

Female: Right.

(Miranda): For measure number 19, follow up after hospitalization for mental illness. All those who vote high? All right, so the measure will be recommended for inclusion on the BCN measure set as a measure.

(Off-Mic)

Female: Onwards.

Female: Did someone count them, do we have (42 measures)?

Female: We have 43

(Jim Bosch): Forty three.

Female: OK.

(Jim Bosch): Now, we're done with 42.

(Andrea): All right, moving on to Measure 17. Follow up after emergency department visit for alcohol and other drugs dependent. The overall measures score is (2.15). This is the percentage of emergency department visit for members 13 years of age and also with a primary diagnosis of alcohol and other drug dependent, who have an outpatient visit and intensive outpatient encounter or a partial hospitalization for (AOD). Is there any general discussion?

(Howard Chaps): I have one point. The one measures I brought in addition to what we've …

(Off-Mic)

(Howard Chaps): … I mean the threshold was (inaudible) after losing (inaudible) at all cause …

(Off-Mic)

(Howard Chaps): … fixing up the verbiage but it's similar and we're going to see this mentioned – this is (Howard Chaps) by the way. And I'm a (inaudible) by trade so I have a strong passion for follow-up after (inaudible) youth which can be much better that way.

(Off-Mic)

(Howard Chaps): The opportunity out there for care coordination. I'm not …

(Off-Mic)

(Howard Chaps): … you know done very well elsewhere, but nonetheless, I think it's a good measure, do we – does the other measure incorporate that as well and it's being duplicative (inaudible) on the other measures as well.

(Off-Mic)

(Howard Chaps): The other measure number is well …

Female: Follow-up after all cause emergency department 14.

(Off-Mic)

(Howard Chaps): Yes.

Female: Fourteen.

(Howard Chaps): Yes.

Female: So, and that one did not meet threshold.

(Howard Chaps): I brought that one in.

Female: Oh OK.

Female: So, as you mentioned earlier, we'll take that information down if you think that these are related in some way or …

(Off-Mic)

Female: But build on that as a measure itself.

(Howard Chaps): Right.

(Off-Mic)

(Howard Chaps): OK. Some of measures out there is to …

(Off-Mic)

(Howard Chaps): … there's a aspect right now to this one and I don't want to go too up course but I'd like to – again, on the E.R. doc, so I think some of the heart failure who gets discharge is only cardiac problem, they need to …

(Off-Mic)

(Howard Chaps): … cardiologist with an x amount of data …

(Off-Mic)

Female: They have (bee sting), do they?

(Off-Mic)

(Howard Chaps): Yes. I always thought that you're not done with the patient until they can be followed by – yes, we can you know bee sting taking a shot, whatever it maybe perhaps not. But that's why the measure as well and the rein that maybe acceptable …

(Off-Mic)

(Howard Chaps): … maybe 72 percent.

(Andrea): And I think your comment is right. And this is (Andrea). I think the comments are absolutely valid. I do think though for the Medicaid population, the substance abuse is identified in the emergency room and it's never acted upon. I think for this population, it's even more, you know …

(Off-Mic)

(Howard Chaps): But where it gets to another one eventually where there's all cause, right.

(Off-Mic)

(Crosstalk)

Female: So, we'll vote on this.

(Howard Chaps): Yes.

Female: And then we get to all cause we'll make a note there

(Howard Chaps): Right.

Female: That this is – I'm taking some notes now.

Female: OK.

Female: This is similar, maybe a broader – that maybe a broader measure. And in the end, do we have broader measures than more targeted measures, I mean that's another discussion.

Female: Yes.

(Howard Chaps): Right.

Female: OK.

(Andrea): Good point. So, for this purposes, we're on number 17 and then we'll go and so there are other measures that maybe better.

Female: And that's really where we want to be, we want to find the best set of measures.

(Jim Bosch): So, that's – because I see 23 again was talking specifically about again alcohol, others didn't know substance use. So we got two very similar within

few of each other. And, you know, in terms of (Howard's) comments, we spent hundreds of thousands of dollars training everyone around the state to do SBIRT and we can't get them to do it. And even though we increased that to the amount, we'd get 70 bucks for doing an SBIRT.

Male: Yes.

(Off-Mic)

(Jim Bosch): And they're still not doing it. So it's a flow problem, that's a little opposition. But it's (to see) how much time and money we spend training people to do SBIRT …

(Off-Mic)

(Jim Bosch): Screening, briefing, intervention and referral to treatment. So this exactly identifies this population and we thought vaguely enough that if you offered enough money for something that's takes five minutes to do. But they won't do five minutes worth of work for 70 bucks, OK? That's what I though.

Male: Yes.

(Jim Bosch): You can only do it in a mandated system.

Female: I think we should go through the same process for each on the measures. And then after if there are measures that we think should be prove and in better – better bucketed for discussion as the next level, yes.

(Miranda): To identify preferred measure.

Female: I think is going to be a big part of the coordinating committee meeting.

Male: OK.

Male: I have a question.

Female: Sure.

Male: Let's talk about (inaudible) for a minute. And this is going to …

(Off-Mic)

Male: … discussion that we have with (Inaudible) that about in between the four group of …

Female: Yes.

Male: (Inaudible) these first two measures that are looking on has relationship with …

(Off-Mic)

Male: … the other one, is that – it's the (inaudible). Which might be a BCN problem or a high (task) problem, but I wonder whether there would be measures that are just exclusively that we should look at them first rather than or – I don't know what the …

(Off-Mic)

Male: … it might be.

(Miranda): Right.

Male: You see what I'm saying. Because it very possible that if we go for the first to majors and they all get the high votes and the – and we might not see enough capital for those that are actually really essential for (inaudible) them.

(Miranda): And I think some other difficulties we run into is the fact that the BCN population is not well defined. So It's hard to characterized like a really great BCN measure because you don't have a definition for BCN, a hard and fast rule for what a BCN measure looks like. But we do understand that among the BCN population a really critical sub-population are those who suffer from substance disorder, or, you know, mental health …

Male: Yes.

(Miranda): … behavioral health problem. So that's why we …

(Off-Mic)

(Miranda): … in this set. But again, and it just – it really is hard and I know that's really abstract and soft and it's not, you know, a great answer but what we have compiled is what we feel are good BCN measure.

(Crosstalk)

(Off-Mic)

(Andrea): As we go through these, I'm going to make note to this, maybe we can talk off-line but maybe it's tomorrow when we come back, the staff can sort of talk about this afterwards. We want to go through each measure on the some, but we'll make note and we'll know that, you know, 14, 17, 23 or whatever somewhat related and you really think that this maybe the best encompassing. It's not the purpose of this because you can do this at BCN, but if you want it really call it down a bit.

You know, we could think about what really just want to bring it back and have an up or down vote on one of this. So I'm just – it's not what we had on the process, but I want – if it keeps coming up then I think we can just again, the team would have to talk about it. I'm just talking offering another thought but we're not there yet. So I just want to offer that if it's – and I have a feeling they come up in other.

I think you have a lot of measures to another similar. I mean it's hard to say. Beyond Medicaid side, it's like Medicare they have a lot of similar measures that look at hospitalization or whatever. But the purpose of today is to really look at the measure on its own and then …

Male: Final outcome. Do you have in mind sort of a threshold for the – or prefer a number of ending up with this process, like the coordination for example.

(Off-Mic)

(Andrea): Yes. We don't have a number, we want to see – and neither does CMS, because we vast in this question multiple times, give us a number. And of

course it depends on the program. So, (LTSS) no so many. But, some of are others more.

And, you know, 43 is probably too many. So that's all I can say. And I don't have any other guidance on that.

Male: Thank you.

Female: But think about some that may not work.

Female: So should we just carry on and …

(Miranda): Absolutely.

Female: OK.

(Miranda): Absolutely.

(Andrea): So the first question, to what extent of this measure address clinical quality – critical quality (adjusted)?

(Miranda): Ready for a vote? OK, so for number 17, follow-up after emergency department visit for alcohol and other drug dependent. All those who vote high for staff number one. Four for high. Medium? One for medium.

The measure continues on a decision logic.

(Andrea): To what extent will this measure address an opportunity for improvement in care?

(Off-Mic)

(Miranda): All right, let's get to a vote. All those who favor high for measure number 17? Four for highs. Medium? One for medium. The measure continues on.

(Off-Mic)

(Andrea): Next question. To what extent is this measure demonstrate efficient use of measurement resources.

(Off-Mic)

(Miranda): OK. We're ready for our votes. All those who vote high for measure number 17? Four for high.

(Off-Mic)

Female: Five.

(Miranda): Five for step number three, efficient use of resources. The measure continues on.

(Andrea): To what extent is this measure ready for immediate use?

Male: And I think there is only one state that might be doing that.

(Off-Mic)

Female: We don't know it certainly, we don't know the others. So …

(Off-Mic)

Male: There's – no.

(Miranda): For the measure number 17, it is reported (to) New York.

(Off-Mic)

Male: Yes.

(Off-Mic)

Male: That's mental illness.

Female: Just being used in one state program.

Female: That we know of.

(Off-Mic)

(Miranda): So with that information, are we ready for our vote?

Female: All right.

(Miranda): All those who favor high for immediate use measure number 17? One for high. Medium. Four for medium. There will be measure will continue as a measure and the decision logic.

Female: (Inaudible) say if it's the medium or low, then we go to what extent do you think this measure is important to …

(Miranda): Well absolutely right. It will continue as a measure concept.

Female: And it continues assuming we think that it's important to state Medicaid agencies, right?

(Miranda): Yes.

Female: And I think we need to take that vote. Yes.

(Miranda): OK.

Female: Yes. And if the measure concept so maybe get to – we start (inaudible) – maybe aren't quite the perfect measure for inclusion, but we got it a number of concept measures that are in a bucket.

(Miranda): So we visit later the measure concepts and we can review it as it is important to stakeholders and then afterwards when we have our final vote for include or exclude we can note is as a sub bucket of essentially, you know, not as a preferred measure, does address your?

Female: No, no, no I was just saying that may get back to your earlier, you know, consternation that we have this all this similar measures and they maybe use in one state and maybe we're going to get the measure concepts is very important. And then we determine prioritize of those measures which is most, which is preferred which is most important.

(Jim Bosch): Right, so we vote high or medium on this next question just to measure concept.

Female: Measure concept, yes.

(Jim Bosch): So we take all these substance abuse, ER follow-ups and put them into the measure concept …

Female: Right.

(Jim Bosch): … together.

(Crosstalk)

Female: Unless one of them …

(Jim Bosch): Stands out.

Female: … stands out and – yes.

(Miranda): OK, so we're going to continue on with the position model.

Female: Yes.

(Miranda): And then of all the measures concepts for this domain.

Female: Yes.

(Miranda): We'll look at it again, and then identify standouts.

(Jim Bosch): Why don't we just take …

Female: Let's just take …

(Jim Bosch): No …

Female: … a process and …

(Jim Bosch): I think I'll vote now.

Female: … and I think – yes. Just take the vote.

Male: We're just over here.

Female: Continue through the process.

(Jim Bosch): And we need this vote to go there or there.

Female: I just think that the decision logic and the voting may actually shake something, you know, and make it clearer for the stand.

Female: So you voted on which one?

(Miranda): Step number four ready for (a meeting). So it's now measure concept.

Female: No, it's not yet, until we go to what extent do you think this measure is important to Medicaid …

(Miranda): OK.

Female: … agencies and other key stakeholders. So we need to take that for.

(Off-Mic)

(Miranda): Right, but it …

(Crosstalk)

Male: It's on a pathway.

Female: Yes. It's on a pathway.

(Miranda): Yes. It's on a pathway.

Female: Yes.

Female: So should we ask how many high?

Female: Absolutely.

Female: How many high? Who would vote for high?

Female: For the stakeholder …

(Off-Mic)

Female: This is primarily the stakeholder, the state Medicaid agency.

Male: State Medicaid and other key stakeholders.

(Andrea): State Medicaid agencies and other key stakeholders, consumers, family, Medicaid managed care organizations and provider. To what extent do we think the measure is important to all those stakeholders.

Male: Yes.

(Miranda): All right, so all those who vote high? Three. Medium? Two.

Female: So high and medium …

(Off-Mic)

Male: Right, OK.

Female: Yes.

(Crosstalk)

Female: Thank you.

(Off-Mic)

Male: Getting better.

Female: Next one.

(Andrea): OK. Next is measure 26. Reconciled medication list received by discharge patient. Discharge from an inpatient facility to home, self care or any other

site of care. The overall measure score in this measure was a little bit lower 1.8.

The description is percentage of discharges from an inpatient facility to home and any other site of care in which the patient, regardless of age or their caregiver. Receive the reconciled medication list at the time of discharge including at a minimum medications in specified category.

And there are number of I think that there are number of medications reconciliation type measures that we're going to be going through.

(Jim Bosch): So my only comments with this – (Jim) again. My only comments regarding this one because I think this is extremely important but extremely difficult to measure and implement.

(David Moskowitz): Yes. I also – I'm also concerned – going back to your comment about gaming …

(Jim Bosch): Yes.

(David Moskowitz): … I'm concerned about the gaming ability of this measure.

Male: They can game the system and doesn't help at all.

(David Moskowitz): Yes.

Male: Checking up the box but you're not seeing any …

(Off-Mic)

(David Moskowitz): Yes.

(Jim Bosch): And exactly, and it's – and until we can really electronically capture this is a lot easier and unless you got a really functional (HIE) in this state. It's sad, because this is so important.

(David Moskowitz): Yes.

(Jim Bosch): In terms of care coordination.

(David Moskowitz): I mean again – so this is (Dave Moskowitz) …

(Off-Mic)

(David Moskowitz): … talking with a frog in my throat. There's other measures that get at – that get at this concept a lot the …

(Jim Bosch): Yes, some of the later ones I think are better.

Male: Yes and they're using a Medicaid Star that …

(Off-Mic)

Male: The provider has to – you can get to see a claim …

(Off-Mic)

Male: … has it in their medical record and signs off on it …

(Off-Mic)

Male: But it's done, it still be gamed a little bit. But nonetheless …

(Off-Mic)

(Miranda): So, we're ready to vote. OK, so the first step so this measure address CMS domains and key concepts measure number 26, all of those who vote high, please raise your hand. Zero for high. Medium, five for medium. So the measure will continue on.

To what extent will this measure address an opportunity for improvement and or significant variation in care evidenced by a quality …

(Off-Mic)

(Miranda): Would anyone likes to provide a rationale before we vote. Any statements?

All right, we'll take it through a vote. Measure number 26. Step number two, opportunities for improvements, all those who vote high, please raise your hand. Medium, three for medium. Low?

Female: Because of the gaming concern.

(Miranda): All right.

(Jim Bosch): I would have (inaudible) got it to the next level.

(David Moskowitz): Yes.

(Off-Mic)

(Miranda): So continue on to the next step?

(Off-Mic)

Female: Wait, wait, wait. Yes, I have three.

Male: Yes, three.

(Off-Mic)

(Miranda): Three in agreement for medium.

Male: OK.

(Miranda): So to what extent this measure demonstrate efficient use of measurement resources? Any discussion? OK. For step number three, measure number 26, all those who vote high, please raise your hand. Medium? Low? Five for low.

Measure number 26. So the measure does not move forward.

(Off-Mic)

Female: At 23, measure 23.

(Andrea): OK, measure 23 is the initiation and engagement of alcohol and other drug dependent treatment. And were all measure score 2.7, the description is a percent of adolescent and adult patients with the new episode of alcohol or other drug dependents who received the following, initiation of (AOT) treatment. Does everyone know this measure? Yes. OK.

(Off-Mic)

Male: I think this was the HEDIS measure, right?

(Off-Mic)

(Andrea): Who uses this measure?

Female: Let's see.

(Off-Mic)

Male: There you go.

Female: Yes.

Female: So report in New York and Vermont.

(Off-Mic)

Male: It's part of MIPS.

Female: Part of MIPS. That's right.

Male: It's a HEDIS measure too.

(Off-Mic)

Female: Tough measure.

(Off-Mic)

(David Moskowitz): Can I say a comment about the – I'm trying to think where here's some of these measures can be applied differently to a population who are complex care eligible and high cost, high need. And something we know about this situation is in order to get to that strata, they have an accumulation of sort of hits to health. Something that strikes me about this measure, the denominator a new episode of alcohol or other drug dependency.

I think it would be unlikely that a patient falls into the strata would have a new episode.

Female: This is my first time.

(David Moskowitz): Yes. I don't know how that sort of relates to this different, the different decision logic, but I don't know.

Female: It's important understanding of the measure.

(David Moskowitz): Yes.

Female: Yes.

(Off-Mic)

Male: (David), in the light of – if you want a predictive analysis or predictive model …

(Off-Mic)

Male: What I'm thinking is I'm thinking …

(Off-Mic)

(David Moskowitz): Yes.

Male: Let's say that I'm trying to prevent this program to come across.

(David Moskowitz): Yes.

Male: So, I'm trying to identify this population before it's becoming a super user group.

Male: Yes.

(Off-Mic)

Male: But I think if you think from that perspective, I'm developing this information at this level …

(David Moskowitz): Yes.

Male: … for example. Where I'm trying to identify who is going to become a …

(Off-Mic)

(David Moskowitz): Yes.

Male: … in the next two years …

(Off-Mic)

(David Moskowitz): Yes.

Male: But I think if we bring that one, maybe they will change a little bit.

(David Moskowitz): No, I agree with you. I just don't know whether that sort of this scope of what we're trying to decide in this group whether it's sort of for population that have already been identified as that strata or whether it's looking at population management strategies for the clinical rising risk patients. So, no, I agree with you.

Male: So, maybe make the foot note that this might be more the substance use because to me, you know, the initial things is these are potential BCNs.

(David Moskowitz): Yes.

Male: Good measure but maybe wrong group.

(David Moskowitz): Yes.

(Miranda): Do we have the numerator?

Female: Yes. Initiation of alcohol and drug dependent treatment. Initiation of alcohol and drug treatments for an inpatient (inaudible) outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days as the index episode start day.

Engagement of alcohol and drug treatment. I think this is the same and two or more inpatient admission, outpatient visit so they're now saying two or more with the intensive outpatient encounters or partial hospitalization (with any) alcohol and drug diagnosis within 30 days after the date of the initial encounter.

But clearly – so there are several aspects to it. And initiation of the treatment …

(Off-Mic)

Female: … inpatient, outpatient in terms of outpatient partial hospitalization …

(Off-Mic)

Female: … as well as engagement of (inaudible) initiation of the treatment and two or more inpatient admissions, outpatient visit, outpatient times or (inaudible) diagnosis within 30 days after the date of initial encounter. Fairly complicated …

(Off-Mic)

Female: The denominator is all patients 13 years of age and older who are diagnosed with a new episode alcohol or other drug dependency during the first 10.5 months of the measurement here. We know there's a reason we do that, but I'm not sure …

(Off-Mic)

(Howard Chaps): We need some meeting time. Right, we have to measure within 14 days and 30 days. That's what's done all year …

(Off-Mic)

(Howard Chaps): It's …

(Off-Mic)

(Howard Chaps): Thinking about this from – I can't help but think about it from a payer perspective, it says a new episode. So, if I'm working for higher A and then somebody …

(Off-Mic)

(Howard Chaps): … payer B. It's going to be a new episode but is …

(Off-Mic)

(Howard Chaps): … state agencies, it also incorporates how managed care organizations would pay for it. So, there's a little bit of some – I guess there are some question about the reliability of the data …

(Off-Mic)

Male: We can do some Medicaid …

(Off-Mic)

(Howard Chaps): It is but it, you know, does it have effect on key stakeholders, consumers, families, Medicaid managed care organizations and providers still.

(Off-Mic)

(Howard Chaps): … stakeholders, I'm programmed to think that way, so I got to …

(Off-Mic)

(Miranda): … for the first step. Does it address CMS domains and key concepts measure number 23. All those who vote high? Three, four for high. Medium? One for medium. The measure will continue on.

Female: To what extent will this measure address an opportunity for improvement and or significant variation here at five quality …

(Off-Mic)

(Miranda): All right, ready for a vote. Number – measure number 23 high. Is that number two, one for high? Medium? Three for medium. Low? One for low. The measure will continue on to efficient use of resources.

To demonstrate an efficient use of resources and or contribute to alignment. So to vote high, please raise your hands. Medium? Three, four for medium. Low? One for low.

Continuing on for is it measure ready for immediate use? Those who vote high please raise your hand. One for high …

(Off-Mic)

Male: The medium, low going through …

(Crosstalk)

(Jim Bosch): Yes, this is a …

(Off-Mic)

(Jim Bosch): … concept.

(Howard Chaps): Concept versus measure.

(Crosstalk)

(Off-Mic)

(Miranda): Right. Yes.

(Jim Bosch): We're not putting on the measure but the measure concept. Right.

(Howard Chaps): So we're at the breaking point?

Female: So, if we …

(David Moskowitz): To immediate users, this is a no.

Female: This is the vote for …

(David Moskowitz): Yes.

(Off-Mic)

Female: Measure versus measure concept.

(Crosstalk)

(Jim Bosch): No, we passed that.

(Howard Chaps): No we're the (inaudible) – we're number four right now.

(Jim Bosch): Now, we're number for now. That's right.

Female: Isn't needed, it's number four.

(Miranda): So, we just passed efficient …

(Jim Bosch): Yes.

Female: … use of resources?

Male: Yes.

(Miranda): And then we're moving on to immediate use and we're about to take that vote.

Female: Yes. Correct.

Male: Yes.

(Crosstalk)

Female: So, I have – so I have it four for medium.

(Crosstalk)

(David Moskowitz): One back.

Male: One back.

Female: One back, yes.

Female: To what extent is this measure ready for immediate use?

Male: This is number three.

(Off-Mic)

(Jim Bosch): Three got a medium.

Female: And that's …

(Off-Mic)

(Miranda): Four for medium, one for low.

Female: Yes.

(Miranda): So, we continue on – is this measure or a measure concept ready for immediate use.

Female: Right.

(Miranda): So those who vote high, please raise your hand.

(Off-Mic)

Male: Yes.

(Jim Bosch): So it seems to be already in use.

Male: Yes.

(Jim Bosch): So it has to be high?

Male: Yes.

Male: Does it have to be high?

(Jim Bosch): No, doesn't have.

Female: No.

(Miranda): It does not have to be high.

(Off-Mic)

(Miranda): Right those who vote high? Zero votes for high. Medium? Four for medium. Low?

(Jim Bosch): I voted for high.

(Off-Mic)

(Miranda): OK, so five for – one for high, four for medium. Got it.

