

NATIONAL QUALITY FORUM

+ + + + +

MEDICAID INNOVATION ACCELERATOR PROJECT  
COORDINATING COMMITTEE

+ + + + +

WEDNESDAY  
JUNE 7, 2017

+ + + + +

The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., William Golden and Jennifer Moore, Co-Chairs, presiding.

PRESENT:

WILLIAM GOLDEN, MD, Co-Chair; Medicaid Director, Arkansas Medicaid; Professor of Medicine and Public Health, University of Arkansas  
JENNIFER MOORE, PhD, RN, Co-Chair; Executive Director, Institute for Medicaid Innovation  
KAREN AMSTUTZ, MD, MBA, FAAP, Chief Medical Officer, Magellan Health, Inc.\*  
SANDRA FINESTONE, PsyD, Executive Director, Association of Cancer Patient Educators  
ANDREA GELZER, MD, MS, FACP, Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas Family of Companies\*  
ALLISON HAMBLIN, MSPH, Vice President for Strategic Planning, Center for Health Care Strategies, Inc.  
MAUREEN HENNESSEY, PhD, CPCC, SVP and Director, Quality and Population Health Solutions, Precision Advisors

DAVID KELLEY, MD, MPA, Chief Medical Officer,  
Office of Medical Assistance Programs,  
Pennsylvania Department of Human Services

DEBORAH KILSTEIN, RN, MBA, JD, VP Quality  
Management and Operational Support, ACAP -  
Association for Community Affiliated Plans

SREYRAM KUY, MD, MHS, FACS, Chief Medical  
Officer, Medicaid, Louisiana Department of  
Health

BARBARA McCANN, BSW, MA, Chief Industry Officer,  
Interim HealthCare Inc.

SARITA MOHANTY, MD, MPH, MBA, Regional Executive  
Director, Medi-Cal Strategy and  
Operations, Northern California, Kaiser  
Permanente\*

MARYBETH MUSUMECI, JD, Associate Director,  
Kaiser Family Foundation

MICHAEL PHELAN, MD, JD, FACEP, RDMS, CQM, Staff  
Physician, Cleveland Clinic

CHERYL POWELL, MPP, Vice President, Truven  
Health Analytics

SHERYL RYAN, MD, FAAP, Professor of Pediatrics,  
Chief Section of Adolescent Medicine,  
Department of Pediatrics, Yale School of  
Medicine

JEFF SCHIFF, MD, MBA, Medical Director,  
Minnesota Health Care Programs, Department  
of Human Services\*

JOHN SHAW, MEng, President, Next Wave

ALVIA SIDDIQI, MD, FAAFP, Medical Director,  
Advocate Physician Partners\*

SUSAN WALLACE, MSW, LSW, Coordinator - Special  
Communications and Projects, LeadingAge  
  
Ohio

JUDY ZERZAN, MD, MPH, Chief Medical Officer,  
  
Colorado Department of Health Care Policy  
and Financing

**NQF STAFF:**

SHANTANU AGRAWAL, MD, MPhil, President and CEO  
KATE BUCHANAN, MPH, Project Manager  
SHACONNA GORHAM, MS, PMP, Senior Project Manager  
MIRANDA KUWAHARA, MPH, Project Analyst  
ELISA MUNTHALI, MPH, Acting Senior Vice  
President, Quality Measurement  
TARA MURPHY, Project Manager, NQF  
MARGARET (PEG) TERRY, PhD, MS, RN, Senior  
Director

**ALSO PRESENT:**

KAREN LLANOS, MBA, Director, Medicaid Innovation  
Accelerator Program, Center for Medicaid  
and CHIP Services, CMS  
BEVERLY LOFTON, Medication Innovation  
Accelerator Program, Center for Medicaid  
and CHIP Services, CMS  
E. CLARKE ROSS, DPA, Consortium for Citizens  
with Disabilities

\* present by teleconference

## CONTENTS

Opening Remarks . . . . .	5
Introductions and Disclosure of Interest . . . . .	.10
Welcome Remarks and Review of Meeting Objectives . . . . .	.25
CMS Opening Remarks . . . . .	.35
Overview of Project Goals and Key Points from Staff Literature Review . . . . .	.48
Overview of Measure Selection Process . . . . .	.75
Opportunity for Public Comment . . . . .	111
Review Medicaid IAP Program Area Measures - BCN . . . . . Andrea Gelzer, Jennifer Moore, Miranda Kuwahara	123
Opportunity for Public Comment . . . . .	216
Review Medicaid IAP Program Area Measures - BCN (cont.) . . . . . Andrea Gelzer, Jennifer Moore, Miranda Kuwahara	217
Opportunity for Public Comment . . . . .	306
Review Medicaid IAP Program Area Measures - BCN (cont.) . . . . . Sheryl Ryan, William Golden, Tara Murphy	307
Opportunity for Public Comment . . . . .	394
Adjourn . . . . .	406

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

2 9:02 a.m.

3 DR. TERRY: So, I'm going to open the  
4 meeting up and just welcome everybody. Oh,  
5 sorry. Can you hear me better now?

6 Good morning everyone. I just want to  
7 welcome everyone and thank you for joining us  
8 today as we begin our deliberations and  
9 recommendations for measures in these four  
10 Medicaid programs.

11 I also want to thank the public and  
12 members both in the room and on the phone for  
13 joining us today as well.

14 Now, I'm going to turn the  
15 presentation over to NQF's President and CEO,  
16 Shantanu Agrawal for some opening remarks.

17 DR. AGRAWAL: Thank you very much.  
18 It's nice to start to meet you all. I had a  
19 chance a little bit this morning. I won't take  
20 up too much time except to say how appreciative  
21 we are of all of you convening and doing this  
22 work. These four program areas are, obviously,

1 extremely important. The substance abuse  
2 disorder work, in particular, for me, is just  
3 something that I have been personally very  
4 interested in.

5 I am most recently coming out of CMS.  
6 I wasn't actually in the Centers for Medicare and  
7 CHIP Services but worked very closely with them  
8 and we did a lot of work together on substance  
9 use and abuse and what we can do to sort of  
10 intervene, including on the opioid crisis. So,  
11 it is just a topic that I feel very connected to.

12 Again, thank you for your work on  
13 this. You know one thing I will mention or a  
14 couple things I will mention, so one is I am  
15 going to actually apologize. I'm not won't be  
16 able to spend as much time with you today as I  
17 wanted but I have some meetings. We have got to  
18 go to The Hill this morning and have a number of  
19 meetings. And I tell you that so that you are  
20 aware NQF's funding is actually running out this  
21 year. So, we get authorized by Congress every  
22 few years and it's obviously very important. So,

1 we are going to do our part to advocate on our  
2 behalf but I mention that to you because, heck,  
3 if you have some time to advocate or find  
4 yourselves on The Hill, please keep us in mind.  
5 We get authorized every two to three years,  
6 depending on the last authorization cycle. And  
7 it might be that actually our authorization gets  
8 combined with the CHIP reauthorization this year.

9 So, I would love to spend more time  
10 with you and the varied meeting topics that you  
11 will be covering but we will be doing that.

12 The other thing that I will mention,  
13 which I think will impact this work down the line  
14 and a little bit indirectly but, just so you're  
15 aware, yesterday, our quality measurement  
16 department released a report that is seeking to  
17 make changes to our endorsement process that will  
18 make endorsement much more efficient, much more  
19 agile, which will allow more measures to go  
20 through -- obviously with the same standard kind  
21 of achievement but will potentially allow them to  
22 go through more quickly. And eventually, those

1 measures will, obviously, impact the work of this  
2 committee and of many, many other committees.  
3 So, when you get a chance, if you get a chance,  
4 please look at that report online. It is a  
5 draft. We are seeking public comment and your  
6 thoughts on that will be really helpful.

7 So with that, I will turn it back over  
8 and just thank everybody again for being here and  
9 participating.

10 CO-CHAIR MOORE: Hi, I'm Jennifer  
11 Moore, the Executive Director at the Institute  
12 for Medicaid Innovation and also on faculty at  
13 the University of Michigan Medical School in the  
14 Department of Obstetrics and Gynecology, although  
15 we're not talking about that area today. My role  
16 at the institute is very relevant to this  
17 discussion and I want to thank each of you for  
18 all the work that you did in advance of this  
19 meeting. Bill and I have been reading everything  
20 and trying to like organize it and prepare for  
21 this meeting. So I know how much work went into  
22 that and am very appreciative of that to help for



1 the preparation.

2 And I also want to thank the NQF  
3 staff. It is amazing how much work they do in  
4 preparation for these meetings and it does not go  
5 unrecognized and I want to thank each and every  
6 one of you for that.

7 CO-CHAIR GOLDEN: Good morning, Bill  
8 Golden, Medical Director of Arkansas Medicaid.  
9 And many of my Medicaid colleagues are here  
10 today. And I am also at the University of  
11 Arkansas for Medical Sciences and kind of an old  
12 veteran of NQF processes.

13 And you know metrics are critical. We  
14 are doing a lot of work these days in accountable  
15 care and the whole interface of how you pay for  
16 value and use metrics to leverage quality  
17 improvement with the financial incentives with  
18 accountable care and total cost of care is I know  
19 something that is a bit of a burning platform for  
20 many of us and these areas and topic areas that  
21 we are talking about today are critical to the  
22 Medicaid program.

1           Those of you not in Medicaid per se,  
2           I mean the big driver of Medicaid expense and  
3           comorbidity is mental health and substances and  
4           other issues. So, we are very pleased to be here  
5           as we being to increase our portfolio in these  
6           important topic areas.

7           So we are hoping that we can develop  
8           things that we can use both locally and to  
9           incentivize change and also to compare  
10          performance across states. So, we look forward  
11          to a good discussion today with all of you.

12          And we're all talking to each other.  
13          We have many people here in the room. And do I  
14          turn it back over for the conflicts of interest?  
15          Is that --

16                 MS. MUNTHALI: Yes. Hello. Good  
17          morning. My name is Elisa Munthali. I am Acting  
18          Senior Vice President for Quality Measurement.  
19          Welcome.

20                 So, today we will be combining the  
21          disclosures of interest with introductions. And  
22          you received a disclosure of interest form before

1 you were seated on this committee. We did ask  
2 you for a number of -- we asked you for a lot of  
3 information regarding your professional  
4 affiliations. Today, what we are asking you to  
5 do is orally disclose anything that might be  
6 relevant to the work that is in front of you.

7 Just as a reminder, we are not asking  
8 you to summarize your entire resume. What we are  
9 particularly interested in is anything related to  
10 consulting, grants, or research that is relevant  
11 to this work but we're not just asking for what  
12 they were paid for. We're asking also for work  
13 that you may not have been paid for like sitting  
14 on a committee like this volunteering.

15 Another reminder is that you are  
16 sitting here as individuals. You are not  
17 representing your employers or anyone who may  
18 have nominated you.

19 And one of the most important  
20 reminders is that because you disclose, does not  
21 mean you have a conflict. We do the disclosures  
22 of interest in the spirit of openness and

1 transparency.

2 And so we will start off with your co-  
3 chairs. We will ask them to introduce  
4 themselves, who they are with, and to let us know  
5 if they have any disclosures. We'll go around  
6 the room and then I will call on those that are  
7 joining us remotely.

8 So, Bill and Jennifer.

9 CO-CHAIR GOLDEN: So, as I mentioned,  
10 I'm with Arkansas Medicaid. I don't have any  
11 active consulting arrangements. I sit on a few  
12 committees here. I am the chair of the ACP's  
13 Delegation of the AMA. So, I do some work with  
14 the ACP.

15 And at the moment, I, aside from  
16 working with the NQF, I have just recently  
17 finished work with the HCP-LAN. But that's -- I  
18 think that's about it.

19 CO-CHAIR MOORE: This is Jennifer  
20 Moore. As with Bill, I don't have any active  
21 consulting arrangements and serve on the  
22 Perinatal Committee here at NQF. And I'm trying

1 to think -- boy.

2 I have some HHS appointments when I'm  
3 breast feeding, CMS with quality measures, and  
4 AHRQ involved with -- I'm on the Disparities  
5 Committee.

6 MS. BUCHANAN: Dr. McCann, if you  
7 would like to --

8 MEMBER MCCANN: Good morning. I'm  
9 Barbara McCann. I'm the Chief Industry Officer  
10 for Interim HealthCare, which provides Medicaid  
11 services in a number of states. I also serve as  
12 a member of the Board of Medicaid Partnership,  
13 which supports home- and community-based services  
14 as the alternative on The Hill and with CMS for  
15 Medicaid.

16 Finally, I currently serve as the  
17 chair of the Community Health Accreditation  
18 Program. Thanks.

19 MEMBER RYAN: Hi, I'm Sheryl Ryan.  
20 I'm a pediatrician and a professor of pediatrics  
21 at Yale School of Medicine in the Department of  
22 Pediatrics there.

1 I have no active consulting roles at  
2 this point but I am an unpaid contributor to a  
3 T32 training grant at Yale on training residents  
4 and fellows in addiction medicine. And I also am  
5 the chair of the American Academy of Pediatrics  
6 Committee on Substance Use and Prevention. And  
7 through that, I am the lead author on a number of  
8 publications and technical reports related to  
9 substance use, particularly marijuana in the  
10 pediatric age group.

11 MEMBER SHAW: I am John Shaw from Next  
12 Wave in Albany and the only current consulting  
13 that is relevant is working with the local FQHC  
14 and they do high service for the Medicaid  
15 population.

16 And I am also on a couple regional  
17 task forces, the Asthma Coalition and Public  
18 Health Improvement in the Albany Capital  
19 District. And that's it for now.

20 MEMBER FINESTONE: Good morning. I'm  
21 Sandra Finestone. I have no financial conflicts.  
22 I sit on two CalOptima committees as a volunteer

1 in Orange County, California.

2 MEMBER PHELAN: I'm Michael Phelan.

3 I'm an emergency medicine physician at the  
4 Cleveland Clinic and I am currently the chair of  
5 the Quality and Patient Safety Committee for  
6 American College of Emergency Physicians.

7 I have one role for quality measure  
8 development for end-stage renal disease and  
9 emergency patients. And I'm not sure who that is  
10 with. It may be CMS or it may be NQF. I cannot  
11 recall.

12 And that's -- I have no other  
13 financial commitments, no current grants.

14 MEMBER MUSUMECI: Good morning, I am  
15 MaryBeth Musumeci. I am an Associate Director at  
16 the Kaiser Family Foundation's Program on  
17 Medicaid and the Uninsured.

18 MEMBER HENNESSEY: Good morning. My  
19 name is Maureen Hennessey and my current relevant  
20 activities are in the Senior Vice President and  
21 Director of Quality and Population Health  
22 Solutions with Precision Advisors and we provide

1 consultation primarily to life science companies,  
2 including pharmaceutical companies and device  
3 manufacturers.

4 In addition to that, I am also -- I  
5 volunteer my services as a peer reviewer for the  
6 Journal of Participatory Medicine and also serve  
7 and participate on the NCQA Industry Roundtable.

8 Thank you.

9 MEMBER KILSTEIN: I'm Deborah  
10 Kilstein. I'm with the Association for Community  
11 Affiliated Plans or ACAP. We represent nonprofit  
12 health plans that serve the Medicaid population,  
13 as well as other populations.

14 I represent ACAP on a number of NCQA  
15 Committees. We're nonvoting. I'm a nonvoting  
16 liaison member for the Standards Committee. I  
17 also sit on their Health Plan Advisory Committee  
18 and their Utilization Management Advisory  
19 Committee.

20 I have been on a number of expert  
21 panels, including the CMS QRS Panel that they had  
22 recently. I was on the NQF Child and Adult Core



1 Measure Task Force.

2 I got some grant money from the Open  
3 Societies Foundation to do some work with the  
4 plans around substance use disorders. And I am  
5 subcontractor on a grant from Hilton Foundation  
6 around SBIRT for adolescents.

7 And my husband is a former employee of  
8 a pharmaceutical manufacturer and does have -- he  
9 did receive benefits from that company.

10 MEMBER ZERZAN: I'm Judy Zerzan. I'm  
11 the Chief Medical Officer for Colorado Medicaid.  
12 I have no financial conflicts of interest. I  
13 have served for a number of years on the CMS  
14 HCPCS Committee and soon will serve on the HCP-  
15 LAN Guiding Committee.

16 MEMBER HAMBLIN: Good morning. I'm  
17 Allison Hamblin with the Center for Health Care  
18 Strategies for a nonprofit organization based in  
19 New Jersey, working nationally on Medicaid policy  
20 issues.

21 I have no financial conflicts to  
22 disclose. I am on a couple of advisory boards

1 that are relevant to the discussion, one for  
2 IHI's Complex Care Playbook and one for the newly  
3 formed National Center for Individuals with  
4 Complex Health and Social Needs.

5 MEMBER KELLEY: Good morning. I'm Dr.  
6 David Kelley. I am the Chief Medical Officer  
7 Pennsylvania Medicaid. I've served there for 13  
8 years. I am a general internist. I oversee nine  
9 managed care plans and I am in charge of their  
10 quality improvement activities.

11 We work with our EQRO IPRO. I think  
12 one of their measures might be discussed today  
13 but I have no financial interests with them. We  
14 work in collaboration with them to develop  
15 quality metrics, above and beyond some of the  
16 NCQA HEDIS.

17 I also sit on the NQF CSAC. I have no  
18 conflicts to report.

19 MEMBER WALLACE: My name is Susan  
20 Wallace. I work with LeadingAge Ohio. We are a  
21 trade association that represents not-for-profit  
22 providers of elder care. So, skilled nursing

1 facilities, home health, hospices, et cetera.

2 I currently have an appointment with  
3 RTI on the Hospice Quality Reporting Program. I  
4 also have been active with the National Hospice  
5 and Palliative Care Organization for many years.  
6 And then I am on a steering committee for some  
7 research on integrating community-based supports  
8 with the Ohio State University.

9 There is no financial interest  
10 involved.

11 MEMBER KUY: Good morning. I'm  
12 SreyRam Kuy. I am a general surgeon by training  
13 and still actively practicing. I work as the  
14 Chief Medical Officer for Louisiana Medicaid.  
15 And so many of the things that people have  
16 mentioned are so relevant to what we're doing. I  
17 don't think we have a financial impact but  
18 absolutely the opioid crisis, behavioral health,  
19 looking at parity, all of these are the things  
20 that we are actually working on that take like 90  
21 percent of my time. So, I am so excited to be  
22 here.

1           And around quality, that is an ongoing  
2 effort that we've been doing for the past year is  
3 trying to overhaul our quality strategy, doing  
4 Town Halls, working with providers to really find  
5 out from the provider level what is important for  
6 quality and then working with the institutions  
7 and seeing how it all comes together. So, I am  
8 excited to be here.

9           MS. MUNTHALI: Thank you. So, now we  
10 will go to our colleagues on the phone. We will  
11 start off with Andrea Gelzer.

12           MEMBER GELZER: Good morning. And  
13 first of all, let me say thank you for the  
14 accommodation to participate by phone. I wish  
15 that I could be there with you. I'm just  
16 recuperating from minor foot surgery.

17           I have had the honor to chair the  
18 medical -- the Beneficiaries with Complex Needs  
19 TEP for this endeavor. I'm Chief Medical Officer  
20 at AmeriHealth Caritas.

21           I have no direct financial conflicts.

22           I am a member of the Chief Medical

1 Officer Leadership Council and the immediate past  
2 chair of that council for AHIP. I am a member of  
3 the Board of Trustees at ACAP. I have been an  
4 invited guest and participant for the recent QRS  
5 TEP activities and I am on various other HHS CMS  
6 TEPs. And I am a standing member of the NQF Cost  
7 and Resource Use Committee.

8 And I am very happy to be  
9 participating today.

10 MS. MUNTHALI: Thank you very much.  
11 And next, Sarita Mohanty.

12 MEMBER MOHANTY: Yes, good morning.  
13 And again, my sincerest apologies for not being  
14 there in person. I also appreciate the  
15 accommodation for joining this morning.

16 So I'm Sarita Mohanty and I serve as  
17 the Regional Executive Director for Medi-Cal  
18 Strategy and Operations for Northern California  
19 Kaiser Permanente.

20 I am actively involved in working on  
21 redesign of our model of care for low-income  
22 populations that we serve at Kaiser Permanente

1 and have been also involved with Complex Care  
2 Initiative both at the region and Kaiser but also  
3 nationally.

4 I am also an internal medicine  
5 physician and practice at the Adult Family  
6 Medicine Clinic in Kaiser.

7 I do have one affiliation. I am a  
8 Board member of a healthcare company called COPE  
9 Health Solutions that is involved in strategic  
10 planning and redesign for Medicare and Medicaid,  
11 as well as population healthcare management.

12 And I have no active consulting  
13 activities at this time.

14 MS. MUNTHALI: Thank you very much.

15 Jeff Schiff.

16 MEMBER SCHIFF: Good morning,  
17 everybody. Thanks for the great technical setup.  
18 We can hear everybody very well.

19 I am the Medical Director at Minnesota  
20 Department of Human Services, which is the agency  
21 that serves our mega Health and Human Services  
22 Agency. We do long-term courts alcohol drug

1 abuse, mental health help, as well as all the  
2 Medicaid programs.

3 I am a pediatric emergency medicine  
4 physician and practice at the Children's Hospital  
5 part-time as well and have been involved in the  
6 development of the pediatric core sets.

7 And I'm on an AHRQ-funded NCQA  
8 Advisory Group that works through -- on the --  
9 it's really the second stage, I guess development  
10 and implementation for the pediatric core set.  
11 It's called the National Collaborative for  
12 Innovation and Quality Management, which is  
13 really working on implementing some of the core  
14 measures that have been developed.

15 And then closer to home, I am one of  
16 the leads for our work with the SAMHSA grants on  
17 state-targeted response to opioids.

18 Thanks.

19 MS. MUNTHALI: Thanks, Jeff. And I  
20 just wanted to check if Karen has joined us or  
21 Alvia.

22 MS. LLANOS: This is Karen.

1 MS. MUNTHALI: Hi, Karen. If you can  
2 just let us know who you are and tell us if you  
3 have any disclosures of interest.

4 MS. LLANOS: Oh, I'm sorry. This is  
5 Karen Llanos. I think you're looking for the  
6 Karen Amstutz.

7 MS. MUNTHALI: Yes, sorry about that,  
8 Karen.

9 MEMBER AMSTUTZ: Yes, so this is Karen  
10 Amstutz. I have been just joined. I am the  
11 Corporate Chief Medical Officer for Magellan  
12 Health.

13 And going down the line, I also serve  
14 as an unpaid clinical assistant professor of  
15 medicine at Indiana University School of  
16 Medicine, where I co-teach a class for combined  
17 degree students, MD MBA students.

18 I serve on a couple of boards in  
19 Indianapolis, including those associated with  
20 YMCA's Diabetes Prevention Programming.

21 And finally, I have no consulting  
22 agreements and no other financial conflicts.



1 MS. MUNTHALI: Thank you all so much.

2 I just have one last reminder. If at  
3 any time during this meeting you feel that you  
4 have a conflict that you haven't disclosed, you  
5 may do so in real-time or you may approach the  
6 co-chairs or any of the NQF team.

7 Likewise, if you feel that one of your  
8 colleagues may have a conflict that hasn't been  
9 disclosed or they are acting in a biased manner,  
10 you may point that out in real-time. Again, you  
11 may approach your co-chairs or any of us on the  
12 team.

13 So, I will just ask if there are any  
14 questions of all of you of everything that you  
15 have heard from your colleagues before we proceed  
16 with the meeting.

17 Great. Thank you.

18 CO-CHAIR GOLDEN: Okay, I guess it's  
19 back to me.

20 So, meeting objectives; so, go to the  
21 next slide. Okay.

22 CO-CHAIR MOORE: Where are we?

1 CO-CHAIR GOLDEN: All right, so we  
2 need to introduce everybody else who is here, who  
3 are not members of the committee. Okay.

4 So, why don't we go around and do  
5 that?

6 MS. GORHAM: Good morning and welcome.  
7 My name is Shaonna Gorham and I am the Senior  
8 Project Manager staffing this project.

9 MS. BUCHANAN: Good morning. I'm Kate  
10 Buchanan. I'm a Project Manager on this project.  
11 I just wanted to provide a couple of housekeeping  
12 announcements.

13 The restrooms are out the doors,  
14 through the glass doors to the right.  
15 Additionally, if you have to take phone calls at  
16 any time, there is a room outside, where you can  
17 do so.

18 In order to help facilitate  
19 communication, if you want to turn your name tag  
20 upright to indicate that you would like to talk  
21 for the discussion, that helps our chairs  
22 facilitate.

1                   Also, really important to turn your  
2                   mike on and talk into it. We can only have three  
3                   mikes on at a time or else we can't talk. So  
4                   just also remember to turn the mike off, when  
5                   you're finished.

6                   Lastly, there is a 5:30 dinner at P.J.  
7                   Clarke's scheduled. I just wanted to remind  
8                   everyone. Thank you.

9                   MS. MURPHY: Good morning. I'm Tara  
10                  Murphy. I'm also a Project Manager on this  
11                  project.

12                  MS. KUWAHARA: And my name is Miranda  
13                  Kuwahara. I'm the Project Analyst.

14                  DR. TERRY: And let me just -- I  
15                  didn't introduce myself. I just welcomed  
16                  everybody. I'm Peg Terry, the Senior Director on  
17                  the project.

18                  MS. GORHAM: And we would also like  
19                  CMS to -- our CMS colleagues to introduce  
20                  themselves.

21                  MS. LOFTON: Hi, this is Beverly  
22                  Lofton. I work with CMS on the Medicaid

1 Innovation Accelerator Program and I am the  
2 Contract Representative over this work.

3 MS. GORHAM: And also Karen on the  
4 phone.

5 MS. LLANOS: Hi, everyone. This is  
6 Karen Llano. I am the Director of the Medicaid  
7 Innovation Accelerator Program at the Center for  
8 Medicaid and CHIP Services.

9 CO-CHAIR GOLDEN: All right, super.  
10 Do we have anybody else? No Uber drivers to  
11 introduce or anyone else? Okay. I had a good  
12 one coming in. So, it was nice.

13 So here we are at meeting objectives.  
14 So we have kind of gone over this and the bottom  
15 bullet is really the key issue is to try to help  
16 Medicaid programs develop a greater roster of  
17 measures to assist them with delivery system  
18 reform. And again for those of you not working  
19 in Medicaid programs, my colleagues we have  
20 actually a Network of Medicaid Medical Directors  
21 that issues dealing with substance abuse and  
22 complex care is really the key item of agenda for

1 all the meetings and we all are comparing notes  
2 on projects, innovations. And each Medicaid  
3 program is, in many ways, its own little  
4 laboratory.

5 So, you can talk to folks at the break  
6 or you can send Jeff all sorts of side emails,  
7 since he can multitask during the meeting. And  
8 everybody has -- it's an interesting laboratory  
9 where all sorts of interesting ways of trying to  
10 improve the health of our communities are going  
11 on with different incentives and different  
12 measures. And out of that people -- I think we  
13 had a former director years ago that said steal  
14 shamelessly to improve what's going on. So if  
15 something works in one state, it gets passed  
16 around pretty quickly to others for adoption and  
17 adaptation.

18 And the four bullet areas on the  
19 screen, you know substance use disorders, again,  
20 the key issue now in our programs; improving  
21 healthcare for beneficiaries with complex needs;  
22 obviously, high-cost beneficiaries in their

1 complexity and their diversity is a key issue;  
2 community integrity; integration of long-term  
3 care, particularly, community-based really an  
4 area of increasing importance and actually a lot  
5 of work going on that may circle back down the  
6 road. And again, today is the first bite of the  
7 apple on that in many ways. And also physical and  
8 mental health integration key to actually the  
9 second bullet. Many of our programs are facing  
10 challenges with cost and management because  
11 mental health comorbidities impact the care of  
12 people with physical ailments. And it is really  
13 a complex and difficult area as well.

14 Let's go to the next slide.

15 We have a complex task today. So we  
16 are going to be reviewing other people's work and  
17 finalizing their recommendations. Okay, I have  
18 got two different screens ahead of me here.

19 So before us are going to be measures  
20 that did not get to the TEPs. So, we will be  
21 looking at things that have not had the luxury of  
22 having them review it and kick the tires. And we

1 will be doing that work for the NQF and CMS  
2 today.

3 We are going to be looking also at  
4 measures that recommended by TEP measures to go  
5 to somebody else, either to be shared or to be  
6 moved to a different bucket of activity.

7 And then there are going to be some  
8 measures that didn't get recommended but there  
9 was a bailout option so that if a member of a TEP  
10 thought well this is really important and I  
11 really couldn't convince people but I really know  
12 it is right, we will take another look at that as  
13 well. It is sort of like I guess tweeting after  
14 the fact or something like that. We'll see. So,  
15 we can do some work in that regard.

16 There will be, I think, an opportunity  
17 for the group also to look for redundancies so  
18 that if we have more than one measure, we want to  
19 look the best in class. I think all of us get  
20 frustrated when you have two or three measures  
21 floating around and they are kind of related but  
22 sort of not. But that is, again, a challenge for

1 many programs because everybody has their own  
2 datasets and so forth. It gets kind of tricky.

3 Then there is an opportunity, after  
4 all of that, for the coordinating committee to  
5 look at there are many things that make a measure  
6 not ideal to be recommended. So we all have the  
7 opportunity to say you know this may not be as  
8 good an idea as was originally thought by some  
9 folks and let's have a discussion about that as  
10 well.

11 And then finally, we will vote about  
12 the whole thing. So that will be I guess sort of  
13 like the ribbon on the Christmas package, after  
14 we have wrapped it up and selected the gift. So,  
15 hopefully, that will be more a formality at the  
16 end because we will all be happy with what we've  
17 done.

18 So, there will be lots of steps.  
19 There will be discussions. There will be votes.  
20 There will be decisionmaking and there will be  
21 breaks so you can sidebar people if people are  
22 concerned about the way things are going or



1 confused about the process. So I'm sure the  
2 staff and everybody will be having little bits on  
3 the side to make sure we are on the right track  
4 and moving forward.

5 So, again, we have the measures to be  
6 looking at for, again, the concept here is for  
7 immediate use, or for additional work, or for  
8 people to try to implement in their communities.

9 And let's go to the next slide. And  
10 so there's the agenda. So, we're already rolling  
11 down the agenda and we have had opening remarks.  
12 We are really open really about at the stage,  
13 once we go to the next slide, to hear from CMS  
14 and their opening remarks.

15 And here is our timetable. And the  
16 key thing about the timetable to look at is that  
17 when we finish today's meeting you are not free  
18 to go. There will be a review of what we did.  
19 People will -- there will be, I think, moments of  
20 messiness and conversation today. And our able  
21 staff will put that altogether and make sense out  
22 of it all and send it back to us.

1                   And so in a couple of weeks, there  
2                   will be a phone call for us to review,  
3                   essentially, a summary of what we've done and how  
4                   we will be moving forward. And then they will go  
5                   back into their cocoon and work hard and create a  
6                   final report that will be delivered to CMS and we  
7                   will look at that track report after it is out  
8                   there for public comment. And we will be  
9                   receiving those public comments for review and to  
10                  identify what is really truly important comments  
11                  that impact the final report, things that we may  
12                  need to make adjustments for.

13                  We will be meeting each other again by  
14                  phone in very many virtual ways to finish the  
15                  product and then we're done. We are done, I  
16                  guess when fall starts and labor day is over.  
17                  And we shall then be moving forward.

18                  So, again, busy agenda, busy day, and  
19                  a busy summer for everybody. So, I thank  
20                  everybody for their continued engagement.

21                  So, Karen, I think it's your turn. We  
22                  will turn it over to you and talk about the

1 vision and the goals that CMS would like to see  
2 from this program.

3 MS. LLANOS: Okay, thank you so much,  
4 Bill. And I just want to say I am making my way  
5 there. I just had a bit of a scheduling  
6 conflict. So I will be on the line until I join  
7 you all a little before noon.

8 But I just wanted to thank you, Bill,  
9 and Jennifer, and certainly the NQF staff for all  
10 of their hard work in getting to today. And with  
11 that, also thanking the Coordinating Committee  
12 for spending the next two days and several  
13 previous hours on web conferences prepping for  
14 this.

15 As you are about to hear, this work is  
16 so important not just to the IAP program, but to  
17 our Center, that we really appreciate the time  
18 that you are spending sharing your insights.

19 Next slide, please.

20 So just by way of background, and I  
21 think we covered a little about this on an  
22 orientation call, that Medicaid Innovation

1 Accelerator Program or IAP, we are housed in the  
2 Center for Medicaid and CHIP Services in the  
3 Office of the Center Director. It is a four-year  
4 commitment by our agency to really focus on  
5 building the capacity, through supporting ongoing  
6 technical, ongoing innovation through technical  
7 assistance and we do that a couple of different  
8 ways.

9           Unfortunately, we are not a grant  
10 program but we are considered as a CMMI model.  
11 Our model is to help states through targeted  
12 technical support move towards their Medicaid  
13 delivery system reform activities.

14           At the end of the day, we want to have  
15 IAP have an impact on increasing the number of  
16 things moving towards their delivery system of  
17 reform goals across key program priority areas,  
18 which we will talk about in just a little bit.

19 Next slide.

20           So this is just a visual  
21 representation of our program at large. You know  
22 our North Star is Medicaid delivery system

1 reform. So because of that, how we get there are  
2 taking program areas in what we call functional  
3 or foundational areas to help states move towards  
4 their delivery system reform goals.

5 The program areas are the topics of  
6 the populations that you all discuss as part of  
7 your introduction. So it is fantastic to hear  
8 that there is so much relevant experience and  
9 that these are priorities and interest areas of  
10 all of you. Certainly, we picked these because  
11 we heard from our states our stakeholders that  
12 these were the big, critical points or  
13 challenges. And certainly as we think about how  
14 a state and Medicaid move forward in delivery  
15 system reform across these areas, we know that  
16 quality measures or having the right quality  
17 measures is critical.

18 So when we think about all of our  
19 program areas, we think about those functional  
20 levers and that's where quality measures comes  
21 in.

22 In addition to that, having the right

1 access to data, thinking about performance  
2 improvement or improvement science, and certainly  
3 value-based payment all have a role to play but  
4 we feel quality measurement is so critical and  
5 this is why this project is really, really  
6 important.

7 Next slide.

8 So again, Bill did a great job about  
9 talking about our program areas. So no need to  
10 go into detail. Obviously, these are important  
11 areas. You all know this. We know this as well.

12 We work with states in IAP in these  
13 areas across a variety of different ways but we  
14 know that there is still a need for access to  
15 really good measures in order to really think  
16 about how to drive change in these populations or  
17 target groups. Next slide.

18 So I want to spend a little bit of  
19 time just framing how we think about quality  
20 measurement in the IAP portfolio. We have a  
21 variety of different quality measurement  
22 activities that we tackle through IAP and some of

1       them, I am sure, come to mind when you are  
2       thinking about what are the right measures for  
3       our program areas. Certainly, gaps, how to fill  
4       critical Medicaid relevant measurement gap is  
5       something that comes up a lot.

6                 We have a quality measurement  
7       development separate project from NQF, from this  
8       particular project that is looking at gaps and we  
9       actually help share some of that information as  
10      part of the environmental scan for this work.  
11      But just know that when it comes to the  
12      development or the pipeline of some key issue-  
13      specific measures, we are handling that in a  
14      separate activity.

15                What you see in bold is this project  
16      here. So we know that there is a need to support  
17      states in selecting or identifying what are some  
18      standardized quality measures that exist today  
19      that could help drive their effort. And this is  
20      why we thought collaborating with the National  
21      Quality Forum to help us identify sets of  
22      existing standardized measures for states and

1 even for our agency to use was so critical.

2 In addition to that, we have two other  
3 projects that are separate from NQF. We're  
4 looking at what are some challenging measurement  
5 issues, benchmarking to non-HEDIS measures, small  
6 numbers issues. Those are more internal-facing  
7 so that we can just be better informed about the  
8 key challenges that our states and that we face  
9 when we think about quality measurement.

10 And then finally, how do we share best  
11 practices and innovations in quality measurement  
12 issues? And that actually hits all of the  
13 different activities that we have in our quality  
14 measure portfolio.

15 So I just wanted to give you a sense  
16 of how this particular activity through NQF fits  
17 as part of the other IAP quality measurement  
18 portfolio activities.

19 Next slide.

20 So finally, the goals for the project  
21 and the measure sets that come out of this  
22 project, I think that is probably a question that



1 is burning, particularly for those that have been  
2 part of our child-adult core sets. This is a  
3 little bit different.

4 What we wanted to be able to do is to  
5 have available a listing or a set of measures  
6 that states and we can use that reflect a variety  
7 of different quality domains across our IAP  
8 program areas. We want measures that are of  
9 value to our Medicaid agencies, which is why we  
10 are working with NQF to pull your expertise in.  
11 Again, focused on measures that are standardized  
12 and that can be collected by states tomorrow, as  
13 opposed to having them undergo changes or tweaks  
14 or what we don't want to do is identify too many  
15 concepts because we want things that are  
16 actionable for say tomorrow.

17 And we want to reflect a wide range of  
18 stakeholder perspectives. Again, we could have  
19 done those projects internally but we really  
20 didn't think that would be as valuable as  
21 leveraging our partnership with National Quality  
22 Forum who has access to a variety of expertise,

1 as reflected by the coordinating committee.

2 And then, finally, considering  
3 measurement alignment is really important for all  
4 of our work. So we wanted to be able to have  
5 measures that are available tomorrow that reflect  
6 a wide variety of perspectives and that are  
7 thinking about measurement alignment across a  
8 variety of different pairs and settings.

9 Next slide.

10 So, when we think about how to think  
11 about each of these sets, I know I think about  
12 our CMS quality measures domain framework and  
13 that is what we are going to ask of you as well.  
14 And just based on a program area, we know that we  
15 can't hit all of these but this is just a really  
16 nice way of guiding, of having guiding frameworks  
17 in terms of how you think about substance use  
18 disorder measures, or a grouping of community-  
19 based LTFS measures or physical-mental health  
20 integration. You know are we looking at access  
21 or clinical care, care coordination, safety,  
22 patient/caregiver experience, and prevention and

1 population health?

2           Again, some of these will have more in  
3 one area than the others. Ideally, we would like  
4 to have the measure sets reflect all of these but  
5 we are in the real world and we know that there  
6 are certain gap areas that exist. But this is  
7 just something helpful for you all to keep in  
8 mind.

9           And then next slide, please. I wanted  
10 to end with just refreshing what we are going to  
11 do with this project with the outputs of this  
12 project.

13           So what states are the audience for  
14 these measures? And I base these on common  
15 questions that we get.

16           So, as I said our ideal scenario is  
17 that the recommendations that we get from you all  
18 we will share publicly and they will be available  
19 for both our staff, as well as any state, whether  
20 they are part of IAP or not, health plans, other  
21 stakeholders, that they have access to just a  
22 good starting set of measures to think about.

1                   We often get asked what are the right  
2                   measures for these program areas. And we know  
3                   that this might not be the whole answer but why  
4                   reinvent the wheel or why ask for everyone to be  
5                   doing the same kind of research in identifying  
6                   the starting point of these measure sets, when we  
7                   can just share this with a broader audience?

8                   Who will have access to the measure  
9                   sets, I just said we will post online. So,  
10                  hopefully, everybody.

11                  How can states use these measure  
12                  listings? Any way they feel is most valuable.  
13                  As I said, we are doing this because we have been  
14                  often asked what are the right integration  
15                  measures or what is a good starting point for  
16                  physical mental health integration measures and  
17                  in our other areas as well. Again, this is just  
18                  to create efficiencies and having some good,  
19                  smart thinking around the table and helping us  
20                  think through what are some listings of measures  
21                  around these areas that are representative of  
22                  care?

1                   And the finally, how is this project  
2 different from federal measure sets? So, this  
3 will not be part of a requirement, a reporting  
4 program but you need to be thinking about or we  
5 ask you to think about aligning with other  
6 measure sets that are out there. So we have  
7 heard folks who represent or have been part of  
8 the AHIP or the Child and Adult Core, bring all  
9 of that experience into your thought process over  
10 the next couple of days. That's what we want to  
11 leverage.

12                   So be thinking about that. We want to  
13 align with those measure sets. Generally we  
14 don't want to be creating measure sets that are  
15 different or completely outside of that realm.

16                   And again, this is a helpful resource.  
17 This is not going to be a statute. It's not  
18 going to be a requirement. We just think that  
19 this is a need that we have and because of that,  
20 probably most likely a need that other states  
21 have as well in terms of what are some good  
22 measures for these program areas.

1                   With that, I think my next slide is  
2 just questions. I'm happy to take any questions  
3 now or when I make it in there.

4                   CO-CHAIR GOLDEN: Comments or  
5 questions for Karen?

6                   I was ready to turn it over to the  
7 next stage, to Jennifer. Tara.

8                   Okay, so I gather Alvia has joined us.  
9 So before we go to the next discussion point,  
10 Alvia, why don't you introduce yourself and  
11 mention if you have any conflicts of interest or  
12 disclosures of note for the committee and the  
13 staff?

14                   MEMBER SIDDIQI: Sure. Good morning,  
15 everybody. My name is Alvia Siddiqi. I am a  
16 family medicine physician and Medical Director at  
17 Advocate Physician Partners. My only disclosure  
18 is really that I am employed by them and my  
19 spouse is employed by CVS Health. But otherwise,  
20 those are the only disclosures that I have.

21                   And I have had the opportunity to  
22 serve on the Medicaid Pediatric and Adult Core

1 Set in the past as well. So I really appreciate  
2 that presentation and I am sorry that I couldn't  
3 be there in person for meeting with all of you  
4 this time.

5 CO-CHAIR GOLDEN: Super. So, Karen,  
6 we hope to see you soon on your way in.

7 MS. LLANOS: Yes.

8 CO-CHAIR GOLDEN: So, I will turn it  
9 over -- we have another member who just joined  
10 in. Okay, welcome.

11 MEMBER POWELL: Hi, Cheryl Powell with  
12 Truven Health Analytics. My apologies. Traffic  
13 was horrible from Baltimore this morning. I  
14 understand why Karen didn't make it down.

15 And I think the only disclosure I have  
16 is that I do work at Truven on TEFT projects  
17 related to some of the HCBS measure surveys,  
18 things like that. Otherwise, I have been at  
19 Truven since October and before that 16 years at  
20 CMS. So, here I am.

21 I'm going to try to find my name tag.  
22 I'm not sure where it is.

1 CO-CHAIR GOLDEN: Super. And again,  
2 we have no other Uber drivers joining us, right?  
3 I keep looking for them under the table, I guess.

4 All right, Tara, it is now your turn.

5 MS. MURPHY: Good morning, everyone.  
6 I'm going to take us through a quick overview of  
7 the project goals and some key points from the  
8 literature that staff conducted.

9 As you well know, the goal of the NQF-  
10 Medicaid IAP Quality Measures project is to  
11 identify and recommend measure sets for the four  
12 program areas of CMS's Medicaid Innovation  
13 Accelerator Program. As you are well familiar  
14 now, these four program areas are: reducing  
15 substance use disorders -- we will call them  
16 SUDs; improving care for Medicaid Beneficiaries  
17 with Complex Care Needs and High Costs -- we  
18 refer to this as BCN; promoting community  
19 integration -- community-based long-term services  
20 and supports -- we will call this LTSS, usually;  
21 and supporting physical and mental health  
22 integration, which we will sometimes refer to as



1 PMH.

2 The recommended measure sets will  
3 support states' ongoing efforts related to  
4 delivery system reform.

5 The measure sets should consist  
6 primarily of measures that are ready to be  
7 immediately implemented by states. Further, the  
8 measure should represent the full continuum of  
9 care. All state Medicaid agencies, regardless of  
10 whether they participate in the IAP will be able  
11 to use these measures and the measures will not  
12 be mandatory. Rather, they will serve as a menu  
13 from which state Medicaid agencies can  
14 voluntarily adopt measures that fit their needs.

15 On this slide, we break down some key  
16 NQF terminology. The first definition we call  
17 out is that of a performance measure. NQF  
18 defines a measure as a fully developed metric  
19 that includes detailed specifications and may  
20 have undergone scientific testing. Clear  
21 specifications of measures allow for  
22 replicability across states, health plans, et

1 cetera.

2 This definition has been revised since  
3 the TEPs met in April. The previous version of  
4 the definition required scientific testing of the  
5 measure; that is, testing of the measure's  
6 reliability and validity. This change comes as  
7 part of our responsiveness to CMS, TEP members,  
8 the public, and other concerned stakeholders who  
9 felt that the original definition didn't  
10 adequately represent the measures that were in  
11 use by state Medicaid agencies.

12 We revised the definition to be more  
13 inclusive of those measures currently in use in  
14 the Medicaid population, many of which have not  
15 undergone full scientific testing but which can  
16 be replicated and have results.

17 This revised definition requires that  
18 in order for a metric to be considered a measure,  
19 it must be fully specified, meaning that it  
20 includes all key components of a measure to  
21 ensure that it is repeatable by many users.  
22 These required components include the measure's

1 title, numerator, denominator, exclusions, data  
2 source, level of analysis, care setting.

3 The change to this definition is  
4 reflected in the immediate use question of the  
5 decision logic we will use during our measure  
6 deliberations later today.

7 The next definition we called out on  
8 this slide is that of a measure concept. A  
9 measure concept is an idea for a measure that  
10 includes a description of the measure, including  
11 a planned target or numerator, a  
12 population/denominator.

13 The difference between a measure and  
14 a measure concept is that a concept may not be  
15 fully specified with all necessary components  
16 and, therefore, may not be ready for immediate  
17 use.

18 During the TEP in-person, another  
19 designation arose for those measures that showed  
20 particular promise for potential adoption. We  
21 call these metrics promising measure concepts.  
22 Both the LTSS and PMH TEPs identified promising

1 measure concepts during their review at their  
2 meeting in April. As we have mentioned many  
3 times over the life of this project, our goal is  
4 to recommend measures that are ready for use in  
5 states tomorrow. Ideally, our final  
6 recommendations would include no more than about  
7 20 percent measure concepts.

8           The next definition on this slide is  
9 that for tools. A tool is an instrument that can  
10 be used for screening and is not a measure but  
11 can be used within measures. An example of this  
12 is the PHQ-9 depression test questionnaire or the  
13 BASIS-24 tool, which is referenced in one of the  
14 SUDs measures that we will discuss later as a  
15 reconsidered measure.

16           And finally, we also note that surveys  
17 are not performance measures but that they can  
18 have measures in them. An example of this is the  
19 CAHPS survey, which is made up of 19 individual  
20 performance measures, each fully tested and NQF  
21 endorsed.

22           And here are those examples I just

1 mentioned. In the first bullet, you see the NQF-  
2 endorsed measure Depression Remission at Twelve  
3 Months. You see that from the description that  
4 the change in the PHQ-9 depression test is used  
5 to calculate this outcome measure but that the  
6 tool itself is not the measure.

7 The second bullet references the CAHPS  
8 survey I mentioned on the previous slide. As you  
9 can see, the CAHPS survey is made up of 19  
10 performance measures which have all undergone  
11 reliability and validity testing. Many surveys  
12 have undergone psychometric testing but the items  
13 within this survey have not been fully tested.

14 We will now briefly take you through  
15 some background information on the four program  
16 areas. Our first program area is the reducing  
17 substance use disorder program area, which  
18 focused on Medicaid beneficiaries who experience  
19 significant impairment such as health problems,  
20 disability, and failure to meet major  
21 responsibilities as a result of substance use  
22 disorders.

1                   According to CMS, two of the top  
2 reasons for hospital readmissions are substance  
3 abuse, in particular, alcohol and substance use  
4 diagnoses. And of all Medicaid beneficiaries, 12  
5 percent of adults and 6 percent of adolescents  
6 have a substance abuse issue.

7                   Compared to patients on Medicare,  
8 private insurance, or even dually-eligible  
9 patients, Medicaid-only beneficiaries have the  
10 highest combined rate of both illicit and  
11 prescription drug use. Lock-in programs, which  
12 limit patients to filling prescriptions at one  
13 location in order to manage patient's  
14 prescription use are again being considered as a  
15 mechanism to address opioid misuse.

16                   Measures in the reducing substance use  
17 disorder program area will focus on the CMS  
18 quality domains, as will the remaining three  
19 program areas. To date, one theme that has  
20 arisen when considering SUDs measures is the  
21 identification of people with substance use  
22 disorders or co-occurring conditions.

1           Of the 114 measures in this program  
2           area that NQF staff collected, 69 of those  
3           measures were characterized as clinical care,  
4           followed in second by care coordination, which  
5           identified 27 measures.

6           The next program area is promoting  
7           community integration through community-based  
8           long-term services and supports, LTSS for short.  
9           This program area focuses on Medicaid delivery  
10          reform for beneficiaries living in the community  
11          and using home- and community-based services and  
12          social supports. This program area does not  
13          include institutional care.

14          Measures in this set will focus on the  
15          CMS quality domains. Some themes that have  
16          arisen to date are finding the right measure to  
17          address this program area, which is changing and  
18          growing all the time and looking for ways to  
19          align measures that are already in use in  
20          multiple states.

21          Of the 66 LTSS measures collected by  
22          NQF staff, the largest domain represented was

1 clinical care with 21 measures after that care  
2 coordination was identified for 16 of those  
3 measures.

4 Living in and participating in the  
5 community are important parts improving life  
6 satisfaction. As individuals with the need for  
7 long-term services and supports look to rejoin  
8 the community following institutionalization,  
9 mental health disability, difficulties with  
10 family members before transition and a lack of  
11 choice and control in one's daily life are often  
12 predictors of re-institutionalization. We can  
13 look to these predictors as areas for possible  
14 intervention in order to reduce re-  
15 institutionalization.

16 I will now turn it over to my  
17 colleague, Kate Buchanan, who will provide an  
18 overview of the remaining program areas.

19 MS. BUCHANAN: Great. Thank you so  
20 much, Tara.

21 So here we can see the improving care  
22 for beneficiaries with complex care needs and



1 high costs, also referred to as BCN. BCN focuses  
2 on supporting Medicaid delivery reform for  
3 beneficiaries who experience high levels of  
4 costly yet preventable services. They are a  
5 small portion of the Medicaid population, making  
6 up just about five percent of all beneficiaries  
7 but they account for more than half of the total  
8 Medicaid expenditures. This group also includes  
9 one percent of beneficiaries who account for 25  
10 percent of total Medicaid expenditures.

11 This group is very heterogeneous, with  
12 beneficiaries experiencing different medical,  
13 behavioral, and psychosocial needs. Patients in  
14 this group often have multiple chronic  
15 conditions. Eighty-three percent of the most  
16 costly one percent of patients have three or more  
17 conditions and sixty percent of that group have  
18 five or more conditions.

19 Federally Qualified Health Centers are  
20 one approach to improving care and reducing costs  
21 in this population. Research has shown that in  
22 areas served by FQHCs, there are lower rates of

1 emergency department use and lower rates of  
2 hospitalizations for ambulatory care-sensitive  
3 conditions.

4 More broadly, however, there are many  
5 challenges for addressing the needs of this  
6 population. Care management interventions often  
7 vary in design, focus, and setting, which makes  
8 the comparison of results challenging.  
9 Consequently, best practices have yet to be  
10 identified for wide implementation.

11 Additionally, there is a lot of churn,  
12 which we define as consumers transition between  
13 different types of coverage and/or becoming  
14 uninsured among individuals characterized as high  
15 utilizers. This characterization of high  
16 utilization can often be temporary, as  
17 individuals often return to normal levels of care  
18 utilization after a brief time. Researchers  
19 attribute this churn to changes in illness, the  
20 impact of care, and mortality.

21 Once again, you can see the six CMS  
22 quality measure domains. And of the 69 measures

1 identified by staff, the majority fell into the  
2 safety and care coordination domains. Staff  
3 identified no measures within the access domain.

4 An example of themes and issues raised  
5 to date in this project are the complexity of  
6 identifying people with complex care needs,  
7 promoting care coordination, and identifying  
8 types of social services or supports appropriate  
9 for this population.

10 The last area that we will discuss is  
11 supporting physical and mental health  
12 integration, also known as PMH. This program  
13 area focuses on supporting Medicaid delivery  
14 reform for beneficiaries with both mental and  
15 physical health conditions. Among these  
16 beneficiaries, the top two most common diagnosis  
17 for re-hospitalizations among Medicaid  
18 beneficiaries are mood disorders or  
19 schizophrenia, as well as other psychotic  
20 disorders. Individuals with mental health needs  
21 often experience comorbid physical conditions as  
22 well. Over half of all Medicaid enrollees in the

1 top five percent of expenditures had asthma or  
2 diabetes, as well as a behavioral health  
3 condition.

4 While there is evidence of effective  
5 integrated care models, they are not widely used  
6 as a result of the many various integration,  
7 including payment, project cuts, workforce  
8 issues, and EHR capabilities.

9 With regards to payment, 24 states  
10 have limits on same-day Medicaid billing for  
11 behavioral and mental health services. Budget  
12 cuts in many states often result in reductions in  
13 state mental health services.

14 In the workforce, significant  
15 workforce shortages exist in many parts of the  
16 country. An estimated 91 million Americans live  
17 in areas without enough mental health  
18 professionals.

19 Limited EHR capabilities prohibit  
20 providers from documenting relevant behavioral  
21 and physical health information, as well as limit  
22 communication among integrated teams.

1                   As with the other three program areas,  
2                   focusing on the CMS quality domains, of the 63  
3                   measures identified by staff in this area, the  
4                   majority fell within care coordination or the  
5                   clinical care domain. Staff identified no  
6                   measures within the population health and  
7                   prevention domain.

8                   And some examples of themes of and  
9                   issues raised during the project are knowledge  
10                  that integration is occurring; enhanced  
11                  coordination, as well as enhanced collaboration;  
12                  the question of whether care is occurring at the  
13                  primary care physician's office or remotely; and  
14                  the question of is care coordination the same as  
15                  integration.

16                  And with that, I will turn it over to  
17                  Jennifer to facilitate any questions or  
18                  discussion.

19                  CO-CHAIR MOORE: AT this time, we want  
20                  to open it up to the committee for any questions.

21                  Anyone on the phone with questions?

22                  MEMBER GELZER: Hello, can you hear

1 me?

2 CO-CHAIR MOORE: Yes, we can.

3 MEMBER GELZER: Hi, it's Andrea  
4 Gelzer.

5 So we have changed what we are  
6 defining as a measure and what was are defining  
7 as a measure concept. I just wanted to ask the  
8 staff, did you go back and then reclassify  
9 measures that each TEP put forward?

10 MS. GORHAM: Hi, Andrea. This is  
11 Shaconna.

12 So we did not do that. As you  
13 remember, we initially used the definition of a  
14 measure for an endorsed measure. And so as a  
15 result of feedback from CMS, as well as some of  
16 our TEP members and the public, we are now using  
17 the measure definition that NQF uses for our  
18 framework projects. And this project falls under  
19 one of the framework projects, which is really in  
20 line with CMS's desire and some of what we need  
21 really to explain the measures in the Medicaid  
22 population.

1           So, we would like for the Coordinating  
2 Committee members, as you all review the measures  
3 today, to, if you, based on the definition,  
4 notice a concept with the TEPs recognized and  
5 appointed as a concept, if you think based on the  
6 definition it should be a measure, then as we  
7 review the measures, then we will note that. And  
8 so then the final report will move forward that  
9 way.

10           So the staff did not change  
11 designations made by the TEP but we are asking  
12 the Coordinating Committee to do that today.

13           MEMBER GELZER: Okay, thank you very  
14 much.

15           CO-CHAIR GOLDEN: So I have a follow-  
16 up question. One thing that has always been a  
17 challenge, when you talk about measures, very  
18 often it gets pretty detailed, I know. So, I  
19 will not talk about NQF. I will talk about NCQA  
20 for a second. And they get very twitchy about  
21 the fact that people play with their  
22 specifications. But I can tell you that if you

1 go to Pennsylvania, Colorado, or Arkansas,  
2 everybody has slightly different code sets so  
3 there are adjustments that need to be made.

4 Have NQF or others begun to assess  
5 that, while alignment is critical, that  
6 implementation often requires tweaks to the  
7 coding? Because otherwise, you'll end up  
8 injuring the validity of the local  
9 implementation.

10 MS. MUNTHALI: Okay, there were too  
11 many mikes on. Hi, this is Elisa.

12 Yes, we actually started a project  
13 about two years ago on variation in measurement  
14 specs to look at that exact issue. We are trying  
15 to resolve it but we do recognize that because of  
16 the limitations of what may be happening on the  
17 ground with different states, different  
18 collaboratives, people that may pick up our  
19 measures anywhere, they may need to vary it so  
20 they can use these measures. It is not the right  
21 thing to do. We always say that we endorse the  
22 measures for the level of analysis or the intent



1 for which they are specified but we do also  
2 recognize that folks are doing this.

3 So this first project was to identify  
4 the what, where, and why. And we are hoping to  
5 do additional work to see how we can mitigate  
6 this going forward. But we do -- we have done  
7 some work on it.

8 CO-CHAIR MOORE: And I have a  
9 clarifying question for CMS and I don't know if  
10 Karen is still on the phone. But the framework  
11 looking at access, clinical care, care  
12 coordination, safety, patient care, caregiver  
13 experience, prevention, and population health,  
14 wanting us to frame our discussion around those  
15 areas and as they were going through the  
16 different measure sets that we're looking at,  
17 there are some areas where there are no measures  
18 identified.

19 So as we move forward, help us  
20 understand what our task is in that space,  
21 recognizing that some of them have like 60  
22 percent of the measures are in like one bucket

1 but there is only one or two in the other areas.

2 So, if we are using these areas as a  
3 framework for our discussion and there is a  
4 measure's that is missing or a very low number,  
5 what is your expectation from us as we use that  
6 framework?

7 MS. LLANOS: Right. So, it's a great  
8 question.

9 As I mentioned, I think of it as a  
10 guiding framework and to help organize folks on  
11 thinking in terms of what are the different types  
12 of measures that should be there. But as I said,  
13 we certainly know that there are some where there  
14 is going to be more in one category or the other.  
15 I think you just acknowledge it.

16 But it's more let's be thinking about  
17 these measures in a broader continuum and that  
18 framework is to help think about that broader  
19 continuum.

20 CO-CHAIR MOORE: Thank you. Go ahead.

21 MEMBER PHELAN: And just to get a  
22 better understanding of the framework that we're

1 --

2 CO-CHAIR MOORE: Introduce yourself.

3 MEMBER PHELAN: Oh, Mike Phelan.

4 Just to get a better idea, an  
5 understanding of what we're trying to do here,  
6 are there basic measures of churning or high  
7 utilizers that are currently being used that are  
8 standardized across all the Medicaid programs?

9 So, we're looking at patients with  
10 complex care needs, patients that are high  
11 utilizers and there is no standard definition of  
12 what these specific group of patients are that  
13 programs like Arkansas Medicaid can look across  
14 each other and say oh, you have a rate of X  
15 number of high ED utilizers across all the  
16 programs, so there's no such measure like that.  
17 Or you have X number of high complex care  
18 patients that aren't getting the coordinated care  
19 that they need. There is no current measure that  
20 looks at those specific, like the hierarchy  
21 above, rather looking at the end product what the  
22 Medicaid programs are currently trying to look at

1 internally.

2 CO-CHAIR MOORE: Yes, I think that's  
3 a great question and I will have Karen answer  
4 also but within the institute we have a great  
5 interest in understanding the concept of churn.  
6 Frequency, disparities, equity issues. We have  
7 not found a measure. We also find it difficult  
8 when we look at databases to be able to capture  
9 that transition from the different -- and even  
10 when we reach out to health plans, they are  
11 unable to know where they are churning from and  
12 to. So, there is an absence of that information  
13 from what research we have done. So, I will  
14 defer to Karen, in case she knows something from  
15 the CMS side.

16 MS. LLANOS: No, it's the same thing.  
17 So I think that is just an area that I don't  
18 think we've been able to identify measures by  
19 either.

20 CO-CHAIR MOORE: And please identify  
21 yourself for the benefit of people on the phone.

22 MEMBER KELLEY: This is Dave Kelley,

1 Pennsylvania Medicaid.

2 I will say that Bill mentioned that we  
3 have a Medical Directors' Network for Medicaid.

4 And actually one of our projects that we are  
5 going to be taking on in the next 2017 is to  
6 actually have multiple states come together and  
7 work to identify these individuals with complex  
8 needs and look at similarities and differences.

9 And we actually are planning to look at our  
10 Medicaid data sets over multiple years, to look  
11 at one of the points that was made, some folks  
12 will be very high cost for a while and then their  
13 needs are met or they have an episodic illness,  
14 or they're homeless and their costs go way up.  
15 So we are going to actually be looking at that  
16 and probably have, I would say, at least 20  
17 states that are right now interested in  
18 participating in that. It's more of a data  
19 initiative, not necessarily a metric development.

20 And we are hoping that some of the  
21 work that comes out of this will also help to  
22 inform us as that project moves forward.

1                   MEMBER KUY: And I assume you are  
2 working with Academy Health on that, just as do  
3 their group?

4                   MEMBER KELLEY: Yes, they are enabling  
5 partners.

6                   MEMBER KUY: Yes, that's helpful.

7                   MEMBER POWELL: Cheryl Powell from  
8 Truven.

9                   I just want to go back to the earlier  
10 issue about measures versus measure concepts and  
11 sticking to the tech specs. I think having  
12 developed both for a state, for Maryland, as well  
13 as for CMS, tech spec for quality measures and  
14 looking across just the great variety not only of  
15 coding but programs and how programs are set up,  
16 I think this is an issue that we should actually  
17 consider tackling in the introduction and really  
18 trying to encourage states to take measures and  
19 use them as measure concepts within their states.

20                   Often, a measure specified at a  
21 provider level but it may be very helpful for a  
22 state Medicaid agency, which is unique, to look

1 at that at a program level or to look at it in  
2 multiple program levels but you can't take the  
3 pure measure and apply it to the program level  
4 because of the way it was configured for a  
5 different program.

6 And so I actually think that  
7 encouraging states to look at the measures and  
8 think how they could apply those even as measure  
9 concepts within their program so that they work  
10 for them is a good thing because that may lead.  
11 That then gets you some similar measures which  
12 may then later be endorsed at a say Medicaid  
13 program level or across fee-for-service and  
14 managed care for states.

15 And so I wouldn't want the purity of  
16 the tech specs to be a limitation. I actually  
17 think that encouraging experimentation with that  
18 to fit the needs of Medicaid because there are so  
19 few measures that help Medicaid agencies see at  
20 the program level or across different HCBS  
21 programs, for example, or across different types  
22 of programs for other parts of the population you

1 know what is really going for specific  
2 populations or their entire Medicaid population.

3 So, I would just encourage us to think  
4 in that terms. And I think that may be some of  
5 why CMS is trying to put together a family of  
6 measures. Here are things that are very much  
7 worth measuring, we think, and here are some  
8 measures that are available but also that  
9 experimentation of those concepts in different  
10 ways and applying them to programs in different  
11 ways I think may be very helpful and helpful to  
12 other states.

13 CO-CHAIR MOORE: Thank you for that.  
14 I think maybe one of the resources that might be  
15 developed at some point is helping states to make  
16 those adjustments but maintaining the validity  
17 and reliability of the underlying measure. I  
18 think that is the crux of the issue to sustain  
19 the quality of the quality measure as these  
20 changes are made because we have seen some really  
21 interesting adjustments that call into question  
22 the quality of the quality measure and what is



1 being reported. So I think that there is a  
2 balance to be made but a good point.

3 I know that we are way behind on time.  
4 So, I am going to take these two and then we'll  
5 turn it back over to Bill.

6 MEMBER SHAW: Hi, John Shaw.

7 Speaking of balance, what struck me  
8 was there is value of having consistent technical  
9 specs to do comparative benchmarking. That's  
10 good. We should have that.

11 There is also value in targeting the  
12 use of a metric to the actual population locally  
13 in your state or local area. That is a value,  
14 too.

15 I'm a systems guy. I would say do  
16 both and there is value in both. But from a  
17 transparency perspective, we need to just specify  
18 that.

19 So have here is the standard specs  
20 that the intent is to be able to benchmark across  
21 populations and then each population can  
22 customize the specs to their best use and maybe

1 state that as a go forward.

2 CO-CHAIR MOORE: Maybe the next phase  
3 of a quality measure after it's endorsed is to  
4 look at the variation that is occurring in the  
5 field and then seeing if there is consistency. I  
6 mean we all think we have a unique population but  
7 there is probably like five buckets in which the  
8 variation is occurring in which we could provide  
9 resources on how to make that adjustment.

10 MEMBER SHAW: And I think the NQF is  
11 in the process of moving more into --

12 CO-CHAIR MOORE: Correct.

13 MEMBER SHAW: -- the implementation  
14 side of things.

15 CO-CHAIR MOORE: Yes.

16 MEMBER SHAW: So this is a perfect fit  
17 for the direction we are going forward.

18 CO-CHAIR MOORE: Yes, like the  
19 Disparities Committee looking at risk adjustment,  
20 as an example. Yes, okay.

21 MEMBER ZERZAN: So this may be a bit  
22 controversial but in looking at the measures,

1 there were very few, if any, that I was like aha,  
2 this is the measure I've been searching for.

3 For the most part, these are well-  
4 trod. They are not super exciting. We all wish  
5 they were a bit better. And my view of looking  
6 at this, especially because the purpose of the  
7 Innovation Accelerator Project is sort of, and  
8 these are optional, is that this is grassroots so  
9 that this is a place for states to sort of figure  
10 out what works best and then the next step might  
11 be the Child and Adult Core Set or figuring out  
12 oh, well this is the way the measure specs were  
13 but here's how states are using them and they are  
14 not exactly following measure specs; so perhaps  
15 we should recommend some change to the measure  
16 specs based on this.

17 So that made me, I think, a little  
18 more comfortable with some of this of like this  
19 is just dipping our toe in the water and there is  
20 a deep ocean we are going to have to wade  
21 through. And this is sort of the beginning.

22 CO-CHAIR GOLDEN: So you know Jennifer

1 said that we have to move along. So we are going  
2 to, I'm sure, after listen to the conversation,  
3 instead of moving thing to the parking lot, we'll  
4 have happy hour areas to move things to. So,  
5 there's lots of discussions for later on today.

6 So, let me turn it over to Shaconna.  
7 Now, this next part is important because it is  
8 going to tell you what we need to be doing for  
9 the rest of the day.

10 MS. GORHAM: Yes, it is important and  
11 it is a lot of information. So, we thought it  
12 would be helpful to give an overview of the  
13 measure selection process, starting with the TEP  
14 review. Barbara, Sheryl, Maureen, and Andrea  
15 have been gracious enough to join us for both the  
16 TEP and the Coordinating Committee meeting and  
17 they will help us to relay the messages and the  
18 measures recommended by each TEP. We'll go to  
19 the next slide.

20 So the measure selection process is  
21 really a standardized approach for selecting the  
22 best available measure in each IAP program area.

1 Each TEP met. They used the standardized  
2 approach to discussing vote on measures. They  
3 were separated into program area-specific  
4 breakout sessions in April to decide on the  
5 measures that will be discussed today.

6 Using a similar process, you, this  
7 committee, will discuss the TEP's recommendation  
8 and the outcome of this two-day meeting will be  
9 finalized for four finalized measure sets in each  
10 program area to recommend to CMS.

11 So this pretty graphic on your screen  
12 really represents the six steps in the TEP  
13 measure selection process. The first step, staff  
14 scan universe of measures; capture those  
15 measures, step two; assign ranking on the  
16 specific measure criteria, step three; assign an  
17 overall score to each measure in step four; step  
18 five, conducted an initial review of the list of  
19 measures and removed measures by measure score;  
20 and finally, the last step, analyze remaining  
21 measures using a decision logic to recommend to  
22 this committee. Over the next several slides, I

1 will walk through each of these steps quickly.

2           So, again, the step number one, NQF  
3 performed a comprehensive search using relevant  
4 measure sources. We searched more than 75  
5 sources, many of which were recommended by  
6 members of this committee, as well as the TEP.  
7 Sources included NQF repository of measures, CMS  
8 measure inventory, American Society of Addiction  
9 Medicine, et cetera. We also searched many state  
10 sources, 17 states to be more specific. To name  
11 a few, we looked at Minnesota, New York,  
12 Colorado, Ohio, Arkansas.

13           We identified measures based, again,  
14 on feedback from CMS and multi-stakeholder  
15 experts regarding the goals of each program area  
16 and the current measurement activities of the  
17 states' delivery system reform efforts.

18           Step number 2, we captured measure  
19 details on each of the IAP program area measure  
20 summary sheet. So, as part of your pre-work, you  
21 received those kind of big, bulky Excel sheets.  
22 We won't torture you and ask you to pull those

1 out today. But we used those sheets as a way of  
2 capturing the measure information in detail. So,  
3 included on those sheets, you have the numerator,  
4 denominator, measure type, the steps basically  
5 for the measure. All of this information was  
6 housed in the fourth separate Excel sheets.

7 As stated earlier, we used the CMS  
8 quality measurement domains as an organizing  
9 framework.

10 Step number 3. So staff ranked the  
11 measure specific criteria as part of the  
12 collection of measure details, using four  
13 measure-specific criteria. We looked at  
14 feasibility, usability, scientific acceptability,  
15 and evidence, assigned a ranking for each measure  
16 criteria.

17 Each measure criteria, the  
18 feasibility, usability, scientific acceptability,  
19 and evidence has its own definition for the high  
20 to low rankings. If we could not find  
21 information to support one of the criteria, then  
22 we mark that as unsure. Of course, you know it

1 is very easy for us to find information on NQF-  
2 endorsed measures but not always as easy to find  
3 information for concepts in those measures in  
4 states.

5 Okay, so you see on your slide some of  
6 the designations for scientific acceptability and  
7 evidence. So, let's go to the next slide.

8 Okay, Step number 4, after the  
9 criteria were ranked and translated into a  
10 numeric score, staff calculated an overall  
11 measure score based on the rankings and rating.

12 Bullet two on your slide describes the  
13 weight of each of the four criteria in the  
14 overall measure score calculation. So you will  
15 see that feasibility and usability each made up  
16 30 percent of the measure score; scientific  
17 acceptability made up 25 percent and then  
18 evidence made up 15 percent.

19 Feasibility and usability were  
20 weighted the highest because, considering  
21 reporting burden, accessibility of data,  
22 alignment with other measure sets, et cetera, is



1 particularly important to the Medicaid  
2 population.

3 The overall measure score was used in  
4 the culling down process.

5 Step 5, the initial review and removal  
6 of measures by measure score. So TEP members  
7 conducted an initial review of the measure  
8 universe. We wanted to make sure that the  
9 process is well-vetted. So, along the way, we  
10 have often asked for feedback from CMS, from our  
11 chairs, we had an Advisory Group, and then TEPs,  
12 and then also from yourself.

13 So before the TEP meeting, the TEP  
14 members received a survey soliciting feedback on  
15 the measures captured to date. Their feedback  
16 was very instrumental in helping staff search for  
17 more measures and find additional information  
18 about the measures already included in the  
19 measure summary sheets.

20 Once the summary sheets were  
21 promulgated and measure scores assigned, staff  
22 conducted an analysis to determine the mean. The

1 mean is the threshold or cutoff to determine  
2 whether a measure or a concept would be  
3 considered for additional consideration.

4 Prior to the meeting, TEP members  
5 received measure summary sheets with overall  
6 measure scores and mean scores for their  
7 particular program area.

8 Again, the measures or the concepts  
9 with scores under the mean were not considered  
10 unless the TEP members identified the measures or  
11 concepts that scored under the threshold that  
12 they wanted to retain. We gave TEP members the  
13 option to propose up to three measures or  
14 concepts below the threshold that they wanted to  
15 retain.

16 So on this next slide is really a  
17 visual of the information that I have shared thus  
18 far. So, the measures were assigned a score  
19 based on the measure's feasibility, usability,  
20 scientific acceptability, and evidence. We found  
21 the mean score of all the measures in the program  
22 area, which became the cutoff.

1           So, here in your diagram you will see  
2           that the cutoff in this case for the program area  
3           was 0.92. The top blue box demonstrates all  
4           measures equal to or greater than the mean  
5           automatically selected for further TEP  
6           discussion.

7           The TEP members were able to select up  
8           to three measures below the mean to be retained  
9           for further discussion. So in the bottom box, we  
10          see that a low-scoring measure retained by TEP  
11          member moved to the decision logic review.

12          This allowed the TEPs the option to --  
13          or allowing the TEPs the option to retain a  
14          measure below the threshold was important because  
15          scores were determined by information the staff  
16          could find. So, again, we easily found the  
17          information for NQF-endorsed measures but the TEP  
18          members, being boots on the ground, having an  
19          expertise in the areas, knew more information  
20          about concepts and so they were able to retain  
21          those concepts.

22                 CO-CHAIR GOLDEN: Can I stop you for

1 a second to ask two questions on the scaling?

2 Do you know what the scale was? So  
3 was it like zero to three? Is that the usual  
4 with these measures?

5 MS. MURPHY: So actually based on the  
6 weighting that we calculated, the maximum score  
7 was a little odd. It was a 2.7, I believe. And  
8 there was a good amount of variation among the  
9 four program areas on the maximum score. The  
10 highest was the integration of physical and  
11 mental health, which I believe had a high cutoff  
12 score of 1.7.

13 MS. BUCHANAN: Yes.

14 MS. MURPHY: And the lowest was the  
15 substance use disorder, which was a 0.92.

16 MS. BUCHANAN: Yes, in that program  
17 area, we did find a lot of poor developed  
18 measures but we also found a lot of measures with  
19 little information.

20 CO-CHAIR GOLDEN: With weighting --  
21 I'm sorry, the scale in substance abuse was zero  
22 to --

1 MS. MURPHY: So the scale -- the  
2 formula used to calculate the measure score was  
3 consistent across all program areas. But the  
4 variation of the scores that we found, based on  
5 the measure information varied.

6 CO-CHAIR GOLDEN: And I'm sorry to be  
7 technical but I looked at the scale. So  
8 something that had a low like you know, we  
9 thought poorly feasible would have gotten a one.  
10 But if you are unsure, it got a zero. Is that  
11 right?

12 MS. MURPHY: That's correct.

13 CO-CHAIR GOLDEN: So people were -- so  
14 you could, technically if you weren't sure, rate  
15 something lower than if you thought it was  
16 terrible.

17 MS. MURPHY: Yes, I think we were  
18 thinking that low didn't mean terrible. That  
19 wasn't quite the translation in our mind.

20 Shaconna or Peg, do you want to add  
21 anything?

22 DR. TERRY: So the ratings that we

1 came up with, and by the way, when we saw the  
2 ratings for each program and they were different,  
3 then we used a cutoff point, as you know,  
4 differently for each program.

5 So when we came up with the original  
6 high, medium, low, and unsure, it was because we  
7 really couldn't find enough information usually.  
8 That was really the biggest problem, especially  
9 with measures that weren't NQF-endorsed or  
10 weren't out there really enough in the public  
11 view. It was a bit of a struggle and that's what  
12 we did, if that helps.

13 MS. GORHAM: All right. And so the  
14 final step, Step 6, describes the work the TEP  
15 completed during the in-person meeting. Steps 1  
16 through 5 was all pre-work. As you know, we love  
17 to give our committees pre-work because you all  
18 had a lot to do.

19 So, 1 through 5 was pre-work and Step  
20 6 was the actual in-person meeting activity or  
21 happenings.

22 So, the remaining measures, those

1 above the threshold and those that TEP members  
2 retained were evaluated initially against the  
3 criteria and the decision logic. Each measure  
4 was considered against the specific criteria or  
5 questions using the following indicators of high,  
6 medium, and low.

7 The next slide is a great illustration  
8 of this step, albeit very small. So really tiny  
9 diagram but keep in mind that it is very similar  
10 to the decision logic that you have at your table  
11 and a few tweaks have been made, based on  
12 feedback received during the TEP meeting. Again,  
13 feedback is very important throughout this  
14 process. And so we made tweaks and Peg will  
15 further elaborate on this on the decision logic  
16 question about immediate use that also goes back  
17 to the tweak for the definition as well.

18 And just a clarifying point, really  
19 the major change for the definition is whether or  
20 not the measure has been tested. And so we know  
21 that a lot of great measures used in Medicaid  
22 will never actually come to NQF for endorsement.

1 And so we can't say that just because it is not  
2 suitable for endorsement or does not have that  
3 testing, it is not a measure.

4 And so we look at the measures. We  
5 are not asking you to change the specifications  
6 or anything like that. You are looking at what  
7 the measure is before you. You just will look to  
8 see whether or not -- well, maybe this measure  
9 was considered a concept because it didn't have  
10 testing but it really is a measure because it has  
11 been fully spec'd out.