Female: So, can I ask a question now?

(Miranda): Sure.

Female: Because it is in use, but can we get a rationale from this group about why you wouldn't have voted as high?

(Jim Bosch): I'd like to hear that.

Female: It's in use in New York and Vermont.

(Jim Bosch): And it's in MIPS.

Female: Well.

(Howard Chaps): I'm not trying to be too negative but who's to say that they're the authority.

Female: Yes.

(Howard Chaps): I mean I respect their decisions. Does that mean the rest of the country is ready for it?

Female: Agree.

Female: So you don't think it could have broad application too?

Female: Agree.

Female: OK.

Male: That's why I gave it medium earlier.

Male: Yes.

Female: OK. Pretty nice.

(Miranda): OK – all right. So, it continues on as a concept. And if we're ready for that vote, for our importance to stakeholders. All those who vote high, please raise your hand? No votes for high. Medium? Four, five for medium. So the measure concept is included in …

(Off-Mic)

Female: Great.

(Andrea): So we're on to measure nine. Three item care transition measure. (Inaudible) the overall measure score is 2.1. The CTM-3 is the half through level measure of performance that reports the average patient reported. So it's patient reported, quality of preparation for self care response among adult patients discharged from general acute care hospitals within the past 30 days. And the measure specification, is there a little bit more description there.

Female: No, that's the description numerator is the numerator is the hospital level, some of the (PTM DAST 3) scores were eligible samples. Patient's denominator includes the number of possible samples. Adult patient discharge for the general future hospital.

Female: Is anybody really familiar with CTM-3?

Male: I'm not. No.

(Off-Mic)

(Andrea): I mean, is that two questions, is it five questions, is it 80 questions.

Male: Three.

Male: I think those are three questions.

(Andrea): OK.

Male: It was added the hospital CAHPS a couple of years ago, to try to address some measure overall care coordination of hospital level.

Male: I think I found it.

Female: It is an NQF endorsed measure.

Male: As invalid data?

(Off-Mic)

Male: OK.

(Howard Chaps): I have the questions here. I found that I believe the hospital staff took my preferences and those of my (inaudible) account in deciding what my healthcare needs would be when I left the hospital. That was question one.

And the question two, when I left the hospital, I had a good understanding of the things I was responsible for in managing my health. And when I left the hospital, I clearly understand the purpose for taking each of my medications

and there's a strongly disagreed to agree to don't know range, answering the question.

(Off-Mic)

(Jim Bosch): So, it this self-reported?

(Howard Chaps): Yes.

(Jim Bosch): By the hospitals.

(Howard Chaps): Like my guess is there's an independent surveyor that, you know, administers the – they probably get a phone call afterwards, or something in the mail they return to the surveyor.

Male: And I think it's reported on Medicare compare.

(Off-Mic)

Male: It's being public reported.

(Andrea): So, this might be a very stupid question but you get credit then for administering or that they had to understand. They had to say they understood, is it just the administration of that?

(Howard Chaps): Disagreeing, it's strongly disagreeing or strongly agree or don't know. They take my preferences and deciding what my healthcare needs would be, good understanding of what I'm responsible for managing my health and because I clearly understand the preference for taking my medication.

Female: But the again, is it another check the box, I did the CTM-3 and maybe they didn't understand anything but …

(Howard Chaps): The survey instrument that …

Female: OK.

(Off-Mic)

Male: That's only one score?

(David Moskowitz): To the extent, that BCN patients have extreme and social instability like we'd have housing, less likely to have a phone number that's accurate …

(Howard Chaps): Yes.

(David Moskowitz): … really, you know, impacts the applicability of this measure to this target population.

(Off-Mic)

Female: So I'm sorry I thought it was done at the time of discharge, obviously not.

Male: I'm get – I don't know for sure, but I would suspect it's kind of like the CAHPS survey, right?

Male: It's part of CAHPS now.

Male: Yes.

Female: It is part of …

Male: It's the same survey.

Male: Oh, OK.

Female: Yes, then it would be …

(Off-Mic)

Male: Care setting these hospitals …

Female: Or the care setting.

(Crosstalk)

Female: They do it, if they did it as part of the CAHPS survey. Is it meeting – it, yes.

Male: All right.

Female: Just taking …

(Off-Mic)

Female: This is a (PRPM) probably not a lot of those, which is patient reported performance measure.

(Off-Mic)

Female: It's a different kinds of measure.

Male: Yes.

(Off-Mic)

(Andrea): And, I mean, I'm sorry if I'm being persistently stubborn here, but if it is being done before the member or the patient leaves the hospital. And if they're not checking the boxes that they understood – I can see the value of that, post op. I mean, post, you know, during the CAHPS survey time, I'm not sure if they even remember.

(Off-Mic)

(Andrea): Yes.

(Jim Bosch): So according – to answer your question, it says numerator is the hospital levels on the CTM-3 scores for all eligible.

(Off-Mic)

Female: So, it is the actual sum of the scores.

(Crosstalk)

(Off-Mic)

(Andrea): OK, so it's just not a process measure.

(Jim Bosch): And the denominator is the number of eligible sample, adult patients discharged in general acute care hospital.

(Andrea): So, that my mind makes it more meaningful.

(Jim Bosch): All right.

Female: Yes.

(Off-Mic)

(Miranda): Are we ready for a vote? For measure number nine, does this measure address the CMS domains or key concepts. All those vote high, please raise your hand. Medium? Five for medium.

Male: No.

(Miranda): No, four for medium. All right, next low, so that's what …

(Crosstalk)

(Miranda): So, that's what – yes, four for medium, one for low, the measure will continue on to the next step.

Does this measure I guess an opportunity for improvement? All those who vote high? Zero for high. Medium? Four medium, low? One for low.

The measure will move on to different use of resources. All of those who vote high? One for high – two, two for high. Medium? One for medium, and low? Two for low, so the measure will continue on to the next step.

Is this measure ready for immediate use? High, one for high – two for high. Medium? One, for medium. And low? Two for low. So the measure will continue – I'm sorry measure concepts will continue to the next question, is this important to stakeholders?

So if you vote high, please raise your hand. Zero votes to high. Medium? Four for medium. And low? One for low. So measure number nine, three

item care transition measure will be recommended for improvement in the core set as a measure concept.

(Andrea): Moving onto measures 30, transition record is specified elements received by discharge patients, emergency department discharges to ambulatory care, home or self-care or home healthcare. Overall measure score is 1.8. The description is the percent of discharge from an emergency department to ambulatory care, home health care emergency patient regardless of age or their caregiver receives a transition record at the time of E.D. discharge, including at a minimum all of the specified elements.

Male: So this used to be a measure that …

(Off-Mic)

Male: Yes.

Female: There's a question right now I think …

Female: It's a low bar. Isn't it?

Male: Yes.

(Off-Mic)

Female: It's going to the public and comment period. It's still endorsed.

Female: Yes.

(Off-Mic)

Female: It was not recommended for endorsement.

Female: This is on your field.

Male: Yes.

(Off-Mic)

Female: Yes. It's not recommended but still is not finalized, not being to …

(Off-Mic)

Female: Yes.

(Off-Mic)

(Andrea): Any other discussion or question about the measure?

(Miranda): OK, we can take your vote. Measure numbers 30, transition method to specified elements proceed by discharge patient. Does this measure address CMS domains and key concepts. All those who vote high, please your raise your hand. No vote for high? Medium, two for medium. And low?

Male: Low. Three for low, all right. So the measure (passes).

(Off-Mic)

Male: They were printing of rims and rims of paper every time …

(Off-Mic)

Male: … then somebody realized it wasn't, I guess, fully (phased) yet and they stopped.

(Off-Mic)

Male: So I remember …

(Off-Mic)

Male: … for an outpatient core measure and then they got (inaudible), anyway.

(Andrea): Measure 28, timely transmission of transition record discharges from an inpatient facility to home or any other site of care. So this is – now, now they did it but they transmitted it in a timely fashion to the receiving site of care. Percent of discharges from an inpatient facility, to home or any other site of care patient regardless of age for which the transition record was transmitted

to the facility or PCP or other health care professional designated for follow-up care within 24 hours of discharge. Is there a discussion? Is this NQF endorsed?

Female: It is endorsed. It went to the endorsement process and it's not finalized but it may not continue the endorsement.

Female: The committee did not recommend …

(Off-Mic)

Female: They did not recommend …

(Off-Mic)

Female: … endorsement, similar to the other measure.

Female: Yes.

(Howard Chaps): Yes, I mean, in theory, this is a great measure. However, there's gaming the system and whether or not person who is receiving the records using it as well.

(David Moskowitz): Yes. I mean that being said, I mean, just to have that connection, have it within 24 hours and have clinically meaningful elements that are specified in the – I mean, it's – I mean, are – this is an incentivized measure in California's Medicaid program. And it's really driving change in some big ways at a bunch of different institutions trying to really get their act together on attributed patient and gain that information transmitted but I – yes, know that it is subject to that for sure about …

Female: What is in a transition record?

(David Moskowitz): Completed discharge summary.

Female: Well, but I mean just an (ADP) count?

(David Moskowitz): No, it's like …

Female: OK. So it is essentially …

(Crosstalk)

Female: Yes.

Male: Meds, you know …

(Off-Mic)

(Crosstalk)

(David Moskowitz): Yes. I mean, it's clinically meaningful like crunching information that the PCP can look at the news.

Female: And I think it's important for accountability?

(David Moskowitz): Yes.

(Jim Bosch): So, yes, I think this is an important concept but my question is – in California state driving change but it's just changing the paper work or isn't really driving the quality information?

(David Moskowitz): No. I mean speaking from hospital, someone is really driving quality improvement. I mean we had, you know, without getting into too much, that's separate inpatient and outpatient in EHR that don't to each other. We haven't really had a sort of monetary instituted driver to really understand the patients that are attributed, that are attributed to us from a primary care standpoint, who are getting hospitalized in our inpatient facilities and to have that information transmitted. And this is really, you know, rating of higher to get those things set up.

(Jim Bosch): If this is a gap I see all the time in transitions between hospitals and SNFs or even the fact, even the primary care.

(David Moskowitz): Yes.

(Jim Bosch): You're not seeing those records following so.

(David Moskowitz): Yes.

(Howard Chaps): Is there a data out there that show that when this is done and done well, there's a decrease in medical …

(David Moskowitz): That's a great question, I don't know.

Female: So that was a …

(Crosstalk)

Female: We didn't have up to date evidence for the developer. That was the reason for the measure …

(Off-Mic)

Male: It's intuitive …

(David Moskowitz): Yes.

(Jim Bosch): Without, you know, this document, you're in the dark.

(David Moskowitz): Yes.

Female: I think for (inaudible), if you transmitted – if you document, you transmitted with 24 hours and the receiving entity if there's something on there, there was red flag and they didn't act on it and I mean, that …

(Howard Chaps): I think it just (bad) medicine in general. It's only the (inaudible) hospital and then they're discharge and they go somewhere, I mean, there's got to be a handoff and there's got to be …

(David Moskowitz): Yes.

Male: Absolutely.

(David Moskowitz): I mean, I don't speak the language of meaningful use fluently but there is that COC summary, which is – from what I understand, not clinically meaningful. And that's another way that this concept has been sort of

quantified and capsulated in a different way but the PCP will look at those COC document. And be like, what the heck is this, I can't really – I can't really do anything with that.

(Andrea): Yes. We're ready for a vote?

Female: I think so.

(Miranda): Measure number 28, timely transmission of transition record. The vote – first vote, is this, does it measure address CMS domains or key concept, for high, please raise your hand. Four. Medium? One. The measure will continue on.

Does this measure addressing the opportunity for improvement? Those who vote high, please raise your hand? There were four for high. Medium? One for medium. The measure will continue on.

(Off-Mic)

(Miranda): … efficient use of resources, those who vote high?

Female: Got to go with medium.

(David Moskowitz): Yes.

(Miranda): Two for medium?

(Off-Mic)

(Miranda): OK. So two for medium, two …

Male: No, one high.

Female: It was one high, there was one high.

(Miranda): One high.

(Jim Bosch): No, there's two high.

(Miranda): Two high. So two high, two medium.

Male: I don't think you will be one of …

(Off-Mic)

(Miranda): Efficient use of resources those who vote high, two for high. Medium?

Female: I'm sorry, medium.

(Miranda): OK, three for medium. So the measure will continue on. Is this measure or measure concept ready for immediate use. For those who vote high, please raise your hand. So three for high. Medium? Two for medium. The measure will continue on as a measure.

Does this measure – is it important to stakeholders? High? Five.

So measure number 28, will be recommended for inclusion as a measure.

(Off-Mic)

Female: All right, measure number 14 follow-up after all cause.

(Off-Mic)

Female: Overall measure score was 0.9. The description (inaudible) in patients with emergency room visit who had timely follow up and (Howard) you're going to discuss.

(Howard Chaps): This is mine, and I mentioned it before and I don't want to rehash everything we said. I think there is a lot of opportunity for improvement. And I don't think it's done very well. And …

(Off-Mic)

(Howard Chaps): But I just see a lot of …

(Off-Mic)

(Howard Chaps): … over the years.

(Off-Mic)

(Howard Chaps): Better at that. Even in total, I've seen a ton of medical records and these records are just – the instruction for discharge are poor and the follow-up after going …

(Off-Mic)

(Howard Chaps): Follow up with your cardiologist. And there's not – your cardiologist is Dr. (Smith), your behavioral health specialist, Dr. (Smith), call tomorrow for appointment here is your number.

(Off-Mic)

(Howard Chaps): And I think there's got to be improvement or you're going to see continuous use of emergency department for needs that are probably not necessary. And I think it would help (inaudible) and improve transitions and quality of care. That's why I brought …

(Off-Mic)

Female: And the measure specifications are anybody. Anybody seeing the emergency room followed up within 7 and 30 days.

Female: Yes. The numerator is all outpatient visits, intensive outpatient (inaudible) partial hospitalization.

Female: I mean – that's intensive, so it's the level, it's not to be things for any …

(Crosstalk)

Female: For any condition …

(Howard Chaps): Or any outpatient visit.

Female: But it's an intensive visit?

(Howard Chaps): Outpatient visit, intensive outpatient can or a partial hospitalization for any condition in (inaudible) 30 days after E.D. discharge.

Female: OK.

(Howard Chaps): I assuming if any claims that (inaudible). They could go to the ER for a bee sting and then seeing other doc because they sprained their ankle.

(Jim Bosch): So I'd looked at our super utilizer program. But I'm seeing some people go into the emergency room Monday, Tuesday, Wednesday, Thursday, Friday, they take weekend off some times. Like I saw one at Christmas off but, you know, you're seeing those records again how are they trying to get out of the E.R. and into the primary care you're saying.

So I tend to agree with (Howard), this is a very important concept. I don't know if this is exactly the right measure. But I'm certain that the concept wants to go forward.

(Howard Chaps): It's not being done anywhere is it?

(Off-Mic)

Male: It doesn't mean anything. But it's a gap. I don't want to beat the dead horse being from Kentucky. But it's a gap in my opinion.

Female: We had trouble getting …

(Howard Chaps): Yes.

(Off-Mic)

(Howard Chaps): So how did we get this one? Where did it come from?

Male: NCQA.

Female: NCQA

(Howard Chaps): It is NCQA. Oh yes, yes, it's NCQA.

(Off-Mic)

Male: … environment.

Female: Is this one that they are new measures in 2018.

(Howard Chaps): Measure concept.

Female: It's not really …

(Off-Mic)

Female: Ready to take a vote?

Female: Hang on, do a time check, we got a lot of measures to take that.

Male: Yes.

Female: Yes.

(Howard Chaps): How many have done so far?

Female: Eight.

(Crosstalk)

(Miranda): We're about half way through this domain?

Female: This is a big domain.

Male: Yes.

(Miranda): It’s a lot of domain.

(Off-Mic)

(Miranda): All right. So the measure number 14, follow-up after all cause emergency department visit. So the first vote to this measure address CMS domains and key concept. Those who vote high, please raise your hand. Three for high. Medium? One for – two for medium, OK. So the measure will move on.

For the second vote, so (inaudible) opportunities for improvement, those who vote high please raise your hand. Two, for high. Medium? Two for medium. And low, one for low. So measure will move on.

Efficient use of resources. Those who vote high, one for high. Medium, three for medium. And low, one for low. The measure will move on.

Is these measure a measure concept ready for immediate use? Those who vote high, no vote for high. Medium? Two for medium …

(Off-Mic)

(Miranda): Two for medium. And then low? Three for low.

Male: Yes, you're right.

(Miranda): It moved on and moved on as a concept.

Male: Yes, yes, yes.

(Miranda): Yes. Is this measure concept important to stakeholders? Those who vote high please your hand, three high. Medium? One medium.

Male: I don't know how many stakeholders.

(Off-Mic)

Male: You can tell us.

Male: Your stakeholder already are your consumers, families, Medicaid managed care members, state Medicaid …

Female: Yes.

Female: Health plans.

Male: I would say Medicaid certainly interested.

Female: Yes.

Female: This is how we …

(Off-Mic)

Male: Go with medium.

(Miranda): So medium, OK, so two for medium, three for high, so this will be – this measure concept will be recommended for inclusion in the BCN.

(Off-Mic)

Female: All righty.

(Miranda): So would you all like to go through one measure before lunch or would like to break a little bit early for lunch, it's up to you?

(Andrea): Maybe we do one more.

(Off-Mic)

(Miranda): OK. Measure number 24, follow-up after hospitalization for schizophrenia.

(Andrea): Percent of discharges for individuals 18 to 64, hospitalized for a treatment of schizophrenia and who had an outpatient visit and intensive outpatient encounter or partial hospitalization with mental health practitioner. (Inaudible) the percent of individual who receive follow-up within 30 days and 7 days.

Female: I think it's NQF endorsed.

(Off-Mic)

(Howard Chaps): In my opinion, it's just a subset of the – of a well established …

(David Moskowitz): Yes. I'm concerned about the single diagnosis …

Male: Yes.

(David Moskowitz): … issue also with particularly high cost patients. There's a subset of folks who have schizophrenia and multiple chronic, physical health condition. They could be admitted for, you know, for increase renal disease because their audio who's nations were telling them to not go to their dialysis appointment. That's not a hospitalization for schizophrenia wouldn't get included in this.

(Howard Chaps): Exactly. (Inaudible) schizophrenia part of primary diagnosis.

(Jim Bosch): I would – I think I actually – the majority of our BCN population get admitted or admitted for the medical complications …

(David Moskowitz): Yes, yes.

Female: I don't think we have any measure – good measurement for serious mental illness. And could that be …

(Off-Mic)

Female: … would like to see this go home. I think it's good enough for that.

(Off-Mic)

Male: This is schizophrenia primary diagnoses, right?

Male: Yes.

Female: Does that specify that?

(Off-Mic)

schizophrenia … principle of schizophrenia diagnosis.

(Off-Mic)

schizophrenia Yes, denominator.

Female: Denominator is …

(Howard Chaps): Oh, there it is. Yeah.

(Off-Mic)

(Jim Bosch): It's a principle, yeah, so it's got to be the principal diagnosis and the comorbidity.

(David Moskowitz): Yes.

(Howard Chaps): So you think they got admitted for dialysis.

(David Moskowitz): Yes.

(Howard Chaps): … and renal failure would be number one.

(David Moskowitz): Yes.

(Howard Chaps): Number two would be …

(David Moskowitz): Yes.

(Howard Chaps): … three and four.

(David Moskowitz): And this one, we know about was the 25 year mortality different between those that, you know, SPMI, it's not the schizophrenia that's…

(Jim Bosch): Exactly. So, good concept but I'm not sure to measure …

(Off-Mic)

Female: Where is this being used?

(David Moskowitz): Yes, good question.

(Off-Mic)

(Jim Bosch): No indication of using …

Female: OK.

(Jim Bosch): … in the field or any programs.

Female: OK, all right.

Female: Sounds like a good measure concept.

Male: That's a measure level for …

(Off-Mic)

Female: It is a measure and it is an NQF endorsed. So it has scientific acceptability, evidence …

(Jim Bosch): The question is, is it too narrow a measure can …

Female: So more accessible were all cause and …

(Off-Mic)

(Jim Bosch): Exactly.

(David Moskowitz): And like a broader attachment of SPMI that I could see.

Female: Yes.

Male: Yes.

(Jim Bosch): Using the variability between each physician on, do they call this schizophrenia or …

Female: Yes, how do they code …

(Crosstalk)

(David Moskowitz): … with psychotic features.

(Jim Bosch): Yes.

(Howard Chaps): Psychosis, right.

(Jim Bosch): I mean everyone got at least five mental health diagnoses. You know, who was looking at.

Female: Ready to vote?

(Jim Bosch): Yes.

(David Moskowitz): Yes.

(Miranda): All right, measure number 20, follow-up after hospitalization for schizophrenia. Step number one, does it measure, a measure concept address CMS domains or two concepts? Those who vote high, please raise your hands. No votes for high. Medium? Five for medium.

Measure concept will move on to (inaudible) does this measure demonstrate an opportunity or I'm sorry address an opportunity for improvement. So, those who vote high, please raise your hands? Medium, four for medium. Low? One for low.

So, this measure demonstrate inefficient use of resources, those who vote high, please raise your hands. (Three) for high? Medium, one for medium. And low, one for low. So this will move on as a measure in the decision logic.

Is this measure important to stakeholders? High …

(Crosstalk)

Male: You skipped four again …

(Miranda): You're right, you're right, I'm so sorry.

(Off-Mic)

(Miranda): … immediate use?

Female: Nobody is using.

(Miranda): Nobody.

Male: Thanks.

(Miranda): Those who vote high for immediate use? No for votes for high. Medium, three for medium. So four for medium. And low, one for low.

(Off-Mic)

(Miranda): So, we'll proceed at the measure concept. Next step, importance to stakeholders. Those who vote for high, please raise your hands. Medium, three for medium. And low. (Andrea), what was your vote?

(Andrea): For the stakeholders, medium.

(Miranda): Medium, so four for medium, one for low? OK.

Female: So passed as a measure concept.

Male: Yes, concept.

Female: All right.

Male: Moving a lot to concepts.

Male: Yes.

Female: We are.

(Off-Mic)

Female: They didn't want us to do that, do they?

Female: No, we have that as an option.

Female: OK.

Female: So, they did want to – if somebody is, that are moving here are really measures in the world that we live in, but it should see where the logic has …

(Off-Mic)

Male: Yes.

Female: … so we're going to have to look at that a little bit, to sort that out as a concept, but I'm not going to stop it because everybody is using the …

(Off-Mic)

Male: Right.

Male: We're using your tool.

(Off-Mic)

Female: … so we got to go with it.

(Off-Mic)

Female: But we'll make note of those the (inaudible) really measures that went over there because they don't really cut it as measures per se.

(David Moskowitz): Yes.

Female: And I think that might be the way we'll have to look at it. I mean, the idea of capturing concepts for those that were not quite there yet, per se, yes.

(Jim Bosch): Well, hopefully, these all side comments we've been making will help those discussions because I mean, we've all been in the field as clinicians.

(David Moskowitz): If, I mean, if some of the things that are falling into the concept buckets are, you know, I think this is (inaudible) placeholder or at broader concept. In that extent there, their concepts, you know, where that maybe we – maybe the ideal thing isn't measuring the schizophrenia is primary diagnosis. Maybe the ideal thing is measuring SPMI.

(Miranda): All right, so break for lunch?

Female: Sounds good.

(Jim Bosch): It sounds good to me.

(Miranda): And so lunch is going to be served in our collaboration (space).

(Off-Mic)

(Jim Bosch): So is that here? That it?

(Miranda): So we're going to – so for members of the public, we're going to break for lunch and then we will return in half an hour.

We got lunch in our room today.

Male: Great, great.

(BREAK)

(Jim Bosch): This in a bad one also – I don't like this anymore. Let me just be clear.

(Off-Mic)

Female: Yes. Yes.

(Jim Bosch): But, you know, sometimes those SNF is the most appropriate setting, and I need some people especially in our waivers, they're (inaudible) over backwards trying to create one person nursing where if I get really substandard care without the regulatory oversight. So I don't want to create a false incentive to say SNF is somehow a failure. Sometimes SNF is the most appropriate and since no one is using it in the field or getting programs.

Female: So just share with it.

Male: So this is…

(Jim Bosch): Yes.

Male: This is a …

(Off-Mic)

(Jim Bosch): Exactly.

Female: Is anybody using this?

(Jim Bosch): No.

Female: Yes.

(Off-Mic)

Male: Discharge to the community.

(Off-Mic)

Female: Nursing center.

Female: I mean, do we have the staff preliminary review on this one.

Female: Yes, I can get quickly get that.

(Off-Mic)

(Miranda): … NQF endorsed measure, feasibility (inaudible) medium because of the data source.

(Off-Mic)

Female: Yes.

(Miranda): It received a high for scientific acceptability because it was NQF endorsed but low for usability because they were not able to identify any use in related program.

Female: Who is the measure developer?

Female: The American Health Care Association, the nursing home.

Male: Trade association.

Male: So it is more to the measure now?

Male: Yes.

Male: And …

Female: How would you even track it?

Female: Obviously …

(Off-Mic)

(Howard Chaps): Going back to community for skilled nursing center within 100 days of admission, out for 30 days. It seems a little complicated.

(David Moskowitz): And then, I believe there is other sort of measures to get at the concept of patients getting out of the SNF appropriately and not in the – yes.

(Jim Bosch): I don't mind the concept.

Male: Yes.

(Off-Mic)

(Howard Chaps): I think there's a better way to measure this.

Male: Yes.

(Miranda): So we'll take it to vote?

Female: Take it to a vote.

(Miranda): All right. So measure number 12, research to community, where vote number one addressed CMS domains and key concepts. There's who vote high, please raise your hand. Medium? And low? Oh, I'm sorry. One medium and four lows, all right.

Female: Moving on.

(Miranda): Moving on to the next measure.

(Off-Mic)

Male: Yes.

(Andrea): Twenty-nine transition record was specified elements received by discharged patients. So if these are discharges from an inpatient facility, a home or self care or any other site of care. Overall measure score was 2.4 and it's the percent of discharges from an inpatients facility could be fit to home or any other site of care in which the patient regardless of age or their caregivers received a transition records and with whom a (inaudible) included information was documented at the time of discharge, including at a minimum of all the specified elements.

(Off-Mic)

(Andrea): This was a measure in the – that was the committee recommended not be endorsed if it's not gone through the entire process which is (inaudible) or whatever to finalize that.

Female: It was not recommended because the evidence was not up-to-date.

Male: OK, anyone using it?

Female: Yes.

Male: The preliminary notes …

(Off-Mic)

Female: Now the federal programs …

(Off-Mic)

(Miranda): It's inpatient psychiatric facility quality reporting …

Female: That’s the only place …

Female: Where is this?

(Miranda): It will sit under using related programs and it's the last acronym, (IOPSQR).

Female: OK.

Female: I think we should take it to a vote?

(Miranda): All righty. So measure number 29, transition record with specified elements received by discharged patients. For step number one, does this measure or measure concept addressed CMS domains of key concepts? All those who vote high, please raise your hand. Medium?

Female: Two for medium.

(Miranda): And low? Three lows.

(Off-Mic)

(Miranda): Right. This measure will not be recommended for inclusion in the measure sets.

Female: We still have quite a few folks.

(Andrea): Measure 25, percent of (LTAC) patients, admission and resource functional assessments and a care list that addresses function, overall measure score of 1.8. And the description is this quality measure reports the percent of all (LTAC) patients within a (MIP) discharged functional assessment can care plan thing that address this function.

I've got to tell you, I worked at an (LTAC) for a little while and – yes, I was a chief medical office there. I also did acute rehab and everybody has functional assessment – everybody. It was – I don't think it's a …

(Jim Bosch): You don't think this is going to add much.

Female: I don't think this is going to add much.

(Off-Mic)

Female: Yes.

(Howard Chaps): It's the right thing to do.

(Off-Mic)

(Crosstalk)

Male: It's so complicated.

Female: So this is – it looks like if the measure source with an IMPACT, it's an IMPACT type of measure. So IMPACT is – it is for post acute care if they've got measure they're trying to have similar measures across one from care, facilities, SNF, home health …

(Miranda): And IRF …

(Off-Mic)

Female: … yes.

(Off-Mic)

Female: And so, they want it. And so, I don't know, is this the one – this is NQF endorsed? Probably because it is an IMPACT Act. You know IMPACT Act was in most of those measures are now coming through, they're fairly new. And it was partly called the care plan. Again they're trying to have similar ways to measure both acute service. That's what they're trying to do. Some people in the end to figure out …

(Off-Mic)

(Crosstalk)

Female: That they have to share the information, doesn't it?

Female: Yes. I just want to tell you what that meant, IMPACT.

(Howard Chaps): Not to pile on to this, but in terms of the overlap of this measure with what we're doing with complex care and high cost patient. I don't see a lot of those – not that that, it couldn't be an out pack base, I don't see that as being served a rich source for improvement work.

Female: Well, they're not the kind of patients I think about when I think about Medicaid …

(Off-Mic)

(Howard Chaps): Yes, exactly.

Female: Yes. And lots of instances, it's carved out, or there – yes. For Medicare, yes, yes.

(Off-Mic)

(Jim Bosch): There's going to be duals (feeling).

(Miranda): All right, voting time. So, for measure number 25 percent of long term care hospital patients with (inaudible) admission and discharge functional assessment and the care plan that addresses this function for the first scope, does this measure address CMS domain or concept? Those who vote high, please raise your hand. No votes for high. Medium? No votes for medium. And low?

(Crosstalk)

(Miranda): All right, five for low.

Male: No.

(Miranda): This measure will not be recommended for inclusion and the BCN measure set.

(Andrea): Measure 16, follow up after discharge from the emergency department for mental health or alcohol or of the drug dependent, overall measure score of 2.4. And so, this – we have another variation on the theme, the percentage

discharges for patients 18 years of age and older who had a visit to the E.D. with a primary diagnosis of mental health or alcohol or other drug dependents, during the measurement year and who had a follow-up with visit with any provider with a corresponding primary diagnosis or mental health for alcohol or other drug dependents within 7 and 30 days of discharge.

Four (rates) are reported, seven days, 30 days, and then the percent of emergency – I'm sorry – (either) the percent of emergency department visits for mental heath for which the patient results within the seven days. The percent of emergency department visits for mental health for which the patient received follow-up within 30 days. The percent of emergency department visits for alcohol for which the patient receive follow-up within seven days. And the percent of alcohol with ED visits, with follow up within 30. So they just break out alcohol versus other.

(Off-Mic)

Female: Measures 17.

Male: That's the first one.

(Off-Mic)

Female: Measure 17, we made a measure concept.

(Jim Bosch): Yes, and this one combines both.

Female: Sure.

Male: OK.

Female: As was 23, yes.

Female: This is an NQF endorsed measure. This one.

(Off-Mic)

Female: It issues …

(Off-Mic)

(Miranda): Yes, remember 17 was (saved) 2.15.

(Jim Bosch): And one of the Medicaid core sets. This one struck me a lot better than the earlier two measures.

Female: Why?

(Jim Bosch): Because it's broader. It gets both of them. Both of them is still going for the same thing, but remember the one was just initial alcohol or substance used and the other one was just mental health. So that's why I …

(Crosstalk)

Female: So this is more specific …

(Off-Mic)

(Howard Chaps): This is our fourth E.D. measure, is that right?

(Jim Bosch): Yes.

(Howard Chaps): There is all cause. There is mental illness. There was I guess strong dependents, now there's mental health and alcohol drug dependence.

(Jim Bosch): Yes.

(Off-Mic)

Female: … measure?

Female: And who to developed this one?

(Off-Mic)

(Howard Chaps): Yes, it’s NCQA.

Male: NCQA.

Female: NCQA, right.

(Off-Mic)

Female: Certainly, we have that Medicaid (book).

(Howard Chaps): Yes.

(Jim Bosch): It can be picked up from claims, it's going to be easy to implement, it's already being reported in Vermont.

Female: Yes. And here.

Male: I'll be getting them.

(Off-Mic)

(Howard Chaps): (Inaudible) the umbrella of all cause E.D. discharge and follow up (inaudible) more specific and you are including the more on this one than you are in the (inaudible).

(Jim Bosch): Well, this would exclude bee stings and sprained ankles.

(Howard Chaps): Yes.

(David Moskowitz): And CHF and …

(Jim Bosch): Well, that's true but these are the super utilizers, so.

(Howard Chaps): The bee sting could be anaphylactic reaction as well.

(Jim Bosch): Well, I'm not saying no. But I'm just saying I – in our program, we do have interest in here and yes, even sprain ankles should be follow up by PCPs but these are higher priority. They are all in best practice of medicine.

(Howard Chaps): Yes. I agree. It's the right thing to do. (Inaudible) and to improve it well as …

(Crosstalk)

Female: Did one seem to be better described.

(David Moskowitz): Yes. I mean that this one makes it through and the other ones that were very close related made it through, I mean …

Male: Both coordinating committee.

(David Moskowitz): … yes, coordinating committee and with that imagine questions around efficient use of measurement resources.

Female: Related and competing …

(David Moskowitz): Yes.

Female: … best in class.

(David Moskowitz): Yes, yes, yes.

(Off-Mic)

Male: Right, so, right.

Female: Yes. But those were just measure concepts, right?

(Crosstalk)

(Jim Bosch): No, actually we (inaudible) with measures.

Female: No. They are measures concepts.

(Jim Bosch): Number 19 and 17, both made it through as measures not concepts.

Female: Oh 19, oh yes, OK. No, 17 was the measure concept, 19 went through …

Male: I think that's after hospitalization that's not ER (inaudible) utilization.

(Miranda): So we take it to vote.

Female: (Andrea), I know that you had to step out …

(Andrea): Yes. I'm going to take this vote and then I'm stepping out.

Female: OK, great.

(Off-Mic)

(Miranda): So for measure number 16, follow-up after discharge from emergency department from mental health or alcohol or other drug dependents. For vote number, does this measure, measure concept address CMS domain or key concepts? Those who vote high, please your hands. We got five for high.

And move on to the next vote. So this does an opportunity for improvement. Raise your hand for high please, five for high. Moving on, does this demonstrate an efficient use of resources? High? Five for high. Does measure, measure concept ready for immediate use? High? Four for high. Medium? One for medium, and no for low. That moves forward as measure.

Is this measure important to stakeholders? High? Five, all right. Measure number 16 will be recommended for inclusion as a measure.

(Off-Mic)

Female: So we're going to move on to. So we go in the next (inaudible), do you want to open this up for public comment …

(Off-Mic)

Female: So before we move on to the next meeting, we're going open it up for public comments. (Shawnn), are you on the line? Operator?

(Off-Mic)

(Miranda): Yes.

(Off-Mic)

(Miranda): This isn’t good.

Female: We could go on (inaudible), you know, a number of other measures …

(Off-Mic)

Female: She is.

(Off-Mic)

Female: OK. So, you know, if we do just go on and then ask …

(Off-Mic)

(Miranda): Yes.

(Off-Mic)

(Miranda): So, we can move on to the clinical care domain. From clinical care, we have six measures, slated for discussion. The first one is measure number five, documentation of current medications in the medical record.

(Jim Bosch): Almost all of these are on reconciliation.

(Off-Mic)

(Howard Chaps): I am not sure we need …

(Off-Mic)

(Howard Chaps): … already done.

Female: OK.

(David Moskowitz): (Inaudible) is an attestation too. Yes.

(Off-Mic)

Male: I am not sure they can change. They just get …

(Off-Mic)

Male: … record to the next.

(Jim Bosch): Yes, getting more and more …

(Off-Mic)

Male: That looks much easier.

(David Moskowitz): Are you using this?

Female: So, med rec was in here because it was considered an approach to, you know …

(Off-Mic)

Female: … or whatever. The invention to this year probably many of them are measures that are …

(Off-Mic)

Female: They have really resource but, you know, obviously looking through them – there are many med rec of these.

(Off-Mic)

Male: Five.

Female: Five. Only one other measure, just mental health utilization.

(Off-Mic)

(Jim Bosch): So, my only comments on this one is, I'm not sure that you got those in records about accuracy with this gap.

Male: Right.

(Off-Mic)

(Jim Bosch): No, but – yes, I mean, we're using it now, but I still – what I still see is a lot of redundancy overlap and accuracy. So I'm – and you'll see later I'm speaking about a measure that talks about error rates and redundancy. Because I will tell you in most of the records I review, I'm thinking errors and redundancy, those current measure isn't capturing of that.

Male: Yes.

(Jim Bosch): So, I'm speaking from …

(Off-Mic)

Male: I would say promoting it, but it's …

(Off-Mic)

(Jim Bosch): It's not (inaudible).

(David Moskowitz): Yes.

(Jim Bosch): So, just because we're using something doesn't mean there's not something better out there.

(Howard Chaps): It doesn't make, you know, make a meaningful improvement it sounds like.

(Jim Bosch): Exactly.

(Miranda): All right, shall we take it to a vote?

So, measure number five, documentation of current medications in the medical record. For vote number one does this address CMS domains and key concepts? Those who vote high, please raise your hands. Medium, one for medium.

Male: Two.

(Miranda): I'm sorry, two for medium. And low, two for low.

Female: We have quorum so …

Male: Yes, we have a quorum but …

(Off-Mic)

(Crosstalk)

Male: 60 percent.

(David Moskowitz): Yes.

Male: So, you need three out of four.

(David Moskowitz): Yes, so.

Male: OK.

(Crosstalk)

(Jim Bosch): There's better ones I think.

Female: Yes.

(Off-Mic)

(Miranda): Agreement of 60 percent.

(Off-Mic)

(Miranda): So the next measure, excuse me, is measure number eight, mental health utilization. Number and percentage of members receiving the following mental health services during the – I mean, I'm sorry, the measurement year any service inpatient, intensive outpatient or partial hospitalization and outpatient or ED.

(Howard Chaps): This is simply a rate.

(Off-Mic)

(Howard Chaps): Yes. That's all – my question – the question I'm proposing is it something that we want to …

(Jim Bosch): Yes. To me, it's much more effective if you're tracking the PHQ-9 and showing things are going down.

(Howard Chaps): Yes.

(Jim Bosch): I mean, how many patients do you have if they're on two different antidepressant and (inaudible), and throw them one or two antipsychotic just for good measure and no one is tracking clinical outcomes.

If we're really moving toward value-based medicine, it's like saying, it's like if your diabetic and say, "Well they had at least one A1c in the air." Of course their A1c was 13 but they measured it. And I think it's – we're trying to move toward high-value care. You know, I look and what we're trying to implement state-wide is, you know, like (units are) IMPACT model but you're actually are tracking PHQ-9s over time to measure the effect of your antidepressants. Sorry, that's one of my hobby courses.

(Howard Chaps): No worries. The measure is purely …

(Off-Mic)

(Jim Bosch): Exactly.

(Off-Mic)

(Howard Chaps): Does the state want to know how many members per 1,000 or the health plan want to know or the – whoever want to know. Providers want to know what the actual incident I think, the prevalence of that issue. So that is number 49 out of 54 poor mental health days and that's measured by …

(Off-Mic)

(Howard Chaps): One is probably Colorado like that, but it is something that you want to – it's something that you want to track, so I want to show that Kentucky is awful and you – which we already know but if you want to track that, you know, and

give – and we should, we do, you know, in the state of (inaudible). But it's just another data point. And …

Female: It's not a measure in a way.

(Off-Mic)

(Howard Chaps): Right.

(David Moskowitz): Yes, yes.

(Howard Chaps): Assuming that it's just measure that data point they track.

(Jim Bosch): And actually the way they have this now we can already track that.

Male: They should be able to

(Jim Bosch): Yes. Or we can.

(Howard Chaps): Right.

(Off-Mic)

(Howard Chaps): Reported in the …

(Crosstalk)

(Jim Bosch): Yes. I'm sure Missouri would.

(Howard Chaps): The HEDIS measure too.

(Jim Bosch): It is HEDIS.

Female: (Inaudible) related?

(Crosstalk)

(Jim Bosch): Yes. I think this is a valid measurement. But the question is, what is that in terms of quality? And so I'm just looking at whether a valid measure or what are we attempting to work towards higher quality.

(Jim Bosch): That's a good question. What do you think (Peg)?

(Peg): Of course you're trying to work towards higher quality but the assumption is that there are valid measures to help you make the revision. And the measure should be giving you a direction. So, you know, whatever you're going to use, I mean you can talk about, you know, the PHQ-9as a tool and the measure. The measure though has a direction, the percentage of people that – or this number that, you know, went down to this number or whatever. Here, and that gives you a clue, a way to evaluate across different population in group's …

(Off-Mic)

(Peg): … whatever. That's been the measurement, but this just shows you, you know, patients in a way that you know I'm not sure I see them going around and around about.

(Off-Mic)

(Peg): I'm not sure it would help them solve the …

(Off-Mic)

Male: States are going to report.

(David Moskowitz): If it were in broader use for general Medicaid population and you're looking at the date was for BCN. Then that – there might be something there, but from what I'm gathering, it's not in that regular use.

(Howard Chaps): So, I can see how Kentucky does versus California versus Mississippi.

(Off-Mic)

(Howard Chaps): But it's not a way to rank from a pure Medicaid population. And the fact that I told you before, it's probably not through Medicaid, it's probably …

(Off-Mic)

(Howard Chaps): There's some clinical data behind.

(Jim Bosch): Right. So but based on what everyone has been saying, I can see that there's a medium for question one but I still see there's a low for question number two.

(Off-Mic)

(David Moskowitz): Yes.

Female: We don't know where you're starting, right.

(David Moskowitz): We don't know where you're starting …

(Jim Bosch): Exactly. So, what …

Male: If you're starting really poorly, then there's an opportunity for improvement.

(Jim Bosch): But the thing is you don't even know what poorly is you just say there's a lot of depression, but how bad is your depression?

Male: Yes.

(Jim Bosch): What's your state average PHQ scoring? All right.

Male: Yes.

(David Moskowitz): Well, I mean we're not comparing – I mean for the purposes of this, whatever group – we're not comparing state to state, we're comparing – it's the BCN …

(Jim Bosch): Exactly.

Male: Yes.

(David Moskowitz): And there's no standard definition as we discussed earlier than …

Male: OK.

Female: All right.

Male: Are you ready?

(Jim Bosch): I think we're ready.

(Miranda): OK. Measure number eight, mental health utilization. I'll leave it at that. So the first vote, is this measure – does it address CMS domains and key concepts, high? Medium? Three for medium. And low? One for low. So we'll continue on.

The next vote, does it address some opportunity for improvement, high? Medium? One for medium. And low? Three for low.

Male: I don't mind.

(Miranda): All right, this measure will not be recommended for improvement …

(Off-Mic)

(Peg): Another medication management …

(Off-Mic)

(Jim Bosch): That's the last one. You saw in antidepressant.

Male: Antidepressant.

Female: OK.

(Off-Mic)

(Miranda): Oh we're on measure number …

(Off-Mic)

(Miranda): No, antidepressant, medication management.

(Jim Bosch): We're on number six.

Female: Three.

(Howard Chaps): Yes, three. We just finished eight.

Oh sorry, I got ahead of myself.

(David Moskowitz): All right, I have a couple of …

(Off-Mic)

(David Moskowitz): It's a single diagnosis. And then in the denominator, there's the phrasing, newly treated with an antidepressant medication. I'm concerned about how you accurately capture that for this target population.

(Jim Bosch): That's really going to be tricky.

(Howard Chaps): This is an NCQA/HEDIS measure that tracked by all the health plans that are out there that are …

(Off-Mic)

(David Moskowitz): Yes.

Female: So you say Georgia, Washington State in this?

(Howard Chaps): We're seeing a lot more on the compliance medications in this, just an example, seeing a lot of compliance measures whether it's a Medicare (SARS) measure or you're seeing it for asthma, you're seeing it for depression.

(Jim Bosch): Well, that numerator go, I just know, it gives us – that is very challenging to do all these wash out continuous gaps overlap, good measure, but high complexity to actually measure.

Male: Yes.

(Howard Chaps): However if the state wanted to implement them …

(Off-Mic)

Male: Yes.

(Howard Chaps): … delivers that with measure, right?

Female: And then the client …

(Off-Mic)

Female: Also they have a pharmacy. So sometimes pharmacy …

(Off-Mic)

(Jim Bosch): Yes. We have them with our (PBN).

(David Moskowitz): Is it – I'm sorry, is the medication. How are we – we're capturing that, they're treated with this, is it through fill data.

Female: It doesn't really – so (inaudible) source claim EHR only and pharmacy (inaudible).

(David Moskowitz): So pharmacy claim measurement?

(Jim Bosch): It's mostly be the pharmacy.

(David Moskowitz): Yes, OK.

(Howard Chaps): When you've got a identification via medical claim.

(David Moskowitz): Yes.

(Howard Chaps): Right?