12 So the next slide.

13 So finally, the decision logic results  
14 for each measure or concept will yield the  
15 following. So either the measure or the concept  
16 will be excluded from the recommended measure  
17 set, the measure is recommended for inclusion in  
18 the measure set, or the concept is recommended  
19 for inclusion in the measure set. Again, just to  
20 reiterate, we are looking for, CMS is looking for  
21 measures ready for immediate implementation and  
22 they have allowed us to have some concepts but we



1 do not want more than 20 percent.

2 So just to quickly review the voting  
3 that the TEPs actually partake in and you will  
4 also partake in the same voting, for the most  
5 part, the TEP members utilized hand votes.  
6 Today, we will do a mixture of hand votes and the  
7 actual clickers but because we were in breakout  
8 sessions, the TEPs used hand votes.

9 Consistent with NQF voting, votes  
10 require at least a 60 percent -- greater than 60  
11 percent agreement. All decisions to support or  
12 not support were accompanied by one or more  
13 statements of rationale as to how and why each  
14 decision was reached. And so we will ask you to  
15 do the same today as you vote. We just want to  
16 make sure we record why we are voting a certain  
17 way.

18 So I know that was a lot. I will turn  
19 it back over to Bill to facilitate any discussion  
20 or questions.

21 CO-CHAIR GOLDEN: You're not off the  
22 hook yet.

1 MS. GORHAM: Okay.

2 CO-CHAIR GOLDEN: So okay, that's  
3 terrific and after our break or comments, we are  
4 going to get back together and we'll start our  
5 work.

6 How are we voting? Are we voting on  
7 the measure as a totality or on subsections?

8 MS. GORHAM: So our voting system is  
9 we have been very strategic about it. So both.  
10 So we will start with program area, the BCN  
11 program area. So we will vote and we will look  
12 at that program area and you will be voting first  
13 on the new measures. Did the BCN have new  
14 measures?

15 MS. KUWAHARA: No, we did not have new  
16 measures -- oh, I'm sorry. I thought I clicked  
17 it.

18 We will not be voting on any new  
19 measures submitted after the deadline because  
20 there were no measures submitted after the  
21 deadline but we will conduct votes on measures  
22 referred to from other program areas. We also

1 will get to measures that were identified for  
2 reconsideration by coordinating committee  
3 members.

4 CO-CHAIR GOLDEN: So again, so a  
5 measure shows up, a percentage of people who  
6 still have their hat check at the end of dinner,  
7 at the restaurant, what elements of that are we  
8 going to be voting on, the whole measure, the  
9 global score, the components, the different  
10 elements, I just want to know the process.

11 MS. GORHAM: So you will vote on the  
12 individual measure. And when we get there, we  
13 will definitely go through the process step by  
14 step. But you will vote on the individual  
15 measure. At that point, we will have you open  
16 your discussion guide so that you will see all of  
17 the measure specs.

18 CO-CHAIR GOLDEN: Right.

19 MS. GORHAM: You will see the  
20 preliminary analysis completed by staff. We  
21 will, if it is, for example, an NQF-endorsed  
22 measure, if we have information from the Standing

1 Committee about the measure and where it is in  
2 the endorsement process, we will share that  
3 information if it is a concept or something that  
4 we have been able to get in contact with the  
5 state about, if we have more information about  
6 that measure.

7 So, you will review all of the  
8 information about the individual measure.

9 CO-CHAIR GOLDEN: So Measure X comes  
10 up for discussion. We have the different  
11 elements of that measure. The discussion is open  
12 on all of that and then we have one vote on the  
13 measure. Is that correct?

14 MS. GORHAM: Yes.

15 CO-CHAIR GOLDEN: So, it is a global  
16 vote but we can discuss all the different aspects  
17 of the measure for the global vote.

18 MS. GORHAM: Yes.

19 CO-CHAIR GOLDEN: Okay.

20 DR. TERRY: Yes, I just -- and thank  
21 you for the questions. I am going to cover some  
22 of this in the next part.

1 CO-CHAIR GOLDEN: Okay.

2 DR. TERRY: And then that's a good  
3 time to jump in and really ask additional  
4 questions.

5 CO-CHAIR GOLDEN: Okay because  
6 Jennifer and I weren't sure if that is what we  
7 would be discussing.

8 DR. TERRY: It's a lot. It's a lot.

9 CO-CHAIR MOORE: And if we are leading  
10 this group, we had better know.

11 (Laughter.)

12 CO-CHAIR GOLDEN: Okay, other comments  
13 or questions about the TEP process and our  
14 compass for the future here, I guess?

15 Anybody on the phone? Okay.

16 MEMBER SIDDIQI: This is Alvia. I'm  
17 sorry, just a quick point.

18 So I know one of the things was trying  
19 to do the pre-work to cull out measures but will  
20 there be opportunity to do more of that in the  
21 future between this meeting and the next meeting  
22 or, at this point, most of that work has been

1 finalized and so there won't be that opportunity  
2 to select new measures again?

3 DR. TERRY: I'm just --

4 CO-CHAIR GOLDEN: She wants to know  
5 whether more measures can come in after today.

6 DR. TERRY: At this point, I think we  
7 have the measures in whatever we talk about  
8 today. I don't think we are going to add  
9 measures that come in to this project for this  
10 project but we will share a little bit about how  
11 this is seen.

12 And this is considered sort of the  
13 beginning. I'm not going to say starter sets but  
14 that's been talked about. So, this is not the  
15 end. This is the beginning of recommended  
16 measures.

17 MEMBER SIDDIQI: Okay, thank you.

18 CO-CHAIR MOORE: So what we're voting  
19 on then is just recommendations to CMS to figure  
20 out what the next steps are. Because some of the  
21 early conversations, and Andrea, I think that you  
22 brought this up on one of the first calls is the

1 issues with gaps; gaps in evidence, gaps in  
2 knowledge, and if we are recommending measures,  
3 we have to acknowledge those pieces. And there  
4 was a desire to focus on that piece first but for  
5 the objectives and purpose of this project, we  
6 are not able to do that.

7 But putting that forward is the  
8 purpose of that and to take it to the next level.

9 MS. GORHAM: And towards the end of  
10 Day 2, you all will notice that we do have a  
11 final overall look at all of the measure sets  
12 and, at that time, you can make suggestions to  
13 CMS for future iterations of the measure sets.

14 CO-CHAIR GOLDEN: Yes, did somebody  
15 else have a question on the phone?

16 MEMBER SCHIFF: Hi, Bill. This is  
17 Jeff. Just one general comment, I think, and  
18 then one specific one.

19 The general comment is I think we have  
20 to look at these measures as sort of guidance and  
21 tools for Medicaid programs so that how they get  
22 used is really sort of a living piece of work

1 that we will just have to see over time.

2           The specific thing, I guess I am just  
3 cautionary in that I noticed, for example, that  
4 in the feasibility, surveys automatically got a  
5 lower score, which is true because they are less  
6 feasible to do. However, I worry. I think as we  
7 look at this we have to be careful that the raw  
8 score is sort an averaging of unlike categories.  
9 So I just want to be cautionary about that  
10 because I think in some situations, especially  
11 things like care coordination for complex  
12 patients, some of the things that may not be  
13 feasible instantly may produce the best  
14 information. Thanks.

15           CO-CHAIR GOLDEN: All right, other  
16 comments or questions?

17           Now, I apologize for jumping ahead.

18           DR. TERRY: No, no.

19           CO-CHAIR GOLDEN: I was looking at my  
20 slide deck in my hands and your material was  
21 missing. So, I was getting concerned. So, I  
22 will turn it over for -- I'm sorry, was there



1 something else?

2 MS. GORHAM: I just wanted to take a  
3 pulse in the room. We are scheduled for a break  
4 right now but we are also behind time. So, just  
5 to take a pulse in the room, if you want to take  
6 a five-minute break?

7 CO-CHAIR GOLDEN: Five minutes would  
8 be great.

9 (Whereupon, the above-entitled matter  
10 went off the record at 10:36 a.m. and resumed at  
11 10:53 a.m.)

12 DR. TERRY: Okay, I know people are  
13 coming back but we are a little tighter on time,  
14 of course. So, I think I should get started.  
15 And what I'm going to do herein the next few  
16 slides is talk about a few things. The measure  
17 selection process, we have begun talking about  
18 that but I am going to go into it in a little  
19 more detail; the voting procedures; and the  
20 decision logic steps.

21 I just want to make sure everybody  
22 knows we are not going to take every one of the

1 measures there through the decision logic. Some  
2 of the measures that were recommended by the TEPs  
3 will just move forward.

4 But we have so many other what ifs,  
5 what ifs, what ifs, and those are that if there  
6 are new measures or measures that are newly  
7 submitted -- we have some; or measures that were  
8 moved from one TEP, one program to another;  
9 measures that we, I call them, saved or recovered  
10 from what the TEP did, the pre-work; and also  
11 measures are related, we will take a look at  
12 those, take another look; and the one other types  
13 of measures we will look at are those that people  
14 here want to pull from the measure set and really  
15 talk about and decide whether we want to keep  
16 that. So, those are the ones we will have an in-  
17 depth look at. So I just wanted to make sure we  
18 all understand where we are going with this.

19 So, go to the next slide. And so this  
20 one I'm just -- would you go to the next one?  
21 Just go to the little more detailed one. Thank  
22 you.

1           So here we have the process for -- and  
2 I just said this so I am going to do this real  
3 quickly. This is the process for selecting the  
4 measure set. The first one is to evaluate newly  
5 submitted measures. I think there is only  
6 program that has it, the PMH program. And also  
7 measures that were moved from one -- suggested to  
8 move from one particular program to the other by  
9 the TEPs.

10           The pre-work that was done, those  
11 measures we will look at separately and that will  
12 be the next step. And I just want to let you  
13 know we had ten measures that were selected from  
14 all the programs to kind of look at to see  
15 whether this group wants to include those  
16 measures.

17           The best in class for, again, the  
18 related measures.

19           And the last one is really to remove  
20 measures -- what I just talked about. So the  
21 ones that this group feels should not be in.

22           And then we will vote en bloc.

1           So, again, here is a little bit more  
2 detail. I'm going to try to go through this  
3 quickly because I think we have just said it but  
4 I do want to say that for each of the measures  
5 that are either new or those moved from one  
6 program to the other, we will take those through  
7 the decision logic and they will need to have  
8 more than 60 percent vote for the measure to be  
9 retained and added to the measure set.

10           For the next one, it is the measures  
11 that in the pre-work were recovered. And I  
12 mentioned that we allowed people to save some  
13 measures. And what we will do -- what we have,  
14 there are ten measures; two for LTSS, two for  
15 BCN, three for PMH, and three for substance use  
16 disorder. And we will also take those measures  
17 through the decision logic as well. And we need,  
18 again, more than 60 percent.

19           For those that are actually measures  
20 that have been pulled prior to the meeting, we  
21 would expect that those who pulled them will be  
22 able to speak to their rationale and some of

1 these measures have two people or three. So,  
2 those are the popular measures that people felt  
3 we needed to reconsider again.

4 So going to the next slide, I think I  
5 just did the reconsideration one. So, the next  
6 slide.

7 And this is the best in class. I do  
8 just want to let you know why we did this. You  
9 know we, if anybody's been part of a CDP process  
10 here at NQF, we do look at related measures.  
11 It's part of what we do but we're not trying to  
12 harmonize them here. So I just want to make sure  
13 you really are aware of that.

14 We are just -- it's another look. And  
15 when you have them in tables, it is really easier  
16 to see whether they are similar or whether  
17 they're different, or whether there is one that  
18 is broader. Really, the goal is to find  
19 parsimony is the word to find the broad measures  
20 if it captures what needs to be captured.

21 So again, the purpose of this is,  
22 again, just to look at this. The staff will go

1 through the measures in terms of the numerator,  
2 which is the target or what the measure is about  
3 and the denominator is really the population.

4 So, just so you know, and you don't, the other  
5 part is if you don't want to remove anything, so  
6 be it. It's just another way to look at it.

7           And then when you get to the  
8 elimination, we are asking on this one, this is  
9 somebody here in the room or on the phone who  
10 says ah, I really don't know why that measure is  
11 on that measure set and I want to really look at  
12 it again, so they need a rationale and they need  
13 a second. So they can talk about the reason and  
14 if somebody seconds it, then we will review that  
15 measure and we will take it through the decision  
16 logic as well.

17           And then the last is just at the end  
18 we will look at each measure set and, based on  
19 everything we've just done, we will remove, we  
20 will discuss, we will second, whatever, and then  
21 we will need to vote more than 60 percent to  
22 approve that set.

1           And then I want to just take a minute  
2           and just talk about voting procedures. You know  
3           the voting procedures at NQF are always a little  
4           complicated. So, some of it we are doing  
5           electronically and some of it we are doing by  
6           hand, just so you know.

7           So electronically -- and you will see  
8           this as we go along, so I don't need to spend a  
9           lot of time on this. But the evaluation of newly  
10          submitted measures, those moved from one program  
11          to another, those recovered by a member, and then  
12          they vote en bloc. And then the ones that are  
13          related, we are just doing a hand vote. And  
14          measures pulled from the block for further  
15          discussion, we are also doing just a hand vote.

16          And I just want to say we will work  
17          with the people on the phone to make this work.  
18          Just so you know we are very experienced at that.

19          So, here is the decision logic. And  
20          I just wanted to really walk you through this a  
21          bit because this is really the core of what  
22          everybody will be doing in each of the groups,

1 led by the chairs of those groups. So, we will  
2 look through these measures.

3 But the first thing I just wanted to  
4 go through and, again, this begins with the first  
5 part of this. And I know this is a little hard  
6 to see. I will just getting my piece of paper  
7 here, so I have it in front of me. Here we go.

8 So the decision logic begins with the  
9 extent that the measure addresses a critical  
10 quality issue. And that critical quality issue  
11 we have high, medium, and low as the kind of  
12 issues here that they need to address.

13 I am just going to kind of let you see  
14 this. I think if something gets a high/medium,  
15 high/medium, it moves, moves, moves to the next,  
16 except that when you get to the extent with the  
17 measure concept or measure concept is ready for  
18 immediate use and there we have a divide. And if  
19 it is a measure, it goes in one track. If it is  
20 a measure concept, it goes in another and you  
21 will see that.

22 So, let's go and just take a little



1 bit of a walk through the decision logic. And  
2 the first one starts with is to what extent does  
3 this measure/concept address critical quality  
4 objectives of CMS quality measurement domain or  
5 key concepts that we have. And so the high is  
6 measure addresses a quality measure domain or all  
7 of the key concepts; medium is addresses the  
8 quality domains but maybe not address the key  
9 areas and concepts.

10 So the key areas and concepts are what  
11 we did early on with I know input from this group  
12 because we had a call just to share with you what  
13 we were doing. And we also had input from CMS on  
14 what those key concepts and key words were. And  
15 so we're using that. We use that as a way to  
16 make sure it addresses those.

17 And then the low is that it does not  
18 address domains or concepts.

19 So, it gives you a sense of how we  
20 walk through that. And what we will do is we  
21 need to get 60 percent vote for that to go  
22 through.

1                   And can I just say this? This is  
2 really what we did in the TEP. So this is not  
3 new to the people who were in the TEP.

4                   The next one that we have here is does  
5 it -- to what extent does this measure or concept  
6 address an opportunity for improvement and/or  
7 significant variation in care by quality  
8 challenges? Again, we want to get at whether  
9 this is something that shows opportunity to  
10 improve or there are some things that can change.

11                   And so we have high, addresses quality  
12 -- multiple quality challenges and opportunities  
13 for improvement; medium measure has potential to  
14 address variation in care and quality challenges;  
15 and measure does not address is low.

16                   So we have kind of gone -- and I don't  
17 need to read all of these because you will hear  
18 all these later. I just wanted to give you a  
19 sense of how we did high, medium, and low.

20                   So the next one is the alignment one.  
21 And so this is -- I think this is always a bit of  
22 a hard one but this is one that we really -- to

1       what extent does the measure or concept  
2       demonstrate efficient use of measurement  
3       resources and/or contribute to alignment of  
4       measures across programs, health plants, et  
5       cetera, et cetera?

6                       So here, we wanted to get at the fact  
7       that we want measures that we think are not  
8       duplicative of other measures but they have some  
9       ability to be used across programs and health  
10      plans. And of course, the issue here, of course,  
11      is also whether it is specified to do that, too.  
12      So that's the next one.

13                      The next one we get to is to what  
14      extent is the measure ready for immediate use.  
15      And you have heard this probably five times  
16      already here, if not more today. And so it is  
17      key and it is key for CMS. I see Beverly smiling  
18      at me as I say that.

19                      And so here we have high is a fully  
20      developed measure that includes detailed  
21      specifications and may have undergone testing  
22      that is currently used or planned for use in

1 states. And so that is high. That is for a  
2 measure.

3 For a concept, a measure concept that  
4 includes a description, numerator, and  
5 denominator is currently in use or planned for  
6 use in states. So it is a little bit -- if it is  
7 a measure concept and it goes to what is the  
8 medium and low is a measure or concept not in  
9 use.

10 So, when you look at this diagram that  
11 you all had, you will see that on the diagram  
12 there is a little different movement for measures  
13 that are high -- measures that are concepts --  
14 measures that are measures and measures that are  
15 concepts.

16 And then the last question is to what  
17 extent do you think this measure is important to  
18 Medicaid agencies and other stakeholders,  
19 including consumers, families, Medicaid managed  
20 care organizations, and providers?

21 This is based on your knowledge, based  
22 on your expertise, based on your background. So,

1 high is important to state Medicaid agencies and  
2 beneficiaries and families; medium is important  
3 to two stakeholders, including state Medicaid  
4 agencies; and low is important to only one  
5 stakeholder.

6 It is a bit of a judgment here but the  
7 goal is to know that this is something that is  
8 considered an important measure to look at.

9 So --

10 CO-CHAIR MOORE: Can I clarify that?

11 DR. TERRY: Yes.

12 CO-CHAIR MOORE: So the high says  
13 state Medicaid agencies and  
14 beneficiaries/families and then medium it says  
15 two stakeholders. So high is also just two  
16 stakeholders. So is high those two plus?

17 DR. TERRY: Right.

18 CO-CHAIR MOORE: Okay.

19 DR. TERRY: So there can be -- yes,  
20 the first can be more and the second one, we  
21 don't really -- we didn't put in important to  
22 consumers. We left it at others. It can be two

1 others.

2 CO-CHAIR MOORE: Got it.

3 CO-CHAIR GOLDEN: And a quick  
4 question. Looking at this, the notion of the  
5 measure feasibility, does that fit in any of  
6 these boxes? Is it in box 3? Is it in box 4?

7 DR. TERRY: Well, we did look at  
8 feasibility already.

9 CO-CHAIR GOLDEN: Okay.

10 DR. TERRY: Remember as we were  
11 looking at and rating the feasibility, knowing  
12 basically that the data and where you get the  
13 data from is really accessible. So, we have  
14 looked at that initially. We don't have it here  
15 in this decision logic.

16 I kind of think it is implied here, as  
17 you ask the question. I'm just thinking about it  
18 but I don't think so. I think we've already  
19 addressed it and it is certainly something you  
20 can talk about. Feasibility is I think something  
21 that can be an issue when you discuss this.

22 Okay, I know I did that kind of

1 quickly but I know we are short for time. Any  
2 other questions?

3 Okay, so next is -- oh, Miranda?

4 MS. BUCHANAN: Isn't it time for  
5 public comment?

6 DR. TERRY: It is.

7 MS. BUCHANAN: Thank you very much. So  
8 we will now open the lines for public comment.  
9 Any members of the public can either participate  
10 via teleconference or type their questions into  
11 the chat box and a member of the staff will read  
12 it.

13 Operator, if you wouldn't mind opening  
14 the lines now.

15 OPERATOR: Okay. At this time if you  
16 would like to make a public comment, please press  
17 \* then the number 1.

18 And you have a public comment from  
19 Clarke Ross.

20 MS. BUCHANAN: Okay.

21 MR. ROSS: Hi. This is Clarke Ross.

22 I work for the American Association on Health and

1 Disability and a member of the National Quality  
2 Forum Work Group on Persons Dually Eligible for  
3 Medicare and Medicaid and the Medicaid Adult  
4 Measures Task Force.

5 And this is really a comment for  
6 tomorrow afternoon's discuss but I am going to be  
7 an hour late in joining the call tomorrow  
8 afternoon.

9 This concerns the concern of home- and  
10 community-based service advocates in the aging  
11 and disability field. So that is two coalitions,  
12 the consortium of citizens with disability and  
13 the disability and aging collaborative, about how  
14 modest and incremental the proposed measures are  
15 for home-and community-based services and that  
16 our practice is farther ahead than the draft  
17 slides indicate.

18 And that the attention should be much  
19 more on community inclusion than transition from  
20 institutions. And there are three or four  
21 different examples we could cite but I want to  
22 encourage your committee to carefully review



1 these tonight before tomorrow afternoon's  
2 discussion, the recommendations from the National  
3 Quality Forum Committee on home- and community-  
4 based services and their vision of what is  
5 important and what is being done in selected  
6 states and program like the National Core  
7 Indicators that you are going to hear from later  
8 at this meeting and the personal outcome measures  
9 that we heard about last month at the Medicaid  
10 Adult Measures.

11 So, I just wanted to plant the seed  
12 that we have this commissioned work by the  
13 National Quality Forum on home- and community-  
14 based services and there is concern by a number  
15 of home- and community-based advocates that what  
16 you are dealing with is quite modest and there is  
17 more happening in the country that should be  
18 considered. So, thank you for your consideration  
19 and we look forward to your work. Thank you.

20 MS. GORHAM: Thank you, Clarke, for  
21 your insightful comments. We share your  
22 sentiments. And again, thank you for your

1 comment.

2 MR. ROSS: Okay.

3 MS. BUCHANAN: And we also want to  
4 invite anyone sitting in the public in the room  
5 to come up to the microphone and ask any  
6 questions, if they have any.

7 OPERATOR: And at this time, there are  
8 no public comments from the phone line.

9 MS. BUCHANAN: Okay, thank you very  
10 much.

11 MS. KUWAHARA: All right, so we can  
12 dive right into our first program area.

13 We will be assessing measures for the  
14 improving care for Medicaid beneficiaries with  
15 complex care needs and high costs.

16 So I know you all have seen this list  
17 of criteria -- I'm sorry, this list of events  
18 that will be taking place today but I will just  
19 provide an overview specific to BCN.

20 First we will go through and evaluate  
21 measures referred to from other program areas.  
22 Then we will evaluate measures that were

1 identified for reconsideration by members of the  
2 Coordinating Committee.

3 There were no related NQF measures  
4 identified through the NQF staff preliminary  
5 analysis, so we will not be conducting voting on  
6 related measures for BCN. Then you all will have  
7 an opportunity to remove any measures that were  
8 recommended by the TEPs from the final  
9 recommendations.

10 And then, finally, we will cast a vote  
11 on the overall measure set. Next slide, please.

12 Andrea, are you on the line?

13 MEMBER GELZER: I am.

14 MS. KUWAHARA: So, I will invite you  
15 to provide an overview of the TEP deliberations.

16 MEMBER GELZER: Thank you. First, I  
17 would like to give a shout out to my other  
18 colleagues on this TEP and they were James Bush,  
19 Dr. James Bush, who is the State Medicaid Medical  
20 Officer for the State of Wyoming; Dan Culica, Dr.  
21 Dan Culica, who is the Senior Research Specialist  
22 for the State of Texas HHS; Dr. David Moskowitz,

1 who is the Medical Director of Hope Center at  
2 Alameda Health System in Oakland, California; and  
3 Howard Shaps, M.D., who is the Medical Director  
4 for WellCare of Kentucky. And kudos to their  
5 hard work that got us to this place and really  
6 the brilliance of all their minds in the  
7 discussion.

8           So with that, with regard to review of  
9 the Beneficiaries with Complex Needs TEP  
10 discussion of the 69 or 70 originally surveyed  
11 measures, the TEP actually reviewed and discussed  
12 43 measures or, at the time, what were deemed  
13 measure concepts and recommended 14 measures to  
14 move on, as well as six measure concepts to go on  
15 to the Coordinating Committee. And you will hear  
16 also that two additional measures were retained  
17 after this process and will be considered  
18 retained by members of the Coordinating  
19 Committee.

20           So throughout our deliberations, as we  
21 discussed, there were really several themes that  
22 kept coming out. And first of all, there really

1 is some ambiguity surrounding who is a complex  
2 beneficiary. And that really posed some degree  
3 of challenge and opportunity in identifying best-  
4 available measures. And we kept having the  
5 discussion as to okay, are we talking about super  
6 utilizers who are really not the five percent who  
7 drive 50 percent of the cost individuals but  
8 really the half a percent that are at the top of  
9 the pyramid, or are they individuals that aren't  
10 quite the super utilizers yet, they are really  
11 people that have a number of chronic conditions  
12 and are in danger of really falling off that  
13 cliff to exponential cost and health care needs?

14 We also had quite a discussion about  
15 whether we were going to consider doing specific  
16 measures or measures that really encompassed  
17 multiple conditions. And we, you know after lots  
18 of discussion, decided that we would favor, in  
19 most cases, measures that encompassed multiple  
20 conditions, rather than a single condition.

21 And then I would just note that many  
22 of these measures -- and it's not just for my TEP

1 but for all of our TEPs and the whole previous  
2 TEP discussion, many of these measures can be  
3 considered cross-cutting measures. I mean if you  
4 look at medication reconciliation measures, cost  
5 and resource use measures, I mean I think it's  
6 important that all of the measures that we  
7 discuss with regard to this TEP are pertinent to  
8 beneficiaries with complex needs but we have to  
9 remember that they are also pertinent to other  
10 populations in other subject areas that we will  
11 discuss later today.

12 And with that, I turn it back over.  
13 We're not going to go over each of the measures  
14 at this time. Is that correct?

15 MS. KUWAHARA: That's correct.

16 MEMBER GELZER: Okay.

17 MS. KUWAHARA: So, if we move on to  
18 the next slide, please.

19 Before moving on, we did want to make  
20 one note. During the TEP in-person meeting, a  
21 few TEP members identified several measures that  
22 were specified for the Medicare population.

1 After the TEP in-person meeting, NQF staff and  
2 CMS determined that in order to maximize the  
3 potential of the BCN measure set, these seven  
4 measures outlined on the slide were inappropriate  
5 for the BCN population. As such, they are  
6 removed from consideration and they will not be  
7 included in the final measures that we ask you  
8 all to vote on later today. Next slide, please.

9 So, as I mentioned previously, there  
10 were no late submission measures for  
11 consideration but TEP members recommended four  
12 measures from other program areas. We will take  
13 each of these four measures through the decision  
14 logic and vote through them individually.

15 We have included a handout at your  
16 desk, if you are joining us in the room. It is  
17 the decision logic handout and guiding questions.  
18 We will be using that to inform our votes today.

19 For individuals joining us remotely,  
20 we sent out an email over the break that has the  
21 exact same handout. So, please use that to your  
22 advantage.

1           So, I would like to ask everyone,  
2 remote and in-person, to please open up your  
3 discussion guide. It's an H channel file and it  
4 is located in one of two places. It was sent out  
5 yesterday via the calendar invitation for this  
6 meeting and it is also included on the NQF web  
7 page for this project.

8           As you load that up, I will be  
9 providing a very brief guide, an overview of the  
10 discussion guide.

11          So everyone should think of this tool  
12 as a continuous very long web page. And the  
13 agenda synopsis serves as a shortcut to all the  
14 different points within the web page.

15          So, as you will notice on the left-  
16 hand side, right now we are in the Review of BCN  
17 Measures stage. And directly to the right of  
18 that section, we have our measures and measure  
19 concepts for reconsideration, as well as new and  
20 referred measures for Coordinating Committee  
21 review. If you click on either of those links,  
22 it will drop you down, if it is working



1 correctly. Hopefully, everyone in the room, it  
2 is working for you all. If it's not, please flag  
3 us down and we'll try to sort something out.

4 This may be a single computer issue.

5           Once you do drop down or you scroll  
6 down, you will notice that we have an overview of  
7 the measures. So, if it is an NQF-endorsed  
8 measure, it will have the NQF number, as well as  
9 the description. And for measures that were  
10 identified for reconsideration, the lead  
11 discussants are also made available there.

12           You'll notice that there is a section  
13 with measure specifications and staff preliminary  
14 review. If you click on either of those links,  
15 it should drop you down to the measure  
16 specification section, which is found below.  
17 This will include fields such as data source,  
18 description, numerator, denominator, as our staff  
19 preliminary analysis.

20           There is also a field labeled status.  
21 That will let you know if the measure was  
22 recommended by the Technical Expert Panel, if it

1 was identified for reconsideration by a member of  
2 the CC, if it is a related measure. And if it is  
3 a related measure, it will let you know which  
4 measures it is related to.

5 If you scroll all the way back up, or  
6 use your back space arrow at the top left-hand  
7 corner of the screen, you can access the measures  
8 -- all the way at the top in the navigation bar,  
9 once you click on "Measures," it will provide you  
10 with a comprehensive list of all measures that  
11 fall under the program areas. So, they are  
12 listed out for BCN, PMH, LTSS, and SUD.

13 We also have links to the measure  
14 repositories for each of the program areas and  
15 that gets you to the Excel spreadsheets that were  
16 distributed several weeks ago.

17 And I just want to get a pulse check  
18 for those in the room. Are you able to utilize  
19 the links?

20 Okay.

21 MS. BUCHANAN: I think it is our  
22 computer.

1 MS. KUWAHARA: That is excellent news.

2 All right, so we can begin with your  
3 first measure slated for review. This is not an  
4 NQF-endorsed measure. This is Adult Access to  
5 Preventive and Ambulatory Care 20-44, 45-64, and  
6 65+. I will read out the description and the  
7 numerator and denominator for everyone.

8 This measure is used to assess the  
9 percentage of members 20 years and older who had  
10 an ambulatory or preventive care visit. The  
11 organization reports three separate percentages  
12 for each product line: Medicaid and Medicare  
13 members who had an ambulatory or preventive care  
14 visit during the measurement year; commercial  
15 members who had an ambulatory or preventive care  
16 visit during the measurement year or the two  
17 years prior to the measurement year.

18 The numerator is Medicaid and  
19 Medicare. One or more ambulatory or preventive  
20 care visits during the measurement year. For  
21 commercial use, one or more ambulatory or  
22 preventive care visits during the measurement

1 year or the two years prior to the measurement  
2 year.

3 And the denominator: members age 20  
4 years and older as of December 31 of the  
5 measurement year.

6 And with that, I will turn it over to  
7 Jennifer to facilitate discussion.

8 CO-CHAIR MOORE: At this time, do we  
9 have any comments or questions about this  
10 measure? Deborah.

11 MEMBER KILSTEIN: Just a quick  
12 question in terms of where there is a carve-out  
13 or where there are situations where a plan is not  
14 responsible for all the services -- I'm sorry.  
15 Did you have a question?

16 MS. KUWAHARA: No, we're just trying  
17 to --

18 MEMBER KILSTEIN: Oh, okay. Do we  
19 need to make any comment on this or exception on  
20 this, where there may be cases where a plan is  
21 responsible for some services but doesn't have  
22 access to whether or not the primary care visit,

1 preventive care visit was done because it was  
2 paid for by Medicare and they may or may not have  
3 access to that data?

4 DR. TERRY: So, I just so I can  
5 understand the question is could we change in  
6 some way the requirements here on the measure?

7 MEMBER KILSTEIN: No, I was thinking  
8 more in terms of at least noting limitations in  
9 some cases. And some of those decisions are made  
10 by the state and how they put their program  
11 together.

12 So in some states, this may be  
13 perfectly appropriate. In other states, it may  
14 be difficult to report, depending on who is  
15 involved in different aspects of -- coordinating  
16 different aspects of the person's care.

17 DR. TERRY: So you know these are not  
18 -- will never be mandatory, these are --

19 MEMBER KILSTEIN: No, I understand.

20 DR. TERRY: Okay.

21 CO-CHAIR MOORE: Yes, so Bill and I  
22 were having a conversation during the break about

1 that because there were a couple of measures that  
2 we quickly identified that these issues  
3 definitely exist and the question about what are  
4 we voting for. And can we add clarification and  
5 caveats and like this package around what our  
6 vote really means. It doesn't mean like we are  
7 endorsing it and everyone has to apply this and  
8 that the vote is a recommendation not for CMS to  
9 then continue the process. It is not for  
10 purposes of endorsement.

11 DR. TERRY: I think what we're doing  
12 here is we're recommending measures or concepts  
13 that we think are ready. What CMS has told us,  
14 and they have said they are going to do, nobody  
15 is -- this is open to any state but these are not  
16 required. These are not any -- there are no  
17 requirements. But I think to your point, I think  
18 we will be able to take -- if we want to say  
19 something and basically, if you want to make a  
20 statement and just tell us that you know the  
21 caveat here is we will be able to capture that.  
22 And I think but we just want to make sure we know

1 clearly that is what, generally, people are  
2 saying.

3 CO-CHAIR MOORE: Yes, I think that is  
4 important to be able to capture for all these for  
5 contextual information because a lot of times  
6 when things come out of NQF, states will just  
7 take it for face value and think this is NQF.  
8 This is what we have to do and not take into  
9 account --

10 CO-CHAIR MOORE: Does that work --

11 DR. TERRY: Yes, okay, good. Thank  
12 you.

13 MS. GORHAM: And then if I could just  
14 add just a clarifying point, I think that  
15 Jennifer definitely touched on it, this is not an  
16 endorsement project. And so we are not endorsing  
17 measures here.

18 Oftentimes in endorsement projects the  
19 reason why a measure is endorsed because we have  
20 all of the information; the developer has  
21 provided details about the measure and we can say  
22 and we have evaluated. The Standing Committee

1 will look at the measure and make sure that this  
2 evidence is good and that we have reliable and  
3 valid testing. And so we don't have all of that  
4 level of detail for some of the measures,  
5 especially those measures that are concepts or  
6 those measures -- especially concepts and those  
7 measures that are not NQF-endorsed.

8           But Deborah, you bring up a really  
9 good point. Whether or not this measure or  
10 concept can be actually implemented in a state,  
11 if some states can do it but other states can't,  
12 those are the things that you want to consider as  
13 you move through your decision logic. So that  
14 will influence your vote because, again, we are  
15 looking for this measure set that states can use.  
16 But if you know, because of your expertise, that  
17 this concept will run into certain problems in  
18 states because of X, Y, and Z, that is something  
19 that we want to know and we want to include in  
20 the report. But also you want to really consider  
21 that as you vote and consider every step in the  
22 decision logic.



1 CO-CHAIR GOLDEN: Okay. Three  
2 comments, I guess, is: A) I'm surprised we don't  
3 have a pediatric version as well because there  
4 are high-cost complex pediatric patients; B) I  
5 was concerned preventive visit codes are complex  
6 but if we are accepting preventive and/or  
7 ambulatory, that is pretty reasonable; and then  
8 C) perhaps down the road having a denominator  
9 directed toward a high-risk population would be  
10 more useful than having -- this measure is for  
11 all patients in the program. It's not for high-  
12 risk patients. But we might get more mileage out  
13 of looking at it if we can define a high-cost  
14 population.

15 Otherwise, it is fine.

16 CO-CHAIR MOORE: Someone on the phone?

17 MEMBER GELZER: Yes, this is Andrea  
18 Gelzer and I do have a comment.

19 So this didn't come from as a TEP. It  
20 was referred in. But I just have to say,  
21 personally, I'm responsible for Medicaid managed  
22 care quality programs in multiple states and we

1 would consider this a well person measure, as a  
2 measure of access and not pertinent to this  
3 specific group.

4 The other point I would make is that  
5 in trying to move these measures, because the  
6 denominators are so huge, you won't see a lot of  
7 significant performance improvement from year to  
8 year or I would not expect that across the board.

9 So, I think it's important that we all  
10 be on the same page with this.

11 CO-CHAIR MOORE: So Andrea, with that  
12 comment, was there a discussion within the TEP  
13 about the value of having this measure, then?

14 MEMBER GELZER: See, I don't even  
15 remember.

16 CO-CHAIR MOORE: Oh, okay.

17 MEMBER GELZER: But I don't remember  
18 the discussion about this measure or I would have  
19 made those comments.

20 CO-CHAIR MOORE: Okay.

21 MS. GORHAM: So I will say that this  
22 was a measure that was initially discussed in the

1 LTSS TEP and the LTSS TEP thought that it was  
2 suitable for some of the other program areas.

3 But with that, Barbara may speak more.

4 MEMBER MCCANN: Actually, a point of  
5 clarification and I want to thank you for  
6 accepting our dump online.

7 From the perspective of the LTSS  
8 group, when measures were presented that clearly  
9 related to health plans, we did not, as a whole,  
10 support them.

11 So in construct, the measure, if you  
12 take out the references to health plans because  
13 that is what this was developed for product  
14 lines, et cetera, could be valid with the  
15 modification discussed about over complex as a  
16 denominator and could actually occur. But that  
17 may be something that you will see come up over  
18 time is that we didn't feel we could, if you  
19 will, mess with the specifications and in  
20 Medicaid, we are not going to have commercial.  
21 Right? I mean it is measure exchange and you  
22 take exchange or whatever.

1                   So that was a key factor in ours as to  
2 why we, if you will, did not take that on.

3                   CO-CHAIR MOORE: Can you clarify what  
4 you mean by not commercial? So Medicaid managed  
5 care has private insurance.

6                   MEMBER MCCANN: Well, this is a health  
7 plan and we understood our task to address fee-  
8 for-service or Medicaid outside Medicaid managed  
9 care.

10                  CO-CHAIR MOORE: Oh.

11                  MEMBER MCCANN: And commercial, for  
12 instance, I wouldn't think would be defined in  
13 Medicaid managed care but the idea of duals, et  
14 cetera, was valid. And we would agree with the  
15 comment on the huge database this would be to  
16 look at.

17                  CO-CHAIR MOORE: Allison?

18                  MEMBER HAMBLIN: Thank you. Yes, I  
19 guess this may be sort of a half-ass question in  
20 that -- well, maybe some specific, some process.  
21 And that is, so the concept of an access measure  
22 here, an access to preventive care measure I

1 think many of us would agree is a critical  
2 measure, a critical concept, whatever the right  
3 terminology is, to include for a complex need  
4 population.

5 And I guess my question is are there  
6 -- I'm sort of scanning the list of other  
7 measures that are included in the BCN category.  
8 And there are some follow-up after  
9 hospitalization measures but this appears to be  
10 the only one on the list that relates to this  
11 notion of are high-need populations getting you  
12 know ongoing access to primary and preventive  
13 care.

14 And so I guess my question is, I think  
15 from the discussion there are clearly some  
16 limitations associated with this measure but are  
17 there other options in any of the other groups to  
18 consider or would anyone else, based on their  
19 expertise -- I know we are not introducing new  
20 measures but there is sort of like a baby in the  
21 bath water issue here of is there value in  
22 including the least imperfect measure on a

1       construct that is important and not knowing this  
2       measurement area particularly well myself, were  
3       there other options considered, given that there  
4       don't seem to be other measures addressing that  
5       on this list?

6                   CO-CHAIR MOORE:   Okay, thank you.

7                   SreyRam.

8                   MEMBER KUY:   Well I was just going to  
9       add that we, in Louisiana, actually have been  
10      developing a measure that is similar to this and  
11      we have been using it since around July when we  
12      did Medicaid expansion to prove that having just  
13      access to health insurance showed a substantial  
14      increase in people getting preventive care or  
15      something that would actually move the needle on  
16      health care.

17                   And it is has been phenomenal what we  
18      have seen.   You know like we had half a million  
19      people who enrolled in Medicaid expansion and  
20      among that, about 90,000 or so got some sort of  
21      preventive care service.   So, I love this  
22      measure.   That is just my standpoint.

1           I am a general surgeon but I see the  
2 end result of people who don't get preventive  
3 care service and end up with complications of  
4 diabetes. So this is just my two cents about how  
5 much I love this measure.

6           CO-CHAIR MOORE: Okay.

7           Andrea, I want to make sure that,  
8 because you are not in the room, that you have an  
9 opportunity to speak after a couple of comments,  
10 in case you have anything to add.

11          MEMBER GELZER: Thanks. No, I have  
12 already I think said my piece.

13          I just think we, as a group, I mean if  
14 you are looking at the different subject matter  
15 areas and you are looking for drivers for  
16 individuals, those individuals with complex needs  
17 that may have fallen off that cliff or may not  
18 quite be there, is it really that access measure  
19 or even whether they got their preventive visit  
20 or not? Is that really what is driving the care?  
21 And I think that that is a matter of some debate.

22          That said, if the majority of the

1 Coordinating Committee feel that it is important  
2 that this measure be included somewhere and this  
3 is the best place to put it, I would not object  
4 to that rationale.

5 CO-CHAIR MOORE: So that goes back to  
6 Allison's point about do we include the measure  
7 even though it's not perfect, with a goal of  
8 having some type of access measure versus having  
9 nothing at all.

10 So, CMS representative Beverly or  
11 Karen, if they are on the line, can you give us  
12 some guidance and if that would be a valuable  
13 response of the committee?

14 MS. LLANOS: Can you guys hear me?  
15 This is Karen.

16 CO-CHAIR MOORE: Yes.

17 MS. LLANOS: I think the earlier  
18 conversation about feedback or caveats, I mean  
19 this falls right into it. So this may not be the  
20 best measure but I think you could have some sort  
21 of feedback in the final report that says this  
22 measure, you know the majority of the committee



1 members agreed that this measure hit on certain  
2 aspects that were not captured in the other  
3 measures. I think something like that could be  
4 helpful and then make the case for what were some  
5 of those aspects that were uncovered, with the  
6 caveat that the measure might not be the best for  
7 purpose.

8 But I think that kind of feedback we  
9 wouldn't to get lost in the report.

10 CO-CHAIR MOORE: Great. I like this  
11 idea of having additional context for each of the  
12 things that we're voting on, like these little  
13 stars, asterisks, we voted for but.

14 And when you flip over your tags,  
15 because I don't know everyone, if you could make  
16 sure that your name is up so I can see it. So  
17 that says Kelley but you're David.

18 MEMBER KELLEY: Hi, this is David  
19 Kelley, Pennsylvania Medicaid.

20 I would actually support adding this  
21 metric. It can be used across populations. I  
22 think the NCQA spec does include lower age bands,

1 I believe. It includes both not just primary  
2 care but any outpatient visit. So there is a  
3 whole host of codes.

4 You can, in a long-term care support  
5 service program, you can couple Medicaid, you  
6 should be able to couple Medicaid plans but  
7 you're not doing coordinated care well if you are  
8 not looking at Medicare claims. This is mainly a  
9 claims-based measure.

10 So I know that we struggle with this  
11 because when we looked at people with complex  
12 needs, unfortunately, these folks are seeing all  
13 kinds of specialists, PCPs, 15, 20 times, 30  
14 times a year.

15 So it is a very basic process but it  
16 doesn't get to measure kind of that quality of  
17 the coordination of care. But I think it is, at  
18 least, a nice proxy and I think folks parse out  
19 subpopulations. You could start to look at  
20 utilization that goes up pretty high but doesn't  
21 necessarily translate into better care.

22 So I think it is a reasonable

1 specification to include in this population and  
2 it applies to Medicaid in general, all  
3 populations, you know pediatrics, adults. I do  
4 believe there are pediatric age bands. And it  
5 can be applied to the dual eligible population.  
6 And it can be applied to both managed care and  
7 fee for service.

8           And I just want to go back to kind of  
9 a question and comment that I'm hoping that these  
10 measures aren't meant just for fee-for-service  
11 Medicaid because now the majority of folks are  
12 actually in Medicaid managed care. And even  
13 though we don't want to necessarily say these  
14 measures are geared for managed care because they  
15 can be taken down the various subpopulation  
16 levels. But hopefully, as we go through this,  
17 we're thinking in terms of individuals that are  
18 covered under Medicaid, whether it's fee-for-  
19 service or managed care.

20           CO-CHAIR MOORE: Thank you. I have  
21 been informed that there is someone on the lines  
22 who has a comment or question.

1                   MEMBER MOHANTY: Yes, hi. This is  
2 Sarita Mohanty. I appreciate the comments here  
3 and I do feel that this measure could have  
4 relevant -- I guess I'm trying to think of it  
5 going back to the definition of beneficiaries  
6 with complex care needs and you know looking at  
7 the definitions that were outlined in the deck.

8                   And you know we talk about how they  
9 are likely to experience high levels of costly  
10 but preventable service utilization and these  
11 care patterns our costs are potentially  
12 impactable.

13                   So when I try to look at measures in  
14 my space, this measure is I think important just  
15 to understand their overall rates of engaging  
16 with, in this case, primary care, ambulatory  
17 care, and I think also to be able to use this  
18 measure to see if there is a correlation between  
19 access to preventable ambulatory care services  
20 and reduction of preventable service utilization  
21 of high-cost utilization.

22                   So I try to look at the measure not

1 only as an independent measure of access but also  
2 how is it correlating to how it impacts, in this  
3 case, preventable high-cost service utilization  
4 like emergency department visits.

5 And I wanted to get kind of a sense  
6 from the group, as we are thinking about these  
7 measures, our approach to looking at how it  
8 correlates to other measures we may be  
9 collecting.

10 I don't know if that makes sense but  
11 I'm trying to go back to the definition of  
12 complex care when we look at these measures.

13 CO-CHAIR MOORE: Sheryl.

14 MEMBER RYAN: I appreciate Bill's  
15 comment about the pediatric population because I  
16 think it is sort of lost in a lot of these  
17 measures.

18 But I think the 20-year-old, I think  
19 to look at that lower of an age range is really  
20 important in terms of being able to measure  
21 whether kids are transitioning out of pediatric  
22 care into adult care. And I think that group in

1 their 20s, particularly when they have complex  
2 needs, really drops out of the healthcare system  
3 and they resurface in emergency settings because  
4 they haven't been able to make that.

5 So this is a really good measure to  
6 capture that aspect of transition that is so  
7 important for all young adults but particularly  
8 those with the chronic medical or mental health  
9 conditions.

10 CO-CHAIR MOORE: Cheryl.

11 MEMBER POWELL: I think noting that we  
12 think this is a great base measure and one that  
13 would provide valuable insights for Medicaid  
14 agencies, particularly if they stratified it  
15 based on things that they were particularly  
16 interested, whether that is age, duals -- I love  
17 the duals. I would do duals. I highly recommend  
18 duals but also by different types of you could  
19 even like get chronic conditions and things like  
20 that. So I think as a base measure, it might be  
21 a little vanilla but it's a great start and  
22 states could really do a lot with it to learn

1 about their programs, figure out where to focus  
2 and see where there is quality.

3 CO-CHAIR MOORE: And I can't see your  
4 tag but you're next.

5 MEMBER HENNESSEY: Hi, Maureen  
6 Hennessey.

7 CO-CHAIR MOORE: Okay, Maureen.

8 MEMBER HENNESSEY: So my question was  
9 for those entities that have used, could anybody  
10 speak to what actions they have taken as a result  
11 of reviewing data on this measure?

12 CO-CHAIR MOORE: So maybe going back  
13 to Srey.

14 MEMBER HENNESSEY: Yes, that would be  
15 great. Thanks.

16 CO-CHAIR MOORE: Can you use the  
17 microphone? Thank you.

18 MEMBER KUY: So in terms of what we've  
19 doing with the data, we are actually able to run  
20 the data on a continuing cycle, like every two  
21 weeks. So we actually see cycles on like  
22 influenza vaccinations going up, or, in this

1 case, preventive services will go up that have a  
2 seasonal variation, we are able to drill down to  
3 the parish level, or in other states you call it  
4 county level, and really see where are the  
5 counties where people are getting these great  
6 preventive services, and where are they not  
7 getting it, and where do we need to do better  
8 outreach.

9 Other things that we're able to see is  
10 the divide by gender and demographics. So, it's  
11 really telling when you see like there is this  
12 huge use among say women and particular in the  
13 Medicaid expansion population. These are women  
14 who didn't have health insurance before. And  
15 Louisiana being a state that had been ranked one  
16 of the worst in the country for women's health,  
17 that shows almost a justification which you kind  
18 of need during this climate for why it is so  
19 important to have access to preventive health  
20 care.

21 So I see it as, 1) being able to help  
22 us do interventions; and 2) to even justify our



1 existence of providing this health care.

2 MEMBER HENNESSEY: So it sounds like  
3 it helps to promote health equity and address  
4 disparities in care for some subpopulations.

5 MEMBER KUY: Absolutely. You phrased  
6 it so much better than I do.

7 MEMBER HENNESSEY: Okay, thank you.

8 No, this has been very helpful  
9 information. Thank you.

10 CO-CHAIR MOORE: I want to be  
11 cognizant of the folks on the phone. I know that  
12 we have someone who would like to jump in. It's  
13 easier when you're in person to jump in. So, I  
14 want to go back to the phone.

15 MEMBER SCHIFF: This is Jeff. I just  
16 had a question about the numerator. Is this any  
17 ambulatory visit that would come about, like if  
18 someone went to their pulmonary specialist for  
19 something like that?

20 CO-CHAIR MOORE: David's nodding his  
21 head, yes. So, David, do you want to comment?

22 MEMBER KELLEY: To answer your

1 question, Jeff, this is Dave Kelley, if this is  
2 the HEDIS spec, it looks at a whole host of  
3 outpatient visits and it can be primary care. It  
4 can be specialty care. I think it includes FQHC  
5 visits as well. There is a whole host of codes  
6 that are thrown in there.

7 So, it really looks at the total of  
8 number of -- it looks at whether or not a person  
9 has gotten access to care at any of those venues.

10 To answer the question about how can  
11 this be used, we did expand in Pennsylvania, 700  
12 and some thousand new people. So we used this as  
13 a sub-metric to look at. Not only did they get  
14 an insurance card, but they actually got access  
15 to care. And how often do they actually get  
16 access to care?

17 We also look at regional variation in  
18 our urban versus our rural areas. And we also  
19 drilled down and actually have looked at race and  
20 ethnicity. This is one of the measures we  
21 require our health plans to actually measure and  
22 look at race as well as ethnicity in the region,

1 regional differences.

2 So we also look at it in the context  
3 of emergency department visits, as well as in-  
4 patient stays. NCQA bundles the three kind of  
5 together. So, we like to look at them in that  
6 kind of overall context.

7 So, it is a fairly useful basic  
8 measure that can be really sliced, and diced, and  
9 parsed to look at the various populations. It's  
10 not perfect, though.

11 CO-CHAIR MOORE: So I just want to  
12 reach around back to the person on the phone,  
13 just to make sure that they were able to follow  
14 through with their thought on their question.

15 MEMBER SCHIFF: Yes, I think the real  
16 question, obviously, is what's the purpose of  
17 this because I think what you're saying, David,  
18 makes perfect sense.

19 I think in terms of advocating a firm  
20 measure or folks with special needs, I think the  
21 challenge is then if somebody just has a  
22 pulmonary problem and they go to their pulmonary

1 doctor, are they getting their other preventive  
2 services and is this a good enough measure of  
3 that.

4 So, I guess the question I just have  
5 is a little bit for the group, is how do we  
6 approach the purpose in that context?

7 CO-CHAIR MOORE: All right, any other  
8 thoughts? It is what it is, yes.

9 So, I had my HHS hat on, even though  
10 I'm not there anymore, in running review meetings  
11 for measures and for research grants, and  
12 recognizing that the first proposal, the first  
13 measure that comes to the table, you always give  
14 a little extra time because you're storming and  
15 your norming, right, where we're trying to get to  
16 a point where we all come together and we work  
17 out some of the bugs and some questions we spent  
18 some time talking about voting again. And I  
19 wanted to give us a chance to be able to do that.

20 For subsequent measures, we're going  
21 to move a little bit quicker but I just wanted to  
22 give that opportunity for us to come together as

1 a group on this.

2 I think that is we're all comfortable,  
3 we are ready to move -- okay.

4 MS. KUWAHARA: All right, so we will  
5 be using the clickers at each of your stations  
6 for voting. When we call for the vote, you will  
7 submit your vote and if the number you select  
8 shows up on your screen that means your vote was  
9 cast. However, if you see a horizontal line,  
10 that is potentially problematic and we will want  
11 to get you a new clicker.

12 For those of you joining us on the  
13 line, please submit your votes via the chat  
14 function at the bottom left-hand corner of your  
15 screen and the staff will cast your votes.

16 All right, shall we get to it?

17 MS. GORHAM: Just remember that we are  
18 voting for each step in the decision logic. So  
19 you will be voting multiple times on the same  
20 measure.

21 MS. KUWAHARA: And for those of you  
22 joining us remotely, please refer to the handout

1 that we sent over the break. That will give you  
2 the definitions of what constitutes high, medium,  
3 and low throughout.

4 So for the first vote, to what extent  
5 does this measure or concept address the CMS  
6 quality measurement domains or program area key  
7 concepts? Please note that this is for Measure  
8 Adult Access to Preventive/Ambulatory Care 20-44,  
9 45-64, and 65+.

10 Polling is now open and you may submit  
11 your votes.

12 MS. BUCHANAN: Can you tell us what  
13 we're voting --

14 MS. KUWAHARA: I apologize. If you  
15 would like to select high, please press 1; if you  
16 would like to select 2, please -- I'm sorry, if  
17 you would like to select medium, please press 2;  
18 and if you would like to select low, please press  
19 3.

20 High is addresses a CMS quality  
21 measurement domain and program area key concepts.  
22 Number 2 is medium, addresses CMS quality

1 measurement domains but does not address program  
2 area key concepts. And 3 does not clearly  
3 address CMS quality measurement domains or  
4 program area key concepts.

5 It is also on the screens for those of  
6 you in the room and this is also included in the  
7 handout for those of you joining us remotely.

8 MS. GORHAM: So, Miranda will direct  
9 this. You can direct your clicker to Miranda to  
10 cast your vote. And we have had a lot of  
11 discussion about the measure but definitely as we  
12 go through each step in the decision logic, if  
13 you feel need more discussion or clarification  
14 then just let us know but voting is open for this  
15 measure.

16 CO-CHAIR GOLDEN: So, has the first  
17 vote gone through? So now we go to the second  
18 vote?

19 MS. BUCHANAN: We are waiting for two  
20 more responses from individuals.

21 CO-CHAIR GOLDEN: Okay.

22 MS. BUCHANAN: So we are now waiting

1 on one vote.

2 Allison?

3 MEMBER HAMBLIN: Hi, is there a place  
4 we can reference the key concept?

5 CO-CHAIR MOORE: So if you open the  
6 sheet that I was referring to, the text on the --

7 MEMBER HAMBLIN: Am I missing the key  
8 concepts?

9 MS. GORHAM: So if you look in your  
10 discussion guide, under the measure information,  
11 so you have a number of measure specifications.  
12 So where your key concepts will be your key  
13 words.

14 So if you go down, you will have NQF  
15 number, description, status, numerator,  
16 denominator, and then key words, that is  
17 synonymous with the key concepts.

18 MEMBER HAMBLIN: Oh, they've been  
19 crossed off.

20 MS. GORHAM: Exactly.

21 MEMBER HAMBLIN: Okay. Is it  
22 internal?



1 CO-CHAIR GOLDEN: So do we know who is  
2 missing? Which number is missing?

3 MS. KUWAHARA: We're missing a vote  
4 from someone -- we have too many mikes on. We're  
5 missing a vote from someone on the phone but I  
6 don't think she's available to submit her vote  
7 right now.

8 CO-CHAIR MOORE: Got it.

9 MS. BUCHANAN: We still have a quorum.

10 CO-CHAIR MOORE: Okay.

11 MS. BUCHANAN: I believe we can still  
12 meet our criteria.

13 CO-CHAIR MOORE: Okay, yes.

14 MS. KUWAHARA: Seventy-four percent of  
15 the 19 voting members voted for high; twenty-one  
16 percent of the 19 voting members voted for 2,  
17 medium; and five percent voted for low.

18 So, we'll move on to the next step in  
19 the decision logic. This is the second step. To  
20 what extent will this measure or concept address  
21 an opportunity for improvement and/or significant  
22 variation in care?

1                   If you would like to select high,  
2 addresses multiple quality challenges and  
3 opportunities for improvement within a program  
4 area, please select 1. If you would like to  
5 select medium, the measure has the potential to  
6 address variation in care and quality challenge,  
7 please select 2; if you would like to select low,  
8 measure does not address quality challenges or  
9 opportunities for improvement within a program  
10 area, please select 3. Polling is open.

11                   Okay, we captured all 20 votes. Sixty  
12 percent of the 20 voting members selected high;  
13 forty percent selected medium; and there were no  
14 votes for low.

15                   We will continue on the decision  
16 logic. For step number 3, to what extent does  
17 this measure demonstrate efficient use of  
18 resources and/or contribute to alignment?

19                   If you believe this measure  
20 demonstrates an efficient use of measurement  
21 resources, addresses a broad population not  
22 duplicative, or contributes to alignment -- if

1 you believe this measure is both duplicative of  
2 other measures and does address some areas of  
3 alignment but does not encompass broad  
4 populations, please select medium. And for low,  
5 please select 3, no evidence that the measure  
6 demonstrates or addresses any of the above  
7 criteria measures similar to this one already in  
8 use.

9 Eighty percent of the 20 voting  
10 members selected high; fifteen percent selected  
11 medium; and five percent selected low.

12 We will move on to the next step in  
13 the decision logic. To what extent is this  
14 measure or concept ready for immediate use?

15 If you would like to select high, a  
16 fully specified measure and may have undergone  
17 scientific testing and is currently in use or  
18 planned to be used in states, select 1. If you  
19 believe this measure demonstrates medium, not  
20 duplicative of other measures and does address  
21 some areas of alignment but does not encompass  
22 broad populations, please select 2; or select 3,

1 low, no evidence that the measure demonstrates or  
2 addresses any of the above criteria.

3 Seventy-five percent of the 20 voting  
4 members selected high. So, it will move forward  
5 as a measure.

6 To what extent do you think this  
7 measures is important to state Medicaid agencies  
8 and other stakeholders? Select 1, high,  
9 important to state Medicaid agencies and  
10 beneficiaries and families; medium, important to  
11 two stakeholders, including state Medicaid  
12 agencies; or low, important to one stakeholder.

13 CO-CHAIR MOORE: Bill's making cheat  
14 sheets up here for us. I think he was a  
15 kindergarten teacher at some point.

16 MS. KUWAHARA: Eighty percent of the  
17 20 voting members selected high; fifteen percent  
18 selected medium; and five percent selected low.  
19 So, this measure will be recommended for  
20 inclusion in the BCN measure set.

21 We can move on to our next measure,  
22 Clinical Risk Score. I will tee it up by

1 providing some of the measures specifications.

2 The description is: Patient's  
3 clinical risks have been assessed and scored.

4 Rationale: An individual's risk score will speak  
5 to degrees of compliance with preventive measure  
6 guidelines, for example, cancer screenings,  
7 addiction screening, and also chronic care  
8 management gaps.

9 The numerator is those having risk  
10 score in their medical records. The denominator  
11 is population by ZIP code, gender, et cetera.

12 MEMBER GELZER: Hi, this is Andrea.

13 Can I make a comment?

14 CO-CHAIR MOORE: Please, Andrea.

15 MEMBER GELZER: There are lots of  
16 different ways to measure a clinical risk score.  
17 I'm very confused by this one. Which one are we  
18 recommending? Are we saying any method that is  
19 utilized should include all of those stipulated  
20 requirements?

21 MEMBER SIDDIQI: This is Alvia and I  
22 just raised my hand as well on the webinar but I

1 agree. I was pretty confused by this one as  
2 well. There are so many different methodologies  
3 to determine a patient's clinical risk score,  
4 depending on the disease condition, or the  
5 screening measure, or testing that we are talking  
6 about here.

7 So, I was very concerned about this  
8 measure as well, that there really is no great  
9 blanket clinical risk score methodology that  
10 encompasses every single different kind of  
11 preventive screening test.

12 CO-CHAIR MOORE: And for the benefit  
13 of those on the phone, folks around the room are  
14 also nodding their head.

15 Deborah?

16 MEMBER KILSTEIN: My question is what  
17 is the source of this measure and where is it  
18 being used?

19 CO-CHAIR MOORE: Good question.

20 DR. TERRY: As you look here, it's not  
21 being used anywhere. Let's see the source of it.  
22 I think we actually got this from a TEP measure

1 -- TEP member is what said.

2 I don't know where -- it doesn't say  
3 it's being used in any programs at this time.

4 MEMBER KILSTEIN: Just a question then  
5 about validity testing, and all the testing. So  
6 there is no indication that is has gone through  
7 any of that.

8 CO-CHAIR MOORE: Yes.

9 MEMBER KILSTEIN: Okay.

10 CO-CHAIR MOORE: So I failed to  
11 mention at the beginning for this particular  
12 measure, that, as your cruise director, I have  
13 been informed that the honeymoon is over and that  
14 we will be limited to about three minutes for  
15 discussion for each of the measures going  
16 forward.

17 So we now have two minutes and I'm a  
18 time keeper.

19 Judy.

20 MEMBER ZERZAN: So I agree this is  
21 super vague and yet I think each of use risk  
22 adjustment in some way. And in the spirit of

1 this is the beginning of this and there needs  
2 more refinement, I am in support of this measure  
3 because both plans and health teams should be  
4 risk-stratifying their population in some way and  
5 I think that you know I didn't nominate this but  
6 that's what this captures for me is that you know  
7 who is high risk and you know who is not and you  
8 focus on those folks.

9 CO-CHAIR MOORE: I guess, not as the  
10 chair but as someone who practices at FQHC here  
11 in D.C., and we get this long list of measures to  
12 potentially use, I don't think we would know what  
13 to do with this because of vagueness of it.

14 So, I'm not sure that it would be  
15 useful for us at the ground level.

16 CO-CHAIR GOLDEN: I suggest we vote  
17 now.

18 CO-CHAIR MOORE: Across the board.

19 Any other comments or thoughts?

20 Anyone on the phone?

21 MEMBER MOHANTY: Yes, hi, this is  
22 Sarita. I kind of agree with the last comment in



1 the sense of I think you're right I think; it's  
2 extremely vague. But if the goal is to maybe  
3 start to have systems and health plans or  
4 delivery systems start to have a risk score,  
5 start to think about how they're defining risk in  
6 their population segmentation. It could kind of  
7 spur some kind of guidance about having a risk  
8 score and what you should be thinking about.

9 I don't know but I do think it is  
10 extremely vague. So I am kind of torn. I am  
11 just kind of trying to decide here. But I think  
12 if there was some ability, if folks feel strongly  
13 the other way, there would have to be a lot of  
14 guidance on this particular measure. I don't  
15 think we could just lay it out like this without  
16 some kind of guidance about how to possibly  
17 utilize it.

18 MEMBER HENNESSEY: Yes, this is  
19 Maureen. The one thing that I would say is that  
20 I would be concerned that because it is so vague,  
21 it might be a measure that would be vulnerable to  
22 biases that might then perhaps create unnecessary

1 barriers to carry down the line for patients.

2 CO-CHAIR MOORE: Yes, that's a really  
3 good point.

4 MEMBER MOHANTY: Yes, that's a good  
5 point.

6 CO-CHAIR MOORE: Any other comments?  
7 Okay, I think we are ready to move on.

8 Good job, you guys; three minutes  
9 exactly. I'm proud of you.

10 MS. KUWAHARA: Okay, this is Measure  
11 Clinical Risk Score. It has the numeric  
12 assignment number of 2 on our discussion guide.

13 For the first question, to what extent  
14 does this measure concept address critical  
15 quality objectives of the CMS quality measurement  
16 domains and/or identified program area key  
17 concepts? Please select 1 if you feel this  
18 measure is high; for medium 2, and low, 3.

19 Fifteen percent of the 20 voting  
20 members selected high; 35 percent selected  
21 medium; and 50 percent selected low.

22 So this measure will not continue

1       forth in the decision logic and it will not be  
2       recommended for inclusion in the BCN measure set.

3               CO-CHAIR MOORE: But you know and I  
4       agree. Even when we vote against them, we also  
5       add the contextual information from the  
6       discussion that goes to CMS, indicating that we  
7       do feel looking at risk is important but this  
8       measure does not meet what we feel would be  
9       sufficient to be used as a recommended measure.

10              MS. KUWAHARA: We will include those  
11       sentiments in the report.

12              CO-CHAIR MOORE: Okay.

13              MS. KUWAHARA: So for our next measure  
14       number 26 on our discussion guide, Referral to  
15       Community Based Health Resources, the description  
16       is referral of high risk score patients to  
17       address social determinates of health.

18       Rationale: referral to community-based health  
19       resources will be a proxy indicator for health  
20       behaviors at large.

21              The numerator is individuals with  
22       referrals and the denominator is population by

1 ZIP code, gender, et cetera.

2 CO-CHAIR MOORE: Can you repeat where  
3 this is found, what number it is?

4 MS. KUWAHARA: Yes, this is measure  
5 number 26 and that's not to be --

6 CO-CHAIR MOORE: So we're not going in  
7 order of what's online?

8 MS. KUWAHARA: Yes, I will make this  
9 distinction. So, every measure, whether or not  
10 it is NQF-endorsed has a numeric assignment  
11 system. For instance, this is 26 and you will  
12 notice that they are out of order. This isn't  
13 used as an ordering system. It is really just an  
14 assignment system mostly for transcript purposes  
15 so we can make sure we are identifying the same  
16 measure but also multiple measures are discussed  
17 in different program areas. So we just want to  
18 make sure we are highlighting the right measure.

19 CO-CHAIR GOLDEN: As the clock starts,  
20 I would like to point out that the denominator on  
21 the item 26 is the entire population and not  
22 people with high risk scores. So something is

1 wrong in how this is specified.

2 CO-CHAIR MOORE: And again, this is a  
3 measure that comes with very little information  
4 for us to go based on.

5 Deborah, go ahead.

6 MEMBER KILSTEIN: I just had the same  
7 issue with this measure, that it wasn't  
8 specified, it hasn't been tested.

9 CO-CHAIR MOORE: Yes.

10 MEMBER KILSTEIN: You know there's no  
11 data on it.

12 CO-CHAIR MOORE: Yes.

13 Andrea, were there discussions in your  
14 group about this that should be added? Because  
15 it looks like in the room we do not have a lot of  
16 comments.

17 MEMBER GELZER: No, I think it's too  
18 general but that's my personal opinion.

19 CO-CHAIR MOORE: Okay. So, if there  
20 are no other comments or questions, we'll move on  
21 to voting.

22 MS. KUWAHARA: That sounds good. And

1 before we dive into voting, I just wanted to make  
2 a note. On your discussion guide, even though it  
3 may not be in numeric order, it is an order if  
4 you follow the agenda. So, we should be able to  
5 keep on time with that.

6 All right so this is Measure 26:  
7 Referral to Community Based Health Resources.  
8 For the first vote, to what extent does this  
9 measure or concept address the CMS quality  
10 measurement domains and/or program area key  
11 concepts?

12 If you would like to select high,  
13 please press 1; medium, 2; and low, 3.

14 MEMBER RYAN: Some of us can't access  
15 these so we're kind of stuck.

16 CO-CHAIR MOORE: Okay, thanks for  
17 letting us know that.

18 MS. KUWAHARA: In the meantime, it  
19 looks like voting technology is working. So, for  
20 this measure, 50 percent of the 20 voting members  
21 selected low, it does not clearly address CMS  
22 quality measurement domains or program area key

1 concepts. So, Measure 26 will not be recommended  
2 for inclusion in the BCN measure set.

3 CO-CHAIR MOORE: Okay and considering  
4 that they do not have access to the information,  
5 I think that we should take a quick break. Okay,  
6 thank you.

7 (Whereupon, the above-entitled matter  
8 went off the record at 12:13 p.m. and resumed at  
9 12:36 p.m.)

10 CO-CHAIR MOORE: All right, you guys.  
11 So in a previous life, I was a cheerleader at  
12 Michigan during football season. So if I have to  
13 break out my cheerleader voice, I will.

14 MS. KUWAHARA: So we will be  
15 evaluating the last and final referred measure  
16 from a separate program area. We'll be looking  
17 at Measure number 14. This is NQF number 1888,  
18 Workforce Development Measure Derived from  
19 Workforce Development Domain of the C-CAT.

20 The description is 0-100 measure of  
21 workforce development related to patient-centered  
22 communication derived from items on the staff and

1 patient surveys of the communication climate  
2 assessment toolkit.

3 The numerator is workforce development  
4 component of patient-centered communication. An  
5 organization should ensure that the structure and  
6 capability of its workforce meets the  
7 communication needs of the population it serves,  
8 including by employing and training a workforce  
9 that reflects and appreciates the diversity of  
10 these populations.

11 Measure is scored on two items from  
12 the C-CAT patient survey, and 21 items from the  
13 C-CAT staff survey. Minimum of 100 patient  
14 responses and 50 staff responses. The  
15 denominator, staff respondents should include all  
16 staff categories, including both and clinical and  
17 non-clinical staff, as well as those in roles  
18 such as building, environmental services, food  
19 services, et cetera.

20 There is more to that denominator, and  
21 I can go into detail if you all would like to.

22 CO-CHAIR MOORE: Yes, I'm just reading



1 some other pieces. So I am struck, if you look  
2 at the gray tag here, that the threshold score is  
3 1.71 and the overall measure score is 1.5, so,  
4 where some of the other ones, they were zero  
5 point.

6 MS. KUWAHARA: So I would like to note  
7 that the threshold score is specific to the BCN  
8 program area. And this measure, I believe, came  
9 from LTSS, and I believe the LTSS program area  
10 had a lower threshold score, so just keep that in  
11 mind. But it is good for comparative purposes.

12 CO-CHAIR MOORE: Great, thank you.  
13 Can you use your microphone?

14 MEMBER HAMBLIN: Sorry, are we on  
15 number four?

16 CO-CHAIR MOORE: Fourteen.

17 MEMBER HAMBLIN: Fourteen, awesome,  
18 thanks.

19 CO-CHAIR MOORE: Yes, we're on number  
20 14. Andrea, did you want to jump in? I just  
21 want to make sure you're on the call, too.

22 (No response.)

1 CO-CHAIR MOORE: Do we know if we have  
2 everyone back on the call?

3 MS. MURPHY: Everyone is on the web  
4 platform. But I suppose we can do a quick roll  
5 call to see who's actually dialed back in after  
6 lunch. Andrea Gelzer, are you still on the line  
7 with us?

8 (No response.)

9 MS. MURPHY: Jeff Schiff, have you  
10 been able to rejoin?

11 MEMBER SCHIFF: Yes.

12 MS. MURPHY: Great. Alvia Siddiqi?

13 MEMBER SIDDIQI: Yes, I'm back.

14 MS. MURPHY: And Sarita?

15 MEMBER MOHANTY: Yes, I'm here.

16 MS. MURPHY: So I think we're just  
17 missing Andrea.

18 CO-CHAIR MOORE: Could we send a email  
19 to her, just to?

20 MS. MURPHY: Yes.

21 CO-CHAIR MOORE: Should we wait for  
22 her to come on, or?

1 CO-CHAIR GOLDEN: I think we should  
2 move on.

3 MS. KUWAHARA: As she didn't assess  
4 this measure, perhaps we can move on and she can  
5 jump in.

6 CO-CHAIR MOORE: Okay, great. Any  
7 questions, thoughts? Does anyone have any  
8 experience using this measure?

9 MEMBER SIDDIQI: I can tell you we've  
10 had experience in trying to capture a similar  
11 sort of measure around follow-up from either, you  
12 know, alcohol diagnoses or alcohol abuse  
13 diagnoses, as well as substance abuse diagnoses,  
14 and there are a lot of challenges.

15 And part of the challenges, as we all  
16 know, is that behavioral health is typically a  
17 carve-out, so that the vendors that manage it are  
18 oftentimes different from the traditional medical  
19 folks who are trying to work on these types of  
20 measures.

21 And so I can tell you that there's a  
22 lot of challenges with the capture of the data as

1 well, in terms of how it's being diagnosed and  
2 reported. So, for example, a patient may come  
3 into the emergency room and not have that  
4 priority diagnosis listed even though that is  
5 part of what they came in for, is maybe  
6 diagnosing anxiety or something else.

7 And so I don't know if that's part of  
8 the challenges that others have experienced. But  
9 I do think that this measure really challenges a  
10 couple things.

11 One is that it's saying really that  
12 emergency room visit needs the follow-up, and  
13 that's sort of the emphasis, rather than  
14 necessarily that intensive outpatient encounter,  
15 or I should say the hospitalization or intensive  
16 inpatient encounter, and that follow-up from that  
17 setting. Which I think many times is more  
18 important, not just the emergency room follow-up.

19 And then also the two parts of the 30-  
20 day, versus the seven-day. I do think that to be  
21 very challenging, especially with the seven-day,  
22 but even 30 days is a good way to at least start,

1 maybe, to have the conversation. But, you know,  
2 I do think this is a very interesting measure.

3 But again, I just think because of the  
4 complexities around behavioral health and vendor  
5 management around that, sometimes unfortunately  
6 this isn't always very well managed. But it's an  
7 interesting measure nonetheless.

8 CO-CHAIR MOORE: So, okay, I'll open  
9 up. Deborah.

10 MEMBER KILSTEIN: I just want to know  
11 how widely used this survey is compared to other  
12 surveys that are looking at --

13 CO-CHAIR MOORE: I'm looking at staff  
14 notes, person and family-centered care projects.  
15 Can you guys clarify?

16 MEMBER GELZER: It gets reported in  
17 New York.

18 DR. TERRY: Well, it went to the  
19 Person and Family-Centered Project. But the use  
20 of the measure appears to be really, it doesn't  
21 have any information about how actually it's used  
22 today, if you go through the details here.

1 C-CHAIR MOORE: So we don't know if  
2 it's been used and it was found to not be useful  
3 or effective?

4 MS. MUNTHALI: Right, and just to add  
5 a little more context to Peg's statement, it was  
6 last looked at at NQF in 2012, so it is due for a  
7 maintenance review. And so then we would  
8 probably find out, you know, how it has been used  
9 in the field.

10 We are trying to pull up the report  
11 from then to see. But I think that was the  
12 initial endorsement date, yes.

13 CO-CHAIR MOORE: So it is a -- NQF  
14 found it to be a valid and reliable measure. So  
15 we do have that, as opposed to some of the other  
16 measures.

17 MS. GORHAM: Yes, and I was able to  
18 finally pull up the information from the last  
19 PFCC report, the last PFCC Project 2015-2016.  
20 Based on the discussion at the meeting and update  
21 from the developer indicated plans for a  
22 substantial update to its assessment data and

1 analysis, the PFCC committee approved a deferment  
2 for the consideration of maintenance endorsement.

3 So NQF will work with the developers  
4 to remain updated on progress, and expects to  
5 review the measure in 2017. So as Elisa said,  
6 the initial endorsement was 2012. And so right  
7 now, we don't have any more information.

8 CO-CHAIR MOORE: Well, I don't see  
9 anything around the room. Anyone online or not  
10 online, but on the phone? And do we know if  
11 Andrea's joined us?

12 PARTICIPANT: She has.

13 CO-CHAIR MOORE: Okay, great. Sheryl.

14 MEMBER SIDDIQI: Yes, and excuse me,  
15 but I don't have any additional comments on this  
16 one.

17 CO-CHAIR MOORE: Okay, thank you.  
18 Sheryl.

19 MEMBER RYAN: Is this part of the  
20 patient experience satisfaction domain? It  
21 wasn't clear what domain it was from.

22 MS. GORHAM: So we designated this,

1 and for the CMS domain it's the safety domain.

2 DR. TERRY: If you look at the  
3 numerator and denominator, they're not looking at  
4 information from patients, so.

5 MEMBER RYAN: It can be related to  
6 patient satisfaction, how well your workforce is  
7 aware of diversity.

8 (Off-mic comment.)

9 COURT REPORTER: I'm sorry, could you  
10 please use your mic.

11 MEMBER PHELAN: Just from what I'm  
12 reading, it looks like they do take two questions  
13 from the C-CAT patient survey.

14 MEMBER RYAN: I see it. Yes, okay.

15 MEMBER PHELAN: And 21 items from the  
16 staff survey to identify this. I just don't have  
17 any experience with this. Does anyone on the  
18 call use this C-CAT or heard of it? Anyone in  
19 the room? No? Because it sounds like a pretty  
20 well validated measure.

21 MEMBER WALLACE: My gut reaction just  
22 from what little information we have is that it



1 might be a really useful tool. It covers a lot  
2 of really interesting domains, workforce and, you  
3 know, having patient voice in a measure. That's  
4 amazing.

5 But the idea of recommending it to a  
6 state-level department of Medicaid for use, just  
7 the implementation barriers would be huge. This  
8 measure seems to me to say, like, provider  
9 improvement for use at like a program level, and  
10 not so much as a part of our recommendations.