(Off-Mic)

Female: If you read the numerator, you get a sense you'll probably have to capture some of the …

(Off-Mic)

(Howard Chaps): Yes, definitely pharmacy.

(Jim Bosch): I think only (PBM) …

(Off-Mic)

(David Moskowitz): Yes.

(Howard Chaps): I don't – I mean the numerator that they mentioned, it says in the prescription diagnose with a major depression but the numerator doesn't have that. So, if somebody is on – I guess this means …

(Off-Mic)

(Miranda): All right. Shall we take it to a vote? For measure number three, antidepressant medication management. For vote number one does this measure, measure concept address CMS domains or key concept? Those who vote high? One for high. Medium? Three for medium. The measure will continue.

Second vote. Is says this measure address an opportunity for improvement. Those who vote high please raise your hands. One for high. Medium? Three for medium.

Vote number three, does this demonstrate efficient use of resources and/or contribute to alignment? Please raise your hands for high, one for high. Medium, two for medium and low, one for low.

Is this measure, measure concept is ready for immediate use. High? One vote. OK, two votes for high. Medium? Two votes for medium.

All right, how should we proceed, as a measure or a measure concept?

(Off-Mic)

(Peg): But we're going to actually look at this later, all the measure including measure concept. We're going to look at – we're going to pull those out and see whether – because that was not – so we talk about failure …

(Off-Mic)

(Peg): It wasn't really the intent that it was (inaudible) that way. But we treated all the other ones that we just moved over there. So I think we just need to do that and figure out how we are going to deal with that going forward.

(Miranda): We will proceed as a measure.

(Peg): Exactly.

(Miranda): OK. So, this will proceed as a measure concept, is this measure concept important to the stakeholders? High? Two? Three for high.

Female: Four for high.

(Off-Mic)

Female: Yes. Yes.

(Miranda): This (inaudible) will be recommended for inclusion on the measure set.

OK, next is measure number six, medication reconciliation and post-discharge.

(Off-Mic)

(Howard Chaps): It's very similar to …

(Off-Mic)

Female: A measure that is it's NQF endorsed, it's used in the state of Colorado and it's claim EHR …

(Off-Mic)

Female: NCQA steward.

(Off-Mic)

(Howard Chaps): Almost identical.

Female: Yes.

(David Moskowitz): This specifies the folks who can do this med rec. It specifies roles. I'm sorry prescribing – I didn't see that. I read that as measure practitioner.

(Jim Bosch): All right, and I think we'll go ahead – a lot of overlap between six here and seven down below.

Female: They're both med recs.

(Jim Bosch): They're both med recs.

(Howard Chaps): If you also have 53.

(Off-Mic)

(Jim Bosch): And about both six and seven would very, very similar. I think it's more of an emphasis on global standard and looking for errors and six and just – I've seen a lot of (slop dash) med recs which is why …

Female: You know …

Male: … five, seven, four.

(David Moskowitz): I mean it's really not clear from this numerator how did discharge medications. I mean, how does it capture, how they reconciled with?

(Howard Chaps): This is either a – it's going to be a hybrid measure.

(David Moskowitz): Yes.

(Howard Chaps): You'll have the ability to get it in as a care transition code.

(David Moskowitz): Right.

(Off-Mic)

(Howard Chaps): At least the Star measure, the medication reconciliation form has to be – has to have an attestation from the prescriber or – I think the prescriber or you can get it off the claim. And this is pretty similar.

(Off-Mic)

(Miranda): So, do we want to proceed on voting? Is everyone comfortable with that?

(Off-Mic)

(Howard Chaps): It all depends on …

(Crosstalk)

(Off-Mic)

(David Moskowitz): Yes.

(Jim Bosch): With our comments.

(David Moskowitz): Right.

(Off-Mic)

(Miranda): All right, so for measure number six, medication reconciliation post-discharge, for vote number one, type of measure – all measure concepts address CMS domains or key concepts. Those who vote high, please raise your hand. Three for high. Medium? One for medium.

For the second vote, does this measure address an opportunity for improvement? Those who vote high, please raise your hand. Three for high. Medium? One for medium.

Moving on to efficient to use of resources and/or does it contribute to alignment? High? One for high. Medium? Three for medium.

Is this measure or measure concept ready for immediate use? High? Four. So it will proceed as a measure.

Is it measure important to stakeholders? High? Three. Medium? One. There we go, measure number six will be recommended for inclusion as a measure.

The next measure up for discussion, measure number two. Annual monitoring for patients on persistent medications.

(Peg): It is NQF-endorsed. It's used in Georgia, Kansas, Medicaid Adult Core Set 2016. NCQA.

(Howard Chaps): This looks like it's an old measure …

Female: It's an old measure.

(Howard Chaps): It looks like it.

(Peg): Yes.

(Off-Mic)

(Peg): It's the same thing claims, pharmacy …

(Off-Mic)

(Jim Bosch): High standard, I mean, base standards of medical care.

(Howard Chaps): Yes.

(Off-Mic)

(David Moskowitz): And I think this – with BCN patients, the challenge is retaining them in primary care and bringing them back in to sort of adjust re-prescribe, continue the medication. And so I'm strolling with the degree to which this measure represent that concept versus the primary care, was just prescribing less than a pro on autopilot.

(Jim Bosch): Yes. I think that's a great point.

(Howard Chaps): If they monitor, so they need a potassium and a creatinine.

(David Moskowitz): Yes. But – I guess what I don't know – what I don't understand fully is the denominator, is it one-time prescription of these medicines or is that based on prescribing – they're having to have this prescribed in an ongoing basis, and if it's the former then it's all different.

Male: I probably say persistent method usually at least to fill.

(David Moskowitz): Yes.

(Off-Mic)

Female: Yes, definitely.

Male: I don't find the measure to be a bit specific like for CHF patients.

(Jim Bosch): Yes. And …

Male: It doesn't say.

Male: Right.

(Peg): Yes. They talked about the numerators in the description, free rates and total rates, annual monitoring patient that ended (inaudible) bringing enzyme, (ACE) and (inaudible) ARB at least one (serum) potassium and (serum) creatinine. Therapeutic monitoring …

(Off-Mic)

(Peg): It talks about the meds.

(Off-Mic)

(Peg): Therapeutic monitoring …

(Off-Mic)

(Peg): … measurement year. It's on to diuretic. So it's just – this is monitoring of some of these other …

(Off-Mic)

(Howard Chaps): Yes, I mean …

(Off-Mic)

(Howard Chaps): … provider – doing what he or she should be doing.

(David Moskowitz): Yes.

(Howard Chaps): All that …

(Off-Mic)

(David Moskowitz): Right.

(Howard Chaps): And if they're high-cost and complex probably they shouldn't be doing this.

(David Moskowitz): Yes.

(Jim Bosch): So, I just want to share a recent case I came up in front of our Q.A. at the meeting. They showed up in the E.R. The measure potassium level of course potassium level severely hypo (inaudible). They didn't report back to the PCP (inaudible) and the patient died in arrhythmia the next day. So, just that you measure does not translate into provided high quality, which is why I want move away from just basic HEDIS measures.

Male: Right.

Female: Process.

(Jim Bosch): Exactly.

(David Moskowitz): Actually that, you brought up a good point there. If these guys are coming to the emergency department, they come in the hospital, they're having (inaudible) checked willy-nilly, right?

Female: Yes.

(David Moskowitz): And so the – whether or not the PCP that they may or not be seeing is actually doing it. They're fulfilling the numerator on this measure by virtue of being hospitalized which makes it a little bit less …

Male: Yes.

(Crosstalk)

(Off-Mic)

Male: … knew nothing about that.

(David Moskowitz): Right, exactly, exactly, yes.

(Crosstalk)

(Jim Bosch): So, good in think theory, less than perfect measure.

(Howard Chaps): That's a great point though.

(Andrea): OK, all right. Vote?

Male: But isn't the (inaudible) tools to work more towards outcomes rather than process (overlap)? They say it's a process measure. To me it looks more like touching went out and it's like having an (impact). Talking about impact (inaudible).

(Jim Bosch): Right. And we're saying this measure as it would not have as much impact. It's measuring the process but not necessarily the outcomes.

Female: Measuring what happened of …

(Off-Mic)

Male: But you can have a high-score, the likelihood of having a larger impact is high.

(Jim Bosch): Presuming it gets to the PCP who actually looks at the result, who actually takes effect, which would be a better measure, would be – just like instead this measuring wasn't (inaudible) performed this, not only are you measuring the (pH) level, the potassium level. But that your scores are that you're potassium was within normal range or (inaudible) level within normal range. So taking it from one step beyond this measuring to is their results in the normal range.

Male: Right.

(Jim Bosch): And then if you scored low or high, the corporate med adjustments were made and then you got back into normal range.

Male: Yes, yes.

(Jim Bosch): That is the difference between a process and an outcome.

Male: No, I understand but for some reason I see this somehow connected into the entire (database) payments process, it's like – it seems to be a performance measure for physicians to make headroom for improvement and to stimulate to include (chair).

Male: If all of the cards fall correctly, yes, it would. But that's not what we're measuring.

Female: So process measure should have a direction towards an outcome, even if it's not dated.

Male: Yes, right.

Female: It should be able to show that it's going through now an outcome, which would be – they're doing all these things would …

Male: I know.

Female: … possibly, you know, reduce …

(Off-Mic)

Female: … other issues.

(Jim Bosch): I have to trouble just going forward, I'm just saying, to me it's not perfect.

Female: OK.

(Off-Mic)

(Miranda): All right, for measure number two annual monitoring from patients on persistent medications. So, number one, that this measure – all measure concepts address CMS domains and key concepts. High? Three for high. Medium? Zero for medium, and low? One for low.

We'll move on to the next vote. Does this measure address an opportunity for improvement? High, one for high; medium, two for medium; and low, one for low.

(Off-Mic)

(Miranda): And so, because we were unable to achieve a 60 percent agreement, this measure will not be included.

(Off-Mic)

(Jim Bosch): So we are three out of four.

(Miranda): You're right, you're right.

Male: Three or four, yes.

(Miranda): High and medium.

Male: Yes.

(Miranda): Sorry. Scrap that, moving on to the next vote.

(Off-Mic)

(Miranda): Does this measure demonstrate efficient use of resources and/or contribute to alignment? High, no for high, oh, I'm sorry, one for high. Medium, three for medium, is this measure of concept ready for immediate use? One for high, yes.

Male: Oh, I'm sorry.

(Miranda): I'm sorry, high.

Male: It's ready, yes.

(Miranda): OK.

Female: Do it.

(Miranda): Four for high.

Female: Four.

(Miranda): All right. So this will be moving forward as a measure, is this measure important to stakeholders? High, one for high. Medium, two for medium …

Male: Three.

(Miranda): Three for medium. So, this measure will be recommended into the BCN measure set.

(Off-Mic)

Female: Much rather than here than where I was.

(Off-Mic)

Male: We can go back and vote again.

(Off-Mic)

(Crosstalk)

Male: We're on the second measure.

Female: OK.

(Off-Mic)

(Miranda): All right, so.

(Off-Mic)

(Miranda): Next measure up for discussion was retained by (Jim). Measure number seven, medication reconciliation, unintentional medication discrepancies for patients.

(Jim Bosch): OK, so, and I've already started to allude to this earlier, which is – just because people say they're doing med reconciliation, often I see cut and paste, here you're actually finding who is responsible, what the gold standard is. So, I wasn't quite sure, you know, it didn't score as high as some of the others but I thought it was definitely worthwhile bringing up for discussion because I was like, when you can establish what the gold standard is, who's responsible and what action should they take. Because like my Q.A. committee, I just see so many cases where there is no method, you know, no real med reconciliation where – depending on what list you're looking at, there's medicine all over the map. So, that was sort of my comments on this one which is why I thought was nice.

(Peg): It is NQF-endorsed.

(David Moskowitz): So the preadmission medication list, what's the source of that? Does it come from patient's self-report? Does it come from EHR?

(Jim Bosch): I think they're – talking about the pharmacy, so I think you're looking at the EMR because, again all prescribed medications. And that was one of the reasons I'm only a little bit …

(David Moskowitz): Yes.

(Jim Bosch): Because I thought it was still a little fuzzy …

(David Moskowitz): Right.

(Jim Bosch): … and I didn't know if we get more clarification here.

(Howard Chaps): It's the hospitalized patient, I mean it could come from the nurse room …

(Off-Mic)

(Jim Bosch): Then it would be the nursing home list.

(David Moskowitz): Yes.

Female: Care setting is the hospital.

(Howard Chaps): I think the theory is very good. I think it can be hard to – I think it's going to be hard to abstract data.

(Jim Bosch): Yes, if you get into all the over the counters, it's going to become very challenging.

(David Moskowitz): Maybe I'm just thinking of sort of the – yes, the extreme case super utilizer who was rehospitalized and doesn't have a PCP and/or their PCP is way out, you know, in the community and it's a – OK what's your – the pharmacy is (inaudible), what's your, what medications are you on? I don't know.

Or even, I mean, even the super utilizer who is beginning to become engaged and I've seen this. They're becoming to get more engaged with their PCP. The PCP is making some changes in their medication that should be reflected in this (PAML) but the patient themselves doesn't bring that to the admission …

(Off-Mic)

(Jim Bosch): The place where I view this coming from, is again from our (PBM). Because the moment we bill for them. And it's actually very easy in our state because we have a continuity to the care document viewer.

(David Moskowitz): Yes.

(Jim Bosch): And so you can bring up a Medicaid client and see all their meds, encounters, diagnoses for the last two years, you know. They basically have a functioning (HIE) …

(David Moskowitz): Yes.

(Off-Mic)

(David Moskowitz): Yes.

Female: Yes.

(Jim Bosch): And so in our state it's easy.

Male: Yeah.

(David Moskowitz): Right.

(Off-Mic)

(Jim Bosch): Yes, I know. The hard part is getting the ERs to want to call the CCD.

Male: Exactly, right.

(Off-Mic)

(David Moskowitz): Yes.

(Jim Bosch): Right. But I think that becomes a measure that incents them …

Male: Yes.

(Jim Bosch): … to go ahead and call the CCD.

(David Moskowitz): Yes. Or just build towards that it's places that are less rural …

(Crosstalk)

(Jim Bosch): … is web access.

(David Moskowitz): Bay Area.

(Jim Bosch): So I would ague for this one. It helped my state.

Male: (Miranda), can I ask you a question?

(Miranda): Sure.

Male: When we …

(Off-Mic)

(Miranda): The final vote.

(Off-Mic)

Male: Yes.

(Off-Mic)

Male: Yes.

(Miranda): All right, voting time. So for measure number seven, medication and reconciliation, number of unintentional medication discrepancies for patients.

(Off-Mic)

Male: The first vote. Does this measure or measure concept address the CMS domains or key concepts. High? Three for high. Medium? One for medium.

Second vote, opportunity for improvement? High? Two for high. Medium? One for medium. And low – oh, I'm sorry. Medium?

Male: No, low.

(Miranda): One for low. Moving on to the next vote. Efficient use of resources. High?

(Off-Mic)

(Miranda): No vote for high. Medium? One vote for medium.

(Off-Mic)

Female: Yes.

(Howard Chaps): It says efficient use of resources and/or contribute to the alignment of measure …

(Off-Mic)

(Howard Chaps): Yes. I'll go with medium.

(Miranda): OK. Three for medium.

(Off-Mic)

(Miranda): Three for medium. And low? One for low. Is this measure or measure concepts providing for immediate use?

(Crosstalk)

(Off-Mic)

Male: No.

(Miranda): OK. So I think this one is going to be …

(Off-Mic)

Male: There you go.

(Off-Mic)

Male: And specifying the numerator and denominator, maybe feasibly extracted. So, it sounds like a medium.

(Off-Mic)

Male: No.

(Off-Mic)

(Miranda): That's our internal measure size for dual. It's not considered a federal.

(Off-Mic)

(Miranda): All right, are we ready for this vote? Is the measure and measured concept ready of immediate use? High? No votes for high. Medium? Two for medium, three for medium?

Male: No.

(Miranda): OK. So two for medium and two for low. OK. So, this will proceed as a measure concept. Is this measure concept important to stakeholders?

Female: This is another measure that's in the measure concept bucket.

(Miranda): Right.

(Off-Mic)

(Jim Bosch): Unless it gets …

(Off-Mic)

(Jim Bosch): If it gets two lows …

(Howard Chaps): Right.

(David Moskowitz): Yes.

(Jim Bosch): However, I would just say for my Medicaid program it will be important.

Female: So what is the (stack) voting?

(Off-Mic)

(David Moskowitz): Right.

(Off-Mic)

(Jim Bosch): We're trying to decide …

(Off-Mic)

(Jim Bosch): Medicaid agencies or stakeholders?

(Miranda): (Inaudible) measure concept.

(Jim Bosch): Yes.

Female: And we're going to resolve the conflict versus the measure of (inaudible).

Female: Right.

(Howard Chaps): We can get to this. We're not going to recommend it for data measure.

Female: Right, right, right.

(Off-Mic)

(Howard Chaps): Right.

(David Moskowitz): If we got two.

(Jim Bosch): If you get – you all can still kill it. Choke it in the (crib).

(Off-Mic)

(Miranda): OK. I suppose we vote for high? No votes for high, medium? Three for medium, and low? One vote for low.

(Off-Mic)

(Miranda): It will be recommended for inclusion as a concept. OK, so that concludes the clinical for domain, and we'll go out for public comments, we'll vote care coordination and clinical care because we were unable to go out for care coordination.

So, Operator, are you on the line?

(Off-Mic)

Female: There's no response.

(Off-Mic)

Female: OK, but we can ask the usual.

(Off-Mic)

Male: Anyone on the phone or on the line? At least put a chat up if they want to raise their hand.

(Off-Mic)

(Miranda): So if they're on the web portal you're absolutely …

(Off-Mic)

(Miranda): A comment, the other chat function.

Male: So …

(Miranda): However, if they're just listening they won't be able to provide a comment.

Male: So, (Lauren) seems to have her name on this. So that wouldn't be a phone call.

(Miranda): No. No audio question.

Well go out for our formal public comment after the next domain. So the next one slated for discussion is patients and caregiver experience. The …

(Jim Bosch): So, again, yes, I was the one who pulled this one forward and I did read up a little bit on the patient activation measure but I think in my experience in primary care, if I did not really get the patient to where they understood the process why we were making the recommendations, the consequences of their

actions or inactions and really get them engaged in the process and I – you would have to use a variety of methods and it's probably age, gender, education of each client, each patient.

You know, that really made all the difference in terms of good outcomes and it was worthwhile for me to spend a lot of time educating patients. I have never actually used the patient activation measure or score before. But it seems to be getting at a lot of the way I practiced my primary care.

And so I wanted to bring that forward for the discussion of this group. It is in NQF recommended measure. So to me, that indicates some higher quality and I wanted to open it up for discussion because it was so important to the way I practice internal medicine.

(David Moskowitz): I'd love to speak more about this. I agree with you that this is a concept. The construct of patient activation is critical for super utilizer work and populations.

(Jim Bosch): Exactly.

(David Moskowitz): We've – our program put a lot of thought and a lot of research into whether we use the PAM or not in talking with other program in our area. We opted not to do for a couple of reasons.

The applicability of the questionnaires to the Medicaid population is marginal at best. But the – there is – the concept is competing demand is – you know, I'm not managing my CHF because housing my alcoholic niece and worrying about getting evicted. Those aren't contained in the questions that the PAM (assesses).

And moreover, there was a concern amongst the couple of experts that I talked about it of a floor effect. Everybody scores low in the PAM who is in this population and you can't measure improvement because their – the incremental changes are such that they're not really affecting the measure. It's sort of skewed to a higher level of activation.

And there is – you know, I didn't – so I – there's a group that I 'm working with – actually I'm not working with. They're studying my clinic, my program from UCSF. And one of the early papers they published was like a literature review of the PAM in taking that high-class diverse population. And they found that there was not a lot of studies to support that. And this is an in-press article.

So, I don't know. It's a great concept and I think this is something that hopefully the Mathematica group that we've mentioned earlier is working on developing something to this.

(Jim Bosch): And I am totally – as I said, I'm fine with this as a concept that I like to see this concept developed.

(David Moskowitz): Yes.

(Jim Bosch): And I'm fine with it as a concept rather than going forward as a measure itself.

(David Moskowitz): Yes.

(Jim Bosch): But I don't want to see the whole concept.

(David Moskowitz): The whole idea. Yes, no, no, I agree.

Female: I will tell you when (Judy), when this first came out, we tried to incorporate PAM into our care management activities and we're never able to find a correlation …

(David Moskowitz): Yes.

Female: … in improvement and PAM with outcomes.

(Off-Mic)

Male: We're getting approached by a vendor to do this?

Female: (Judy) is now with a vendor.

(Off-Mic)

Male: Anyway, that's my familiarity with vendor and their presentation. And this is available off the internet. I just pulled it on the …

(Off-Mic)

(David Moskowitz): Well, that no, I mean that the – the algorithm calculating the score. That's the …

(Off-Mic)

Male: Oh it is.

(David Moskowitz): Yes, it's the questions are out there, but how they're actually the math for how they're processing the scores. That's what they're selling.

Male: OK.

(David Moskowitz): Yes.

Male: Are there multiples?

(David Moskowitz): I think it's just Insignia.

Male: Insignia.

(David Moskowitz): Yes, Insignia.

Female: And I think the measure – the developer …

(Off-Mic)

(David Moskowitz): Yes.

(Off-Mic)

(Jim Bosch): Right. So, was your experience the same that for our beneficiary complex needs, these questions aren't really …

Female: (So it's not) useful.

(Jim Bosch): OK. And that's fine, so then the question, do we just want to, you know, move the concept along back to, you know, the quality measure developing team which I'm fine with. But they're not probably not argue for the measure as it is going forward.

Male: (Inaudible) anywhere.

(Off-Mic)

(Jim Bosch): Yes, conflict of interest.

(David Moskowitz): I mean there's one research theme that I know have been probably a lot more that I don't know of that are doing sort of foundation or work just like interviewing …

(Off-Mic)

(David Moskowitz): Yes.

(Jim Bosch): Because our experience working with the national government association are super utilizer program is you got to be working on the social determinant.

(David Moskowitz): Yes.

(Jim Bosch): We got to take care of all those things.

(David Moskowitz): Yes.

(Jim Bosch): But patient education engagement still important, it's just one of those many variable.

(David Moskowitz): Right. Right. Right.

(Jim Bosch): And I don't think we've come up this. So sounds like PAM may not be the correct tool …

(David Moskowitz): Yes.

(Jim Bosch): … based the programs experience for this population.

(Miranda): Well for formality purposes, can we go through the vote?

Male: Oh, yes.

(Miranda): And then we can see where …

Male: Ready to vote.

(Miranda): All right, so for measure number 32, (inaudible) at 12 months. Vote number one. So does this measure and measure concept address CMS domains or key concepts, high? Medium? Two for medium and low. Three for low.

(Jim Bosch): OK.

(Miranda): So this measure will not be included.
.

Male: Yes.

(Miranda): The measure set. All right, so that …

(David Moskowitz): Well thanks for – and I think the discussion can hopefully feed forward in some …

(Jim Bosch): Yes, and I hope the comments go back to the measure development.

(David Moskowitz): Yes.

(Miranda): We're note taking the entire time.

Male: Yes.

(Miranda): And I don't know that it'll reach that audience but we'll have in our report.

(Peg): I'm actually seeing it news in non-Medicaid.

Female: That's what I was going to say it's …

(Off-Mic)

Female: For If it's going to correlate somewhere, it’s going to correlate in a commercial population.

(Off-Mic)

(Peg): Yes. And I’ve seen it use in the state of New Jersey with the high income population, very effectively and there’s Carolina …

Male: Yes.

(Peg): Again it depends on the (inaudible) depends on the population but the systems abuse, the patients that move through can see how they're engage …

(Off-Mic)

(Jim Bosch): That's fine. Good concept. Good discussion. Thank you all.

(Miranda): All righty, so this concludes the patient caregiver experience domain. And we just learned that we are – we do not believe them. No. We do not believe – no.

So we will go out for public comment and we just learned that we are on our own. So we don't have operator assisted lines. So members of the are – may join us. We'll just have to ask for formal public comment for care coordination, clinical care and patient, and patient caregiver experience domain.

(Off-Mic)

(Miranda): So they should have open line?

Female: They have open lines.

(Off-Mic)

Male: OK.

(Miranda): So if you have any comments to make up this time for any of the three domains, please (raise your) hand.

Hearing none. We can …

Male: How about public comments in the room?

(Miranda): Oh by all means.

(Crosstalk)

John Shaw: John Shaw from Next Wave and I'm on the coordinating committee. So listening in on the discussions was quite useful because we're going to have to deal with everything that you've deferred to us. Particularly, interesting is trying to define the measures for the BCN process …

(Off-Mic)

John Shaw: And is this too much, too general, too specific and so that tells me we want to be ready to answer those kinds of questions in June when we get back together. And so we're waiting for the guidance from NQF to do that.

On the specific measure, I am somewhat familiar with the PAM tool. It actually is being utilize in New York State in the Medicaid population.

Female: Right.

John Shaw: And so we're going to be – we just started March 1st or April 1st, its done year three of our DSRIP process. So we have several hundred thousand Medicaid and uninsured who have done – (water) more PAMs and we'll be interested to see what the processes are.

In looking through some of the more recent literature, we found that it is unused nationally in the U.K. and NHS for everybody.

It's in use in several other states not for Medicaid fee-for-service. But for Medicaid managed care in a couple of states. I don't have my note with me. So it is being looked at and utilize there.

I strongly believed in the concept. I'm wired to look at the whole system particularly bottom up aspects and patient, family, and the on-the-ground caregivers is important to me personally. And this is one of the areas where were trying to capture the half of the unexplained variation that patient adherence and compliance, that I've been hearing about for decades and decades and this is one of the areas that is the concept is starting to bring in measure there. So, I'd probably will be bringing it back for reconsideration for the committee. Hopefully, with better information at the time.

One thing that would be useful is the failures that you've discussed. It would be useful to have a little more detail about that. So if there is any way you can share I'll give you my card or send it to NQF or whatever.

Female: Are there any success you can share?

John Shaw: I have seen correlations between the change overtime. They're looking at the endorsed measure. I think 3 percent is normal and 6 percent is excellent. And they're seeing improvement in some of the other clinical measures and things like readmissions. And so some of the states, I don't remember the specifics but we'll pull that stuff together.

I've seen others where not everybody improved particularly the challenge populations for a variety of reasons, one of which that's mentioned is that people didn't fill out very judiciously shall will say the first time around. And that could impact improving or not improving. But we'll see. It's definitely concept I want to see going forward, specific measures. I'm not sure if there's anything in town right now.

And the other that struck me is we're looking for measures in general across all four domains, that are giving us clues as to the rapid improvement. So the acceleration is part of IAP. And what's going to accelerate so we've gotten the metrics here feasibility and usability 50 percent of the weight which is good. We've got – it this ready for use right now which is good.

The other question is what we don't have in here yet are – are there some measures that if you do well on this, it means you're probably going to achieve

measurable result overall quicker and that sort of measure concept across them that it would be nice to equip some of these measures in to that bucket to say, if you do these things you probably get success sooner than others. And we've say a lot differences when state implement new concept, some take years, some take months. And why is that and might it be due to some of the things that are on its list. So, as you go through the list and think about things, are there measures on here that might also be an indicator for rapid implementation.

Female: Thank you. We got 20 measures …

(Off-Mic)

Male: Yes.

Female: So we are now moving to measure 36?

(Miranda): That is correct.

Female: Total resource use population.

Female: I can't read. The resources index is a risk-adjusted measure of the frequency and intensity services utilized to manage a provider's group patient.

These sources includes all resources associated with treating members including professional facility, professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. The total cost of care index, NQF endorsed 1604 when viewed together with the total resource use measure provides some more complete picture of population-based drivers on health care cost. And I -- do we have the total cost of care index on here? Yes, that's the next around here. So are we considering these together or by themselves?

Female: They're separate measures.

Male: This is pretty …

(Off-Mic)

Female: Yes.

(Howard Chaps): Group risk score at PMPM.

Female: Right.

(Off-Mic)

Female: Right.

(Howard Chaps): At the group level though.

(Off-Mic)

(Howard Chaps): At the tax ID number. I mean it's …

(Off-Mic)

Female: This was just endorsed by the customary (refused).

Female: I was at that meeting.

Female: OK.

Female: And there was lots of discussions about …

(David Moskowitz): So this says …

Female: … the liability – you know, the actual scientific validity and method…

(Off-Mic)

Female: I think it's just a group level, isn't it?

Male: Right.

(Off-Mic)

Female: The care setting is possible ED, hospice, home health …

(Off-Mic)

Female: On the care setting.

Female: It's a PCP group.

(Off-Mic)

Female: Yes.

(David Moskowitz): So then this would effectively measure like if it's measuring at the group level, how do we – I'm worried about the lack of specificity to the high cost high need BCN population.

(Howard Chaps): My guess is the resource is indexed probably risk effect …

(David Moskowitz): Oh OK.

(Off-Mic)

(David Moskowitz): So it's a risk adjustment measure for the group.

(Jim Bosch): But I didn't see anything talking about severity of illness indicators, you know, with …

(Off-Mic)

(Jim Bosch): Well, yes, but I didn't see where – how it was risk adjusted. They say risk adjusted but they don't say how.

(Off-Mic)

(Jim Bosch): Well, because what happened, first wave of managed care came along, is all of a sudden as an interns all the family physicians, I needed to take care of all the high complexity patients who we're going to utilize more resources. So if you don't have risk adjustment really nailed down, you're going to be adversely selecting.

And if there's an answer, I'm happy to hear it, but I didn't – I couldn't find it.

Female: I don't know if we can back to it …

(Off-Mic)

(Jim Bosch): Well …

Female: You can. So we can look at the report.

(Off-Mic)

(Howard Chaps): … risk-adjusted frequency and the (inaudible) services used to manage patients using standardized (price list).

(Off-Mic)

(Peg): Health partners in 1995. They all developed total cost of care measure the next one. And then this is their – this is a complementary measure.

(Off-Mic)

Female: Cost and resource use.

Female: Cost and resource use. Maybe it sounds like a project.

(Off-Mic)

Male: It seems to me that it's a measure that's applicable for the managed care companies like health plans. Those that are Medicaid involvement managed care might be relevant for them.

Female: I would say state of Iowa Medicaid and all of their – in that same grant with the value-based purchasing. We all have to use the total cost of care measures as what we're measuring our providers well. So that one is being used. It's the total resource use that I think people don't have a lot of history for.

(David Moskowitz): So this is – I'm just trying to think through on how this would drive change for the BCN population. And so, it would do that by means of

identifying to the state Medicaid or the plans which provided groups have higher RUIs and therefore a sensibly higher rates of those patients in there. And then they could do different things. That's how it drives change.

Female: It's a data point.

(David Moskowitz): Yes, OK. So yes, it's a data point like the one you're talking about. It's just a rate – or not just a rate, it's a rate.

Male: It's an important rate though.

(David Moskowitz): Yes.

Male: So …

(Off-Mic)

Male: … high cost members, right?

(Jim Bosch): This is a report that we actually generate internally now. We can tell you based from the patients or their medical home, what the total cost of all the patients in that patients room. So who's going to be reporting to us because we'll have the most accurate data, because we paid for everything.

And so, for both of these things we already know the total cost PMPM for the entire Medicaid population and can break it down by provider. So, why are we asking other people to go to the, you know, busy work of repeating ourselves in complete data.

Male: Yes.

(Jim Bosch): Well …

(Off-Mic)

(Howard Chaps)So we at CDPS (inaudible) providers. Now, I'll give you an example on what we've done in the past. Looking at – so I've got – if you look at a pharmacy utilization, I can look at those prescriber were prescribing

a lot of prescription per member per month, PMPM. And I can then look at their percentile among their peers versus the CDPS score and their CDPS percentile among the peers. So I have Dr. (Schiff) out there, was a CDPS percentile of 8 or 9 percent, put as PMPM percentile as 95. There's something going on …

(Off-Mic)

(Jim Bosch): Well, that's my point. But are these measures for the providers to report to us or these reports for us to generate. It's like I said I'm already – and it sounds like you are – you are already generating these reports and using them. So, I don't know what they're doing here.

Female: I'm trying to look at it. How is this – how are these appropriate for the Medicaid population? I mean, as you said we're measuring this for everyone.

Male: Right.

Female: So – but if you're doing a core set of measures, if it – you ultimately want to get a core set of measures that can be used in purchasing and state Medicaid director's latitude, right? It's from the menu. You want to have both quality measures and cost measures. This is the valid cost metric for the state that we're using.

I mean, that's the way I'm looking at it. And I have a hard time discuss this at the – and this was approved in NQF in 2012 for the first time. And so, we looked at it and just this past year. End …

Female: End of the year.

Female: At the end of the year. And there was lots of discussion about it. And ultimately that was passed as being valid and reasonable to use as a …

Male: Yes.

Female: … top measure. But if I had – if I'm a Medicaid director and I want to have X number of measures, I wish I'm going to rate however the providers are doing

or the managed care entity as a proxy for how the providers are doing. I'm not sure if that – that's measured.

(Jim Bosch): So in our end game where I'm going with our high value care project, you look at the quality measures. So you're comparing your (CPN) scores, severity of illness scores with their total cost scores, with their utilization scores. If you don't have all four, you don't have a fully accurate measure for high value care. So, I'm just saying, this is an important measure, but until you can integrate all four, you're missing parts of the puzzle.

Female: So, you're using it in a vacuum where it doesn't work.

(Jim Bosch): Right. Using it in the vacuum, we will be penalizing those taken care of the …

Female: You're not getting the complete picture.

(Jim Bosch): Exactly. So, I don't mind it as a measure, but again, the question comes, is this for us as payers to be using? You want us to be reporting these measures or do we just use them internally, which is the way we're doing them now?

Male: You might (kick) through us of all the adjustments.

(Off-Mic)

Male: If the population level cost …

(Off-Mic)

Male: … unknown, and they use Johns Hopkins suggest …

(Off-Mic)

Female: OK.

(Off-Mic)

(Jim Bosch): OK, thank you, that helps.

(Miranda): All right, shall we take it for a vote? OK. Measure number 36, total resource use populations based …

(Off-Mic)

(Miranda): … index. For the first vote, does this measure or measure concept address CMS domains or key concept? If you vote high, please raise your hands, three for high. Medium, two for medium.

For the second vote, does this measure address an opportunity for improvement? So, if you vote high please raise you hands, two for high. Medium, three for medium.

For the third vote, does it measure demonstrate efficient use of resources and or contribute to alignment. Raise your hand for high please? Three for high, medium, two for medium. Is this measure or measure concept ready for immediate use?

(Off-Mic)

Female: Being used.

(Miranda): It's already being used.

Female: So, five for high. This will proceed as a measure. So is this measure important to stakeholder?

Female: High.

(Off-Mic)

(Miranda): All right, so …

(Off-Mic)

Female: Is there a way that we can say it's – that this measure should be use in conjunction with …

(Off-Mic)

Female: Yes.

Male: Yes.

(Off-Mic)

Male: Yes.

(Off-Mic)

Female: Yes.

Female: Yes.

Male: Yes.

Female: Yes.

Female: All right. It looks so evaluated.

Female: OK.

(Off-Mic)

Female: So, 36 total cost of care population based PMPM index, overall measure score 2.1. Reflects a mix of complicated factors that total cost of care index a mix of complicated factor such us patient illness burdens, service utilization, negotiated prices.

Total of cost index is the measure of the primary care providers risk adjusted cost effectiveness and managing the population to care for. PCI includes all class associated with treating members excluding professional facility inpatient and outpatient. Pharmacy lab, radiology, ancillary behavioral. A total cost of care index when viewed together with total resource use measure NQF 1598 provides a more complete picture of population base drivers of healthcare cost.

(Off-Mic)

Female: Yes. We'll proceed to the vote.

(Miranda): Sure. For measure number 35, total cost of care, population base the number of (inaudible). For the first vote, does this measure address the CMS domains or key concept? High, four for high.

Male: Are we on the 35 or 36.

Female: We are on 35.

Female: We just talked through that 36.

Female: We're finish with 36 now …

Male: All right.

Female: … we're down to 35.

Male: OK, good, got it.

(Miranda): We can take more time and do a revote on that.

Female: We can take 35 …

(Off-Mic)

Male: Not it's the same way on mine.

Female: We have 36 and then 35, they're not in numerical order.

(Off-Mic)

Female: OK.

(Jim Bosch): All right, so where are we?

(Miranda): So, we're back to 35 total cost of care population based per member per month index and we can do a revote on that first vote. So does this measure address CMS domains and key concepts? High, five vote high. The second vote,

does this measure address an opportunity for improvement. High, five vote high. Does this measure and measure concept demonstrate efficient use of resources and or contribute to alignment? High, five vote high.

Is this measure or measure concept ready bring immediate use. High, five vote high. So, it will move forward as a measure. Does this – is this measure important to stakeholders? High, five.

(Jim Bosch): I think that's the first measure today that …

(Miranda): That's true.

(Off-Mic)

Female: All right safety.

(Off-Mic)

Male: Yes.

(Miranda): (Andrea) before we move on to 50, can we do the (inaudible) for public comments …

(Andrea): Sure. Is there any public comments on which is the domain where …

(Miranda): This was population heath and prevention.

(Andrea): Population, health and prevention.

(Miranda): All right. There are no comments.

(Andrea): OK. We're moving on to the …

Male: I have a comment on.

Female: So sorry.

Female: I'm sorry.

John Shaw: Just this is an example of the kind of cross measure that would be useful to look at the speed of implementation because if the kitchen sink measure, it's looking at everything. To be successful on this, you have to get your staff and patients engage in it. So I think that's quite useful and I think there's only reflect that to some extent. So thank you.

Female: Thank you.

Female: So we are actually slated to take a15 minutes break, is everyone would like to take the time to …

(Off-Mic)

(Miranda): … use the restroom.

(Andrea): How about we just take a five-minute restroom break, OK.

Male: We got just one more domain.

(Miranda): Just one more domain …

(Off-Mic)

(BREAK)

Male: Yes.

(Off-Mic)

Male: This morning they were mentioning that the – like the concept (inaudible) like that weren't even at the measurement the concept phase was being done for the …

Female: We have measures not slated for discussion. You don't have to discuss all of them.

Male: Right.

Female: Oh they provide the majority.

Male: Yes.

Female: OK.

Male: Right, right.

Female: So we have about 90 …

(Off-Mic)

Male: Yes.

Female: And do we have any time for morning …

(Off-Mic)

(Miranda): Definitely have time tomorrow and then we reconvene …

(Off-Mic)

Female: We will just talk about the measures moving and measure concept.

(Off-Mic)

(David Moskowitz): They were just really getting like it wasn't adding to there stratification …

(Off-Mic)

(David Moskowitz): No, it was just taking that population, it was a Medicaid population and I mean that was – that was one of the data points …

(Crosstalk)

Female: Yes, yes.

Male: Yes.

(Off-Mic)

Female: Yes. They are moving forward and I think.

Female: That's good.

(Off-Mic)

(Crosstalk)

(David Moskowitz): Great. And we're going to know within year.

Male: Yes.

(David Moskowitz): Sorry, I'll get some – some more specific on the implementation I just spoke off as well as a few other things. Yes, and then there's a research team at UCSF who's got to …

(Off-Mic)

Male: So I'll get it on there.

(Off-Mic)

(Crosstalk)

(Jim Bosch): I really want this concept.

(David Moskowitz): I want the concept too but this measure is I think should be …

(Miranda): We – I mean we have all the …

(Off-Mic)

Female: Oh OK.

(Miranda): All right until 2:30.

(Off-Mic)

Female: So be – so lunch …

(Off-Mic)

Female: And then we have another breakout session after lunch …

(David Moskowitz): And then so much of the barriers there …

(Miranda): And then we reconvene …

(David Moskowitz): The barriers here, the activation are competing demand …

(Off-Mic)

(David Moskowitz): The biggest barriers is to sort of engagement …

Female: How many Medicaid …

(David Moskowitz): You know, I mean they kicked me out of my house and living on the street and you tell me …

Female: That's Iowa, I got Iowa on the break.

(David Moskowitz): Yes and …

(Off-Mic)

(Jim Bosch): It’s about Iowa, 86,000.

(David Moskowitz): Is a PAM equivalent …

(Off-Mic)

(Jim Bosch): We're still the larger majority.

(Off-Mic)

(Crosstalk)

Male: What I'm going to try to do now?

(Off-Mic)

(Jim Bosch): Yes, you know, it's the funny state we have essentially a 100 …

Male: Yes.

(Off-Mic)

Male: Yes.

(Jim Bosch): Reimbursed extremely well, or one of the most popular …

(Crosstalk)

(Off-Mic)

(Jim Bosch): Because we pay promptly, we understand provider concerns, they know how to reach me and know …

(Off-Mic)

(Jim Bosch): Best quality care right at the very beginning.

(Off-Mic)

(Jim Bosch): Which makes it sort of fun.

(Off-Mic)

(Crosstalk)

(Jim Bosch): So, yes, I wouldn't do this job for another state. I seriously and that would just broke the (prior) thing. We have one of the best Medicaid programs in the nation. You know, we had this (RHIE) working for …

(Andrea): You're not a Medicaid expansion state are you?

(Jim Bosch): No. It doesn't matter. It's quality not quantity. So, and if we go to block grants, fine, we'll make it best block grant program in the nation.

Male: The thing is, it's not just small state that you don't have as many political factions. (Inaudible) factions, you know, you try to move forward, something Colorado and someone jumps up with somewhere and blocks it.

(Andrea): Sure.

(Jim Bosch): And you got to go to so many committees that, you know, it's like, you know, the elephant is of course designed by committee.

(Off-Mic)

Female: Sure.

Male: Yes.

(Off-Mic)

Female: Are you …

(Off-Mic)

(Andrea): OK.

(Off-Mic)

(Andrea): OK.

(Off-Mic)

(Andrea): Yes and he was at Humana then he came to us and then he went back to Louisville to a small …

(Off-Mic)

(Andrea): Yes. Now he's at HighMark.

(Off-Mic)

(Andrea): He's at HighMark, yes.

(Off-Mic)

Female: This is very nice, very nice.

(Off-Mic)

(Andrea): OK.

(Off-Mic)

Female: Well we haven't used it years.

(Off-Mic)

(Crosstalk)

Female: No, I will do what I can get for you, OK?

(Off-Mic)

Female: OK.

(Off-Mic)

Male: That's the Cincinnati guy or Cleveland guy?

(Off-Mic)

Female: Are we all back? We're all back. Yes, no.

(Off-Mic)

(Andrea): OK. Moving on to safety. Measure 49, hospital wide all cause, unplanned, readmission rate, overall measure of score 2.7. So this is – is this the CMS …

Female: Yes.

(Andrea): Measure, I think (Gale) actually developed it. This estimate – this standardized admission rate (inaudible) all cause admission after admission for any eligible condition within 30 days of discharge.

Reports of single summary RSRR derived from the volume weighted results of five different models that we met. I'm not sure this is a CMS measure.

(Off-Mic)

(Andrea): OK, so it is. OK. Does anyone want me to go further?

Male: Yes.

(Andrea): I think this is being commonly – well, it's commonly used.

Female: Actually, reported in Colorado.

(Off-Mic)

(Andrea): I believe – I know is all of our plans, we use it internally as a measure in terms all of our – yes.

Male: And notes.

Female: Is it a fair measure?

(Off-Mic)

(Andrea): All cause, unplanned.

(David Moskowitz): So, hospital-wide versus plan-wide, I think later on there's a measure that get that plan-wide. I could be mistaken on that.

(Andrea): Readmission?

(Off-Mic)

(David Moskowitz): OK. Where am I? If there's another measure that …

Female: There's a point, a plan all cause readmission.

(David Moskowitz): Yes. That's …

Male: Right.

(Jim Bosch): That's 42?

(Andrea): Yes, that's the number of acute inpatient during the measurement year that were followed by an unplanned acute readmission.

(Off-Mic)

(Andrea): Yes, admission plan.

(David Moskowitz): And so, measuring this at the hospital level versus a planned level for BCN patient who have very high numbers of admissions. My concern about measuring this at the hospital level, is this using the balloon phenomenon where the patients may not be getting hospitalized, it's hospital A anymore but now they're showing up at hospital B.

(Jim Bosch): That's a good example, the difference in states. When you got a couple of – you got at least 100 miles between each hospital.

(David Moskowitz): Sure. Yes.

(Jim Bosch): What we really want to do is we want to measure it at the hospital level. Because I can tell you that Fremont County is in a lot worse shape than say Natrona County.

(David Moskowitz): Yes.

(Jim Bosch): And if you don't identify the hospitals at higher readmission rate, how can we help them with correct pension plan?