11 CO-CHAIR MOORE: Any other comments.  
12 Are we ready to vote? Okay.

13 MS. KUWAHARA: So we are voting on  
14 Measure number 14, NQF 1888, Workforce  
15 Development Measure Derived from Workforce  
16 Development Domain of the C-CAT. For the first  
17 vote, to what extent does this measure or concept  
18 address the CMS quality measurement domains,  
19 and/or program area key concepts?

20 For high, please select one; medium,  
21 please select two; and low, please select three.  
22 Polling is now open.

1 (Voting.)

2 MS. KUWAHARA: And Alvia, if you're on  
3 the line, if you wouldn't mind typing in your  
4 vote into the commenting box.

5 MEMBER SIDDIQI: Sure, I just realized  
6 I was on the wrong measure when I called in late,  
7 so I apologize for that.

8 MS. KUWAHARA: Could everyone please  
9 submit their votes one additional time? Great.

10 Twenty percent of the 20 voting  
11 members selected high, 55% selected medium, and  
12 25% selected low. So this will move on to the  
13 next step in the decision logic.

14 For vote number two, to what extent  
15 will this measure/concept address an opportunity  
16 for improvement and/or significant variation in  
17 care? Please select one if you choose high.  
18 Medium, please select two, or low, please select  
19 three.

20 (Voting.)

21 CO-CHAIR MOORE: He has a fancy  
22 clicker.

1 MS. KUWAHARA: So 15% of the 20 voting  
2 members selected high, 45 selected medium, and  
3 40% selected low. And this, we'll move on to the  
4 next step in the decision logic.

5 Vote number three, to what extent does  
6 this measure or concept demonstrate efficient use  
7 of resources, and/or contribute to alignment?  
8 For high, select one; medium, select two; or low,  
9 please select three.

10 (Voting.)

11 MS. KUWAHARA: For those on the phone,  
12 we're just conferring over here. Okay, NQF staff  
13 had some quick deliberations over here. So we  
14 are actually going to modify the last vote.

15 So the last vote was -- I'm sorry.  
16 The last vote was related to an opportunity for  
17 improvement or significant variation in care.  
18 Although 60% was achieved between high and  
19 medium, we did not achieve greater than 60%, so  
20 the measure will go down and not be included for  
21 the BCN measure set.

22 Okay, so that concludes our portion

1 for measures referred from other program areas.  
2 We can move into measures which were identified  
3 for reconsideration by members of the  
4 Coordinating Committee.

5 So the Committee identified two  
6 measures for reconsideration. Reasons for  
7 reconsideration include: the measure is  
8 currently in use in state programs; stakeholders,  
9 particularly state agencies, consider this  
10 measure important; or the measure addresses a  
11 high-impact area for the BCN population.

12 The Committee Member who retained the  
13 measure is the lead discussant, and will discuss  
14 with the rest of the committee why the measure  
15 should be included in the final program area  
16 measure set.

17 Following a brief discussion, the  
18 committee will vote on the discussion using the  
19 decision logic. And before I hand it over to the  
20 lead discussants, I wanted to provide some of the  
21 TEP's rationale for not including the measures.  
22 And we'll begin with the first measure slated for

1 discussion.

2 CO-CHAIR MOORE: Is there a number for  
3 this one? Okay.

4 MS. KUWAHARA: Yes, so this is NQF  
5 number 2483, and let me get the numeric number  
6 for you. This is, on your discussion guide,  
7 number 17, NQF number 2483, Gains in Patient  
8 Activation Scores at 12 Months. This measure was  
9 identified for reconsideration by David Kelley  
10 and John Shaw.

11 So the TEP recognized this measure as  
12 a critical construct for beneficiaries with  
13 complex care needs and high costs, and they  
14 unanimously agreed that this measure is a  
15 promising concept. One member of the TEP noted  
16 that this measure was considered for the  
17 California Medicaid 1115 Waiver Program.

18 During the state's discussions and  
19 research, it chose not to include the PAM measure  
20 for a number of reasons. One, the applicability  
21 of the questionnaire to the Medicaid population  
22 was considered marginal. The concept of

1 competing demands, for example, the inability to  
2 manage congestive heart failure due to concerns  
3 about eviction, are not contained in the  
4 questions that the PAM assesses.

5 There was also a perceived floor  
6 effect. Everyone score a low in the PAM, and it  
7 was difficult to measure improvement because the  
8 incremental changes are such that they did not  
9 affect the measure. Simply, the measure is  
10 skewed to a higher level of activation.

11 And finally, a literature review of  
12 the PAM and safety net high risk/high cost  
13 populations found that found that there are few  
14 studies to support its use in the population. So  
15 with that, I'll turn it over to our lead  
16 discussants. John, we can start with you. Can  
17 you use your microphone, please.

18 MEMBER SHAW: I think my viewpoint is  
19 affected by where I'm coming from and looking at  
20 the whole system. And I've seen for decades the  
21 issues with beneficiaries with complex needs tend  
22 to be much broader than clinical areas.

1                   And when I look at the overall measure  
2 set, we've got a hundred-plus measures, mostly on  
3 clinical and coordination and safety, but very  
4 few, if any, in really engaging the patient.

5                   And yet, from a responsibility  
6 perspective, for those who look, the patients may  
7 be responsible, or their indirect caregivers, for  
8 half of the variation in outcomes. So that's the  
9 context I'm coming from.

10                   And so this appeared to be the only  
11 measure, definitely within BCN and somewhat  
12 across the board, really trying to address that  
13 aspect of this whole area that we're trying to  
14 address.

15                   Several technical points. It's  
16 indicating in the scoring that there's no use of  
17 this anywhere, and I'm not sure that that's  
18 correct, because we've been using a form of it in  
19 New York state for a couple years. There was  
20 historically, you mentioned California looking  
21 at, and there wasn't a huge amount of movement,  
22 and that's when they were looking at four levels,

1 rather than a score of 100.

2 And so much of that came through in  
3 discussions of NQF endorsement where they shifted  
4 the measure to not go from one level to another  
5 of the four, but a point score with three to six  
6 increase in points of activation being the  
7 threshold for use.

8 And recognizing that New York state  
9 and CMS, in their 1115 waiver, shifted what was  
10 used and is currently being used for payment pay-  
11 for-performance in New York state, to the NQF-  
12 endorsed measure that we're looking at here.

13 The other thing is that LTSS also  
14 looked at this measure and did recommend it for  
15 use. And I'm scratching my head, trying to see  
16 how do we align yes and no for the same measure,  
17 and is it really different in those populations.

18 Whereas the LTSS population tends to  
19 be mostly Medicaid, this being addressed to  
20 mostly Medicaid. The use that I'm aware of in  
21 New York is for the Medicaid and uninsured  
22 population, which is that population.



1           And there's a variety of studies over  
2           the last several years looking at the correlation  
3           with improvements in patient activation, with  
4           reductions in readmission and unnecessary  
5           admissions and ER visits. So to me this says  
6           this is a good one, and a high one on my own  
7           personal priority list.

8           MEMBER KELLEY: I would echo  
9           everything that John said. I will say that  
10          within the Pennsylvania Medicaid -- first of all,  
11          it's an outcome. We have very few outcome  
12          measures across this entire portfolio. It's  
13          patient-focused, which, I think, one of our  
14          public commenters earlier today was encouraging  
15          us to think about that and the importance of  
16          that.

17          And within our Medicaid program, we  
18          have always learned to listen to our  
19          stakeholders, and especially our consumers. And  
20          if you're not measuring the consumer's voice or  
21          their potential, how well they're being engaged  
22          in care or how well they're being activated to be

1 engaged in care, I think we're missing the boat.

2 I will say that, and there is some  
3 literature that does suggest as you move  
4 activation scores up that there is reduction in  
5 utilization. I also, in my comments that I  
6 submitted, reached out to one of our behavioral  
7 health managed care plans who has used us in a  
8 PCORI grant that'll probably be released some  
9 time this summer that had very nice outcomes.

10 And it was used in a model of  
11 individuals with persistent serious mental  
12 illness, as well as, many of those folks also had  
13 co-occurring substance use disorder, and oh, by  
14 the way, they had all kinds of physical health  
15 comorbidities. Very high-risk population, I  
16 think almost 2,000 studied in various care  
17 management models.

18 And one of the key components of the  
19 care management model was the staff were taught  
20 how to administer these activation scores. And  
21 that was part of the program. And these  
22 individuals were able to become much more active

1 in their care. They got more physical health  
2 actually done, and a lot of the other patient  
3 satisfaction outcomes were very good.

4 They, on the physical health side,  
5 they actually said they didn't feel as good.  
6 Probably because they actually understood some of  
7 their physical health conditions. So in that  
8 model, studying probably 1800 patients, and this  
9 did not cost -- PCORI grants, they don't get a  
10 lot of money to operationalize.

11 They were able to do it. They were  
12 able to show an effect. And the outcomes were  
13 positive. What PCORI doesn't allow you to do is  
14 to do a cost-effectiveness. Well, we as a  
15 Medicaid program were able to look at cost  
16 effectiveness as well, and I will just tell you  
17 that we did see reduction in utilization, even  
18 with those very mild, modest gains in patient  
19 activation.

20 So it's an outcome measure, it can be  
21 done clinically, the clinical level. I think  
22 it's helpful, it is very patient-focused, so.

1 CO-CHAIR MOORE: All right, thank you.  
2 I'm not sure which of you is first, Maureen or  
3 Judy, but I'll just go with Maureen.

4 MEMBER HENNESSEY: Thanks. Maureen  
5 Hennessey. So my question is, is do we have a  
6 sense at this point of what kind of cost and  
7 administrative burden this represents for  
8 Medicaid plans? And then is that factored in  
9 when we look at the cost-effectiveness, or  
10 essentially the health economic outcomes for the  
11 use of this tool when implemented? Does anybody  
12 know?

13 CO-CHAIR MOORE: So I mean, I don't  
14 want to jump in with my own thoughts, but I will.  
15 So I actually take issue with some of the  
16 critique that came out related to that. Patient  
17 activation is actually the focus of a lot of my  
18 research that I do. It's focused in the Medicaid  
19 population, and women, at the University of  
20 Michigan.

21 And we did find that there was high  
22 levels of activation. Patient activation is sort

1 of this utility to take action. There are social  
2 determinants of health that affect an individual,  
3 but their ability to take action and be  
4 activated, they're not always correlated. So I  
5 think that we have to careful about that comment.  
6 So that's an issue that I had.

7 What we found within our research, and  
8 we use patient activation all the time, is that  
9 when there's a low outcome, it's typically, or  
10 poor outcome even though the patient was highly  
11 activated, it's because the clinician was not  
12 activated.

13 And so what we're trying to push is to  
14 create a clinician activation score, because both  
15 have to come to the table highly activated for  
16 patient activation to actually be associated with  
17 positive outcomes and to know what we're looking  
18 at.

19 The cost effectiveness piece, it's not  
20 a PCORI restriction, that's a member of Congress,  
21 just to clarify. Yes, absolutely.

22 MEMBER KELLEY: (Off-mic)

1 CO-CHAIR MOORE: Yes, exactly.

2 MEMBER KELLEY: (Off-mic)

3 CO-CHAIR MOORE: Yes, exactly.

4 MEMBER KELLEY: (Off-mic)

5 CO-CHAIR MOORE: Mic, please. Yes.

6 So --

7 MEMBER KELLEY: I will say that that  
8 health plan saw a lot of cost-effectiveness in  
9 that their already disseminating. They have  
10 these patient-centered medical homes for people  
11 with serious mental illness. They started with  
12 ten and a PCORI grant. They didn't wait to  
13 complete the PCORI process; they started to  
14 actually disseminate this more widely to other  
15 clinical sites.

16 So if that bespeaks the financial  
17 motivations of a managed care plan, you can infer  
18 what you want. But as a Medicaid program, we're  
19 very excited about this, because --

20 CO-CHAIR MOORE: Well, I think what  
21 I'm trying to understand is what is the  
22 responsibility of the health plan. So from my

1 setting at the University of Michigan, we  
2 administer the survey, we respond to it as  
3 clinicians, we do the analysis internally.

4 So I'm curious what role does the  
5 health plan play in this, other than if in a  
6 state, you find a way to reimburse the clinician  
7 for doing this work? I guess I'm not  
8 understanding the link to health plans.

9 MEMBER ZERZAN: So I'll be brief about  
10 -- I totally support this measure, and it's in  
11 use in Colorado in one of our RCCOs that is a  
12 health plan, Rocky Mountain. And they started  
13 just measuring scores, and now they're moving  
14 towards improving. But we pay them incentives  
15 based on doing it, so it is part of them.

16 And I think there are options, either  
17 the clinic does it or the health plan does it on  
18 behalf of the clinic and feeds the information  
19 back. So it depends on how you're set up. And  
20 that's how Colorado does it.

21 CO-CHAIR MOORE: Cool. Allison.

22 MEMBER HAMBLIN: So I largely support

1 this measure. I just want to, and I hate to be  
2 negative in the conversation, because I think  
3 patient activation is a really important concept.  
4 I think the patient activation measure is a  
5 really well studied and validated tool.

6           However, in our experience working  
7 with either state-level programs or plan-led or  
8 provider-led programs, I've heard some variable  
9 feedback over the years in terms of, I guess I  
10 would put it in the context of, I think providers  
11 who are administering the PAM need to be really  
12 well trained in terms of how they're  
13 administering it.

14           And oftentimes we hear feedback of  
15 people aren't sure how much to trust the  
16 responses that they're getting back. And I think  
17 part of that gets to literacy issues, and is the  
18 instrument worded in a way that's sort of  
19 universally understood and applicable to, you  
20 know, in some cases a highly transient, highly  
21 vulnerable, low literacy, low health literacy  
22 Medicaid population.



1                   And so I do think it's a very  
2                   important construct. I think it's arguably the  
3                   best we have in this space. But I do think it's  
4                   important to recognize that the implementation  
5                   experience from where I sit has not been  
6                   universally positive.

7                   CO-CHAIR MOORE: I mean, I think  
8                   that's really good feedback. Because if this is  
9                   a measure that goes forward to CMS as a  
10                  recommendation, this could be something that they  
11                  could look at, especially looking at the  
12                  variation within the Medicaid population and  
13                  those barriers that may come up, and how people  
14                  have overcome them or haven't been able to.  
15                  Because we're an incubator for innovation, and  
16                  there's opportunities there.

17                  I know that we have someone on the  
18                  call that wants to speak.

19                  MEMBER SIDDIQI: Yes, this is Alvia.  
20                  I just didn't want it to go without notice that  
21                  the PAM -- use of that PAM tool actually has a  
22                  significant amount of expense as well.

1                   And so to assume that sort of everyone  
2                   or all Medicaid agencies would be able to afford  
3                   the use of the tool and then use that tool across  
4                   the board, there is definitely fiscal impact. So  
5                   it does impact, I think, feasibility.

6                   I do like the idea behind obviously  
7                   trying to look at how do we measure activation  
8                   and do we continue to have patients be very much  
9                   engaged with their clinician or with their care  
10                  plans. However, I do think that the fact that it  
11                  is Insignia Health that is the measure steward,  
12                  in conjunction with the University of Oregon, I  
13                  do think I need to just call that out.

14                  CO-CHAIR GOLDEN: So is PAM in the  
15                  public domain, or is it fee-related? Okay.

16                  MEMBER HAMBLIN: My understanding is  
17                  anyone can access the tool, but the scoring is  
18                  proprietary. And so you need to pay for the  
19                  scoring.

20                  CO-CHAIR GOLDEN: How does that square  
21                  with NQF policy? I'm just curious.

22                  MS. MUNTHALI: It's a great question.

1 So for the purposes of endorsement, we ask  
2 developers or stewards to disclose that  
3 information that might be proprietary. But it is  
4 one of the issues that we discuss, the  
5 feasibility. It is a criteria, it's not a must-  
6 pass.

7 But this would go into the discussions  
8 around our table on feasibility of use of the  
9 measure that's based on this tool.

10 CO-CHAIR MOORE: Yes, I think it would  
11 be challenging for us at our FQHC to use it. But  
12 at the University of Michigan, we have the  
13 resources to be able to make that happen. I'm  
14 not seeing any other -- oh, you have one final  
15 comment? We're running out of time, so I assume  
16 it can be brief.

17 MEMBER KELLEY: Last parting comment.  
18 Again, I think there, even though it may be a  
19 variation on a theme, I think there is another  
20 tool that is in the tool that is in the public  
21 domain that is free.

22 Within our program, we will probably

1 pay for this through our patient-centered medical  
2 home program. So, and our value-based  
3 purchasing. So we as a state are certainly  
4 willing to put up dollars to make this happen.

5 We think it's important going forward,  
6 so probably in a year or so, this will probably  
7 be the key metric that we want to be able to  
8 measure across, maybe not all populations, but  
9 especially this population. And especially,  
10 again, many of these folks overlap, they have  
11 serious mental illness and they have substance  
12 use disorder.

13 CO-CHAIR MOORE: I just want to check  
14 one more time to see if there's anyone on the  
15 phone. Oh, one quick question. Okay, I'm sorry.

16  
17 MEMBER PHELAN: So the survey's  
18 administered at the patient level.

19 CO-CHAIR MOORE: Correct.

20 MEMBER PHELAN: And somebody's got to  
21 administer the survey. Who would do that? Would  
22 it be the clinician? Would it be --

1 CO-CHAIR MOORE: So, yes, we typically  
2 give it to them on a clipboard, or now we have  
3 iPads that we give to them. And it's a really  
4 well validated tool, it's really phenomenal.

5 We have our issues with it, so it's  
6 really well researched in chronic conditions. I  
7 mean, that's where it first started. It's done a  
8 lot work in cancer. We run into a lot of issues  
9 within women's health.

10 It's such a dynamic area. It's an  
11 area in health care where there's a lot of  
12 overuse that's not necessarily evidence-based.  
13 It's an area where, for some reason, the  
14 clinician-patient dynamic, there tends to be more  
15 of hierarchical power dynamic between women and  
16 their clinician. Kind of a theme for this year.  
17 I didn't say that.

18 Anyway, so that's where we're finding  
19 that in the area of activation specific to  
20 women's health, that we really need to be looking  
21 also at clinician activation specific to this  
22 population. But it wouldn't cause me to have any

1 hesitation about moving forward so that CMS could  
2 continue to develop and explore this as a  
3 potential.

4 MS. GORHAM: I just wanted to clarify,  
5 as John stated in the opening remarks, the usage  
6 information in the discussion guide was  
7 incorrect.

8 So you've already heard some places  
9 were issues. I just wanted to add to that. So I  
10 have here in front of me Monroe Health in New  
11 York State, the District program, and New York  
12 state is requiring the PAM in their Medicaid  
13 program.

14 Washington State Medical Health Homes,  
15 as well as South Carolina, DHHS Healthy Outcomes  
16 Program. So those are just a few, just for  
17 transparency.

18 CO-CHAIR MOORE: Great. Are we ready  
19 for a vote? Okay.

20 MS. KUWAHARA: This is Measure number  
21 17, NQF number 2483, Gains in Patient Activation  
22 Scores at 12 Months. For the first vote, to what

1 extent does this measure or measure concept  
2 address critical quality objectives and/or  
3 identify program area key concepts?

4 For high, please select one. Medium,  
5 please select two, or low, please select three.

6 (Voting.)

7 Eighty-five percent of the 20 voting  
8 members selected high, and 15% selected medium.

9 Moving on to vote number two, to what  
10 extent will this measure address an opportunity  
11 for improvement and/or significant variation in  
12 care? For high, select one. Medium, select two,  
13 or low, please select three.

14 (Voting.)

15 Sixty percent of the 20 voting members  
16 selected high, 35% selected medium, and five  
17 percent selected low.

18 For the third vote, to what extent  
19 does this measure or measure concept demonstrate  
20 efficient use of resources and/or contribute to  
21 alignment? For high, please select one, medium,  
22 select two, or three -- I'm sorry, low, please

1 select three.

2 (Voting.)

3 Thirty-five percent of the 20 voting  
4 members selected high, 40% selected medium, and  
5 25% selected low.

6 Moving on to the next vote, to what  
7 extent is this measure or measure concept ready  
8 for immediate use? And I would like to point out  
9 that if you select high, you vote for it as a  
10 measure, and if you select medium, you are voting  
11 for it as measure concept.

12 If you would like to select high,  
13 please press one; medium, please press two; and  
14 low, please press three.

15 (Voting.)

16 Sixty percent selected high, 30%  
17 selected medium, and ten percent selected low.

18 MS. GORHAM: So if I can just clarify,  
19 the only difference between one and two is one is  
20 a measure and two is a concept. We know that  
21 this is a measure; this is NQF-endorsed. So two  
22 is really not an option, because you can't put



1 this forward as a recommendation as a concept  
2 because this is definitely a measure.

3 So as we vote on this for other  
4 measures or concepts, just know that on this  
5 question, the only difference between one or two  
6 is that one is a measure and two is concept. So  
7 we should vote on this again, so that we know  
8 that this is a measure.

9 CO-CHAIR MOORE: Shaconna.

10 MS. GORHAM: Okay, so our chair has  
11 spoke, and so because it passes, we'll just pass  
12 it as a measure. Sheryl.

13 MEMBER RYAN: Could I just point out  
14 you used the greater than 60 as the cutoff, when  
15 in the TEP groups, there were always five of us.  
16 So a sixty percent, three out of five, that  
17 carried the day.

18 So I wonder, you know, our scale is a  
19 little bit different than it was before, because  
20 it was 60 and above. So I'm just, yeah, I know  
21 it was hard to make it like, you know, you were  
22 stuck with equal numbers, but still.

1 DR. TERRY: It was really hard when we  
2 only had five people. That was really the issue.  
3 So now that we have more than five, at NQF it's  
4 usually greater than 60. Just so you know, we  
5 kind of lowered it a bit because of the number.

6 MEMBER WALLACE: Can I ask just a  
7 clarifying question about measure, because in  
8 most of these you can tell pretty easily if it's  
9 a measure or a measure concept, because you  
10 pretty clearly laid out the definitions.

11 So the purpose of this group voting  
12 for that, I'm trying to -- there may be a few  
13 that are ambiguous, but for that particular  
14 decision, in my mind, when I was looking it at  
15 it, if there's a measure that needs changes or  
16 whatever, that might be sort of downgraded or you  
17 know, sort of, to a measure concept. But is that  
18 the right thinking, or what's the utility in that  
19 vote?

20 MS. GORHAM: So we can't, you can't  
21 really change a measure. So what's in front of  
22 you is what is in front of you. So you're voting

1 on it as is. You're voting, we know the NQF  
2 measures are NQF measures.

3 When you look at those measures and  
4 the specifications are not clear, or some  
5 measures you all -- or concepts you all have  
6 looked at, and you say, well, there's not enough  
7 detail. So you know that those are concepts. So  
8 when you're voting, again, on those concepts,  
9 you're using two. Does that answer your  
10 question?

11 MEMBER SIDDIQI: This is Alvia and I  
12 kind of agree with that last comment. Because  
13 there may be many endorsed measures, but I  
14 thought the part of the TEP's role was to  
15 actually say which measures did we want to sort  
16 of prioritize as a measure that CMS should be  
17 working on including, or trying to promote within  
18 states, versus others that may be more at a  
19 concept stage, even though it may have an  
20 endorsement.

21 MS. GORHAM: I'm sorry, Alvia, repeat  
22 your question.

1                   MEMBER SIDDIQI: Sure, so I was  
2                   basically saying that, you know, in my mind the  
3                   way I think about it is there are a multitude,  
4                   many, many endorsed measures that are out there.

5                   But I thought that the work of this  
6                   TEP as part of the decision logic was to sort of  
7                   prioritize which of existing endorsed measures  
8                   should be used more and promoted as measure  
9                   concepts, versus measures that we would really  
10                  promote with the states, and for CMS to actually  
11                  work on with the states.

12                  So I guess I kind of see that we were  
13                  doing one, two, or three, we're really trying to  
14                  help in that prioritization, not necessarily just  
15                  saying, Well, it's an endorsed measure already.  
16                  So we would just move that through.

17                  MS. GORHAM: So I'll take a stab at  
18                  your question, and then I'll ask probably Karen  
19                  to weigh in. But we have not been asked to  
20                  prioritize the measures within the measure sets.  
21                  What we are doing is recommending measure sets.  
22                  And so when you recommend those measure sets,

1 then we are recommending the measures as  
2 measures, or concepts as concepts.

3 But within the measure sets, we have  
4 not been asked to prioritize the measures in the  
5 measure set. So we're recommending as a whole  
6 measure set, but.

7 MS. LLANOS: Yes, I agree. This is  
8 Karen. I think it would just get too complicated  
9 for that to prioritize this in measure set.

10 MS. MUNTHALI: And this is Elisa. I  
11 think what we probably should mention is a  
12 commentary that you mentioned that accompanied  
13 the discussion will go along with the inclusion  
14 of those measures in there.

15 So even though, I mean, we can't, the  
16 measures are what they are. That was an NQF-  
17 endorsed measure. We know that it is reliable,  
18 it's valid, and it's gone through all of the  
19 criteria. But you do have concerns. So it's not  
20 changing the inclusion of that measure in the  
21 menu, or it's not changing the inclusion of that  
22 measure.

1           What it is doing is saying that you  
2 recognize it's a fully specified measure, it has  
3 been tested. But you do have some concerns, and  
4 I think that language can be added. I don't know  
5 if that will address --

6           MEMBER SIDDIQI: Yes, that helps.  
7 That helps, thank you.

8           CO-CHAIR GOLDEN: If 80 percent vote  
9 red or green, then it passes and we go to the  
10 next question.

11          MS. GORHAM: So we're fine with that.  
12 It passes, and we know that it is a measure. So  
13 when we add it into the set, it will be added as  
14 a measure that was recommended.

15          MS. KUWAHARA: Okay, so this moves  
16 forward as a measure.

17                 To what extent do you think this  
18 measure is important to state Medicaid agencies  
19 and other key stakeholders, for instance,  
20 consumers, families, Medicaid managed care  
21 organizations, and providers? For high, please  
22 select one; medium, select two; and low, please

1 select three.

2 (Voting.)

3 Sixty-five percent of the 20 voting  
4 members selected high, 25% selected medium, and  
5 ten percent selected low. So this measure will  
6 be recommended for inclusion in the BCN measure  
7 set.

8 So we'll move on to our second measure  
9 identified for reconsideration. This is Measure  
10 number 19 on your discussion guide, it's NQF  
11 number 2631, Percent of Long-Term Care Hospital  
12 Patients with an Admission and Discharge  
13 Functional Assessment and a Care Plan That  
14 Addresses Function.

15 This measure was identified for  
16 reconsideration by Cheryl Powell. But before I  
17 turn it over to Cheryl, I wanted to provide the  
18 TEP's rationale for not including this measure in  
19 their recommendations.

20 One TEP member noted that functional  
21 assessments are invariably performed at LTACHs.  
22 As such, the measure may not add value to the

1 measure set. Although this measure could capture  
2 dually eligible beneficiaries, the TEP determined  
3 that the measure is not appropriately suited for  
4 the Medicaid BCN population. Cheryl

5 MEMBER POWELL: Okay, sorry, that last  
6 piece is confusing to me. So I'm just going to  
7 skip that and move on. I think it's incredibly  
8 valuable for a Medicaid population, particularly  
9 given how much Medicaid pays for HCBS.

10 Yes, the functional assessment may be  
11 done already, but it's that discharge plan based  
12 on the assessment I think is very important to  
13 assure that the individuals that are being  
14 discharged have the care plan that's based on  
15 that assessment and that follows them.

16 You know, we found doing some work  
17 with QIOs in one area that, even discharged from  
18 a hospital to home health, there was only ten  
19 percent that had a discharge plan that followed  
20 them.

21 And so I think this is incredibly  
22 important. It's, I think, focuses very much on



1 the Medicaid population. It's something that the  
2 long-term care hospitals are reporting within the  
3 current programs for impact.

4 And so the additional burden, I like,  
5 I personally, having been the duals deputy  
6 director for several years, like to focus on  
7 what, you know, what can be used across and I  
8 think about what's feasible and least burdensome.

9 So I think for a Medicaid agency with  
10 the large population that the functional  
11 assessment would be important for, particularly  
12 for the programs where, you know, within  
13 Medicaid, there's personal care assistance,  
14 there's actually payment for the services that  
15 support an individual with limitations in any of  
16 these areas, that that would be critical for  
17 Medicaid. And within this larger population  
18 group, and focus for IAP, it seemed incredibly  
19 important, and also beyond just the clinical idea  
20 of quality, but more focused on a broader and  
21 more holistic concept of health and quality,  
22 which is something that Medicaid agencies

1 certainly are focused on.

2 DR. TERRY: And Cheryl, you're at RTI,  
3 correct?

4 MEMBER POWELL: No, I am not. I'm at  
5 Truven.

6 DR. TERRY: Who's at RTI? Oh, Truven.  
7 Because I noticed that RTI was the steward of  
8 this, so I just wanted to -- Barbara.

9 MEMBER McCANN: Yes, if I could  
10 clarify. I don't understand the measure as  
11 requiring a handoff to home and community-based  
12 services of a care plan that includes functional  
13 assessment. And was that the reason I just heard  
14 as to why we should consider it?

15 CO-CHAIR MOORE: Cheryl, do you want  
16 to respond to that?

17 MEMBER POWELL: Sure, sorry, I lost my  
18 place. I was trying to review it, but I've lost  
19 it now. But I will look at it in a second. I  
20 think the care plan at discharge, given that  
21 Medicaid and HCBS require that care plan too, if  
22 you have the discharge and the care plan, that,

1 and I don't know, because I would have to look  
2 more deeply into this, and perhaps the  
3 researchers looked into this, at NQF, as to  
4 whether that handoff is required.

5 I think it's probably more likely if  
6 it's done at least, that the handoff would be  
7 required. And then it would inform the piece  
8 needed under HCBS. But I don't know.

9 MEMBER McCANN: I would just make two  
10 comments. It's not required as an HCBS provider.  
11 The other thing we significantly acknowledge as a  
12 provider is that functional status in a facility  
13 with life safety code is very different than  
14 functional status in your home, and the ADLs and  
15 IADLs.

16 So if the primary reason for  
17 reconsideration of this is because it will pass  
18 off to the community, I would question whether  
19 that happens, and the validity of that assessment  
20 outside the home.

21 CO-CHAIR MOORE: Good point. Judy.

22 MEMBER ZERZAN: I want to like this

1 measure, but it's not quite it for me, and I  
2 think part of the reason is that this is only in  
3 long-term care hospitals, and that's such a  
4 narrow, teensy, tiny population.

5 And it also seems weird to be in the  
6 BCN TEP and not the LTSS one. So it seems like  
7 this is a measure that's not quite there yet.

8 CO-CHAIR MOORE: Thank you. Susan.  
9 No. You sure? Speak now.

10 MEMBER WALLACE: No, I'm trying to  
11 remember if this is -- I've looked at a couple of  
12 these impact measures, and I know at least some  
13 of them make the downstream provider responsible  
14 for the upstream information. And that was sort  
15 of what I was trying to get from reading this  
16 numerator statement and trying to remember if  
17 this is one of those or not.

18 CO-CHAIR MOORE: We have a comment on  
19 the phone. You've got to take it off mute. And  
20 they decided not to. All right, David, and then  
21 we'll go over here. Did you have a comment?

22 MEMBER KELLEY: Again, just to

1 reiterate what Judy said. This is probably, from  
2 a Medicaid standpoint -- first of all,  
3 Pennsylvania Medicaid doesn't recognize LTACHs as  
4 a provider type.

5 So we don't pay for this. Sometimes  
6 our managed care plans have creative ways of  
7 paying for it, but we typically don't even pay  
8 for this service for straight-up Medicaid.

9 Now, for duals and long-term care, you  
10 know, that might be another issue. It may be it  
11 really belongs under long-term support services.  
12 But it is a very, very, very narrow -- this is a  
13 niche industry. There aren't like tons of these  
14 hospitals around.

15 For this population, I can guarantee  
16 you that my straight-up Medicaid population that  
17 is extremely complex, these facilities tend to be  
18 -- shall we say, they do wallet biopsies before  
19 anybody gets in. So even if it was a provider  
20 type that we recognized, very few people in  
21 Pennsylvania Medicaid have access to this  
22 service.

1           They either get it in other sites or  
2 services, or they actually go home and get the  
3 support services at home, so. But also, I think  
4 that within a long-term care support system, I  
5 would think that -- and this is a nice measure  
6 for the facility, but quite honestly, a really  
7 good program is going to -- there are going to be  
8 care coordinators that should be hovering over  
9 folks like this as they leave this facility.

10           They are the ones who really -- in a  
11 good managed care program, they're the ones that  
12 should be doing this and making sure. Because I  
13 can tell you, these facilities are like, see you,  
14 bye byes. And you're gone. And, you know,  
15 they'll check all the boxes and this will look  
16 great. But it's really -- it's those  
17 coordinators who take care of them once they  
18 leave and once they're back in the community.

19           CO-CHAIR MOORE: Thank you. Michael.  
20 Microphone, please.

21           MEMBER PHELAN: I'm sorry, what was the  
22 cut-off for this? Because I think this was 1.8.

1 And again, it was the same question, why was it  
2 in the BCN and not the LTSS? Was there a reason  
3 for that?

4 And the cutoff was 1.8 for this group.  
5 What was the actual -- yeah, so the overall  
6 measure score was 1.8. Oh, the threshold score  
7 was --

8 CO-CHAIR MOORE: 1.71.

9 MEMBER PHELAN: 1.71. But it still  
10 got rejected anyway.

11 CO-CHAIR MOORE: Yeah.

12 MS. KUWAHARA: Correct. The TEP  
13 evaluated it because it did meet the threshold  
14 score, it exceeded it. And then they threw it  
15 out, correct.

16 CO-CHAIR MOORE: All right. Susan.

17 MEMBER WALLACE: I just want to make  
18 the additional comment. It looks, from the  
19 measure specs here, that it is in use in the SNF  
20 QRP, which makes me think that this one of the  
21 ones that align. So just to bring that up,  
22 because I know that some folks criticize the, it

1 only applies to long-term care hospitals.

2 I don't -- is this measure, I think  
3 they're -- when they're done, they're parallel  
4 measures, that they look a lot the same, but --  
5 as how the impact measures are working. But --

6 DR. TERRY: Exactly. This is clearly  
7 an impact measure if you look at what they're  
8 evaluating, and there are each of the post-acute  
9 sectors. But they're a little different  
10 sometimes, depending on -- yeah.

11 CO-CHAIR MOORE: Someone on the phone?  
12 Just a second, is there someone on the phone?

13 CO-CHAIR GOLDEN: Was it a public  
14 comment?

15 MS. BUCHANAN: No, it's Andrea.

16 CO-CHAIR MOORE: Oh, okay. Do we want  
17 to wait, or continue? Yeah, we need her to --

18 MS. BUCHANAN: Hi, Operator, it looks  
19 like Andrea Gelzer's line is muted. Is it  
20 possible to unmute her?

21 OPERATOR: She is actually dialing  
22 back in.



1 MS. BUCHANAN: Okay, thank you.

2 CO-CHAIR MOORE: Cheryl.

3 MEMBER POWELL: Yes, I just wanted to  
4 highlight this is part of that family of  
5 measures. This was the only measure that was on  
6 our list. But I meant to bring it up for that  
7 family of impact measures. And they are looking  
8 across settings to align all of those, including  
9 the home and community-based waiver setting, SNF,  
10 LTACH.

11 So yes, the reason this one is  
12 selected is because it was the one on our list.  
13 But it's really meant to be broader than that.  
14 My apologies for not saying that earlier.

15 CO-CHAIR MOORE: Susan, did you want  
16 to follow up? Okay. Andrea, are you on the  
17 line?

18 MEMBER GELZER: Hello, can you hear me  
19 now?

20 CO-CHAIR MOORE: Yeah. Welcome back,  
21 Andrea.

22 MEMBER GELZER: Oh, what do you know.

1 I thought, well, they've finally cut me off.

2 (Laughter.)

3 CO-CHAIR MOORE: No, we know where to  
4 find you.

5 MEMBER GELZER: But anyway, I just  
6 wanted to reiterate that the TEP -- you know,  
7 this got to our TEP. For whatever reason,  
8 however reason, we felt it was too low bar. And  
9 I mean, you do a functional assessment -- I  
10 believe that nursing does a functional assessment  
11 on any acute inpatient hospitalization, as well  
12 as at discharge, with regard to function. We  
13 just did not see that this was going to be  
14 impactful.

15 CO-CHAIR MOORE: Thank you. Any other  
16 comments or questions? I'm doing a horrible job  
17 of holding us to the three minutes. I'm afraid  
18 I'm going to lose my job. So are we ready to  
19 move for the vote? Okay.

20 MS. KUWAHARA: We are voting on  
21 measure number 19, NQF number 2631, Percent of  
22 Long-Term Care Hospital Patients with an

1 Admission and Discharge Functional Assessment and  
2 a Care Plan That Addresses Function.

3 For the first vote, to what extent  
4 does this measure or measure concept address the  
5 CMS quality measurement domains and/or a program  
6 area key concepts? Please select one for high,  
7 two for medium, or three for low.

8 (Voting.)

9 Twenty percent of the 20 voting  
10 members selected high, 25 percent selected  
11 medium, and 55 selected low. So this measure  
12 will not be recommended for inclusion in the BCN  
13 measure set.

14 CO-CHAIR MOORE: Susan.

15 MEMBER WALLACE: Is it possible that  
16 we could bump this to tomorrow's discussion on  
17 LTSS? Because I think it might have some utility  
18 there. I don't think it is appropriate in this  
19 setting, or in this -- is that something that's  
20 feasible?

21 CO-CHAIR MOORE: Let me consult with  
22 the experts. If this measure we just voted on

1           could be moved to the discussion for tomorrow  
2           under LTSS.

3                       CO-CHAIR GOLDEN:   Didn't LTSS already  
4           vote on this?

5                       DR. TERRY:   No, BCN.

6                       CO-CHAIR MOORE:   No, BCN did.

7                       CO-CHAIR GOLDEN:   So, but the LTSS  
8           moved it here, right?

9                       CO-CHAIR MOORE:   No, it was saved by  
10          I believe --

11                      DR. TERRY:   It was Cheryl.

12                      CO-CHAIR MOORE: Cheryl, yes. Somebody  
13          saved it, yes.

14                      MS. GORHAM:   So I just looked at the  
15          list. Of those recommended, it was not one  
16          recommended. But give me a minute, and I'll look  
17          and see if it's one that we considered, because I  
18          can't remember off the top of my head.

19                      MEMBER McCANN:   I believe that we  
20          looked at home and community-based, and not LTSS.

21                      MEMBER WALLACE:   Did you have the --  
22          this is Susan.

1 CO-CHAIR GOLDEN: So the notion here  
2 would be that this would be useful for home and  
3 community-based by having the plan at the  
4 discharge from the institution. Because I think  
5 we were told this was not for institutional care.

6 MEMBER McCANN: No, this is LTECH.

7 CO-CHAIR GOLDEN: Right.

8 MEMBER McCANN: So that would be  
9 institutional.

10 CO-CHAIR GOLDEN: Right, but the LTSS  
11 group was for non-institutional care. That was -  
12 -

13 MEMBER McCANN: Right, home and  
14 community-based, right. Yeah. Which there is an  
15 impact measure of functional status, but it's  
16 different than this.

17 MEMBER WALLACE: This is Susan. Was  
18 that impact -- the home health one, was  
19 considered in your group or it wasn't?

20 MEMBER McCANN: No, because I don't  
21 think it's finished actually.

22 MEMBER WALLACE: Okay, all right,

1 that's good clarification. Thank you.

2 MEMBER McCANN: Our group gauges.

3 Yeah.

4 MEMBER WALLACE: Thank you.

5 MS. KUWAHARA: So as I mentioned  
6 previously, there were no related NQF measures  
7 identified for the BCN program area. So we will  
8 not be conducting voting on this section. But we  
9 will move on.

10 CO-CHAIR MOORE: To lunch. Think  
11 there are some leftovers over there if you want  
12 lunch number two. That's how good of a chair I'm  
13 doing, we're really keeping us on time.

14 MS. KUWAHARA: But right now, we are  
15 pulling up the revised BCN measure set in its  
16 entirety, and our staff diligently reported the  
17 up-to-date measures that were just included in  
18 the measure set. So this is the most up-to-date  
19 version.

20 So if everyone would like to take a  
21 few moments to take a look at these measures in  
22 your discussion guides, review them, and then

1 we'll vote on any measures for potential removal.

2 CO-CHAIR MOORE: So how will we, I  
3 guess I'm trying --

4 CO-CHAIR GOLDEN: So let me go back to  
5 process. I was under the impression we were  
6 voting on all of these individually. We're not,  
7 we're just going to vote them in whole?

8 MS. KUWAHARA: So, we're looking at  
9 the measure set as a whole. If you find a  
10 measure that you deem unworthy of the measure  
11 set, then you would ask to have a discussion.  
12 But that must be seconded by another member of  
13 the Coordinating Committee to vote.

14 CO-CHAIR MOORE: Okay, so this is what  
15 the TEP -- the BCN TEP -- recommends as the  
16 measure set.

17 MS. KUWAHARA: Correct.

18 CO-CHAIR MOORE: Okay.

19 MS. KUWAHARA: And this also includes  
20 the measures that we just recommended to the set.

21 CO-CHAIR MOORE: Got it, all right.

22 MEMBER GELZER: Could you display it

1 on the webinar, what we're looking at here?

2 MS. BUCHANAN: This is Kate. I  
3 thought I had, but let me try that one more time.

4 CO-CHAIR MOORE: Could somebody who is  
5 on that committee or perhaps the lead walk  
6 through and talk about why -- just give a high  
7 level -- high, high level -- summary and discuss  
8 why these were selected? Or some background on  
9 the discussion that the TEP had I think would be  
10 helpful.

11 DR. TERRY: Sure, so --

12 MEMBER GELZER: Can you hear me? This  
13 is Andrea.

14 CO-CHAIR MOORE: Yeah, yeah, we can  
15 hear you.

16 MEMBER GELZER: Okay, and if NQF staff  
17 would feel free to chime in after me. You have  
18 to understand that -- and this is similar, I  
19 think, to every group. Each TEP was presented --  
20 you know, we started -- NQF started with a  
21 universe of measures that might be applicable, I  
22 think, to any of these four areas.



1           So when you got to the universe that  
2           was deemed potentially applicable to  
3           beneficiaries with chronic needs, we started  
4           with, what, like some 43 measures that actually  
5           got to the TEP and went through. And these were  
6           the measures of that subset of the universe that  
7           we determined were -- should move forward and be  
8           recommended to the Coordinating Committee for  
9           inclusion in the set.

10           So we didn't -- you know, are these  
11           the best measures that could possibly indicate  
12           outcomes, process measures of quality for  
13           beneficiaries with chronic measure? Perhaps  
14           they're not the best, but they're the best of  
15           what we were able to collate -- what NQF was able  
16           to collate and we were able to cull, if that  
17           makes sense.

18           DR. TERRY: I just wanted to mention  
19           there is a measure on here, it's an NQF-endorsed  
20           measure. But we know the measure has just gone  
21           through one of our committees, and it looks like  
22           it has not gone to CSAC yet, which is the final

1 decision. But at this point, the measure does  
2 not look like it will retain its endorsement.

3 So I just wanted to raise that. And  
4 that is Measure number 0647. It is a timely  
5 transition record from inpatient to home self-  
6 care.

7 CO-CHAIR MOORE: You mean 0648?

8 DR. TERRY: Did I not say that? 0648,  
9 yeah, I'm sorry.

10 CO-CHAIR MOORE: Okay.

11 DR. TERRY: And I can just tell you  
12 the reason it's probably not going to be endorsed  
13 is it did not have up-to-date performance data,  
14 it was very old, it was not re-presented during  
15 this current review of the measure. And there  
16 were some issues regarding reliability.

17 So I just wanted to let you know these  
18 measures may come back to NQF in the future, the  
19 committee really liked the concept, the thought.  
20 But they were not really -- it does not look like  
21 it'll retain it. So again, we didn't take it  
22 out, because CSAC has not had the final vote, and

1 that happens later this month.

2 MEMBER GELZER: And this is Andrea  
3 again. I would note on this specific measure  
4 that one of the members of our committee was from  
5 California and had experience with the measure  
6 because California's Medicaid program has been  
7 using it. And noted that the measure was  
8 currently driving change in California.

9 The TEP members did acknowledge that  
10 this measure could be subject to gaming, and we  
11 probably -- or we did pass it because of the  
12 advocacy of the member and the use in the  
13 California Medicaid program. We did not have the  
14 benefit of the most recent determination at NQF.

15 MS. GORHAM: So for sake of  
16 organization purposes and to respond to Cheryl,  
17 we do have -- we would like to go in order, so  
18 the measures on the screen in front of you and  
19 then for you all on the phone, for the measures  
20 that you see before you in your webinar. We have  
21 the rationale for why the TEP included the  
22 measures that are before you.

1           So for, again, sake of organization,  
2 we will go one by one and state those rationale.  
3 If -- for those of you in the room would like to  
4 also look at the specifications in your  
5 discussion guide, if you click on that measures  
6 tab, and there is a list of the -- not the --  
7 yeah, this. If you click -- yeah, if you click  
8 on the measures tab, it will give you the first,  
9 Improving Care for Beneficiary Complex Care Needs  
10 and High Costs.

11           You have the measures in front of you  
12 in a list, so you can click on the links as we  
13 discuss each measure. So Miranda will go through  
14 the rationale. Andrea, please chime in if you  
15 want to add any additional information from the  
16 discussion.

17           MS. KUWAHARA: All right, we'll begin  
18 with Follow-up after All-Cause Emergency  
19 Department Visit. And the TEP determined that  
20 this measure addresses an opportunity for  
21 improvement specifically pertaining to  
22 unnecessary emergency department utilization,

1 transitions of care, and quality of care. The  
2 TEP viewed this metric as an important concept.

3 The next measure, Follow-up after  
4 Emergency Department Visit for Alcohol and Other  
5 Drug Dependence. The TEP identified substance  
6 abuse as a critical indicator among the Medicaid  
7 BCN population.

8 Although SUD is often identified in  
9 the emergency room, it is inconsistently acted  
10 upon. The TEP flagged this measure as similar to  
11 Follow-up after All-Cause Emergency Department  
12 Visit.

13 CO-CHAIR MOORE: I think it would be  
14 helpful -- because you're going over it with a  
15 rationale -- if folks have something to  
16 contribute about the issue or the measure, that  
17 we do it then, as opposed to doing all of them  
18 and then going backwards. If that works for you.

19 MS. KUWAHARA: That sounds great.

20 CO-CHAIR MOORE: Okay, good.

21 CO-CHAIR GOLDEN: Okay, so item number  
22 one, I have an issue with that, if people want to

1 go into it. Having used this measure, please  
2 note the numerator is an outpatient visit, an  
3 intensive outpatient encounter or partial  
4 hospitalization.

5 And for all-cause ED visits, which  
6 could be a sore throat or a sprained ankle, it is  
7 quite a burden and probably unnecessary to  
8 require a visit.

9 So we have modified our measure back  
10 in our state for medical homes as a visit or a  
11 phone call or contact with the patient. Which  
12 makes a lot more sense for an all-cause ED visit.

13 So as written, I cannot support this material.

14 MEMBER GELZER: This is Andrea chiming  
15 in. And I would note that when the TEP reviewed  
16 this measure, we recommended it as a measure  
17 concept. So I know we were -- we've gone through  
18 that clarification and determined that the  
19 measure concepts are actually going to -- moving  
20 through now as measures.

21 But we did not feel it was ready for  
22 prime time as a measure per se, but was an

1 important concept.

2 MEMBER PHELAN: It looks like the  
3 threshold score was 1.71 for this, but the  
4 overall measure just made it to 0.9. What was  
5 the reasoning for keeping it? Just because of  
6 the idea of a measure concept?

7 MEMBER GELZER: Yes.

8 MEMBER PHELAN: Okay.

9 MS. KUWAHARA: So moving on to the  
10 next measure, this one was the Follow-up after  
11 Emergency Department Visit for Alcohol and Other  
12 Drug Dependence. The TEP identified substance  
13 abuse as a critical indicator among the Medicaid  
14 BCN population. Although SUD is often identified  
15 in the emergency room, it is inconsistently acted  
16 upon.

17 The TEP flagged this measure as  
18 similar to Follow-up after All-Cause Emergency  
19 Department Visit.

20 MEMBER SIDDIQI: And this is Alvia.  
21 I know I commented earlier. This is to reiterate  
22 that my concern with this one is that it's

1 following up on the emergency room visit but not  
2 the inpatient hospitalization for those same  
3 conditions. So I'm not sure, it sounds like we  
4 have follow-up after hospitalization for mental  
5 illness later below.

6 So I can still support it, but I agree  
7 with the earlier comment that for the other  
8 follow-up after all-cause ED, I do think that  
9 should remain as a concept around where there may  
10 be prioritized follow-up indicated.

11 MEMBER SCHIFF: This is Jeff, can I  
12 just make a comment about why is this one in this  
13 category versus the SUD?

14 CO-CHAIR MOORE: Yeah, that's a good  
15 question, why it's not in the SUD group.

16 MEMBER ZERZAN: Jeff, this is Judy.  
17 My guess would be most of our complex folks have  
18 substance use, whereas the Jeff Thompson's  
19 schizophrenic, diabetic alcoholic, that that is  
20 the definition of this group.

21 MEMBER SCHIFF: Yeah, I just think  
22 that in some ways this is -- the ED is an



1 opportunity to identify SUD folks at an earlier  
2 or a different presentation. And I think of -- I  
3 probably think of this category as folks who we  
4 know already to have complex needs versus folks  
5 who may show up acutely with an opportunity to  
6 identify and treat them out of the ER.

7 So I support this measure, but I  
8 wonder if we could support taking it and moving  
9 it over to that to the SUD list. If there's a  
10 mechanism to do that.

11 MEMBER GELZER: I will tell you that  
12 the TEP chair has no -- that would be perfectly  
13 all right if there is a mechanism to do that. We  
14 would be supportive of that.

15 CO-CHAIR MOORE: Does it need to go  
16 back to SUD TEP, or?

17 MS. GORHAM: Now, so you all again  
18 have the overall authority to do that, so that's  
19 fine. I think that just for a sake of a process,  
20 and again, to make this as easy as possible,  
21 we're making notes as you go along.

22 But remember, these are the measure

1 that the TEPs recommended. You have the option  
2 to pull the measure from the set and say, you  
3 know, for example, Bill mentioned for that first  
4 one, Follow-up after All-Cause Emergency  
5 Department Visit, he did not support that  
6 measure.

7 So you all have the option to say --  
8 to motion -- to make a second motion that you  
9 also do not support that, and we will take a  
10 separate vote on that measure. So I think it's  
11 best to do that while we're at that particular  
12 measure, versus going through all of them and  
13 then coming back.

14 So I just want -- so, so far that's  
15 what I've heard for the measures that we  
16 discussed. And then this Medication  
17 Reconciliation Post-Discharge, I haven't heard  
18 that we should pull it, but I did hear that it  
19 should also be recommended for the SUDs.

20 So, but before we handle that, can we  
21 go back to the Follow-up after All-Cause  
22 Emergency Department Visit, and just see if we

1 have a second to say that you don't support or  
2 you would like to have more discussion and vote  
3 on this measure.

4 But it should not automatically be  
5 passed as a recommendation, because that is what  
6 we're doing in this step.

7 MEMBER SIDDIQI: This is Alvia, and I  
8 would second that.

9 MS. GORHAM: Okay, so we're going to  
10 take that, we're going to put it aside for right  
11 now. Because we're going to come back and  
12 discuss that measure and vote on that measure,  
13 because we have heard and there's a motion that  
14 it may not be appropriate, although it was  
15 recommended.

16 CO-CHAIR GOLDEN: So I would suggest,  
17 why don't we go through these and approve  
18 measures. And if we want to move them around  
19 later for the final report, we'll do that later.

20 MS. GORHAM: Sounds good.

21 CO-CHAIR GOLDEN: So we can play  
22 Rubik's Cube later in the day.

1 CO-CHAIR MOORE: And what's the  
2 utility of having them in certain buckets as  
3 opposed to -- I mean, could one measure be in two  
4 buckets? Okay, as opposed to moving it, okay.  
5 Because it seems like that makes more sense for  
6 this one, as opposed to moving it. Okay,  
7 Allison, and then we'll go over.

8 MEMBER HAMBLIN: So that was just a  
9 really helpful clarification, that they can be in  
10 multiple. And just since we're taking comments  
11 right now, I would just like really want to  
12 underscore that SUD measures have a -- there's a  
13 lot of value to having them in the BCN, even if  
14 it means having them in duplicate.

15 CO-CHAIR MOORE: Yeah, great comment.

16 MEMBER MUSUMECI: This is MaryBeth.  
17 I just had a clarifying question about number  
18 three versus number four, the all-cause ER versus  
19 the ER for SUD. Is there some duplication there  
20 if we ended up retaining both, or can someone  
21 speak to how one isn't caught up in the other?

22 CO-CHAIR GOLDEN: Well, I mean, if you

1 are in the ER because you overdosed or because  
2 you had a psychotic break, you know, a follow-up  
3 visit might be a good idea --

4 MEMBER MUSUMECI: Right.

5 CO-CHAIR GOLDEN: In an all-cause visit  
6 --

7 MEMBER MUSUMECI: That's what I'm  
8 saying. I understand the all-cause is broader.  
9 But if we did keep the all-cause, which I  
10 understand we may not, wouldn't the next one be  
11 duplicative? No?

12 CO-CHAIR GOLDEN: No, it's for a  
13 specific event, as opposed to an all-cause event.  
14 So there might be specific events -- specific  
15 health events -- that would be beneficial to have  
16 a visit, as opposed to an all-cause event, which  
17 may be many cases of the visit may not require a  
18 visit.

19 MEMBER MUSUMECI: Okay, so all-cause  
20 is something that is separate, it's not -- I  
21 thought that it would be -- got it, okay, thank  
22 you.

1                   MEMBER PHELAN: So is this measure  
2 currently being used in any other health plans?  
3 Because this looks like a very common measure  
4 that's used in -- the first one, the Follow-up  
5 after All-Cause Emergency Department Visits. If  
6 it's a common measure used --

7                   CO-CHAIR MOORE: It's not a measure.  
8 It's currently not an endorsed measure. So it's  
9 a concept, yes.

10                  MEMBER PHELAN: This looks familiar,  
11 I've seen it on some of the, like, plans sending,  
12 I think maybe our employee health plan has a --

13                  CO-CHAIR GOLDEN: I think that that  
14 measure does exist in some form or another. But  
15 as I said, as written, it really is not a viable  
16 -- I mean, we've actually changed it, because we  
17 had a visit and we told them to get rid of it.  
18 Where did I get it from? You know, it might have  
19 been part of CPC+, or CPC Classic. Yeah, I think  
20 it was in CPC Classic.

21                  MEMBER PHELAN: Because even if you  
22 don't capture everybody that comes in for a sore

1 throat that comes back, because that's going to,  
2 those are going to wash out. Do you know what I  
3 mean? So you're going to have a population of  
4 people that you definitely want to get a follow-  
5 up, and unless you identify them specifically and  
6 say, okay, anyone with CHF, anyone with  
7 hypertension.

8 Unless you do that, the fact that  
9 you're capturing all ED patients that come in  
10 with complex behavior or complex needs, so  
11 there's already a defined population of that.

12 CO-CHAIR GOLDEN: But we're having  
13 discussion before the vote. I think we want to  
14 go through the list.

15 But I'm just saying, but we changed it  
16 to be not necessarily a visit, but at least  
17 contact and a note that you've contacted the  
18 patient.

19 MEMBER HENNESSEY: The note of  
20 clarification. We can ask questions on any of  
21 those measures in the set right now? Okay,  
22 thanks. So could someone --

1 CO-CHAIR MOORE: No, we're going to go  
2 in order.

3 MEMBER HENNESSEY: We're going in  
4 order.

5 CO-CHAIR MOORE: We're going to go in  
6 order. They just got off onto a deeper  
7 discussion. They should have waited, and I  
8 failed as a chair to knock them off.

9 MEMBER HENNESSEY: I'll table my  
10 question until we get to that one.

11 CO-CHAIR MOORE: All right, Miranda,  
12 you get the floor.

13 MS. KUWAHARA: Okay, the third measure  
14 on the list, Medication Reconciliation Post-  
15 Discharge Percentage of Discharges from January 1  
16 to December 1 of the Measurement Year from  
17 Members 18 Years of Age and Older for Whom  
18 Medications Were Reconciled the Date of Discharge  
19 through 30 Days After Discharge. That's the  
20 longest title we have to go through today.

21 The TEP determined that this measure  
22 addressed the BCN population and is important to



1 key stakeholders. The TEP finds this measure as  
2 similar to NQF number 0097, Medication  
3 Reconciliation Post-Discharge.

4 One member noted that including this  
5 measure in the measure set would give providers  
6 consistency in measure recording while also  
7 aligning with Medicare.

8 CO-CHAIR MOORE: Any comments? Any  
9 comments on the phone? Okay, next one.

10 MS. KUWAHARA: Measure number 6 on  
11 your discussion guide, NQF number 0097,  
12 Medication Reconciliation Post-Discharge.

13 TEP members noted similarities between  
14 this measure and NQF Number 2456, Medication  
15 Reconciliation Number of Unintentional Medication  
16 Discrepancies Per Patient. TEP members  
17 recognized that NQF number 0097 placed emphasis  
18 on a global standard and the measure's ability to  
19 identify errors.

20 CO-CHAIR MOORE: Any comments? Any  
21 comments on the phone?

22 MEMBER GELZER: Hey, this is Andrea

1 speaking. So there are four medication  
2 reconciliation measures, I believe, in -- no,  
3 more than four, actually. We felt that  
4 medication reconciliation is an important concept  
5 for this population, and that's why so many of  
6 these were retained.

7 So again, we're giving a -- the  
8 guidance we were given is we're giving them a  
9 menu of measures to the states, or recommending  
10 that CMS be able to give a menu of recommended  
11 measures to the state. So I'm not sure, you  
12 know, to debate, are we debating each one per se,  
13 or are we debating, or are we looking at them as  
14 to do they make sense to include in that menu?

15 CO-CHAIR MOORE: Yeah, we're looking  
16 at --

17 MEMBER GELZER: Question in my mind.

18 CO-CHAIR MOORE: Yeah, we're looking  
19 at each one individually. And Bill had asked if  
20 we're looking at best in class. And just to  
21 reiterate Karen's comment, we're not  
22 prioritizing. We're just simply recommending.

1                   So if we have eight medication  
2 reconciliation ones that we recommend, then  
3 that's eight that we recommend. And then CMS can  
4 figure out what they're going to do with it.  
5 Yeah.

6                   MEMBER KELLEY: But one of the key  
7 concepts really is harmonization, to make sure  
8 that you're not being redundant. And it looks  
9 like one of these is not NQF-endorsed, so it's  
10 more of a concept, versus we have an NQF-endorsed  
11 med reconciliation post-discharge.

12                   I mean, are there enough differences  
13 here in the populations or the methodology to  
14 recommend both?

15                   CO-CHAIR MOORE: Well, I think  
16 probably the purpose is to give the universe of  
17 recommendations. And then as a second phase, CMS  
18 will take on that work as the next phase of the  
19 work. That's my understanding. Is that correct,  
20 Karen?

21                   MS. LLANOS: Yeah, I mean, so we don't  
22 have an official second phase of the work. I

1 think we wanted to see what the first phase  
2 produced. But yes, I mean, I think that's one of  
3 the considerations, and that's why the context  
4 and the caveats are so helpful for us to make  
5 sure we're capturing.

6 MEMBER KELLEY: I mean, if I'm given  
7 this list, the first thing I'm going to say is  
8 I'm not going both. So I need to pick one. I  
9 mean, that's what I'm going to do as a Medicaid  
10 program. I'm going to do as few, I'm not going  
11 to be redundant at all.

12 CO-CHAIR MOORE: Yeah, of course.

13 MEMBER KELLEY: Because we can't  
14 afford it.

15 CO-CHAIR MOORE: But it's my  
16 understanding that this isn't going to then be  
17 released just based on our recommendation to CMS.  
18 If they have a second phase, we continue to work  
19 on this.

20 MS. LLANOS: So I think the redundancy  
21 piece, if there are some that just seem like they  
22 are many of the same, I think you should flag

1 those, right.

2 But I think if there's, I think what  
3 we want to make sure is it is a menu approach.  
4 So think about it that way. If one state might  
5 need one particular measure, another one might  
6 need another type of measure within the broader  
7 bucket.

8 MS. GORHAM: I want to be a little  
9 contradictory, because we are going to look at  
10 kind of best in class in some of these program  
11 areas where we have multiple measures of the same  
12 type and they're NQF-endorse. Because we can  
13 compare those. This, we can't really compare  
14 because we're talking about a measure versus a  
15 concept.

16 So we didn't set up a table, a related  
17 table to do that, because it is not apples to  
18 apples, if you will. But we will definitely do  
19 that for NQF measures. We do it across all of  
20 our programs so that we are not recommending to  
21 CMS a bunch of measures that we clearly can look  
22 at and say, This is the best measure.

1                   So we didn't do it here, again,  
2                   because this is a concept versus a measure. But  
3                   you will see in the other program areas that we  
4                   will do that.

5                   CO-CHAIR MOORE: Thank you. Oh, one  
6                   more.

7                   MEMBER PHELAN: Is our job to do that  
8                   for you, to get rid of the concept one and pick  
9                   the measure, or get rid of the measure and pick  
10                  the concept? Is that our job?

11                  CO-CHAIR MOORE: No, it's not my  
12                  understanding that, is that correct?

13                  DR. TERRY: Not at this point.

14                  CO-CHAIR MOORE: Okay.

15                  DR. TERRY: We will be doing something  
16                  on related measures. But again, those are only  
17                  NQF-endorsed ones, so.

18                  MS. KUWAHARA: The next measure is  
19                  Measure number 7, NQF number 0105, Anti-  
20                  Depressant Medication Management. TEP members  
21                  expressed concern about the single diagnosis  
22                  distinction in the measure specifications, as

1 well as the phrasing, Newly treated with an anti-  
2 depressant medication.

3 TEP members were concerned about  
4 accurately capturing those newly treated for the  
5 BCN population. Ultimately, TEP members noted  
6 that the measure is reported by HEDIS, health  
7 plans, and multiple states, which supports  
8 states' ability to report this measure.

9 CO-CHAIR MOORE: Comments? Allison?  
10 No?

11 MEMBER HAMBLIN: Sorry, I'm  
12 backtracking here. So just going back to the  
13 process. If somebody wanted to make a motion to  
14 --

15 CO-CHAIR MOORE: Remove.

16 MEMBER HAMBLIN: Remove. Can we go  
17 back to the --

18 CO-CHAIR MOORE: To number 6?

19 MEMBER HAMBLIN: To number 5?

20 CO-CHAIR MOORE: Okay.

21 MEMBER HAMBLIN: So this is one, just  
22 to make sure, the one that's a measure concept.

1 MS. GORHAM: Yes, you definitely can.  
2 And we would need a motion for a second.

3 MEMBER HAMBLIN: Okay, so I will make  
4 a motion to remove.

5 PARTICIPANT: Can you give a brief  
6 statement why you want it removed?

7 MEMBER HAMBLIN: I think, given the,  
8 trying to balance the objectives of having  
9 measures on the menu that reflect important areas  
10 of focus and important opportunities for quality  
11 measurement for the states.

12 But also using the opportunity to put  
13 some stake in the ground when there is a  
14 validated measure that's getting that largely the  
15 same measurement construct, preferring to limit  
16 the menu where it's reasonable to do so.

17 CO-CHAIR MOORE: It's my  
18 understanding that this is a validated measure.  
19 It just hasn't gone through NQF endorsement. Is  
20 that correct, am I reading that correct, number  
21 5? Because it looks like measure source is from  
22 AHRQ, for the number 5, and the steward is NCQA.



1 It's a HEDIS measure. So it's, number 5 is an  
2 existing measure. It appears that it's not NQF-  
3 endorsed.

4 MEMBER HAMBLIN: Thank you for  
5 clarifying that, because that wasn't clear to me  
6 in the conversation. This is the one, just to be  
7 sure we're all talking about the same thing.  
8 This has been referenced in this conversation as  
9 a measure concept.

10 CO-CHAIR MOORE: As a measure concept.

11 MEMBER HAMBLIN: And now we're  
12 clarifying that it --

13 CO-CHAIR GOLDEN: With your comment,  
14 do you want to continue with your motion or  
15 rescind your motion?

16 MEMBER HAMBLIN: I will not continue  
17 with my motion if it's a validated measure.  
18 Further, I do think it would be helpful, and I  
19 don't want to belabor the conversation, I don't  
20 feel like I have a good understanding of what the  
21 utility of one of these is versus the other. I  
22 think it would be helpful to hear from the TEP if

1 there is a meaningful distinction between these  
2 two.

3 MEMBER GELZER: I wish that that had  
4 been the charge. But that is not the charge.  
5 The charge was to go through this set of measures  
6 and determine which ones we thought were valuable  
7 to go through, as either a measure or a measure  
8 concept for consideration going forward.

9 I mean, with the states and the whole  
10 menu concept. I don't know how to answer you, I  
11 apologize.

12 CO-CHAIR MOORE: Judy.

13 MEMBER ZERZAN: Can we sort of, since  
14 we don't have any of that information here today  
15 and I think that's sort of too deep in the weeds  
16 for us, can we make some sort of recommendation  
17 to CMS to say, it's sort of weird to have both of  
18 these in there, and maybe you could -- that we  
19 support medication reconciliation in general.

20 And go forth and figure out which one  
21 of these is better for whatever reason, we'll  
22 trust you.

1 CO-CHAIR MOORE: That is on record,  
2 that you trust CMS.

3 MEMBER ZERZAN: I know that's  
4 dangerous.

5 MEMBER HENNESSEY: I would reinforce  
6 what Judy just said from the perspective of  
7 usability. Because the first reconciliation  
8 measure doesn't appear to have any information  
9 regarding what entities are using it, whereas the  
10 second one does have that information.

11 CO-CHAIR MOORE: Yeah, I appreciate  
12 that. John, you have something to say? Can you  
13 use your microphone?

14 MEMBER SHAW: To reiterate and maybe  
15 save us some time in the future, I think the  
16 sense I'm getting is this group does have  
17 opinions. They would perhaps like to see those  
18 opinions reflected. And a mechanism to do so  
19 that you've talked about is to actually state  
20 context with pro's and con's for each of these  
21 measures, and maybe focusing on the words that go  
22 into there, instead of is this a concept or a

1 measure, and which is better at this point.

2 So let's give CMS the pro's and con's,  
3 and the eventual users of metrics the pro's and  
4 con's to make it easier for them to select off  
5 the menu what I'm interested in eating today.

6 CO-CHAIR MOORE: Yeah, because I think  
7 that the TEP spent a lot of time on these  
8 measures. And we are not purview to that in-  
9 depth discussion, that we are now trying to dive  
10 into. And I do appreciate that, John, and if  
11 everyone's comfortable with that, maybe we can  
12 proceed that way. Okay, all right.

13 MS. KUWAHARA: So the next measure is  
14 Measure number 8, NQF number 0576, Follow-up  
15 after Hospitalization for Mental Illness.

16 TEP members viewed this measure as  
17 potentially valuable for states with inadequate  
18 behavioral health networks because it could  
19 potentially highlight deficiencies or critical  
20 issues. TEP members noted that this measure does  
21 not count patients who move from an inpatient  
22 setting to a residential setting.

1           TEP members concluded that excluding  
2 this measure from the BCN measure set would  
3 create a critical gap.

4           CO-CHAIR MOORE: Any concerns for this  
5 one, comments? Anyone from the phone. Bill.

6           CO-CHAIR GOLDEN: And for the record,  
7 it's already part of the adult core set, I think,  
8 for Medicare/Medicaid, and I think even the child  
9 set as well.

10           MEMBER MOHANTY: Actually, this is  
11 Sarita Mohanty. I actually, I was going to ask  
12 that question for the last of the anti-depression  
13 medication management measure is also, I believe,  
14 part of the endorsed measure or the core set of  
15 behavioral health measures for Medicaid and CHIP  
16 from CMS.

17           So I guess my question would be, as  
18 we're looking at these measures, you know, is  
19 there information that tells us if some of these  
20 have already been recommended as core set  
21 measures from CMS?

22           DR. TERRY: Yeah, we have on this,

1       yes, we do have that. We just should go down and  
2       read a little bit further if we have it. But  
3       this measure is also used in multiple states:  
4       Oregon, Washington State, Ohio, Kansas, Missouri,  
5       and Colorado.

6               So, just a little more information  
7       about its use. But it is part of the adult and  
8       child core sets as well, Medicaid. Does that  
9       help?

10              CO-CHAIR MOORE: Comment on the phone.  
11       Maybe your phone's on mute?

12              MS. BUCHANAN: Sarita, do you still  
13       have a comment? We can't hear you if you're  
14       trying to talk to us.

15              MEMBER MOHANTY: No, I'm sorry. That  
16       was my comment, actually, the one I just. Yeah,  
17       this is Sarita.

18              MS. BUCHANAN: Thank you.

19              MEMBER MOHANTY: Thank you so much.

20              MS. KUWAHARA: So the next measure is  
21       Measure number 9, NQF number 0648, Timely  
22       Transmission of Transition Record. Andrea just

1 provided the TEP's rationale for this a little  
2 bit earlier. This is the measure that's also  
3 going through the Care Coordination Standing  
4 Committee review currently.

5 The next measure --

6 CO-CHAIR MOORE: This is the one that  
7 you just talked about, that may not be endorsed.  
8 Now, we can recommend, just to clarify, recommend  
9 a measure that's not NQF-endorsed, or that we  
10 know is, okay.

11 DR. TERRY: Yeah, and we didn't do  
12 that initially. Initially, we had a measure that  
13 was not continued in endorsement, we did not  
14 include it. We couldn't really determine always  
15 why that was.

16 This measure, because I'm on that  
17 committee I knew the reasons, they needed more  
18 updated information. So if you choose to do  
19 that, just know that it won't be endorsed now, it  
20 may be endorsed in the future. But those are the  
21 reasons.

22 MEMBER ZERZAN: So this is one I'd

1       like to make a motion to remove, actually,  
2       because it is not on the adult core set anymore.  
3       It's going to be removed, is my understanding,  
4       with the next go-round, because it's extremely  
5       burdensome and I think one state's reporting it,  
6       or maybe no states are reporting it.

7                   And I just think this is sort of too  
8       hard. And if it's going to lose its NQF  
9       endorsement and it's also coming off of the core  
10      set, it doesn't really make sense in my mind to  
11      have this on a set.

12                   CO-CHAIR GOLDEN: Judy, do you know,  
13      it was my understanding this was a Joint  
14      Commission measure. I don't have timely  
15      transmission of discharge information. And it's  
16      part of hospital accreditation. So in some ways,  
17      is it redundant? Are they still keeping it or  
18      not?

19                   MEMBER McCANN: It's PCPI.

20                   CO-CHAIR GOLDEN: Oh, I thought the  
21      Joint took it up. No? Okay.

22                   CO-CHAIR MOORE: Do we have a sec, are



1 you -- Deborah, you second the motion? Okay.

2 MS. KUWAHARA: All right, the next  
3 measure is NQF number 0709, Proportion of  
4 Patients with a Chronic Condition That Have a  
5 Potentially Avoidable Complication during the  
6 Calendar Year. The TEP determined that this  
7 measure specifically addresses the Medicaid BCN  
8 population, and identified the measure as  
9 actionable.

10 CO-CHAIR MOORE: Any comments from the  
11 group? Anyone from the phone? Okay.

12 MS. KUWAHARA: And I apologize, that  
13 measure was Measure number 10 on your discussion  
14 guide.

15 CO-CHAIR MOORE: Thank you.

16 MS. KUWAHARA: So measures number 11  
17 and 12 on your discussion guide, those are NQF  
18 number 1598, Total Resource Use Population-Based  
19 Per Member Per Month Index, and NQF number 1604,  
20 Total Cost of Care Population-Based Per Member  
21 Per Month Index, respectively.

22 During the TEP's review of both of

1 these measures, they concluded that one measure  
2 alone would not provide the complete picture of  
3 quality, but they viewed these as extremely  
4 important. So the TEP recommended both of these  
5 measures that they be recorded in conjunction  
6 with one another as a stipulation of their  
7 recommendation.

8 CO-CHAIR MOORE: And so used together.

9 MS. KUWAHARA: Exactly.

10 CO-CHAIR MOORE: Any comments or  
11 concerns from the crew? Anyone on the phone?  
12 Should we ask that question individually, or can  
13 we group it together, since it's being  
14 recommended as a group?

15 MS. KUWAHARA: I think you can.

16 CO-CHAIR MOORE: That's okay? Okay.  
17 All right, let's move to 13.

18 MS. KUWAHARA: This is Measure number  
19 13 on your discussion guide, NQF number 1768,  
20 Plan All-Cause Readmissions.

21 Unlike similar measures evaluated  
22 during the TEP in-person meeting, NQF number 1768

1 appropriately addresses the squeezing the balloon  
2 phenomenon, where patients are no longer  
3 hospitalized at hospital A, but are instead  
4 hospitalized at hospital B.

5 TEP members also identified this  
6 measure as appropriate for the Medicaid  
7 population.

8 DR. TERRY: And it's part of the adult  
9 core set.

10 CO-CHAIR MOORE: Any comments or  
11 concerns from the group? Anyone on the phone?  
12 Okay.

13 MS. KUWAHARA: Measure number 15 on  
14 your discussion guide, NQF number 2371, Annual  
15 Monitoring for --

16 CO-CHAIR MOORE: Wait, I think you  
17 skipped number 14.

18 MS. KUWAHARA: I'm sorry.

19 CO-CHAIR MOORE: Yup.

20 MS. KUWAHARA: Let's see.

21 CO-CHAIR MOORE: Have we done 14?

22 MS. KUWAHARA: We took that one out.

1 CO-CHAIR MOORE: Okay.

2 MS. KUWAHARA: Fifteen, yeah, sorry.

3 CO-CHAIR MOORE: It's okay.

4 MEMBER KELLEY: Questions, all-cause  
5 readmission. Is that, I know it's in the adult  
6 core measure set, but has NCQA finally developed  
7 a Medicaid specific? Okay, great, finally.  
8 Okay.

9 MS. LLANOS: It's 2018.

10 (Off mic comments.)

11 (Laughter.)

12 MEMBER KELLEY: Happy to hear that.

13 MS. KUWAHARA: Okay, so number 15.

14 Number 15 is NQF number 2371, Annual Monitoring  
15 for Patients on Persistent Medications.

16 The TEP determined that this measure  
17 captures what providers should be doing in cases  
18 of beneficiaries with complex care needs and high  
19 costs. The TEP noted that NQF number 2371 is a  
20 process measure, making it less favorable than an  
21 outcome measure.

22 CO-CHAIR MOORE: Any comments or

1 concerns from the group? Anything from the  
2 phone? Okay.

3 MS. KUWAHARA: All right. Measure  
4 number 16, NQF number 2456, Medication  
5 Reconciliation, Number of Unintentional  
6 Medication Discrepancies Per Patient.

7 One TEP member noted that the measure  
8 established the gold standard of medication  
9 reconciliation due to the measure's ability to  
10 identify who is responsible in delineating which  
11 action should be taken.

12 Additionally, TEP members noted that  
13 the measure could incentivize emergency  
14 departments to pull continuity of care documents.  
15 The TEP acknowledged potential challenges in  
16 extracting data.

17 CO-CHAIR MOORE: Any comments or  
18 concerns from the group? Anyone on the phone?  
19 Great. You guys are doing good, you know. This  
20 three minute thing, we're down to like 30  
21 seconds.

22 CO-CHAIR GOLDEN: Your soothing voice

1 has put them to sleep.

2 CO-CHAIR MOORE: On to the next.

3 MS. KUWAHARA: So this is number 18 in  
4 your discussion guides, this is NQF number 2605,  
5 Follow-up after Emergency Department Visit for a  
6 Mental Illness or Alcohol and Other Drug  
7 Dependence. TEP members acknowledged that the  
8 measure is derived from claims data, making it  
9 feasible to implement.

10 TEP members flagged NQF number 2605 as  
11 similar to follow-up after emergency department  
12 visit for alcohol and other drug dependence, and  
13 NQF number 0576, Follow-up after Hospitalization  
14 for Mental Illness. However, TEP members  
15 identified number 2605, this measure we're  
16 discussing here, as the stronger measure because  
17 it encompasses both mental health and substance  
18 use.