(David Moskowitz): Right, right, right. I mean, focusing specific on these BCN patients, I mean – and coming from an area where there's a lot higher density of hospitals and …

(Jim Bosch): And California has …

(Off-Mic)

(David Moskowitz): Yes, you know, where, I don't know what the population is of Alameda County but I think we're pretty close to Wyoming. You know, and I think (Jeff Bernard) and his crew published a really nice study that showed the rate of hospitalizations correlates with the rate of different hospital hospitalized.

(Jim Bosch): Right, right, right.

(David Moskowitz): And so I'm not trying to shoot against this measure which seems really robust and really, really valid but I have a little bit of problems with the hospital, the unit of analysis.

(Jim Bosch): Well, that's – I mean, that's really fascinating because in every report I'm saying don't get me state-wide, give me hospital specific and practice specific. Because I can't take action at a state level.

(David Moskowitz): Sure.

(Off-Mic)

(Jim Bosch): I got to know which …

(Off-Mic)

(David Moskowitz): Yes, different geography, I get it.

(Jim Bosch): Or if you probably got as many hospitals in the L.A. as we got in the state.

(Andrea): To be honest, and this was discussed at NQF. I don't remember, the transfer question came up, you know, and being admitted at a different hospital came up and they adequately answered it. I don't remember what – do you remember the rationale? I know the biggest concern of the hospital was the risks adjustment and I think they sent – yes.

Female: Big pharma is controversial measure by the way.

Male: Oh really?

(Andrea): Because of the risk adjustments. Yes, because the safety net hospital thinks they're adverse, so yes.

(Off-Mic)

(Andrea): Well CMS uses it, in Medicare, yes. This is a Medicare measure, right?

Male: Right.

(Andrea): Yes.

(Peg): But it's used in the state.

(Off-Mic)

(Howard Chaps): … 18 or higher.

(Andrea): Oh you're right. From Medicaid, right.

(David Moskowitz): Yes.

(Howard Chaps): Good point. I mean you're not going to – you don't have an (ABD) population but you're not going to get a clear picture.

Male: This is why I was trying to make reference to the extent …

(Off-Mic)

Male: … CMS is trying for envisioning that duals are going to be included as the future BCN …

(Off-Mic)

Male: Multiple factor.

Male: Yes.

Male: For this population group to become high-cost …

(Off-Mic)

(Andrea): So, I think you will have a much lower readmission rate score, obviously if you're looking at Medicaid population and a Medicare population. But measure doesn't even apply for the – or does it?

Female: It don't look like the denominator is on Medicare …

(Off-Mic)

Female: … is over 65. So I don't know what they're doing.

(Off-Mic)

(Andrea): Yes, so, I mean it's the same measures, but it could be the same measure specification.

Male: Right.

(Andrea): Do you believe it's Medicare?

Male: We don't know that.

(Andrea): So, we should probably make that note that …

(Off-Mic)

(Andrea): If it says Medicare, yes.

Male: Yes.

(Peg): So a huge issue we have is what we call off-label use for measures being specified of regular method of analysis of population. And we can't control how they're adopted outside. And I think this is …

(Andrea): But I don't think that's an issue with this measure technically, I think that CMS desperately needed some cost of care measures and they were using this readmission rate as a proxy.

(Peg): It would matter if it's for just the Medicare population, 65 and older. Because it hasn't been tested for population younger than 65.

(Jim Bosch): And it's fee for service. In most of the Medicate duals are managed care in a lot of states these days.

(Andrea): So, technically if we put this through it would be better to put it through as a measure concept? But I mean it's a good …

(Peg): It's a measure. I mean …

Female: OK.

Male: I mean this is …

Female: I will just say maybe add your concerns.

Female: OK.

Female: I think it is a strong enough measure, we've had enough …

(Off-Mic)

(Andrea): OK. Are there any other discussion? If not let's move to the vote.

(Off-Mic)

(Andrea): I know.

(Miranda): OK, for measure number 49, hospital wide all cause unplanned readmission measure. For the first vote, is this measure – does it address the CMS domains or key concept? High? Five for high.

Moving on to the second vote, does this measure address an opportunity for improvement? High? Five for high. Vote number three, does this measure demonstrate efficient use of resources and/or contribute to alignment? High? Five for high. Is this measure or measure concept ready for immediate use? High?

Male: Yes.

(Miranda): Three for high. Medium? Two for medium. This will proceed as a measure. Is this measure important to stakeholders? High? Five votes for high. Measure will be recommended from inclusion as a measure.

(Andrea): OK. Measure 66, rehospitalization during the – I'm sorry?

Male: Sixty-five.

(Andrea): Oh, sorry. Measure 65, psychiatric inpatient readmission, Medicaid, PRCRP, the overall measure score is 1.5, the description for members is 18 years of age and older, the proportion of acute inpatient psych stays during the measurement year, that was followed by an acute site readmission within 30 days.

Male: This is me.

(Off-Mic)

(Andrea): So this did not quite meet the cutoff, OK.

Male: Right.

(Off-Mic)

(Howard Chaps): It seems like it's pretty self-explanatory. We looked at it and this doesn't (inaudible) very well …

(Off-Mic)

(Howard Chaps): And I think we need to do a better job as a state, as a country …

(Off-Mic)

(Howard Chaps): I don't think the coordination is very good. I think there's a lot of patients …

(Off-Mic)

(Andrea): Who's the measure developer on this?

(Off-Mic)

(Andrea): And is anybody using it?

(Off-Mic)

(Crosstalk)

Male: Washington.

(Off-Mic)

(Andrea): Why didn't it move forward?

(Peg): Well, there's, you know, we couldn't find it as (inaudible) acceptability.

(Off-Mic)

(Peg): We couldn't determine if it was really evidence. We did know it was feasible. So that was OK, we didn't – couldn't figure out the scientific acceptability.

(Off-Mic)

(Peg): But we do, so the medium rate on …

(Off-Mic)

(Peg): And it got a high rate on the fact that it was claim, but the other two factors …

(Off-Mic)

(Peg): … it's a big measure, that's the downside of what we did …

(Off-Mic)

(Jim Bosch): And it's not here.

(Peg): It's not NQF endorsed, no.

(Andrea): Has it ever come to NQF?

(Peg): I don't know.

Female: I don't think so. It hasn't been …

(Andrea): Is there – has there been a call for behavioral health measures?

Female: Yes, we just had one. Yes.

(Andrea): And it didn't come?

(Peg): So. Someone in Washington state …

(Off-Mic)

(Peg): … the last 10 years. So I'm just …

(Off-Mic)

Female: They were putting together a lot of finance.

(Off-Mic)

(Andrea): All right, just wonder why CMS could have used that – allowing, you know, the measure we just discussed, all cause unplanned readmission report a single summary, RSRR derived from the volume weighted result of five different models. One for each of the following specialty cohorts, so they've got surgery, gynecology, general medicine, et cetera. Well I couldn't psychiatry just be an acute – yes.

Male: Maybe because this …

(Andrea): Why wouldn't that just be another condition?

(Jim Bosch): Maybe because the difference between acute care hospital and psychiatric hospital. That's what I would think.

Male: Maybe.

(Off-Mic)

(Andrea): Yes, an inpatient.

Male: Right.

(Andrea): Inpatient.

(Off-Mic)

(Jim Bosch): But most of our, you know, acute care hospitals don't have psychiatric beds. So, I mean I think they're both valid, and you're right, and they're both there but maybe combined that might have led to some skewing between those who do have psych or even those who don't.

Male: Psych readmissions, it doesn't have the things specified …

(Jim Bosch): Yes, yes, yes.

Male: Right. So, if I'm in Wyoming, I have a psychotic break …

(Off-Mic)

(Jim Bosch): It's very common.

Male: And maybe. Yes.

(Off-Mic)

(Jim Bosch): They won't do that.

Male: Right. But they'll have a – hopefully they'll have a psychiatrist …

(Off-Mic)

(Jim Bosch): No, they won't.

Male: You're on your own.

Female: Let's call the questions.

(Miranda): All right. For measure number 65, psychiatric inpatient readmission Medicaid. For the first vote, does this measure or measure concept address CMS domain or key concepts? High? Five votes for high.

Does this measure address an opportunity for improvement? High? Three for high. Medium? Two for medium.

Does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment? High? Two for high. Medium? Three for medium.

Is this measure or measure concept ready for immediate use? High? OK, three for high. Medium? One for medium. And low? One for low. This will move on as a measure.

Does this measure important to stakeholders? High? Four for high. Medium? One for medium.

(Andrea): (Inaudible). We don't know if that's a scientific validity of the measure …

(Crosstalk)

(Peg): Yes, but it's highly a Medicaid measure, which is we don't know that much yet, by the way.

Female: Right.

(Peg): You know, I think is there are not a lot of Medicaid measures.

(Off-Mic)

(Jim Bosch): Maybe there's not as much scientific evidence, but from a program standpoint, it's important.

(Andrea): It's important. It makes difference. Measure 66, rehospitalization during the first 30 days of home health, overall measures for 2.7. Description, percentage of home health stay in which patient who had an acute inpatient hospitalization of five days before the start of their home health stay. What's a home …

(Peg): It just means that …

(Off-Mic)

(Andrea): Oh, OK, at home. Were admitted to an acute care hospital during the 30 days following the third – the home health say. So they received home care and they bounced back, is that?

(David Moskowitz): Yes.

(Peg): It's the readmission …

(Off-Mic)

(Peg): They have another …

(Off-Mic)

(Jim Bosch): So, if they were in the hospital within five days of going in home health, they were in the hospital, that's your denominator. And numerator is then, again, admitted within 30 days starting.

Female: OK, this patient …

(Off-Mic)

(Andrea): So different to say when the home services were provided, and what day following the discharge were they provided, I mean?

(Peg): So this is – this should be …

(Off-Mic)

(Peg): … said right. In the five days before that start of their home health visit, it was then a different hospital during the 30-day following discharge from home health. I think what this measure is supposed to say is that they're not going to start counting to the fifth day after discharge and even within two days and three days, whatever.

Male: Yes.

(Peg): I think that's the way it should state, it goes up to 30-day. So, it's really a brief 30-day readmission measure …

(Off-Mic)

(Jim Bosch): Well, if you read the denominator, it say the acute inpatient hospitalization from the five days prior to the start. So as long as they start their home health within five days …

(Peg): That's it.

(Jim Bosch): … of being in the hospital.

(Peg): That's right. That's right. So they have (inaudible) health.

(Jim Bosch): Right.

Female: Yes, yes.

(Jim Bosch): They have to get into home health and …

(Andrea): So, if the home health agency doesn't get out there until 10 days after the patient got home and they still got back, they don't get deemed. But even though the order was written, I'm not sure this is a good measure. Is it NQF-endorsed?

(Jim Bosch): Yes.

(Peg): It is.

(Jim Bosch): 2380.

(Peg): My background is home health. So, that's an endorsed. It's readmission measure. And so, if you take the admission measures, all patient …

(Off-Mic)

(Peg): … these are only patient you take to the hospital which is a smaller number. Most of – only 38 percent of patients …

(Off-Mic)

(Peg): You know, it an OK measure too. It's not using …

(Off-Mic)

(Andrea): So help me, I still may not have an understanding. Is there a way to game this measure?

(Peg): I'm not sure …

(Off-Mic)

(Peg): It's data that's collected with people who are still going in. I don't think anybody would admit to the home care agencies …

(Off-Mic)

Male: Yes, yes.

(Andrea): I think there are other issues.

(Off-Mic)

(Andrea): OK.

(Off-Mic)

Female: With this one?

(Andrea): It is?

(Off-Mic)

(Andrea): Right?

(Jim Bosch): The core measure.

(Andrea): Yes, but it's not a (inaudible).

(Jim Bosch): Yes. OK.

(Andrea): It wasn't …

(Off-Mic)

(Jim Bosch): Got it.

(Andrea): Yes, you're right …

Male: I think you're from (Inaudible) here. I'm not sure (inaudible) measure, maybe a measure concept.

(Off-Mic)

(Howard Chaps): … patient would fall from the denominator are going to be high cost, complex …

Male: Yes.

(Howard Chaps): For the most part.

(Jim Bosch): In some way, you could almost say, again, the real measure, should they have been in from health, should they have gone first to a SNF.

(David Moskowitz): Right, that's …

(Jim Bosch): So, you're not saying that there's a problem but you're certainly looking at …

Male: Yes.

(Peg): And it lines up with all the readmission issue …

(Off-Mic)

Male: Right.

(Andrea): But if I don't get it out there until six days?

(Off-Mic)

(Andrea): Then this doesn't count?

Male: So somebody has a wound and …

(Off-Mic)

Female: They did have a measure called timely administration of care.

Male: Right.

Female: I just don't think (haven't) worked, which was speaking to the issue of, you know, (48) hours timely initiation. Most states have (inaudible) 24 or 48 hours admission.

Male: Yes.

(Andrea): OK.

Female: Yes.

(Jim Bosch): Yes. And if they don't go after 15 days, that's 10 days you're not billing.

(Off-Mic)

Male: Yes.

(Andrea): OK. Any other discussion? All right.

(Miranda): Measure number 66, rehospitalization during the first 30 days of home health. For the first vote, does this measure address CMS domain or key concepts? High? One for high. Medium? Four for medium.

And the second vote. Does this measure address an opportunity for improvement? High? Zero votes for high. Medium? Five.

Vote number three. Does this measure demonstrate effectiveness use of resources and/or contribute to alignment? High? Three for high. Medium? Two for medium. And low? One for low.

Is this measure or measure concept ready for immediate use? High? Two for high. Medium? Three for medium.

Well, let's then move forward at the measure concepts. Does this measure concept important to stakeholders? High? No votes for high. Medium? Three votes for medium. And low? Three votes for low.

So this measure will be recommended for inclusion as a measure concept.

(Off-Mic)

Male: I know we voted, but when you see this measure will be useful the concepts that didn't – those were at risk …

(Off-Mic)

Male: Yes.

(Off-Mic)

Male: There's a literature behind home health.

(Off-Mic)

Male: I know there's a company in Louisville that – I don't know them that well …

(Off-Mic)

(Andrea): OK. I'm sorry. Measure 44, emergency department release without hospital readmission during the first 30 days of home health. This had the same overall measure score 2.7 is the last description. Percent of home health stay in which patients who had an acute inpatient hospitalization in the five days before they started on home health stay. It's an emergency department. So this is an E.D. visit, right?

Male: Yes.

(Andrea): So same measures. OK.

Male: Same measure.

(Andrea): Almost the same. Almost the same measure, yes.

Male: It's E.R.

(Andrea): It wasn't quite as bad.

(Off-Mic)

(David Moskowitz): Or your – or the, I don't know, the home health nurse that – and sort of need to escalate. I don't know. I mean that I see this as being less 100 percent bad. Like there could be medically appropriate reasons for this.

(Andrea): Yes.

(David Moskowitz): That you wouldn't want to ding.

(Jim Bosch): So, you have to take the last days …

(Off-Mic)

(Jim Bosch): It's not true.

(Off-Mic)

(Jim Bosch): … primary care.

(David Moskowitz): Sure. Yes.

(Off-Mic)

(Andrea): So, let's vote.

(David Moskowitz): Wait, just a …

(Andrea): Oh, I'm sorry.

(David Moskowitz): The thing about the numerator, it does say Medicare claim – I mean as the numerator specified here, Medicare claim for outpatient emergency department – I mean if this goes through, we would, I don't know, put in the notes that that would not be Medicare since we're Medicaid here.

(Andrea): So just the previous one as well probably.

(David Moskowitz): Oh, yes, I missed that.

(Crosstalk)

(Off-Mic)

Male: There's another one with this concept …

(Off-Mic)

Male: Yes.

Female: Yes.

Male: The other one …

(Miranda): So, shall we vote?

Male: OK.

(Miranda): OK. Measure number 44, emergency department use for that hospital readmission during the first 30 days of home health.

For the first vote, does this measure or measure concept address CMS domains or key concepts? Please raise your hands for high. No votes for high. Medium? Five for medium.

For the second vote, does this measure address an opportunity for improvement? High? No votes for high. Medium? Four for medium. And low? One for low.

Does this measure demonstrate efficient use of resources and/or contribute to alignment? High? No votes for high. Medium? Five for medium.

Is this measure or measure concept ready for immediate use? High? No votes for high. Medium? Three, four votes for medium. And low? (Andrea), were you a medium?

(Andrea): That was the medium, I'm sorry.

(Miranda): That's OK. So this will move forward as a measure concept.

Is this measure concept important to stakeholders? High? No votes for high. Medium?

Female: Aye.

(Miranda): Five votes for medium. This measure will be recommended for inclusion as a measure concept.

(Andrea): Measure 68, skilled nursing facility 30-day all-cause readmission measure.

(Off-Mic)

(Andrea): Pardon me?

(Off-Mic)

(Andrea): So this estimates the risk standardized rate of all-cause unplanned hospital readmissions for patients who have been admitted to a SNF within 30 days of discharge from their prior proximal hospitalization. The prior proximal

hospitalization is defined as an admission to an inpatient facility with the CAH.

Male: The Critical Access Hospital.

(Andrea): Critical Access Hospital or psych hospital. The measure is based on data for 12 months of SNF admission, a risk-adjusted readmission rate for each facility is calculated. We have the following step.

Male: For Medicare measurement?

(Jim Bosch): Yes. Do they have anything about unrelated diagnosis? So, again, the initial one may have been COPD exacerbation but when they have a broken hip.

Male: All-cause is everything, all-cause.

Female: OK.

(Off-Mic)

(Andrea): So this – this is somewhat redundant. I mean, the all-cause readmission rate is going to include these hospitalizations. I mean …

Male: Yes.

(Andrea): … members who went to a SNF and bounced back, right?

(Off-Mic)

Male: They should be captured in the earlier ones.

(Howard Chaps): They may have been a SNF for the last 73 days. They're not going to be caught in the (inaudible) patient readmission.

(Andrea): And for Medicaid – I guess for an LTSS program, this could be important.

(Off-Mic)

Male: … initial Medicaid will go as well. I mean patient is sick …

(Off-Mic)

Male: … so again, it's as far as they get.

(Off-Mic)

(Andrea): They might call out LTSS waiver recipient as, you know, as the measure on this population, so the denominator might include all LTSS beneficiaries who had been admitted to the hospital.

(Off-Mic)

(Andrea): Yes.

Female: They had some rebound …

(Off-Mic)

(Andrea): Anyone has any other comments? Shall we vote?

(Miranda): For measure number 68, skilled nursing facility 30-day all-cause readmission measure. For the first vote, does this measure address CMS domains or key concepts? High? One vote for high. Medium? Four votes for medium.

Does this measure address an opportunity for improvement? High? No votes for high.

Female: One.

(Miranda): I'm sorry. High? One for high. Medium? Three for medium.

(Andrea): Four for medium.

(Miranda): Four for medium.

(Off-Mic)

(Miranda): And then for the third vote, does it measure demonstrate efficient of resources and/or contribute to alignment? High? One vote for high. Medium? Four votes for medium.

Is this measure or measure concept ready for immediate use? High? One vote for high. Medium? Four for medium. So this measure concept will move forward.

Is this measure concept important to stakeholders? High? One vote for high. Medium? Four for medium. This measure concept will be recommended currently in the measure set.

(Andrea): Forty two, all-cause, unplanned readmission measure for 30 days discharge from (LTAC).

(Off-Mic)

(Andrea): So, calculate risk standardized rate of unplanned, all-cause readmission for patients. Again, it's Medicare fee-for-service beneficiaries. Discharge from an (LTAC) were readmitted to the acute care hospital or a long term or an (LTAC) within 30 days of an (LTAC) discharge based on data for 24 months of the (LTAC)C discharges to non-hospital post acute levels of care or to …

(Off-Mic)

(Andrea): Anyone familiar with this measure?

(Jim Bosch): So I think in the other one was the rate. This one is the ratio.

Female: I think that this was the 30-day readmission for post acute and acute …

(Off-Mic)

Female: … there's a different description for the …

(Off-Mic)

(Andrea): … the rules that govern the organization.

(Off-Mic)

Male: Just to spin off the inpatient …

(Off-Mic)

(Andrea): So for – it's part of the Medicaid Accelerator project. How many Medicaid recipients end up in an (LTAC)?

Male: Not a lot.

Male: Not a lot.

Male: Not a lot.

(Jim Bosch): So the fact that this is – or should we score this where it's pertinent to Medicaid or just as a …

(Miranda): Yes, I think …

(John): Oh, yes, I mean …

(Miranda): … (it's pertinent) …

(Crosstalk)

(John): … (BCN) …

(Crosstalk)

(John): … too, right?

Male: Yes.

(Crosstalk)

(Jim Bosch): (It nearly is important to bring these two) …

(Crosstalk)

(Off-Mic)

Male: (If they hit an (LTAC)), they're not …

(Off-Mic)

(Howard Chaps): I think at the moment, we have zero for the year in (LTAC).

(Off-Mic)

(Howard Chaps): Actually, we have a couple …

(Off-Mic)

(Howard Chaps): We just don't see them.

(Andrea): So – because they have to a reasonable expectation for recovery and recovery of functions. So the chronically ill Medicaid beneficiary, I think, on a (chronic event) is probably …

(Off-Mic)

(Andrea): They're probably not going to – yes, they are level – or their percent likelihood of returning to acute functioning is probably significantly …

(Crosstalk)

(Andrea): … because of their baseline, yes.

(Jim Bosch): It's the difference between Medicare and Medicaid. Medicare is going to SNF (inaudible) to come out or they're going to age out, you know, time out (in the) Medicaid. If you are Medicaid and getting to a SNF, the odds are you're in a chronic defining process and you're almost not expecting, we keep looking but those who try to get out often have the highest readmission rates back into the SNF or through acute care hospitals. It's a completely different population.

(Miranda): (I hear the) discussion.

(David Moskowitz): I'm just wondering again about the applicability of patients who are or in (LTAC)s, not only to Medicaid but to those who are like high cost with potentially (ambulatory) reasons, right? That's how I'm interpreting this BCN population. So, not high cost because they had a, you know, a (car crash) or on a permanent event, but high cost because they've got yada, yada, yada, and could potentially improve that. I don't know. I didn't know how applicable this measure is to that population.

(Crosstalk)

(Jim Bosch): (That's how we can get down to is as it does become) – and, again, I have to look up from my program's perspective.

Male: Sure.

(Jim Bosch): That's what I bring. But you're not going to be statistically significant. You know, if you go from one, one year to two (to the next), that's going to be a 100 percent increase. It's a 100 percent increase (statistically).

(Crosstalk)

(Jim Bosch): (No, of course not)

(Crosstalk) .