19 CO-CHAIR MOORE: And this measure is  
20 part of the adult core set.

21 DR. TERRY: It says map Medicaid adult  
22 core set.

1 CO-CHAIR MOORE: Any comments or  
2 concerns from the group? Allison?

3 MEMBER HAMBLIN: Sorry, just a  
4 question, and I'm worried about going back and  
5 losing my spot. The other follow-up, the TEP  
6 mentioned this, it was just summarizing the  
7 comments, but I was confused by it. There is  
8 another follow-up after emergency department.

9 I think the comment that was just read  
10 said that that one was not about both mental  
11 health and substance use. Is that what the  
12 comment was? I thought they both were. No?

13 MS. KUWAHARA: One measure is for  
14 alcohol and other drug dependence. The other one  
15 is just for mental illness.

16 CO-CHAIR MOORE: Thank you. Sheryl.

17 MEMBER RYAN: I mean, I don't know, do  
18 we want them to be redundant in different TEPs?  
19 Because both of these that you just mentioned are  
20 included in the substance use TEP. I mean, will  
21 we look for redundancies after?

22 CO-CHAIR MOORE: But we also agreed

1 that it's okay to have them in multiple groups.

2 MEMBER RYAN: Okay, okay.

3 CO-CHAIR MOORE: Yup. Anyone on the  
4 phone? Okay.

5 MS. KUWAHARA: The next measure is  
6 Measure number 25 in your discussion guides.  
7 This is not an NQF-endorsed measure. It's  
8 Psychiatric Inpatient Readmissions, Medicaid PCR-  
9 P.

10 The TEP agreed that this measure  
11 addresses an opportunity for improvement.  
12 Readmissions for this measure's target cohort are  
13 particularly high. These readmissions could be  
14 mitigated with enhanced care coordination.

15 CO-CHAIR MOORE: You're on number 25?

16 MS. KUWAHARA: This is 25. And the  
17 name of the measure is Psychiatric Inpatient  
18 Readmissions.

19 CO-CHAIR MOORE: Okay, got it.

20 MS. KUWAHARA: Medicaid PCR-P.

21 CO-CHAIR MOORE: Any comments or  
22 concerns from the group? Anything from -- oh,



1 Allison, you look like.

2 MEMBER HAMBLIN: I think a few of us  
3 are just lost. I think we skipped a bunch.

4 CO-CHAIR MOORE: I think we did.

5 MS. GORHAM: We went out of order just  
6 a bit. The psychiatric inpatient readmission is  
7 actually the last measure listed on your slides.  
8 So you might want to before you go back, go back  
9 up in order.

10 CO-CHAIR MOORE: Because it appears we  
11 skipped 20, 21, 22, 24, and then we went to 25.  
12 So we're on number 25, but we will go back to  
13 those others. Okay.

14 MS. KUWAHARA: We'll jump back to  
15 Measure number 19, NQF number 2631, Percent of  
16 Long-Term Care Hospital Patients with an  
17 Admission and Discharge Functional Assessment and  
18 Care Plan That Addresses Function.

19 DR. TERRY: We did that one.

20 MS. KUWAHARA: I'm sorry.

21 DR. TERRY: So we're on 20.

22 MS. KUWAHARA: This is Potentially

1       Avoidable Emergency Department Utilization. And  
2       this was in a bundle with 20, 21, Potentially  
3       Preventable Emergency Room Visits; 23,  
4       Potentially Preventable Readmissions; and 22,  
5       Potentially Preventable Emergency Room Visits for  
6       Persons with Behavioral Health Diagnosis.

7               Four measures were evaluated as a  
8       group. TEP members noted that the 3M measures,  
9       which are 21, 22, and 23, were widely used across  
10       states, but due to proprietary restrictions, TEP  
11       members were unable to evaluate the measures'  
12       detailed specifications.

13               The TEP concluded that the measures  
14       are insufficient as currently designed. However,  
15       they represent promising concepts measuring  
16       potentially avoidable visits and  
17       hospitalizations.

18               MEMBER GELZER: Yeah, and I just want  
19       to clarify. We did not -- I think that's not  
20       quite written accurately. We said that they were  
21       insufficient as currently designed because of the  
22       potential, some of the blackbox proprietary

1 nature of the 3M measures and the fact that they  
2 were not NQF-endorsed, we did not pass them on as  
3 measures, just as concepts.

4 But in view of today's discussion, we  
5 would have passed them on as measures. So I  
6 don't want you to think we thought they were  
7 inadequate. And we noted that they were in  
8 common use in many state Medicaid programs, as  
9 well as in common use in many pay-for-value  
10 programs in Medicaid.

11 CO-CHAIR MOORE: Aren't they used,  
12 didn't CDC do some work with these measures?  
13 They adapted them, or?

14 MEMBER GELZER: That I can't comment  
15 on.

16 CO-CHAIR MOORE: Yeah, so NQF staff  
17 have it noted that it has been adapted for use by  
18 the CDC to describe characteristics of high  
19 safety net burden.

20 CO-CHAIR GOLDEN: Yeah, but that's  
21 item 20, I want to pull that one. I'm going to  
22 make a motion to pull Item 20 for deletion, which

1 is Potentially Avoidable ER Admissions.

2 When I was a medical student in Texas,  
3 I learned many Texas legends, of which there are  
4 many. One of which was, Governor Dolph Briscoe  
5 once appointed a dead man to the Texas Railroad  
6 Commission. And this is the equivalent of  
7 appointing a dead person to a national measure  
8 set.

9 We have used this measure, and NYU was  
10 the steward. And they created the NYU algorithm,  
11 and it was okay. It wasn't very discriminating,  
12 it had everything clustered around a small area.  
13 The problem is, it's written in ICD-9, and they  
14 are not making it available in ICD-10.

15 They don't have the time, energy, and  
16 money. So essentially it is not ICD-10  
17 compatible. So I would recommend it be moved.

18 CO-CHAIR MOORE: Second the motion.  
19 Yeah, we could vote now on that one.

20 MEMBER GELZER: And in keeping the  
21 three 3M measures but not the potentially  
22 avoidable ED utilization measure.

1 CO-CHAIR MOORE: Yeah.

2 MEMBER GELZER: Is that correct?

3 Okay.

4 CO-CHAIR MOORE: Correct.

5 MS. KUWAHARA: So I think the last  
6 measure is the Prevention Quality Indicators,  
7 number 90. This measure is currently used in  
8 California's 1115 Waiver Program as a pay-for-  
9 performance measure across all public hospital  
10 systems, both for complex care management  
11 intervention, as well as intervention more  
12 broadly.

13 The TEP determined that PQI #90 is an  
14 actionable measure that addresses avoidable  
15 admissions. Guys, this is number 24 in your  
16 discussion guides.

17 CO-CHAIR MOORE: Andrea, was there any  
18 conversation during the TEP meeting that this is  
19 a composite measure?

20 MEMBER GELZER: And I'm sorry, I'm  
21 having a heck of a time following the measures,  
22 with the notes that I have in front of me.

1 CO-CHAIR MOORE: Yeah, okay, no  
2 problem.

3 MEMBER GELZER: So which measure are  
4 you referring to?

5 CO-CHAIR MOORE: We're on number 24,  
6 Prevention Quality Indicators #90.

7 MEMBER GELZER: So it's just PQI #90.

8 CO-CHAIR MOORE: Yeah.

9 MEMBER GELZER: There wasn't, no, I  
10 think that the gentleman on the TEP from  
11 California has so much experience in it and was  
12 very passionate about his advocacy for it. So we  
13 included it.

14 CO-CHAIR MOORE: Okay. Any additional  
15 comments or questions? Karen, did you have the?

16 MS. LLANOS: I think it's a composite.  
17 I don't know 90 as well, but I think --

18 CO-CHAIR MOORE: It's listed as a  
19 composite.

20 MS. LLANOS: If it's a composite, then  
21 it's not the individual ones that are stand-  
22 alones that are part of the adult core set. At

1 least from what I'm reading.

2 CO-CHAIR MOORE: Okay. You want to  
3 use your microphone.

4 MEMBER PHELAN: California and New  
5 York on the specs are using it in their Medicaid  
6 waiver programs as a measure of quality. So, I  
7 mean, if we believe our coastal cities, coastal  
8 states drive where we're going, I have a feeling  
9 this is a pretty decent measure.

10 CO-CHAIR MOORE: Okay, any other  
11 comments or concerns? Anything from the phone?  
12 Miranda, I have one more listed, 26, Referral to  
13 Community-Based Health Resources.

14 MS. KUWAHARA: Let's see. This is the  
15 measure that was referred to from another program  
16 we already, that we discussed earlier this  
17 morning.

18 CO-CHAIR MOORE: Okay, great. Thank  
19 you.

20 MS. KUWAHARA: So by our accounts, we  
21 will be voting to strike two measures. The first  
22 is Measure 9, NQF number 0648, Timely

1 Transmission of Transition Record, Discharges  
2 from an Inpatient Facility to Home Self-Care and  
3 Any Other Site of Care.

4 The other measure is Measure 20,  
5 Potentially Avoidable Emergency Department  
6 Utilization.

7 CO-CHAIR GOLDEN: We also had number  
8 1 for discussion. Number 3?

9 MS. KUWAHARA: Number 3, Follow-up  
10 after All-Cause Emergency Department Visit.

11 CO-CHAIR MOORE: And just to  
12 incentivize everyone, we'll take a break after  
13 we're done with voting.

14 MS. GORHAM: Just for clarification,  
15 Judy, you actually made this motion and someone  
16 seconded. I just want to make sure we have the  
17 measure correct. Did you ask for 0576 or 0648 to  
18 removed? 0576 is number 8 in your discussion  
19 guide, and 0648 is number 9 in your discussion  
20 guide.

21 MEMBER ZERZAN: Number 9.

22 MS. GORHAM: Okay.



1 CO-CHAIR MOORE: Okay. So we'll open  
2 up for discussion for number 1, Adult Access to  
3 Preventive Ambulatory Care, 20-40, 45-64, 65+.

4 MS. GORHAM: So it's, no. It's number  
5 3.

6 CO-CHAIR MOORE: Number 3.

7 MS. GORHAM: In your discussion guide.

8 CO-CHAIR GOLDEN: Number 1 on the  
9 list, number 3 on --

10 MS. GORHAM: Exactly, it's number --  
11 it's listed as the first measure on your slide.  
12 But in your discussion guide, it's number 3. And  
13 it's the Follow-up After All-Cause Emergency  
14 Department Visit.

15 CO-CHAIR GOLDEN: And again, my main  
16 reason is having implemented it as written, it  
17 actually had unintended consequences of  
18 pressuring practices to reach out to make people  
19 come in. So it was actually generating  
20 unnecessary visits and increasing the burden of  
21 care. That's why it needs to be modified.

22 CO-CHAIR MOORE: Any other questions

1 or comments or concerns? Anyone from the phone?  
2 Do we move to a vote now?

3 MS. KUWAHARA: Yes, so we'll be moving  
4 through the decision logic, but we will not be  
5 using our clickers. We're going to be going to a  
6 hand vote.

7 CO-CHAIR MOORE: Okay, and those on  
8 the phone type in their responses? Okay.

9 MS. KUWAHARA: Yeah.

10 CO-CHAIR MOORE: Hand up or hand down,  
11 thumbs up or thumbs down, do they have that  
12 option? And we're just going to pull up the  
13 questions so that you can see them as well when  
14 we go through them.

15 MS. KUWAHARA: So we'll be voting on  
16 Measure 3, Follow-up after All-Cause Emergency  
17 Department Visit first. To what extent does this  
18 measure or measure concept address the CMS  
19 quality measurement domains and/or program area  
20 key concepts? Those who vote high, please raise  
21 your hand.

22 CO-CHAIR MOORE: I mean, I guess I'm

1 -- it sounds like this is a good concept, but  
2 needs context, just like some of the other  
3 measures that we discussed for modifications. Or  
4 --

5 MEMBER GELZER: That's exactly what  
6 the TEP concluded.

7 CO-CHAIR MOORE: Yeah, so are we  
8 really voting for this to be eliminated, or are  
9 we --

10 CO-CHAIR GOLDEN: Yeah, I mean we  
11 could -- do we have to go through all these five  
12 question, or can go up the measure, up or down?

13 MEMBER GELZER: Yeah, that's what I  
14 thought we were doing.

15 DR. TERRY: To go through all five  
16 questions at this point in time. I mean, if it's  
17 easier to you -- I can't hear you.

18 MS. GORHAM: I think that to stick to  
19 the standardized process is probably best. But  
20 remember, so you're voting, this is the measure  
21 concept. And when you get to the first question,  
22 if it doesn't pass, then it can fail and can stop

1 right here.

2 So you want to go take the concept  
3 through the logic and address the question at  
4 hand.

5 CO-CHAIR GOLDEN: Yeah, I didn't get,  
6 as the person who made the motion, I think it  
7 passes the first concept. It might even possibly  
8 pass the second concept. But it fails the third  
9 concept, and possibly the fourth concept. So I  
10 mean, that's, you know, so.

11 MS. GORHAM: So for record purposes --

12 CO-CHAIR GOLDEN: I recommend a no vote  
13 on three and four.

14 MS. GORHAM: Right. So for record  
15 purposes, we know how Bill will vote. But we  
16 want to know how everyone else in the  
17 Coordinating Committee will vote.

18 CO-CHAIR MOORE: But this is specific  
19 to complex care needs, right. Medicaid  
20 beneficiaries with complex care needs. So we're  
21 not necessarily going to get the sore throat and  
22 have to follow --

1 CO-CHAIR GOLDEN: If it's all-cause --

2 CO-CHAIR MOORE: But they do

3 everything, and then the denominator. Okay.

4 I mean, I'm struggling with this.

5 Having, I mean, you know, having a child with

6 complex care needs, you know, even if you come in

7 with a sore throat, it's nice to have that

8 follow-up. I mean, having to physically come in

9 is very challenging, but --

10 MEMBER PHELAN: But I think what Bill

11 mentioned was the fact that this isn't specified

12 in detail enough to get to where you want to be

13 at. If it was specified the other way, where it

14 said a follow-up, a phone call, a this or a that,

15 where it could be -- then, that would be a

16 decent.

17 So the measure as specified will fail

18 in one of the third or fourth category because it

19 just doesn't do that. We just have to let CMS

20 know that that's where it failed, is if they had

21 added the word telephone follow-up or some other

22 sort of follow-up, it would have done it.

1                   Because this was forcing his group,  
2                   his Medicaid providers to call these patients in  
3                   when, oh, you had a sore throat. Well, you  
4                   feeling better? Oh, great, okay, well, come on  
5                   in. Or, you're feeling worse, come let me see  
6                   you and see what's going on.

7                   MS. GORHAM: I just want to highlight  
8                   the importance of the mic. So we can hear you in  
9                   the room. I just want to make sure the folks on  
10                  the phone can hear you. So cut your mic on and  
11                  also speak into the mic if you would, please.

12                  MS. KUWAHARA: Sure, so again, this is  
13                  Measure number 3, Follow-up after All-Cause  
14                  Emergency Department Visit.

15                  To what extent does this measure or  
16                  measure concept address critical quality  
17                  objectives of the CMS quality measurement  
18                  domains, and/or identified program area key  
19                  concepts? Those who vote high, please raise your  
20                  hand or submit your votes online.

21                  (Show of hands.)

22                  Those who vote medium, please raise

1 your hand.

2 DR. TERRY: Could you put your speaker  
3 on?

4 MS. KUWAHARA: And those who vote low,  
5 please raise your hand.

6 Sixteen total between high and medium,  
7 so we'll move on to the next set.

8 To what extent will this measure or  
9 measure concept address an opportunity for  
10 improvement and/or significant variation in care  
11 evidenced by quality challenges for each program  
12 area? Did you want to weigh in?

13 CO-CHAIR MOORE: Yeah, I just wanted  
14 to ask a clarifying question. Do we have to  
15 identify the percentage, because that's what  
16 we're using, as opposed to a number?

17 DR. TERRY: We should do both.

18 MS. KUWAHARA: So we had 80% for set  
19 one. We're now voting on vote number 2. To what  
20 extent will this measure or measure concept  
21 address an opportunity for improvement and/or  
22 significant variation in care evidenced by

1 quality challenges? Those who vote high, please  
2 raise your hand.

3 (Show of hands.)

4 MS. KUWAHARA: Medium.

5 And low, please raise your hand.

6 Eighty-nine percent for high and  
7 medium combined. We'll move on to the next set.

8 To what extent does this measure or  
9 measure concept demonstrate efficient use of  
10 resources, and/or contribute to alignment? Those  
11 how vote high, please raise your hand.

12 (Show of hands.)

13 MS. KUWAHARA: Medium. And low.

14 Twenty-two percent between high and  
15 medium, so this measure will fail and not be  
16 recommended for inclusion in the BCN measure set.

17 Okay, this is Measure number 9 on your  
18 discussion guide, it's NQF number 0648, Timely  
19 Transmission of Transition Record Discharges from  
20 an Inpatient Facility to a Home or Self-Care, or  
21 Any Other Site of Care.

22 CO-CHAIR GOLDEN: And Judy, since you



1 announced this, do you want to discuss which  
2 elements it's not going to work well for?

3 MEMBER ZERZAN: I anticipate it will  
4 fail at the same place the last one did. I mean,  
5 I think really the challenge is, is this is  
6 really administratively burdensome, so there's  
7 not efficient use. And it doesn't contribute to  
8 alignment because it's coming out of places where  
9 it's at now.

10 MEMBER KELLEY: I'll speak for  
11 Pennsylvania Medicaid. Within our state we have  
12 health information organizations that are linked  
13 to statewide exchange. And several of them are  
14 pushing continuity of care documents from the  
15 hospitals, and in some instances, from EDs to  
16 PCPs and to our managed care plans.

17 So, at least in Pennsylvania, again,  
18 we're not using it right now. But we're probably  
19 in the next year or two we'll start to use this.  
20 And we know that, especially in our Philadelphia  
21 area, this is in heavy use, where the continuity  
22 of care documents are being pushed electronically

1 from the hospital to the health plan and to the  
2 PCP of record.

3 And they're doing it with emergency  
4 department visits as well. So it's one of those  
5 metrics that if you don't have an infrastructure  
6 in place, it's probably burdensome, it's a paper  
7 chase. But increasingly, I think we're still  
8 interested in meaningful use, I think, within the  
9 Medicaid program.

10 So you know, even though operationally  
11 it may difficult, some states may not be anywhere  
12 close to doing that. I know at least for us in  
13 some parts of Pennsylvania, both, we have one  
14 health information organization, Geisinger, that  
15 they're pinging this stuff to their rural PCPs.

16 So where that's operational, this is  
17 certainly a measure. If it's automated, to know  
18 somebody who has been multiple times to an  
19 emergency room, if a PCP knows that or they know  
20 that they've been in and out of various hospitals  
21 all over, you know, within a geographic region,  
22 it's very valuable, so. It raises a challenge,

1        though.

2                   CO-CHAIR GOLDEN: I would -- Arkansas  
3        has a similar experience. We made this part of a  
4        P for P program for hospitals about seven years  
5        ago. We had a lot of whining and gnashing of  
6        teeth, but they redesigned their discharge  
7        documents. And now it's electronic from the  
8        health information exchange.

9                   So it actually, you know, we've  
10       removed it from our pay for performance program,  
11       but we did double and triple the transmission of  
12       useful data. So there is some value to some of  
13       the elements of being adopted and incorporated.

14                   MEMBER PHELAN: Why did you remove it  
15       from your pay for performance program?

16                   CO-CHAIR GOLDEN: Because it was my  
17       understanding it was being done by the Joint  
18       Commission. And we'd already done it, so many of  
19       the hospitals were already doing this. Yeah.

20                   CO-CHAIR MOORE: Judy, can you share  
21       more about who, from your perspective, who takes  
22       on the burden so I can get a better understanding

1 of that.

2 MEMBER ZERZAN: So I think the hard  
3 part is, I mean this is, I think it is done a lot  
4 at the local level, and a lot of hospitals do  
5 this or have done quality improvement things to  
6 do that. Where this measure is, especially at  
7 the core set, is the Medicaid agency or the  
8 health plan reporting on how much that was done.

9 And unless you have a really good  
10 electronic medical record way of doing it, I  
11 mean, this is potentially an electronic clinical  
12 quality measure. But those things, again, I want  
13 to like them, but they're just not there yet. So  
14 there's a lot of burden in terms of the paper  
15 chase, and I think that's sort of the how do you  
16 know that this has been done or not.

17 And then I agree with Bill that this  
18 is happening already at a lot of hospitals. And  
19 so sort of which is the place to make it happen.  
20 I'm definitely not arguing this is not an  
21 important thing, because I do think this is  
22 important. But I'm not sure what benefit it has

1 of the health plan or the Medicaid agency  
2 reporting where this is. This is sort of a  
3 better perhaps hospital measure.

4 MEMBER GELZER: This is Andrea Gelzer  
5 on the phone, and I'm representing, I mean I work  
6 for a health plan, and I think it's hugely  
7 important. And to Dave's point, I mean, I'm on  
8 the board of the Health Share Exchange in  
9 Philadelphia, and we are working very hard to get  
10 not just encounter notifications, but also CCDs  
11 in place across the region.

12 I think it's very important to  
13 approve. I also think that I don't see why if we  
14 approved this measure, why we wouldn't put those  
15 caveats in along with the approval.

16 MEMBER ZERZAN: The part that I  
17 struggle with is that it's being taken off of NQF  
18 endorsement, according to Peg, and it's being  
19 taken out of the Medicaid adult core set. And so  
20 I sort of think this is an important thing, but  
21 maybe this is not the measure.

22 Or maybe people need to use it more or

1 something else. But I struggle with if it's  
2 being taken off of those different measure sets,  
3 then why would we include it.

4 CO-CHAIR GOLDEN: Good question. I  
5 could see the core set removal as a burden issue.  
6 Why is it losing NQF endorsement?

7 DR. TERRY: Yeah, I'll just mention it  
8 again. This was presented this spring, and the  
9 developer did not present new performance data.  
10 Every time measures come back, which is about  
11 every three years, they need to update the  
12 performance data.

13 There was no information, it was PCPI,  
14 and they were working with another developer  
15 before. So it may be a complication of that.

16 I will tell you the committee liked  
17 these measures, there are several of them. But  
18 there's a little problem with the reliability  
19 testing too, I think it was only one site,  
20 didn't, you know, didn't, was a large number.

21 CO-CHAIR GOLDEN: Technical issue.

22 DR. TERRY: Yeah, a little technical.

1 You know, it just was soft, I will call it in  
2 that way. But because they, you know, it was  
3 very clear that there was nothing that they could  
4 look at to say, ah, what is the, you know, how is  
5 it performing today. So that's why probably it  
6 hasn't. But it will go to CSAC, it may lose  
7 endorsement.

8 CO-CHAIR MOORE: Any other -- John,

9 MEMBER SHAW: Just a point of  
10 clarification.

11 CO-CHAIR MOORE: Microphone please.

12 MEMBER SHAW: Just a point of  
13 clarification. I think there's a variety of  
14 metrics that are not NQF-endorsed, and this one  
15 that was and may not be now. How are they worse  
16 than the ones that were never endorsed?

17 From a practical perspective, I've  
18 been looking at endorsement over the years, and a  
19 number of measures the developer has not come  
20 back for endorsement because they didn't want to  
21 go through the burden and cost of doing that,  
22 particularly if people are using it anyway. So I

1 don't think losing endorsement in the context of  
2 this particular project is that meaningful to me.

3 CO-CHAIR MOORE: Appreciate that.  
4 Deborah.

5 MEMBER KILSTEIN: I think part of  
6 things are too is it makes sense as a hospital  
7 number, I mean as a hospital measure. But when  
8 you start slicing and dicing this by line of  
9 business and then within health plans, you know,  
10 how many of that hospital's membership is  
11 associated with each of the different managed  
12 care plans, the number becomes less relevant.

13 So it made sense at a hospital level,  
14 but it doesn't necessarily make sense as it flows  
15 through, especially when you get to an individual  
16 health plan that may only be serving one line of  
17 business.

18 CO-CHAIR MOORE: So you're saying the  
19 utility from a health plan perspective is that  
20 this measure isn't useful.

21 CO-CHAIR GOLDEN: So a point of  
22 clarification. So since we developed these



1 measures, I mean, we have managed care plans, but  
2 I think we're developing, aren't we, a toolkit to  
3 be used throughout the system. So does it have  
4 to be plan-specific, or can it be a hospital  
5 measure?

6 CO-CHAIR MOORE: Yeah.

7 CO-CHAIR GOLDEN: I mean --

8 MEMBER GELZER: This is Andrea again.

9 Isn't it important to patient outcomes to get  
10 that timely transmission of a transition record?

11 CO-CHAIR MOORE: Yeah.

12 MEMBER GELZER: I mean, doesn't it  
13 impact follow-up rates, and don't follow-up rates  
14 impact returns to the hospital? So I mean, at  
15 least intuitively it makes lots of sense not just  
16 for a hospital.

17 I mean, I think it's a hospital's duty  
18 to ensure timely transmission. But it's very  
19 important for me as a health plan to get this  
20 information in a timely manner so I can act upon  
21 it.

22 CO-CHAIR MOORE: Yeah, I can say at

1 the FQHC, we have a hospital in the area, in the  
2 DC area, who never, ever sends us this  
3 information. So eliminating this measure I am  
4 afraid there'd be no accountability to push them  
5 to do this kind of stuff, because we can't get  
6 anything now. But go ahead, Maureen.

7 MEMBER HENNESSEY: Yeah, from my  
8 perspective I think as a health plan, having  
9 worked in health plans at executive positions for  
10 several decades, I think it's very important.  
11 However, there's two things that concern me. The  
12 first is that we do have a plan all-cause  
13 readmissions measure, which from my perspective  
14 is even more important than that transmission of  
15 data.

16 But the other thing I'm concerned  
17 about is that if there is no updated performance  
18 data for the past three years, I have some real  
19 questions about what we are measuring, what our  
20 benchmarks are at this point and what we are  
21 comparing it to.

22 Because hopefully over the past three

1 years we've seen improvements in transmission of  
2 information because of electronic records. So at  
3 this point, I don't know that we've got really  
4 good data to compare whatever is being collect  
5 to.

6 CO-CHAIR MOORE: And I'm going to  
7 allow Andy to respond after an NQF staff member  
8 wants to jump in.

9 MS. GORHAM: Yeah, I just wanted to  
10 jump in to share some more information on what  
11 Judy said and just thinking about Karen's  
12 introductory presentation that these measures  
13 will be for the use of the Medicaid state  
14 agencies. We spoke or Judy mentioned that this  
15 measure was removed from the core set, and I just  
16 wanted to provide CMCS's reasons.

17 So they have after consulting with  
18 states, this measure that we're speaking on now  
19 was removed due to low number of states reporting  
20 this measure, a decrease in the number of states  
21 reporting over time, and the challenges that  
22 states have described in collecting the

1 information in the measures. I just wanted to  
2 share actual.

3 CO-CHAIR MOORE: Andrea, do you want  
4 to respond?

5 MEMBER GELZER: And exactly what am I  
6 responding to, I'm sorry?

7 CO-CHAIR MOORE: Maureen's comment.  
8 Maureen, you want to sum up your comment?

9 MEMBER HENNESSEY: Oh, sure. So I  
10 would say two components. One is, is that we do  
11 have a measure of plan all-cause readmissions,  
12 and theoretically if we believed that one of the  
13 reasons why people readmit is because poor  
14 transmission of data from one point of care to  
15 another is the case. And we already have one way  
16 of measuring it.

17 I think the other concern that I have  
18 is because this is lacking current performance  
19 data, it's been three years, my concern is is  
20 that we don't necessarily have really good  
21 benchmarks to compare performance to at this  
22 point in time. Because theoretically, one would

1 think that the bar has risen because of the  
2 increase in electronic health records, which can  
3 facilitate this transmission. So it's a concern.

4 CO-CHAIR MOORE: Andrea, did you want  
5 to respond to that?

6 MEMBER GELZER: Yeah, and I would just  
7 say that we have lots of measures to hold the  
8 plans accountable. The plans are also looking  
9 for tools as they develop more value-based  
10 constructs to hold the hospitals, to hold the  
11 primary care providers responsible and share in  
12 the accountability.

13 So I think for that reason, it's a  
14 decent measure. Perhaps it's aspirational in  
15 nature, but I just don't want to lose it going  
16 forward, and to throw it out and say it wasn't  
17 without merit.

18 CO-CHAIR MOORE: John.

19 MEMBER KELLEY: From a Medicaid  
20 program and from a managed care standpoint, and  
21 again, we don't measure this as a Medicaid  
22 program at this point. I will, full disclosure,

1 when we did the adult core measures, I think I  
2 was the one that was pushing to put this on as a  
3 stretch measure in whenever, 2000-whenever.

4 That being said, though, I don't think  
5 the steward has really been a steward of the  
6 measure. There's a lot of this activity going  
7 on, it just hasn't been measured by the steward.

8 So how can a health plan use this? I  
9 would be looking at this. This is a gold mine.  
10 A health plan that doesn't use this -- my plans  
11 and AmeriHealth Caritas is one of them, they love  
12 this stuff. Because in the constitutive care  
13 documents, they have their meds.

14 You want to do med reconciliation,  
15 this facilitates that. If you want to look at  
16 some of the quality metrics, some of the  
17 documents have blood pressures, and hemoglobin  
18 A1Cs, weights, BMIs. I mean, it's like a gold  
19 mine of activity.

20 We're actually thinking, as a state,  
21 to start to move towards collecting some of the  
22 ECQMs, but also some of the constitutive care

1 documents. Because it is actually a gold mine of  
2 information.

3 So as a health plan, if you're not  
4 thinking in terms of, and you know, we haven't  
5 contractually required our managed care plans to  
6 do this yet, but we're thinking about that. And  
7 some states have actually done that with their  
8 managed care plans, where they have required them  
9 to be parts of the HIO.

10 So I mean, this is, in my mind, this  
11 is enlightened the managed care. This is managed  
12 care 2017 and beyond. And just because the  
13 steward hasn't done their due diligence -- I  
14 think there's a great opportunity still intact,  
15 it's not perfect.

16 CO-CHAIR MOORE: So I think we've had  
17 a chance to debate this and express concerns. I  
18 think we --

19 MEMBER ZERZAN: I apologize, everyone,  
20 for opening this can of worms.

21 CO-CHAIR MOORE: And I have realized  
22 that breaks is not enough of an incentive. So

1 tomorrow when I lead another section, I'm going  
2 to have to think of something more creative. So  
3 Miranda, can you lead us through a vote.

4 MS. KUWAHARA: Sure, so to refresh  
5 everyone, this is Measure number 9, NQF number  
6 0648, Timely Transmission of Transition Record at  
7 Discharges from an Inpatient Facility to Home  
8 Self-Care or Any Other Site of Care.

9 For vote number 1, to what extent does  
10 this measure address the CMS quality measurement  
11 domains and/or program area key concepts? Please  
12 raise your hand for high.

13 (Show of hands.)

14 MS. KUWAHARA: We have 15 members for  
15 high. Those who vote medium, please raise your  
16 hand. And low.

17 So we have 100% for high/medium.

18 Great, so moving on to the next vote.

19 To what extent will this measure address an  
20 opportunity for improvement and/or significant  
21 variation in the care? Those who vote high,  
22 please raise your hand.



1 (Show of hands.)

2 MS. KUWAHARA: We have 14 for high.  
3 Medium. And we have six for medium, so 100% for  
4 high and medium combined.

5 Moving on to the next vote. To what  
6 extent does this measure demonstrate efficient  
7 use of resources and/or contribute to alignment?  
8 High, please raise your hand.

9 (Show of hands.)

10 MS. KUWAHARA: We have seven for high,  
11 I'm sorry, eight for high.

12 Those who vote medium, please raise  
13 your hand. Seven for medium. And those who vote  
14 low, please raise your hand. We have seventy-  
15 five percent combined for high and medium.

16 Moving on to the next step. To what  
17 extent is this measure ready for immediate use?  
18 And please remember that because it's NQF-  
19 endorsed currently, we'll vote for it as a  
20 measure. Those who vote high, please raise your  
21 hand.

22 (Show of hands.)

1 MS. KUWAHARA: Twelve for high. Those  
2 who vote medium, please raise your hand. I'm  
3 sorry, I apologize. Low, please raise your hand.

4 DR. TERRY: I think people may have  
5 been confused that we're only voting high and  
6 low, right. It's either a measure or not at this  
7 point, yeah.

8 MEMBER ZERZAN: But I thought you  
9 couldn't vote low really either. This is a weird  
10 one because it's already a measure, and so it's  
11 already set, this doesn't really apply.

12 MS. GORHAM: Actually, if you look at  
13 your definition for low, low is a measure or a  
14 concept that is not in use or planned for use in  
15 the Medicaid populations. So I know that this is  
16 a measure. Did we specify that it is in use, or  
17 is that?

18 CO-CHAIR GOLDEN: Yes.

19 MS. GORHAM: Okay.

20 MEMBER HENNESSEY: So it would appear  
21 that really the only choice that's appropriate is  
22 high, correct? Okay.

1 MS. KUWAHARA: NQF staff is  
2 conferring. Just a couple minutes.

3 CO-CHAIR GOLDEN: We will take a  
4 commercial break while the referees go to the  
5 video tape.

6 MEMBER SIDDIQI: This is Alvia, but  
7 just to add to the second criteria under low, it  
8 would be nice if it said a measure or measure  
9 concept with no indication of specifications  
10 cannot be easily replicated. That way we would  
11 be able to vote low on measure that is endorsed  
12 but not easily replicated or has, you know, no  
13 indication of specification.

14 MS. GORHAM: So you all are smarter  
15 than a fifth grader, you are on the ball. So  
16 actually, so right, so it will default to high.  
17 But we understand that there are some people who  
18 would not like this to be recommended. So it  
19 defaults to high, we can take it to the next  
20 step, and that is where, you know, it will either  
21 be recommended or it will either fall out.

22 Defaulting to high, there's no really

1 reason to vote, yeah. Could we just go to the  
2 next one.

3 MS. KUWAHARA: All right, so for the  
4 next vote, to what extent do you think this  
5 measure is important to state Medicaid agencies  
6 and other stakeholders? High, please raise your  
7 hand.

8 (Show of hands.)

9 MS. GORHAM: And actually, they can be  
10 high, medium, or low. If it is low, it will fall  
11 out, it will not recommended. If you go high or  
12 medium, it will be recommended. So we'll take  
13 time to give you a minute to read, and then we'll  
14 open the vote.

15 MS. KUWAHARA: Again, this is to what  
16 extent do you think this measure is important to  
17 state Medicaid agencies and other key  
18 stakeholders. Those who vote high, please raise  
19 your hand.

20 (Show of hands.)

21 MS. KUWAHARA: Those who vote medium,  
22 please raise your hand. And those who vote low,

1 please raise your hand.

2 MS. GORHAM: Do not have all of the  
3 voting members voting, so if you could actually,  
4 we'll go to vote again. If you can raise your  
5 hand high and keep them up until we actually  
6 count hands. So Miranda.

7 MS. KUWAHARA: Those who vote high,  
8 please raise your hand.

9 (Show of hands.)

10 MS. KUWAHARA: Medium, please raise  
11 your hand. And low.

12 CO-CHAIR MOORE: It's because they  
13 haven't had a break.

14 MS. KUWAHARA: So we have 85% combined  
15 for high and medium, so this measure will be  
16 recommended for inclusion in the BCN measure set.

17 We'll move on to our next and final  
18 measure. This is Measure number 20, Potentially  
19 Avoidable Emergency Department Utilization.

20 CO-CHAIR GOLDEN: So it'll pass, it  
21 should pass one. Might pass. But it will  
22 absolutely fail item 4. So I don't know if you

1 want to jump to that. So it'll fail 4 because  
2 it's not usable anymore, that's all.

3 CO-CHAIR MOORE: So do we need to go  
4 through each of the decision tree if we know that  
5 it's not even usable?

6 MS. GORHAM: So we'll take the pause.  
7 I mean, I'm all for standardization, but I also  
8 recognize that it is now 3:10 and we are a hour  
9 and ten minutes behind schedule. So we will,  
10 whatever the chairs.

11 CO-CHAIR MOORE: Let's do one big  
12 vote. Is everyone comfortable with that, unless  
13 there's any opposition? Okay, one vote. Anyone  
14 on the phone, opposition? Sorry.

15 MEMBER SCHIFF: No.

16 MEMBER GELZER: No.

17 CO-CHAIR MOORE: Okay, let's move  
18 forward. One vote.

19 MS. KUWAHARA: One up or down vote.  
20 If you would like to see this measure removed  
21 from the BCN measure set, please raise your hand.

22 CO-CHAIR MOORE: Removal.

1 MS. KUWAHARA: Yes.

2 CO-CHAIR MOORE: We have over 60%, so  
3 we're done.

4 MS. KUWAHARA: Ninety-five percent  
5 voted to remove this measure from the BCN.

6 CO-CHAIR MOORE: Good job, everyone.

7 MS. GORHAM: Okay, so this is an up-  
8 or-down vote. The measures that remain on the  
9 set that we did not disagree, no one made a  
10 motion to remove, we are going to do a up-or-down  
11 vote for the en bloc voting.

12 Okay, so you are now voting for all of  
13 the measures that you see on your screen and the  
14 next slide is on, go to the next slide, those  
15 measures as well. So one vote, one up-or-down  
16 vote. Everyone I guess should agree, because  
17 we've already discussed and no one had any  
18 opposition. So Miranda.

19 CO-CHAIR MOORE: Allison, do you have  
20 a process question or? You can't throw any more  
21 measures in the bus.

22 MEMBER HAMBLIN: I'm not trying to do

1 that. I would like to make one comment, since  
2 there will be comments reflected in the report,  
3 and I can do that at any time.

4 CO-CHAIR MOORE: Okay, let's do that  
5 afterwards then so we can do the vote. Thank  
6 you.

7 MS. KUWAHARA: So for record purposes,  
8 we just want to note that 20 people voted to  
9 remove the measure from the BCN measure set. And  
10 that was Measure number 20, Potentially Avoidable  
11 Emergency Department Utilization. All right.

12 So this is the up-or-down vote for the  
13 BCN measure set as a whole. We're going to be  
14 going back to our clickers, and Kate will no  
15 longer be on calculation duty. If you would like  
16 to recommend the BCN measure set to CMS's  
17 Medicaid Innovation Accelerator Program, please  
18 press 1 on your clickers. If not, please press  
19 2.

20 (Voting.)

21 MS. MURPHY: We're just waiting on one  
22 vote over the phone. Yes. One of our



1 participants can't access the online portion but  
2 is emailing the vote. So we're a multi-platform  
3 machine right here.

4 CO-CHAIR MOORE: How many stars would  
5 give for that delivery?

6 MS. MURPHY: So Sarita, if you're --  
7 here we go.

8 MEMBER SIDDIQI: Did you get it? I  
9 sent it. I'm so sorry, I'm having major  
10 technical issues. So I appreciate you letting me  
11 email. I just can't get on the web at all.

12 MS. BUCHANAN: No worries, thank you.

13 MS. KUWAHARA: All right, 100% of the  
14 20 voting members voted to recommend the BCN  
15 measure set.

16 MS. BUCHANAN: And just one more  
17 comment before we take a break. We would like to  
18 open up the lines for public comment. And so  
19 anyone on the line is able to comment either  
20 through the phone or using the chatbox. Staff  
21 will read it, and we will hold the comment period  
22 open for 20 seconds.

1 OPERATOR: At this time, if you would  
2 like to make a comment, please press star then  
3 the number 1.

4 MS. MURPHY: Jeff Schiff on the phone  
5 says he has a comment. Committee member, but I  
6 think he's still eligible.

7 MEMBER SCHIFF: Yeah, I didn't know if  
8 that was public comment or not. I just would  
9 like the notes to reflect that there's really a  
10 shortage of measures for children with special  
11 healthcare needs in this set. That means some  
12 measures go down to young age, but there's really  
13 nothing specifically addressing parents or  
14 schools. So I think we have a good set to go  
15 forward, but I just think that should be noted.

16 CO-CHAIR MOORE: Thank you for that.  
17 Lots of heads are nodding.

18 CO-CHAIR GOLDEN: So it's time for a  
19 break. We can take a good break. Good job,  
20 everybody, good job, Madame Chair.

21 CO-CHAIR MOORE: Thank you, sir.

22 CO-CHAIR GOLDEN: And we can come back

1 from the break and do it all over again, so.

2 MS. GORHAM: And so I stated earlier,  
3 we are grossly behind. So if we can take a hard  
4 stop in ten minutes. So if we can start back in  
5 ten minutes. Oh, five. That's even better.

6 CO-CHAIR MOORE: I'm still chair.

7 MS. GORHAM: All right.

8 (Whereupon, the above-entitled matter  
9 went off the record at 3:15 p.m. and  
10 resumed at 3:25 p.m.)

11 CO-CHAIR GOLDEN: Okay, and we do not  
12 include too much coffee in substance abuse. It's  
13 not part of the tranche. So I know many of you  
14 are probably over-caffeinated, but that's okay.  
15 It's not part of our domain and not part of our  
16 agenda. And we will do the same process we did  
17 for the middle of the day.

18 So we will have new and referred  
19 measures for our review. And this one looks  
20 awfully familiar. It's about adult access to  
21 preventive care. So here's a question. We've  
22 already reviewed and approved this for the other

1 measure set, correct?

2 MS. MURPHY: So actually though before  
3 we get started, I'm going to go through just a  
4 couple of updates and hopefully some  
5 clarifications from everyone before we jump into  
6 this second set.

7 CO-CHAIR GOLDEN: Sure.

8 MS. MURPHY: Great.

9 CO-CHAIR GOLDEN: I got people back.

10 MS. MURPHY: So thank you all for  
11 bearing with us through this very process-heavy  
12 part of the day. Just a couple of updates that  
13 we made during our brief break.

14 So given this concern over the NQF-  
15 endorsed measures in their designation as either  
16 a measure or a measure concept, moving forward,  
17 for NQF-endorsed measures, they will  
18 automatically receive a high ranking and we will  
19 skip that portion of the decision logic. So we  
20 will be skipping a question for the NQF-endorsed  
21 measures as they go through the decision logic.

22 The second change we made was that

1 pursuant to our brief change we just made in the  
2 last measure set, we will be doing an up-and-down  
3 vote on measures that we pull off of the measure  
4 set.

5 So in that last step where we walk  
6 through the recommended measures and review the  
7 measure sets in full, rather than having to go  
8 through the decision logic to fail a measure, we  
9 will do an up-or-down vote.

10 This will definitely save us time as  
11 we move through the day, but we are still asking  
12 that if you would like to pull a measure, we'll  
13 still be using the process of motioning to remove  
14 the measure. The motion must be seconded, and  
15 further, we ask that you provide as detailed as  
16 possible a rationale for why you think this  
17 measure should be removed.

18 And we ask that you try to base that  
19 rationale in some criteria on the decision logic.  
20 So while we're not walking through it explicitly,  
21 if you can tie reasoning to one of the criteria  
22 that we had previously gone through, that would

1 be especially helpful for us.

2 But we do hope that these little  
3 ironing out the wrinkles in our process will  
4 smooth this along for our second, third, and  
5 fourth sets. Okay.

6 So, yeah, just to start us off, we are  
7 now turning our attention to the Reducing  
8 Substance Use Disorders TEP, or program area, I  
9 should say. So once again, on this previous  
10 slide we listed out your role. I just went  
11 through this.

12 If you have any questions about what  
13 we're doing, at this point, please continue to  
14 bring them up, but I think we're all pretty good  
15 now, having been through it.

16 Before we dive into the measure  
17 specifics, I will turn it over to Sheryl. Sheryl  
18 Ryan was the TEP chair of the Reducing Substance  
19 Use Disorder TEP. And Sheryl will give us an  
20 overview of the conversation that was had at that  
21 meeting. Sheryl.

22 MEMBER RYAN: Okay, thank you. I will

1 be brief, I promise. I want to thank the other  
2 members of our TEP. We had Richard Brown from  
3 the University of Wisconsin, Dennis McCarty from  
4 the Oregon Health System, Tiffany Wedlake from  
5 the Department of Health in Maryland, and  
6 Christine Andrews from University of South  
7 Carolina. And were very, very helpful with the  
8 discussion.

9 So we started out with probably more  
10 than 100 that the committee reviewed, and then we  
11 ended up having 43 measures and measures concepts  
12 that we ended up reviewing during the in-person  
13 meeting. And we ultimately recommended 19  
14 measures and six concept measures.

15 So there were a number of these, and  
16 these consisted of we felt that we needed more  
17 measures that really covered the whole scope of  
18 substance use disorders, starting with screening,  
19 prevention, and ending with assessment and  
20 intervention. And we felt that we were really  
21 missing measures that really addressed the early  
22 aspects of prevention or screening.

1           We also felt that we needed to broaden  
2           some of the tobacco measures to include not just  
3           tobacco but drugs and other nicotine products.  
4           And we found a number of critical gap areas,  
5           substance abuse measures that focused on pregnant  
6           women, the lack of available outcome measures.  
7           I'll also put a plug in, there were not very many  
8           measures for anybody under the age of 18, when  
9           much of our substance use starts.

10           And we also felt that a lot of the  
11           process measures sort of set a low bar. So I  
12           think those are pretty much, you know, the themes  
13           that we identified.

14           MS. MURPHY: Thank you so much,  
15           Sheryl. So you might recognize this next  
16           measure, or actually, let me back up and just say  
17           that we received no late submission measures in  
18           this program area, so we can move on from there.

19           The next set of measures we'll review  
20           are those that were moved between the technical  
21           expert panels. So this next measure comes to us  
22           from the LTSS TEP. If it looks familiar, it's



1 because we just discussed it as part of the BCN  
2 TEP.

3 So what we will do is we will open  
4 this back up for discussion. You will most  
5 likely want to focus your conversation on how it  
6 relates to the substance use disorder program  
7 area. And rather than taking this through the  
8 entire decision logic again, we'll take this  
9 through the first two components of the decision  
10 logic, as though as the two that relate most  
11 closely to the actual suitability for the program  
12 area.

13 The other three we presume will hold  
14 over from your previous vote. If anybody has any  
15 objections to skipping those last three votes,  
16 please let us know, and we're happy to --

17 CO-CHAIR GOLDEN: I would suggest that  
18 we not even do that, because I thought we were  
19 going to, at the end of the day, look at all the  
20 measures and where they fit. And we talked about  
21 that earlier. Because the measure's already  
22 approved. Unless you just want to make that

1 decision.

2 MS. MURPHY: It's up to you. I mean,  
3 you are the Chair. I will say that our end of  
4 the day time is getting smaller and smaller. But  
5 --

6 MEMBER PHELAN: I second that motion.  
7 If it's been already approved, we just --

8 MS. MURPHY: Sure.

9 CO-CHAIR GOLDEN: Okay.

10 MS. MURPHY: On to the next one.

11 Yeah.

12 CO-CHAIR GOLDEN: I'm pushing work  
13 till later. So then we would go to measures for  
14 --

15 MS. MURPHY: Microphone.

16 CO-CHAIR GOLDEN: Okay, so now we got  
17 to measures for reconsideration. Is that  
18 correct? So tell us where this one's coming  
19 from. Did somebody pull it?

20 MS. MURPHY: Sure. So members of the  
21 Coordinating Committee identified three separate  
22 measures for reconsideration. Just as a

1 reminder, these measures were reviewed by the  
2 TEPs, went through the decision logic, and they  
3 found them to be unsuitable, and they were not  
4 recommended.

5 The first measure we will reconsider  
6 is Mental Health, Substance Abuse, Mean of  
7 Patients' Overall Change on the BASIS-24 Survey.  
8 This is Measure 46 in your discussion guides, and  
9 it is not NQF-endorsed.

10 The TEP noted that the BASIS-24 Survey  
11 upon which this measure is built is a proprietary  
12 behavioral and symptom identification tool, and  
13 has feasibility concerns about recommending a  
14 proprietary tool. The TEP also noted that the  
15 tool is available online and can be acquired in  
16 other ways.

17 The TEP also raised concerns around  
18 providers being able to differentiate between  
19 using the BASIS-24, the PHQ-9, the CAGE, or some  
20 other tool or combination of tools.

21 And just for some context, this went  
22 down on the first decision logic question, which

1 was suitability, or applies to a critical quality  
2 objective. So we'll open this up for discussion.  
3 And this was retained by Deborah Kelley. So  
4 Deborah, you'll serve as our lead discussant for  
5 this.

6 CO-CHAIR GOLDEN: Debbie Kelley?

7 MS. MURPHY: David Kelley, oh gosh.  
8 There's a Deborah Kilstein, right? I'm sorry.  
9 Oh gosh.

10 CO-CHAIR GOLDEN: So before Deb gets  
11 started here, you said the measure source is AHRQ  
12 Clearinghouse, but the clearinghouse is usually a  
13 repository from other sources, so I would not --  
14 were they the steward or was somebody else the  
15 steward of this?

16 MS. MURPHY: Which one is it?

17 CO-CHAIR GOLDEN: This is number 46.

18 CO-CHAIR MOORE: Because I may have  
19 that information.

20 DR. TERRY: It's a person, Susan  
21 Eisen. An individual person.

22 MS. GORHAM: So we have the AHRQ

1 Clearinghouse as the measure's source. So we  
2 found the measure information there.

3 CO-CHAIR GOLDEN: David.

4 MEMBER KELLEY: Even though this is  
5 not a perfect measure, and we actually used  
6 something a little bit different, 15  
7 questionnaire, not proprietary in our Opioid Use  
8 Disorders Centers of Excellence.

9 There is no way to measure someone  
10 moving towards recovery, and we are spending  
11 hundreds of millions of dollars in opiate use  
12 disorder treatment. And we have no objective  
13 validated way, we've stolen, all 15 of those  
14 questions come off of one of SAMHSA's I think  
15 hundred-and-some question questionnaire.

16 So the bottom line is this is, this  
17 would be in my mind an outcome measure. I  
18 thought that the tool was validated. I guess I  
19 didn't realize it was proprietary, but that  
20 shouldn't preclude us from saying that this, you  
21 know, a concept we would like to move forward  
22 with.

1           But it is an outcome. It starts to  
2 measure as people move towards recovery, it looks  
3 at certain domains. And it's patient-centric,  
4 patient-focused. So from my standpoint, I  
5 thought it was important --

6           CO-CHAIR GOLDEN: You have not used it  
7 but you used something like it?

8           MEMBER KELLEY: We used something  
9 similar to it. And because otherwise you can't  
10 rely on claims data to look at this type of  
11 information. So it's asking about things like  
12 are you reunited with your family, are you  
13 seeking employment, do you have stable housing,  
14 are you reunited with family. Are you, you know,  
15 reconnecting with social institutions like church  
16 or other important.

17           So again, it's an outcome measure,  
18 helps you measure folks as they're moving towards  
19 recovery. It's patient-centered, patient-  
20 focused.

21           CO-CHAIR GOLDEN: You're advocating it  
22 could be useful to some programs for the

1 consideration for a concept.

2 MEMBER KELLEY: Yes.

3 CO-CHAIR GOLDEN: Type of comments.

4 MEMBER KELLEY: It's a measure  
5 concept, not as a measure.

6 MEMBER RYAN: Also, we agreed with  
7 what you say. The group felt it was one of the  
8 rare outcome measures. I guess we just felt like  
9 the feasibility of a proprietary measure being  
10 used by Medicaid. That was really the only,  
11 really the main concern. We didn't think it was  
12 appropriate to --

13 MEMBER KELLEY: At all time and each  
14 stages. I mean, there are other screening tools  
15 that are proprietary that as a Medicaid program  
16 we pay for in development screening and autism  
17 screening. Fortunately or unfortunately, we do  
18 it all. We love to find validated tools in the  
19 public domain that we don't have to pay for.

20 CO-CHAIR GOLDEN: I just want to make  
21 sure I'm not out of school here, I'll check with  
22 Peg and the staff. If we were doing a required

1 measure, prior proprietary measure would be  
2 precluded if we were looking for tools and a  
3 proprietary measure is an option. Would that be  
4 a fair way to say it?

5 DR. TERRY: I would say that we could  
6 use them. I mean, I think we've actually now  
7 looked at some from 3M, as well as the PAM, which  
8 was, you know, endorsed. So yeah.

9 MS. MUNTHALI: But I do want to remind  
10 you that we don't endorse tools. We endorse the  
11 performance measures that are based on the tools.

12 DR. TERRY: Yeah, sorry.

13 CO-CHAIR GOLDEN: Do we have other  
14 comments on this measure.

15 CO-CHAIR MOORE: So do we know that  
16 this is proprietary? Because it was funded  
17 through and RO1 through NIH. So it has, there's  
18 a large element that has to be publicly  
19 available. And also to clarify, I went to a  
20 resource I have when I was at AHRQ. It's not an  
21 AHRQ measure.

22 AHRQ has a clearinghouse -- did we



1 already discuss that? Okay, sorry. Anyway. But  
2 it's been funded by NIH, so I'd like to clarify  
3 whether or not it really is proprietary. It has  
4 a registered trademark, but that could just be in  
5 terms of name, not necessarily analysis.

6 But going back to your point that, you  
7 know, we looked at patient activation and you  
8 know, didn't have that issue.

9 CO-CHAIR GOLDEN: Michael, do you have  
10 something?

11 MEMBER PHELAN: I see so little of  
12 adequate measures on this topic, like you were  
13 saying. And if this is one that's actually been  
14 studied at, I don't know where it's been used, or  
15 if it even has any usability.

16 But if Medicaid programs are willing  
17 to purchase this, and it actually does what it  
18 says it does, you know, this is such an area of  
19 high patient distress and things like that, that  
20 I think this can show a way of some improvement  
21 and give people some hard evidence that they're  
22 going along the improvement process.

1 I see it almost like a no-brainer,  
2 from this aspect of this disease entity that kind  
3 of ravaging our communities right now. If  
4 there's a better one out there or something  
5 that's even close to this, you know, take it and  
6 grab at it.

7 But from the people that I see on a  
8 daily basis in our EDs and stuff like that, this  
9 is, you know, probably a measure that -- and I  
10 don't know the science behind it. I don't know  
11 who's used it, has it been validated. Do you  
12 know it?

13 CO-CHAIR MOORE: Yes, I want to for  
14 the record update the, what's in the guidance  
15 document for number 46 under usability.  
16 According to ARQH, which I don't know that this  
17 is actually publically available, but this is  
18 being used across all the VAs health service  
19 research and development program system specific  
20 to mental health and substance use.

21 So it's fully integrated into the VA  
22 system, and it continues to go through testing at

1 specifically 27 treatment sites across the United  
2 States that are affiliated with the VA health  
3 system.

4 CO-CHAIR GOLDEN: Okay, Deborah.

5 CO-CHAIR MOORE: Yeah, there are  
6 publications. In Medical Care, there's a JAMA.  
7 That's all I can see right now, but I can dig  
8 deeper.

9 MEMBER KILSTEIN: I just want to  
10 confirm, though, we're talking about approving  
11 this as a concept only, so that we're saying the  
12 idea of doing some kind of screening to identify  
13 people as they approach recovery is worthwhile,  
14 but we're not necessarily endorsing this tool or  
15 any other tool to do that.

16 CO-CHAIR GOLDEN: I think technically  
17 we would be saying that we are endorsing the idea  
18 of using the BASIS tool to track progress in  
19 recovery. But it's not a mandated activity, it's  
20 something that one can consider in your local  
21 programs.

22 MEMBER KILSTEIN: Well, none of these

1 are mandated, right. So I mean, yeah, okay.

2 MS. GORHAM: Just for terminology  
3 purposes, we are not endorsing anything. We are  
4 recommending to CMS.

5 CO-CHAIR GOLDEN: Jennifer and I will  
6 learn this by the end of tomorrow. Other  
7 comments or questions on this one? On the phone,  
8 anybody want to say anything on the phone?

9 MEMBER SCHIFF: This is Jeff. I just  
10 want to pile on a little bit. A tool that gets  
11 at some of the social determinants is I think a  
12 worthwhile thing for us as we try to integrate  
13 those into our value-based purchasing products.  
14 Thanks.

15 CO-CHAIR GOLDEN: And another comment,  
16 Allison.

17 MEMBER HAMBLIN: So I don't know about  
18 others, I feel like I'm doing like a speed  
19 education here, trying to read through this  
20 BASIS-24 and trying to understand it. And I  
21 agree that it seems incredibly promising, and I  
22 want to underscore the desire to see some type of

1 measures that address social determinants, both  
2 in this program area, as well as in the BCN  
3 program area.

4 I didn't have a chance to make this  
5 comment before, and I think there's sort of a  
6 very regrettably lack of measures in the BCN area  
7 that address sort of the concept of social  
8 determinants at all. And so I would really  
9 appreciate if the final report would acknowledge  
10 that, recognizing that perhaps it's due to just a  
11 lack of validated measures at this point.

12 But there should be an aspiration to  
13 move towards including some measures of social  
14 determinants of health in the BCN group. And so  
15 wrapping it up back to the SUD measure here, it  
16 maybe, I mean the group may feel like they can  
17 vote on this measure perhaps folks need to spend  
18 more time understanding what this tool is.

19 And in the absence of recommending the  
20 addition of this measure, it could also be a  
21 comment that there's a recommendation to CMS to  
22 explore tools like this further, and the science

1 behind these tools further to ultimately include  
2 them in this list.

3 CO-CHAIR MOORE: I just want to  
4 clarify that it has been validated. It has  
5 undergone reliability and validity testing, it's  
6 been published. It just appears that the  
7 developer has never taken it through NQF process.

8 But it has publications in Medical  
9 Care and JAMA about reliability and validity  
10 testing. And then the VA has also published  
11 extensively on the impact of this measure in  
12 their population.

13 MEMBER HENNESSEY: Yeah, I would just  
14 add I'm on the McLean Hospital, and they've got a  
15 site called eBASIS, B-A-S-I-S, and they list  
16 their tools, one of which is the BASIS-24.

17 CO-CHAIR GOLDEN: Are we ready to  
18 vote? Final last comments? Vote time.

19 MS. MURPHY: All righty, this is  
20 mental health substance use mean of patients'  
21 overall change on the BASIS-24 survey. This is  
22 Measure number 46 on your discussion guide.

1 We're going to be returning to our clicker vote.

2 If you would like to select high for  
3 to what extent does this measure address critical  
4 quality objectives of the CMS quality measurement  
5 domains and/or identify program area key  
6 concepts, please press one. For medium, please  
7 press two, and for low please press three.

8 (Voting.)

9 Okay, we're waiting for one more vote  
10 on the phone. Eighty percent of the 20 voting  
11 members voted high, 15% voted medium, and five  
12 percent voted low.

13 Moving on to the next step, to what  
14 extent will this measure address an opportunity  
15 for improvement and/or significant variation in  
16 care? If you would like to vote high, please  
17 press one; medium press two; or low, please press  
18 three.

19 (Voting.)

20 We're just waiting on one more over  
21 the phone.

22 MS. MURPHY: Sarita, if it's easier

1 for you, you're welcome to call out your vote  
2 over the phone. It is entirely up to you,  
3 however.

4 CO-CHAIR GOLDEN: She's among friends.

5 MEMBER MOHANTY: I'm sending the  
6 emails. Maybe it's just there's a delay, I  
7 think. I'm trying to send them as soon as you  
8 say vote, so maybe it's just not coming through  
9 that quickly. But I'll be voting high for this  
10 one.

11 MS. KUWAHARA: Sixty percent of the 20  
12 voting members selected high, 30% selected  
13 medium, and ten percent selected low.

14 MS. BUCHANAN: One moment. We're  
15 working with our voting slides, which are being a  
16 little finicky.

17 MS. KUWAHARA: Okay for vote number  
18 three, to what extent does this measure or  
19 concept demonstrate efficient use of resources  
20 and/or contribute to alignment? Please select  
21 high -- I'm sorry, please select one for high,  
22 two for medium, or three for low.



1 (Voting.)

2 MEMBER KILSTEIN: Require, unless you  
3 have an EMR that captures the survey results,  
4 this would require chart review? Just wanted to  
5 make sure I understand it.

6 MEMBER HAMBLIN: Similar to the PAM.

7 CO-CHAIR GOLDEN: It's a bit of a  
8 survey date, I would think also, isn't it? Yeah,  
9 so. I guess we're missing a vote or two?

10 MS. KUWAHARA: We're missing one, I  
11 think. We're about to get it in just a moment.

12 CO-CHAIR GOLDEN: Alex Trebek is  
13 getting nervous.

14 MS. MURPHY: Sarita, can you --

15 MEMBER MOHANTY: Are you still waiting  
16 --

17 MS. MURPHY: Yes, I haven't --

18 MEMBER MOHANTY: Okay, so I guess the,  
19 so the email thing is not working, okay. So,  
20 yeah, you can put me on high on that one as well.

21 MS. MURPHY: Great, thank you.

22 MS. KUWAHARA: Sixty percent of the 20

1 voting members selected high, 25% selected  
2 medium, and 15% selected low.

3 Moving on to the next vote, to what  
4 extent is this measure or measure concept ready  
5 for immediate use? If you would like to select  
6 high, please press one, medium press two -- or,  
7 I'm sorry.

8 MS. MURPHY: So because this is not an  
9 NQF-endorsed measure, this question still  
10 applies. I'm sorry?

11 DR. TERRY: I said it's a concept,  
12 it's not a measure at this point. Then we should  
13 take it through.

14 MS. GORHAM: So you would not vote two  
15 then, because two is for a concept.

16 DR. TERRY: But it is a measure, yeah,  
17 okay.

18 CO-CHAIR GOLDEN: Okay, so we're  
19 voting on the item. A one is a measure, a two is  
20 concept. Is that? And a three is I don't like  
21 it.

22 (Voting.)

1                   MEMBER MOHANTY: I'm sorry, is this,  
2 I'm sorry, did you say, this is a measure, or is  
3 this a concept? I think I got a little confused  
4 about the distinction here.

5                   CO-CHAIR GOLDEN: It is an item for  
6 reconsideration. If it's already an existing  
7 measure, it's a measure, all right.

8                   DR. TERRY: That's right.

9                   MS. GORHAM: And we just determined,  
10 based on what Jennifer reported, that this is a  
11 measure.

12                   MEMBER MOHANTY: Thank you. So my  
13 vote is high.

14                   CO-CHAIR GOLDEN: All right, we have  
15 to vote. That's fine. Appreciate it.

16                   MS. KUWAHARA: Voting is open.

17                   CO-CHAIR GOLDEN: We got her voice  
18 vote, right?

19                   MS. KUWAHARA: So we -- oh, there we  
20 go. Sixty percent of members, I'm sorry, sixty  
21 percent of the 20 voting members selected high.  
22 Twenty-five percent selected medium, and 15%

1 selected low. It's 60% high.

2 DR. TERRY: Was unclear, because you  
3 were saying it's a measure. It's either high or  
4 a zero.

5 CO-CHAIR MOORE: So I guess the  
6 question is why do we vote on this one if it's a  
7 measure. Because the question is essentially is  
8 this a measure, yes or no. Is this a concept,  
9 yes or no. So I think that's the confusion,  
10 because --

11 MS. GORHAM: Yeah, so this would be  
12 the same as what we said earlier about the NQF  
13 measure. So it's just kind of defaults. And so  
14 we know that we can just pass this because you're  
15 going to go to the next question in the decision  
16 logic.

17 CO-CHAIR GOLDEN: It has passed, so.  
18 So go to the last item.

19 MS. KUWAHARA: To what extent do you  
20 think this measure is important to state Medicaid  
21 agencies and other key stakeholders? If you  
22 would like to select high, please press one,

1 medium, two; or low, three.

2 CO-CHAIR GOLDEN: And does our phone  
3 colleague want to throw their vote in?

4 MS. MURPHY: We're also waiting on --  
5 Andrea, I don't know if you've sent your vote  
6 yet, but we haven't received it.

7 MEMBER MOHANTY: My vote is high.

8 MS. MURPHY: Is that Andrea or Sarita,  
9 just to?

10 MEMBER MOHANTY: Oh, sorry, Sarita.

11 MS. MURPHY: Hi Sarita, okay, thank  
12 you.

13 MEMBER GELZER: And I just sent mine  
14 as well.

15 MS. MURPHY: Thank you, Andrea.

16 MS. KUWAHARA: Sixty-five percent of  
17 the 20 voting members voted high, 25% voted  
18 medium, and ten percent voted low. And this  
19 measure will be recommended for inclusion in the  
20 SUD measure set.

21 MS. GORHAM: So before we do that, I  
22 just want to clarify. It's late in the day, so

1 bear with us for one minute. So let's go back  
2 for a minute. We discussed the fact that the NQF  
3 measure kind of defaulted through because we knew  
4 that it was used in the states according to what  
5 our immediate use question states.

6 For this particular measure, we do  
7 need to look at whether it is used in the states.  
8 So is it ready for immediate use. So we do need  
9 to actually go back to that question and vote,  
10 because we need to answer the question, I'm going  
11 to steal Bill's decision logic just so I can get  
12 the wording correct.

13 So to what extent is this measure or  
14 concept ready for immediate use. So we know that  
15 it is a measure, but the measure, a fully  
16 developed measure, we know that is currently in  
17 use or planned to be used in states. Or low, it  
18 could be a measure that is not used or planned  
19 for use in Medicaid populations.

20 So what I didn't hear in the  
21 conversation, and maybe I missed it, correct me  
22 if I'm wrong, is this measure used now or planned

1 to be used in the Medicaid population. That's  
2 what we need to vote on, the immediate use piece.

3 CO-CHAIR GOLDEN: Well, no, I  
4 interpreted it differently, so maybe help me out  
5 here. I thought is it sufficiently specified and  
6 available that it can be used now. And that's  
7 different than is it already in use.

8 DR. TERRY: No, is it ready.

9 CO-CHAIR GOLDEN: Yeah, can you take  
10 it off the shelf. Can somebody go tomorrow and  
11 use it? So we're having heads nodding and  
12 shaking.

13 DR. TERRY: So it is a little  
14 confusing. I think the difference between this  
15 measure and an NQF-endorsed measure is we can  
16 attest to that, because it's come through our  
17 process. Even though this is a fully specified  
18 measure, we haven't, we don't know. We just know  
19 the information that was there, so.

20 CO-CHAIR GOLDEN: However, it is being  
21 used at the VA.

22 CO-CHAIR MOORE: Yeah, it is in the

1 AHRQ Clearinghouse, which would imply that it's  
2 gone through their process to identify that it  
3 can be used.

4 MS. MUNTHALI: But it's not NQF. We  
5 can attest to the NQF process.

6 CO-CHAIR MOORE: Yeah.

7 MS. MUNTHALI: But there's an  
8 implication that it has, but we can't. And you  
9 can say yes or no, but I mean, that's why we have  
10 to go through the process to decide.

11 CO-CHAIR MOORE: Yeah, I mean from my  
12 perspective, while I value NQF, I also recognize  
13 that others could also identify that a measure  
14 can be used. So for me personally, I feel like I  
15 can trust our process.

16 MEMBER PHELAN: I'm not sure ARHQ does  
17 that. I think that's just something you could  
18 self-nominate a measure to. I don't think --

19 CO-CHAIR MOORE: You can self-  
20 nominate, but there's a process. They just don't  
21 automatically get put into the clearinghouse.

22 CO-CHAIR GOLDEN: You've got to submit



1 a dossier.

2 MEMBER PHELAN: Right.

3 CO-CHAIR MOORE: And it goes --

4 MEMBER PHELAN: But I'm not sure  
5 anyone does any --

6 CO-CHAIR MOORE: Yes, they do.

7 MEMBER PHELAN: Oh, they?

8 CO-CHAIR MOORE: Yeah, it has to go  
9 through a review. The whole intention is to make  
10 sure that there's a repository of measures that  
11 meet certain criteria that can be utilized, that  
12 may or may not be ready for NQF endorsement. But  
13 it's to get things moving.

14 MEMBER PHELAN: Can someone ask the,  
15 from NQF reach out to Dr. Eisen and say, have you  
16 ever thought about submitting this as an NQF  
17 measure. She may not know that that's an avenue  
18 to get something like this promoted.

19 DR. TERRY: Yeah, it's a very good  
20 point, because people think it's an important  
21 measure. So thank you.

22 MEMBER SHAW: I'm not sure if I'm

1       begging the question here on this. I'm trying to  
2       follow the logic. So are we saying that if it's  
3       not already in use, we can't move it forward as  
4       ready for use ever, as either a measure or a  
5       measure concept? Reading the words, it looks  
6       that way. Nothing new is ever going to be ready  
7       for use?

8                   DR. TERRY: Well, if it's NQF and it's  
9       just gotten through, it could be ready for use.  
10      It's not always used. That's one way. But this  
11      one is apparently used in the VA and other  
12      places. So we know it's in use. So I don't know  
13      if that answers it, John.

14                   CO-CHAIR GOLDEN: Yeah, I think the  
15      second bullet below is a measure that's not in  
16      use or planned to be used in Medicaid. One could  
17      argue that a VA population is Medicaid-like. So  
18      there would be, I mean, maybe that needs to be,  
19      that bullet might need to be tweaked. Because  
20      the second bullet is nobody can use it, or it's  
21      not, there's no specs, so.

22                   Okay, so we're being asked to vote.

1 We have -- okay, have we voted on number 5? I  
2 just want to make sure. Have we voted on the  
3 fifth item too or not? Where have we voted?

4 MS. KUWAHARA: Oh, yes, we're done  
5 with this measure.

6 CO-CHAIR GOLDEN: No, we're not. I'm  
7 having a request for a revote on item 4.

8 DR. TERRY: Item 4, please.

9 CO-CHAIR GOLDEN: I will, without  
10 discuss, we will vote on item 4.

11 DR. TERRY: And we just want to  
12 clarify, this is either a measure or it's not. I  
13 mean we're not going to vote on it as a measure  
14 concept at this point, because we have  
15 information, more information. So. Two is not  
16 an option.

17 CO-CHAIR GOLDEN: So ready, have we  
18 opened?

19 MS. KUWAHARA: Polling is now open.  
20 If you would like to select high, please press  
21 one, or low, please press three.

22 (Voting.)

1 CO-CHAIR GOLDEN: I don't follow that  
2 at all, no.

3 MEMBER SCHIFF: Bill, can I say  
4 something? I'm just wondering if we're getting a  
5 little confused between the tool and the measure  
6 itself. Because it seems like we have a  
7 validated tool but we don't have a measure that's  
8 been endorsed yet on what the change in the score  
9 means.

10 CO-CHAIR GOLDEN: Yeah, I have to say  
11 that I'm a little concerned that medium is still  
12 a valid vote. Because one is a, scientific  
13 testing for a measure is one thing. Medium says  
14 it's actually, you know, it hasn't formally been  
15 tested, but people are using it for whatever  
16 purposes in their environments, which.

17 Right, and that's what I think that  
18 one does. I think that's the whole direction of,  
19 you know. I think that to some extent, the  
20 fourth bullet, the fourth question is more of a  
21 technical question than it is a vote.

22 CO-CHAIR MOORE: I agree. I think

1 that's a really good point.

2 CO-CHAIR GOLDEN: So that's where  
3 we're getting hung. I mean it either has been  
4 tested to scientific validity, a la NQF  
5 standards. It is in use, and people are using it  
6 and getting, for whatever purposes. Or it's not  
7 really, or it's truly just out there kind of  
8 floating around.

9 And I think that there are, as we said  
10 earlier, there are some perfectly useful  
11 measurement devices that haven't met NQF testing.  
12 And probably never will. So it's almost a  
13 technical assessment as opposed to an opinion  
14 poll.

15 CO-CHAIR MOORE: And I think there's  
16 a need to define terms that are in this question  
17 too.

18 CO-CHAIR GOLDEN: So tell you what.  
19 Why don't we -- well, we can have this, this is a  
20 happy hour discussion. We could have a parking  
21 lot, the happy hour. I think that the measure  
22 has passed, with the exception of what level of

1 item it is on the fourth bullet.

2 We can discuss that later. Let's put  
3 that aside for now. And we can back to that.  
4 That's a technical nuance.

5 So let's go to the, I think we're done  
6 with this measure or this item. So let's go to  
7 the pediatric psychosis before we go there  
8 ourselves.

9 MS. MURPHY: Great. Thank you, so  
10 moving on to the next measure that was selected  
11 for reconsideration by a member of the  
12 Coordinating Committee. We'll review NQF Measure  
13 number 2806, for reference that is number 58 on  
14 your discussion guide. The measure title is  
15 Pediatric Psychosis, Screening for Drugs of Abuse  
16 in the Emergency Department.

17 The description of the measure is  
18 percentage of children or adolescents aged five  
19 to 19 years old seen in the emergency department  
20 with psychotic symptoms who are screened for  
21 alcohol or drugs of abuse.

22 The numerator is eligible patients

1 with documentation of drug and alcohol screening  
2 use, using urine drug or serum alcohol tests.  
3 The denominator is patients aged five to 19 years  
4 old seen in the emergency department with  
5 psychotic symptoms.

6 So the TEP agreed that, the TEP's  
7 objection to this measure was around the premise  
8 of the psychosis screening. They felt that  
9 unless a person already has an existing diagnosis  
10 of psychosis, usually children will receive a  
11 health screening first. And if the screening is  
12 negative, will then be referred to the  
13 psychiatrics for the psychiatric screening.

14 The TEP did, however, note that they  
15 thought it addressed a critical population that's  
16 often under-represented in SUDs measurement.

17 But they also felt that the practice  
18 was a minimum standard of care. This wasn't  
19 anything above and beyond, they didn't feel it  
20 addressed a critical measurement gap. But that  
21 this is already being done and should be standard  
22 practice already.

1                   So we can open it up for discussion.  
2                   The lead discussant on this was Karen Amstutz.  
3                   Karen unexpectedly couldn't be with us today. So  
4                   if anybody else would like to jump in and discuss  
5                   this, please feel free.

6                   MEMBER PHELAN: I can speak a little  
7                   to this because I'm an emergency medicine  
8                   physician. There is no one that comes in with  
9                   psychosis that doesn't get a substance abuse  
10                  screening. That just, I can't call a  
11                  psychiatrist, I can't get a psych bed outside  
12                  without having.

13                  Because they'll call and say, Oh, you  
14                  didn't get us a urine tox screen yet. You're  
15                  like, they're ten, they haven't peed yet. I  
16                  don't think they've got it. And they still, they  
17                  are very resistant to take these patients because  
18                  they have protocols that they follow.

19                  Now I know the people behind the  
20                  scene, so I'm usually able to call and you know,  
21                  call Marymount or wherever I'm at, and say, I  
22                  can't get a urine. Can you accept her? If she



1 pees for us in the next nine hours, I'll send it  
2 over. But can we go over process going?

3 So I'm not sure there's, and I mean,  
4 and I don't know, and I have colleagues all over  
5 the country. We all complain about the  
6 standardized psychiatric screening eval. There's  
7 no child that would have psychosis and being  
8 needing mental health screening that wouldn't get  
9 the substance abuse screening and the alcohol  
10 screening up front. So.

11 CO-CHAIR GOLDEN: The question is  
12 you're not debating the appropriateness. You may  
13 be saying that the practice variation is small  
14 and the question is, is it universal. And I  
15 mean, does every ER do it. And you're pretty  
16 confident they do?

17 MEMBER PHELAN: Very confident. You  
18 can't get a psych bed without doing the  
19 prescreening, so.

20 CO-CHAIR GOLDEN: So you would be  
21 concerned that this would be difficult for the  
22 second item.

1 MS. MURPHY: Just for some context,  
2 the TEP voiced the same exact concerns. And they  
3 also failed this on the first item in the  
4 decision logic, which was addresses a critical  
5 quality objective.

6 CO-CHAIR GOLDEN: Thank you. Do we  
7 have --

8 MEMBER SCHIFF: Bill.

9 CO-CHAIR GOLDEN: Yes. Is that Jeff?

10 MEMBER SCHIFF: Yeah, from the  
11 pediatric yard, I just want to, I second that.  
12 And I'm also curious when this was approved  
13 whether, where the --

14 CO-CHAIR GOLDEN: It wasn't approved.  
15 It was approved, this was for reconsideration.

16 MEMBER SCHIFF: No, it was an approved  
17 as an NQF -- and then when it was approved as an  
18 NQF measure, where the gap was. Because it seems  
19 like, I agree that that screen would always be  
20 done.

21 And then it gets into a secondary  
22 thing, which is the drugs or abuse screen misses

1 things like LSD and mushrooms and rohypnol and  
2 those sort of things. So you have to wonder  
3 what's an adequate screen depending on symptoms.  
4 So I don't think this is a good, I think it could  
5 fail on the first bullet because it's not a big  
6 gap.

7 CO-CHAIR GOLDEN: Okay, any other  
8 comments in the room or on the phone? In the  
9 room or on the phone? I think we're ready to  
10 vote.

11 MS. KUWAHARA: This is Measure number  
12 58, NQF number 2806, Screening for SUD in Child  
13 and Adolescents with Psychosis. For the first  
14 vote, to what extent does this measure or measure  
15 concept address the CMS quality measurement  
16 domains and/or program area key concepts?

17 Polling is now open. If you would  
18 like to select high, please press one. Medium  
19 two, or low, three.

20 (Voting.)

21 Eleven percent of the 19 voting  
22 members selected high, 16% voted medium, and 74%

1 voted low. So this measure will not be  
2 recommended for inclusion in the SUD measure set.

3 CO-CHAIR GOLDEN: Okay. And we will  
4 move on to the next item. So this goes to use of  
5 opioids at high doses. And Cheryl, you want to  
6 make some comments?

7 MEMBER POWELL: Yes, I think this  
8 group basically felt that --

9 CO-CHAIR GOLDEN: All right, it's  
10 number 61 in the massive big list.

11 MEMBER POWELL: One of the members who  
12 is active in treating opioid patients felt that  
13 the CDC guidelines is really 90 milligrams is  
14 considered a high dose, and not the 120. So that  
15 the measure, it includes a level of opioid use  
16 that is really out of, not in the standard of  
17 care at this point.

18 So that was the main issue there. And  
19 we felt like couldn't change the measure to  
20 reflect 90 milligrams versus 120. We were  
21 limited to what we had.

22 MEMBER GELZER: This is Andrea. These

1 are for individuals with cancer pain.

2 DR. TERRY: No, this excludes,  
3 specifically excludes patients with cancer or who  
4 are on hospice.

5 MS. MURPHY: So just for a little bit  
6 of background, we can jump into discussion.  
7 There are two very similar measures to this that  
8 were recommended and are in the set now, and we  
9 have the opportunity to discuss those later.

10 This measure is specified for use of  
11 opioids at high doses from multiple providers in  
12 persons without cancer. In the recommended set,  
13 we have use of opioids at high doses and use of  
14 opioids from multiple providers. So this is both  
15 of those together.

16 Also, I will note that Cheryl Powell,  
17 we have two Cheryls here, was the one who opted  
18 to retain this measure. So we'll Cheryl give her  
19 reasoning, and then open it up for conversation.

20 MEMBER FINESTONE: I just have one  
21 clarification. Yeah, it's without.

22 MS. MURPHY: Oh, I'm very sorry about

1 that.

2 MEMBER FINESTONE: It's incorrect,  
3 yeah.

4 MS. MURPHY: It is without cancer, not  
5 with cancer, yes.

6 CO-CHAIR GOLDEN: All right, Cheryl.

7 MEMBER POWELL: Yeah, so the reason  
8 that I asked for this one to be reconsidered was  
9 I noticed that there were the others, and I  
10 wanted to know the reasoning about the why those  
11 two and not this one, particularly this one. And  
12 it was 2950 had the same score.

13 And from the notes that we had that I  
14 could find, I couldn't tell why one and not the  
15 other and why two and not the other. So it was  
16 really more just to open up the discussion about  
17 the three and to understand the reasoning for why  
18 those two were better than this one. That was  
19 really, I mean, I only saw the one.

20 I think you said two, but I was having  
21 trouble understanding the difference and wanted  
22 to hear about what that discussion was from that

1 TEP. That was it.

2 CO-CHAIR GOLDEN: So let me ask a  
3 question to someone. So five years ago, I'd say  
4 this is great. From my perspective now, this is  
5 becoming less relevant because most plans, most  
6 Medicaid programs are putting prescribing limits  
7 into operation so you can't get, under the  
8 Medicaid program, more medication paid for.

9 But you can certainly do it by cash.  
10 So then you get into what's in the PMP items.  
11 And there are laws being passed now to require  
12 accessing the PMP directories before you  
13 prescribe the opioids.

14 So while the concept here is good, the  
15 question is, is it reflective of what the current  
16 way of managing this problem currently is. And  
17 so maybe other folks can comment about whether or  
18 not this will be a useful tool or just another  
19 redundant tool on top of something that would be  
20 managed administratively. Judy or?

21 MEMBER WALLACE: This is Susan  
22 Wallace, and I would just echo that. But yeah,

1 this is a quickly becoming a moot point, just  
2 because of the kind of regulations. At least in  
3 the State of Ohio, we've got a number, we have at  
4 least 15 or 20 now different legislative  
5 regulatory initiatives to tighten up the  
6 prescribing of opioids. So I'm not sure this  
7 could even happen in a lot of cases in some  
8 communities.

9 MEMBER PHELAN: I still think there is  
10 value in keeping this measure on, even though it  
11 may seem redundant or a mute point across maybe  
12 your platform and our platform, because I'm in  
13 Ohio.

14 But I still think this idea that this  
15 is a decent measure of over-prescribing, and if  
16 people want to look to it and point to it, they  
17 can say, The over-prescriber right here, it's  
18 more than 30 in your plan, or that you're higher.  
19 We need to get that number down, we need to go  
20 and address providers.

21 So I think some plans may want to keep  
22 that in there. And they may choose from a



1 measure set or a toolkit and say, You know what,  
2 this is going to really help us in New Mexico,  
3 because we're not as advanced as Pennsylvania or  
4 Ohio right now. Let's use this. So I still  
5 think there's value in it.

6 MEMBER KELLEY: I would agree. We  
7 actually have run this measure, and we also  
8 looked at varying MMEs. So we started with 120,  
9 we went down to 90, we went down to 50. We ran  
10 it across our entire Medicaid population. That  
11 will tell you there were a lot of folks that were  
12 over 120.

13 We are in the process of helping, or  
14 might could say forcing, but helping our managed  
15 care plans that are managed that -- I'm thinking  
16 that there were at least ten or eleven thousand  
17 people in 1.2 million adults. About ten thousand  
18 that were on and above 120 MMEs.

19 So it's a valuable tool, because  
20 unfortunately, the prescribing has happened. And  
21 we now have ten thousand individuals that are  
22 already on this high dose. So, and our managed

1 care plans are using this as a tool to say, You  
2 know what, we need to be judicious. We are, for  
3 new starts that we know of, we're going to start  
4 at a lower.

5 But we know we have this population,  
6 and we're going to have to titrate and manage  
7 them. So there is value. Even though it's above  
8 the current CDC guidelines, we have found a lot  
9 of value.

10 We want to do this judiciously, and  
11 we've told our plans this is not about denial,  
12 denying claims. This is about identifying those  
13 individuals with these high MMEs and working with  
14 them to wean and get them into better pain  
15 management.

16 CO-CHAIR GOLDEN: Again, a technical  
17 question. So Tara, do we have other measures?  
18 Because I suddenly looked at the numerator, and  
19 it's high MME and more prescribers and four  
20 pharmacies. Is that something --

21 MS. MURPHY: So yes.

22 MEMBER ZERZAN: And it appears that

1 the two measures that are in are high doses and  
2 multiple providers.

3 CO-CHAIR GOLDEN: Right.

4 MEMBER ZERZAN: And so I feel like  
5 that, my comment was going to be that sort of  
6 nicely separates the two issues. One's a  
7 prescriber problem, one's a person problem, that  
8 you need to offer addiction treatment or do other  
9 things. And that the actions are very different  
10 in them.

11 I'd also say that Colorado Medicaid's  
12 at 300 MME limit. We're moving down to 250, but  
13 90 is way low, and we have a lot of pushback on  
14 it. So baby steps.

15 CO-CHAIR GOLDEN: But looking at the  
16 numerator as specified, the number of people that  
17 would hit all three of those in the numerator  
18 would be very tiny.

19 MS. MURPHY: So I just wanted to chime  
20 in with a little more detail on the TEP's  
21 conversation. I think, similar to what a lot of  
22 you are saying, they noted that in their

1 experience, something like this is usually  
2 measured in terms of a flat number, and rarely a  
3 rate.

4 And they found that that might not  
5 work so well, that that could undermine this  
6 measure's suitability for use in the Medicaid  
7 population.

8 They also mentioned that it didn't  
9 seem to them as though the numerator and  
10 denominator really went together very well. They  
11 thought there were some issues with the  
12 specifications. So I just wanted to raise those  
13 points.

14 CO-CHAIR GOLDEN: Michael.

15 MS. MURPHY: Microphone, please.

16 MEMBER PHELAN: The staff preliminary  
17 review gave, the measure was tested in different  
18 health plans, so the Medicaid population, the  
19 mean was 23 per thousand. So is that what you're  
20 referring to, that that number wouldn't be  
21 appropriate?

22 CO-CHAIR GOLDEN: 2.3.

1 MS. MURPHY: Right, I can't really  
2 speak exactly from their thoughts. But from my  
3 memory of the conversation, it was that they felt  
4 that this was usually provided as a flat number,  
5 there were X number of prescribers within some  
6 body. It wasn't as a rate, it wasn't per 1,000  
7 or per 100.

8 CO-CHAIR GOLDEN: All right, are there  
9 people in queue? Oh, you are, okay.

10 MEMBER HENNESSEY: Yeah, just as a  
11 point of clarification. Isn't this a NQF-  
12 endorsed measure? Yeah, that's what I thought.

13 MS. MURPHY: Yes.

14 MEMBER HENNESSEY: And it is a rate  
15 per thousand, that's my understanding.

16 CO-CHAIR GOLDEN: And Cheryl.

17 MEMBER POWELL: I just wanted to ask  
18 David, but I'll wait. Sorry, David, when you  
19 said you use this measure, which one of the three  
20 did you use, or did you use something slightly  
21 different?

22 MEMBER KELLEY: We've done all.

1                   MEMBER POWELL: All. All three? Is  
2 one better than the other? Is there a reason why  
3 this one should be left off and the other two  
4 kept, just from your experience? I thought that  
5 would be helpful.

6                   MS. GORHAM: David, please cut your  
7 mic on.

8                   MEMBER KELLEY: Reflects really, this  
9 measure reflects kind of the problematic  
10 individuals that are both on a high dose and  
11 they're doctor and pharmacy shopping. And to the  
12 point earlier, yeah, you can find the high dose  
13 and then you can find the people that are doctor-  
14 shopping. This combines it.

15                   I mean, these are people that I would  
16 tell my managed care plans, You guys need to  
17 really figure out what's happening with them.  
18 These are not people that you just carte blanche  
19 deny the next prescription, you need to get them  
20 in the lock-in or you need to get them into pain  
21 management. And then you need to work with and  
22 get them to behavioral health.

1                   So it is a, I think the 10,000 I  
2                   quoted was actually, I think that was the high  
3                   dose measure. When you combine it the number  
4                   goes down. But these are patients that, from a  
5                   managed care plan, this is a sweet spot. I'm  
6                   going to, right to these individuals, because I  
7                   need to really figure out what the heck is going  
8                   on.

9                   And I need to talk the PCP, I need to  
10                  talk to their four prescribers. Hopefully,  
11                  they're using the, we call it the PDMP in our  
12                  state. So, there's value to all of them. And we  
13                  don't make our managed care plans do this. Some  
14                  of them are already doing it.

15                  But as a program, we have started to  
16                  this. We're going to do it on an annual basis.  
17                  We actually had University of Pittsburgh run it  
18                  for us in our claims data.

19                  CO-CHAIR GOLDEN: Andrea, you have  
20                  something to say.

21                  MEMBER GELZER: Yeah, I would just  
22                  add, and I agree with all of those comments. And

1 I think it is valuable to retain this measure.  
2 And I think there may even be some cross-border  
3 issues with registries, such that while you might  
4 think, if you have a regulation in the state and  
5 a requirement to check the registry in your  
6 state, you may not be catching all these  
7 different providers.

8 I think it's valuable. I think the  
9 measure's valuable

10 CO-CHAIR GOLDEN: Other comments  
11 before we go to vote? Phone, room? Room, phone?  
12 Okay, let's vote. Oh, got something, Deborah?

13 MEMBER KILSTEIN: It's not going to  
14 catch everybody the way it's drafted now is  
15 because managed care plans are going to use their  
16 claims data, and they don't have access to the  
17 PDMP.

18 So they could only know what they paid  
19 for it, they can't tell what the patient paid  
20 cash for. So this is, if you're catching  
21 somebody with this, they're probably actually  
22 much worse.



1 CO-CHAIR GOLDEN: Okay, vote.

2 MS. KUWAHARA: This is Measure number  
3 61, NQF 2951, Use of Opioids at High Dosages from  
4 Multiple Providers in Persons without Cancer.

5 To what extent does this measure or  
6 measure concept address critical quality  
7 objectives of the CMS quality measurement domains  
8 and/or identified program area key concepts? For  
9 high, please vote one; medium, two; or low,  
10 three.

11 (Voting.)

12 MS. KUWAHARA: Seventy-nine percent of  
13 the 19 voting members voted high, five percent  
14 voted medium, and 16% voted low. We'll move on  
15 to the next step.

16 To what extent will this measure  
17 address an opportunity for improvement and/or  
18 significant variation in care? Please select one  
19 for high, two for medium, or three for low.

20 (Voting.)

21 MS. KUWAHARA: Fifty-eight percent of  
22 the 19 voting members selected high, 21% voted

1 medium, and 21% voted low.

2 To step number 3, to what extent does  
3 this measure -- I tried to get my place. To what  
4 extent does this measure demonstrate efficient  
5 use of measurement resources and/or contribute to  
6 alignment of measures across programs, health  
7 plans, and/or states? For high, please select  
8 one; medium, select two; low, select three.

9 (Voting.)

10 MS. KUWAHARA: Forty-seven percent  
11 selected high, 26% selected medium, and 26%  
12 selected low. Because this measure is NQF-  
13 endorsed, we're going to skip this question  
14 because it would be high.

15 To what extent do you think this  
16 measure is important to state Medicaid agencies  
17 and other key stakeholders? Press one for high,  
18 two for medium, or three for low.

19 (Voting.)

20 MS. KUWAHARA: Sixty-three percent of  
21 the 19 voting members selected high, 32% selected  
22 medium, and five percent selected low. This

1 measure will be recommended for inclusion in the  
2 SUD measure set.

3 CO-CHAIR GOLDEN: So now, if I get  
4 this correct, we're supposed to have public  
5 comment. And wait a second here, let me just  
6 look at my agenda. Yeah, so we have to -- do you  
7 want to do public comment now, or do you want to  
8 do the entire tranche for BCN?

9 MS. MURPHY: Well, so actually our  
10 next step, this is a new step, we didn't --

11 CO-CHAIR GOLDEN: For SUD, I'm sorry.

12 MS. MURPHY: Yeah, this is a step we  
13 didn't have to do for the BCN group. But we'll  
14 be looking at some related measures. So these  
15 are measures, NQF measures, that are due for  
16 review for endorsement. The standing committees  
17 felt that these measures were related to one  
18 another.

19 So we've created some tables that my  
20 colleagues are passing around now for your  
21 viewing pleasure. We had to wait because this  
22 was a real nail-biter, that 2951, we had some

1 contingency planning if you all struck that down.  
2 So please refer to those as we go through this  
3 next portion of the conversation.

4 MEMBER RYAN: I'd like to add to that  
5 there were, you know, we had to do each, as went  
6 down our list, we didn't know that we would, you  
7 know, approve one and then five later we'd find  
8 one that was better than the one we'd approved.  
9 And you couldn't go back and unapprove.

10 So we found that there were some that  
11 actually are probably duplicative and one is  
12 better than the other. So that happened a number  
13 of times, and I think that is one of the reason's  
14 Tara's put this together. And some were very  
15 similar. You'll see that.

16 MS. MURPHY: Yeah, you'll see. So  
17 just from the standpoint of voting, your role in  
18 this part of the process is to review these  
19 similar measure specifications or these similar  
20 measures and decide if you'd like to remove any  
21 of the measures on these tables on the basis of  
22 redundancy or a superior measure.

1 CO-CHAIR GOLDEN: So help me out here,  
2 I'm confused.

3 MS. MURPHY: Sure.

4 CO-CHAIR GOLDEN: So the SUD TEP met.

5 MS. MURPHY: Yes.

6 CO-CHAIR GOLDEN: And they approved  
7 some measures?

8 MS. MURPHY: They did. So the --

9 CO-CHAIR GOLDEN: Are these those  
10 measures?

11 MS. MURPHY: So these are a subset of  
12 those measures. So in these tables that you're  
13 looking at now, all of the measures listed here  
14 are measures that were recommended by the TEPs.

15 CO-CHAIR GOLDEN: Yeah.

16 MS. MURPHY: These measures were  
17 identified by approving NQF standing committees  
18 to be related to one another. So we've laid them  
19 out here as a chance for you to review again and  
20 potentially choose a best-in-class or two best-  
21 in-class measures.

22 There is no obligation to remove any

1 of these measures. This is simply an opportunity  
2 for you to look at them and potentially remove  
3 some redundant measures.

4 As Cheryl said, our ask of the TEP was  
5 that they reviewed measures individually, based  
6 on the merits of the individual measures. And  
7 now we're giving the Coordinating Committee the  
8 opportunity to review some of these measures that  
9 NQF committees have identified as related. Yeah,  
10 go ahead.

11 CO-CHAIR MOORE: Could Sheryl, I  
12 assume the ones that are on the page are the ones  
13 that are for comparison?

14 MS. MURPHY: Yes.

15 CO-CHAIR MOORE: So would it be  
16 possible to have Sheryl to point out the ones  
17 where as a TEP, they had conversations about,  
18 well, we can't back but this is really where  
19 we're at? So that we can expedite this?

20 MS. MURPHY: Yes, I mean, yeah.

21 DR. TERRY: It's a little bit  
22 different, my list is going to be a little bit

1 different than these tables. I'm kind of like  
2 trying to --

3 MS. MURPHY: Right.

4 DR. TERRY: But I could indicate,  
5 because I tried to pull some together. So for  
6 example, let's see if I can, okay. If you look  
7 at number 2152, now is that somewhere on these  
8 pages?

9 MS. MURPHY: Well, if it would be  
10 helpful at all, and please tell me what works  
11 best for you, I've prepared a synopsis of these  
12 measures that I think will be helpful, that kind  
13 of highlights some of the TEP's thinking and does  
14 just kind of a once-over of their similarities.

15 Would that be helpful? And then  
16 Sheryl, if you want to add any commentary.

17 DR. TERRY: 2152, I know. I'm trying  
18 to show you how I tried to clarify some of the  
19 overlap.

20 MS. MURPHY: So I think this is a  
21 great point of clarification. Our review for  
22 related measures was limited to those measures

1 that are NQF-endorsed.

2 So it's very possible that, as a  
3 member of the TEP, Sheryl recognized some other  
4 measure that was from another source that is not  
5 has not come through NQF that was related. And  
6 you will have, members of the CC will have an  
7 opportunity to remove those measures as part of  
8 the review of the final measure set. So I'm not  
9 sure exactly --

10 DR. TERRY: No, I'm comparing two NQF  
11 measures.

12 MS. MURPHY: Okay.

13 DR. TERRY: So that's not entirely  
14 true.

15 MS. MURPHY: Gotcha. Okay, so we'll  
16 definitely have time to take those considerations  
17 into account. But for the purposes of this  
18 portion of the review, we're limiting the scope  
19 of this portion to NQF measures.

20 And any member of the TEP is free to  
21 raise concerns of redundancy or related measures  
22 with the review of the final measure sets. And



1 that will come at the end, when you have the  
2 opportunity to strike measures.

3 CO-CHAIR GOLDEN: So again, everything  
4 in this document was approved by the TEP.

5 DR. TERRY: Right, correct.

6 CO-CHAIR GOLDEN: Okay.

7 DR. TERRY: They're on the list. But  
8 I don't know if you've gotten your question  
9 answered.

10 MEMBER RYAN: Well, I was trying to  
11 give an example how they would be two that we  
12 found one we found better. For example, if  
13 people can look at just, this is an example, if  
14 you look at 2152, NQF number 2152 versus NQF  
15 number 2957, okay.

16 One is screening for unhealthy alcohol  
17 use, and the other is screening for unhealthy  
18 alcohol use, but it includes and intervention.  
19 So we felt like, we took the first one, that was  
20 great. But then we were like, Hey, this one's  
21 got an intervention. So of course we would  
22 prefer the one that has the intervention along

1 with a very similar type of screening.

2 So that would be one example where we  
3 felt, in that case, maybe the first one was. Or  
4 there'd be follow-up for people with serious  
5 mental illness and alcohol and drug.

6 And then other one would be just  
7 follow-up with alcohol and drug. And we thought,  
8 Well, of course you want to do the one that has  
9 both if it's a follow-up from the ED. So those  
10 are examples.

11 Now I haven't seen, haven't, you know,  
12 absorbed your table. But those were example  
13 where two right there you might not need the one  
14 that was similar but not quite as comprehensive.  
15 But similar in all other respects.

16 CO-CHAIR GOLDEN: So let me just --  
17 that may not be true. Because if you have, say,  
18 the one with the screen and the treatment and  
19 it's a low rate, you don't know if they didn't  
20 screen or they didn't treat, or they couldn't  
21 treat.

22 So, you know, I mean start putting in

1 treatment in with the screening. They've done  
2 that with tobacco screening, I think, in -- it  
3 gets very confusing as to what you've actually  
4 measured.

5 MEMBER HENNESSEY: But don't some of  
6 these measures actually have sub-measure  
7 components, like for example, with the tobacco  
8 one, you can get three sub-measures so you can  
9 find out whether, you know, they're doing the  
10 screening but then they're not doing the  
11 intervention.

12 So the question would be in my mind  
13 whether that's the case for the two measures  
14 you're talking about.

15 DR. TERRY: Can I suggest that we start  
16 with what we have here. And if there's some that  
17 we miss that you think we should look at, why  
18 don't we do that first thing in the morning.

19 MS. MURPHY: Yeah, so maybe Terry, you  
20 should walk people through it. I think walk  
21 through the chart would be helpful.

22 MEMBER ZERZAN: Yeah, so in like the

1 matter of time because we still have the whole  
2 next thing to go through, is this a place that we  
3 can tell CMS similar to what we did with the  
4 first set of look for parsimony and we recognize  
5 there's overlap, we like outcomes more than not.  
6 Do something smart with it.

7 DR. TERRY: Right, that's what we're  
8 trying to do there. But are you asking, is this  
9 where we're going to stop today?

10 MEMBER ZERZAN: I'm saying do we need  
11 to -- no, no. I'm saying do we need to review  
12 all this and make any decision? Or can we just  
13 say yup, we recognize there's overlap in this.  
14 Yup, these are all input alcohol screening,  
15 tobacco screening is important. CMS, you know  
16 measures as well as we do.

17 And these are only suggestions anyway.  
18 So look at these, don't have too much overlap.  
19 We like outcomes in favor of other things, but do  
20 your good work. And we'll keep working on these,  
21 especially since this is the first year of this.

22 MS. MUNTHALI: I love that idea. I

1 think you guys should do that in the interest of  
2 time. And also, just one point of clarification.  
3 These are not competing measures. So a best-in-  
4 class decision would not be very appropriate  
5 here. These are actually related measures. So I  
6 think that is very appropriate, that decision.

7 CO-CHAIR GOLDEN: Judy, I think we're  
8 actually, potentially if we do what you say,  
9 we'll be sort of ahead of schedule, which is  
10 good. David.

11 MEMBER KELLEY: I would advocate that  
12 we take Judy's approach. And again, in looking  
13 at these measures and eyeballing them, I don't  
14 really see them as competing. And states and  
15 other, you know, MCOs in other programs may say,  
16 you know, I can, at this point, I can  
17 operationalize this because it's easier.

18 But here is the menu, and CMS is  
19 offering this menu. More sophisticated  
20 organizations may go deeper and may. So I like -  
21 -

22 CO-CHAIR GOLDEN: Just talk about one

1 measure then go to the next measure in a year or  
2 two or something, yeah.

3 MEMBER KELLEY: So I think we could  
4 expedite.

5 MEMBER ZERZAN: And I definitely agree  
6 states are at different places. So that might be  
7 appropriate. And I'd also like to take credit  
8 for the time I've saved to balance off what I did  
9 earlier.

10 CO-CHAIR MOORE: I think that means  
11 you might be chair next year.

12 CO-CHAIR GOLDEN: But I think you  
13 still owe us five minutes.

14 MS. GORHAM: Since it's an agree and  
15 we all love Judy's recommendation, we'll move  
16 forward with that. I want to propose something,  
17 because we were going to stop here after this  
18 related conversation, realizing that we still  
19 have to look at the overall measure set  
20 recommended by the TEP.

21 So we can do one of two things, and  
22 it's totally optional and up to you in your

1 preference. So we can --

2 CO-CHAIR GOLDEN: I would say we  
3 should do the whole set and identify measures for  
4 potential discussion.

5 MS. GORHAM: Okay, so do we want to do  
6 that now --

7 CO-CHAIR GOLDEN: Yes, you want to do  
8 that now.

9 MS. GORHAM: Or do we want to come  
10 early in the morning?

11 CO-CHAIR GOLDEN: We'll see if  
12 anything gets pulled, and if we have lots to  
13 pull, we can carry them over. But let's see what  
14 we want to pull.

15 MS. GORHAM: Okay.

16 CO-CHAIR GOLDEN: So this will not be  
17 a democratic decision. I just said let's keep  
18 going, we're ahead of schedule, let's keep going.

19 MS. GORHAM: Just one minute to  
20 rearrange the slides just a bit.

21 CO-CHAIR GOLDEN: That's slide 94?  
22 Okay.

1                   PARTICIPANT: And for people on the  
2 webinar, I'm unloading it now. Technology is  
3 being a little slow.

4                   CO-CHAIR GOLDEN: Wow, that's a big  
5 measure set. Okay.

6                   MS. MURPHY: So while that's loading  
7 up -- oh, it's loaded. So just a brief reminder  
8 on how we're handling this review of the total  
9 measure set now. So we will go through this list  
10 of measures that's on the screen in front of you.  
11 I will provide a brief synopsis summary of the  
12 TEP's rationale for recommending the measure.

13                   If someone in the room or on the phone  
14 feels that the measure's unsuitable and they'd  
15 like to propose removing it from the set, that  
16 person should motion to remove the measure. That  
17 motion will need to be seconded in order to open  
18 the measure up for discussion.

19                   Once the committee has discussed, we  
20 will call, the chairs will call for an up-and-  
21 down vote to remove the measure from the set. So  
22 we will not need to use the decision logic.



1                   Again, as a reminder, in those  
2                   rationale, we ask that you do provide as detailed  
3                   a rationale as possible for why you feel the  
4                   measure's unsuitable. And to also try to base  
5                   that rationale in something related to the  
6                   decision logic so we can tie it back to all those  
7                   criteria.

8                   So we will start with the first  
9                   measure on our slide. This is Measure number 44  
10                  on your discussion guide. The measure is  
11                  Documentation of Signed Opioid Treatment  
12                  Agreement.

13                  The TEP unanimously voted high on all  
14                  decision logic criteria for this measure, noting  
15                  that the use of the signed opioid treatment  
16                  agreement is a standard best practice among  
17                  providers, but that the practice is rarely  
18                  reviewed and enforced as a standard of care.

19                  The TEP also noted that many EHRs  
20                  already include a standard opioid agreement that  
21                  can be easily printed and signed. The TEP  
22                  commented that the measure would use chart

1 review, which can be expensive, but that  
2 individual organizations could decide if the  
3 measure was feasible for them.

4 Are there any comments on this  
5 measure?

6 CO-CHAIR GOLDEN: Concerns or  
7 comments, anybody raising your hands, phone or  
8 room? Next item.

9 MS. MURPHY: Next item. This'll be  
10 number 45 on your discussion guide. This measure  
11 is called Evaluation or Interview for Risk of  
12 Opioid Misuse.

13 The TEP again unanimously voted high  
14 on all decision logic criteria for this measure,  
15 noting that using a validated tool for evaluating  
16 risk of opioid misuse as the measure specifies  
17 aligns with the CDC recommendations. The TEP  
18 voiced concern on the fact that the measure  
19 applies only to those in treatment for longer  
20 than six weeks, rather than at day one.

21 CO-CHAIR GOLDEN: Comments or  
22 questions on this one? Concerns? Next item.

1 MS. MURPHY: Okay. The next measure  
2 is number 47 on your discussion guide, and it is  
3 NQF number 0004, Initiation and Engagement of  
4 Alcohol and Other Drug-Dependence Treatment.

5 The TEP again unanimously voted high  
6 on all decision logic components for this  
7 measure. I promise that was not the case for all  
8 of them. The TEP noted that the measure is in  
9 widespread use, and that the initiation of care  
10 that the measure addresses is an important need  
11 to CMS and to the field.

12 Additionally, the TEP noted that this  
13 measure offers a quick capture and treatment  
14 measure as patients are given access to treatment  
15 within 14 days of diagnosis.

16 CO-CHAIR GOLDEN: Comments, questions,  
17 concerns? Okay, keep going.

18 MS. MURPHY: All right, next. This  
19 measure is number 52 on your discussion guide.  
20 It is NQF number 1664, this is SUB-3, part of the  
21 SUB group of measures, as you can see in the  
22 discussion guide. We will also review SUB-1 and

1 SUB-2.

2 SUB-3 is Alcohol and Other Drug Use  
3 Disorder Treatment Provided or Offered at  
4 Discharge. The TEP discussed the fact that this  
5 EHR measure looks at whether a prescription or a  
6 referral was offered, not whether the  
7 prescription was filled.

8 The TEP would have preferred the  
9 measure to use claims data to determine whether a  
10 prescription was filled, rather than EHR to  
11 measure whether it was offered.

12 The TEP noted that this measure  
13 exemplified the need for more outcome measures in  
14 SUD measurement, as this could easily be gamed for  
15 providers. Ultimately, however, the TEP noted  
16 that the measure would encourage physicians to  
17 consider medication assistance for substance use  
18 disorders and the underutilization of these  
19 treatments.

20 CO-CHAIR GOLDEN: Again, floor open  
21 for comments, questions, concerns? Hearing none,  
22 next item.

1 MS. MURPHY: Okay, we are flying ahead  
2 of my notes. Okay, the next is NQF Measure  
3 number 2152, this is number 53 on your discussion  
4 guide, Preventative Care and Screening, Unhealthy  
5 Alcohol Use.

6 One member of the TEP noted that the  
7 24-month time frame used in this measure could be  
8 problematic because Medicaid patients often do  
9 not have sustained enrollment for 24 months,  
10 especially within one health plan. The enrollment  
11 concerns the extent to both enrollment in  
12 Medicaid and enrollment in a singular MCO as both  
13 would impact the ability to measure the same  
14 patient over 24 months.

15 Other TEP members noted, however, that  
16 the variability across state Medicaid programs  
17 could mean the churn is not a problem, or could  
18 mean that the churn is not a problem in other  
19 states. That is to say, they felt it wasn't the  
20 case in all states, and that it could still be  
21 suitable for states that would use it.

22 The TEP was also concerned that the

1 24-month time frame created a two-year lag in the  
2 availability of the performance data, which  
3 prohibits rapid quality improvement. Ultimately,  
4 the TEP discussed the ability for the measure to  
5 continue to capture data on a patient across  
6 multiple providers within the two-year time  
7 frame, and decided that the measure addressed a  
8 critical quality issue.

9 In further measure discussions, the  
10 TEP noted that other similar screening measures  
11 were preferred over this measure.

12 CO-CHAIR GOLDEN: And what was the  
13 issue about the 24 months it's being done?

14 MS. MURPHY: So the issue with the 24  
15 months was that there was, some members of the  
16 TEP felt that patients often don't stay, they may  
17 not be on Medicaid for 24 consecutive months.  
18 And so the measure, they may not be --

19 CO-CHAIR GOLDEN: What is the 24-month  
20 requirement? I'm sorry.

21 MS. MURPHY: That would be in the  
22 measure specifications, which I can pull up.

1 MEMBER RYAN: To be screened at least  
2 once.

3 CO-CHAIR GOLDEN: Okay.

4 MEMBER RYAN: Within the last 24  
5 months.

6 CO-CHAIR GOLDEN: Okay, that's --  
7 HEDIS measures do that all the time. There's a  
8 requirement for continuous enrollment or X number  
9 of months per year or something like that.

10 CO-CHAIR MOORE: But this isn't for  
11 high-risk patients, so I'm not sure I would  
12 screen everybody for this. For me, there's not a  
13 trigger. Percentage of patients age 18 years or  
14 older screened at least once within the last 24  
15 months for unhealthy alcohol use. It doesn't say  
16 because they're at high risk or they've  
17 exhibited.

18 CO-CHAIR GOLDEN: That's all right.

19 CO-CHAIR MOORE: 52.

20 MEMBER ZERZAN: I'd like to say I  
21 think alcohol use in general in our society is  
22 highly underdiagnosed. And so I don't need a

1 trigger.

2 I'll also say my good colleague Dr.  
3 David and I did a project about  
4 rehospitalization, and most physical health  
5 hospitalizations were related to substance use.  
6 And I think probably the biggest chunk of that  
7 was alcohol. So I say screen everybody, and I  
8 don't care if you're at risk or you're telling me  
9 what to do.

10 CO-CHAIR GOLDEN: Again, sometimes  
11 it's best not to be democratic, right. Okay.  
12 All right, other comments, questions, or  
13 concerns? Next item.

14 MS. MURPHY: Next one, so I believe  
15 we're at 2597. So this NQF Measure 2597, this  
16 will be number 54 on your discussion guide. And  
17 this measure is Substance Use Screening and  
18 Intervention Composite. And I believe these were  
19 the two measures you were discussing earlier,  
20 Sheryl.

21 So for this measure, the TEP  
22 unanimously voted high on all decision logic



1 criteria for this measure. And also noted that  
2 this screening measure is preferred above other  
3 screening measures that the TEP recommended,  
4 including NQF 2152, Preventative Care and  
5 Screening and NQF 2599, Alcohol Screening and  
6 Follow-up for People with Serious Mental Illness.

7 The TEP preferred this measure due to  
8 its more comprehensive approach to screening and  
9 brief intervention. The TEP was concerned that  
10 the definition of illegal substances differs  
11 across states. For instance, marijuana is no  
12 longer illegal in certain places, so it wouldn't  
13 be included as an illegal substance.

14 There were also concerns about the  
15 perception of illegal, and how oftentimes people  
16 may not perceive marijuana to be an illegal  
17 substance, yes, and therefore under-report its  
18 use.

19 MEMBER WALLACE: I have a question  
20 about this measure, and actually the previous one  
21 too. So when I'm looking at the numerator  
22 statement, what was mentioned before where you

1 have and this and this both in the numerator  
2 statement.

3 This is denoted as a composite  
4 measure, but when I hear composite measure, I  
5 think two simple measures that go together versus  
6 one measure that has a compound numerator.

7 And I'm concerned about both the  
8 previous measure and this one because screening  
9 and intervention might be two different problems.  
10 And so if the measure doesn't allow for that  
11 drilling down on the provider's part, that's just  
12 a flaw.

13 CO-CHAIR MOORE: Or there isn't a  
14 provider who can do that. I mean, that's a  
15 common thing that would come up that in rural  
16 areas that if you screen, then what do you do  
17 with it? I mean, do you have someone on site  
18 who's able to -- that doesn't mean you shouldn't  
19 have a measure, but I think that's a good point.

20 CO-CHAIR GOLDEN: Are you concerned  
21 enough to pull it? That's the question on the  
22 table, do you want further discussion, you want

1 to pull it from the consent calendar?

2 MEMBER WALLACE: I guess I wouldn't  
3 mind if anyone else had an opinion on it.

4 CO-CHAIR GOLDEN: Consent calendar.  
5 Essentially before you is a consent calendar of  
6 measures that you can pull. Do you want to pull  
7 it off the consent calendar for further  
8 discussion?

9 MEMBER PHELAN: But just for  
10 discussion later. It's not like it gets pulled  
11 off for good.

12 MEMBER WALLACE: Yes, I wouldn't mind  
13 tabling it for the discussion. I guess when I'm  
14 -- in my mind --

15 CO-CHAIR GOLDEN: So there's a motion  
16 to pull this for further discussion off the  
17 consent calendar. Do we have a second?

18 MEMBER RYAN: I just want to mention  
19 that this is one of the only ones that has any  
20 intervention at all mentioned. It's all  
21 screening. That was kind of pretty much not very  
22 many of them in the outpatient setting have a lot

1 of intervention.

2 MEMBER WALLACE: Yeah, and I think  
3 that's why I'd like to further discuss this.  
4 Because I think I'd have a better sense of how I  
5 feel about these measures once I see the whole  
6 set, and if their sort of their value outweighs.

7 CO-CHAIR GOLDEN: So do we have a  
8 second about pulling this off? We have a second,  
9 so it's off the consent calendar for discussion,  
10 okay. Next item.

11 MS. MURPHY: Okay, next item, NQF  
12 number 2599, Alcohol Screening and Follow-up for  
13 People with Serious Mental Illness. This is  
14 number 55 on your discussion guides.

15 The TEP felt that this measure focused  
16 on a gap in care for a high-risk population who  
17 often doesn't seek or receive care. That  
18 includes substance use screening as result of  
19 their mental illness.

20 The TEP noted that this measure was  
21 similar to the previously recommended measure NQF  
22 2152, Preventative Care and Screening Unhealthy

1 Alcohol Use, and voiced concerns over  
2 recommending too many measures with similar  
3 numerators and different denominators, which  
4 could lead to redundancy and an inefficient use  
5 of resources.

6 The TEP also noted that by having a  
7 measure that has a denominator that focuses on  
8 people with serious mental illness, states can  
9 decide to more easily target that high-risk  
10 population and can compare disparities across  
11 states, which may not be available if states were  
12 to simply stratify a broader measure as variation  
13 among the states would limit that comparison.

14 CO-CHAIR GOLDEN: Same thing,  
15 comments, questions, concerns. Next item.

16 MS. MURPHY: The next item is number  
17 56 on your discussion guide, NQF Measure number  
18 2600, Tobacco Use Screening and Follow-up for  
19 People with Serious Mental Illness or Alcohol or  
20 Other Drug Dependence.

21 The TEP noted that this measure  
22 addresses a high-risk population similar to the

1 previously reviewed NQF measure number 2599.  
2 Similar to the previous measure, by using a  
3 measure with a specific denominator addressing  
4 the high-risk population, data can be compared  
5 across states with greater accuracy than if  
6 states were to simply stratify a broader measure  
7 for serious mental illness.

8 CO-CHAIR GOLDEN: Anybody? Next item.  
9 The NQF 2605.

10 MS. MURPHY: Yes. So number 2605, this  
11 is number 57 on your discussion guide. NQF  
12 Measure number 2605, Follow-up after Discharge  
13 from the Emergency Department for Mental Health  
14 or Alcohol or Other Drug Dependence.

15 The TEP unanimously voted high on all  
16 decision logic criteria for this measure, noting  
17 the importance of the issue that the measure  
18 addresses. The TEP discussed how the measure  
19 would be important to help plans by ensuring that  
20 patients receive follow-up care after an  
21 emergency department visit to minimize patients  
22 bouncing around in the system and not getting

1 care for their problem.

2 CO-CHAIR GOLDEN: Don't hear anyone.

3 Now, before you go to the next item, it's five to  
4 five, so a couple things. One, there may be some  
5 housekeeping. We have a dinner for tonight, and  
6 you know where it is, so you can tell us where it  
7 is.

8 MS. MURPHY: Yes, our dinner is at PJ  
9 Clark's. In for a treat. It's right down the  
10 block. If you head out of the building and make  
11 a right, and then make another right on K Street,  
12 it's one block down across the street. We will -  
13 -

14 CO-CHAIR GOLDEN: Where is it related  
15 to the hotel if we all go back and freshen up?

16 MS. MURPHY: I have to say I'm not  
17 quite sure where you're staying.

18 CO-CHAIR GOLDEN: Go left one block  
19 out of the hotel. Okay.

20 MS. MURPHY: Yeah, we -- I'm not quite  
21 sure where you guys are staying, but. Oh, yes,  
22 then yeah.

1 CO-CHAIR GOLDEN: No, we're at the  
2 Hyatt.

3 MS. MURPHY: And go left, it's right  
4 across that street and that's it. It's right  
5 there, right on the corner. It's on 16th and K.

6 CO-CHAIR GOLDEN: And that's at six  
7 o'clock, okay.

8 MS. MURPHY: Five-thirty, actually.

9 CO-CHAIR GOLDEN: Oh, five-thirty.  
10 Well, it's a good thing I asked, okay.

11 MS. MURPHY: Yes. And we'll all be  
12 walking over from here. If anybody will be  
13 lingering around, we can walk over together.

14 CO-CHAIR GOLDEN: Okay, so that's, any  
15 other housekeeping before we move on?

16 MS. MURPHY: Well, we will need to  
17 open for public comment once discussion formally  
18 closes.

19 CO-CHAIR GOLDEN: That was my next  
20 item, yes. So do you want to do public comment  
21 now, or after we do all the slides?

22 MS. MURPHY: It is up to you. I do



1 have to tell you that we are not quite close to  
2 being done with SUDs. So now might be as good a  
3 time as any.

4 CO-CHAIR GOLDEN: See, I thought we'd  
5 do public comment to end the day, and then the  
6 next question would be to the group do you want  
7 to do another slide or push them over to the  
8 morning. So I would suggest we do public comment  
9 now, see if anybody has any comments, see what's  
10 there. Because that's comments for the whole  
11 discussion up to now.

12 MS. MURPHY: Yes. Well, we would need  
13 to, so just, we would need to open for public  
14 comment again once we conclude our additional  
15 discussion. So we may as well just hold off.

16 CO-CHAIR GOLDEN: Well, I may not be  
17 here in the morning. So let's give people a  
18 chance. I have a feeling there will not be a  
19 torrent of comments. Yeah.

20 MS. MURPHY: Okay, so, okay, so we'll  
21 do public now and end for the day.

22 CO-CHAIR GOLDEN: Let's do public

1 comment now, and then we'll make a decision.

2 MS. MURPHY: Okay, so we might be  
3 doing public comment twice. So that works.  
4 Operator, are there any public comments on the  
5 phone?

6 OPERATOR: And at this time, if you  
7 would like to make a public comment, please press  
8 star then the number one on your telephone  
9 keypad. Again, that's star one to make a public  
10 comment.

11 MS. MURPHY: I don't think we have --

12 OPERATOR: We have no public comments.

13 CO-CHAIR GOLDEN: Okay, so I played  
14 that card right. So now the question is how many  
15 people want to do another slide of measures for  
16 discussion for today? How many people want to  
17 quit? Let's do another slide.

18 MS. MURPHY: Okay, so I just want to  
19 add one thing for the record. We did receive  
20 just a brief comment a while back from a member  
21 of the public asking around the materials that  
22 we've been referencing. And we have noted that

1 those are available on the project page and can  
2 be accessed on the National Quality Forum  
3 website.

4 So our next measure, NQF Measure 2940.  
5 This is number 59 on your discussion guide. This  
6 is Use of Opioids at High Doses in Persons  
7 Without Cancer. So this is, you'll remember we  
8 discussed a very similar measure to this earlier  
9 today.

10 The TEP initially voted to note  
11 recommend this measure, but ultimately re-voted  
12 following discussion on NQF Measure 2950, Use of  
13 Opioid for Multiple Providers in Persons without  
14 Cancer.

15 The TEP initially noted concerns with  
16 the validity of the measure, given the different  
17 time frames in the numerator and denominator, but  
18 ultimately found that the measure addressed an  
19 important critical issue that is relevant, very  
20 relevant to states.

21 CO-CHAIR GOLDEN: Again, comments,  
22 questions, concerns. Next item.

1 MS. MURPHY: Next item. This is  
2 number 6060 on your discussion guide, NQF Measure  
3 number 2950, Use of Opioid from Multiple  
4 Providers in Persons without Cancer.

5 The TEP voiced concerns about the  
6 potential unintended consequences of using this  
7 measure, given that the measure of success would  
8 not and should not ever be to reach zero percent,  
9 and therefore there is no clinical basis for what  
10 the percentage of this measure should reach.

11 The TEP agreed that this population  
12 measure addresses an important issue and provides  
13 a good option to states for states to benchmark  
14 opioid prescriptions among multiple providers.  
15 The TEP also noted that the measure could make a  
16 difference in reducing the number of patients  
17 prescribed both opioids and benzodiazepenes.

18 CO-CHAIR GOLDEN: I'm not sure where  
19 the benzos come in, but that's okay. And the  
20 numerator's four prescribers and four pharmacies.  
21 Any comments or questions? Next item.

22 MS. MURPHY: Okay, our next item is

1 number 50 on your discussion guide, that's NQF  
2 number 1661, SUB-1 Alcohol Use Screening. This  
3 is again in that SUB series of measures.

4 The TEP noted the similarities between  
5 this measure and the previously reviewed tobacco  
6 measures, TOB measures, which we will discuss  
7 shortly.

8 The TEPs discussed that while alcohol  
9 is less of a cost driver than tobacco, alcohol  
10 intervention generates proportionately greater  
11 cost reductions within the first year, mostly as  
12 a result of reduced readmissions and a reduction  
13 in the complications that care teams experience  
14 when dealing with a patient with an alcohol use  
15 disorder.

16 And just to clarify my previous  
17 statement that it's similar to the tobacco, other  
18 tobacco measures. It's similar in the way that  
19 they're constructed with a series, in a series of  
20 measures. It obviously, this is addressing  
21 alcohol use and the other will address tobacco.

22 CO-CHAIR GOLDEN: Going once, twice?

1 Next item.

2 MS. MURPHY: This TEP is airtight,  
3 Sheryl. You did a good job.

4 Next measure is number 51 on your  
5 discussion guide, NQF number 1663, SUB-2 Alcohol  
6 Use Brief Intervention Provided or Offered, and  
7 SUB-2a, Alcohol Use Brief Intervention.

8 The TEP agreed that this measure  
9 addressed an important quality objective, but  
10 noted that part 2a of the measure, which focuses  
11 on the provision of a brief intervention, is the  
12 most useful component.

13 The TEP noted that the numerator,  
14 which includes patients who received or refused  
15 brief intervention, is confusing and seeks to  
16 measure two separate items at once. The measure  
17 is used in conjunction with a previously  
18 recommended measure, NQF number 1661 SUB-1,  
19 Alcohol Use Screening.

20 CO-CHAIR GOLDEN: So what did they say  
21 was confusing?

22 MS. MURPHY: Sorry, they thought that

1 the fact that this kind of has two parts to it,  
2 this 2 and 2a, and that they seemed to be  
3 measuring two different things at once was a  
4 little confusing.

5 I think it was specifically around the  
6 fact that it measures both intervention that was  
7 provided and intervention that was refused. It's  
8 not necessarily an exclusion. It's included in  
9 the numerator, which I think they thought was a  
10 little odd.

11 MEMBER RYAN: It was confusing because  
12 one of the numerators is the number of patients  
13 who received or who refused a brief intervention.  
14 So as opposed to 2a, which was the number of  
15 patients who received a brief intervention.

16 You know, maybe somebody refused to  
17 have the intervention. Doesn't mean the provider  
18 didn't attempt to, after screening, to give that.  
19 So I don't know whether they were trying to  
20 capture that, but that's --

21 CO-CHAIR GOLDEN: I think they're  
22 trying to capture intent to treat. And then a

1 lot of patients will say they're not ready.

2 MEMBER RYAN: Or, you know, don't talk  
3 to me about it. Then at least it's a provided --

4 CO-CHAIR GOLDEN: I think most of the  
5 time if you're not ready for treatment, it's not  
6 worth.

7 MEMBER RYAN: Right.

8 CO-CHAIR GOLDEN: Comments, questions,  
9 concerns. Okay, one more.

10 MS. MURPHY: Okay, the next item, I'm  
11 sorry, was that 163? Okay, so our next one is  
12 NQF Measure 1654, and this is measure 48 on your  
13 discussion guide. This is Measure TOB-2, Tobacco  
14 2, Tobacco Use Treatment Provided or Offered, and  
15 the subset measure TOB2a, Tobacco Use Treatment.

16 So this is again that series that we  
17 said that was similar to the SUB measures we just  
18 discussed.

19 The TEP noted the use of EHR data as  
20 potential challenge for implementation of the  
21 measure, but ultimately decided that the addition  
22 of the corresponding fields to the EHR was not a



1 significant burden to hospitals. One member of  
2 the TEP discussed the critical issue that the  
3 measure addresses as tobacco as the leading of  
4 preventable death in the U.S.

5 The TEP also noted that the hospital  
6 setting could advantageously capture patients who  
7 may otherwise not receive care, and/or  
8 potentially experiencing the negative  
9 consequences of their tobacco use.

10 CO-CHAIR GOLDEN: Once again,  
11 comments, question?

12 MEMBER PHELAN: I'm just not sure  
13 where the difficulty in pulling this from the  
14 medical record would be or from getting it from -  
15 - because this is all billable stuff, the tobacco  
16 cessation counseling. So I'm not sure that's a  
17 barrier to this measure at all.

18 MEMBER HENNESSEY: Yes, and it is  
19 typically captured in meaningful use in an  
20 electronic health record.

21 CO-CHAIR GOLDEN: All right, other  
22 comments, questions, concerns? Next item.

1 MS. MURPHY: Next item is number 49 on  
2 your discussion guide. This is NQF number 1656,  
3 TOB-3, Tobacco Use Treatment Provided or Offered  
4 at Discharge. And the subset measure, TOB3a,  
5 Tobacco Use Treatment at Discharge.

6 The TEP noted that this measure  
7 strongly overlaps with the previous measure, NQF  
8 1654 TOB-2, and is a part of a series of tobacco  
9 measures by the Joint Commission. And the  
10 measure differs by focusing on the services that  
11 are delivered at discharge. They did ultimately  
12 recommend it in conjunction with those other two  
13 measures.

14 CO-CHAIR GOLDEN: Any concerns or  
15 people wanting to extract? Let's do one tobacco  
16 measure, and then we'll call it a day.

17 MS. MURPHY: So I think that was our  
18 last tobacco. We went through 1, 2, 3, right?

19 CO-CHAIR GOLDEN: Well, you have 3225.

20 MS. MURPHY: Sorry, sorry, yes. I was  
21 thinking the TOB ones. So 3225 formerly NQF  
22 number 0028. This measure is number 62 in your

1 discussion guide, and is Preventative Care and  
2 Screening, Tobacco Use Screening and Cessation.

3 The TEP unanimously voted high on all  
4 decision logic components for this measure,  
5 noting the well specified denominator and the  
6 critical quality issue that the measure  
7 addresses.

8 The TEP noted, however, that the  
9 measure should be broadened to include patients  
10 under the age of 18, as well as the use of other  
11 nicotine products including e-cigarettes. This  
12 was a theme that came up, that saying tobacco  
13 products doesn't really apply anymore, as e-  
14 cigarettes and marijuana and other products are  
15 just as popular.

16 CO-CHAIR GOLDEN: Comments, questions?  
17 Michael.

18 MEMBER PHELAN: This is an outpatient  
19 measure?

20 MS. MURPHY: We can check those  
21 specification.

22 MEMBER PHELAN: I did send a concern

1 when I was looking at all these measures that I  
2 did not see an outpatient measure for tobacco  
3 cessation. But this must be the corresponding  
4 outpatient measure.

5 MEMBER RYAN: The denominator has at  
6 least one preventative visit during the  
7 measurement period.

8 MS. GORHAM: And this measure, 3225,  
9 is a eMeasure, so it is the exact same measure as  
10 the 0028.

11 PARTICIPANT: 0225, this was formerly?

12 MS. MURPHY: This is claim space  
13 version, it's not the eMeasure version.

14 CO-CHAIR GOLDEN: Okay, final  
15 comments, questions, concerns? I think, as they  
16 say in sports, you've done good. I think we've  
17 earned our break and the staff a break. Thank  
18 you.

19 Question for the group. We will  
20 adjourn, the folks on the phone, we'll save you a  
21 to-go box. We can go mail it to you by FedEx if  
22 you want. Do you want, is it feasible to start

1 tomorrow at 8:45?

2 DR. TERRY: Yeah, that sounds good.

3 CO-CHAIR GOLDEN: So breakfast will be  
4 here in the morning. And so folks on the phone,  
5 why don't we start at 8:45 and continue with  
6 slides. I think we're kind of caught up or  
7 close.

8 DR. TERRY: Yeah, we're pretty good.  
9 I just wanted to say that we'll do a little  
10 summary, Jennifer and I, tomorrow morning of the  
11 day. We should finish the day, though, tomorrow,  
12 before we do the summary.

13 I think we have a few more things to  
14 do, so. We'll do that and we'll give you a  
15 little summary of where we are. And thank you  
16 everybody. And I think we have a few unresolved  
17 things we need to talk about too. So thank you  
18 very much.

19 CO-CHAIR GOLDEN: Final comments or  
20 questions from the group before we adjourn?

21 MS. MURPHY: Comment one more time.

22 CO-CHAIR GOLDEN: We have a public

1 comment floating out there, okay.

2 MS. MURPHY: Offer public comment one  
3 more time, since we discussed a few more  
4 measures.

5 CO-CHAIR GOLDEN: But can't we do that  
6 tomorrow? That's fine.

7 OPERATOR: Again, if you'd like to  
8 make a public comment, please press star one.  
9 And we have no public comment.

10 MS. MURPHY: Thank you, everyone. We  
11 will meet in the lobby downstairs in a couple  
12 minutes to head over for dinner, if anyone's  
13 interested in joining.

14 (Whereupon, the above-entitled matter  
15 went off the record at 5:09 p.m.)

16

17

18

19

20

21

22

<b>A</b>	
<b>a.m</b> 1:9 5:2 97:10,11	<b>accompanied</b> 89:12 205:12
<b>A1Cs</b> 294:18	<b>account</b> 57:7,9 127:9 368:17
<b>ability</b> 107:9 161:12 189:3 241:18 247:8 261:9 381:13 382:4	<b>accountability</b> 290:4 293:12
<b>able</b> 6:16 33:20 41:4 42:4 49:10 68:8,18 73:20 83:7,20 92:4 95:6 100:22 122:18 126:18,21 127:4 138:6 140:17 141:20 142:4 143:19 144:2,9 144:21 147:13 148:19 166:4 170:10 174:17 186:22 187:11,12,15 193:14 194:2 195:13 196:7 225:15,15,16 242:10 299:11 305:19 315:18 344:20 386:18	<b>accountable</b> 9:14,18 293:8
<b>above-entitled</b> 97:9 167:7 307:8 406:14	<b>accounts</b> 271:20
<b>absence</b> 68:12 325:19	<b>accreditation</b> 13:17 256:16
<b>absolutely</b> 19:18 145:5 189:21 301:22	<b>accuracy</b> 390:5
<b>absorbed</b> 370:12	<b>accurately</b> 247:4 266:20
<b>abuse</b> 6:1,9 23:1 28:21 54:3,6 84:21 171:12 171:13 229:6 231:13 307:12 312:5 315:6 342:15,21 344:9 345:9 346:22	<b>achieve</b> 179:19
<b>Academy</b> 14:5 70:2	<b>achieved</b> 179:18
<b>ACAP</b> 2:3 16:11,14 21:3	<b>achievement</b> 7:21
<b>Accelerator</b> 1:3 3:8,10 28:1,7 36:1 48:13 75:7 304:17	<b>acknowledge</b> 66:15 95:3 211:11 227:9 325:9
<b>accept</b> 344:22	<b>acknowledged</b> 261:15 262:7
<b>acceptability</b> 79:14,18 80:6,17 82:20	<b>ACP</b> 12:14
<b>accepting</b> 129:6 131:6	<b>ACP's</b> 12:12
<b>access</b> 38:1,14 41:22 42:20 43:21 44:8 59:3 65:11 122:7 123:4 124:22 125:3 130:2 132:21,22 133:12 134:13 135:18 136:8 140:19 141:1 144:19 146:9,14,16 150:8 166:14 167:4 194:17 213:21 273:2 305:1 307:20 360:16 379:14	<b>act</b> 289:20
<b>accessed</b> 395:2	<b>acted</b> 229:9 231:15
<b>accessibility</b> 80:21	<b>acting</b> 3:4 10:17 25:9
<b>accessible</b> 110:13	<b>action</b> 189:1,3 261:11
<b>accessing</b> 351:12	<b>actionable</b> 41:16 257:9 269:14
<b>accommodation</b> 20:14 21:15	<b>actions</b> 143:10 355:9
	<b>activated</b> 185:22 189:4 189:11,12,15
	<b>activation</b> 181:8 182:10 184:6 185:3 186:4,20 187:19 188:17,22,22 189:8,14,16 192:3,4 194:7 197:19,21 198:21 321:7
	<b>active</b> 12:11,20 14:1 19:4 22:12 186:22 348:12
	<b>actively</b> 19:13 21:20
	<b>activities</b> 15:20 18:10 21:5 22:13 36:13 38:22 40:13,18 78:16
	<b>activity</b> 31:6 39:14 40:16 86:20 294:6,19 323:19
	<b>actual</b> 73:12 86:20 89:7 215:5 292:2 313:11
	<b>acute</b> 218:11
	<b>acutely</b> 233:5
	<b>adaptation</b> 29:17
	<b>adapted</b> 267:13,17
	<b>add</b> 85:20 94:8 126:4 127:14 134:9 135:10
	163:5 174:4 198:9 206:13 207:22 228:15 299:7 326:14 359:22 364:4 367:16 394:19
	<b>added</b> 100:9 165:14 206:4,13 277:21
	<b>addiction</b> 14:4 78:8 157:7 355:8
	<b>adding</b> 137:20
	<b>addition</b> 16:4 37:22 40:2 325:20 400:21
	<b>additional</b> 33:7 65:5 81:17 82:3 93:3 116:16 137:11 175:15 178:9 209:4 215:18 228:15 270:14 393:14
	<b>Additionally</b> 26:15 58:11 261:12 379:12
	<b>address</b> 54:15 55:17 104:12 105:3,8,18 106:6,14,15 132:7 145:3 150:5 151:1,3 153:20 154:6,8 155:2 155:20 162:14 163:17 166:9,21 177:18 178:15 183:12,14 199:2,10 206:5 219:4 274:18 276:3 278:16 279:9,21 296:10,19 325:1,7 327:3,14 347:15 352:20 361:6 361:17 397:21
	<b>addressed</b> 110:19 184:19 240:22 311:21 343:15,20 382:7 395:18 398:9
	<b>addresses</b> 104:9 105:6 105:7,16 106:11 150:20,22 154:2,21 155:6 156:2 180:10 207:14 219:2 228:20 257:7 259:1 264:11 265:18 269:14 346:4 379:10 389:22 390:18 396:12 401:3 403:7
	<b>addressing</b> 58:5 134:4 306:13 390:3 397:20
	<b>adequate</b> 321:12 347:3
	<b>adequately</b> 50:10
	<b>adjourn</b> 4:21 404:20 405:20
	<b>adjustment</b> 74:9,19 159:22
	<b>adjustments</b> 34:12 64:3 72:16,21
	<b>ADLs</b> 211:14
	<b>administer</b> 186:20 191:2 196:21
	<b>administered</b> 196:18
	<b>administering</b> 192:11 192:13
	<b>administrative</b> 188:7
	<b>administratively</b> 281:6 351:20
	<b>Admission</b> 207:12 219:1 265:17
	<b>admissions</b> 185:5 268:1 269:15
	<b>Adolescent</b> 2:12
	<b>adolescents</b> 17:6 54:5 342:18 347:13
	<b>adopt</b> 49:14
	<b>adopted</b> 283:13
	<b>adoption</b> 29:16 51:20
	<b>adult</b> 16:22 22:5 45:8 46:22 75:11 112:3 113:10 123:4 141:22 150:8 253:7 254:7 256:2 259:8 260:5 262:20,21 270:22 273:2 285:19 294:1 307:20
	<b>adults</b> 54:5 139:3 142:7 353:17
	<b>advance</b> 8:18
	<b>advanced</b> 353:3
	<b>advantage</b> 119:22
	<b>advantageously</b> 401:6
	<b>Advisors</b> 1:22 15:22
	<b>advisory</b> 16:17,18 17:22 23:8 81:11
	<b>advocacy</b> 227:12 270:12
	<b>advocate</b> 2:16 7:1,3 46:17 373:11
	<b>advocates</b> 112:10 113:15
	<b>advocating</b> 147:19 318:21
	<b>affect</b> 182:9 189:2
	<b>affiliated</b> 2:3 16:11 323:2
	<b>affiliation</b> 22:7
	<b>affiliations</b> 11:4
	<b>afford</b> 194:2 244:14
	<b>afraid</b> 218:17 290:4
	<b>afternoon</b> 112:8
	<b>afternoon's</b> 112:6 113:1
	<b>age</b> 14:10 124:3 137:22 139:4 141:19 142:16 240:17 306:12 312:8 383:13 403:10
	<b>aged</b> 342:18 343:3
	<b>agencies</b> 41:9 49:9,13 50:11 71:19 108:18

109:1,4,13 142:14  
 156:7,9,12 180:9  
 194:2 206:18 209:22  
 291:14 300:5,17  
 332:21 362:16  
**agency** 22:20,22 36:4  
 40:1 70:22 209:9  
 284:7 285:1  
**agenda** 28:22 33:10,11  
 34:18 120:13 166:4  
 307:16 363:6  
**agile** 7:19  
**aging** 112:10,13  
**ago** 29:13 64:13 122:16  
 283:5 351:3  
**Agrawal** 3:2 5:16,17  
**agree** 132:14 133:1  
 158:1 159:20 160:22  
 163:4 203:12 205:7  
 232:6 284:17 303:16  
 324:21 340:22 346:19  
 353:6 359:22 374:5  
 374:14  
**agreed** 137:1 181:14  
 263:22 264:10 319:6  
 343:6 396:11 398:8  
**agreement** 89:11  
 377:12,16,20  
**agreements** 24:22  
**ah** 102:10 287:4  
**aha** 75:1  
**ahead** 30:18 66:20  
 96:17 112:16 165:5  
 290:6 366:10 373:9  
 375:18 381:1  
**AHIP** 21:2 45:8  
**AHRQ** 13:4 248:22  
 316:11,22 320:20,21  
 320:22 336:1  
**AHRQ-funded** 23:7  
**ailments** 30:12  
**airtight** 398:2  
**Alameda** 116:2  
**Albany** 14:12,18  
**albeit** 87:8  
**alcohol** 22:22 54:3  
 171:12,12 229:4  
 231:11 262:6,12  
 263:14 342:21 343:1  
 343:2 345:9 369:16  
 369:18 370:5,7  
 372:14 379:4 380:2  
 381:5 383:15,21  
 384:7 385:5 388:12  
 389:1,19 390:14  
 397:2,8,9,14,21 398:5  
 398:7,19  
**alcoholic** 232:19

**Alex** 329:12  
**algorithm** 268:10  
**align** 45:13 55:19  
 184:16 215:21 217:8  
**aligning** 45:5 241:7  
**alignment** 42:3,7 64:5  
 80:22 106:20 107:3  
 154:18,22 155:3,21  
 179:7 199:21 280:10  
 281:8 297:7 328:20  
 362:6  
**aligns** 378:17  
**all-cause** 228:18  
 229:11 230:5,12  
 231:18 232:8 234:4  
 234:21 236:18 237:5  
 237:8,9,13,16,19  
 238:5 258:20 260:4  
 272:10 273:13 274:16  
 277:1 278:13 290:12  
 292:11  
**Allison** 1:19 17:17  
 132:17 152:2 191:21  
 236:7 247:9 263:2  
 265:1 303:19 324:16  
**Allison's** 136:6  
**allow** 7:19,21 49:21  
 187:13 291:7 386:10  
**allowed** 83:12 88:22  
 100:12  
**allowing** 83:13  
**alones** 270:22  
**alternative** 13:14  
**altogether** 33:21  
**Alvia** 2:15 23:21 46:8  
 46:10,15 93:16  
 157:21 170:12 178:2  
 193:19 203:11,21  
 231:20 235:7 299:6  
**AMA** 12:13  
**amazing** 9:3 177:4  
**ambiguity** 117:1  
**ambiguous** 202:13  
**ambulatory** 58:2 123:5  
 123:10,13,15,19,21  
 129:7 140:16,19  
 145:17 273:3  
**American** 14:5 15:6  
 78:8 111:22  
**Americans** 60:16  
**AmeriHealth** 1:18 20:20  
 294:11  
**amount** 84:8 183:21  
 193:22  
**Amstutz** 1:15 24:6,9,10  
 344:2  
**analysis** 51:2 64:22  
 81:22 91:20 115:5

121:19 175:1 191:3  
 321:5  
**Analyst** 3:3 27:13  
**Analytics** 2:11 47:12  
**analyze** 77:20  
**and/or** 58:13 106:6  
 107:3 129:6 153:21  
 154:18 162:16 166:10  
 177:19 178:16 179:7  
 199:2,11,20 219:5  
 274:19 278:18 279:10  
 279:21 280:10 296:11  
 296:20 297:7 327:5  
 327:15 328:20 347:16  
 361:8,17 362:5,7  
 401:7  
**Andrea** 1:17 4:11,14  
 20:11 62:3,10 76:14  
 94:21 115:12 129:17  
 130:11 135:7 157:12  
 157:14 165:13 169:20  
 170:6,17 216:15,19  
 217:16,21 224:13  
 227:2 228:14 230:14  
 241:22 254:22 269:17  
 285:4 289:8 292:3  
 293:4 333:5,8,15  
 348:22 359:19  
**Andrea's** 175:11  
**Andrews** 311:6  
**Andy** 291:7  
**ankle** 230:6  
**announced** 281:1  
**announcements** 26:12  
**annual** 259:14 260:14  
 359:16  
**answer** 44:3 68:3  
 145:22 146:10 203:9  
 250:10 334:10  
**answered** 369:9  
**answers** 338:13  
**anti-** 246:19 247:1  
**anti-depression** 253:12  
**anticipate** 281:3  
**anxiety** 172:6  
**anybody** 28:10 93:15  
 143:9 188:11 213:19  
 312:8 313:14 324:8  
 344:4 378:7 390:8  
 392:12 393:9  
**anybody's** 101:9  
**anymore** 148:10 256:2  
 302:2 403:13  
**anyone's** 406:12  
**anyway** 197:18 215:10  
 218:5 287:22 321:1  
 372:17  
**apologies** 21:13 47:12

217:14  
**apologize** 6:15 96:17  
 150:14 178:7 250:11  
 257:12 295:19 298:3  
**apparently** 338:11  
**appear** 251:8 298:20  
**appeared** 183:10  
**appears** 133:9 173:20  
 249:2 265:10 326:6  
 354:22  
**apple** 30:7  
**apples** 245:17,18  
**applicability** 181:20  
**applicable** 192:19  
 224:21 225:2  
**applied** 139:5,6  
**applies** 139:2 216:1  
 316:1 330:10 378:19  
**apply** 71:3,8 126:7  
 298:11 403:13  
**applying** 72:10  
**appointed** 63:5 268:5  
**appointing** 268:7  
**appointment** 19:2  
**appointments** 13:2  
**appreciate** 21:14 35:17  
 47:1 140:2 141:14  
 251:11 252:10 288:3  
 305:10 325:9 331:15  
**appreciates** 168:9  
**appreciative** 5:20 8:22  
**approach** 25:5,11 57:20  
 76:21 77:2 141:7  
 148:6 245:3 323:13  
 373:12 385:8  
**appropriate** 59:8  
 125:13 219:18 235:14  
 259:6 298:21 319:12  
 356:21 373:4,6 374:7  
**appropriately** 208:3  
 259:1  
**appropriateness**  
 345:12  
**approval** 285:15  
**approve** 102:22 235:17  
 285:13 364:7  
**approved** 175:1 285:14  
 307:22 313:22 314:7  
 346:12,14,15,16,17  
 364:8 365:6 369:4  
**approving** 323:10  
 365:17  
**April** 50:3 52:2 77:4  
**area** 4:10,13,16 8:15  
 30:4,13 42:14 43:3  
 53:16,17 54:17 55:2,6  
 55:9,12,17 59:10,13  
 61:3 68:17 73:13



76:22 77:10 78:15,19  
 82:7,22 83:2 84:17  
 90:10,11,12 114:12  
 134:2 150:6,21 151:2  
 151:4 154:4,10  
 162:16 166:10,22  
 167:16 169:8,9  
 177:19 180:11,15  
 183:13 197:10,11,13  
 197:19 199:3 208:17  
 219:6 222:7 268:12  
 274:19 278:18 279:12  
 281:21 290:1,2  
 296:11 310:8 312:18  
 313:7,12 321:18  
 325:2,3,6 327:5  
 347:16 361:8  
**area-specific** 77:3  
**areas** 5:22 9:20,20 10:6  
 29:18 36:17 37:2,3,5  
 37:9,15,19 38:9,11,13  
 39:3 41:8 43:6 44:2  
 44:17,21 45:22 48:12  
 48:14 53:16 54:19  
 56:13,18 57:22 60:17  
 61:1 65:15,17 66:1,2  
 76:4 83:19 84:9 85:3  
 90:22 105:9,10  
 114:21 118:10 119:12  
 122:11,14 131:2  
 135:15 146:18 155:2  
 155:21 164:17 180:1  
 182:22 209:16 224:22  
 245:11 246:3 248:9  
 312:4 386:16  
**arguably** 193:2  
**argue** 338:17  
**arguing** 284:20  
**ARHQ** 336:16  
**arisen** 54:20 55:16  
**Arkansas** 1:13,13 9:8  
 9:11 12:10 64:1 67:13  
 78:12 283:2  
**arose** 51:19  
**ARQH** 322:16  
**arrangements** 12:11,21  
**arrow** 122:6  
**aside** 12:15 235:10  
 342:3  
**asked** 11:2 44:1,14  
 81:10 204:19 205:4  
 242:19 338:22 350:8  
 392:10  
**asking** 11:4,7,11,12  
 63:11 88:5 102:8  
 309:11 318:11 372:8  
 394:21  
**aspect** 142:6 183:13

322:2  
**aspects** 92:16 125:15  
 125:16 137:2,5  
 311:22  
**aspiration** 325:12  
**aspirational** 293:14  
**assess** 64:4 123:8  
 171:3  
**assessed** 157:3  
**assesses** 182:4  
**assessing** 114:13  
**assessment** 168:2  
 174:22 207:13 208:10  
 208:12,15 209:11  
 210:13 211:19 218:9  
 218:10 219:1 265:17  
 311:19 341:13  
**assessments** 207:21  
**assign** 77:15,16  
**assigned** 79:15 81:21  
 82:18  
**assignment** 162:12  
 164:10,14  
**assist** 28:17  
**assistance** 2:1 36:7  
 209:13 380:17  
**assistant** 24:14  
**Associate** 2:8 15:15  
**associated** 24:19  
 133:16 189:16 288:11  
**association** 1:17 2:3  
 16:10 18:21 111:22  
**assume** 70:1 194:1  
 195:15 366:12  
**assure** 208:13  
**asterisks** 137:13  
**asthma** 14:17 60:1  
**attempt** 399:18  
**attention** 112:18 310:7  
**attest** 335:16 336:5  
**attribute** 58:19  
**audience** 43:13 44:7  
**author** 14:7  
**authority** 233:18  
**authorization** 7:6,7  
**authorized** 6:21 7:5  
**autism** 319:16  
**automated** 282:17  
**automatically** 83:5 96:4  
 235:4 308:18 336:21  
**availability** 382:2  
**available** 41:5 42:5  
 43:18 72:8 76:22  
 117:4 121:11 153:6  
 268:14 312:6 315:15  
 320:19 322:17 335:6  
 389:11 395:1  
**avenue** 337:17

**averaging** 96:8  
**avoidable** 257:5 266:1  
 266:16 268:1,22  
 269:14 272:5 301:19  
 304:10  
**aware** 6:20 7:15 101:13  
 176:7 184:20  
**awesome** 169:17  
**awfully** 307:20

---

**B**


---

**B** 129:4 259:4  
**B-A-S-I-S** 326:15  
**baby** 133:20 355:14  
**back** 8:7 10:14 25:19  
 30:5 33:22 34:5 62:8  
 70:9 73:5 87:16 89:19  
 90:4 97:13 118:12  
 122:5,6 136:5 139:8  
 140:5 141:11 143:12  
 145:14 147:12 170:2  
 170:5,13 191:19  
 192:16 214:18 216:22  
 217:20 223:4 226:18  
 230:9 233:16 234:13  
 234:21 235:11 239:1  
 247:12,17 263:4  
 265:8,8,12,14 286:10  
 287:20 304:14 306:22  
 307:4 308:9 312:16  
 313:4 321:6 325:15  
 334:1,9 342:3 364:9  
 366:18 377:6 391:15  
 394:20  
**background** 35:20  
 53:15 108:22 224:8  
 349:6  
**backtracking** 247:12  
**backwards** 229:18  
**bailout** 31:9  
**balance** 73:2,7 248:8  
 374:8  
**ball** 299:15  
**balloon** 259:1  
**Baltimore** 47:13  
**bands** 137:22 139:4  
**bar** 122:8 218:8 293:1  
 312:11  
**Barbara** 2:5 13:9 76:14  
 131:3 210:8  
**barrier** 401:17  
**barriers** 162:1 177:7  
 193:13  
**base** 43:14 142:12,20  
 309:18 377:4  
**based** 17:18 42:14,19  
 63:3,5 75:16 78:13  
 80:11 82:19 84:5 85:4

87:11 102:18 108:21  
 108:21,22 113:4,14  
 133:18 142:15 163:15  
 165:4 166:7 174:20  
 191:15 195:9 208:11  
 208:14 244:17 320:11  
 331:10 366:5  
**basic** 67:6 138:15 147:7  
**basically** 79:4 110:12  
 126:19 204:2 348:8  
**basis** 322:8 323:18  
 359:16 364:21 396:9  
**BASIS-24** 52:13 315:7  
 315:10,19 324:20  
 326:16,21  
**bath** 133:21  
**BCN** 4:10,13,16 48:18  
 57:1,1 90:10,13  
 100:15 114:19 115:6  
 119:3,5 120:16  
 122:12 133:7 156:20  
 163:2 167:2 169:7  
 179:21 180:11 183:11  
 207:6 208:4 212:6  
 215:2 219:12 220:5,6  
 222:7,15 223:15  
 229:7 231:14 236:13  
 240:22 247:5 253:2  
 257:7 280:16 301:16  
 302:21 303:5 304:9  
 304:13,16 305:14  
 313:1 325:2,6,14  
 363:8,13  
**bear** 334:1  
**bearing** 308:11  
**becoming** 58:13 351:5  
 352:1  
**bed** 344:11 345:18  
**begging** 338:1  
**beginning** 75:21 94:13  
 94:15 159:11 160:1  
**begins** 104:4,8  
**begun** 64:4 97:17  
**behalf** 7:2 191:18  
**behavior** 239:10  
**behavioral** 19:18 57:13  
 60:2,11,20 171:16  
 173:4 186:6 252:18  
 253:15 266:6 315:12  
 358:22  
**behaviors** 163:20  
**belabor** 249:19  
**believe** 84:7,11 138:1  
 139:4 153:11 154:19  
 155:1,19 169:8,9  
 218:10 220:10,19  
 242:2 253:13 271:7  
 384:14,18

**believed** 292:12  
**belongs** 213:11  
**benchmark** 73:20  
 396:13  
**benchmarking** 40:5  
 73:9  
**benchmarks** 290:20  
 292:21  
**beneficial** 237:15  
**beneficiaries** 20:18  
 29:21,22 48:16 53:18  
 54:4,9 55:10 56:22  
 57:3,6,9,12 59:14,16  
 59:18 109:2 114:14  
 116:9 118:8 140:5  
 156:10 181:12 182:21  
 208:2 225:3,13  
 260:18 276:20  
**beneficiaries/families**  
 109:14  
**beneficiary** 117:2 228:9  
**benefit** 68:21 158:12  
 227:14 284:22  
**benefits** 17:9  
**benzodiazepenes**  
 396:17  
**benzos** 396:19  
**bespeaks** 190:16  
**best** 31:19 40:10 58:9  
 73:22 75:10 76:22  
 96:13 99:17 101:7  
 136:3,20 137:6 193:3  
 225:11,14,14 234:11  
 242:20 245:10,22  
 275:19 367:11 377:16  
 384:11  
**best-** 117:3 365:20  
**best-in-** 373:3  
**best-in-class** 365:20  
**better** 5:5 40:7 66:22  
 67:4 75:5 93:10  
 138:21 144:7 145:6  
 250:21 252:1 278:4  
 283:22 285:3 307:5  
 322:4 350:18 354:14  
 358:2 364:8,12  
 369:12 388:4  
**Beverly** 3:9 27:21  
 107:17 136:10  
**beyond** 18:15 209:19  
 295:12 343:19  
**biased** 25:9  
**biases** 161:22  
**big** 10:2 37:12 78:21  
 302:11 347:5 348:10  
 376:4  
**biggest** 86:8 384:6  
**Bill** 8:19 9:7 12:8,20