(Jim Bosch): So …

Male: Yes.

(Off-Mic)

(Jim Bosch): … is it worthwhile tracking this down or just to sort of following them individually?

Male: Yes.

(Howard Chaps): I think that you got to draw a line (inaudible) how they measure program …

(Off-Mic)

Female: Yes, you want a parsimony …

Male: Yes.

(David Moskowitz): Yes. And this might be a very different discussion about this measure in the ((LTAC)s).

Male: Correct. Yes.

(David Moskowitz): Right?

Male: Yes. OK.

(Miranda): OK. So, shall we vote?

Male: Yes.

Male: Yes.

(Miranda): OK. Measure number 42, all-cause, unplanned readmission number for 30 days …

(Off-Mic)

(Miranda): … from long-term care hospitals. For the first vote, does this measure address CMS domains …

(Off-Mic)

(Miranda): … allergies, I'm sorry. Does it address CMS domains or (key concepts)? High? No votes for high. Medium? No votes for medium. And low? Five votes for low. This measure will not be recommended for inclusion (inaudible) (measure side).

Measure 38, acute care hospitalization during the first 60 days of home health. And the description is percentage of home health stay in which patient is admitted to an acute care hospital during the 60 days following the start of

home health. Why we are calling these home health stays, it's really the start of home health services, right?

(Off-Mic)

(Miranda): Oh, OK, yes.

Female: Episode of care …

(Off-Mic)

(Miranda): OK. OK.

Male: This is the same as 66. (We've just added 60) …

(Crosstalk)

(Off-Mic)

(John): Oh, yes, sure.

(Off-Mic)

(John): I mean from a care perspective that might be a distinction without a difference. I mean, I don't now.

(Andrea): That's where you measure the doctor orders of home health or the home health.

(Off-Mic)

(Andrea): So the doctor maybe should have ordered the home health services 20 days sooner or I mean …

(Off-Mic)

(Andrea): Yes.

(Off-Mic)

(Jim Bosch): I can correct. That would worry me because sometimes you're seeing that the patient is starting …

(Off-Mic)

(Jim Bosch): … inadequate care at home, no family members, community support. So you say, God, maybe we could keep him out of the hospital by throwing some intensive home health at him and the patient continues to decline is …

(Crosstalk)

(Jim Bosch): Fifty days is a long term – long time if you're looking at patient's influx. And it makes more sense to start with the home health and say, oh, this is either no support or into the hospital. So I don't – I get your concerns about this one.

Female: Is this NQF-endorsed, (Trish)?

(Trish): It is. This is part of their (strong) program. (You notice the average) …

(Off-Mic)

Male: (Bridge program).

(Andrea): During the first 60 days.

(Off-Mic)

Female: Which program?

Male: Maybe it's part of NQF program.

Female: (Bridging) program.

Male: (Is that a program)?

(Crosstalk)

Male: (Or a measure)?

Female: Oh, it's in the home health drug measure program?

(Off-Mic)

Female: It's the Star measure. (It’s using) …

Female: It used to be …

(Off-Mic)

(Crosstalk)

Female: So, I hope that home health (can translate) …

(Off-Mic)

Male: So question is, is this applicable to the Medicaid population …

(Off-Mic)

Female: Oh, it is.

Female: I think when the patient becomes (inaudible), you know, it's not just …

(Crosstalk)

(Off-Mic)

Female: Any other discussion?

(Miranda): OK. You can (take it) for a vote. Measure number 38, acute care hospitalization during the first 60 days of home health.

For the first vote, does this measure address CMS domains for key concepts? High? No votes for high. Medium? Four votes for medium. And low? One vote for low.

For the second vote, does this measure address an opportunity for improvement? High? No votes for high. Medium? Three votes for medium. And low? One vote for low.

(Off-Mic)

Male: … two.

(Miranda): I'm sorry, yes, two votes for low. And so the third vote, does this measure demonstrate efficient use of resources and/or contribute to alignment? High? No votes for high. Medium? Three for medium. And low?

(Off-Mic)

(Miranda): Two for low. Is this measure or measure concept ready for immediate use? High? Medium? Three for medium. And low? Two for low.

So this will proceed as a measure concept. Is this measure concept important to stakeholders? High? Medium? And low? Five for low. This measure concept will not be recommended for inclusion.

(David Moskowitz): We haven't gone down that way yet …

(Crosstalk)

(Miranda): Oh, yes, yes, yes.

(Jim Bosch): No, actually, yes, because we said three. It got three on the medium to …

Male: Right.

(Jim Bosch): So as the concept and then it got five lows …

(Crosstalk)

Male: Yes.

(Crosstalk)

Male: Yes.

(Jim Bosch): Right.

(Andrea): OK. Measure – I'm sorry?

Male: Can we do 45 next?

(Andrea): Yes, we can do 45 next. Emergency department use without hospitalization in the first 60 days of home health. So they didn't get admitted, they just got on to the ER.

(Off-Mic)

(Andrea): I think it's the same – otherwise same measure. Any discussion?

Male: I guess I can say …

(Off-Mic)

(Miranda): All right, let's (call the row).

(Off-Mic)

(Andrea): Oh, should you be?

(Off-Mic)

Female: … forty-two?

Female: No.

Female: Forty five.

Male: Forty five.

Female: Yes.

(Off-Mic)

(Miranda): All right, are we ready for a vote? OK. Measure number 45, emergency department use without hospitalization in the first 60 days of home health. For the first vote, does this measure or measure concept address CMS domains or key concepts? High? No votes for high. Medium? One for medium. And low? Four for low. This measure will not be recommended for inclusion in the measure set.

(Andrea): OK, medication reconciliation post discharge. Percent of discharge is from January 1st to December 1 – is that December 31 of the measurement year?

Male: December 31.

(Andrea): For members 18 years of age and older, (some of the) medications were reconciled, the date of discharge through 30 days after discharge. So, it's a process measure, they receive the medication reconciliation, correct?

Male: Yes.

(Andrea): (OK).

Male: This is my …

(Howard Chaps): This isn't the same as Star measure and there's – I guess there's some potential (gain) in the system. I think it's a difficult measure …

(Off-Mic)

(Howard Chaps): … harder to obtain. I think it's the right thing to do (so that the) primary care provider has (inaudible) (reconciled) …

(Off-Mic)

(Howard Chaps): … (not) reconciling the patients (inaudible) (readmissions) to the hospital …

(Off-Mic)

(Howard Chaps): … medications with – I can – I mean I can list …

(Off-Mic)

(Howard Chaps): I have a subset of (members) of local pharmacies, local prescribers, and if told you the numbers, you'll (probably fall) …

(Off-Mic)

(Howard Chaps): (In exposing) the hospital, it's identified …

(Off-Mic)

(Howard Chaps): I feel strongly about this one. (It is in line) with the Medicare …

(Off-Mic)

(Howard Chaps): … as well. It's a good – I think it's a good measure to hold on (basically) as well as our stakeholders.

(Jim Bosch): So can you explain to me because we had dropped number five, and that's the inclusion (for the meds). We approved number six med reconciliation. We have (inaudible) number seven (med) reconciliation. So how does number 52 – (how do you see that as different)?

(Off-Mic)

(Miranda): Which other one are we looking at, 47?

(Howard Chaps): Oh, we – you know …

(Off-Mic)

(Miranda): Yes, I remember that …

(Crosstalk)

(Howard Chaps): … ago, we (usually have about) three or four med reconciliations. Again, post discharge and we – (we already have) (inaudible) post discharge, and actually two of them went through as concepts.

Male: On the reconciliation?

(Howard Chaps): One is a real measure and one got scoffers, so.

Male: So six – did six get through the measure?

(Off-Mic)

(Andrea): Six got through the measure?

Female: Is that correct?

(Andrea): Right, that was right, yes.

Male: Yes.

(Crosstalk)

(Miranda): … as a measure.

(Crosstalk)

(Peg): … concept.

(Off-Mic)

(John): Six is a no.

(Off-Mic)

(Howard Chaps): This is – yes, this was discrepancy one, right?

(Off-Mic)

(Andrea): Measure concept.

(Off-Mic)

(Howard Chaps): I think the question is they're similar to six, right? And I think they're very similar. The difference here is that the six …

Male: Yes.

(Howard Chaps): You know, there (was a month) of inclusion criteria versus 12 months. And, again, the reason that I threw it back in was because (inaudible) (CMS), Medicare …

(Off-Mic)

(Howard Chaps): The providers like to have consistency. They (don't like digging). They don't like to keep on (setting) new measures (or rules) that will give them …

(Off-Mic)

(Howard Chaps): … Medicare-Medicaid perspective.

(Andrea): So are there any other medication, reconciliation measures for …

(Off-Mic)

(Andrea): … I mean other than the ones that (you) went through?

Male: No.

(Crosstalk)

(Andrea): I don't think there are any others coming up …

(Crosstalk)

(Jim Bosch): I think that's the last one.

(Off-Mic)

(Jim Bosch): (So on a similar note), I think the Coordinating Committee might look at these sometime with both have been going forward. (I think you all) …

(Off-Mic)

(Andrea): Why don't we vote?

Male: Good idea.

(Miranda): All right. Measure number 53, medication reconciliation post discharge. Percent of discharges from January 1st to December 31st of the measurement year from members 18 years of age and the older where these medications were reconciled. The date of discharge, 330 days after discharge. Vote number one, does this measure or measure concept address CMS domains or key concepts? High? Four for high. Medium? One for medium.

For the second vote, does this measure address an opportunity for improvement? High? One for high. Medium? Four for medium.

Does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment? High? Two for high. Medium? Two for medium. And low? One for low.

Is this measure or measure concept ready for immediate use? High? One for high. Medium? Three for medium. And low? One for low. This will move forward as a measure concept. I'm sorry?

Male: (It’s measure), right?

(Miranda): So, if it's medium or low, it moves forward as a measure …

(Crosstalk)

(Off-Mic)

(Miranda): Right.

Female: Why would this not be ready for immediate use (inaudible)?

(Andrea): Yes. Is anybody using – this is CMS Star measure, so it's ready to move forward …

(Crosstalk)

(Andrea): … to use it.

(Off-Mic)

Female: Yes, so I would change mine to high.

(Miranda): OK. So, we have two high, two medium, one low.

Male: No, I'll go high. I'm sorry.

(Miranda): OK. Vote is three high.

Female: Three high.

(Crosstalk)

(Off-Mic)

Male: (We'll think through).

(Miranda): It's OK.

(Crosstalk)

(Miranda): Let's get into session.

(Off-Mic)

Female: I would – no, wait, wait.

(Off-Mic)

Female: Which one …

(Off-Mic)

Male: Fifty three.

(Crosstalk)

Female: Fifty three is (not. I don't think so).

Male: No.

Female: It does not, so.

(Off-Mic)

Male: Yes.

(Off-Mic)

Female: OK.

Male: (HEDIS) measure.

(Off-Mic)

Male: So, is this a Star measure?

Male: It is.

Male: All right.

Male: And I don’t see it – it doesn't say it is.

(Crosstalk)

Male: … NCQA.

(Off-Mic)

(Jim Bosch): (It says it’s HEDIS) measure.

(Off-Mic)

(Jim Bosch): So, there is an initial …

(Off-Mic)

Male: Well, there is a …

(Off-Mic)

Female: (Let me just say again), sometimes it is difficult to get …

(Crosstalk)

(Off-Mic)

(Andrea): OK, (inaudible).

(Miranda): So, we have one (to vote). So it's moving forward as a measure. Is this measure important to stakeholders? High? Three high. Medium? Two medium. So, this will be recommended as a measure.

(Andrea): Thank you. Measure 64, proportion of patients with a chronic condition that have a potentially avoidable complication during the calendar year. The description is …

(Crosstalk)

Male: Yes.

(Andrea): … a potentially avoidable complication. Yes. We use potentially avoidable hospitalization, I mean the (3O stuff) and ED visit, but a potentially avoidable complication. Six percent of adult population aged 18 to 65 who are identified as having each one of the following six chronic conditions -- diabetes, CHF, coronary artery disease, hypertension, COPD or asthma were following for one year.

And I'm sorry, I've got writing over my writing. They had a potentially avoidable and were noted to have potentially avoidable complications; had one or more potentially avoidable complications. A potentially avoidable complication is an event that negatively impacts the patient and is potentially controllable by the physician. And there are a list of them, aren't there? I believe that this is a (3M-3O) measure.

Male: It's not.

(Andrea): It's not?

Male: No.

(Andrea): What is this?

(Off-Mic)

(Crosstalk)

Male: It’s Bridges to Excellence.

(Andrea): Bridges to Excellence. Says who?

Female: Bridges to Excellence.

Female: Oh, I think it's up for endorsed maintenance review then.

(Andrea): So they have – so who had defined the potentially avoidable complication?

(Off-Mic)

Female: There – I think there are hundreds. A lot.

(Andrea): And Bridges to Excellence came up with that?

Female: Yes. I think the steward has changed. I'm just double checking. We just got the voting results from this measure, so.

(Andrea): I'm not going to – you – we can all read this.

Male: Yes.

(Off-Mic)

Female: Bridges to Excellence.

Male: Second, what is Bridges – no, OK, I didn't know what is the (inaudible) and I didn't …

(Crosstalk)

(John): Robert Wood Johnson, I think, funded the whole series of experiment on Bridges to Excellence.

(Off-Mic)

Male: I mean …

(Andrea): It was – they're very active or were active with commercial insurers, so private insurers not Medicaid, yes. And try to develop some measures that employer groups could use to measure the effectiveness of the plan who were the stewards of the employer's money.

(David Moskowitz): I mean this – I like the – I like what the measure is getting at. I mean these are the – I think CHCS appears (to go to this) really great analysis of co-morbidity patterns that are particularly high cost and particularly high – resulting in high utilization patterns. And I mean the different diagnoses and co-morbidity patterns that this measure specify has really aligned well with what they found.

And I mean, this is really what we're with super utilizer work. This is what's we're trying to do. This is what we're trying to impact. I don't know how sort of rigorously evaluated this measure is. But, man, this is something really crunchy and actionable that I could look at and potentially impact.

Female: Are any state Medicaid agencies using this? We don't have …

(Crosstalk)

Male: … Medicaid.

(Off-Mic)

(Jim Bosch): Yes. Actually that is one of the things we're starting to look at. We haven't formally been reporting on it. But we are tracking now starting this year are potentially preventable readmissions and preventable ER visits.

Female: Is Medicare using this?

(Peg): It doesn't look …

(Off-Mic)

(Peg): … population (the last) …

Male: What (Peg) says that's interesting is – but potentially in the event of ER visits and the readmissions …

(Andrea): Yes.

(Off-Mic)

(Andrea): Yes.

(Off-Mic)

Male: … Medicaid program.

(Crosstalk)

Male: But it is a measure that could be used; the 30-day (rule complication).

Male: (Inaudible). (Is that a problem)?

(Off-Mic)

(Howard Chaps): These people shouldn't be – I'm sorry. This population should be (better controlled) and not winding up in the ER or in the hospital (inaudible) sensitive conditions where you should be …

Male: Yes, yes.

(Howard Chaps): … winding up in the hospital …

(Off-Mic)

(Peg): (This is Peg), I'm sorry. Who is using this?

Female: It's just they are the same (as part of the rule) …

(Off-Mic)

(Peg): But no …

Female: But I don't see anybody really using it now.

(Miranda): So we know it's not in use at the federal level and federal programs. Just because we weren't able to identify any states that were using it doesn't necessarily mean that states aren't using this measure.

(Crosstalk)

Male: Yes, that's correct.

(Peg): How many states do we actually find?

(Crosstalk)

Female: Seventeen.

Female: Seventeen?

Female: Yes.

(Peg): I mean those that we actually had inputs from. And, you know, a nice number and probably the more active Medicaid (states) …

(Off-Mic)

Female: So the complications, they are essentially avoidable here and avoidable hospitalizations, right?

Male: Yes.

Male: I think those data (inaudible) population that we went ahead.

Female: (It is, that’s right).

(Andrea): (You do say). And the scientific validity of it has been …

(Peg): Has been (acceptability and we don't know).

(Andrea): Oh, thank you …

(Crosstalk)

Male: Yes, it's NQF.

Male: Yes, (0709).

(Miranda): Yes, it's got it. It's got that. It's got – I think, you know, it …

(Off-Mic)

(Andrea): Two-point-one.

(Howard Chaps): It's like multiple choice test. The longer they – no, it's true or false, probably true or false. The longer the question, the most likely it's (true).

(Crosstalk)

(Off-Mic)

(Andrea): So, there is no reason this wouldn't be applicable to a Medicaid population, right?

Female: Absolutely not.

Female: That's right. (Inaudible) (duals) project here …

(Off-Mic)

(Andrea): And how recent was that?

(Miranda): I don't know. I think it was in and out last review.

(Off-Mic)

(Peg): I think the last review. But this measure was looked at very recently.

(Andrea): And the retained endorsement. Oh, there were …

(Crosstalk)

(Peg): Yes, they were. I'm trying – I think the developer has changed to, it's no longer Bridges to Excellence. I think it's some alt term.

Male: Yes.

Female: Yes.

(Andrea): So, what did they do? Is it still NQF-endorsed?

(Peg): I actually just got the voting results right now. We haven't informed anyone. But there were significant issues with validity.

(Off-Mic)

(Andrea): So, it's not going to be endorsed anymore?

Female: I don't know.

(Crosstalk)

(Peg): It's been processed.

(Howard Chaps): (Stopped now).

(Peg): I mean part of it is the (inaudible). There was some concern that there were a significant number of potential avoidable complications. And they weren't necessarily attributed to, you know, some of the – they couldn't tie it back to some of the diagnoses and things like that.

I don't know if this is the one. There are number of measures that are very similar. I can't say for sure if this is enough. I have to go back and look. There are like five or six measures that are going under review by the same

developer with the (MedPack) and different situations. And one is like a year out. I don't think this is it. This is 60 days or?

(Off-Mic)

(Howard Chaps): And during the calendar year.

(Crosstalk)

(Peg): Calendar year. So that was the time period was also significant.

(Off-Mic)

Male: Yes.

(Off-Mic)

Male: … COPD. (I mean) …

(Off-Mic)

(David Moskowitz): Yes. It's these (comorbidity) patterns …

Male: Yes.

(David Moskowitz): … and clusters that – yes.

(Peg): So part of the concern, the Patient Safety Committee, had who reviewed this was that this may be a better (Q.I.) tool.

(Off-Mic)

(Peg): … so that might be – you know, they said, well, it's played for, you know, improvement in that situation. But when you bring in accountability, they're thinking around the measure change.

Male: (May I read you a quote) from the owners that say that as part of the development of (the component) …

(Off-Mic)

Male: … it has developed and published in several papers …

(Off-Mic)

Male: … the impact of potentially avoidable complication on both the cost of care, potentially avoidable complications for patients with one or more chronic illnesses include events as emergency department (inaudible).

So they are not talking about the specific complication (but whether) an impact or future utilization, more of a broader (inaudible) preventable events (inaudible), which they are very specific like infection or hospital-acquired infection for …

(Off-Mic)

(Andrea): Shall we take a vote?

(Miranda): Measure number 64, (compression) of patient with a chronic condition that have a potentially avoidable complication during a calendar year. For the first vote, does this measure or measure concept address CMS domains or key concepts? High? Four for – five for high.

For the second vote, does this measure or measure concept address an opportunity for improvement? High? Four. Medium? One.

Does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment? High? No votes for high. Medium? I'm sorry, one vote for high. Medium? Three for medium.

(Off-Mic)

(Miranda): OK, three for medium. And low? One vote for low.

Is this measure or measure concept ready for immediate use? High? No votes for high. Medium? Four votes for medium. And low? One vote for low. This will now move forward as a measure concept.

Is this measure concept important to stakeholders? High? Three. Medium? Two. These measure concepts will be recommended for inclusion.

(Off-Mic)

(Crosstalk)

(Andrea): How many do we have left? One, two, three.

(Off-Mic)

(Andrea): We have 11.

Male: Eleven more, is what I count.

(Crosstalk)

(Off-Mic)

(Andrea): Yes.

(Crosstalk)

Female: Well, I'm just wondering, you know – I'm just reading on where we are so you all know.

Female: So, you have a hard stop at 4:40 and then (we'll forward out)?

Female: Yes.

(Off-Mic)

(Crosstalk)

Male: (And we can barely slow down to moderate).

Male: Yes.

(Crosstalk)

(Off-Mic)

(Peg): And possibly go back and talk about …

Male: Yes.

(Crosstalk)

(Peg): … some issues that, you know, came up that, you know, we may want to (set), you know, this – a lot of these measures …

(Off-Mic)

(Peg): … the measure concept, you know, questionable that, you know, maybe we want …

Male: Yes.

(Peg): … to go back and look at …

(Off-Mic)

(Peg): It is the chance to look at it in a broader way (from this) committee …

(Off-Mic)

(Peg): I mean we could, you know, (check to everybody when to do) another one or two.

(David Moskowitz): Right. The next one up is the discussion is very closely related to the discussion on the previous measure, so …

(Crosstalk)

(Andrea): So, why don't we go on to the next?

(Crosstalk)

Male: All right, I think the next two were actually pretty aligned with (a number) …

(David Moskowitz): Right.

(Crosstalk)

(Off-Mic)

(Andrea): All right, measure 63 …

(Crosstalk)

(Andrea): … prevention quality indicators number 90, PQI number 90. Overall composite per 100,000 population age 18 years and over includes admission for one of the following conditions -- diabetes and short-term complications, diabetes with long-term complications, uncontrolled diabetes, and diabetes with lower extremity amputation, so COPD, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection. So these are PQI.

(Crosstalk)

(Andrea): Save it.

(David Moskowitz): And so, I wanted to bring this up for discussion. This was (spell) below the mean. You know, this gets at the same kind of concept that we're talking about with the previous measure -- ambulatory care, sensitive conditions, you know, specified in a different manner.

California's (inaudible) waiver program is using this as an incentivized measure across all public hospital systems, both for our complex care management intervention as well as another sort of – another intervention more broadly. So, yes, it's just another nice way of getting at, you know, how we're impacting these avoidable admissions.

(Off-Mic)

Male: No, it's a statewide …

(Andrea): So Mass Medicaid used to use this, didn't they? Massachusetts Medicaid?

Female: I don't know.

(Off-Mic)

Female: I don't know.

(Andrea): I thought they did.

(Off-Mic)

Female: But you're telling that the …

(Off-Mic)

(David Moskowitz): Yes, the Cal – yes, California is, you know, we're not calling it DSRIP, but the DSRIP that we're doing, DSRIP 2.0. We were told not to call it DSRIP 2.0. (Inaudible) 2020, this is the measure that's going statewide to incent public hospital systems.