35:4,8 38:8 69:2 73:5  
 89:19 95:16 125:21  
 234:3 242:19 253:5  
 276:15 277:10 284:17  
 340:3 346:8  
**Bill's** 141:14 156:13  
 334:11  
**billable** 401:15  
**billing** 60:10  
**biopsies** 213:18  
**bit** 5:19 7:14 9:19 35:5  
 36:18 38:18 41:3  
 74:21 75:5 86:11  
 94:10 100:1 103:21  
 105:1 106:21 108:6  
 109:6 148:5,21  
 201:19 202:5 254:2  
 255:2 265:6 317:6  
 324:10 329:7 349:5  
 366:21,22 375:20  
**bite** 30:6  
**bits** 33:2  
**blackbox** 266:22  
**blanche** 358:18  
**blanket** 158:9  
**bloc** 99:22 103:12  
 303:11  
**block** 103:14 391:10,12  
 391:18  
**blood** 294:17  
**blue** 83:3  
**BMI's** 294:18  
**board** 13:12 21:3 22:8  
 130:8 160:18 183:12  
 194:4 285:8  
**boards** 17:22 24:18  
**boat** 186:1  
**body** 357:6  
**bold** 39:15  
**boots** 83:18  
**bottom** 28:14 83:9  
 149:14 317:16  
**bouncing** 390:22  
**box** 83:3,9 110:6,6  
 111:11 178:4 404:21  
**boxes** 110:6 214:15  
**boy** 13:1  
**break** 29:5 49:15 90:3  
 97:3,6 119:20 125:22  
 150:1 167:5,13 237:2  
 272:12 299:4 301:13  
 305:17 306:19,19  
 307:1 308:13 404:17  
 404:17  
**breakfast** 405:3  
**breakout** 77:4 89:7  
**breaks** 32:21 295:22  
**breast** 13:3

**brief** 58:18 120:9  
 180:17 191:9 195:16  
 248:5 308:13 309:1  
 311:1 376:7,11 385:9  
 394:20 398:6,7,11,15  
 399:13,15  
**briefly** 53:14  
**brilliance** 116:6  
**bring** 45:8 128:8 215:21  
 217:6 310:14  
**Briscoe** 268:4  
**broad** 101:19 154:21  
 155:3,22  
**broaden** 312:1  
**broadened** 403:9  
**broader** 44:7 66:17,18  
 101:18 182:22 209:20  
 217:13 237:8 245:6  
 389:12 390:6  
**broadly** 58:4 269:12  
**brought** 94:22  
**Brown** 311:2  
**BSW** 2:5  
**Buchanan** 3:2 13:6  
 26:9,10 56:17,19  
 84:13,16 111:4,7,20  
 114:3,9 122:21  
 150:12 151:19,22  
 153:9,11 216:15,18  
 217:1 224:2 254:12  
 254:18 305:12,16  
 328:14  
**bucket** 31:6 65:22  
 245:7  
**buckets** 74:7 236:2,4  
**Budget** 60:11  
**bugs** 148:17  
**building** 36:5 168:18  
 391:10  
**built** 315:11  
**bulky** 78:21  
**bullet** 28:15 29:18 30:9  
 53:1,7 80:12 338:15  
 338:19,20 340:20  
 342:1 347:5  
**bump** 219:16  
**bunch** 245:21 265:3  
**bundle** 266:2  
**bundles** 147:4  
**burden** 80:21 188:7  
 209:4 230:7 267:19  
 273:20 283:22 284:14  
 286:5 287:21 401:1  
**burdensome** 209:8  
 256:5 281:6 282:6  
**burning** 9:19 41:1  
**bus** 303:21  
**Bush** 115:18,19

**business** 288:9,17  
**busy** 34:18,18,19  
**bye** 214:14  
**byes** 214:14

---

**C**


---

**C** 129:8  
**C-CAT** 167:19 168:12  
 168:13 176:13,18  
 177:16  
**C-CHAIR** 174:1  
**CAGE** 315:19  
**CAHPS** 52:19 53:7,9  
**calculate** 53:5 85:2  
**calculated** 80:10 84:6  
**calculation** 80:14  
 304:15  
**calendar** 120:5 257:6  
 387:1,4,5,7,17 388:9  
**California** 2:7 15:1  
 21:18 116:2 181:17  
 183:20 227:5,8,13  
 270:11 271:4  
**California's** 227:6  
 269:8  
**call** 12:6 34:2 35:22  
 37:2 48:15,20 49:16  
 51:21 72:21 98:9  
 105:12 112:7 144:3  
 149:6 169:21 170:2,5  
 176:18 193:18 194:13  
 230:11 277:14 278:2  
 287:1 328:1 344:10  
 344:13,20,21 359:11  
 376:20,20 402:16  
**called** 22:8 23:11 51:7  
 178:6 326:15 378:11  
**calls** 26:15 94:22  
**CalOptima** 14:22  
**cancer** 1:17 157:6  
 197:8 349:1,3,12  
 350:4,5 361:4 395:7  
 395:14 396:4  
**capabilities** 60:8,19  
**capability** 168:6  
**capacity** 36:5  
**Capital** 14:18  
**capture** 68:8 77:14  
 126:21 127:4 142:6  
 171:10,22 208:1  
 238:22 379:13 382:5  
 399:20,22 401:6  
**captured** 78:18 81:15  
 101:20 137:2 154:11  
 401:19  
**captures** 101:20 160:6  
 260:17 329:3  
**capturing** 79:2 239:9

244:5 247:4  
**card** 146:14 394:14  
**care-sensitive** 58:2  
**careful** 96:7 189:5  
**carefully** 112:22  
**caregiver** 65:12  
**caregivers** 183:7  
**Caritas** 1:18 20:20  
 294:11  
**Carolina** 198:15 311:7  
**carried** 201:17  
**carry** 162:1 375:13  
**carte** 358:18  
**carve-out** 124:12  
 171:17  
**case** 68:14 83:2 135:10  
 137:4 140:16 141:3  
 144:1 292:15 370:3  
 371:13 379:7 381:20  
**cases** 117:19 124:20  
 125:9 192:20 237:17  
 260:17 352:7  
**cash** 351:9 360:20  
**cast** 115:10 149:9,15  
 151:10  
**catch** 360:14  
**catching** 360:6,20  
**categories** 96:8 168:16  
**category** 66:14 133:7  
 232:13 233:3 277:18  
**caught** 236:21 405:6  
**cause** 197:22  
**cautionary** 96:3,9  
**caveat** 126:21 137:6  
**caveats** 126:5 136:18  
 244:4 285:15  
**CC** 122:2 368:6  
**CCDs** 285:10  
**CDC** 267:12,18 348:13  
 354:8 378:17  
**CDP** 101:9  
**Center** 1:20 3:8,10  
 17:17 18:3 28:7 35:17  
 36:2,3 116:1  
**Centers** 6:6 57:19  
 317:8  
**cents** 135:4  
**CEO** 3:2 5:15  
**certain** 43:6 89:16  
 128:17 137:1 236:2  
 318:3 337:11 385:12  
**certainly** 35:9 37:10,13  
 38:2 39:3 66:13  
 110:19 196:3 210:1  
 282:17 351:9  
**cessation** 401:16 403:2  
 404:3  
**cetera** 19:1 50:1 78:9

80:22 107:5,5 131:14  
 132:14 157:11 164:1  
 168:19  
**chair** 12:12 13:17 14:5  
 15:4 20:17 21:2  
 160:10 201:10 222:12  
 233:12 240:8 306:20  
 307:6 310:18 314:3  
 374:11  
**chairs** 12:3 26:21 81:11  
 104:1 302:10 376:20  
**challenge** 31:22 63:17  
 117:3 147:21 154:6  
 281:5 282:22 400:20  
**challenges** 30:10 37:13  
 40:8 58:5 106:8,12,14  
 154:2,8 171:14,15,22  
 172:8,9 261:15  
 279:11 280:1 291:21  
**challenging** 40:4 58:8  
 172:21 195:11 277:9  
**chance** 5:19 8:3,3  
 148:19 295:17 325:4  
 365:19 393:18  
**change** 10:9 38:16 50:6  
 51:3 53:4 63:10 75:15  
 87:19 88:5 106:10  
 125:5 202:21 227:8  
 308:22 309:1 315:7  
 326:21 340:8 348:19  
**changed** 62:5 238:16  
 239:15  
**changes** 7:17 41:13  
 58:19 72:20 182:8  
 202:15  
**changing** 55:17 205:20  
 205:21  
**channel** 120:3  
**characteristics** 267:18  
**characterization** 58:15  
**characterized** 55:3  
 58:14  
**charge** 18:9 250:4,4,5  
**chart** 329:4 371:21  
 377:22  
**chase** 282:7 284:15  
**chat** 111:11 149:13  
**chatbox** 305:20  
**cheat** 156:13  
**check** 23:20 91:6  
 122:17 196:13 214:15  
 319:21 360:5 403:20  
**cheerleader** 167:11,13  
**Cheryl** 2:10 47:11 70:7  
 142:10 207:16,17  
 208:4 210:2,15 217:2  
 220:11,12 227:16  
 348:5 349:16,18

350:6 357:16 366:4  
**Cheryls** 349:17  
**CHF** 239:6  
**Chief** 1:15,18 2:1,4,5,12  
 2:19 13:9 17:11 18:6  
 19:14 20:19,22 24:11  
**child** 16:22 45:8 75:11  
 253:8 254:8 277:5  
 345:7 347:12  
**child-adult** 41:2  
**children** 306:10 342:18  
 343:10  
**Children's** 23:4  
**chime** 224:17 228:14  
 355:19  
**chiming** 230:14  
**CHIP** 3:9,10 6:7 7:8  
 28:8 36:2 253:15  
**choice** 56:11 298:21  
**choose** 178:17 255:18  
 352:22 365:20  
**chose** 181:19  
**Christine** 311:6  
**Christmas** 32:13  
**chronic** 57:14 117:11  
 142:8,19 157:7 197:6  
 225:3,13 257:4  
**chunk** 384:6  
**church** 318:15  
**churn** 58:11,19 68:5  
 381:17,18  
**churning** 67:6 68:11  
**cigarettes** 403:14  
**circle** 30:5  
**cite** 112:21  
**cities** 271:7  
**citizens** 3:11 112:12  
**claim** 404:12  
**claims** 138:8 262:8  
 318:10 354:12 359:18  
 360:16 380:9  
**claims-based** 138:9  
**clarification** 126:4  
 131:5 151:13 222:1  
 230:18 236:9 239:20  
 272:14 287:10,13  
 288:22 349:21 357:11  
 367:21 373:2  
**clarifications** 308:5  
**clarify** 109:10 132:3  
 173:15 189:21 198:4  
 200:18 210:10 255:8  
 266:19 320:19 321:2  
 326:4 333:22 339:12  
 367:18 397:16  
**clarifying** 65:9 87:18  
 127:14 202:7 236:17  
 249:5,12 279:14

**Clark's** 391:9  
**Clarke** 3:11 111:19,21  
 113:20  
**Clarke's** 27:7  
**class** 24:16 31:19 99:17  
 101:7 242:20 245:10  
 373:4  
**Classic** 238:19,20  
**clear** 49:20 175:21  
 203:4 249:5 287:3  
**clearinghouse** 316:12  
 316:12 317:1 320:22  
 336:1,21  
**clearly** 127:1 131:8  
 133:15 151:2 166:21  
 202:10 216:6 245:21  
**Cleveland** 2:10 15:4  
**click** 120:21 121:14  
 122:9 228:5,7,7,12  
**clicked** 90:16  
**clicker** 149:11 151:9  
 178:22 327:1  
**clickers** 89:7 149:5  
 274:5 304:14,18  
**cliff** 117:13 135:17  
**climate** 144:18 168:1  
**clinic** 2:10 15:4 22:6  
 191:17,18  
**clinical** 24:14 42:21  
 55:3 56:1 61:5 65:11  
 156:22 157:3,16  
 158:3,9 162:11  
 168:16 182:22 183:3  
 187:21 190:15 209:19  
 284:11 396:9  
**clinically** 187:21  
**clinician** 189:11,14  
 191:6 194:9 196:22  
 197:16,21  
**clinician-patient**  
 197:14  
**clinicians** 191:3  
**clipboard** 197:2  
**clock** 164:19  
**close** 282:12 322:5  
 393:1 405:7  
**closely** 6:7 313:11  
**closer** 23:15  
**closes** 392:18  
**clustered** 268:12  
**CMCS's** 291:16  
**CMMI** 36:10  
**CMS** 3:9,10 4:5 6:5 13:3  
 13:14 15:10 16:21  
 17:13 21:5 27:19,19  
 27:22 31:1 33:13 34:6  
 35:1 42:12 47:20 50:7  
 54:1,17 55:15 58:21

61:2 62:15 65:9 68:15  
 70:13 72:5 77:10 78:7  
 78:14 79:7 81:10  
 88:20 94:19 95:13  
 105:4,13 107:17  
 119:2 126:8,13  
 136:10 150:5,20,22  
 151:3 162:15 163:6  
 166:9,21 176:1  
 177:18 184:9 193:9  
 198:1 203:16 204:10  
 219:5 242:10 243:3  
 243:17 244:17 245:21  
 250:17 251:2 252:2  
 253:16,21 274:18  
 277:19 278:17 296:10  
 324:4 325:21 327:4  
 347:15 361:7 372:3  
 372:15 373:18 379:11  
**CMS's** 48:12 62:20  
 304:16  
**co-** 12:2  
**co-chairs** 1:10 25:6,11  
**co-occurring** 54:22  
 186:13  
**co-teach** 24:16  
**Coalition** 14:17  
**coalitions** 112:11  
**coastal** 271:7,7  
**cocoon** 34:5  
**code** 64:2 157:11 164:1  
 211:13  
**codes** 129:5 138:3  
 146:5  
**coding** 64:7 70:15  
**coffee** 307:12  
**cognizant** 145:11  
**cohort** 264:12  
**collaborating** 39:20  
**collaboration** 18:14  
 61:11  
**collaborative** 23:11  
 112:13  
**collaboratives** 64:18  
**collate** 225:15,16  
**colleague** 56:17 333:3  
 384:2  
**colleagues** 9:9 20:10  
 25:8,15 27:19 28:19  
 115:18 345:4 363:20  
**collect** 291:4  
**collected** 41:12 55:2,21  
**collecting** 141:9 291:22  
 294:21  
**collection** 79:12  
**College** 15:6  
**Colorado** 2:20 17:11  
 64:1 78:12 191:11,20

254:5 355:11  
**combination** 315:20  
**combine** 359:3  
**combined** 7:8 24:16  
 54:10 280:7 297:4,15  
 301:14  
**combines** 358:14  
**combining** 10:20  
**come** 39:1 40:21 69:6  
 87:22 94:5,9 114:5  
 127:6 129:19 131:17  
 145:17 148:16,22  
 170:22 172:2 189:15  
 193:13 226:18 235:11  
 239:9 273:19 277:6,8  
 278:4,5 286:10  
 287:19 306:22 317:14  
 335:16 368:5 369:1  
 375:9 386:15 396:19  
**comes** 20:7 37:20 39:5  
 39:11 50:6 69:21 92:9  
 148:13 165:3 238:22  
 239:1 312:21 344:8  
**comfortable** 75:18  
 149:2 252:11 302:12  
**coming** 6:5 28:12 97:13  
 116:22 182:19 183:9  
 234:13 256:9 281:8  
 314:18 328:8  
**comment** 4:9,12,15,19  
 8:5 34:8 95:17,19  
 111:5,8,16,18 112:5  
 114:1 124:19 129:18  
 130:12 132:15 139:9  
 139:22 141:15 145:21  
 157:13 160:22 176:8  
 189:5 195:15,17  
 203:12 212:18,21  
 215:18 216:14 232:7  
 232:12 236:15 242:21  
 249:13 254:10,13,16  
 263:9,12 267:14  
 292:7,8 304:1 305:17  
 305:18,19,21 306:2,5  
 306:8 324:15 325:5  
 325:21 351:17 355:5  
 363:5,7 392:17,20  
 393:5,8,14 394:1,3,7  
 394:10,20 405:21  
 406:1,2,8,9  
**commentary** 205:12  
 367:16  
**commented** 231:21  
 377:22  
**commenters** 185:14  
**commenting** 178:4  
**comments** 34:9,10 46:4  
 90:3 93:12 96:16

113:21 114:8 124:9  
 129:2 130:19 135:9  
 140:2 160:19 162:6  
 165:16,20 175:15  
 177:11 186:5 211:10  
 218:16 236:10 241:8  
 241:9,20,21 247:9  
 253:5 257:10 258:10  
 259:10 260:10,22  
 261:17 263:1,7  
 264:21 270:15 271:11  
 274:1 304:2 319:3  
 320:14 324:7 326:18  
 347:8 348:6 359:22  
 360:10 378:4,7,21  
 379:16 380:21 384:12  
 389:15 393:9,10,19  
 394:4,12 395:21  
 396:21 400:8 401:11  
 401:22 403:16 404:15  
 405:19  
**commercial** 123:14,21  
 131:20 132:4,11  
 299:4  
**Commission** 256:14  
 268:6 283:18 402:9  
**commissioned** 113:12  
**commitment** 36:4  
**commitments** 15:13  
**committee** 1:3,8 8:2  
 11:1,14 12:22 13:5  
 14:6 15:5 16:16,17,19  
 17:14,15 19:6 21:7  
 26:3 32:4 35:11 42:1  
 46:12 61:20 63:2,12  
 74:19 76:16 77:7,22  
 78:6 91:2 92:1 112:22  
 113:3 115:2 116:15  
 116:19 120:20 127:22  
 136:1,13,22 175:1  
 180:4,5,12,14,18  
 223:13 224:5 225:8  
 226:19 227:4 255:4  
 255:17 276:17 286:16  
 306:5 311:10 314:21  
 342:12 366:7 376:19  
**committees** 8:2 12:12  
 14:22 16:15 86:17  
 225:21 363:16 365:17  
 366:9  
**common** 43:14 59:16  
 238:3,6 267:8,9  
 386:15  
**communication** 26:19  
 60:22 167:22 168:1,4  
 168:7  
**Communications** 2:17  
**communities** 29:10

33:8 322:3 352:8  
**community** 2:3 13:17  
 16:10 30:2 48:18 55:7  
 55:10 56:5,8 112:19  
 163:15 166:7 211:18  
 214:18  
**community-** 42:18  
 113:3,13  
**community-based**  
 13:13 19:7 30:3 48:19  
 55:7,11 112:10,15  
 113:15 163:18 210:11  
 217:9 220:20 221:3  
 221:14 271:13  
**comorbid** 59:21  
**comorbidities** 30:11  
 186:15  
**comorbidity** 10:3  
**companies** 1:19 16:1,2  
**company** 17:9 22:8  
**comparative** 73:9  
 169:11  
**compare** 10:9 245:13  
 245:13 291:4 292:21  
 389:10  
**compared** 54:7 173:11  
 390:4  
**comparing** 29:1 290:21  
 368:10  
**comparison** 58:8  
 366:13 389:13  
**compass** 93:14  
**compatible** 268:17  
**competing** 182:1 373:3  
 373:14  
**complain** 345:5  
**complete** 190:13 258:2  
**completed** 86:15 91:20  
**completely** 45:15  
**complex** 18:2,4 20:18  
 22:1 28:22 29:21  
 30:13,15 48:17 56:22  
 59:6 67:10,17 69:7  
 96:11 114:15 116:9  
 117:1 118:8 129:4,5  
 131:15 133:3 135:16  
 138:11 140:6 141:12  
 142:1 181:13 182:21  
 213:17 228:9 232:17  
 233:4 239:10,10  
 260:18 269:10 276:19  
 276:20 277:6  
**complexities** 173:4  
**complexity** 30:1 59:5  
**compliance** 157:5  
**complicated** 103:4  
 205:8  
**complication** 257:5

- 286:15  
**complications** 135:3  
 397:13  
**component** 168:4  
 398:12  
**components** 50:20,22  
 51:15 91:9 186:18  
 292:10 313:9 371:7  
 379:6 403:4  
**composite** 269:19  
 270:16,19,20 384:18  
 386:3,4  
**compound** 386:6  
**comprehensive** 78:3  
 122:10 370:14 385:8  
**computer** 121:4 122:22  
**con's** 251:20 252:2,4  
**concepts** 41:15 51:21  
 52:1,7 70:10,19 71:9  
 72:9 80:3 82:8,11,14  
 83:20,21 88:22 105:5  
 105:7,9,10,14,18  
 108:13,15 116:13,14  
 120:19 126:12 128:5  
 128:6 150:7,21 151:2  
 151:4 152:8,12,17  
 162:17 166:11 167:1  
 177:19 199:3 201:4  
 203:5,7,8 204:9 205:2  
 205:2 219:6 230:19  
 243:7 266:15 267:3  
 274:20 278:19 296:11  
 311:11 327:6 347:16  
 361:8  
**concern** 112:9 113:14  
 231:22 246:21 290:11  
 292:17,19 293:3  
 308:14 319:11 378:18  
 403:22  
**concerned** 32:22 50:8  
 96:21 129:5 158:7  
 161:20 247:3 290:16  
 340:11 345:21 381:22  
 385:9 386:7,20  
**concerns** 112:9 182:2  
 205:19 206:3 253:4  
 258:11 259:11 261:1  
 261:18 263:2 264:22  
 271:11 274:1 295:17  
 315:13,17 346:2  
 368:21 378:6,22  
 379:17 380:21 381:11  
 384:13 385:14 389:1  
 389:15 395:15,22  
 396:5 400:9 401:22  
 402:14 404:15  
**conclude** 393:14  
**concluded** 253:1 258:1
- 266:13 275:6  
**concludes** 179:22  
**condition** 60:3 117:20  
 158:4 257:4  
**conditions** 54:22 57:15  
 57:17,18 58:3 59:15  
 59:21 117:11,17,20  
 142:9,19 187:7 197:6  
 232:3  
**conduct** 90:21  
**conducted** 48:8 77:18  
 81:7,22  
**conducting** 115:5  
 222:8  
**Conference** 1:8  
**conferences** 35:13  
**conferring** 179:12  
 299:2  
**confident** 345:16,17  
**configured** 71:4  
**confirm** 323:10  
**conflict** 11:21 25:4,8  
 35:6  
**conflicts** 10:14 14:21  
 17:12,21 18:18 20:21  
 24:22 46:11  
**confused** 33:1 157:17  
 158:1 263:7 298:5  
 331:3 340:5 365:2  
**confusing** 208:6 335:14  
 371:3 398:15,21  
 399:4,11  
**confusion** 332:9  
**congestive** 182:2  
**Congress** 6:21 189:20  
**conjunction** 194:12  
 258:5 398:17 402:12  
**connected** 6:11  
**consecutive** 382:17  
**consent** 387:1,4,5,7,17  
 388:9  
**consequences** 273:17  
 396:6 401:9  
**Consequently** 58:9  
**consider** 70:17 117:15  
 128:12,20,21 130:1  
 133:18 180:9 210:14  
 323:20 380:17  
**consideration** 82:3  
 113:18 119:6,11  
 175:2 250:8 319:1  
**considerations** 244:3  
 368:16  
**considered** 36:10 50:18  
 54:14 82:3,9 87:4  
 88:9 94:12 109:8  
 113:18 116:17 118:3  
 134:3 181:16,22
- 220:17 221:19 348:14  
**considering** 42:2 54:20  
 80:20 167:3  
**consist** 49:5  
**consisted** 311:16  
**consistency** 74:5 241:6  
**consistent** 73:8 85:3  
 89:9  
**consortium** 3:11  
 112:12  
**constitutes** 150:2  
**constitutive** 294:12,22  
**construct** 131:11 134:1  
 181:12 193:2 248:15  
**constructed** 397:19  
**constructs** 293:10  
**consult** 219:21  
**consultation** 16:1  
**consulting** 11:10 12:11  
 12:21 14:1,12 22:12  
 24:21 291:17  
**consumer's** 185:20  
**consumers** 58:12  
 108:19 109:22 185:19  
 206:20  
**cont** 4:13,16  
**contact** 92:4 230:11  
 239:17  
**contacted** 239:17  
**contained** 182:3  
**CONTENTS** 4:1  
**context** 137:11 147:2,6  
 148:6 174:5 183:9  
 192:10 244:3 251:20  
 275:2 288:1 315:21  
 346:1  
**contextual** 127:5 163:5  
**contingency** 364:1  
**continue** 126:9 154:15  
 162:22 194:8 198:2  
 216:17 244:18 249:14  
 249:16 310:13 382:5  
 405:5  
**continued** 34:20 255:13  
**continues** 322:22  
**continuing** 143:20  
**continuity** 261:14  
 281:14,21  
**continuous** 120:12  
 383:8  
**continuum** 49:8 66:17  
 66:19  
**Contract** 28:2  
**contractually** 295:5  
**contradictory** 245:9  
**contribute** 107:3  
 154:18 179:7 199:20  
 229:16 280:10 281:7
- 297:7 328:20 362:5  
**contributes** 154:22  
**contributor** 14:2  
**control** 56:11  
**controversial** 74:22  
**convening** 5:21  
**conversation** 33:20  
 76:2 125:22 136:18  
 173:1 192:2 249:6,8  
 249:19 269:18 310:20  
 313:5 334:21 349:19  
 355:21 357:3 364:3  
 374:18  
**conversations** 94:21  
 366:17  
**convince** 31:11  
**Cool** 191:21  
**coordinated** 67:18  
 138:7  
**coordinating** 1:3,8 32:4  
 35:11 42:1 63:1,12  
 76:16 91:2 115:2  
 116:15,18 120:20  
 125:15 136:1 180:4  
 223:13 225:8 276:17  
 314:21 342:12 366:7  
**coordination** 42:21  
 55:4 56:2 59:2,7 61:4  
 61:11,14 65:12 96:11  
 138:17 183:3 255:3  
 264:14  
**Coordinator** 2:16  
**coordinators** 214:8,17  
**COPE** 22:8  
**core** 16:22 23:6,10,13  
 41:2 45:8 46:22 75:11  
 103:21 113:6 253:7  
 253:14,20 254:8  
 256:2,9 259:9 260:6  
 262:20,22 270:22  
 284:7 285:19 286:5  
 291:15 294:1  
**corner** 122:7 149:14  
 392:5  
**Corporate** 1:18 24:11  
**correct** 74:12 85:12  
 92:13 118:14,15  
 183:18 196:19 210:3  
 215:12,15 223:17  
 243:19 246:12 248:20  
 248:20 269:2,4  
 272:17 298:22 308:1  
 314:18 334:12,21  
 363:4 369:5  
**correctly** 121:1  
**correlated** 189:4  
**correlates** 141:8  
**correlating** 141:2

- correlation** 140:18  
 185:2  
**corresponding** 400:22  
 404:3  
**cost** 9:18 21:6 30:10  
 69:12 117:7,13 118:4  
 182:12 187:9,15  
 188:6 189:19 257:20  
 287:21 397:9,11  
**cost-effectiveness**  
 187:14 188:9 190:8  
**costly** 57:4,16 140:9  
**costs** 48:17 57:1,20  
 69:14 114:15 140:11  
 181:13 228:10 260:19  
**council** 21:1,2  
**counseling** 401:16  
**count** 252:21 301:6  
**counties** 144:5  
**country** 60:16 113:17  
 144:16 345:5  
**county** 15:1 144:4  
**couple** 6:14 14:16  
 17:22 24:18 26:11  
 34:1 36:7 45:10 126:1  
 135:9 138:5,6 172:10  
 183:19 212:11 299:2  
 308:4,12 391:4  
 406:11  
**course** 79:22 97:14  
 107:10,10 244:12  
 369:21 370:8  
**COURT** 176:9  
**courts** 22:22  
**cover** 92:21  
**coverage** 58:13  
**covered** 35:21 139:18  
 311:17  
**covering** 7:11  
**covers** 177:1  
**CPC** 238:19,19,20  
**CPCC** 1:21  
**CQM** 2:9  
**create** 34:5 44:18  
 161:22 189:14 253:3  
**created** 268:10 363:19  
 382:1  
**creating** 45:14  
**creative** 213:6 296:2  
**credit** 374:7  
**crew** 258:11  
**crisis** 6:10 19:18  
**criteria** 77:16 79:11,13  
 79:16,17,21 80:9,13  
 87:3,4 114:17 153:12  
 155:7 156:2 195:5  
 205:19 299:7 309:19  
 309:21 337:11 377:7  
 377:14 378:14 385:1  
 390:16  
**critical** 9:13,21 37:12  
 37:17 38:4 39:4 40:1  
 64:5 104:9,10 105:3  
 133:1,2 162:14  
 181:12 199:2 209:16  
 229:6 231:13 252:19  
 253:3 278:16 312:4  
 316:1 327:3 343:15  
 343:20 346:4 361:6  
 382:8 395:19 401:2  
 403:6  
**criticize** 215:22  
**critique** 188:16  
**cross-border** 360:2  
**cross-cutting** 118:3  
**crossed** 152:19  
**cruise** 159:12  
**crux** 72:18  
**CSAC** 18:17 225:22  
 226:22 287:6  
**Cube** 235:22  
**Culica** 115:20,21  
**cull** 93:19 225:16  
**culling** 81:4  
**curious** 191:4 194:21  
 346:12  
**current** 14:12 15:13,19  
 67:19 78:16 209:3  
 226:15 292:18 351:15  
 354:8  
**currently** 13:16 15:4  
 19:2 50:13 67:7,22  
 107:22 108:5 155:17  
 180:8 184:10 227:8  
 238:2,8 255:4 266:14  
 266:21 269:7 297:19  
 334:16 351:16  
**customize** 73:22  
**cut** 218:1 278:10 358:6  
**cut-off** 214:22  
**cutoff** 82:1,22 83:2  
 84:11 86:3 201:14  
 215:4  
**cuts** 60:7,12  
**CVS** 46:19  
**cycle** 7:6 143:20  
**cycles** 143:21
- 
- D**
- 
- D.C** 1:9 160:11  
**daily** 56:11 322:8  
**Dan** 115:20,21  
**danger** 117:12  
**dangerous** 251:4  
**data** 38:1 51:1 69:10,18  
 80:21 110:12,13  
 121:17 125:3 143:11  
 143:19,20 165:11  
 171:22 174:22 226:13  
 261:16 262:8 283:12  
 286:9,12 290:15,18  
 291:4 292:14,19  
 318:10 359:18 360:16  
 380:9 382:2,5 390:4  
 400:19  
**database** 132:15  
**databases** 68:8  
**datasets** 32:2  
**date** 54:19 55:16 59:5  
 81:15 174:12 240:18  
 329:8  
**Dave** 68:22 146:1  
**Dave's** 285:7  
**David** 2:1 18:6 115:22  
 137:17,18 145:21  
 147:17 181:9 212:20  
 316:7 317:3 357:18  
 357:18 358:6 373:10  
 384:3  
**David's** 145:20  
**day** 34:16,18 36:14 76:9  
 95:10 172:20 201:17  
 235:22 307:17 308:12  
 309:11 313:19 314:4  
 333:22 378:20 393:5  
 393:21 402:16 405:11  
 405:11  
**days** 9:14 35:12 45:10  
 172:22 240:19 379:15  
**DC** 290:2  
**dead** 268:5,7  
**deadline** 90:19,21  
**dealing** 28:21 113:16  
 397:14  
**death** 401:4  
**Deb** 316:10  
**debate** 135:21 242:12  
 295:17  
**debating** 242:12,13  
 345:12  
**Debbie** 316:6  
**Deborah** 2:2 16:9  
 124:10 128:8 158:15  
 165:5 173:9 257:1  
 288:4 316:3,4,8 323:4  
 360:12  
**decades** 182:20 290:10  
**December** 124:4  
 240:16  
**decent** 271:9 277:16  
 293:14 352:15  
**decide** 77:4 98:15  
 161:11 336:10 364:20  
 378:2 389:9  
**decided** 117:18 212:20  
 382:7 400:21  
**decision** 51:5 77:21  
 83:11 87:3,10,15  
 88:13 89:14 97:20  
 98:1 100:7,17 102:15  
 103:19 104:8 105:1  
 110:15 119:13,17  
 128:13,22 149:18  
 151:12 153:19 154:15  
 155:13 163:1 178:13  
 179:4 180:19 202:14  
 204:6 226:1 274:4  
 302:4 308:19,21  
 309:8,19 313:8,9  
 314:1 315:2,22  
 332:15 334:11 346:4  
 372:12 373:4,6  
 375:17 376:22 377:6  
 377:14 378:14 379:6  
 384:22 390:16 394:1  
 403:4  
**decisionmaking** 32:20  
**decisions** 89:11 125:9  
**deck** 96:20 140:7  
**decrease** 291:20  
**deem** 223:10  
**deemed** 116:12 225:2  
**deep** 75:20 250:15  
**deeper** 240:6 323:8  
 373:20  
**deeply** 211:2  
**default** 299:16  
**defaulted** 334:3  
**Defaulting** 299:22  
**defaults** 299:19 332:13  
**defer** 68:14  
**deferment** 175:1  
**deficiencies** 252:19  
**define** 58:12 129:13  
 341:16  
**defined** 132:12 239:11  
**defines** 49:18  
**defining** 62:6,6 161:5  
**definitely** 91:13 126:3  
 127:15 151:11 183:11  
 194:4 201:2 239:4  
 245:18 248:1 284:20  
 309:10 368:16 374:5  
**definition** 49:16 50:2,4  
 50:9,12,17 51:3,7  
 52:8 62:13,17 63:3,6  
 67:11 79:19 87:17,19  
 140:5 141:11 232:20  
 298:13 385:10  
**definitions** 140:7 150:2  
 202:10  
**degree** 24:17 117:2

- degrees** 157:5  
**delay** 328:6  
**Delegation** 12:13  
**deletion** 267:22  
**deliberations** 5:8 51:6  
115:15 116:20 179:13  
**delineating** 261:10  
**delivered** 34:6 402:11  
**delivery** 28:17 36:13,16  
36:22 37:4,14 49:4  
55:9 57:2 59:13 78:17  
161:4 305:5  
**demands** 182:1  
**democratic** 375:17  
384:11  
**demographics** 144:10  
**demonstrate** 107:2  
154:17 179:6 199:19  
280:9 297:6 328:19  
362:4  
**demonstrates** 83:3  
154:20 155:6,19  
156:1  
**denial** 354:11  
**Dennis** 311:3  
**denominator** 51:1 79:4  
102:3 108:5 121:18  
123:7 124:3 129:8  
131:16 152:16 157:10  
163:22 164:20 168:15  
168:20 176:3 277:3  
343:3 356:10 389:7  
390:3 395:17 403:5  
404:5  
**denominators** 130:6  
389:3  
**denoted** 386:3  
**deny** 358:19  
**denying** 354:12  
**department** 2:2,4,12,14  
2:20 7:16 8:14 13:21  
22:20 58:1 141:4  
147:3 177:6 228:19  
228:22 229:4,11  
231:11,19 234:5,22  
238:5 262:5,11 263:8  
266:1 272:5,10  
273:14 274:17 278:14  
282:4 301:19 304:11  
311:5 342:16,19  
343:4 390:13,21  
**departments** 261:14  
**dependence** 229:5  
231:12 262:7,12  
263:14 389:20 390:14  
**depending** 7:6 125:14  
158:4 216:10 347:3  
**depends** 191:19
- depressant** 246:20  
247:2  
**depression** 52:12 53:2  
53:4  
**depth** 98:17 252:9  
**deputy** 209:5  
**derived** 167:18,22  
177:15 262:8  
**describe** 267:18  
**described** 291:22  
**describes** 80:12 86:14  
**description** 51:10 53:3  
108:4 121:9,18 123:6  
152:15 157:2 163:15  
167:20 342:17  
**design** 58:7  
**designated** 175:22  
**designation** 51:19  
308:15  
**designations** 63:11  
80:6  
**designed** 266:14,21  
**desire** 62:20 95:4  
324:22  
**desk** 119:16  
**detail** 38:10 79:2 97:19  
100:2 128:4 168:21  
203:7 277:12 355:20  
**detailed** 49:19 63:18  
98:21 107:20 266:12  
309:15 377:2  
**details** 78:19 79:12  
127:21 173:22  
**determinants** 189:2  
324:11 325:1,8,14  
**determinates** 163:17  
**determination** 227:14  
**determine** 81:22 82:1  
158:3 250:6 255:14  
380:9  
**determined** 83:15  
119:2 208:2 225:7  
228:19 230:18 240:21  
257:6 260:16 269:13  
331:9  
**develop** 10:7 18:14  
28:16 198:2 293:9  
**developed** 23:14 49:18  
70:12 72:15 84:17  
107:20 131:13 260:6  
288:22 334:16  
**developer** 127:20  
174:21 286:9,14  
287:19 326:7  
**developers** 175:3 195:2  
**developing** 134:10  
289:2  
**development** 15:8 23:6  
23:9 39:7,12 69:19  
167:18,19,21 168:3  
177:15,16 319:16  
322:19  
**device** 16:2  
**devices** 341:11  
**DHHS** 198:15  
**diabetes** 24:20 60:2  
135:4  
**diabetic** 232:19  
**diagnosed** 172:1  
**diagnoses** 54:4 171:12  
171:13,13  
**diagnosing** 172:6  
**diagnosis** 59:16 172:4  
246:21 266:6 343:9  
379:15  
**diagram** 83:1 87:9  
108:10,11  
**dialed** 170:5  
**dialing** 216:21  
**diced** 147:8  
**dicing** 288:8  
**difference** 51:13 200:19  
201:5 335:14 350:21  
396:16  
**differences** 69:8 147:1  
243:12  
**different** 29:11,11  
30:18 31:6 36:7 38:13  
38:21 40:13 41:3,7  
42:8 45:2,15 57:12  
58:13 64:2,17,17  
65:16 66:11 68:9 71:5  
71:20,21 72:9,10 86:2  
91:9 92:10,16 101:17  
108:12 112:21 120:14  
125:15,16 135:14  
142:18 157:16 158:2  
158:10 164:17 171:18  
184:17 201:19 211:13  
216:9 221:16 233:2  
263:18 286:2 288:11  
317:6 335:7 352:4  
355:9 356:17 357:21  
360:7 366:22 367:1  
374:6 386:9 389:3  
395:16 399:3  
**differentiate** 315:18  
**differently** 86:4 335:4  
**differs** 385:10 402:10  
**difficult** 30:13 68:7  
125:14 182:7 282:11  
345:21  
**difficulties** 56:9  
**difficulty** 401:13  
**dig** 323:7  
**diligence** 295:13
- diligently** 222:16  
**dinner** 27:6 91:6 391:5  
391:8 406:12  
**dipping** 75:19  
**direct** 20:21 151:8,9  
**directed** 129:9  
**direction** 74:17 340:18  
**directly** 120:17  
**director** 1:12,14,16,21  
2:7,8,13,15 3:6,8 8:11  
9:8 15:15,21 21:17  
22:19 27:16 28:6  
29:13 36:3 46:16  
116:1,3 159:12 209:6  
**directories** 351:12  
**Directories** 28:20  
**Directors'** 69:3  
**Disabilities** 3:11  
**disability** 53:20 56:9  
112:1,11,12,13  
**disagree** 303:9  
**discharge** 207:12  
208:11,19 210:20,22  
218:12 219:1 221:4  
240:15,18,19 256:15  
265:17 283:6 380:4  
390:12 402:4,5,11  
**discharged** 208:14,17  
**Discharges** 240:15  
272:1 280:19 296:7  
**disclose** 11:5,20 17:22  
195:2  
**disclosed** 25:4,9  
**disclosure** 4:3 10:22  
46:17 47:15 293:22  
**disclosures** 10:21  
11:21 12:5 24:3 46:12  
46:20  
**Discrepancies** 241:16  
261:6  
**discriminating** 268:11  
**discuss** 37:6 52:14  
59:10 77:7 92:16  
102:20 110:21 112:6  
118:7,11 180:13  
195:4 224:7 228:13  
235:12 281:1 321:1  
339:10 342:2 344:4  
349:9 388:3 397:6  
**discussant** 180:13  
316:4 344:2  
**discussants** 121:11  
180:20 182:16  
**discussed** 18:12 77:5  
116:11,21 130:22  
131:15 164:16 234:16  
271:16 275:3 303:17  
313:1 334:2 376:19

380:4 382:4 390:18  
395:8 397:8 400:18  
401:2 406:3  
**discussing** 77:2 93:7  
262:16 384:19  
**discussions** 32:19 76:5  
165:13 181:18 184:3  
195:7 382:9  
**disease** 15:8 158:4  
322:2  
**disorder** 6:2 42:18  
53:17 54:17 84:15  
100:16 186:13 196:12  
310:19 313:6 317:12  
380:3 397:15  
**disorders** 17:4 29:19  
48:15 53:22 54:22  
59:18,20 310:8  
311:18 317:8 380:18  
**disparities** 13:4 68:6  
74:19 145:4 389:10  
**display** 223:22  
**disseminate** 190:14  
**disseminating** 190:9  
**distinction** 164:9  
246:22 250:1 331:4  
**distress** 321:19  
**distributed** 122:16  
**District** 14:19 198:11  
**dive** 114:12 166:1 252:9  
310:16  
**diversity** 30:1 168:9  
176:7  
**divide** 104:18 144:10  
**doctor** 148:1 358:11  
**doctor-** 358:13  
**document** 322:15 369:4  
**documentation** 343:1  
377:11  
**documenting** 60:20  
**documents** 261:14  
281:14,22 283:7  
294:13,17 295:1  
**doing** 5:21 7:11 9:14  
19:16 20:2,3 31:1  
44:5,13 65:2 76:8  
103:4,5,13,15,22  
105:13 117:15 126:11  
138:7 143:19 191:7  
191:15 204:13,21  
206:1 208:16 214:12  
218:16 222:13 229:17  
235:6 246:15 260:17  
261:19 275:14 282:3  
282:12 283:19 284:10  
287:21 309:2 310:13  
319:22 323:12 324:18  
345:18 359:14 371:9

371:10 394:3  
**dollars** 196:4 317:11  
**Dolph** 268:4  
**domain** 42:12 55:22  
59:3 61:5,7 105:4,6  
150:21 167:19 175:20  
175:21 176:1,1  
177:16 194:15 195:21  
307:15 319:19  
**domains** 41:7 54:18  
55:15 58:22 59:2 61:2  
79:8 105:8,18 150:6  
151:1,3 162:16  
166:10,22 177:2,18  
219:5 274:19 278:18  
296:11 318:3 327:5  
347:16 361:7  
**doors** 26:13,14  
**Dosages** 361:3  
**dose** 348:14 353:22  
358:10,12 359:3  
**doses** 348:5 349:11,13  
355:1 395:6  
**dossier** 337:1  
**double** 283:11  
**downgraded** 202:16  
**downstairs** 406:11  
**downstream** 212:13  
**DPA** 3:11  
**Dr** 5:3,17 13:6 18:5  
27:14 85:22 92:20  
93:2,8 94:3,6 96:18  
97:12 109:11,17,19  
110:7,10 111:6  
115:19,20,22 125:4  
125:17,20 126:11  
127:11 158:20 173:18  
176:2 202:1 210:2,6  
216:6 220:5,11  
224:11 225:18 226:8  
226:11 246:13,15  
253:22 255:11 259:8  
262:21 265:19,21  
275:15 279:2,17  
286:7,22 298:4  
316:20 320:5,12  
330:11,16 331:8  
332:2 335:8,13  
337:15,19 338:8  
339:8,11 349:2  
366:21 367:4,17  
368:10,13 369:5,7  
371:15 372:7 384:2  
405:2,8  
**draft** 8:5 112:16  
**drafted** 360:14  
**drill** 144:2  
**drilled** 146:19

**drilling** 386:11  
**drive** 38:16 39:19 117:7  
271:8  
**driver** 10:2 397:9  
**drivers** 28:10 48:2  
135:15  
**driving** 135:20 227:8  
**drop** 120:22 121:5,15  
**drops** 142:2  
**drug** 22:22 54:11 229:5  
231:12 262:6,12  
263:14 343:1,2 370:5  
370:7 380:2 389:20  
390:14  
**Drug-Dependence**  
379:4  
**drugs** 312:3 342:15,21  
346:22  
**dual** 139:5  
**dually** 112:2 208:2  
**dually-eligible** 54:8  
**duals** 132:13 142:16,17  
142:17,18 209:5  
213:9  
**due** 174:6 182:2 261:9  
266:10 291:19 295:13  
325:10 363:15 385:7  
**dump** 131:6  
**duplicate** 236:14  
**duplication** 236:19  
**duplicative** 107:8  
154:22 155:1,20  
237:11 364:11  
**duty** 289:17 304:15  
**dynamic** 197:10,14,15

---

**E**

---

**E** 3:11  
**e-** 403:13  
**e-cigarettes** 403:11  
**earlier** 70:9 79:7 136:17  
185:14 217:14 231:21  
232:7 233:1 255:2  
271:16 307:2 313:21  
332:12 341:10 358:12  
374:9 384:19 395:8  
**early** 94:21 105:11  
311:21 375:10  
**earned** 404:17  
**easier** 101:15 145:13  
252:4 275:17 327:22  
373:17  
**easily** 83:16 202:8  
299:10,12 377:21  
380:14 389:9  
**easy** 80:1,2 233:20  
**eating** 252:5  
**eBASIS** 326:15

**echo** 185:8 351:22  
**economic** 188:10  
**ECQMs** 294:22  
**ED** 67:15 230:5,12  
232:8,22 239:9  
268:22 370:9  
**EDs** 281:15 322:8  
**education** 324:19  
**Educators** 1:17  
**effect** 182:6 187:12  
**effective** 60:4 174:3  
**effectiveness** 187:16  
189:19  
**efficiencies** 44:18  
**efficient** 7:18 107:2  
154:17,20 179:6  
199:20 280:9 281:7  
297:6 328:19 362:4  
**effort** 20:2 39:19  
**efforts** 49:3 78:17  
**EHR** 60:8,19 380:5,10  
400:19,22  
**EHRs** 377:19  
**eight** 243:1,3 297:11  
**Eighty** 155:9 156:16  
327:10  
**Eighty-five** 199:7  
**Eighty-nine** 280:6  
**Eighty-three** 57:15  
**Eisen** 316:21 337:15  
**either** 31:5 68:19 88:15  
100:5 111:9 120:21  
121:14 171:11 191:16  
192:7 214:1 250:7  
298:6,9 299:20,21  
305:19 308:15 332:3  
338:4 339:12 341:3  
**elaborate** 87:15  
**elder** 18:22  
**electronic** 283:7 284:10  
284:11 291:2 293:2  
401:20  
**electronically** 103:5,7  
281:22  
**element** 320:18  
**elements** 91:7,10 92:11  
281:2 283:13  
**eleven** 347:21 353:16  
**eligible** 112:2 139:5  
208:2 306:6 342:22  
**eliminated** 275:8  
**eliminating** 290:3  
**elimination** 102:8  
**Elisa** 3:4 10:17 64:11  
175:5 205:10  
**email** 119:20 170:18  
305:11 329:19  
**emailing** 305:2



- emails** 29:6 328:6  
**eMeasure** 404:9,13  
**emergency** 15:3,6,9  
 23:3 58:1 141:4 142:3  
 147:3 172:3,12,18  
 228:18,22 229:4,9,11  
 231:11,15,18 232:1  
 234:4,22 238:5  
 261:13 262:5,11  
 263:8 266:1,3,5 272:5  
 272:10 273:13 274:16  
 278:14 282:3,19  
 301:19 304:11 342:16  
 342:19 343:4 344:7  
 390:13,21  
**emphasis** 172:13  
 241:17  
**employed** 46:18,19  
**employee** 17:7 238:12  
**employers** 11:17  
**employing** 168:8  
**employment** 318:13  
**EMR** 329:3  
**en** 99:22 103:12 303:11  
**enabling** 70:4  
**encompass** 155:3,21  
**encompassed** 117:16  
 117:19  
**encompasses** 158:10  
 262:17  
**encounter** 172:14,16  
 230:3 285:10  
**encourage** 70:18 72:3  
 112:22 380:16  
**encouraging** 71:7,17  
 185:14  
**end-stage** 15:8  
**endeavor** 20:19  
**ended** 236:20 311:11  
 311:12  
**endorse** 64:21 320:10  
 320:10  
**endorsed** 52:21 53:2  
 62:14 71:12 74:3 80:2  
 127:19 184:12 203:13  
 204:4,7,15 205:17  
 226:12 238:8 249:3  
 253:14 255:7,19,20  
 287:16 297:19 299:11  
 308:15 320:8 340:8  
 357:12 362:13  
**endorsement** 7:17,18  
 87:22 88:2 92:2  
 126:10 127:16,18  
 174:12 175:2,6 184:3  
 195:1 203:20 226:2  
 248:19 255:13 256:9  
 285:18 286:6 287:7  
 287:18,20 288:1  
 337:12 363:16  
**endorsing** 126:7  
 127:16 323:14,17  
 324:3  
**energy** 268:15  
**enforced** 377:18  
**engaged** 185:21 186:1  
 194:9  
**engagement** 34:20  
 379:3  
**engaging** 140:15 183:4  
**enhanced** 61:10,11  
 264:14  
**enlightened** 295:11  
**enrolled** 134:19  
**enrollees** 59:22  
**enrollment** 381:9,10,11  
 381:12 383:8  
**ensure** 50:21 168:5  
 289:18  
**ensuring** 390:19  
**entire** 11:8 72:2 164:21  
 185:12 313:8 353:10  
 363:8  
**entirely** 328:2 368:13  
**entirety** 222:16  
**entities** 143:9 251:9  
**entity** 322:2  
**environmental** 39:10  
 168:18  
**environments** 340:16  
**episodic** 69:13  
**EQRO** 18:11  
**equal** 83:4 201:22  
**equity** 68:6 145:3  
**equivalent** 268:6  
**ER** 185:5 233:6 236:18  
 236:19 237:1 268:1  
 345:15  
**errors** 241:19  
**especially** 75:6 86:8  
 96:10 128:5,6 172:21  
 185:19 193:11 196:9  
 196:9 281:20 284:6  
 288:15 310:1 372:21  
 381:10  
**essentially** 34:3 188:10  
 268:16 332:7 387:5  
**established** 261:8  
**estimated** 60:16  
**et** 19:1 49:22 78:9 80:22  
 107:4,5 131:14  
 132:13 157:11 164:1  
 168:19  
**ethnicity** 146:20,22  
**eval** 345:6  
**evaluate** 99:4 114:20  
 114:22 266:11  
**evaluated** 87:2 127:22  
 215:13 258:21 266:7  
**evaluating** 167:15  
 216:8 378:15  
**evaluation** 103:9  
 378:11  
**event** 237:13,13,16  
**events** 114:17 237:14  
 237:15  
**eventual** 252:3  
**eventually** 7:22  
**everybody** 5:4 8:8  
 22:17,18 26:2 27:16  
 29:8 32:1 33:2 34:19  
 34:20 44:10 46:15  
 64:2 97:21 103:22  
 238:22 306:20 360:14  
 383:12 384:7 405:16  
**everyone's** 252:11  
**eviction** 182:3  
**evidence** 60:4 79:15,19  
 80:7,18 82:20 95:1  
 128:2 155:5 156:1  
 321:21  
**evidence-based** 197:12  
**evidenced** 279:11,22  
**exact** 64:14 119:21  
 346:2 404:9  
**exactly** 75:14 152:20  
 162:9 190:1,3 216:6  
 258:9 273:10 275:5  
 292:5 357:2 368:9  
**example** 52:11,18 59:4  
 71:21 74:20 91:21  
 96:3 157:6 172:2  
 182:1 234:3 367:6  
 369:11,12,13 370:2  
 370:12 371:7  
**examples** 52:22 61:8  
 112:21 370:10  
**exceeded** 215:14  
**Excel** 78:21 79:6  
 122:15  
**Excellence** 317:8  
**excellent** 123:1  
**exception** 124:19  
 341:22  
**exchange** 131:21,22  
 281:13 283:8 285:8  
**excited** 19:21 20:8  
 190:19  
**exciting** 75:4  
**excluded** 88:16  
**excludes** 349:2,3  
**excluding** 253:1  
**exclusion** 399:8  
**exclusions** 51:1  
**excuse** 175:14  
**executive** 1:14,16 2:6  
 8:11 21:17 290:9  
**exemplified** 380:13  
**exhibited** 383:17  
**exist** 39:18 43:6 60:15  
 126:3 238:14  
**existence** 145:1  
**existing** 39:22 204:7  
 249:2 331:6 343:9  
**expand** 146:11  
**expansion** 134:12,19  
 144:13  
**expect** 100:21 130:8  
**expectation** 66:5  
**expects** 175:4  
**expedite** 366:19 374:4  
**expenditures** 57:8,10  
 60:1  
**expense** 10:2 193:22  
**expensive** 378:1  
**experience** 37:8 42:22  
 45:9 53:18 57:3 59:21  
 65:13 140:9 171:8,10  
 175:20 176:17 192:6  
 193:5 227:5 270:11  
 283:3 356:1 358:4  
 397:13  
**experienced** 103:18  
 172:8  
**experiencing** 57:12  
 401:8  
**experimentation** 71:17  
 72:9  
**expert** 16:20 121:22  
 312:21  
**expertise** 41:10,22  
 83:19 108:22 128:16  
 133:19  
**experts** 78:15 219:22  
**explain** 62:21  
**explicitly** 309:20  
**explore** 198:2 325:22  
**exponential** 117:13  
**express** 295:17  
**expressed** 246:21  
**extensively** 326:11  
**extent** 104:9,16 105:2  
 106:5 107:1,14  
 108:17 150:4 153:20  
 154:16 155:13 156:6  
 162:13 166:8 177:17  
 178:14 179:5 199:1  
 199:10,18 200:7  
 206:17 219:3 274:17  
 278:15 279:8,20  
 280:8 296:9,19 297:6  
 297:17 300:4,16

327:3,14 328:18  
 330:4 332:19 334:13  
 340:19 347:14 361:5  
 361:16 362:2,4,15  
 381:11  
**extra** 148:14  
**extract** 402:15  
**extracting** 261:16  
**extremely** 6:1 161:2,10  
 213:17 256:4 258:3  
**eyeballing** 373:13

## F

**FAAFP** 2:15  
**FAAP** 1:15 2:11  
**face** 40:8 127:7  
**FACEP** 2:9  
**facilitate** 26:18,22  
 61:17 89:19 124:7  
 293:3  
**facilitates** 294:15  
**facilities** 19:1 213:17  
 214:13  
**facility** 211:12 214:6,9  
 272:2 280:20 296:7  
**facing** 30:9  
**FACP** 1:17  
**FACS** 2:4  
**fact** 31:14 63:21 107:6  
 194:10 239:8 267:1  
 277:11 334:2 378:18  
 380:4 399:1,6  
**factor** 132:1  
**factored** 188:8  
**faculty** 8:12  
**fail** 275:22 277:17  
 280:15 281:4 301:22  
 302:1 309:8 347:5  
**failed** 159:10 240:8  
 277:20 346:3  
**fails** 276:8  
**failure** 53:20 182:2  
**fair** 320:4  
**fairly** 147:7  
**fall** 34:16 122:11 299:21  
 300:10  
**fallen** 135:17  
**falling** 117:12  
**falls** 62:18 136:19  
**familiar** 48:13 238:10  
 307:20 312:22  
**families** 108:19 109:2  
 156:10 206:20  
**family** 1:18 2:9 15:16  
 22:5 46:16 56:10 72:5  
 217:4,7 318:12,14  
**family-centered** 173:14  
 173:19

**fancy** 178:21  
**fantastic** 37:7  
**far** 82:18 234:14  
**farther** 112:16  
**favor** 117:18 372:19  
**favorable** 260:20  
**feasibility** 79:14,18  
 80:15,19 82:19 96:4  
 110:5,8,11,20 194:5  
 195:5,8 315:13 319:9  
**feasible** 85:9 96:6,13  
 209:8 219:20 262:9  
 378:3 404:22  
**federal** 45:2  
**Federally** 57:19  
**FedEx** 404:21  
**fee** 139:7  
**fee-** 132:7  
**fee-for-** 139:18  
**fee-for-service** 71:13  
 139:10  
**fee-related** 194:15  
**feedback** 62:15 78:14  
 81:10,14,15 87:12,13  
 136:18,21 137:8  
 192:9,14 193:8  
**feeding** 13:3  
**feeds** 191:18  
**feel** 6:11 25:3,7 38:4  
 44:12 131:18 136:1  
 140:3 151:13 161:12  
 162:17 163:7,8 187:5  
 224:17 230:21 249:20  
 324:18 325:16 336:14  
 343:19 344:5 355:4  
 377:3 388:5  
**feeling** 271:8 278:4,5  
 393:18  
**feels** 99:21 376:14  
**fell** 59:1 61:4  
**fellows** 14:4  
**felt** 50:9 101:2 218:8  
 242:3 311:16,20  
 312:1,10 319:7,8  
 343:8,17 348:8,12,19  
 357:3 363:17 369:19  
 370:3 381:19 382:16  
 388:15  
**field** 74:5 112:11  
 121:20 174:9 379:11  
**fields** 121:17 400:22  
**fifteen** 155:10 156:17  
 162:19 260:2  
**fifth** 299:15 339:3  
**Fifty-eight** 361:21  
**figure** 75:9 94:19 143:1  
 243:4 250:20 358:17  
 359:7

**figuring** 75:11  
**file** 120:3  
**fill** 39:3  
**filled** 380:7,10  
**filling** 54:12  
**final** 34:6,11 52:5 63:8  
 86:14 95:11 115:8  
 119:7 136:21 167:15  
 180:15 195:14 225:22  
 226:22 235:19 301:17  
 325:9 326:18 368:8  
 368:22 404:14 405:19  
**finalized** 77:9,9 94:1  
**finalizing** 30:17  
**finally** 13:16 24:21  
 32:11 40:10,20 42:2  
 45:1 52:16 77:20  
 88:13 115:10 174:18  
 182:11 218:1 260:6,7  
**financial** 9:17 14:21  
 15:13 17:12,21 18:13  
 19:9,17 20:21 24:22  
 190:16  
**Financing** 2:21  
**find** 7:3 20:4 47:21 68:7  
 79:20 80:1,2 81:17  
 83:16 84:17 86:7  
 101:18,19 174:8  
 188:21 191:6 218:4  
 223:9 319:18 350:14  
 358:12,13 364:7  
 371:9  
**finding** 55:16 197:18  
**finds** 241:1  
**fine** 129:15 206:11  
 233:19 331:15 406:6  
**Finestone** 1:16 14:20  
 14:21 349:20 350:2  
**finicky** 328:16  
**finish** 33:17 34:14  
 405:11  
**finished** 12:17 27:5  
 221:21  
**firm** 147:19  
**first** 20:13 30:6 49:16  
 53:1,16 65:3 77:13  
 90:12 94:22 95:4 99:4  
 104:3,4 105:2 109:20  
 114:12,20 115:16  
 116:22 123:3 148:12  
 148:12 150:4 151:16  
 162:13 166:8 177:16  
 180:22 185:10 188:2  
 197:7 198:22 213:2  
 219:3 228:8 234:3  
 238:4 244:1,7 251:7  
 271:21 273:11 274:17  
 275:21 276:7 290:12

313:9 315:5,22  
 343:11 346:3 347:5  
 347:13 369:19 370:3  
 371:18 372:4,21  
 377:8 397:11  
**fiscal** 194:4  
**fit** 49:14 71:18 74:16  
 110:5 313:20  
**fits** 40:16  
**five** 57:6,18 60:1 74:7  
 77:18 97:7 107:15  
 117:6 153:17 155:11  
 156:18 199:16 201:15  
 201:16 202:2,3  
 275:11,15 297:15  
 307:5 327:11 342:18  
 343:3 351:3 361:13  
 362:22 364:7 374:13  
 391:3,4  
**five-minute** 97:6  
**five-thirty** 392:8,9  
**flag** 121:2 244:22  
**flagged** 229:10 231:17  
 262:10  
**flat** 356:2 357:4  
**flaw** 386:12  
**flip** 137:14  
**floating** 31:21 341:8  
 406:1  
**floor** 1:8 182:5 240:12  
 380:20  
**flows** 288:14  
**flying** 381:1  
**focus** 36:4 54:17 55:14  
 58:7 95:4 143:1 160:8  
 188:17 209:6,18  
 248:10 313:5  
**focused** 41:11 53:18  
 188:18 209:20 210:1  
 312:5 318:20 388:15  
**focuses** 55:9 57:1  
 59:13 208:22 389:7  
 398:10  
**focusing** 61:2 251:21  
 402:10  
**folks** 29:5 32:9 45:7  
 65:2 66:10 69:11  
 138:12,18 139:11  
 145:11 147:20 158:13  
 160:8 161:12 171:19  
 186:12 196:10 214:9  
 215:22 229:15 232:17  
 233:1,3,4 278:9  
 318:18 325:17 351:17  
 353:11 404:20 405:4  
**follow** 147:13 166:4  
 217:16 276:22 338:2  
 340:1 344:18

**follow-** 63:15 239:4  
**follow-up** 133:8 171:11  
 172:12,16,18 228:18  
 229:3,11 231:10,18  
 232:4,8,10 234:4,21  
 237:2 238:4 252:14  
 262:5,11,13 263:5,8  
 272:9 273:13 274:16  
 277:8,14,21,22  
 278:13 289:13,13  
 370:4,7,9 385:6  
 388:12 389:18 390:12  
 390:20  
**followed** 55:4 208:19  
**following** 56:8 75:14  
 87:5 88:15 180:17  
 232:1 269:21 395:12  
**follows** 208:15  
**food** 168:18  
**foot** 20:16  
**football** 167:12  
**for-performance**  
 184:11  
**for-service** 132:8  
**Force** 17:1 112:4  
**forces** 14:17  
**forcing** 278:1 353:14  
**form** 10:22 183:18  
 238:14  
**formality** 32:15  
**formally** 340:14 392:17  
**formed** 18:3  
**former** 17:7 29:13  
**formerly** 402:21 404:11  
**formula** 85:2  
**forth** 32:2 163:1 250:20  
**Fortunately** 319:17  
**forty** 154:13  
**Forty-seven** 362:10  
**Forum** 1:1,8 39:21  
 41:22 112:2 113:3,13  
 395:2  
**forward** 10:10 33:4 34:4  
 34:17 37:14 62:9 63:8  
 65:6,19 69:22 74:1,17  
 95:7 98:3 113:19  
 156:4 159:16 193:9  
 196:5 198:1 201:1  
 206:16 225:7 250:8  
 293:16 302:18 306:15  
 308:16 317:21 338:3  
 374:16  
**found** 68:7 82:20 83:16  
 84:18 85:4 121:16  
 164:3 174:2,14  
 182:13,13 189:7  
 208:16 312:4 315:3  
 317:2 354:8 356:4

364:10 369:12,12  
 395:18  
**Foundation** 2:9 17:3,5  
**Foundation's** 15:16  
**foundational** 37:3  
**four** 5:9,22 29:18 48:11  
 48:14 53:15 77:9,17  
 79:12 80:13 84:9  
 112:20 119:11,13  
 169:15 183:22 184:5  
 224:22 236:18 242:1  
 242:3 266:7 276:13  
 354:19 359:10 396:20  
 396:20  
**four-year** 36:3  
**Fourteen** 169:16,17  
**fourth** 79:6 276:9  
 277:18 310:5 340:20  
 340:20 342:1  
**FQHC** 14:13 146:4  
 160:10 195:11 290:1  
**FQHCs** 57:22  
**frame** 65:14 381:7  
 382:1,7  
**frames** 395:17  
**framework** 42:12 62:18  
 62:19 65:10 66:3,6,10  
 66:18,22 79:9  
**frameworks** 42:16  
**framing** 38:19  
**free** 33:17 195:21  
 224:17 344:5 368:20  
**Frequency** 68:6  
**freshen** 391:15  
**friends** 328:4  
**front** 11:6 104:7 198:10  
 202:21,22 227:18  
 228:11 269:22 345:10  
 376:10  
**frustrated** 31:20  
**full** 49:8 50:15 293:22  
 309:7  
**fully** 49:18 50:19 51:15  
 52:20 53:13 88:11  
 107:19 155:16 206:2  
 322:21 334:15 335:17  
**function** 149:14 207:14  
 218:12 219:2 265:18  
**functional** 37:2,19  
 207:13,20 208:10  
 209:10 210:12 211:12  
 211:14 218:9,10  
 219:1 221:15 265:17  
**funded** 320:16 321:2  
**funding** 6:20  
**further** 49:7 83:5,9  
 87:15 103:14 249:18  
 254:2 309:15 325:22

326:1 382:9 386:22  
 387:7,16 388:3  
**future** 93:14,21 95:13  
 226:18 251:15 255:20

## G

**gains** 181:7 187:18  
 198:21  
**gamed** 380:14  
**gaming** 227:10  
**gap** 39:4 43:6 253:3  
 312:4 343:20 346:18  
 347:6 388:16  
**gaps** 39:3,8 95:1,1,1  
 157:8  
**gather** 46:8  
**gauges** 222:2  
**geared** 139:14  
**Geisinger** 282:14  
**Gelzer** 1:17 4:11,14  
 20:11,12 61:22 62:3,4  
 63:13 115:13,16  
 118:16 129:17,18  
 130:14,17 135:11  
 157:12,15 165:17  
 170:6 173:16 217:18  
 217:22 218:5 223:22  
 224:12,16 227:2  
 230:14 231:7 233:11  
 241:22 242:17 250:3  
 266:18 267:14 268:20  
 269:2,20 270:3,7,9  
 275:5,13 285:4,4  
 289:8,12 292:5 293:6  
 302:16 333:13 348:22  
 359:21  
**Gelzer's** 216:19  
**gender** 144:10 157:11  
 164:1  
**general** 18:8 19:12  
 95:17,19 135:1 139:2  
 165:18 250:19 383:21  
**generally** 45:13 127:1  
**generates** 397:10  
**generating** 273:19  
**gentleman** 270:10  
**geographic** 282:21  
**getting** 35:10 67:18  
 96:21 104:6 133:11  
 134:14 144:5,7 148:1  
 192:16 248:14 251:16  
 314:4 329:13 340:4  
 341:3,6 390:22  
 401:14  
**gift** 32:14  
**give** 40:15 76:12 86:17  
 106:18 115:17 136:11  
 148:13,19,22 150:1

197:2,3 220:16 224:6  
 228:8 241:5 242:10  
 243:16 248:5 252:2  
 300:13 305:5 310:19  
 321:21 349:18 369:11  
 393:17 399:18 405:14  
**given** 134:3 208:9  
 210:20 242:8 244:6  
 248:7 308:14 379:14  
 395:16 396:7  
**gives** 105:19  
**giving** 242:7,8 366:7  
**glass** 26:14  
**global** 91:9 92:15,17  
 241:18  
**gnashing** 283:5  
**go-round** 256:4  
**goal** 48:9 52:3 101:18  
 109:7 136:7 161:2  
**goals** 4:6 35:1 36:17  
 37:4 40:20 48:7 78:15  
**gold** 261:8 294:9,18  
 295:1  
**Gorham** 3:3 26:6,7  
 27:18 28:3 62:10  
 76:10 86:13 90:1,8  
 91:11,19 92:14,18  
 95:9 97:2 113:20  
 127:13 130:21 149:17  
 151:8 152:9,20  
 174:17 175:22 198:4  
 200:18 201:10 202:20  
 203:21 204:17 206:11  
 220:14 227:15 233:17  
 235:9,20 245:8 248:1  
 265:5 272:14,22  
 273:4,7,10 275:18  
 276:11,14 278:7  
 291:9 298:12,19  
 299:14 300:9 301:2  
 302:6 303:7 307:2,7  
 316:22 324:2 330:14  
 331:9 332:11 333:21  
 358:6 374:14 375:5,9  
 375:15,19 404:8  
**gosh** 316:7,9  
**Gotcha** 368:15  
**gotten** 85:9 146:9 338:9  
 369:8  
**Governor** 268:4  
**grab** 322:6  
**gracious** 76:15  
**grader** 299:15  
**grant** 14:3 17:2,5 36:9  
 186:8 190:12  
**grants** 11:10 15:13  
 23:16 148:11 187:9  
**graphic** 77:11

**grassroots** 75:8  
**gray** 169:2  
**greater** 28:16 83:4  
 89:10 179:19 201:14  
 202:4 390:5 397:10  
**green** 206:9  
**grossly** 307:3  
**ground** 64:17 83:18  
 160:15 248:13  
**group** 14:10 23:8 31:17  
 57:8,11,14,17 67:12  
 70:3 81:11 93:10  
 99:15,21 105:11  
 112:2 130:3 131:8  
 135:13 141:6,22  
 148:5 149:1 165:14  
 202:11 209:18 215:4  
 221:11,19 222:2  
 224:19 232:15,20  
 251:16 257:11 258:13  
 258:14 259:11 261:1  
 261:18 263:2 264:22  
 266:8 278:1 319:7  
 325:14,16 348:8  
 363:13 379:21 393:6  
 404:19 405:20  
**grouping** 42:18  
**groups** 38:17 103:22  
 104:1 133:17 201:15  
 264:1  
**growing** 55:18  
**guarantee** 213:15  
**guess** 23:9 25:18 31:13  
 32:12 34:16 48:3  
 93:14 96:2 129:2  
 132:19 133:5,14  
 140:4 148:4 160:9  
 191:7 192:9 204:12  
 223:3 232:17 253:17  
 274:22 303:16 317:18  
 319:8 329:9,18 332:5  
 387:2,13  
**guest** 21:4  
**guidance** 95:20 136:12  
 161:7,14,16 242:8  
 322:14  
**guide** 91:16 120:3,9,10  
 152:10 162:12 163:14  
 166:2 181:6 198:6  
 207:10 228:5 241:11  
 257:14,17 258:19  
 259:14 272:19,20  
 273:7,12 280:18  
 326:22 342:14 377:10  
 378:10 379:2,19,22  
 381:4 384:16 389:17  
 390:11 395:5 396:2  
 397:1 398:5 400:13

402:2 403:1  
**guidelines** 157:6  
 348:13 354:8  
**guides** 222:22 262:4  
 264:6 269:16 315:8  
 388:14  
**guiding** 17:15 42:16,16  
 66:10 119:17  
**gut** 176:21  
**Gynecology** 8:14

---

**H**


---

**H** 120:3  
**half** 57:7 59:22 117:8  
 134:18 183:8  
**half-ass** 132:19  
**Halls** 20:4  
**Hamblin** 1:19 17:16,17  
 132:18 152:3,7,18,21  
 169:14,17 191:22  
 194:16 236:8 247:11  
 247:16,19,21 248:3,7  
 249:4,11,16 263:3  
 265:2 303:22 324:17  
 329:6  
**hand** 89:5,6,8 103:6,13  
 103:15 120:16 157:22  
 180:19 274:6,10,10  
 274:21 276:4 278:20  
 279:1,5 280:2,5,11  
 296:12,16,22 297:8  
 297:13,14,21 298:2,3  
 300:7,19,22 301:1,5,8  
 301:11 302:21  
**handle** 234:20  
**handling** 39:13 376:8  
**handoff** 210:11 211:4,6  
**handout** 119:15,17,21  
 149:22 151:7  
**hands** 96:20 278:21  
 280:3,12 296:13  
 297:1,9,22 300:8,20  
 301:6,9 378:7  
**happen** 195:13 196:4  
 284:19 352:7  
**happened** 353:20  
 364:12  
**happening** 64:16  
 113:17 284:18 358:17  
**happenings** 86:21  
**happens** 211:19 227:1  
**happy** 21:8 32:16 46:2  
 76:4 260:12 313:16  
 341:20,21  
**hard** 34:5 35:10 104:5  
 106:22 116:5 201:21  
 202:1 256:8 284:2  
 285:9 307:3 321:21

**harmonization** 243:7  
**harmonize** 101:12  
**hat** 91:6 148:9  
**hate** 192:1  
**HCBS** 47:17 71:20  
 208:9 210:21 211:8  
 211:10  
**HCP-** 17:14  
**HCP-LAN** 12:17  
**HCPCS** 17:14  
**head** 145:21 158:14  
 184:15 220:18 391:10  
 406:12  
**heads** 306:17 335:11  
**healthcare** 2:6 13:10  
 22:8,11 29:21 142:2  
 306:11  
**Healthy** 198:15  
**hear** 5:5 22:18 33:13  
 35:15 37:7 61:22  
 106:17 113:7 116:15  
 136:14 192:14 217:18  
 224:12,15 234:18  
 249:22 254:13 260:12  
 275:17 278:8,10  
 334:20 350:22 386:4  
 391:2  
**heard** 25:15 37:11 45:7  
 107:15 113:9 176:18  
 192:8 198:8 210:13  
 234:15,17 235:13  
**Hearing** 380:21  
**heart** 182:2  
**heavy** 281:21  
**heck** 7:2 269:21 359:7  
**HEDIS** 18:16 146:2  
 247:6 249:1 383:7  
**Hello** 10:16 61:22  
 217:18  
**help** 8:22 23:1 26:18  
 28:15 36:11 37:3 39:9  
 39:19,21 65:19 66:10  
 66:18 69:21 71:19  
 76:17 144:21 204:14  
 254:9 335:4 353:2  
 365:1 390:19  
**helpful** 8:6 43:7 45:16  
 70:6,21 72:11,11  
 76:12 137:4 145:8  
 187:22 224:10 229:14  
 236:9 244:4 249:18  
 249:22 310:1 311:7  
 358:5 367:10,12,15  
 371:21  
**helping** 44:19 72:15  
 81:16 353:13,14  
**helps** 26:21 86:12  
 145:3 206:6,7 318:18

**hemoglobin** 294:17  
**Hennessey** 1:21 15:18  
 15:19 143:5,6,8,14  
 145:2,7 161:18 188:4  
 188:5 239:19 240:3,9  
 251:5 290:7 292:9  
 298:20 326:13 357:10  
 357:14 371:5 401:18  
**hesitation** 198:1  
**heterogeneous** 57:11  
**Hey** 241:22 369:20  
**HHS** 13:2 21:5 115:22  
 148:9  
**hi** 8:10 13:19 24:1 27:21  
 28:5 47:11 62:3,10  
 64:11 73:6 95:16  
 111:21 137:18 140:1  
 143:5 152:3 157:12  
 160:21 216:18 333:11  
**hierarchical** 197:15  
**hierarchy** 67:20  
**high-** 129:11  
**high-cost** 29:22 129:4  
 129:13 140:21 141:3  
**high-impact** 180:11  
**high-need** 133:11  
**high-risk** 129:9 186:15  
 383:11 388:16 389:9  
 389:22 390:4  
**high/medium** 104:14  
 104:15 296:17  
**higher** 182:10 352:18  
**highest** 54:10 80:20  
 84:10  
**highlight** 217:4 252:19  
 278:7  
**highlighting** 164:18  
**highlights** 367:13  
**highly** 142:17 189:10  
 189:15 192:20,20  
 383:22  
**Hill** 6:18 7:4 13:14  
**Hilton** 17:5  
**HIO** 295:9  
**historically** 183:20  
**hit** 42:15 137:1 355:17  
**hits** 40:12  
**hold** 293:7,10,10  
 305:21 313:13 393:15  
**holding** 218:17  
**holistic** 209:21  
**home** 19:1 23:15 196:2  
 208:18 210:11 211:14  
 211:20 214:2,3 217:9  
 220:20 221:2,13,18  
 226:5 272:2 280:20  
 296:7  
**home-** 13:13 55:11

112:9 113:3,13,15  
**home-and** 112:15  
**homeless** 69:14  
**homes** 190:10 198:14  
 230:10  
**honestly** 214:6  
**honeymoon** 159:13  
**honor** 20:17  
**hook** 89:22  
**hope** 47:6 116:1 310:2  
**hopefully** 32:15 44:10  
 121:1 139:16 290:22  
 308:4 359:10  
**hoping** 10:7 65:4 69:20  
 139:9  
**horizontal** 149:9  
**horrible** 47:13 218:16  
**hospice** 19:3,4 349:4  
**hospices** 19:1  
**hospital** 23:4 54:2  
 207:11 208:18 218:22  
 256:16 259:3,4  
 265:16 269:9 282:1  
 285:3 288:6,7,13  
 289:4,14,16 290:1  
 326:14 401:5  
**hospital's** 288:10  
 289:17  
**hospitalization** 133:9  
 172:15 218:11 230:4  
 232:2,4 252:15  
 262:13  
**hospitalizations** 58:2  
 266:17 384:5  
**hospitalized** 259:3,4  
**hospitals** 209:2 212:3  
 213:14 216:1 281:15  
 282:20 283:4,19  
 284:4,18 293:10  
 401:1  
**host** 138:3 146:2,5  
**hotel** 391:15,19  
**hour** 76:4 112:7 302:8  
 341:20,21  
**hours** 35:13 345:1  
**housed** 36:1 79:6  
**housekeeping** 26:11  
 391:5 392:15  
**housing** 318:13  
**hovering** 214:8  
**Howard** 116:3  
**huge** 130:6 132:15  
 144:12 177:7 183:21  
**hugely** 285:6  
**Human** 2:2,14 22:20,21  
**hundred-and-some**  
 317:15  
**hundred-plus** 183:2