(Off-Mic)

(Jim Bosch): Yes, they are. In fact …

(Off-Mic)

Female: They are.

(Off-Mic)

Male: I think using the three to one per …

(Off-Mic)

(David Moskowitz): What do you mean by …

(Off-Mic)

(David Moskowitz): The hospital, the public hospital does.

Male: OK.

(David Moskowitz): Yes. And it's a (P for P) kind of thing.

Male: OK.

(Crosstalk)

Female: … as well.

Female: Yes.

Male: It is hospital specific?

Male: Population.

(David Moskowitz): Yes, so I mean, so it's – I mean, the mechanics of this in California are the public hospitals all have clinics affiliated with them. And this is – our DSRIP is to – is sort of pushing the hospitals to manage their populations more proactively. So it doesn't – it's not that every patient is hospitalized that our public hospital system is tracking this measure. It's our attributed patients, our Medi-Cal managed care patients, and other patients who were seen in our medical homes who are also hospitalized in our acute care sides account for this.

(Jim Bosch): So these programs (inaudible) so program in L.A and different (figures) results from those in San Francisco?

(David Moskowitz): Oh yes, yes, yes.

(Jim Bosch): OK.

Female: So why it would it be the hospital not the physician?

(Howard Chaps): Well, it's something – it's a population measure.

(David Moskowitz): It's a – yes, it's population measure.

(Jim Bosch): Of course, per 100,000, that's more than my entire state Medicaid.

(David Moskowitz): Yes.

(Howard Chaps): The number I mean.

(Off-Mic)

(Jim Bosch): I don't think it's a good measure …

(Off-Mic)

(David Moskowitz): Yes. Yes.

(Off-Mic)

(David Moskowitz): Lower is better? Right, lower is better. There are – there's a whole benchmarking process. I mean, because there is – because it's a (P for P) metric, there's a benchmark …

(Off-Mic)

(David Moskowitz): … to show them that the hospitals need to show improvement against – if I was – if I was smart, I would have brought some more details on how that benchmark gets set because that would have helped the – help guide the discussion on sort of the previous validation of this, but I didn't.

Female: I can see that if the hospital owns the physician. But if the hospital does not own the physician, how can you grade the hospitals?

(David Moskowitz): No, no, no.

Female: The (inflection) of the outpatient care.

(David Moskowitz): It's the outpatient care. I misspoke when I said it's the hospital. It's the way that we are using this right now. Because the FQHCs that are affiliated with the public hospitals in California have such extreme data sharing issues, that the easiest way for them to get data for this measure, for the (inaudible) and MD is to look at the patients who are assigned to their clinic, who are

hospitalized at their hospital, knowing that we need to push (omni) on that. But that is how it's being used right now. So, not a hospital measure, it's a physician to our clinic measure.

Female: They're aggregated to a higher level.

(David Moskowitz): Aggregated, yes, aggregated to a population level. Exactly.

(Andrea): In Medicaid, there may be so many – is it applicable to Medicaid?

(David Moskowitz): That's how we're using it.

(Andrea): You are – oh, I apologize.

(David Moskowitz): Yes, yes. No, this is Medicaid. This is the Medicaid waver.

(Howard Chaps): These are all – not all but, you know, typically, these are – they look like patients or members that have complex needs that from a (inaudible).

(David Moskowitz): Yes.

(Howard Chaps): So you mentioned for dehydration, (pneumonia). Well, it depends on the (inaudible). But there, I can see Medicaid easily on this one.

(David Moskowitz): Yes.

(Off-Mic)

Male: Yes.

Male: And the reason I'm asking (inaudible) for example, in fact (inaudible) the statewide programs, it's not processed, it's not directed to Medicaid population.

(David Moskowitz): So right. So our – I mean, the public – the clinics …

Female: So they're being – they are using – yes, efficiently using all the resource support.

(David Moskowitz): Right. Yes. So I mean, our clinics use some residually uninsured and, you know, some, you know, very miniscule percentage of commercial pay patients. And they all fall into this sort denominator target population that we're measuring this for. But I mean, far and away, they're Medicaid. And, you know, in terms of driving up these PQI 90 scores amongst those patients, it's even more enriched in Medicaid and these super utilizers.

(Jim Bosch): So this population is just like with (our CQM) quality measures and (inaudible) to make. We asked them report on all their patients not just the Medicaid clients, only paying them. So and again that's just another – like I said, we have essentially 100 percent of all providers, (R&Rs) and almost none of them are in FQHCs.

(David Moskowitz): Yes, yes.

(Jim Bosch): And but if you're reporting your Medicare and Medicaid, Blue Cross, Cigna …

(David Moskowitz): Right.

(Jim Bosch): You know, that's real population health and that would make this more valuable.

(David Moskowitz): Yes.

(Andrea): (Inaudible) to vote?

(Miranda): Measure number 63, prevention quality indicators number 90. For the first vote, does this measure and measure concept address the CMS domain or key concepts? High? Three high. Medium? Two medium.

For the second vote, does this measure or measure concept address an opportunity for improvement. High? One vote for high. Medium? Four for medium. Does this measure and measure concept demonstrate efficient use of resources and/or contribute to alignment? High? Medium? Five for medium.

Is this measure or measure concept ready for immediate use? High? Three for high. Medium? Two for medium. So we'll proceed as a measure. Is this

measure important to stakeholders? High? Three for high. Medium? Two for medium.

(Andrea): That moves forward as a measure.

Do the rest for tomorrow?

(Off-Mic)

(Jim Bosch): I thought I would just – all cause readmissions, but we can save that for tomorrow. We have 10 minutes left now. I don't have any objection. We got 10 to go tomorrow.

(Off-Mic)

(Peg): … summary remarks. Actually, what I thought I would do or (Miranda) and I could talk after this …

(Off-Mic)

(Peg): … and kind of see what was a measure that actually felt …

(Off-Mic)

(Peg): … how many measures went through and …

(Andrea): Sure. That would be really helpful.

(Peg): We'll do an analysis of where we are …

(Off-Mic)

(Peg): And you know it will …

(Off-Mic)

(Andrea): So we are going to reconvene this afternoon?

Female: No, no.

(Off-Mic)

(Peg): I think it ends at – it actually ends at about 4:40 …

(Off-Mic)

Female: OK.

(Peg): But in the breakout session.

(Miranda): Right. So we don't reconvene as larger group until tomorrow afternoon. So tomorrow, we'll have breakfast together, but then we'll come back here …

(Off-Mic)

(Andrea): OK.

Male: Public comments.

(Off-Mic)

Male: Don't forget particularly out there on the phone.

(Off-Mic)

Female: She's gone.

(Off-Mic)

(Andrea): So we are going – we haven't finished that section though. Should we do a couple of comments on the measures we have done to date for this section?

(Miranda): We …

(Off-Mic)

(Miranda): … for the comments or discussions at the end of each domain but we have them the member of the public in the room with us, so …

(Andrea): Do you have any comments on the safety measures we have discussed?

John Shaw: The same area that the group has raised, I think we're going to be even more concerned about many of the safety measures are based on Medicare fee for service population. And question we came up a number of times is, is this applicable to Medicaid and specifically to the Medicaid BCN population.

And in general, the concept probably is my concern is that in looking at risk factors in the Medicaid versus Medicare population, there was quite a bit a difference because there's not much in the way have risk factor, risk adjustment for behavior and substance in the Medicare fee for service population because there's not that many people with mental health and substance issues in the Medicare fee for service population.

And so this maybe something to consider kicking back before we have to deal with it to CMS and see if they're OK for us to say you think this is a good idea, but it needs to be validated and these scores rebalanced for the Medicaid or Medicaid BCN population to be applicable better. So how to do that, go ahead and please before June.

(Jim Bosch): Can I – since we have some time, can I introduce some areas that I have a huge concern over and I don't really see addressed in the communities. And as, you know, with the CMS' expansion of the mortality reviews to include abuse, neglect, exploitation, restraints and standards of care. That's when we set up our 1915(c) Q.A. committee. And we are seeing significant volumes of A&E restraints. I'm sorry?

Female: Restraint?

(Jim Bosch): Abuse, neglect, exploitation. Oh restraints? (Inaudible) restraints, still …

(Andrea): It happened at joint commission then after a restraints …

(Off-Mic)

(Jim Bosch): Yes. Yes.

(Off-Mic)

(Jim Bosch): We are going to round and round with attorney general. Our attorney generals are giving this contradictory advice, the amount of A&E that still occurs in the state. We just even have to convene the governor's taskforce on elderly, vulnerable adults. But the (D.E.) population and the home and community base continue to see things that are really hair raising and we're not taking any safety issues around those specific populations. No quality measures around in populations. We are seeing (D.E.) populations who are clearly chemically restrained. There are two or three different psychotropics along with stabilizers, along with benzos. We're still getting prone (for) restraints and highly restricted plan for care.

So far, we've been fighting sort of one man crusade. I've got at least (RAGs) on board right at this point in time, but this is an area that's not been measured before until we open this Q.A. committees so I would find anecdotes and now we're getting a lot more. And when we're talking about some Medicaid specific things, these are the most vulnerable population in Medicaid. And I think we should be looking at some measure-specific to those two populations. And so specifically around our 1915(c) waivers.

(Off-Mic)

Female: There is a …

(Off-Mic)

Female: Although I don’t know …

(Off-Mic)

(Jim Bosch): (Inaudible) homeland communities.

(Off-Mic)

Female: It isn’t …

(Off-Mic)

Female: But I don’t know that they have measured …

(Off-Mic)

(Jim Bosch): Well, for example – and then again, adult protected services is in such a state of infancy as compared to child protected services. We still get APS workers who are saying, well, this patient is choosing to abused. Well, these are very vulnerable adults and a vulnerable adult cannot choose to be abuse and more than a child can choose to be abused.

But because they're so – there's a bunch of lack of clarity here, we are actually getting people where their children are stealing their funds. They are stealing their drugs. They are neglecting them. They're letting them sit in their excrement all day. And APS comes in and then they say, "Oh no, don't do anything with Johnny. I'm happy." Really? And these go to the point where they end up on Medicaid roll because their funds have been be stolen.

We're working with programming in (inaudible) but APS, more often than not, just says, “Well, they're choosing to be exploited. We can't do anything.”

So it is, I would say, it's the Wild West and I don't think it's isolated to Wyoming because as part of our governor's taskforce on elderly vulnerable adults, such a large proportion of adult around this nation are victims of A&E. But until we start tracking them, you're not going to know the extent, right? I'm shocked about the extent I've discovered being on these two committees. So, I don't know if you all have thought about that or what you already doing about that but I do think specific measures would be warranted.

(Andrea): Have you seen the – I mean, for the purposes of this committee, did they – are they high cost?

(Jim Bosch): Heavily high cost. As a matter of fact, initially we excluded them from our super-utilizer program – Wyoming super-utilizer program, we call it WySUP, very clever.

But anyway, so in our WySUP program, we initially excluded the ones on the waiver because we said, they already have case managers but then when I pulled the reports, some of our most frequent ER utilizers and frequent

hospital admission and highest cost of care and highest pharmacy were in those waivers that their waiver case managers are not clinical case managers, so.

(Off-Mic)

(Jim Bosch): And so suddenly, if we were to include them in our WySUP programs, they were paying for two case – so we're paying them over $400 a month for case management with two case managers. But that maybe where we need to go because they, are as a group costing us an arm and a leg. They are some of our most high cost complex cases in our Medicaid program.

(Off-Mic)

(Peg): But it could be something we can, you know, reported as something that's now has been, you know, being reported as potential population, you know, population and issues that has not been dealt with and could potentially, you know, these people, you know, without the data. You have the data but …

(Off-Mic)

(Jim Bosch): I can …

(Off-Mic)

(Peg): Right. But, you know, other data that supports this and you're probably right, it's probably not isolated. And so we could include that.

(Off-Mic)

(Jim Bosch): No, that's why I didn't bring it up before.

(Peg): OK.

(Jim Bosch): I just saw we had a little window.

(Peg): That's great. Thank you.

(David Moskowitz): And just to add another sort of subpopulation who are BCN who we haven't talked about today, homeless and housing related …

(Jim Bosch): Yes.

(David Moskowitz): And I mean …

(Andrea): Yes.

(David Moskowitz): We've got – there's, you know, HUD has a sort of set of measures around homelessness as part of our waiver separate from DSRIP thing, we're calling it a whole person care in California. There is, you know, there's a number of measures around permanent housing, housing services and supportive housing that counties around the state are measuring specifically with the goal of coordinating care for these patients, you know, yes, so.

(Howard Chaps): OK. Right. Other than …

(Off-Mic)

Female: OK.

(Howard Chaps): I mean it's a social determinant to health that we need.

(Jim Bosch): But in our state though not Medicaid but, you know, expansion say they should certainly would be.

(Howard Chaps): Yes.

(Off-Mic)

(David Moskowitz): I mean, there are measures that are self-reported and then there's measures that are …

(Off-Mic)

(David Moskowitz): There's a summary document of – in California, (CHDS) on the whole person care metrics which I can pass along.

Female: Yes. Thank you.

(Off-Mic)

(Andrea): Sure. So with that, we adjourn. (Inaudible) tomorrow?

(Off-Mic)

Female: … summary in the morning if that's OK for everybody? Or just …

(Off-Mic)

(Jim Bosch): Sure. Can we leave our papers here?

Male: I have a question actually. The agenda …

(Off-Mic)

(Andrea): For 15 minutes.

Female: Just to get breakfast.

(Andrea): Oh, we're there for the whole day?

(Jim Bosch): No, just for breakfast.

(Crosstalk)

(Andrea): So the breakout session, we have it there tomorrow?

(Miranda): We will be here tomorrow.

(Andrea): OK.

Female: But we start …

(Off-Mic)

(Miranda): Well, we start for breakfast …

(Off-Mic)

(Crosstalk)

Male: Here it says, we're on the 9th floor …

(Off-Mic)

(Miranda): We will be definitely in this room.

Male: Oh OK.

(Andrea): So we can leave our notebooks here?

Female: I think that's fine.

Male: So the door man will take us up to 9 and you all …

(Off-Mic)

(Crosstalk)

Female: But there is dinner tonight.

(Jim Bosch): Oh, there is?

(Off-Mic)

(Miranda): It’s walking distance from the office.

(Off-Mic)

(Miranda): We assumed that everyone was falling asleep because we …

(Crosstalk)

(Miranda): So, we assume that we would come – go straight from the office. But I am happy to walk you over. So if you want to head back to the hotel, I'm happy to walk you …

(Off-Mic)

Female: Yes. And, you know, we're probably a little early at 4:30.

Male: Yes.

(Jim Bosch): Generally, 4:30 seems …

(Crosstalk)

(Off-Mic)

Female: We have in Iowa, there are all sorts of race issues but …

Male: Everybody …

(Crosstalk)

(Off-Mic)

Female: Managed care was …

Male: But I am not coming. I'd have to do dinner with …

(Crosstalk)

Female: … all the waiver, case manager.

Male: I have a kid.

(Crosstalk)

(Off-Mic)

Male: We're having those discussions right now.

(Crosstalk)

(Off-Mic)

Female: And they will take individual checks at …

(Off-Mic)

Female: I'm just saying that when you go to the restaurant you have to use (inaudible) with your reimbursement and they do take check …

(Off-Mic)

Female: OK.

(Jim Bosch): So, what's the name of the session?

(Off-Mic)

Female: I think that's 6 p.m., right?

Female: Mm-hmm.

Male: 6 p.m.

(Off-Mic)

Male: Take the long way.

Female: And go – and then you go left to end of the hall.

Female: Here, and then left?

Female: Left and then you go down …

(Crosstalk)

(Jim Bosch): Where they were on the other floor but just don't go through the glass doors.

(Crosstalk)

(Off-Mic)

Male: OK, so …

Male: Check it out on your own.

(Crosstalk)

Female: No, no, no. I'm glad you pointed that out because I …

(Off-Mic)

Female: I'm sorry about that.

Male: Yes.

Female: You want to go up?

(Off-Mic)

(Jim Bosch): So and then, you will meet us at the hotel lobby at 6?

(Miranda): Yes, I can do that. So where are you all staying because we use a few hotels, so.

(Jim Bosch): Residence?

(Off-Mic)

Female: I don't know.

(Off-Mic)

(Jim Bosch): Yes, and few things – same Residence Inn …

Female: Great.

(Jim Bosch): … above CVS pharmacy.

Male: Yes.

(Off-Mic)

Female: Yes.

(Jim Bosch): I'll leave all of my papers here. I'm just taking my iPad.

(Miranda): OK, sounds good. Thank you, everybody.

(Jim Bosch): Thank you.

(Off-Mic)

Male: Yes. Yes.

(Off-Mic)

Male: Thanks for reminding me.

(Off-Mic)

(Miranda): Don't worry. No, actually, (Inaudible) recently got laptops but before, we didn't even have laptops, so a dinosaur is better than no laptops.

Male: Really?

(Miranda): Yes.

Male: You had just the desktop?

(Miranda): Just the desktop. Mm-hmm.

(Off-Mic)

(Miranda): Yes.

Male: Touch screen?

(Miranda): They are touch screen. It really comes in handy, I really didn't think that I would use it very much, but I like that feature.

(Off-Mic)

(Miranda): Oh my gosh. OK, thank you very much. OK. All right.

(Off-Mic)

Female: Near Metro Center. So how far?

Female: It's about maybe 15, 20-minute walk.

Female: OK.

Female: Oh, gosh, thank you.

(Crosstalk)

(Off-Mic)

Male: Yes. Yes.

Female: She printed everything. I think I've got it printed three times.

(Off-Mic)

(Crosstalk)

Female: Yes, I'm going to go right from here if that's all right.

(Miranda): Yes, that sounds good.

(Off-Mic)

Female: Maybe 13-minute walk.

Female: 13-minute walk?

Female: OK. Perfect. Perfect. Perfect. Perfect.

(Off-Mic)

Female: I did. Yes.

(Miranda): No matter how diligent I am, no matter how many notes I make, I always forgot something when I …

(Off-Mic)

(Miranda): So, when you walk out of the office …

Female: Is that the main door?

(Miranda): That's the main door. And you'll be dropped off.

Male: Wow.

(Miranda): On 15th Street. Then you're going to get to the Square, cut it …

Female: I'm going to make a left turn …

(Off-Mic)

(Miranda): So when you walk out, make a right.

Female: OK.

(Miranda): And then cut (inaudible) across the circle. And then, you are on 15th Street.

Female: Oh, is this going back towards the hotel.

(Miranda): You guys said you're at the Residence Inn, right?

Female: Uh-huh.

(Miranda): Let's see. I think so, yes. And then, instead of continuing on like towards the White House, you would cut over on (G) …

(Off-Mic)

Female: OK.

(Miranda): All right.

Female: Sounds good. So this was a good discussion, I think we (inaudible).

(Miranda): I think so too. But tomorrow, I think we'll have a little bit more of leeway …

(Off-Mic)

Female: Good.

(Miranda): … hopefully measure deliberation does a little …

(Off-Mic)

Female: Yes, we don't have that. Yes, we don't have that many left, so we should be able to, OK. All right, thanks so much.

(Miranda): No problem. Have a good night.

Female: Yes, take care.

(Off-Mic)

(Miranda): He may have gone to the restroom. All his stuff is still here, he may have gone to the restroom.

(Off-Mic)

Female: I do not know that he walked over.

Male: I don't know.

Male: Yes. Yes. Yes.

(Off-Mic)

Female: Are you in meeting 5:45 at the hotel, no?

(Off-Mic)

Male: You're welcome to …

(Crosstalk)

(Off-Mic)

Female: OK, but I'll see you at the restaurant.

Female: We all have Google Maps, so I can get there.

(Off-Mic)

Male: Hey, you coming?

Male: Yes.

(Off-Mic)

(Miranda): So, I just like a quick analysis of what have we done and we voted for 11 measures – I'm sorry not – but …

Female: They need to get through. Yes. Yes.

(Miranda): Exactly. We recommended 11 measures and 11 measure concepts.

Female: The measure concept …

(Off-Mic)

Male: Yes, right, right, right.

(Off-Mic)

Female: So, to finish …

(Off-Mic)

Female: It wasn't …

Male: Yes, yes.

(Off-Mic)

(Miranda): Yes.

(Off-Mic)

(Miranda): No, absolutely.

(Off-Mic)

Female: We did great. We did great.

(Off-Mic)

Female: Thank you very much.

Male: Thank you.

Female: Yes, we're trying. We're muddling through Medicaid, how about that? I find with a number of states …

(Off-Mic)

Male: Oh, OK.

Female: … and many people from different states, New York, Kentucky, California, Wyoming, Texas. I mean, there are five states …

(Off-Mic)

(Miranda): Yes, the diversity is great.

Female: It's fabulous.

(Off-Mic)

Female: It is.

(Off-Mic)

Male: I have no idea.

(Off-Mic)

Female: So, we don't have to do that now. What I wanted to talk about number one is, I don't know why I just did …

(Off-Mic)

(Miranda): There are same moments I was like, why am I this tired? Usually, like I'm OK …

Female: Another cup of coffee. I said, really?

(Miranda): I know. It's because we didn't sleep last night. But yes, I know, it's just, I didn't – when it initially started happening, I didn't see it coming.

Female: Yes. And I didn't stop you. So, you – I didn't want to stop you because …

(Miranda): No.

Female: … I didn't want to kind of make a big deal out of it. And I also didn't know if anybody else interpreted that way.

(Miranda): Yes, well because the thing is I looked down and the way it's written – yes, let's see. And so I'll use the slides. The way it's written, they were – like this …

Female: Yes, you could do that.

(Miranda): Yes.

Female: You could do that.

(Miranda): And it's just – it was …

Female: But I think it was geared to the concept going in that direction.

(Miranda): Yes.

Female: I do know that.

(Miranda): Already in use the Medicaid population.

Female: Yes. Yes. Yes.

(Miranda): That was the …

Female: Right, right, right.

(Off-Mic)

(Miranda): Because if we have framed it like immediate use as in, is it scientifically acceptable or, you know, is it feasible.

Female: Right, right.

(Miranda): We would have been fine but because of this …

Female: Yes, and it's not – it's sort of …

(Off-Mic)

(Miranda): I know. I know.

Female: And I said, yes, I think we did. So, I think that I just thought that we go back and we look at these because when I mentioned it with (Karen) …

(Off-Mic)

Female: Sorry, I forget my stuff.

(Off-Mic)

END