**hundreds** 317:11  
**hung** 341:3  
**husband** 17:7  
**Hyatt** 392:2  
**hypertension** 239:7

---

**I**

---

**IADLs** 211:15  
**IAP** 4:10,13,16 35:16  
 36:1,15 38:12,20,22  
 40:17 41:7 43:20  
 48:10 49:10 76:22  
 78:19 209:18  
**ICD-10** 268:14,16  
**ICD-9** 268:13  
**idea** 32:8 51:9 67:4  
 132:13 137:11 177:5  
 194:6 209:19 231:6  
 237:3 323:12,17  
 352:14 372:22  
**ideal** 32:6 43:16  
**Ideally** 43:3 52:5  
**identification** 54:21  
 315:12  
**identified** 51:22 55:5  
 56:2 58:10 59:1,3  
 61:3,5 65:18 78:13  
 82:10 91:1 115:1,4  
 118:21 121:10 122:1  
 126:2 162:16 180:2,5  
 181:9 207:9,15 222:7  
 229:5,8 231:12,14  
 257:8 259:5 262:15  
 278:18 312:13 314:21  
 361:8 365:17 366:9  
**identify** 34:10 39:21  
 41:14 48:11 65:3  
 68:18,20 69:7 176:16  
 199:3 233:1,6 239:5  
 241:19 261:10 279:15  
 323:12 327:5 336:2  
 336:13 375:3  
**identifying** 39:17 44:5  
 59:6,7 117:3 164:15  
 354:12  
**ifs** 98:4,5,5  
**IHI's** 18:2  
**illegal** 385:10,12,13,15  
 385:16  
**illicit** 54:10  
**illness** 58:19 69:13  
 186:12 190:11 196:11  
 232:5 252:15 262:6  
 262:14 263:15 370:5  
 385:6 388:13,19  
 389:8,19 390:7  
**illustration** 87:7  
**immediate** 21:1 33:7

51:4,16 87:16 88:21  
 104:18 107:14 155:14  
 200:8 297:17 330:5  
 334:5,8,14 335:2  
**immediately** 49:7  
**impact** 7:13 8:1 19:17  
 30:11 34:11 36:15  
 58:20 194:4,5 209:3  
 212:12 216:5,7 217:7  
 221:15,18 289:13,14  
 326:11 381:13  
**impactable** 140:12  
**impactful** 218:14  
**impacts** 141:2  
**impairment** 53:19  
**imperfect** 133:22  
**implement** 33:8 262:9  
**implementation** 23:10  
 58:10 64:6,9 74:13  
 88:21 177:7 193:4  
 400:20  
**implemented** 49:7  
 128:10 188:11 273:16  
**implementing** 23:13  
**implication** 336:8  
**implied** 110:16  
**imply** 336:1  
**importance** 30:4  
 185:15 278:8 390:17  
**important** 6:1,22 10:6  
 11:19 20:5 27:1 31:10  
 34:10 35:16 38:6,10  
 42:3 56:5 76:7,10  
 81:1 83:14 87:13  
 108:17 109:1,2,4,8,21  
 113:5 118:6 127:4  
 130:9 134:1 136:1  
 140:14 141:20 142:7  
 144:19 156:7,9,10,12  
 163:7 172:18 180:10  
 192:3 193:2,4 196:5  
 206:18 208:12,22  
 209:11,19 229:2  
 231:1 240:22 242:4  
 248:9,10 258:4  
 284:21,22 285:7,12  
 285:20 289:9,19  
 290:10,14 300:5,16  
 318:5,16 332:20  
 337:20 362:16 372:15  
 379:10 390:19 395:19  
 396:12 398:9  
**impression** 223:5  
**improve** 29:10,14  
 106:10  
**improvement** 9:17  
 14:18 18:10 38:2,2  
 106:6,13 130:7

153:21 154:3,9 177:9  
 178:16 179:17 182:7  
 199:11 228:21 264:11  
 279:10,21 284:5  
 296:20 321:20,22  
 327:15 361:17 382:3  
**improvements** 185:3  
 291:1  
**improving** 29:20 48:16  
 56:5,21 57:20 114:14  
 191:14 228:9  
**in-** 98:16 147:3 252:8  
**in-class** 365:21  
**in-person** 51:18 86:15  
 86:20 118:20 119:1  
 120:2 258:22 311:12  
**inability** 182:1  
**inadequate** 252:17  
 267:7  
**inappropriate** 119:4  
**incentive** 295:22  
**incentives** 9:17 29:11  
 191:14  
**incentivize** 10:9 261:13  
 272:12  
**include** 50:22 52:6  
 55:13 99:15 121:17  
 128:19 133:3 136:6  
 137:22 139:1 157:19  
 163:10 168:15 180:7  
 181:19 242:14 255:14  
 286:3 307:12 312:2  
 326:1 377:20 403:9  
**included** 78:7 79:3  
 81:18 119:7,15 120:6  
 133:7 136:2 151:6  
 179:20 180:15 222:17  
 227:21 263:20 270:13  
 385:13 399:8  
**includes** 49:19 50:20  
 51:10 57:8 107:20  
 108:4 138:1 146:4  
 210:12 223:19 348:15  
 369:18 388:18 398:14  
**including** 6:10 16:2,21  
 24:19 51:10 60:7  
 108:19 109:3 133:22  
 156:11 168:8,16  
 180:21 203:17 207:18  
 217:8 241:4 325:13  
 385:4 403:11  
**inclusion** 88:17,19  
 112:19 156:20 163:2  
 167:2 205:13,20,21  
 207:6 219:12 225:9  
 280:16 301:16 333:19  
 348:2 363:1  
**inclusive** 50:13

**inconsistently** 229:9  
 231:15  
**incorporated** 283:13  
**incorrect** 198:7 350:2  
**increase** 10:5 134:14  
 184:6 293:2  
**increasing** 30:4 36:15  
 273:20  
**increasingly** 282:7  
**incredibly** 208:7,21  
 209:18 324:21  
**incremental** 112:14  
 182:8  
**incubator** 193:15  
**independent** 141:1  
**Index** 257:19,21  
**Indiana** 24:15  
**Indianapolis** 24:19  
**indicate** 26:20 112:17  
 225:11 367:4  
**indicated** 174:21  
 232:10  
**indicating** 163:6 183:16  
**indication** 159:6 299:9  
 299:13  
**indicator** 163:19 229:6  
 231:13  
**indicators** 87:5 113:7  
 269:6 270:6  
**indirect** 183:7  
**indirectly** 7:14  
**individual** 52:19 91:12  
 91:14 92:8 189:2  
 209:15 270:21 288:15  
 316:21 366:6 378:2  
**individual's** 157:4  
**individually** 119:14  
 223:6 242:19 258:12  
 366:5  
**individuals** 11:16 18:3  
 56:6 58:14,17 59:20  
 69:7 117:7,9 119:19  
 135:16,16 139:17  
 151:20 163:21 186:11  
 186:22 208:13 349:1  
 353:21 354:13 358:10  
 359:6  
**industry** 2:5 13:9 16:7  
 213:13  
**inefficient** 389:4  
**infer** 190:17  
**influence** 128:14  
**influenza** 143:22  
**inform** 69:22 119:18  
 211:7  
**information** 11:3 39:9  
 53:15 60:21 68:12  
 76:11 79:2,5,21 80:1

80:3 81:17 82:17  
 83:15,17,19 84:19  
 85:5 86:7 91:22 92:3  
 92:5,8 96:14 127:5,20  
 145:9 152:10 163:5  
 165:3 167:4 173:21  
 174:18 175:7 176:4  
 176:22 191:18 195:3  
 198:6 212:14 228:15  
 250:14 251:8,10  
 253:19 254:6 255:18  
 256:15 281:12 282:14  
 283:8 286:13 289:20  
 290:3 291:2,10 292:1  
 295:2 316:19 317:2  
 318:11 335:19 339:15  
 339:15  
**informed** 40:7 139:21  
 159:13  
**infrastructure** 282:5  
**initial** 77:18 81:5,7  
 174:12 175:6  
**initially** 62:13 87:2  
 110:14 130:22 255:12  
 255:12 395:10,15  
**initiation** 379:3,9  
**initiative** 22:2 69:19  
**initiatives** 352:5  
**injuring** 64:8  
**innovation** 1:3,15 3:8,9  
 8:12 23:12 28:1,7  
 35:22 36:6 48:12 75:7  
 193:15 304:17  
**innovations** 29:2 40:11  
**inpatient** 172:16 218:11  
 226:5 232:2 252:21  
 264:8,17 265:6 272:2  
 280:20 296:7  
**input** 105:11,13 372:14  
**insightful** 113:21  
**insights** 35:18 142:13  
**Insignia** 194:11  
**instance** 132:12 164:11  
 206:19 385:11  
**instances** 281:15  
**instantly** 96:13  
**institute** 1:14 8:11,16  
 68:4  
**institution** 221:4  
**institutional** 55:13  
 221:5,9  
**institutionalization**  
 56:8,15  
**institutions** 20:6  
 112:20 318:15  
**instrument** 52:9 192:18  
**instrumental** 81:16  
**insufficient** 266:14,21

**insurance** 54:8 132:5  
 134:13 144:14 146:14  
**intact** 295:14  
**integrate** 324:12  
**integrated** 60:5,22  
 322:21  
**integrating** 19:7  
**integration** 30:2,8  
 42:20 44:14,16 48:19  
 48:22 55:7 59:12 60:6  
 61:10,15 84:10  
**integrity** 30:2  
**intensive** 172:14,15  
 230:3  
**intent** 64:22 73:20  
 399:22  
**intention** 337:9  
**interest** 4:3 10:14,21,22  
 11:22 17:12 19:9 24:3  
 37:9 46:11 68:5 373:1  
**interested** 6:4 11:9  
 69:17 142:16 252:5  
 282:8 406:13  
**interesting** 29:8,9  
 72:21 173:2,7 177:2  
**interests** 18:13  
**interface** 9:15  
**Interim** 2:6 13:10  
**internal** 22:4 152:22  
**internal-facing** 40:6  
**internally** 41:19 68:1  
 191:3  
**internist** 18:8  
**interpreted** 335:4  
**intervene** 6:10  
**intervention** 56:14  
 269:11,11 311:20  
 369:18,21,22 371:11  
 384:18 385:9 386:9  
 387:20 388:1 397:10  
 398:6,7,11,15 399:6,7  
 399:13,15,17  
**interventions** 58:6  
 144:22  
**Interview** 378:11  
**introduce** 12:3 26:2  
 27:15,19 28:11 46:10  
 67:2  
**introducing** 133:19  
**introduction** 37:7 70:17  
**introductions** 4:3 10:21  
**introductory** 291:12  
**intuitively** 289:15  
**invariably** 207:21  
**inventory** 78:8  
**invitation** 120:5  
**invite** 114:4 115:14  
**invited** 21:4

**involved** 13:4 19:10  
 21:20 22:1,9 23:5  
 125:15  
**iPads** 197:3  
**IPRO** 18:11  
**ironing** 310:3  
**issue** 28:15 29:20 30:1  
 54:6 64:14 70:10,16  
 72:18 104:10,10  
 107:10 110:21 121:4  
 133:21 165:7 188:15  
 189:6 202:2 213:10  
 229:16,22 286:5,21  
 321:8 348:18 382:8  
 382:13,14 390:17  
 395:19 396:12 401:2  
 403:6  
**issue-** 39:12  
**issues** 10:4 17:20 28:21  
 40:5,6,12 59:4 60:8  
 61:9 68:6 95:1 104:12  
 126:2 182:21 192:17  
 195:4 197:5,8 198:9  
 226:16 252:20 305:10  
 355:6 356:11 360:3  
**it'll** 226:21 301:20 302:1  
**item** 28:22 164:21  
 229:21 267:21,22  
 301:22 330:19 331:5  
 332:18 339:3,7,8,10  
 342:1,6 345:22 346:3  
 348:4 378:8,9,22  
 380:22 384:13 388:10  
 388:11 389:15,16  
 390:8 391:3 392:20  
 395:22 396:1,21,22  
 398:1 400:10 401:22  
 402:1  
**items** 53:12 167:22  
 168:11,12 176:15  
 351:10 398:16  
**iterations** 95:13

---

**J**


---

**JAMA** 323:6 326:9  
**James** 115:18,19  
**January** 240:15  
**JD** 2:2,8,9  
**Jeff** 2:13 22:15 23:19  
 29:6 95:17 145:15  
 146:1 170:9 232:11  
 232:16,18 306:4  
 324:9 346:9  
**Jennifer** 1:9,14 4:11,14  
 8:10 12:8,19 35:9  
 46:7 61:17 75:22 93:6  
 124:7 127:15 324:5  
 331:10 405:10

**Jersey** 17:19  
**job** 38:8 162:8 218:16  
 218:18 246:7,10  
 303:6 306:19,20  
 398:3  
**John** 2:15 14:11 73:6  
 181:10 182:16 185:9  
 198:5 251:12 252:10  
 287:8 293:18 338:13  
**join** 35:6 76:15  
**joined** 23:20 24:10 46:8  
 47:9 175:11  
**joining** 5:7,13 12:7  
 21:15 48:2 112:7  
 119:16,19 149:12,22  
 151:7 406:13  
**Joint** 256:13,21 283:17  
 402:9  
**Journal** 16:6  
**judgment** 109:6  
**judicious** 354:2  
**judiciously** 354:10  
**Judy** 2:19 17:10 159:19  
 188:3 211:21 213:1  
 232:16 250:12 251:6  
 256:12 272:15 280:22  
 283:20 291:11,14  
 351:20 373:7  
**Judy's** 373:12 374:15  
**July** 134:11  
**jump** 93:3 145:12,13  
 169:20 171:5 188:14  
 265:14 291:8,10  
 302:1 308:5 344:4  
 349:6  
**jumping** 96:17  
**JUNE** 1:6  
**justification** 144:17  
**justify** 144:22

---

**K**


---

**K** 391:11 392:5  
**Kaiser** 2:7,9 15:16  
 21:19,22 22:2,6  
**Kansas** 254:4  
**Karen** 1:15 3:8 23:20,22  
 24:1,5,6,8,9 28:3,6  
 34:21 46:5 47:5,14  
 65:10 68:3,14 136:11  
 136:15 204:18 205:8  
 243:20 270:15 344:2  
 344:3  
**Karen's** 242:21 291:11  
**Kate** 3:2 26:9 56:17  
 224:2 304:14  
**keep** 7:4 43:7 48:3 87:9  
 98:15 166:5 169:10  
 237:9 301:5 352:21

372:20 375:17,18  
 379:17  
**keeper** 159:18  
**keeping** 222:13 231:5  
 256:17 268:20 352:10  
**Kelley** 2:1 18:5,6 68:22  
 68:22 70:4 137:17,18  
 137:19 145:22 146:1  
 181:9 185:8 189:22  
 190:2,4,7 195:17  
 212:22 243:6 244:6  
 244:13 260:4,12  
 281:10 293:19 316:3  
 316:6,7 317:4 318:8  
 319:2,4,13 353:6  
 357:22 358:8 373:11  
 374:3  
**Kentucky** 116:4  
**kept** 116:22 117:4  
 358:4  
**key** 4:6 28:15,22 29:20  
 30:1,8 33:16 36:17  
 39:12 40:8 48:7 49:15  
 50:20 105:5,7,8,10,14  
 105:14 107:17,17  
 132:1 150:6,21 151:2  
 151:4 152:4,7,12,12  
 152:16,17 162:16  
 166:10,22 177:19  
 186:18 196:7 199:3  
 206:19 219:6 241:1  
 243:6 274:20 278:18  
 296:11 300:17 327:5  
 332:21 347:16 361:8  
 362:17  
**keypad** 394:9  
**kick** 30:22  
**kids** 141:21  
**Kilstein** 2:2 16:9,10  
 124:11,18 125:7,19  
 158:16 159:4,9 165:6  
 165:10 173:10 288:5  
 316:8 323:9,22 329:2  
 360:13  
**kindergarten** 156:15  
**kinds** 138:13 186:14  
**knew** 83:19 255:17  
 334:3  
**knock** 240:8  
**knowing** 110:11 134:1  
**knowledge** 61:9 95:2  
 108:21  
**known** 59:12  
**knows** 68:14 97:22  
 282:19  
**kudos** 116:4  
**Kuy** 2:4 19:11,12 70:1,6  
 134:8 143:18 145:5

---

**L**


---

**la** 341:4  
**labeled** 121:20  
**labor** 34:16  
**laboratory** 29:4,8  
**lack** 56:10 312:6 325:6  
 325:11  
**lacking** 292:18  
**lag** 382:1  
**laid** 202:10 365:18  
**LAN** 17:15  
**language** 206:4  
**large** 36:21 163:20  
 209:10 286:20 320:18  
**largely** 191:22 248:14  
**larger** 209:17  
**largest** 55:22  
**Lastly** 27:6  
**late** 112:7 119:10 178:6  
 312:17 333:22  
**Laughter** 93:11 218:2  
 260:11  
**laws** 351:11  
**lay** 161:15  
**lead** 14:7 71:10 121:10  
 180:13,20 182:15  
 224:5 296:1,3 316:4  
 344:2 389:4  
**Leadership** 21:1  
**leading** 93:9 401:3  
**LeadingAge** 2:17 18:20  
**leads** 23:16  
**learn** 142:22 324:6  
**learned** 185:18 268:3  
**leave** 214:9,18  
**led** 104:1  
**left** 109:22 358:3  
 391:18 392:3  
**left-** 120:15  
**left-hand** 122:6 149:14  
**leftovers** 222:11  
**legends** 268:3  
**legislative** 352:4  
**let's** 30:14 32:9 33:9  
 66:16 80:7 104:22  
 158:21 252:2 258:17  
 259:20 271:14 302:11  
 302:17 304:4 334:1  
 342:2,5,6 353:4  
 360:12 367:6 375:13  
 375:17,18 393:17,22  
 394:17 402:15  
**letting** 166:17 305:10  
**level** 20:5 51:2 64:22  
 70:21 71:1,3,13,20  
 95:8 128:4 144:3,4  
 160:15 177:9 182:10  
 184:4 187:21 196:18

224:7,7 284:4 288:13  
 341:22 348:15  
**levels** 57:3 58:17 71:2  
 139:16 140:9 183:22  
 188:22  
**leverage** 9:16 45:11  
**leveraging** 41:21  
**levers** 37:20  
**liaison** 16:16  
**life** 16:1 52:3 56:5,11  
 167:11 211:13  
**liked** 226:19 286:16  
**Likewise** 25:7  
**limit** 54:12 60:21  
 248:15 355:12 389:13  
**limitation** 71:16  
**limitations** 64:16 125:8  
 133:16 209:15  
**limited** 60:19 159:14  
 348:21 367:22  
**limiting** 368:18  
**limits** 60:10 351:6  
**line** 7:13 24:13 35:6  
 62:20 114:8 115:12  
 123:12 136:11 149:9  
 149:13 162:1 170:6  
 178:3 216:19 217:17  
 288:8,16 305:19  
 317:16  
**lines** 111:8,14 131:14  
 139:21 305:18  
**lingering** 392:13  
**link** 191:8  
**linked** 281:12  
**links** 120:21 121:14  
 122:13,19 228:12  
**list** 77:18 114:16,17  
 122:10 133:6,10  
 134:5 160:11 185:7  
 217:6,12 220:15  
 228:6,12 233:9  
 239:14 240:14 244:7  
 273:9 326:2,15  
 348:10 364:6 366:22  
 369:7 376:9  
**listed** 122:12 172:4  
 265:7 270:18 271:12  
 273:11 310:10 365:13  
**listen** 76:2 185:18  
**listing** 41:5  
**listings** 44:12,20  
**literacy** 192:17,21,21  
**literature** 4:7 48:8  
 182:11 186:3  
**little** 5:19 7:14 29:3  
 33:2 35:7,21 36:18  
 38:18 41:3 75:17 84:7  
 84:19 94:10 97:13,18

98:21 100:1 103:3  
 104:5,22 108:6,12  
 137:12 142:21 148:5  
 148:14,21 165:3  
 174:5 176:22 201:19  
 216:9 245:8 254:2,6  
 255:1 286:18,22  
 310:2 317:6 321:11  
 324:10 328:16 331:3  
 335:13 340:5,11  
 344:6 349:5 355:20  
 366:21,22 376:3  
 399:4,10 405:9,15  
**live** 60:16  
**living** 55:10 56:4 95:22  
**Llano** 28:6  
**Llanos** 3:8 23:22 24:4,5  
 28:5 35:3 47:7 66:7  
 68:16 136:14,17  
 205:7 243:21 244:20  
 260:9 270:16,20  
**load** 120:8  
**loaded** 376:7  
**loading** 376:6  
**lobby** 406:11  
**local** 14:13 64:8 73:13  
 284:4 323:20  
**locally** 10:8 73:12  
**located** 120:4  
**location** 54:13  
**lock-in** 54:11 358:20  
**Lofton** 3:9 27:21,22  
**logic** 51:5 77:21 83:11  
 87:3,10,15 88:13  
 97:20 98:1 100:7,17  
 102:16 103:19 104:8  
 105:1 110:15 119:14  
 119:17 128:13,22  
 149:18 151:12 153:19  
 154:16 155:13 163:1  
 178:13 179:4 180:19  
 204:6 274:4 276:3  
 308:19,21 309:8,19  
 313:8,10 315:2,22  
 332:16 334:11 338:2  
 346:4 376:22 377:6  
 377:14 378:14 379:6  
 384:22 390:16 403:4  
**long** 120:12 160:11  
**long-term** 22:22 30:2  
 48:19 55:8 56:7 138:4  
 207:11 209:2 212:3  
 213:9,11 214:4 216:1  
 218:22 265:16  
**longer** 259:2 304:15  
 378:19 385:12  
**longest** 240:20  
**look** 8:4 10:10 31:12,17

31:19 32:5 33:16 34:7  
 56:7,13 64:14 67:13  
 67:22 68:8 69:8,9,10  
 70:22 71:1,7 74:4  
 88:4,7 90:11 95:11,20  
 96:7 98:11,12,13,17  
 99:11,14 101:10,14  
 101:22 102:6,11,18  
 104:2 108:10 109:8  
 110:7 113:19 118:4  
 128:1 132:16 138:19  
 140:13,22 141:12,19  
 146:13,17,22 147:2,5  
 147:9 152:9 158:20  
 169:1 176:2 183:1,6  
 187:15 188:9 193:11  
 194:7 203:3 210:19  
 211:1 214:15 216:4,7  
 220:16 222:21 226:2  
 226:20 228:4 245:9  
 245:21 263:21 265:1  
 287:4 294:15 298:12  
 313:19 318:10 334:7  
 352:16 363:6 366:2  
 367:6 369:13,14  
 371:17 372:4,18  
 374:19  
**looked** 78:11 79:13  
 85:7 110:14 138:11  
 146:19 174:6 184:14  
 203:6 211:3 212:11  
 220:14,20 320:7  
 321:7 353:8 354:18  
**looking** 19:19 24:5  
 30:21 31:3 33:6 39:8  
 40:4 42:20 48:3 55:18  
 65:11,16 67:9,21  
 69:15 70:14 74:19,22  
 75:5 88:6,20,20 96:19  
 110:4,11 128:15  
 129:13 135:14,15  
 138:8 140:6 141:7  
 163:7 167:16 173:12  
 173:13 176:3 182:19  
 183:20,22 184:12  
 185:2 189:17 193:11  
 197:20 202:14 217:7  
 223:8 224:1 242:13  
 242:15,18,20 253:18  
 287:18 293:8 294:9  
 320:2 355:15 363:14  
 365:13 373:12 385:21  
 404:1  
**looks** 67:20 146:2,7,8  
 165:15 166:19 176:12  
 215:18 216:18 225:21  
 231:2 238:3,10 243:8  
 248:21 307:19 312:22

318:2 338:5 380:5  
**lose** 218:18 256:8 287:6  
 293:15  
**losing** 263:5 286:6  
 288:1  
**lost** 137:9 141:16  
 210:17,18 265:3  
**lot** 6:8 9:14 11:2 30:4  
 39:5 58:11 76:3,11  
 84:17,18 86:18 87:21  
 89:18 93:8,8 103:9  
 127:5 130:6 141:16  
 142:22 151:10 161:13  
 165:15 171:14,22  
 177:1 187:2,10  
 188:17 190:8 197:8,8  
 197:11 216:4 230:12  
 236:13 252:7 283:5  
 284:3,4,14,18 294:6  
 312:10 341:21 352:7  
 353:11 354:8 355:13  
 355:21 387:22 400:1  
**lots** 32:18 76:5 117:17  
 157:15 289:15 293:7  
 306:17 375:12  
**Louisiana** 2:4 19:14  
 134:9 144:15  
**love** 7:9 86:16 134:21  
 135:5 142:16 294:11  
 319:18 372:22 374:15  
**low** 66:4 79:20 85:8,18  
 86:6 87:6 104:11  
 105:17 106:15,19  
 108:8 109:4 150:3,18  
 153:17 154:7,14  
 155:4,11 156:1,12,18  
 162:18,21 166:13,21  
 177:21 178:12,18  
 179:3,8 182:6 189:9  
 192:21,21 199:5,13  
 199:17,22 200:5,14  
 200:17 206:22 207:5  
 218:8 219:7,11 279:4  
 280:5,13 291:19  
 296:16 297:14 298:3  
 298:6,9,13,13 299:7  
 299:11 300:10,10,22  
 301:11 312:11 327:7  
 327:12,17 328:13,22  
 330:2 332:1 333:1,18  
 334:17 339:21 347:19  
 348:1 355:13 361:9  
 361:14,19 362:1,8,12  
 362:18,22 370:19  
**low-income** 21:21  
**low-scoring** 83:10  
**lower** 57:22 58:1 85:15  
 96:5 137:22 141:19

169:10 354:4  
**lowered** 202:5  
**lowest** 84:14  
**LSD** 347:1  
**LSW** 2:16  
**LTACH** 217:10  
**LTACHs** 207:21 213:3  
**LTECH** 221:6  
**LTFS** 42:19  
**LTSS** 48:20 51:22 55:8  
 55:21 100:14 122:12  
 131:1,1,7 169:9,9  
 184:13,18 212:6  
 215:2 219:17 220:2,3  
 220:7,20 221:10  
 312:22  
**lunch** 170:6 222:10,12  
**luxury** 30:21

---

**M**


---

**M.D** 116:3  
**MA** 2:5  
**machine** 305:3  
**Madame** 306:20  
**Magellan** 1:16 24:11  
**mail** 404:21  
**main** 273:15 319:11  
 348:18  
**maintaining** 72:16  
**maintenance** 174:7  
 175:2  
**major** 53:20 87:19  
 305:9  
**majority** 59:1 61:4  
 135:22 136:22 139:11  
**making** 35:4 57:5  
 156:13 214:12 233:21  
 260:20 262:8 268:14  
**man** 268:5  
**manage** 54:13 171:17  
 182:2 354:6  
**managed** 18:9 71:14  
 108:19 129:21 132:4  
 132:8,13 139:6,12,14  
 139:19 173:6 186:7  
 190:17 206:20 213:6  
 214:11 281:16 288:11  
 289:1 293:20 295:5,8  
 295:11,11 351:20  
 353:14,15,22 358:16  
 359:5,13 360:15  
**management** 2:3 16:18  
 22:11 23:12 30:10  
 58:6 157:8 173:5  
 186:17,19 246:20  
 253:13 269:10 354:15  
 358:21  
**Manager** 3:2,3,5 26:8



26:10 27:10  
**managing** 351:16  
**mandated** 323:19 324:1  
**mandatory** 49:12  
 125:18  
**manner** 25:9 289:20  
**manufacturer** 17:8  
**manufacturers** 16:3  
**map** 262:21  
**MARGARET** 3:5  
**marginal** 181:22  
**marijuana** 14:9 385:11  
 385:16 403:14  
**mark** 79:22  
**MaryBeth** 2:8 15:15  
 236:16  
**Maryland** 70:12 311:5  
**Marymount** 344:21  
**massive** 348:10  
**material** 96:20 230:13  
**materials** 394:21  
**matter** 97:9 135:14,21  
 167:7 307:8 372:1  
 406:14  
**Maureen** 1:21 15:19  
 76:14 143:5,7 161:19  
 188:2,3,4 290:6 292:8  
**Maureen's** 292:7  
**maximize** 119:2  
**maximum** 84:6,9  
**MBA** 1:15 2:2,6,13 3:8  
 24:17  
**McCANN** 2:5 13:6,8,9  
 131:4 132:6,11 210:9  
 211:9 220:19 221:6,8  
 221:13,20 222:2  
 256:19  
**McCarty** 311:3  
**McLean** 326:14  
**MCO** 381:12  
**MCOs** 373:15  
**MD** 1:12,15,17 2:1,4,6,9  
 2:11,13,15,19 3:2  
 24:17  
**mean** 10:2 11:21 74:6  
 81:22 82:1,6,9,21  
 83:4,8 85:18 118:3,5  
 126:6 131:21 132:4  
 135:13 136:18 188:13  
 193:7 197:7 205:15  
 218:9 226:7 236:3,22  
 238:16 239:3 243:12  
 243:21 244:2,6,9  
 250:9 263:17,20  
 271:7 274:22 275:10  
 275:16 276:10 277:4  
 277:5,8 281:4 284:3  
 284:11 285:5,7 288:7

289:1,7,12,14,17  
 294:18 295:10 302:7  
 314:2 315:6 319:14  
 320:6 324:1 325:16  
 326:20 336:9,11  
 338:18 339:13 341:3  
 345:3,15 350:19  
 356:19 358:15 366:20  
 370:22 381:17,18  
 386:14,17,18 399:17  
**meaning** 50:19  
**meaningful** 250:1 282:8  
 288:2 401:19  
**means** 126:6 149:8  
 236:14 306:11 340:9  
 374:10  
**meant** 139:10 217:6,13  
**measure's** 50:5,22 66:4  
 82:19 241:18 261:9  
 264:12 313:21 317:1  
 356:6 360:9 376:14  
 377:4  
**measure-specific**  
 79:13  
**measure/concept**  
 105:3 178:15  
**measured** 294:7 356:2  
 371:4  
**measurement** 3:4 7:15  
 10:18 38:4,20,21 39:4  
 39:6 40:4,9,11,17  
 42:3,7 64:13 78:16  
 79:8 105:4 107:2  
 123:14,16,17,20,22  
 124:1,5 134:2 150:6  
 150:21 151:1,3  
 154:20 162:15 166:10  
 166:22 177:18 219:5  
 240:16 248:11,15  
 274:19 278:17 296:10  
 327:4 341:11 343:16  
 343:20 347:15 361:7  
 362:5 380:14 404:7  
**measures'** 266:11  
**measuring** 72:7 185:20  
 191:13 266:15 290:19  
 292:16 399:3  
**mechanism** 54:15  
 233:10,13 251:18  
**med** 243:11 294:14  
**Medi-Cal** 2:7 21:17  
**Medicaid's** 355:11  
**Medicaid-like** 338:17  
**Medicaid-only** 54:9  
**medical** 1:15,18 2:1,1,4  
 2:13,15,19 8:13 9:8  
 9:11 17:11 18:6 19:14  
 20:18,19,22 22:19

24:11 28:20 46:16  
 57:12 69:3 115:19  
 116:1,3 142:8 157:10  
 171:18 190:10 196:1  
 198:14 230:10 268:2  
 284:10 323:6 326:8  
 401:14  
**Medicare** 6:6 22:10  
 54:7 112:3 118:22  
 123:12,19 125:2  
 138:8 241:7  
**Medicare/Medicaid**  
 253:8  
**medication** 3:9 118:4  
 234:16 240:14 241:2  
 241:12,14,15 242:1,4  
 243:1 246:20 247:2  
 250:19 253:13 261:4  
 261:6,8 351:8 380:17  
**Medications** 240:18  
 260:15  
**medicine** 1:13 2:12,13  
 13:21 14:4 15:3 16:6  
 22:4,6 23:3 24:15,16  
 46:16 78:9 344:7  
**medium** 86:6 87:6  
 104:11 105:7 106:13  
 106:19 108:8 109:2  
 109:14 150:2,17,22  
 153:17 154:5,13  
 155:4,11,19 156:10  
 156:18 162:18,21  
 166:13 177:20 178:11  
 178:18 179:2,8,19  
 199:4,8,12,16,21  
 200:4,10,13,17  
 206:22 207:4 219:7  
 219:11 278:22 279:6  
 280:4,7,13,15 296:15  
 297:3,3,4,12,13,15  
 298:2 300:10,12,21  
 301:10,15 327:6,11  
 327:17 328:13,22  
 330:2,6 331:22 333:1  
 333:18 340:11,13  
 347:18,22 361:9,14  
 361:19 362:1,8,11,18  
 362:22  
**meds** 294:13  
**meet** 5:18 53:20 153:12  
 163:8 215:13 337:11  
 406:11  
**meeting** 4:4 5:4 7:10  
 8:19,21 25:3,16,20  
 28:13 29:7 33:17  
 34:13 47:3 52:2 76:16  
 77:8 81:13 82:4 86:15  
 86:20 87:12 93:21,21

100:20 113:8 118:20  
 119:1 120:6 174:20  
 258:22 269:18 310:21  
 311:13  
**meetings** 6:17,19 9:4  
 29:1 148:10  
**meets** 168:6  
**mega** 22:21  
**members** 5:12 26:3  
 50:7 56:10 62:16 63:2  
 78:6 81:6,14 82:4,10  
 82:12 83:7,18 87:1  
 89:5 91:3 111:9 115:1  
 116:18 118:21 119:11  
 123:9,13,15 124:3  
 137:1 153:15,16  
 154:12 155:10 156:4  
 156:17 162:20 166:20  
 178:11 179:2 180:3  
 199:8,15 200:4 207:4  
 219:10 227:4,9  
 240:17 241:13,16  
 246:20 247:3,5  
 252:16,20 253:1  
 259:5 261:12 262:7  
 262:10,14 266:8,11  
 296:14 301:3 305:14  
 311:2 314:20 327:11  
 328:12 330:1 331:20  
 331:21 333:17 347:22  
 348:11 361:13,22  
 362:21 368:6 381:15  
 382:15  
**membership** 288:10  
**memory** 357:3  
**MEng** 2:15  
**mental** 10:3 23:1 30:8  
 30:11 44:16 48:21  
 56:9 59:11,14,20  
 60:11,13,17 84:11  
 142:8 186:11 190:11  
 196:11 232:4 252:15  
 262:6,14,17 263:10  
 263:15 315:6 322:20  
 326:20 345:8 370:5  
 385:6 388:13,19  
 389:8,19 390:7,13  
**mention** 6:13,14 7:2,12  
 46:11 159:11 205:11  
 225:18 286:7 387:18  
**mentioned** 12:9 19:16  
 52:2 53:1,8 66:9 69:2  
 100:12 119:9 183:20  
 205:12 222:5 234:3  
 263:6,19 277:11  
 291:14 356:8 385:22  
 387:20  
**menu** 49:12 205:21

242:9,10,14 245:3  
 248:9,16 250:10  
 252:5 373:18,19  
**merit** 293:17  
**merits** 366:6  
**mess** 131:19  
**messages** 76:17  
**messiness** 33:20  
**met** 1:8 50:3 69:13 77:1  
 341:11 365:4  
**method** 157:18  
**methodologies** 158:2  
**methodology** 158:9  
 243:13  
**metric** 49:18 50:18  
 69:19 73:12 137:21  
 196:7 229:2  
**metrics** 9:13,16 18:15  
 51:21 252:3 282:5  
 287:14 294:16  
**Mexico** 353:2  
**MHS** 2:4  
**mic** 176:10 190:5  
 260:10 278:8,10,11  
 358:7  
**Michael** 2:9 15:2 214:19  
 321:9 356:14 403:17  
**Michigan** 8:13 167:12  
 188:20 191:1 195:12  
**microphone** 114:5  
 143:17 169:13 182:17  
 214:20 251:13 271:3  
 287:11 314:15 356:15  
**middle** 307:17  
**mike** 27:2,4 67:3  
**mikes** 27:3 64:11 153:4  
**mild** 187:18  
**mileage** 129:12  
**milligrams** 348:13,20  
**million** 60:16 134:18  
 353:17  
**millions** 317:11  
**mind** 7:4 39:1 43:8  
 85:19 87:9 111:13  
 169:11 178:3 202:14  
 204:2 242:17 256:10  
 295:10 317:17 371:12  
 387:3,12,14  
**minds** 116:6  
**mine** 294:9,19 295:1  
 333:13  
**minimize** 390:21  
**minimum** 168:13  
 343:18  
**Minnesota** 2:14 22:19  
 78:11  
**minor** 20:16  
**minute** 103:1 220:16

261:20 300:13 334:1  
 334:2 375:19  
**minutes** 97:7 159:14,17  
 162:8 218:17 299:2  
 302:9 307:4,5 374:13  
 406:12  
**Miranda** 3:3 4:11,14  
 27:12 111:3 151:8,9  
 228:13 240:11 271:12  
 296:3 301:6 303:18  
**missed** 334:21  
**misses** 346:22  
**missing** 66:4 96:21  
 152:7 153:2,2,3,5  
 170:17 186:1 311:21  
 329:9,10  
**Missouri** 254:4  
**misuse** 54:15 378:12  
 378:16  
**mitigate** 65:5  
**mitigated** 264:14  
**mixture** 89:6  
**MME** 354:19 355:12  
**MMEs** 353:8,18 354:13  
**model** 21:21 36:10,11  
 186:10,19 187:8  
**models** 60:5 186:17  
**modest** 112:14 113:16  
 187:18  
**modification** 131:15  
**modifications** 275:3  
**modified** 230:9 273:21  
**modify** 179:14  
**Mohanty** 2:6 21:11,12  
 21:16 140:1,2 160:21  
 162:4 170:15 253:10  
 253:11 254:15,19  
 328:5 329:15,18  
 331:1,12 333:7,10  
**moment** 12:15 328:14  
 329:11  
**moments** 33:19 222:21  
**money** 17:2 187:10  
 268:16  
**Monitoring** 259:15  
 260:14  
**Monroe** 198:10  
**month** 113:9 227:1  
 257:19,21  
**months** 53:3 181:8  
 198:22 381:9,14  
 382:13,15,17 383:5,9  
 383:15  
**mood** 59:18  
**moot** 352:1  
**morning** 5:6,19 6:18  
 9:7 10:17 13:8 14:20  
 15:14,18 17:16 18:5

19:11 20:12 21:12,15  
 22:16 26:6,9 27:9  
 46:14 47:13 48:5  
 271:17 371:18 375:10  
 393:8,17 405:4,10  
**mortality** 58:20  
**Moskowitz** 115:22  
**motion** 234:8,8 235:13  
 247:13 248:2,4  
 249:14,15,17 256:1  
 257:1 267:22 268:18  
 272:15 276:6 303:10  
 309:14 314:6 376:16  
 376:17 387:15  
**motioning** 309:13  
**motivations** 190:17  
**Mountain** 191:12  
**move** 36:12 37:3,14  
 63:8 65:19 76:1,4  
 98:3 99:8 116:14  
 118:17 128:13 130:5  
 134:15 148:21 149:3  
 153:18 155:12 156:4  
 156:21 162:7 165:20  
 171:2,4 178:12 179:3  
 180:2 186:3 204:16  
 207:8 208:7 218:19  
 222:9 225:7 235:18  
 252:21 258:17 274:2  
 279:7 280:7 294:21  
 301:17 302:17 309:11  
 312:18 317:21 318:2  
 325:13 338:3 348:4  
 361:14 374:15 392:15  
**moved** 31:6 83:11 98:8  
 99:7 100:5 103:10  
 220:1,8 268:17  
 312:20  
**movement** 108:12  
 183:21  
**moves** 69:22 104:15,15  
 104:15 206:15  
**moving** 33:4 34:4,17  
 36:16 74:11 76:3  
 118:19 191:13 198:1  
 199:9 200:6 230:19  
 231:9 233:8 236:4,6  
 274:3 296:18 297:5  
 297:16 308:16 317:10  
 318:18 327:13 330:3  
 337:13 342:10 355:12  
**MPA** 2:1  
**MPH** 2:6,19 3:2,3,4  
**MPhil** 3:2  
**MPP** 2:10  
**MSPH** 1:19  
**MSW** 2:16  
**multi-platform** 305:2

**multi-stakeholder**  
 78:14  
**multiple** 55:20 57:14  
 69:6,10 71:2 106:12  
 117:17,19 129:22  
 149:19 154:2 164:16  
 236:10 245:11 247:7  
 254:3 264:1 282:18  
 349:11,14 355:2  
 361:4 382:6 395:13  
 396:3,14  
**multitask** 29:7  
**multitude** 204:3  
**Munthali** 3:4 10:16,17  
 20:9 21:10 22:14  
 23:19 24:1,7 25:1  
 64:10 174:4 194:22  
 205:10 320:9 336:4,7  
 372:22  
**mushrooms** 347:1  
**must-** 195:5  
**Musumeci** 2:8 15:14,15  
 236:16 237:4,7,19  
**mute** 212:19 254:11  
 352:11  
**muted** 216:19

---

**N**


---

**N.W** 1:9  
**nail-biter** 363:22  
**name** 10:17 15:19  
 18:19 26:7,19 27:12  
 46:15 47:21 78:10  
 137:16 264:17 321:5  
**narrow** 212:4 213:12  
**national** 1:1,8 18:3 19:4  
 23:11 39:20 41:21  
 112:1 113:2,6,13  
 268:7 395:2  
**nationally** 17:19 22:3  
**nature** 267:1 293:15  
**navigation** 122:8  
**NCQA** 16:7,14 18:16  
 23:7 63:19 137:22  
 147:4 248:22 260:6  
**necessarily** 69:19  
 138:21 139:13 172:14  
 197:12 204:14 239:16  
 276:21 288:14 292:20  
 321:5 323:14 399:8  
**necessary** 51:15  
**need** 26:2 34:12 38:9  
 38:14 39:16 45:4,19  
 45:20 56:6 62:20 64:3  
 64:19 67:19 73:17  
 76:8 100:7,17 102:12  
 102:12,21 103:8  
 104:12 105:21 106:17

124:19 133:3 144:7  
 144:18 151:13 192:11  
 194:13,18 197:20  
 216:17 233:15 244:8  
 245:5,6 248:2 285:22  
 286:11 302:3 325:17  
 334:7,8,10 335:2  
 338:19 341:16 352:19  
 352:19 354:2 355:8  
 358:16,19,20,21  
 359:7,9,9 370:13  
 372:10,11 376:17,22  
 379:10 380:13 383:22  
 392:16 393:12,13  
 405:17  
**needed** 101:3 211:8  
 255:17 311:16 312:1  
**needing** 345:8  
**needle** 134:15  
**needs** 18:4 20:18 29:21  
 48:17 49:14 56:22  
 57:13 58:5 59:6,20  
 67:10 69:8,13 71:18  
 101:20 114:15 116:9  
 117:13 118:8 135:16  
 138:12 140:6 142:2  
 147:20 160:1 168:7  
 172:12 181:13 182:21  
 202:15 225:3 228:9  
 233:4 239:10 260:18  
 273:21 275:2 276:19  
 276:20 277:6 306:11  
 338:18  
**negative** 192:2 343:12  
 401:8  
**nervous** 329:13  
**net** 182:12 267:19  
**Network** 28:20 69:3  
**networks** 252:18  
**never** 87:22 125:18  
 287:16 290:2 326:7  
 341:12  
**new** 17:19 78:11 90:13  
 90:13,15,18 94:2 98:6  
 100:5 106:3 120:19  
 133:19 146:12 149:11  
 173:17 183:19 184:8  
 184:11,21 198:10,11  
 271:4 286:9 307:18  
 338:6 353:2 354:3  
 363:10  
**newly** 18:2 98:6 99:4  
 103:9 247:1,4  
**news** 123:1  
**nice** 5:18 28:12 42:16  
 138:18 186:9 214:5  
 277:7 299:8  
**nicely** 355:6

**niche** 213:13  
**nicotine** 312:3 403:11  
**NIH** 320:17 321:2  
**nine** 18:8 345:1  
**Ninety-five** 303:4  
**no-brainer** 322:1  
**nodding** 145:20 158:14  
 306:17 335:11  
**nominate** 160:5 336:20  
**nominated** 11:18  
**non-clinical** 168:17  
**non-HEDIS** 40:5  
**non-institutional**  
 221:11  
**nonprofit** 16:11 17:18  
**nonvoting** 16:15,15  
**noon** 35:7  
**normal** 58:17  
**norming** 148:15  
**North** 36:22  
**Northern** 2:7 21:18  
**not-for-profit** 18:21  
**note** 46:12 52:16 63:7  
 117:21 118:20 150:7  
 166:2 169:6 227:3  
 230:2,15 239:17,19  
 304:8 343:14 349:16  
 395:10  
**noted** 181:15 207:20  
 227:7 241:4,13 247:5  
 252:20 260:19 261:7  
 261:12 266:8 267:7  
 267:17 306:15 315:10  
 315:14 355:22 377:19  
 379:8,12 380:12,15  
 381:6,15 382:10  
 385:1 388:20 389:6  
 389:21 394:22 395:15  
 396:15 397:4 398:10  
 398:13 400:19 401:5  
 402:6 403:8  
**notes** 29:1 173:14  
 233:21 269:22 306:9  
 350:13 381:2  
**notice** 63:4 95:10  
 120:15 121:6,12  
 164:12 193:20  
**noticed** 96:3 210:7  
 350:9  
**notifications** 285:10  
**noting** 125:8 142:11  
 377:14 378:15 390:16  
 403:5  
**notion** 110:4 133:11  
 221:1  
**NQF's** 5:15 6:20  
**NQF-** 48:9 53:1 80:1  
 184:11 205:16 249:2

297:18 308:14 357:11  
 362:12  
**NQF-endorse** 245:12  
**NQF-endorsed** 83:17  
 86:9 91:21 121:7  
 123:4 128:7 164:10  
 200:21 225:19 243:9  
 243:10 246:17 255:9  
 264:7 267:2 287:14  
 308:17,20 315:9  
 330:9 335:15 368:1  
**nuance** 342:4  
**numbers** 40:6 201:22  
**numerator** 51:1,11 79:3  
 102:1 108:4 121:18  
 123:7,18 145:16  
 152:15 157:9 163:21  
 168:3 176:3 212:16  
 230:2 342:22 354:18  
 355:16,17 356:9  
 385:21 386:1,6  
 395:17 398:13 399:9  
**numerator's** 396:20  
**numerators** 389:3  
 399:12  
**numeric** 80:10 162:11  
 164:10 166:3 181:5  
**nursing** 18:22 218:10  
**NYU** 268:9,10

---

**O**

---

**o'clock** 392:7  
**Oakland** 116:2  
**object** 136:3  
**objection** 343:7  
**objections** 313:15  
**objective** 316:2 317:12  
 346:5 398:9  
**objectives** 4:4 25:20  
 28:13 95:5 105:4  
 162:15 199:2 248:8  
 278:17 327:4 361:7  
**obligation** 365:22  
**Obstetrics** 8:14  
**obviously** 5:22 6:22  
 7:20 8:1 29:22 38:10  
 147:16 194:6 397:20  
**occur** 131:16  
**occurring** 61:10,12  
 74:4,8  
**ocean** 75:20  
**October** 47:19  
**odd** 84:7 399:10  
**Off-mic** 176:8 189:22  
 190:2,4  
**offer** 355:8 406:2  
**offered** 380:3,6,11  
 398:6 400:14 402:3

**offering** 373:19  
**offers** 379:13  
**office** 2:1 36:3 61:13  
**Officer** 1:16,18 2:1,4,5  
 2:19 13:9 17:11 18:6  
 19:14 20:19 21:1  
 24:11 115:20  
**official** 243:22  
**oftentimes** 127:18  
 171:18 192:14 385:15  
**Ohio** 2:18 18:20 19:8  
 78:12 254:4 352:3,13  
 353:4  
**old** 9:11 226:14 342:19  
 343:4  
**older** 123:9 124:4  
 240:17 383:14  
**once** 33:13 58:21 81:20  
 121:5 122:9 214:17  
 214:18 268:5 310:9  
 376:19 383:2,14  
 388:5 392:17 393:14  
 397:22 398:16 399:3  
 401:10  
**once-over** 367:14  
**one's** 56:11 314:18  
 355:6,7 369:20  
**ones** 98:16 99:21  
 103:12 169:4 214:10  
 214:11 215:21 243:2  
 246:17 250:6 270:21  
 287:16 366:12,12,16  
 387:19 402:21  
**ongoing** 20:1 36:5,6  
 49:3 133:12  
**online** 8:4 44:9 131:6  
 164:7 175:9,10  
 278:20 305:1 315:15  
**open** 5:3 17:2 33:12  
 61:20 91:15 92:11  
 111:8 120:2 126:15  
 150:10 151:14 152:5  
 154:10 173:8 177:22  
 273:1 300:14 305:18  
 305:22 313:3 316:2  
 331:16 339:19 344:1  
 347:17 349:19 350:16  
 376:17 380:20 392:17  
 393:13  
**opened** 339:18  
**opening** 4:2,5 5:16  
 33:11,14 111:13  
 198:5 295:20  
**openness** 11:22  
**operation** 351:7  
**operational** 2:3 282:16  
**operationalize** 187:10  
 373:17

**operationally** 282:10  
**Operations** 2:7 21:18  
**Operator** 111:13,15  
 114:7 216:18,21  
 306:1 394:4,6,12  
 406:7  
**opiate** 317:11  
**opinion** 165:18 341:13  
 387:3  
**opinions** 251:17,18  
**opioid** 6:10 19:18 54:15  
 317:7 348:12,15  
 377:11,15,20 378:12  
 378:16 395:13 396:3  
 396:14  
**opioids** 23:17 348:5  
 349:11,13,14 351:13  
 352:6 361:3 395:6  
 396:17  
**opportunities** 106:12  
 154:3,9 193:16  
 248:10  
**opportunity** 4:9,12,15  
 4:19 31:16 32:3,7  
 46:21 93:20 94:1  
 106:6,9 115:7 117:3  
 135:9 148:22 153:21  
 178:15 179:16 199:10  
 228:20 233:1,5  
 248:12 264:11 279:9  
 279:21 295:14 296:20  
 327:14 349:9 361:17  
 366:1,8 368:7 369:2  
**opposed** 41:13 174:15  
 229:17 236:3,4,6  
 237:13,16 279:16  
 341:13 399:14  
**opposition** 302:13,14  
 303:18  
**opted** 349:17  
**option** 31:9 82:13 83:12  
 83:13 200:22 234:1,7  
 274:12 320:3 339:16  
 396:13  
**optional** 75:8 374:22  
**options** 133:17 134:3  
 191:16  
**or-down** 303:8  
**orally** 11:5  
**Orange** 15:1  
**order** 26:18 38:15 50:18  
 54:13 56:14 119:2  
 164:7,12 166:3,3  
 227:17 240:2,4,6  
 265:5,9 376:17  
**ordering** 164:13  
**Oregon** 194:12 254:4  
 311:4

**organization** 17:18  
 19:5 123:11 168:5  
 227:16 228:1 282:14  
**organizations** 108:20  
 206:21 281:12 373:20  
 378:2  
**organize** 8:20 66:10  
**organizing** 79:8  
**orientation** 35:22  
**original** 50:9 86:5  
**originally** 32:8 116:10  
**outcome** 53:5 77:8  
 113:8 185:11,11  
 187:20 189:9,10  
 260:21 312:6 317:17  
 318:1,17 319:8  
 380:13  
**outcomes** 183:8 186:9  
 187:3,12 188:10  
 189:17 198:15 225:12  
 289:9 372:5,19  
**outlined** 119:4 140:7  
**outpatient** 138:2 146:3  
 172:14 230:2,3  
 387:22 403:18 404:2  
 404:4  
**outputs** 43:11  
**outreach** 144:8  
**outside** 26:16 45:15  
 132:8 211:20 344:11  
**outweighs** 388:6  
**over-caffeinated**  
 307:14  
**over-prescriber** 352:17  
**over-prescribing**  
 352:15  
**overall** 77:17 80:10,14  
 81:3 82:5 95:11  
 115:11 140:15 147:6  
 169:3 183:1 215:5  
 231:4 233:18 315:7  
 326:21 374:19  
**overcome** 193:14  
**overdosed** 237:1  
**overhaul** 20:3  
**overlap** 196:10 367:19  
 372:5,13,18  
**overlaps** 402:7  
**oversee** 18:8  
**overuse** 197:12  
**overview** 4:6,8 48:6  
 56:18 76:12 114:19  
 115:15 120:9 121:6  
 310:20  
**owe** 374:13

---

**P**


---

**P** 264:9 283:4,4

**P-R-O-C-E-E-D-I-N-G-S**  
 5:1  
**P.J** 27:6  
**p.m** 167:8,9 307:9,10  
 406:15  
**package** 32:13 126:5  
**page** 120:7,12,14  
 130:10 366:12 395:1  
**pages** 367:8  
**paid** 11:12,13 125:2  
 351:8 360:18,19  
**pain** 349:1 354:14  
 358:20  
**pairs** 42:8  
**Palliative** 19:5  
**PAM** 181:19 182:4,6,12  
 192:11 193:21,21  
 194:14 198:12 320:7  
 329:6  
**Panel** 16:21 121:22  
**panels** 16:21 312:21  
**paper** 104:6 282:6  
 284:14  
**parallel** 216:3  
**parents** 306:13  
**parish** 144:3  
**parity** 19:19  
**parking** 76:3 341:20  
**parse** 138:18  
**parsed** 147:9  
**parsimony** 101:19  
 372:4  
**part** 7:1 37:6 39:10  
 40:17 41:2 43:20 45:3  
 45:7 50:7 75:3 76:7  
 78:20 79:11 89:5  
 92:22 101:9,11 102:5  
 104:5 171:15 172:5,7  
 175:19 177:10 186:21  
 191:15 192:17 203:14  
 204:6 212:2 217:4  
 238:19 253:7,14  
 254:7 256:16 259:8  
 262:20 270:22 283:3  
 284:3 285:16 288:5  
 307:13,15,15 308:12  
 313:1 364:18 368:7  
 379:20 386:11 398:10  
 402:8  
**part-time** 23:5  
**partake** 89:3,4  
**partial** 230:3  
**participant** 21:4 175:12  
 248:5 376:1 404:11  
**participants** 305:1  
**participate** 16:7 20:14  
 49:10 111:9  
**participating** 8:9 21:9

56:4 69:18  
**Participatory** 16:6  
**particular** 6:2 39:8  
 40:16 51:20 54:3 82:7  
 99:8 144:12 159:11  
 161:14 202:13 234:11  
 245:5 288:2 334:6  
**particularly** 11:9 14:9  
 30:3 41:1 81:1 134:2  
 142:1,7,14,15 180:9  
 208:8 209:11 264:13  
 287:22 350:11  
**parting** 195:17  
**partners** 2:16 46:17  
 70:5  
**partnership** 13:12  
 41:21  
**parts** 56:5 60:15 71:22  
 172:19 282:13 295:9  
 399:1  
**pass** 195:6 201:11  
 211:17 227:11 267:2  
 275:22 276:8 301:20  
 301:21,21 332:14  
**passed** 29:15 235:5  
 267:5 332:17 341:22  
 351:11  
**passes** 201:11 206:9,12  
 276:7  
**passing** 363:20  
**passionate** 270:12  
**patient** 1:17 15:5 65:12  
 147:4 168:1,12,13  
 172:2 175:20 176:6  
 176:13 177:3 181:7  
 183:4 185:3 187:2,18  
 188:16,22 189:8,10  
 189:16 192:3,4  
 196:18 198:21 230:11  
 239:18 241:16 261:6  
 289:9 321:7,19  
 360:19 381:14 382:5  
 397:14  
**patient's** 54:13 157:2  
 158:3  
**patient-** 318:19  
**patient-centered**  
 167:21 168:4 190:10  
 196:1 318:19  
**patient-centric** 318:3  
**patient-focused** 185:13  
 187:22 318:4  
**patient/caregiver** 42:22  
**patients** 15:9 54:7,9,12  
 57:13,16 67:9,10,12  
 67:18 96:12 129:4,11  
 129:12 162:1 163:16  
 176:4 183:6 187:8

194:8 207:12 218:22  
 239:9 252:21 257:4  
 259:2 260:15 265:16  
 278:2 342:22 343:3  
 344:17 348:12 349:3  
 359:4 379:14 381:8  
 382:16 383:11,13  
 390:20,21 396:16  
 398:14 399:12,15  
 400:1 401:6 403:9  
**patients'** 315:7 326:20  
**patterns** 140:11  
**pause** 302:6  
**pay** 9:15 191:14 194:18  
 196:1 213:5,7 283:10  
 283:15 319:16,19  
**pay-** 184:10  
**pay-for-** 269:8  
**pay-for-value** 267:9  
**paying** 213:7  
**payment** 38:3 60:7,9  
 184:10 209:14  
**pays** 208:9  
**PCORI** 186:8 187:9,13  
 189:20 190:12,13  
**PCP** 282:2,19 359:9  
**PCPI** 256:19 286:13  
**PCPs** 138:13 281:16  
 282:15  
**PCR-** 264:8  
**PCR-P** 264:20  
**PDMP** 359:11 360:17  
**pediatric** 14:10 23:3,6  
 23:10 46:22 129:3,4  
 139:4 141:15,21  
 342:7,15 346:11  
**pediatrician** 13:20  
**pediatrics** 2:11,12  
 13:20,22 14:5 139:3  
**peed** 344:15  
**peer** 16:5  
**pees** 345:1  
**Peg** 3:5 27:16 85:20  
 87:14 285:18 319:22  
**Peg's** 174:5  
**Pennsylvania** 2:2 18:7  
 64:1 69:1 137:19  
 146:11 185:10 213:3  
 213:21 281:11,17  
 282:13 353:3  
**people** 10:13 19:15  
 29:12 30:12 31:11  
 32:21,21 33:8,19  
 54:21 59:6 63:21  
 64:18 68:21 85:13  
 91:5 97:12 98:13  
 100:12 101:1,2  
 103:17 106:3 117:11

127:1 134:14,19  
 135:2 138:11 144:5  
 146:12 164:22 190:10  
 192:15 193:13 202:2  
 213:20 229:22 239:4  
 273:18 285:22 287:22  
 292:13 298:4 299:17  
 304:8 308:9 318:2  
 321:21 322:7 323:13  
 337:20 340:15 341:5  
 344:19 352:16 353:17  
 355:16 357:9 358:13  
 358:15,18 369:13  
 370:4 371:20 376:1  
 385:6,15 388:13  
 389:8,19 393:17  
 394:15,16 402:15  
**people's** 30:16  
**perceive** 385:16  
**perceived** 182:5  
**percent** 19:21 52:7 54:5  
 54:5 57:6,9,10,15,16  
 57:17 60:1 65:22  
 80:16,17,18 89:1,10  
 89:11 100:8,18  
 102:21 105:21 117:6  
 117:7,8 153:14,16,17  
 154:12,13 155:9,10  
 155:11 156:3,16,17  
 156:18 162:19,20,21  
 166:20 178:10 199:7  
 199:15,17 200:3,16  
 200:17 201:16 206:8  
 207:3,5,11 208:19  
 218:21 219:9,10  
 265:15 280:6,14  
 297:15 303:4 327:10  
 327:12 328:11,13  
 329:22 331:20,21,22  
 333:16,18 347:21  
 361:12,13,21 362:10  
 362:20,22 396:8  
**percentage** 91:5 123:9  
 240:15 279:15 342:18  
 383:13 396:10  
**percentages** 123:11  
**perception** 385:15  
**perfect** 74:16 136:7  
 147:10,18 295:15  
 317:5  
**perfectly** 125:13 233:12  
 341:10  
**performance** 10:10  
 38:1 49:17 52:17,20  
 53:10 130:7 226:13  
 269:9 283:10,15  
 286:9,12 290:17  
 292:18,21 320:11

382:2  
**performed** 78:3 207:21  
**performing** 287:5  
**Perinatal** 12:22  
**period** 305:21 404:7  
**Permanente** 2:8 21:19  
 21:22  
**persistent** 186:11  
 260:15  
**person** 21:14 47:3  
 130:1 145:13 146:8  
 147:12 173:14,19  
 268:7 276:6 316:20  
 316:21 343:9 355:7  
 376:16  
**person's** 125:16  
**personal** 113:8 165:18  
 185:7 209:13  
**personally** 6:3 129:21  
 209:5 336:14  
**persons** 112:2 266:6  
 349:12 361:4 395:6  
 395:13 396:4  
**perspective** 73:17  
 131:7 183:6 251:6  
 283:21 287:17 288:19  
 290:8,13 336:12  
 351:4  
**perspectives** 41:18  
 42:6  
**pertaining** 228:21  
**pertinent** 118:7,9 130:2  
**PFCC** 174:19,19 175:1  
**pharmaceutical** 16:2  
 17:8  
**pharmacies** 354:20  
 396:20  
**pharmacy** 358:11  
**phase** 74:2 243:17,18  
 243:22 244:1,18  
**PhD** 1:14,21 3:5  
**Phelan** 2:9 15:2,2 66:21  
 67:3,3 176:11,15  
 196:17,20 214:21  
 215:9 231:2,8 238:1  
 238:10,21 246:7  
 271:4 277:10 283:14  
 314:6 321:11 336:16  
 337:2,4,7,14 344:6  
 345:17 352:9 356:16  
 387:9 401:12 403:18  
 403:22  
**phenomenal** 134:17  
 197:4  
**phenomenon** 259:2  
**Philadelphia** 281:20  
 285:9  
**phone** 5:12 20:10,14

26:15 28:4 34:2,14  
 61:21 65:10 68:21  
 93:15 95:15 102:9  
 103:17 114:8 129:16  
 145:11,14 147:12  
 153:5 158:13 160:20  
 175:10 179:11 196:15  
 212:19 216:11,12  
 227:19 230:11 241:9  
 241:21 253:5 254:10  
 257:11 258:11 259:11  
 261:2,18 264:4  
 271:11 274:1,8  
 277:14 278:10 285:5  
 302:14 304:22 305:20  
 306:4 324:7,8 327:10  
 327:21 328:2 333:2  
 347:8,9 360:11,11  
 376:13 378:7 394:5  
 404:20 405:4  
**phone's** 254:11  
**PHQ-9** 52:12 53:4  
 315:19  
**phrased** 145:5  
**phrasing** 247:1  
**physical** 30:7,12 44:16  
 48:21 59:11,15,21  
 60:21 84:10 186:14  
 187:1,4,7 384:4  
**physical-mental** 42:19  
**physically** 277:8  
**physician** 2:10,16 15:3  
 22:5 23:4 46:16,17  
 344:8  
**physician's** 61:13  
**physicians** 15:6 380:16  
**pick** 64:18 244:8 246:8  
 246:9  
**picked** 37:10  
**picture** 258:2  
**piece** 95:4,22 104:6  
 135:12 189:19 208:6  
 211:7 244:21 335:2  
**pieces** 95:3 169:1  
**pile** 324:10  
**pinging** 282:15  
**pipeline** 39:12  
**Pittsburgh** 359:17  
**PJ** 391:8  
**place** 75:9 114:18 116:5  
 136:3 152:3 210:18  
 281:4 282:6 284:19  
 285:11 362:3 372:2  
**placed** 241:17  
**places** 120:4 198:8  
 281:8 338:12 374:6  
 385:12  
**plan** 16:17 124:13,20

- 132:7 190:8,17,22  
191:5,12,17 207:13  
208:11,14,19 210:12  
210:20,21,22 219:2  
221:3 238:12 258:20  
265:18 282:1 284:8  
285:1,6 288:16,19  
289:19 290:8,12  
292:11 294:8,10  
295:3 352:18 359:5  
381:10  
**plan-led** 192:7  
**plan-specific** 289:4  
**planned** 51:11 107:22  
108:5 155:18 298:14  
334:17,18,22 338:16  
**planning** 1:20 22:10  
69:9 364:1  
**plans** 2:3 16:11,12 17:4  
18:9 43:20 49:22  
68:10 107:10 131:9  
131:12 138:6 146:21  
160:3 161:3 174:21  
186:7 188:8 191:8  
194:10 213:6 238:2  
238:11 247:7 281:16  
288:9,12 289:1 290:9  
293:8,8 294:10 295:5  
295:8 351:5 352:21  
353:15 354:1,11  
356:18 358:16 359:13  
360:15 362:7 390:19  
**plant** 113:11  
**plants** 107:4  
**platform** 9:19 170:4  
352:12,12  
**play** 38:3 63:21 191:5  
235:21  
**Playbook** 18:2  
**played** 394:13  
**pleased** 10:4  
**pleasure** 363:21  
**plug** 312:7  
**plus** 109:16  
**PMH** 49:1 51:22 59:12  
99:6 100:15 122:12  
**PMP** 3:3 351:10,12  
**point** 14:2 25:10 44:6  
44:15 46:9 72:15 73:2  
86:3 87:18 91:15  
93:17,22 94:6 126:17  
127:14 128:9 130:4  
131:4 136:6 148:16  
156:15 162:3,5  
164:20 169:5 184:5  
188:6 200:8 201:13  
211:21 226:1 246:13  
252:1 275:16 285:7  
287:9,12 288:21  
290:20 291:3 292:14  
292:22 293:22 298:7  
310:13 321:6 325:11  
330:12 337:20 339:14  
341:1 348:17 352:1  
352:11,16 357:11  
358:12 366:16 367:21  
373:2,16 386:19  
**points** 4:6 37:12 48:7  
69:11 120:14 183:15  
184:6 356:13  
**policy** 2:20 17:19  
194:21  
**poll** 341:14  
**Polling** 150:10 154:10  
177:22 339:19 347:17  
**poor** 84:17 189:10  
292:13  
**poorly** 85:9  
**popular** 101:2 403:15  
**population** 1:21 14:15  
15:21 16:12 22:11  
43:1 50:14 57:5,21  
58:6 59:9 61:6 62:22  
65:13 71:22 72:2  
73:12,21 74:6 81:2  
102:3 118:22 119:5  
129:9,14 133:4 139:1  
139:5 141:15 144:13  
154:21 157:11 160:4  
161:6 163:22 164:21  
168:7 180:11 181:21  
182:14 184:18,22,22  
186:15 188:19 192:22  
193:12 196:9 197:22  
208:4,8 209:1,10,17  
212:4 213:15,16  
229:7 231:14 239:3  
239:11 240:22 242:5  
247:5 257:8 259:7  
326:12 335:1 338:17  
343:15 353:10 354:5  
356:7,18 388:16  
389:10,22 390:4  
396:11  
**Population-Based**  
257:18,20  
**population/denomin...**  
51:12  
**populations** 16:13  
21:22 37:6 38:16 72:2  
73:21 118:10 133:11  
137:21 139:3 147:9  
155:4,22 168:10  
182:13 184:17 196:8  
243:13 298:15 334:19  
**portfolio** 10:5 38:20  
40:14,18 185:12  
**portion** 57:5 179:22  
305:1 308:19 364:3  
368:18,19  
**posed** 117:2  
**positions** 290:9  
**positive** 187:13 189:17  
193:6  
**possible** 56:13 216:20  
219:15 233:20 309:16  
366:16 368:2 377:3  
**possibly** 161:16 225:11  
276:7,9  
**post** 44:9  
**Post-** 240:14  
**post-acute** 216:8  
**post-discharge** 234:17  
241:3,12 243:11  
**potential** 51:20 106:13  
119:3 154:5 185:21  
198:3 223:1 261:15  
266:22 375:4 396:6  
400:20  
**potentially** 7:21 140:11  
149:10 160:12 225:2  
252:17,19 257:5  
265:22 266:2,4,5,16  
268:1,21 272:5  
284:11 301:18 304:10  
365:20 366:2 373:8  
401:8  
**Powell** 2:10 47:11,11  
70:7,7 142:11 207:16  
208:5 210:4,17 217:3  
348:7,11 349:16  
350:7 357:17 358:1  
**power** 197:15  
**PQI** 269:13 270:7  
**practical** 287:17  
**practice** 22:5 23:4  
112:16 343:17,22  
345:13 377:16,17  
**practices** 40:11 58:9  
160:10 273:18  
**practicing** 19:13  
**pre-work** 78:20 86:16  
86:17,19 93:19 98:10  
99:10 100:11  
**Precision** 1:22 15:22  
**preclude** 317:20  
**precluded** 320:2  
**predictors** 56:12,13  
**prefer** 369:22  
**preference** 375:1  
**preferred** 380:8 382:11  
385:2,7  
**preferring** 248:15  
**pregnant** 312:5  
**preliminary** 91:20  
115:4 121:13,19  
356:16  
**premise** 343:7  
**preparation** 9:1,4  
**prepare** 8:20  
**prepared** 367:11  
**prepping** 35:13  
**prescreening** 345:19  
**prescribe** 351:13  
**prescribed** 396:17  
**prescriber** 355:7  
**prescribers** 354:19  
357:5 359:10 396:20  
**prescribing** 351:6  
352:6 353:20  
**prescription** 54:11,14  
358:19 380:5,7,10  
**prescriptions** 54:12  
396:14  
**present** 1:11 3:7,15  
286:9  
**presentation** 5:15 47:2  
233:2 291:12  
**presented** 131:8 224:19  
286:8  
**President** 1:18,19 2:10  
2:15 3:2,4 5:15 10:18  
15:20  
**presiding** 1:10  
**press** 111:16 150:15,17  
150:18 166:13 200:13  
200:13,14 304:18,18  
306:2 327:6,7,7,17,17  
327:17 330:6,6  
332:22 339:20,21  
347:18 362:17 394:7  
406:8  
**pressures** 294:17  
**pressuring** 273:18  
**presume** 313:13  
**pretty** 29:16 63:18  
77:11 129:7 138:20  
158:1 176:19 202:8  
202:10 271:9 310:14  
312:12 345:15 387:21  
405:8  
**preventable** 57:4  
140:10,19,20 141:3  
266:3,4,5 401:4  
**preventative** 381:4  
385:4 388:22 403:1  
404:6  
**prevention** 14:6 24:20  
42:22 61:7 65:13  
269:6 270:6 311:19  
311:22  
**preventive** 123:5,10,13

123:15,19,22 125:1  
 129:5,6 132:22  
 133:12 134:14,21  
 135:2,19 144:1,6,19  
 148:1 157:5 158:11  
 273:3 307:21  
**Preventive/Ambulato...**  
 150:8  
**previous** 35:13 50:3  
 53:8 118:1 167:11  
 310:9 313:14 385:20  
 386:8 390:2 397:16  
 402:7  
**previously** 119:9 222:6  
 309:22 388:21 390:1  
 397:5 398:17  
**primarily** 16:1 49:6  
**primary** 61:13 124:22  
 133:12 138:1 140:16  
 146:3 211:16 293:11  
**prime** 230:22  
**printed** 377:21  
**prior** 82:4 100:20  
 123:17 124:1 320:1  
**priorities** 37:9  
**prioritization** 204:14  
**prioritized** 203:16 204:7  
 204:20 205:4,9  
**prioritized** 232:10  
**prioritizing** 242:22  
**priority** 36:17 172:4  
 185:7  
**private** 54:8 132:5  
**pro's** 251:20 252:2,3  
**probably** 40:22 45:20  
 69:16 74:7 107:15  
 174:8 186:8 187:6,8  
 195:22 196:6,6  
 204:18 205:11 211:5  
 213:1 226:12 227:11  
 230:7 233:3 243:16  
 275:19 281:18 282:6  
 287:5 307:14 311:9  
 322:9 341:12 360:21  
 364:11 384:6  
**problem** 86:8 147:22  
 268:13 270:2 286:18  
 351:16 355:7,7  
 381:17,18 391:1  
**problematic** 149:10  
 358:9 381:8  
**problems** 53:19 128:17  
 386:9  
**procedures** 97:19  
 103:2,3  
**proceed** 25:15 252:12  
**process** 4:8 7:17 33:1  
 45:9 74:11 76:13,20

77:6,13 81:4,9 87:14  
 91:10,13 92:2 93:13  
 97:17 99:1,3 101:9  
 116:17 126:9 132:20  
 138:15 190:13 223:5  
 225:12 233:19 247:13  
 260:20 275:19 303:20  
 307:16 309:13 310:3  
 312:11 321:22 326:7  
 335:17 336:2,5,10,15  
 336:20 345:2 353:13  
 364:18  
**process-heavy** 308:11  
**processes** 9:12  
**produce** 96:13  
**produced** 244:2  
**product** 34:15 67:21  
 123:12 131:13  
**products** 312:3 324:13  
 403:11,13,14  
**professional** 11:3  
**professionals** 60:18  
**professor** 1:13 2:11  
 13:20 24:14  
**Programming** 24:20  
**programs** 2:1,14 5:10  
 23:2 28:16,19 29:20  
 30:9 32:1 54:11 67:8  
 67:13,16,22 70:15,15  
 71:21,22 72:10 95:21  
 99:14 107:4,9 129:22  
 143:1 159:3 180:8  
 192:7,8 209:3,12  
 245:20 267:8,10  
 271:6 318:22 321:16  
 323:21 351:6 362:6  
 373:15 381:16  
**progress** 175:4 323:18  
**prohibit** 60:19  
**prohibits** 382:3  
**project** 1:3 3:2,3,3,5 4:6  
 26:8,8,10,10 27:10,11  
 27:13,17 38:5 39:7,8  
 39:15 40:20,22 43:11  
 43:12 45:1 48:7,10  
 52:3 59:5 60:7 61:9  
 62:18 64:12 65:3  
 69:22 75:7 94:9,10  
 95:5 120:7 127:16  
 173:19 174:19 288:2  
 384:3 395:1  
**projects** 2:17 29:2 40:3  
 41:19 47:16 62:18,19  
 69:4 127:18 173:14  
**promise** 51:20 311:1  
 379:7  
**promising** 51:21,22  
 181:15 266:15 324:21

**promote** 145:3 203:17  
 204:10  
**promoted** 204:8 337:18  
**promoting** 48:18 55:6  
 59:7  
**promulgated** 81:21  
**Proportion** 257:3  
**proportionately** 397:10  
**proposal** 148:12  
**propose** 82:13 374:16  
 376:15  
**proposed** 112:14  
**proprietary** 194:18  
 195:3 266:10,22  
 315:11,14 317:7,19  
 319:9,15 320:1,3,16  
 321:3  
**protocols** 344:18  
**proud** 162:9  
**prove** 134:12  
**provide** 15:22 26:11  
 56:17 74:8 114:19  
 115:15 122:9 142:13  
 180:20 207:17 258:2  
 291:16 309:15 376:11  
 377:2  
**provided** 127:21 255:1  
 357:4 380:3 398:6  
 399:7 400:3,14 402:3  
**provider** 20:5 70:21  
 177:8 211:10,12  
 212:13 213:4,19  
 386:14 399:17  
**provider's** 386:11  
**provider-led** 192:8  
**providers** 18:22 20:4  
 60:20 108:20 192:10  
 206:21 241:5 260:17  
 278:2 293:11 315:18  
 349:11,14 352:20  
 355:2 360:7 361:4  
 377:17 380:15 382:6  
 395:13 396:4,14  
**provides** 13:10 396:12  
**providing** 120:9 145:1  
 157:1  
**provision** 398:11  
**proxy** 138:18 163:19  
**psych** 344:11 345:18  
**psychiatric** 264:8,17  
 265:6 343:13 345:6  
**psychiatrics** 343:13  
**psychiatrist** 344:11  
**psychometric** 53:12  
**psychosis** 342:7,15  
 343:8,10 344:9 345:7  
 347:13  
**psychosocial** 57:13

**psychotic** 59:19 237:2  
 342:20 343:5  
**PsyD** 1:16  
**public** 1:13 4:9,12,15  
 4:19 5:11 8:5 14:17  
 34:8,9 50:8 62:16  
 86:10 111:5,8,9,16,18  
 114:4,8 185:14  
 194:15 195:20 216:13  
 269:9 305:18 306:8  
 319:19 363:4,7  
 392:17,20 393:5,8,13  
 393:21,22 394:3,4,7,9  
 394:12,21 405:22  
 406:2,8,9  
**publically** 322:17  
**publications** 14:8 323:6  
 326:8  
**publicly** 43:18 320:18  
**published** 326:6,10  
**pull** 41:10 78:22 98:14  
 174:10,18 234:2,18  
 261:14 267:21,22  
 274:12 309:3,12  
 314:19 367:5 375:13  
 375:14 382:22 386:21  
 387:1,6,6,16  
**pulled** 100:20,21  
 103:14 375:12 387:10  
**pulling** 222:15 388:8  
 401:13  
**pulmonary** 145:18  
 147:22,22  
**pulse** 97:3,5 122:17  
**purchase** 321:17  
**purchasing** 196:3  
 324:13  
**pure** 71:3  
**purity** 71:15  
**purpose** 75:6 95:5,8  
 101:21 137:7 147:16  
 148:6 202:11 243:16  
**purposes** 126:10  
 164:14 169:11 195:1  
 227:16 276:11,15  
 304:7 324:3 340:16  
 341:6 368:17  
**pursuant** 309:1  
**purview** 252:8  
**push** 189:13 290:4  
 393:7  
**pushback** 355:13  
**pushed** 281:22  
**pushing** 281:14 294:2  
 314:12  
**put** 33:21 62:9 72:5  
 109:21 125:10 136:3  
 192:10 196:4 200:22

235:10 248:12 262:1  
279:2 285:14 294:2  
312:7 329:20 336:21  
342:2 364:14  
**putting** 95:7 351:6  
370:22  
**pyramid** 117:9

---

**Q**

---

**QIOs** 208:17  
**QRP** 215:20  
**QRS** 16:21 21:4  
**Qualified** 57:19  
**question** 40:22 51:4  
61:12,14 63:16 65:9  
66:8 68:3 72:21 87:16  
95:15 108:16 110:4  
110:17 124:12,15  
125:5 126:3 132:19  
133:5,14 139:9,22  
143:8 145:16 146:1  
146:10 147:14,16  
148:4 158:16,19  
159:4 162:13 188:5  
194:22 196:15 201:5  
202:7 203:10,22  
204:18 206:10 211:18  
215:1 232:15 236:17  
240:10 242:17 253:12  
253:17 258:12 263:4  
275:12,21 276:3  
279:14 286:4 303:20  
307:21 308:20 315:22  
317:15 330:9 332:6,7  
332:15 334:5,9,10  
338:1 340:20,21  
341:16 345:11,14  
351:3,15 354:17  
362:13 369:8 371:12  
385:19 386:21 393:6  
394:14 401:11 404:19  
**questionnaire** 52:12  
181:21 317:7,15  
**questions** 25:14 43:15  
46:2,2,5 61:17,20,21  
84:1 87:5 89:20 92:21  
93:4,13 96:16 111:2  
111:10 114:6 119:17  
124:9 148:17 165:20  
171:7 176:12 182:4  
218:16 239:20 260:4  
270:15 273:22 274:13  
275:16 290:19 310:12  
317:14 324:7 378:22  
379:16 380:21 384:12  
389:15 395:22 396:21  
400:8 401:22 403:16  
404:15 405:20

**queue** 357:9  
**quick** 48:6 93:17 110:3  
124:11 167:5 170:4  
179:13 196:15 379:13  
**quicker** 148:21  
**quickly** 7:22 29:16 78:1  
89:2 99:3 100:3 111:1  
126:2 328:9 352:1  
**quit** 394:17  
**quite** 85:19 113:16  
117:10,14 135:18  
212:1,7 214:6 230:7  
266:20 370:14 391:17  
391:20 393:1  
**quorum** 153:9  
**quoted** 359:2

---

**R**

---

**race** 146:19,22  
**Railroad** 268:5  
**raise** 226:3 274:20  
278:19,22 279:5  
280:2,5,11 296:12,15  
296:22 297:8,12,14  
297:20 298:2,3 300:6  
300:18,22 301:1,4,8  
301:10 302:21 356:12  
368:21  
**raised** 59:4 61:9 157:22  
315:17  
**raises** 282:22  
**raising** 378:7  
**ran** 353:9  
**range** 41:17 141:19  
**ranked** 79:10 80:9  
144:15  
**ranking** 77:15 79:15  
308:18  
**rankings** 79:20 80:11  
**rapid** 382:3  
**rare** 319:8  
**rarely** 356:2 377:17  
**rate** 54:10 67:14 85:14  
356:3 357:6,14  
370:19  
**rates** 57:22 58:1 140:15  
289:13,13  
**rating** 80:11 110:11  
**ratings** 85:22 86:2  
**rationale** 89:13 100:22  
102:12 136:4 157:4  
163:18 180:21 207:18  
227:21 228:2,14  
229:15 255:1 309:16  
309:19 376:12 377:2  
377:3,5  
**ravaging** 322:3  
**raw** 96:7

**RCCOs** 191:11  
**RDMS** 2:9  
**re-** 56:14  
**re-hospitalizations**  
59:17  
**re-institutionalization**  
56:12  
**re-presented** 226:14  
**re-voted** 395:11  
**reach** 68:10 147:12  
273:18 337:15 396:8  
396:10  
**reached** 89:14 186:6  
**reaction** 176:21  
**read** 106:17 111:11  
123:6 254:2 263:9  
300:13 305:21 324:19  
**reading** 8:19 168:22  
176:12 212:15 248:20  
271:1 338:5  
**readmission** 185:4  
260:5 265:6  
**readmissions** 54:2  
258:20 264:8,12,13  
264:18 266:4 290:13  
292:11 397:12  
**readmit** 292:13  
**ready** 46:6 49:6 51:16  
52:4 88:21 104:17  
107:14 126:13 149:3  
155:14 162:7 177:12  
198:18 200:7 218:18  
230:21 297:17 326:17  
330:4 334:8,14 335:8  
337:12 338:4,6,9  
339:17 347:9 400:1,5  
**real** 43:5 99:2 147:15  
290:18 363:22  
**real-time** 25:5,10  
**realize** 317:19  
**realized** 178:5 295:21  
**realizing** 374:18  
**realm** 45:15  
**rearrange** 375:20  
**reason** 102:13 127:19  
197:13 210:13 211:16  
212:2 215:2 217:11  
218:7,8 226:12  
250:21 273:16 293:13  
300:1 350:7 358:2  
**reason's** 364:13  
**reasonable** 129:7  
138:22 248:16  
**reasoning** 231:5 309:21  
349:19 350:10,17  
**reasons** 54:2 180:6  
181:20 255:17,21  
291:16 292:13

**reauthorization** 7:8  
**recall** 15:11  
**receive** 17:9 308:18  
343:10 388:17 390:20  
394:19 401:7  
**received** 10:22 78:21  
81:14 82:5 87:12  
312:17 333:6 398:14  
399:13,15  
**receiving** 34:9  
**reclassify** 62:8  
**recognize** 64:15 65:2  
193:4 206:2 213:3  
302:8 312:15 336:12  
372:4,13  
**recognized** 63:4 181:11  
213:20 241:17 368:3  
**recognizing** 65:21  
148:12 184:8 325:10  
**recommend** 48:11 52:4  
75:15 77:10,21  
142:17 184:14 204:22  
243:2,3,14 255:8,8  
268:17 276:12 304:16  
305:14 395:11 402:12  
**recommendation** 77:7  
126:8 193:10 201:1  
235:5 244:17 250:16  
258:7 325:21 374:15  
**recommendations** 5:9  
30:17 43:17 52:6  
94:19 113:2 115:9  
177:10 207:19 243:17  
378:17  
**recommended** 31:4,8  
32:6 49:2 76:18 78:5  
88:16,17,18 94:15  
98:2 115:8 116:13  
119:11 121:22 156:19  
163:2,9 167:1 206:14  
207:6 219:12 220:15  
220:16 223:20 225:8  
230:16 234:1,19  
235:15 242:10 253:20  
258:4,14 280:16  
299:18,21 300:11,12  
301:16 309:6 311:13  
315:4 333:19 348:2  
349:8,12 363:1  
365:14 374:20 385:3  
388:21 398:18  
**recommending** 95:2  
126:12 157:18 177:5  
204:21 205:1,5 242:9  
242:22 245:20 315:13  
324:4 325:19 376:12  
389:2  
**recommends** 223:15



- Reconciled** 240:18  
**reconciliation** 118:4  
 234:17 240:14 241:3  
 241:12,15 242:2,4  
 243:2,11 250:19  
 251:7 261:5,9 294:14  
**reconnecting** 318:15  
**reconsider** 101:3 315:5  
**reconsideration** 91:2  
 101:5 115:1 120:19  
 121:10 122:1 180:3,6  
 180:7 181:9 207:9,16  
 211:17 314:17,22  
 331:6 342:11 346:15  
**reconsidered** 52:15  
 350:8  
**record** 89:16 97:10  
 167:8 226:5 251:1  
 253:6 254:22 272:1  
 276:11,14 280:19  
 282:2 284:10 289:10  
 296:6 304:7 307:9  
 322:14 394:19 401:14  
 401:20 406:15  
**recorded** 258:5  
**recording** 241:6  
**records** 157:10 291:2  
 293:2  
**recovered** 98:9 100:11  
 103:11  
**recovery** 317:10 318:2  
 318:19 323:13,19  
**recuperating** 20:16  
**red** 206:9  
**redesign** 21:21 22:10  
**redesigned** 283:6  
**reduce** 56:14  
**reduced** 397:12  
**reducing** 48:14 53:16  
 54:16 57:20 310:7,18  
 396:16  
**reduction** 140:20 186:4  
 187:17 397:12  
**reductions** 60:12 185:4  
 397:11  
**redundancies** 31:17  
 263:21  
**redundancy** 244:20  
 364:22 368:21 389:4  
**redundant** 243:8  
 244:11 256:17 263:18  
 351:19 352:11 366:3  
**refer** 48:18,22 149:22  
 364:2  
**referees** 299:4  
**reference** 152:4 342:13  
**referenced** 52:13 249:8  
**references** 53:7 131:12  
**referencing** 394:22  
**referral** 163:14,16,18  
 166:7 271:12 380:6  
**referrals** 163:22  
**referred** 57:1 90:22  
 114:21 120:20 129:20  
 167:15 180:1 271:15  
 307:18 343:12  
**referring** 152:6 270:4  
 356:20  
**refinement** 160:2  
**reflect** 41:6,17 42:5  
 43:4 248:9 306:9  
 348:20  
**reflected** 42:1 51:4  
 251:18 304:2  
**reflective** 351:15  
**reflects** 168:9 358:8,9  
**reform** 28:18 36:13,17  
 37:1,4,15 49:4 55:10  
 57:2 59:14 78:17  
**refresh** 296:4  
**refreshing** 43:10  
**refused** 398:14 399:7  
 399:13,16  
**regard** 31:15 116:8  
 118:7 218:12  
**regarding** 11:3 78:15  
 226:16 251:9  
**regardless** 49:9  
**regards** 60:9  
**region** 22:2 146:22  
 282:21 285:11  
**regional** 2:6 14:16  
 21:17 146:17 147:1  
**registered** 321:4  
**registries** 360:3  
**registry** 360:5  
**regrettably** 325:6  
**regulation** 360:4  
**regulations** 352:2  
**regulatory** 352:5  
**rehospitalization** 384:4  
**reimburse** 191:6  
**reinforce** 251:5  
**reinvent** 44:4  
**reiterate** 88:20 213:1  
 218:6 231:21 242:21  
 251:14  
**rejected** 215:10  
**rejoin** 56:7 170:10  
**relate** 313:10  
**related** 11:9 14:8 31:21  
 47:17 49:3 98:11  
 99:18 101:10 103:13  
 115:3,6 122:2,3,4  
 131:9 167:21 176:5  
 179:16 188:16 222:6  
 245:16 246:16 363:14  
 363:17 365:18 366:9  
 367:22 368:5,21  
 373:5 374:18 377:5  
 384:5 391:14  
**relates** 133:10 313:6  
**relay** 76:17  
**released** 7:16 186:8  
 244:17  
**relevant** 8:16 11:6,10  
 14:13 15:19 18:1  
 19:16 37:8 39:4 60:20  
 78:3 140:4 288:12  
 351:5 395:19,20  
**reliability** 50:6 53:11  
 72:17 226:16 286:18  
 326:5,9  
**reliable** 128:2 174:14  
 205:17  
**rely** 318:10  
**remain** 175:4 232:9  
 303:8  
**remaining** 54:18 56:18  
 77:20 86:22  
**remarks** 4:2,4,5 5:16  
 33:11,14 198:5  
**remember** 27:4 62:13  
 110:10 118:9 130:15  
 130:17 149:17 212:11  
 212:16 220:18 233:22  
 275:20 297:18 395:7  
**remind** 27:7 320:9  
**reminder** 11:7,15 25:2  
 315:1 376:7 377:1  
**reminders** 11:20  
**Remission** 53:2  
**remote** 120:2  
**remotely** 12:7 61:13  
 119:19 149:22 151:7  
**removal** 81:5 223:1  
 286:5 302:22  
**remove** 99:19 102:5,19  
 115:7 247:15,16  
 248:4 256:1 283:14  
 303:5,10 304:9  
 309:13 364:20 365:22  
 366:2 368:7 376:16  
 376:21  
**removed** 77:19 119:6  
 248:6 256:3 272:18  
 283:10 291:15,19  
 302:20 309:17  
**removing** 376:15  
**renal** 15:8  
**repeat** 164:2 203:21  
**repeatable** 50:21  
**replicability** 49:22  
**replicated** 50:16 299:10  
 299:12  
**report** 7:16 8:4 18:18  
 34:6,7,11 63:8 125:14  
 128:20 136:21 137:9  
 163:11 174:10,19  
 235:19 247:8 304:2  
 325:9  
**reported** 73:1 172:2  
 173:16 222:16 247:6  
 331:10  
**REPORTER** 176:9  
**reporting** 19:3 45:3  
 80:21 209:2 256:5,6  
 284:8 285:2 291:19  
 291:21  
**reports** 14:8 123:11  
**repositories** 122:14  
**repository** 78:7 316:13  
 337:10  
**represent** 16:11,14  
 45:7 49:8 50:10  
 266:15  
**representation** 36:21  
**representative** 28:2  
 44:21 136:10  
**represented** 55:22  
**representing** 11:17  
 285:5  
**represents** 18:21 77:12  
 188:7  
**request** 339:7  
**require** 89:10 146:21  
 210:21 230:8 237:17  
 329:2,4 351:11  
**required** 50:4,22  
 126:16 211:4,7,10  
 295:5,8 319:22  
**requirement** 45:3,18  
 360:5 382:20 383:8  
**requirements** 125:6  
 126:17 157:20  
**requires** 50:17 64:6  
**requiring** 198:12  
 210:11  
**rescind** 249:15  
**research** 11:10 19:7  
 44:5 57:21 68:13  
 115:21 148:11 181:19  
 188:18 189:7 322:19  
**researched** 197:6  
**researchers** 58:18  
 211:3  
**residential** 252:22  
**residents** 14:3  
**resistant** 344:17  
**resolve** 64:15  
**resource** 21:7 45:16  
 118:5 257:18 320:20

**resources** 72:14 74:9  
 107:3 154:18,21  
 163:15,19 166:7  
 179:7 195:13 199:20  
 271:13 280:10 297:7  
 328:19 362:5 389:5  
**respectively** 257:21  
**respects** 370:15  
**respond** 191:2 210:16  
 227:16 291:7 292:4  
 293:5  
**respondents** 168:15  
**responding** 292:6  
**response** 23:17 136:13  
 169:22 170:8  
**responses** 151:20  
 168:14,14 192:16  
 274:8  
**responsibilities** 53:21  
**responsibility** 183:5  
 190:22  
**responsible** 124:14,21  
 129:21 183:7 212:13  
 261:10 293:11  
**responsiveness** 50:7  
**rest** 76:9 180:14  
**restaurant** 91:7  
**restriction** 189:20  
**restrictions** 266:10  
**restrooms** 26:13  
**result** 53:21 60:6,12  
 62:15 135:2 143:10  
 388:18 397:12  
**results** 50:16 58:8  
 88:13 329:3  
**resume** 11:8  
**resumed** 97:10 167:8  
 307:10  
**resurface** 142:3  
**retain** 82:12,15 83:13  
 83:20 226:2,21  
 349:18 360:1  
**retained** 83:8,10 87:2  
 100:9 116:16,18  
 180:12 242:6 316:3  
**retaining** 236:20  
**return** 58:17  
**returning** 327:1  
**returns** 289:14  
**reunited** 318:12,14  
**review** 4:4,7,10,13,16  
 30:22 33:18 34:2,9  
 52:1 63:2,7 76:14  
 77:18 81:5,7 83:11  
 89:2 92:7 102:14  
 112:22 116:8 120:16  
 120:21 121:14 123:3  
 148:10 174:7 175:5

182:11 210:18 222:22  
 226:15 255:4 257:22  
 307:19 309:6 312:19  
 329:4 337:9 342:12  
 356:17 363:16 364:18  
 365:19 366:8 367:21  
 368:8,18,22 372:11  
 376:8 378:1 379:22  
**reviewed** 116:11  
 230:15 307:22 311:10  
 315:1 366:5 377:18  
 390:1 397:5  
**reviewer** 16:5  
**reviewing** 30:16 143:11  
 311:12  
**revised** 50:2,12,17  
 222:15  
**revote** 339:7  
**ribbon** 32:13  
**Richard** 311:2  
**rid** 238:17 246:8,9  
**righty** 326:19  
**risen** 293:1  
**risk** 74:19 129:12  
 156:22 157:4,9,16  
 158:3,9 159:21 160:7  
 161:4,5,7 162:11  
 163:7,16 164:22  
 378:11,16 383:16  
 384:8  
**risk-stratifying** 160:4  
**risk/high** 182:12  
**risks** 157:3  
**RN** 1:14 2:2 3:5  
**RO1** 320:17  
**road** 30:6 129:8  
**Rocky** 191:12  
**rohypnol** 347:1  
**role** 8:15 15:7 38:3  
 191:4 203:14 310:10  
 364:17  
**roles** 14:1 168:17  
**roll** 170:4  
**rolling** 33:10  
**room** 1:9 5:12 10:13  
 12:6 26:16 97:3,5  
 102:9 114:4 119:16  
 121:1 122:18 135:8  
 151:6 158:13 165:15  
 172:3,12,18 175:9  
 176:19 228:3 229:9  
 231:15 232:1 266:3,5  
 278:9 282:19 347:8,9  
 360:11,11 376:13  
 378:8  
**Ross** 3:11 111:19,21,21  
 114:2  
**roster** 28:16

**Roundtable** 16:7  
**RTI** 19:3 210:2,6,7  
**Rubik's** 235:22  
**run** 128:17 143:19  
 197:8 353:7 359:17  
**running** 6:20 148:10  
 195:15  
**rural** 146:18 282:15  
 386:15  
**Ryan** 2:11 4:17 13:19  
 13:19 141:14 166:14  
 175:19 176:5,14  
 201:13 263:17 264:2  
 310:18,22 319:6  
 364:4 369:10 383:1,4  
 387:18 399:11 400:2  
 400:7 404:5

## S

**safety** 15:5 42:21 59:2  
 65:12 176:1 182:12  
 183:3 211:13 267:19  
**sake** 227:15 228:1  
 233:19  
**same-day** 60:10  
**SAMHSA** 23:16  
**SAMHSA's** 317:14  
**Sandra** 1:16 14:21  
**Sarita** 2:6 21:11,16  
 140:2 160:22 170:14  
 253:11 254:12,17  
 305:6 327:22 329:14  
 333:8,10,11  
**satisfaction** 56:6  
 175:20 176:6 187:3  
**save** 100:12 251:15  
 309:10 404:20  
**saved** 98:9 220:9,13  
 374:8  
**saw** 86:1 190:8 350:19  
**saying** 127:2 147:17  
 157:18 172:11 204:2  
 204:15 206:1 217:14  
 237:8 239:15 288:18  
 317:20 321:13 323:11  
 323:17 332:3 338:2  
 345:13 355:22 372:10  
 372:11 403:12  
**says** 102:10 109:12,14  
 136:21 137:17 185:5  
 262:21 306:5 321:18  
 340:13  
**SBIRT** 17:6  
**scale** 84:2,21 85:1,7  
 201:18  
**scaling** 84:1  
**scan** 39:10 77:14  
**scanning** 133:6

**scenario** 43:16  
**scene** 344:20  
**schedule** 302:9 373:9  
 375:18  
**scheduled** 27:7 97:3  
**scheduling** 35:5  
**Schiff** 2:13 22:15,16  
 95:16 145:15 147:15  
 170:9,11 232:11,21  
 302:15 306:4,7 324:9  
 340:3 346:8,10,16  
**schizophrenia** 59:19  
**schizophrenic** 232:19  
**school** 2:12 8:13 13:21  
 24:15 319:21  
**schools** 306:14  
**science** 16:1 38:2  
 322:10 325:22  
**Sciences** 9:11  
**scientific** 49:20 50:4,15  
 79:14,18 80:6,16  
 82:20 155:17 340:12  
 341:4  
**scope** 311:17 368:18  
**score** 77:17,19 80:10  
 80:11,14,16 81:3,6  
 82:18,21 84:6,9,12  
 85:2 91:9 96:5,8  
 156:22 157:4,10,16  
 158:3,9 161:4,8  
 162:11 163:16 169:2  
 169:3,7,10 182:6  
 184:1,5 189:14 215:6  
 215:6,14 231:3 340:8  
 350:12  
**scored** 82:11 157:3  
 168:11  
**scores** 81:21 82:6,6,9  
 83:15 85:4 164:22  
 181:8 186:4,20  
 191:13 198:22  
**scoring** 183:16 194:17  
 194:19  
**scratching** 184:15  
**screen** 29:19 77:11  
 122:7 149:8,15  
 227:18 303:13 344:14  
 346:19,22 347:3  
 370:18,20 376:10  
 383:12 384:7 386:16  
**screened** 342:20 383:1  
 383:14  
**screening** 52:10 157:7  
 158:5,11 311:18,22  
 319:14,16,17 323:12  
 342:15 343:1,8,11,11  
 343:13 344:10 345:6  
 345:8,9,10 347:12

369:16,17 370:1  
 371:1,2,10 372:14,15  
 381:4 382:10 384:17  
 385:2,3,5,5,8 386:8  
 387:21 388:12,18,22  
 389:18 397:2 398:19  
 399:18 403:2,2  
**screenings** 157:6  
**screens** 30:18 151:5  
**scroll** 121:5 122:5  
**se** 10:1 230:22 242:12  
**search** 78:3 81:16  
**searched** 78:4,9  
**searching** 75:2  
**season** 167:12  
**seasonal** 144:2  
**seated** 11:1  
**sec** 256:22  
**second** 23:9 30:9 53:7  
 55:4 63:20 84:1  
 102:13,20 109:20  
 151:17 153:19 207:8  
 210:19 216:12 234:8  
 235:1,8 243:17,22  
 244:18 248:2 251:10  
 257:1 268:18 276:8  
 299:7 308:6,22 310:4  
 314:6 338:15,20  
 345:22 346:11 363:5  
 387:17 388:8,8  
**secondary** 346:21  
**seconded** 223:12  
 272:16 309:14 376:17  
**seconds** 102:14 261:21  
 305:22  
**section** 2:12 120:18  
 121:12,16 222:8  
 296:1  
**sectors** 216:9  
**seed** 113:11  
**seeing** 20:7 74:5  
 138:12 195:14  
**seek** 388:17  
**seeking** 7:16 8:5  
 318:13  
**seeks** 398:15  
**seen** 72:20 94:11  
 114:16 134:18 182:20  
 238:11 291:1 342:19  
 343:4 370:11  
**segmentation** 161:6  
**select** 83:7 94:2 149:7  
 150:15,16,17,18  
 154:1,4,5,7,7,10  
 155:4,5,15,18,22,22  
 156:8 162:17 166:12  
 177:20,21,21 178:17  
 178:18,18 179:8,8,9

199:4,5,5,12,12,13,21  
 199:22 200:1,9,10,12  
 206:22,22 207:1  
 219:6 252:4 327:2  
 328:20,21 330:5  
 332:22 339:20 347:18  
 361:18 362:7,8,8  
**selected** 32:14 83:5  
 99:13 113:5 154:12  
 154:13 155:10,10,11  
 156:4,17,18,18  
 162:20,20,21 166:21  
 178:11,11,12 179:2,2  
 179:3 199:8,8,16,16  
 199:17 200:4,4,5,16  
 200:17,17 207:4,4,5  
 217:12 219:10,10,11  
 224:8 328:12,12,13  
 330:1,1,2 331:21,22  
 332:1 342:10 347:22  
 361:22 362:11,11,12  
 362:21,21,22  
**selecting** 39:17 76:21  
 99:3  
**selection** 4:8 76:13,20  
 77:13 97:17  
**self-** 226:5 336:19  
**Self-Care** 272:2 280:20  
 296:8  
**self-nominate** 336:18  
**send** 29:6 33:22 170:18  
 328:7 345:1 403:22  
**sending** 238:11 328:5  
**sends** 290:2  
**Senior** 1:17 3:3,4,5  
 10:18 15:20 26:7  
 27:16 115:21  
**sense** 33:21 40:15  
 105:19 106:19 141:5  
 141:10 147:18 161:1  
 188:6 225:17 230:12  
 236:5 242:14 251:16  
 256:10 288:6,13,14  
 289:15 388:4  
**sent** 119:20 120:4  
 150:1 305:9 333:5,13  
**sentiments** 113:22  
 163:11  
**separate** 39:7,14 40:3  
 79:6 123:11 167:16  
 234:10 237:20 314:21  
 398:16  
**separated** 77:3  
**separately** 99:11  
**separates** 355:6  
**series** 397:3,19,19  
 400:16 402:8  
**serious** 186:11 190:11

196:11 370:4 385:6  
 388:13 389:8,19  
 390:7  
**serum** 343:2  
**serve** 12:21 13:11,16  
 16:6,12 17:14 21:16  
 21:22 24:13,18 46:22  
 49:12 316:4  
**served** 17:13 18:7  
 57:22  
**serves** 22:21 120:13  
 168:7  
**service** 14:14 112:10  
 134:21 135:3 138:5  
 139:7,19 140:10,20  
 141:3 213:8,22  
 322:18  
**services** 2:2,14 3:9,10  
 6:7 13:11,13 16:5  
 22:20,21 28:8 36:2  
 48:19 55:8,11 56:7  
 57:4 59:8 60:11,13  
 112:15 113:4,14  
 124:14,21 140:19  
 144:1,6 148:2 168:18  
 168:19 209:14 210:12  
 213:11 214:2,3  
 402:10  
**serving** 288:16  
**sessions** 77:4 89:8  
**set** 23:10 41:5 43:22  
 47:1 55:14 70:15  
 75:11 88:17,18,19  
 98:14 99:4 100:9  
 102:11,18,22 115:11  
 119:3 128:15 156:20  
 163:2 167:2 179:21  
 180:16 183:2 191:19  
 205:5,6,9 206:13  
 207:7 208:1 219:13  
 222:15,18 223:9,11  
 223:16,20 225:9  
 234:2 239:21 241:5  
 245:16 250:5 253:2,7  
 253:9,14,20 256:2,10  
 256:11 259:9 260:6  
 262:20,22 268:8  
 270:22 279:7,18  
 280:7,16 284:7  
 285:19 286:5 291:15  
 298:11 301:16 302:21  
 303:9 304:9,13,16  
 305:15 306:11,14  
 308:1,6 309:2,4  
 312:11,19 333:20  
 348:2 349:8,12 353:1  
 363:2 368:8 372:4  
 374:19 375:3 376:5,9

376:15,21 388:6  
**sets** 23:6 39:21 40:21  
 41:2 42:11 43:4 44:6  
 44:9 45:2,6,13,14  
 48:11 49:2,5 64:2  
 65:16 69:10 77:9  
 80:22 94:13 95:11,13  
 204:20,21,22 205:3  
 254:8 286:2 309:7  
 310:5 368:22  
**setting** 51:2 58:7  
 172:17 191:1 217:9  
 219:19 252:22,22  
 387:22 401:6  
**settings** 42:8 142:3  
 217:8  
**setup** 22:17  
**seven** 119:3 283:4  
 297:10,13  
**seven-day** 172:20,21  
**seventy-** 297:14  
**Seventy-five** 156:3  
**Seventy-four** 153:14  
**Seventy-nine** 361:12  
**Shaonna** 3:3 26:7  
 62:11 76:6 85:20  
 201:9  
**shaking** 335:12  
**shamelessly** 29:14  
**Shantanu** 3:2 5:16  
**Shaps** 116:3  
**share** 39:9 40:10 43:18  
 44:7 92:2 94:10  
 105:12 113:21 283:20  
 285:8 291:10 292:2  
 293:11  
**shared** 31:5 82:17  
**sharing** 35:18  
**Shaw** 2:15 14:11,11  
 73:6,6 74:10,13,16  
 181:10 182:18 251:14  
 287:9,12 337:22  
**sheet** 78:20 152:6  
**sheets** 78:21 79:1,3,6  
 81:19,20 82:5 156:14  
**shelf** 335:10  
**Sheryl** 2:11 4:17 13:19  
 76:14 141:13 175:13  
 175:18 201:12 263:16  
 310:17,17,19,21  
 312:15 366:11,16  
 367:16 368:3 384:20  
 398:3  
**shifted** 184:3,9  
**shopping** 358:11,14  
**short** 55:8 111:1  
**shortage** 306:10  
**shortages** 60:15

**shortcut** 120:13  
**shortly** 397:7  
**shout** 115:17  
**show** 187:12 233:5  
 278:21 280:3,12  
 296:13 297:1,9,22  
 300:8,20 301:9  
 321:20 367:18  
**showed** 51:19 134:13  
**shown** 57:21  
**shows** 91:5 106:9  
 144:17 149:8  
**Siddiqi** 2:15 46:14,15  
 93:16 94:17 157:21  
 170:12,13 171:9  
 175:14 178:5 193:19  
 203:11 204:1 206:6  
 231:20 235:7 299:6  
 305:8  
**side** 29:6 33:3 68:15  
 74:14 120:16 187:4  
**sidebar** 32:21  
**signed** 377:11,15,21  
**significant** 53:19 60:14  
 106:7 130:7 153:21  
 178:16 179:17 193:22  
 199:11 279:10,22  
 296:20 327:15 361:18  
 401:1  
**significantly** 211:11  
**similar** 71:11 77:6 87:9  
 101:16 134:10 155:7  
 171:10 224:18 229:10  
 231:18 241:2 258:21  
 262:11 283:3 318:9  
 329:6 349:7 355:21  
 364:15,19,19 370:1  
 370:14,15 372:3  
 382:10 388:21 389:2  
 389:22 390:2 395:8  
 397:17,18 400:17  
**similarities** 69:8 241:13  
 367:14 397:4  
**simple** 386:5  
**simply** 182:9 242:22  
 366:1 389:12 390:6  
**sincerest** 21:13  
**single** 117:20 121:4  
 158:10 246:21  
**singular** 381:12  
**sir** 306:21  
**sit** 12:11 14:22 16:17  
 18:17 193:5  
**site** 272:3 280:21  
 286:19 296:8 326:15  
 386:17  
**sites** 190:15 214:1  
 323:1

**sitting** 11:13,16 114:4  
**situations** 96:10 124:13  
**six** 58:21 77:12 116:14  
 184:5 297:3 311:14  
 378:20 392:6  
**Sixteen** 279:6  
**sixty** 57:17 154:11  
 199:15 200:16 201:16  
 328:11 329:22 331:20  
 331:20  
**Sixty-five** 207:3 333:16  
**Sixty-three** 362:20  
**skewed** 182:10  
**skilled** 18:22  
**skip** 208:7 308:19  
 362:13  
**skipped** 259:17 265:3  
 265:11  
**skipping** 308:20 313:15  
**slated** 123:3 180:22  
**sleep** 262:1  
**sliced** 147:8  
**slicing** 288:8  
**slide** 25:21 30:14 33:9  
 33:13 35:19 36:19  
 38:7,17 40:19 42:9  
 43:9 46:1 49:15 51:8  
 52:8 53:8 76:19 80:5  
 80:7,12 82:16 87:7  
 88:12 96:20 98:19  
 101:4,6 115:11  
 118:18 119:4,8  
 273:11 303:14,14  
 310:10 375:21 377:9  
 393:7 394:15,17  
**slides** 77:22 97:16  
 112:17 265:7 328:15  
 375:20 392:21 405:6  
**slightly** 64:2 357:20  
**slow** 376:3  
**small** 40:5 57:5 87:8  
 268:12 345:13  
**smaller** 314:4,4  
**smart** 44:19 372:6  
**smarter** 299:14  
**smiling** 107:17  
**smooth** 310:4  
**SNF** 215:19 217:9  
**social** 18:4 55:12 59:8  
 163:17 189:1 318:15  
 324:11 325:1,7,13  
**Societies** 17:3  
**society** 78:8 383:21  
**soft** 287:1  
**soliciting** 81:14  
**Solutions** 1:21 15:22  
 22:9  
**somebody** 31:5 95:14

102:9,14 147:21  
 220:12 224:4 247:13  
 282:18 314:19 316:14  
 335:10 360:21 399:16  
**somebody's** 196:20  
**somewhat** 183:11  
**soon** 17:14 47:6 328:7  
**soothing** 261:22  
**sophisticated** 373:19  
**sore** 230:6 238:22  
 276:21 277:7 278:3  
**sorry** 5:5 24:4,7 47:2  
 84:21 85:6 90:16  
 93:17 96:22 114:17  
 124:14 150:16 169:14  
 176:9 179:15 196:15  
 199:22 203:21 208:5  
 210:17 214:21 226:9  
 247:11 254:15 259:18  
 260:2 263:3 265:20  
 269:20 292:6 297:11  
 298:3 302:14 305:9  
 316:8 320:12 321:1  
 328:21 330:7,10  
 331:1,2,20 333:10  
 349:22 357:18 363:11  
 382:20 398:22 400:11  
 402:20,20  
**sort** 6:9 31:13,22 32:12  
 75:7,9,21 94:12 95:20  
 95:22 96:8 121:3  
 132:19 133:6,20  
 134:20 136:20 141:16  
 171:11 172:13 188:22  
 192:18 194:1 202:16  
 202:17 203:15 204:6  
 212:14 250:13,15,16  
 250:17 256:7 277:22  
 284:15,19 285:2,20  
 312:11 325:5,7 347:2  
 355:5 373:9 388:6  
**sorts** 29:6,9  
**sounds** 145:2 165:22  
 176:19 229:19 232:3  
 235:20 275:1 405:2  
**source** 51:2 121:17  
 158:17,21 248:21  
 316:11 317:1 368:4  
**sources** 78:4,5,7,10  
 316:13  
**South** 198:15 311:6  
**space** 65:20 122:6  
 140:14 193:3 404:12  
**speak** 100:22 131:3  
 135:9 143:10 157:4  
 193:18 212:9 236:21  
 278:11 281:10 344:6  
 357:2

**speaker** 279:2  
**speaking** 73:7 242:1  
 291:18  
**spec** 70:13 137:22  
 146:2  
**spec'd** 88:11  
**special** 2:16 147:20  
 306:10  
**specialist** 115:21  
 145:18  
**specialists** 138:13  
**specialty** 146:4  
**specific** 39:13 67:12,20  
 72:1 77:16 78:10  
 79:11 87:4 95:18 96:2  
 114:19 117:15 130:3  
 132:20 169:7 197:19  
 197:21 227:3 237:13  
 237:14,14 260:7  
 276:18 322:19 390:3  
**specifically** 228:21  
 239:5 257:7 306:13  
 323:1 349:3 399:5  
**specification** 121:16  
 139:1 299:13 403:21  
**specifications** 49:19,21  
 63:22 88:5 107:21  
 121:13 131:19 152:11  
 157:1 203:4 228:4  
 246:22 266:12 299:9  
 356:12 364:19 382:22  
**specifics** 310:17  
**specified** 50:19 51:15  
 65:1 70:20 107:11  
 118:22 155:16 165:1  
 165:8 206:2 277:11  
 277:13,17 335:5,17  
 349:10 355:16 403:5  
**specifies** 378:16  
**specify** 73:17 298:16  
**specs** 64:14 70:11  
 71:16 73:9,19,22  
 75:12,14,16 91:17  
 215:19 271:5 338:21  
**speed** 324:18  
**spend** 6:16 7:9 38:18  
 103:8 325:17  
**spending** 35:12,18  
 317:10  
**spent** 148:17 252:7  
**spirit** 11:22 159:22  
**spoke** 201:11 291:14  
**sports** 404:16  
**spot** 263:5 359:5  
**spouse** 46:19  
**sprained** 230:6  
**spreadsheets** 122:15  
**spring** 286:8

- spur** 161:7  
**square** 194:20  
**squeezing** 259:1  
**Srey** 143:13  
**SreyRam** 2:4 19:12 134:7  
**stab** 204:17  
**stable** 318:13  
**staff** 2:9 3:1 4:7 9:3 33:2,21 35:9 43:19 46:13 48:8 55:2,22 59:1,2 61:3,5 62:8 63:10 77:13 79:10 80:10 81:16,21 83:15 91:20 101:22 111:11 115:4 119:1 121:13 121:18 149:15 167:22 168:13,14,15,16,17 173:13 176:16 179:12 186:19 222:16 224:16 267:16 291:7 299:1 305:20 319:22 356:16 404:17  
**staffing** 26:8  
**stage** 23:9 33:12 46:7 120:17 203:19  
**stages** 319:14  
**stake** 248:13  
**stakeholder** 41:18 109:5 156:12  
**stakeholders** 37:11 43:21 50:8 108:18 109:3,15,16 156:8,11 180:8 185:19 206:19 241:1 300:6,18 332:21 362:17  
**stand-** 270:21  
**standard** 7:20 67:11 73:19 241:18 261:8 343:18,21 348:16 377:16,18,20  
**standardization** 302:7  
**standardized** 39:18,22 41:11 67:8 76:21 77:1 275:19 345:6  
**standards** 16:16 341:5  
**standing** 21:6 91:22 127:22 255:3 363:16 365:17  
**standpoint** 134:22 213:2 293:20 318:4 364:17  
**star** 36:22 306:2 394:8 394:9 406:8  
**stared** 191:12  
**stars** 137:13 305:4  
**start** 5:18 12:2 20:11 90:4,10 138:19 142:21 161:3,4,5 172:22 182:16 281:19 288:8 294:21 307:4 310:6 354:3 370:22 371:15 377:8 404:22 405:5  
**started** 64:12 97:14 190:11,13 197:7 224:20,20 225:3 308:3 311:9 316:11 353:8 359:15  
**starter** 94:13  
**starting** 43:22 44:6,15 76:13 311:18  
**starts** 34:16 105:2 164:19 312:9 318:1 354:3  
**state** 19:8 29:15 37:14 43:19 49:9,13 50:11 60:13 70:12,22 73:13 74:1 78:9 92:5 109:1 109:3,13 115:19,20 115:22 125:10 126:15 128:10 144:15 156:7 156:9,11 180:8,9 183:19 184:8,11 191:6 196:3 198:11 198:12,14 206:18 228:2 230:10 242:11 245:4 251:19 254:4 267:8 281:11 291:13 294:20 300:5,17 332:20 352:3 359:12 360:4,6 362:16 381:16  
**state's** 181:18 256:5  
**state-level** 177:6 192:7  
**state-targeted** 23:17  
**stated** 79:7 198:5 307:2  
**statement** 126:20 174:5 212:16 248:6 385:22 386:2 397:17  
**statements** 89:13  
**states** 10:10 13:11 36:11 37:3,11 38:12 39:17,22 40:8 41:6,12 43:13 44:11 45:20 49:7,22 52:5 55:20 60:9,12 64:17 69:6,17 70:18,19 71:7,14 72:12,15 75:9,13 78:10 80:4 108:1,6 113:6 125:12,13 127:6 128:11,11,15 128:18 129:22 142:22 144:3 155:18 203:18 204:10,11 242:9 247:7 248:11 250:9 252:17 254:3 256:6 266:10 271:8 282:11 291:18,19,20,22 295:7 323:2 334:4,5,7 334:17 362:7 373:14 374:6 381:19,20,21 385:11 389:8,11,11 389:13 390:5,6 395:20 396:13,13  
**states'** 49:3 78:17 247:8  
**statewide** 281:13  
**stations** 149:5  
**status** 121:20 152:15 211:12,14 221:15  
**statute** 45:17  
**stay** 382:16  
**staying** 391:17,21  
**stays** 147:4  
**steal** 29:13 334:11  
**steering** 19:6  
**step** 75:10 77:13,15,16 77:17,17,20 78:2,18 79:10 80:8 81:5 86:14 86:14,19 87:8 91:13 91:14 99:12 128:21 149:18 151:12 153:18 153:19 154:16 155:12 178:13 179:4 235:6 297:16 299:20 309:5 327:13 361:15 362:2 363:10,10,12  
**steps** 32:18 77:12 78:1 79:4 86:15 94:20 97:20 355:14  
**steward** 194:11 210:7 248:22 268:10 294:5 294:5,7 295:13 316:14,15  
**stewards** 195:2  
**stick** 275:18  
**sticking** 70:11  
**stipulated** 157:19  
**stipulation** 258:6  
**stolen** 317:13  
**stop** 83:22 275:22 307:4 372:9 374:17  
**storming** 148:14  
**straight-up** 213:8,16  
**strategic** 1:20 22:9 90:9  
**Strategies** 1:20 17:18  
**strategy** 2:7 20:3 21:18  
**stratified** 142:14  
**stratify** 389:12 390:6  
**street** 1:9 391:11,12 392:4  
**stretch** 294:3  
**strike** 271:21 369:2  
**stronger** 262:16  
**strongly** 161:12 402:7  
**struck** 73:7 169:1 364:1  
**structure** 168:5  
**struggle** 86:11 138:10 285:17 286:1  
**struggling** 277:4  
**stuck** 166:15 201:22  
**student** 268:2  
**students** 24:17,17  
**studied** 186:16 192:5 321:14  
**studies** 182:14 185:1  
**studying** 187:8  
**stuff** 282:15 290:5 294:12 322:8 401:15  
**SUB** 379:21 397:3 400:17  
**SUB-1** 379:22 397:2 398:18  
**SUB-2** 380:1 398:5  
**SUB-2a** 398:7  
**SUB-3** 379:20 380:2  
**sub-measure** 371:6  
**sub-measures** 371:8  
**sub-metric** 146:13  
**subcontractor** 17:5  
**subject** 118:10 135:14 227:10  
**submission** 119:10 312:17  
**submit** 149:7,13 150:10 153:6 178:9 278:20 336:22  
**submitted** 90:19,20 98:7 99:5 103:10 186:6  
**submitting** 337:16  
**subpopulation** 139:15  
**subpopulations** 138:19 145:4  
**subsections** 90:7  
**subsequent** 148:20  
**subset** 225:6 365:11 400:15 402:4  
**substance** 6:1,8 14:6,9 17:4 28:21 29:19 42:17 48:15 53:17,21 54:2,3,6,16,21 84:15 84:21 100:15 171:13 186:13 196:11 229:5 231:12 232:18 262:17 263:11,20 307:12 310:8,18 311:18 312:5,9 313:6 315:6 322:20 326:20 344:9 345:9 380:17 384:5 384:17 385:13,17 388:18

**substances** 10:3  
385:10  
**substantial** 134:13  
174:22  
**success** 396:7  
**SUD** 122:12 229:8  
231:14 232:13,15  
233:1,9,16 236:12,19  
325:15 333:20 347:12  
348:2 363:2,11 365:4  
380:14  
**suddenly** 354:18  
**SUDs** 48:16 52:14  
54:20 234:19 343:16  
393:2  
**sufficient** 163:9  
**sufficiently** 335:5  
**suggest** 160:16 186:3  
235:16 313:17 371:15  
393:8  
**suggested** 99:7  
**suggestions** 95:12  
372:17  
**suitability** 313:11 316:1  
356:6  
**suitable** 88:2 131:2  
381:21  
**suited** 208:3  
**sum** 292:8  
**summarize** 11:8  
**summarizing** 263:6  
**summary** 34:3 78:20  
81:19,20 82:5 224:7  
376:11 405:10,12,15  
**summer** 34:19 186:9  
**super** 28:9 47:5 48:1  
75:4 117:5,10 159:21  
**superior** 364:22  
**support** 2:3 36:12  
39:16 49:3 79:21  
89:11,12 131:10  
137:20 138:4 160:2  
182:14 191:10,22  
209:15 213:11 214:3  
214:4 230:13 232:6  
233:7,8 234:5,9 235:1  
250:19  
**supporting** 36:5 48:21  
57:2 59:11,13  
**supportive** 233:14  
**supports** 13:13 19:7  
48:20 55:8,12 56:7  
59:8 247:7  
**suppose** 170:4  
**supposed** 363:4  
**surgeon** 19:12 135:1  
**surgery** 20:16  
**surprised** 129:2

**surrounding** 117:1  
**survey** 52:19 53:8,9,13  
81:14 168:12,13  
173:11 176:13,16  
191:2 196:21 315:7  
315:10 326:21 329:3  
329:8  
**survey's** 196:17  
**surveyed** 116:10  
**surveys** 47:17 52:16  
53:11 96:4 168:1  
173:12  
**Susan** 2:16 18:19 212:8  
215:16 217:15 219:14  
220:22 221:17 316:20  
351:21  
**sustain** 72:18  
**sustained** 381:9  
**SVP** 1:21  
**sweet** 359:5  
**symptom** 315:12  
**symptoms** 342:20  
343:5 347:3  
**synonymous** 152:17  
**synopsis** 120:13  
367:11 376:11  
**system** 28:17 36:13,16  
36:22 37:4,15 49:4  
78:17 90:8 116:2  
142:2 164:11,13,14  
182:20 214:4 289:3  
311:4 322:19,22  
323:3 390:22  
**systems** 73:15 161:3,4  
269:10

---

**T**

---

**T32** 14:3  
**tab** 228:6,8  
**table** 44:19 48:3 87:10  
148:13 189:15 195:8  
240:9 245:16,17  
370:12 386:22  
**tables** 101:15 363:19  
364:21 365:12 367:1  
**tabling** 387:13  
**tackle** 38:22  
**tackling** 70:17  
**tag** 26:19 47:21 143:4  
169:2  
**tags** 137:14  
**taken** 139:15 143:10  
261:11 285:17,19  
286:2 326:7  
**takes** 283:21  
**talk** 26:20 27:2,3 29:5  
34:22 36:18 63:17,19  
63:19 94:7 97:16

98:15 102:13 103:2  
110:20 140:8 224:6  
254:14 359:9,10  
373:22 400:2 405:17  
**talked** 94:14 99:20  
251:19 255:7 313:20  
**talking** 8:15 9:21 10:12  
38:9 97:17 117:5  
148:18 158:5 245:14  
249:7 323:10 371:14  
**tape** 299:5  
**Tara** 3:5 4:17 27:9 46:7  
48:4 56:20 354:17  
**Tara's** 364:14  
**target** 38:17 51:11  
102:2 264:12 389:9  
**targeted** 36:11  
**targeting** 73:11  
**task** 14:17 17:1 30:15  
65:20 112:4 132:7  
**taught** 186:19  
**teacher** 156:15  
**team** 25:6,12  
**teams** 60:22 160:3  
397:13  
**tech** 70:11,13 71:16  
**technical** 14:8 22:17  
36:6,6,12 73:8 85:7  
121:22 183:15 286:21  
286:22 305:10 312:20  
340:21 341:13 342:4  
354:16  
**technically** 85:14  
323:16  
**technology** 166:19  
376:2  
**tee** 156:22  
**teensy** 212:4  
**teeth** 283:6  
**TEFT** 47:16  
**teleconference** 3:15  
111:10  
**telephone** 277:21 394:8  
**tell** 6:19 24:2 63:22 76:8  
126:20 150:12 171:9  
171:21 187:16 202:8  
214:13 226:11 233:11  
286:16 314:18 341:18  
350:14 353:11 358:16  
360:19 367:10 372:3  
391:6 393:1  
**telling** 144:11 384:8  
**tells** 253:19  
**temporary** 58:16  
**ten** 99:13 100:14  
190:12 200:17 207:5  
208:18 302:9 307:4,5  
328:13 333:18 344:15

353:16,17,21  
**tend** 182:21 213:17  
**tends** 184:18 197:14  
**TEP's** 77:7 180:21  
203:14 207:18 255:1  
257:22 343:6 355:20  
367:13 376:12  
**TEPs** 21:6 30:20 50:3  
51:22 63:4 81:11  
83:12,13 89:3,8 98:2  
99:9 115:8 118:1  
234:1 263:18 315:2  
365:14 397:8  
**terminology** 49:16  
133:3 324:2  
**terms** 42:17 45:21  
66:11 72:4 102:1  
124:12 125:8 139:17  
141:20 143:18 147:19  
172:1 192:9,12  
284:14 295:4 321:5  
341:16 356:2  
**terrible** 85:16,18  
**terrific** 90:3  
**Terry** 3:5 5:3 27:14,16  
85:22 92:20 93:2,8  
94:3,6 96:18 97:12  
109:11,17,19 110:7  
110:10 111:6 125:4  
125:17,20 126:11  
127:11 158:20 173:18  
176:2 202:1 210:2,6  
216:6 220:5,11  
224:11 225:18 226:8  
226:11 246:13,15  
253:22 255:11 259:8  
262:21 265:19,21  
275:15 279:2,17  
286:7,22 298:4  
316:20 320:5,12  
330:11,16 331:8  
332:2 335:8,13  
337:19 338:8 339:8  
339:11 349:2 366:21  
367:4,17 368:10,13  
369:5,7 371:15,19  
372:7 405:2,8  
**test** 52:12 53:4 158:11  
**tested** 52:20 53:13  
87:20 165:8 206:3  
340:15 341:4 356:17  
**testing** 49:20 50:4,5,15  
53:11,12 88:3,10  
107:21 128:3 155:17  
158:5 159:5,5 286:19  
322:22 326:5,10  
340:13 341:11  
**tests** 343:2

**Texas** 115:22 268:2,3,5  
**text** 152:6  
**thank** 5:7,11,17 6:12  
 8:8,17 9:2,5 16:8 20:9  
 20:13 21:10 22:14  
 25:1,17 27:8 34:19  
 35:3,8 56:19 63:13  
 66:20 72:13 92:20  
 94:17 98:21 111:7  
 113:18,19,20,22  
 114:9 115:16 127:11  
 131:5 132:18 134:6  
 139:20 143:17 145:7  
 145:9 167:6 169:12  
 175:17 188:1 206:7  
 212:8 214:19 217:1  
 218:15 222:1,4  
 237:21 246:5 249:4  
 254:18,19 257:15  
 263:16 271:18 304:5  
 305:12 306:16,21  
 308:10 310:22 311:1  
 312:14 329:21 331:12  
 333:11,15 337:21  
 342:9 346:6 404:17  
 405:15,17 406:10  
**thanksgiving** 35:11  
**thanks** 13:18 22:17  
 23:18,19 96:14  
 135:11 143:15 166:16  
 169:18 188:4 239:22  
 324:14  
**theme** 54:19 195:19  
 197:16 403:12  
**themes** 55:15 59:4 61:8  
 116:21 312:12  
**theoretically** 292:12,22  
**they'd** 376:14  
**things** 6:14 10:8 19:15  
 19:19 30:21 32:5,22  
 34:11 36:16 41:15  
 47:18 72:6 74:14 76:4  
 93:18 96:11,12 97:16  
 106:10 127:6 128:12  
 137:12 142:15,19  
 144:9 172:10 284:5  
 284:12 288:6 290:11  
 318:11 321:19 337:13  
 347:1,2 355:9 372:19  
 374:21 391:4 399:3  
 405:13,17  
**third** 199:18 240:13  
 276:8 277:18 310:4  
**Thirty-five** 200:3  
**This'll** 378:9  
**Thompson's** 232:18  
**thought** 31:10 32:8  
 39:20 45:9 76:11 85:9

85:15 90:16 131:1  
 147:14 203:14 204:5  
 218:1 224:3 226:19  
 237:21 250:6 256:20  
 263:12 267:6 275:14  
 298:8 313:18 317:18  
 318:5 335:5 337:16  
 343:15 356:11 357:12  
 358:4 370:7 393:4  
 398:22 399:9  
**thoughts** 8:6 148:8  
 160:19 171:7 188:14  
 357:2  
**thousand** 146:12  
 353:16,17,21 356:19  
 357:15  
**three** 7:5 27:2 31:20  
 54:18 57:16 61:1  
 77:16 82:13 83:8 84:3  
 100:15,15 101:1  
 112:20 123:11 129:1  
 147:4 159:14 162:8  
 177:21 178:19 179:5  
 179:9 184:5 199:5,13  
 199:22 200:1,14  
 201:16 204:13 207:1  
 218:17 219:7 236:18  
 261:20 268:21 276:13  
 286:11 290:18,22  
 292:19 313:13,15  
 314:21 327:7,18  
 328:18,22 330:20  
 333:1 339:21 347:19  
 350:17 355:17 357:19  
 358:1 361:10,19  
 362:8,18 371:8  
**threshold** 82:1,11,14  
 83:14 87:1 169:2,7,10  
 184:7 215:6,13 231:3  
**threw** 215:14  
**throat** 230:6 239:1  
 276:21 277:7 278:3  
**throw** 293:16 303:20  
 333:3  
**thrown** 146:6  
**thumbs** 274:11,11  
**tie** 309:21 377:6  
**Tiffany** 311:4  
**tighten** 352:5  
**tighter** 97:13  
**till** 314:13  
**timely** 226:4 254:21  
 256:14 271:22 280:18  
 289:10,18,20 296:6  
**times** 52:3 107:15  
 127:5 138:13,14  
 149:19 172:17 282:18  
 364:13

**timetable** 33:15,16  
**tiny** 87:8 212:4 355:18  
**tires** 30:22  
**title** 51:1 240:20 342:14  
**titrate** 354:6  
**to-go** 404:21  
**TOB** 397:6 402:21  
**TOB-2** 400:13 402:8  
**TOB-3** 402:3  
**TOB2a** 400:15  
**TOB3a** 402:4  
**tobacco** 312:2,3 371:2  
 371:7 372:15 389:18  
 397:5,9,17,18,21  
 400:13,14,15 401:3,9  
 401:15 402:3,5,8,15  
 402:18 403:2,12  
 404:2  
**today** 5:8,13 6:16 8:15  
 9:10,21 10:11,20 11:4  
 18:12 21:9 30:6,15  
 31:2 33:20 35:10  
 39:18 51:6 63:3,12  
 76:5 77:5 79:1 89:6  
 89:15 94:5,8 107:16  
 114:18 118:11 119:8  
 119:18 173:22 185:14  
 240:20 250:14 252:5  
 287:5 344:3 372:9  
 394:16 395:9  
**today's** 33:17 267:4  
**toe** 75:19  
**told** 126:13 221:5  
 238:17 354:11  
**tomorrow** 41:12,16  
 42:5 52:5 112:6,7  
 113:1 220:1 296:1  
 324:6 335:10 405:1  
 405:10,11 406:6  
**tomorrow's** 219:16  
**tonight** 113:1 391:5  
**tons** 213:13  
**tool** 52:9,13 53:6  
 120:11 177:1 188:11  
 192:5 193:21 194:3,3  
 194:17 195:9,20,20  
 197:4 315:12,14,15  
 315:20 317:18 323:14  
 323:15,18 324:10  
 325:18 340:5,7  
 351:18,19 353:19  
 354:1 378:15  
**toolkit** 168:2 289:2  
 353:1  
**tools** 52:9 95:21 293:9  
 315:20 319:14,18  
 320:2,10,11 325:22  
 326:1,16

**top** 54:1 59:16 60:1  
 83:3 117:8 122:6,8  
 220:18 351:19  
**topic** 6:11 9:20 10:6  
 321:12  
**topics** 7:10 37:5  
**torn** 161:10  
**torrent** 393:19  
**torture** 78:22  
**total** 9:18 57:7,10 146:7  
 257:18,20 279:6  
 376:8  
**totality** 90:7  
**totally** 191:10 374:22  
**touched** 127:15  
**Town** 20:4  
**tox** 344:14  
**track** 33:3 34:7 104:19  
 323:18  
**trade** 18:21  
**trademark** 321:4  
**traditional** 171:18  
**Traffic** 47:12  
**trained** 192:12  
**training** 14:3,3 19:12  
 168:8  
**tranche** 307:13 363:8  
**transcript** 164:14  
**transient** 192:20  
**transition** 56:10 58:12  
 68:9 112:19 142:6  
 226:5 254:22 272:1  
 280:19 289:10 296:6  
**transitioning** 141:21  
**transitions** 229:1  
**translate** 138:21  
**translated** 80:9  
**translation** 85:19  
**transmission** 254:22  
 256:15 272:1 280:19  
 283:11 289:10,18  
 290:14 291:1 292:14  
 293:3 296:6  
**transparency** 12:1  
 73:17 198:17  
**treat** 233:6 370:20,21  
 391:9 399:22  
**treated** 247:1,4  
**treating** 348:12  
**treatment** 317:12 323:1  
 355:8 370:18 371:1  
 377:11,15 378:19  
 379:4,13,14 380:3  
 400:5,14,15 402:3,5  
**treatments** 380:19  
**Trebek** 329:12  
**tree** 302:4  
**tricky** 32:2

**tried** 362:3 367:5,18  
**trigger** 383:13 384:1  
**triple** 283:11  
**trod** 75:4  
**trouble** 350:21  
**true** 96:5 368:14 370:17  
**truly** 34:10 341:7  
**trust** 192:15 250:22  
 251:2 336:15  
**Trustees** 21:3  
**Truven** 2:10 47:12,16  
 47:19 70:8 210:5,6  
**try** 28:15 33:8 47:21  
 100:2 121:3 140:13  
 140:22 224:3 309:18  
 324:12 377:4  
**trying** 8:20 12:22 20:3  
 29:9 64:14 67:5,22  
 70:18 72:5 93:18  
 101:11 124:16 130:5  
 140:4 141:11 148:15  
 161:11 171:10,19  
 174:10 183:12,13  
 184:15 189:13 190:21  
 194:7 202:12 203:17  
 204:13 210:18 212:10  
 212:15,16 223:3  
 248:8 252:9 254:14  
 303:22 324:19,20  
 328:7 338:1 367:2,17  
 369:10 372:8 399:19  
 399:22  
**turn** 5:14 8:7 10:14  
 26:19 27:1,4 34:21,22  
 46:6 47:8 48:4 56:16  
 61:16 73:5 76:6 89:18  
 96:22 118:12 124:6  
 182:15 207:17 310:17  
**turning** 310:7  
**tweak** 87:17  
**tweaked** 338:19  
**tweaks** 41:13 64:6  
 87:11,14  
**tweeting** 31:13  
**Twelve** 53:2 298:1  
**Twenty** 178:10 219:9  
**Twenty-five** 331:22  
**twenty-one** 153:15  
**Twenty-two** 280:14  
**twice** 394:3 397:22  
**twitchy** 63:20  
**two-day** 77:8  
**two-year** 382:1,6  
**type** 79:4 111:10 136:8  
 213:4,20 245:6,12  
 274:8 318:10 319:3  
 324:22 370:1  
**types** 58:13 59:8 66:11

71:21 98:12 142:18  
 171:19  
**typically** 171:16 189:9  
 197:1 213:7 401:19  
**typing** 178:3

---

**U**


---

**U.S** 401:4  
**Uber** 28:10 48:2  
**ultimately** 247:5 311:13  
 326:1 380:15 382:3  
 395:11,18 400:21  
 402:11  
**unable** 68:11 266:11  
**unanimously** 181:14  
 377:13 378:13 379:5  
 384:22 390:15 403:3  
**unapprove** 364:9  
**unclear** 332:2  
**uncovered** 137:5  
**under-report** 385:17  
**under-represented**  
 343:16  
**underdiagnosed**  
 383:22  
**undergo** 41:13  
**undergone** 49:20 50:15  
 53:10,12 107:21  
 155:16 326:5  
**underlying** 72:17  
**undermine** 356:5  
**underscore** 236:12  
 324:22  
**understand** 47:14  
 65:20 98:18 125:5,19  
 140:15 190:21 210:10  
 224:18 237:8,10  
 299:17 324:20 329:5  
 350:17  
**understanding** 66:22  
 67:5 68:5 191:8  
 194:16 243:19 244:16  
 246:12 248:18 249:20  
 256:3,13 283:17,22  
 325:18 350:21 357:15  
**understood** 132:7  
 187:6 192:19  
**underutilization** 380:18  
**unexpectedly** 344:3  
**unfortunately** 36:9  
 138:12 173:5 319:17  
 353:20  
**unhealthy** 369:16,17  
 381:4 383:15 388:22  
**uninsured** 15:17 58:14  
 184:21  
**unintended** 273:17  
 396:6

**Unintentional** 241:15  
 261:5  
**unique** 70:22 74:6  
**United** 323:1  
**universal** 345:14  
**universally** 192:19  
 193:6  
**universe** 77:14 81:8  
 224:21 225:1,6  
 243:16  
**University** 1:13 8:13  
 9:10 19:8 24:15  
 188:19 191:1 194:12  
 195:12 311:3,6  
 359:17  
**unloading** 376:2  
**unmute** 216:20  
**unnecessary** 161:22  
 185:4 228:22 230:7  
 273:20  
**unpaid** 14:2 24:14  
**unrecognized** 9:5  
**unresolved** 405:16  
**unsuitable** 315:3  
 376:14 377:4  
**unsure** 79:22 85:10  
 86:6  
**unworthy** 223:10  
**up-** 303:7  
**up-and-** 376:20  
**up-and-down** 309:2  
**up-or-down** 303:10,15  
 304:12 309:9  
**up-to-date** 222:17,18  
 226:13  
**update** 174:20,22  
 286:11 322:14  
**updated** 175:4 255:18  
 290:17  
**updates** 308:4,12  
**upright** 26:20  
**upstream** 212:14  
**urban** 146:18  
**urine** 343:2 344:14,22  
**usability** 79:14,18  
 80:15,19 82:19 251:7  
 321:15 322:15  
**usable** 302:2,5  
**usage** 198:5  
**useful** 129:10 147:7  
 160:15 174:2 177:1  
 221:2 283:12 288:20  
 318:22 341:10 351:18  
 398:12  
**users** 50:21 252:3  
**uses** 62:17  
**usual** 84:3  
**usually** 48:20 86:7

202:4 316:12 343:10  
 344:20 356:1 357:4  
**utility** 189:1 202:18  
 219:17 236:2 249:21  
 288:19  
**utilization** 16:18 58:16  
 58:18 138:20 140:10  
 140:20,21 141:3  
 186:5 187:17 228:22  
 266:1 268:22 272:6  
 301:19 304:11  
**utilize** 122:18 161:17  
**utilized** 89:5 157:19  
 337:11  
**utilizers** 58:15 67:7,11  
 67:15 117:6,10

---

**V**


---

**VA** 322:21 323:2 326:10  
 335:21 338:11,17  
**vaccinations** 143:22  
**vague** 159:21 161:2,10  
 161:20  
**vagueness** 160:13  
**valid** 128:3 131:14  
 132:14 174:14 205:18  
 340:12  
**validated** 176:20 192:5  
 197:4 248:14,18  
 249:17 317:13,18  
 319:18 322:11 325:11  
 326:4 340:7 378:15  
**validity** 50:6 53:11 64:8  
 72:16 159:5 211:19  
 326:5,9 341:4 395:16  
**valuable** 41:20 44:12  
 136:12 142:13 208:8  
 250:6 252:17 282:22  
 353:19 360:1,8,9  
**value** 9:16 41:9 73:8,11  
 73:13,16 127:7  
 130:13 133:21 207:22  
 236:13 283:12 336:12  
 352:10 353:5 354:7,9  
 359:12 388:6  
**value-based** 38:3 196:2  
 293:9 324:13  
**vanilla** 142:21  
**variability** 381:16  
**variable** 192:8  
**variation** 64:13 74:4,8  
 84:8 85:4 106:7,14  
 144:2 146:17 153:22  
 154:6 178:16 179:17  
 183:8 193:12 195:19  
 199:11 279:10,22  
 296:21 327:15 345:13  
 361:18 389:12



**varied** 7:10 85:5  
**variety** 38:13,21 41:6  
 41:22 42:6,8 70:14  
 185:1 287:13  
**various** 21:5 60:6  
 139:15 147:9 186:16  
 282:20  
**vary** 58:7 64:19  
**varying** 353:8  
**VAs** 322:18  
**vendor** 173:4  
**vendors** 171:17  
**venues** 146:9  
**version** 50:3 129:3  
 222:19 404:13,13  
**versus** 70:10 136:8  
 146:18 172:20 203:18  
 204:9 232:13 233:4  
 234:12 236:18,18  
 243:10 245:14 246:2  
 249:21 348:20 369:14  
 386:5  
**veteran** 9:12  
**viable** 238:15  
**Vice** 1:17,19 2:10 3:4  
 10:18 15:20  
**video** 299:5  
**view** 75:5 86:11 267:4  
**viewed** 229:2 252:16  
 258:3  
**viewing** 363:21  
**viewpoint** 182:18  
**virtual** 34:14  
**vision** 35:1 113:4  
**visit** 123:10,14,16  
 124:22 125:1 129:5  
 135:19 138:2 145:17  
 172:12 228:19 229:4  
 229:12 230:2,8,10,12  
 231:11,19 232:1  
 234:5,22 237:3,5,16  
 237:17,18 238:17  
 239:16 262:5,12  
 272:10 273:14 274:17  
 278:14 390:21 404:6  
**visits** 123:20,22 141:4  
 146:3,5 147:3 185:5  
 230:5 238:5 266:3,5  
 266:16 273:20 282:4  
**visual** 36:20 82:17  
**voice** 167:13 177:3  
 185:20 261:22 331:17  
**voiced** 346:2 378:18  
 389:1 396:5  
**voluntarily** 49:14  
**volunteer** 14:22 16:5  
**volunteering** 11:14  
**voted** 137:13 153:15,16

153:17 219:22 303:5  
 304:8 305:14 327:11  
 327:11,12 333:17,17  
 333:18 339:1,2,3  
 347:22 348:1 361:13  
 361:14,14,22 362:1  
 377:13 378:13 379:5  
 384:22 390:15 395:10  
 403:3  
**votes** 32:19 89:5,6,8,9  
 90:21 119:18 149:13  
 149:15 150:11 154:11  
 154:14 178:9 278:20  
 313:15  
**voting** 89:2,4,9,16 90:6  
 90:6,8,12,18 91:8  
 94:18 97:19 103:2,3  
 115:5 126:4 137:12  
 148:18 149:6,18,19  
 150:13 151:14 153:15  
 153:16 154:12 155:9  
 156:3,17 162:19  
 165:21 166:1,19,20  
 177:13 178:1,10,20  
 179:1,10 199:6,7,14  
 199:15 200:2,3,10,15  
 202:11,22 203:1,8  
 207:2,3 218:20 219:8  
 219:9 222:8 223:6  
 271:21 272:13 274:15  
 275:8,20 279:19  
 298:5 301:3,3 303:11  
 303:12 304:20 305:14  
 327:8,10,19 328:9,12  
 328:15 329:1 330:1  
 330:19,22 331:16,21  
 333:17 339:22 347:20  
 347:21 361:11,13,20  
 361:22 362:9,19,21  
 364:17  
**VP** 2:2  
**vulnerable** 161:21  
 192:21

---

**W**

---

**wade** 75:20  
**wait** 170:21 190:12  
 216:17 259:16 357:18  
 363:5,21  
**waited** 240:7  
**waiting** 151:19,22  
 304:21 327:9,20  
 329:15 333:4  
**waiver** 181:17 184:9  
 217:9 269:8 271:6  
**walk** 78:1 103:20 105:1  
 105:20 224:5 309:5  
 371:20,20 392:13

**walking** 309:20 392:12  
**Wallace** 2:16 18:19,20  
 176:21 202:6 212:10  
 215:17 219:15 220:21  
 221:17,22 222:4  
 351:21,22 385:19  
 387:2,12 388:2  
**wallet** 213:18  
**wanted** 6:17 23:20  
 26:11 27:7 35:8 40:15  
 41:4 42:4 43:9 62:7  
 81:8 82:12,14 97:2  
 98:17 103:20 104:3  
 106:18 107:6 113:11  
 141:5 148:19,21  
 166:1 180:20 198:4,9  
 207:17 210:8 217:3  
 218:6 225:18 226:3  
 226:17 244:1 247:13  
 279:13 291:9,16  
 292:1 329:4 350:10  
 350:21 355:19 356:12  
 357:17 405:9  
**wanting** 65:14 402:15  
**wants** 94:4 99:15  
 193:18 291:8  
**wash** 239:2  
**Washington** 1:9 198:14  
 254:4  
**wasn't** 6:6 85:19 165:7  
 175:21 183:21 221:19  
 249:5 268:11 270:9  
 293:16 343:18 346:14  
 357:6,6 381:19  
**water** 75:19 133:21  
**Wave** 2:15 14:12  
**way** 32:22 35:4,20  
 42:16 44:12 47:6 63:9  
 69:14 71:4 73:3 75:12  
 79:1 81:9 86:1 89:17  
 102:6 105:15 122:5,8  
 125:6 159:22 160:4  
 161:13 172:22 186:14  
 191:6 192:18 204:3  
 245:4 252:12 277:13  
 284:10 287:2 292:15  
 299:10 317:9,13  
 320:4 321:20 338:6  
 338:10 351:16 355:13  
 360:14 397:18  
**ways** 29:3,9 30:7 34:14  
 36:8 38:13 55:18  
 72:10,11 157:16  
 213:6 232:22 256:16  
 315:16  
**wean** 354:14  
**web** 35:13 120:6,12,14  
 170:3 305:11

**webinar** 157:22 224:1  
 227:20 376:2  
**website** 395:3  
**Wedlake** 311:4  
**WEDNESDAY** 1:5  
**weeds** 250:15  
**weeks** 34:1 122:16  
 143:21 378:20  
**weigh** 204:19 279:12  
**weight** 80:13  
**weighted** 80:20  
**weighting** 84:6,20  
**weights** 294:18  
**weird** 212:5 250:17  
 298:9  
**welcome** 4:4 5:4,7  
 10:19 26:6 47:10  
 217:20 328:1  
**welcomed** 27:15  
**well-** 75:3  
**well-vetted** 81:9  
**WellCare** 116:4  
**went** 8:21 97:10 145:18  
 167:8 173:18 225:5  
 265:5,11 307:9  
 310:10 315:2,21  
 320:19 353:9,9  
 356:10 364:5 402:18  
 406:15  
**weren't** 85:14 86:9,10  
 93:6  
**wheel** 44:4  
**whining** 283:5  
**wide** 41:17 42:6 58:10  
**widely** 60:5 173:11  
 190:14 266:9  
**widespread** 379:9  
**William** 1:9,12 4:17  
**willing** 196:4 321:16  
**Wisconsin** 311:3  
**wish** 20:14 75:4 250:3  
**women** 144:12,13  
 188:19 197:15 312:6  
**women's** 144:16 197:9  
 197:20  
**wonder** 201:18 233:8  
 347:2  
**wondering** 340:4  
**word** 101:19 277:21  
**worded** 192:18  
**wording** 334:12  
**words** 105:14 152:13  
 152:16 251:21 338:5  
**work** 5:22 6:2,8,12 7:13  
 8:1,18,21 9:3,14 11:6  
 11:11,12 12:13,17  
 17:3 18:11,14,20  
 19:13 23:16 27:22

28:2 30:5,16 31:1,15  
 33:7 34:5 35:10,15  
 38:12 39:10 42:4  
 47:16 65:5,7 69:7,21  
 71:9 86:14 90:5 93:22  
 95:22 103:16,17  
 111:22 112:2 113:12  
 113:19 116:5 127:10  
 148:16 171:19 175:3  
 191:7 197:8 204:5,11  
 208:16 243:18,19,22  
 244:18 267:12 281:2  
 285:5 314:12 356:5  
 358:21 372:20  
**worked** 6:7 290:9  
**workforce** 60:7,14,15  
 167:18,19,21 168:3,6  
 168:8 176:6 177:2,14  
 177:15  
**working** 12:16 14:13  
 17:19 19:20 20:4,6  
 21:20 23:13 28:18  
 41:10 70:2 120:22  
 121:2 166:19 192:6  
 203:17 216:5 285:9  
 286:14 328:15 329:19  
 354:13 372:20  
**works** 23:8 29:15 75:10  
 229:18 367:10 394:3  
**world** 43:5  
**worms** 295:20  
**worried** 263:4  
**worries** 305:12  
**worry** 96:6  
**worse** 278:5 287:15  
 360:22  
**worst** 144:16  
**worth** 72:7 400:6  
**worthwhile** 323:13  
 324:12  
**wouldn't** 71:15 111:13  
 132:12 137:9 178:3  
 197:22 237:10 285:14  
 345:8 356:20 385:12  
 387:2,12  
**Wow** 376:4  
**wrapped** 32:14  
**wrapping** 325:15  
**wrinkles** 310:3  
**written** 230:13 238:15  
 266:20 268:13 273:16  
**wrong** 165:1 178:6  
 334:22  
**Wyoming** 115:20

---

**X**

---

**X** 67:14,17 92:9 128:18  
 357:5 383:8

**Y**

---

**Y** 128:18  
**Yale** 2:12 13:21 14:3  
**yard** 346:11  
**year** 6:21 7:8 20:2  
 123:14,16,17,20  
 124:1,2,5 130:7,8  
 138:14 196:6 197:16  
 240:16 257:6 281:19  
 372:21 374:1,11  
 383:9 397:11  
**years** 6:22 7:5 17:13  
 18:8 19:5 29:13 47:19  
 64:13 69:10 123:9,17  
 124:1,4 183:19 185:2  
 192:9 209:6 240:17  
 283:4 286:11 287:18  
 290:18 291:1 292:19  
 342:19 343:3 351:3  
 383:13  
**yesterday** 7:15 120:5  
**yield** 88:14  
**YMCA's** 24:20  
**York** 78:11 173:17  
 183:19 184:8,11,21  
 198:11,11 271:5  
**young** 142:7 306:12  
**yup** 259:19 264:3  
 372:13,14

**Z**

---

**Z** 128:18  
**zero** 84:3,21 85:10  
 169:4 332:4 396:8  
**Zerzan** 2:19 17:10,10  
 74:21 159:20 191:9  
 211:22 232:16 250:13  
 251:3 255:22 272:21  
 281:3 284:2 285:16  
 295:19 298:8 354:22  
 355:4 371:22 372:10  
 374:5 383:20  
**ZIP** 157:11 164:1

**0**

---

**0-100** 167:20  
**0.9** 231:4  
**0.92** 83:3 84:15  
**0004** 379:3  
**0028** 402:22 404:10  
**0097** 241:2,11,17  
**0105** 246:19  
**0225** 404:11  
**0576** 252:14 262:13  
 272:17,18  
**0647** 226:4  
**0648** 226:7,8 254:21  
 271:22 272:17,19

280:18 296:6  
**0709** 257:3

---

**1**

---

**1,000** 357:6  
**1.2** 353:17  
**1.5** 169:3  
**1.7** 84:12  
**1.71** 169:3 215:8,9  
 231:3  
**1.8** 214:22 215:4,6  
**10** 4:3 257:13  
**10,000** 359:1  
**10:36** 97:10  
**10:53** 97:11  
**100** 168:13 184:1  
 311:10 357:7  
**100%** 296:17 297:3  
 305:13  
**1030** 1:9  
**11** 257:16  
**111** 4:9  
**1115** 181:17 184:9  
 269:8  
**114** 55:1  
**12** 54:4 181:8 198:22  
 257:17  
**12:13** 167:8  
**12:36** 167:9  
**120** 348:14,20 353:8,12  
 353:18  
**123** 4:10  
**13** 18:7 258:17,19  
**14** 116:13 167:17  
 169:20 177:14 259:17  
 259:21 297:2 379:15  
**15** 80:18 138:13 259:13  
 260:13,14 296:14  
 317:6,13 352:4  
**15%** 179:1 199:8 327:11  
 330:2 331:22  
**1598** 257:18  
**15th** 1:9  
**16** 47:19 56:2 261:4  
**16%** 347:22 361:14  
**1604** 257:19  
**163** 400:11  
**1654** 400:12 402:8  
**1656** 402:2  
**1661** 397:2 398:18  
**1663** 398:5  
**1664** 379:20  
**16th** 392:5  
**17** 78:10 181:7 198:21  
**1768** 258:19,22  
**18** 240:17 262:3 312:8  
 383:13 403:10  
**1800** 187:8

**1888** 167:17 177:14  
**19** 52:19 53:9 153:15,16  
 207:10 218:21 265:15  
 311:13 342:19 343:3  
 347:21 361:13,22  
 362:21

---

**2**

---

**2** 78:18 95:10 144:22  
 150:16,17,22 153:16  
 154:7 155:22 162:12  
 162:18 166:13 279:19  
 304:19 399:2 400:14  
 402:18  
**2,000** 186:16  
**2.3** 356:22  
**2.7** 84:7  
**20** 52:7 69:16 89:1  
 123:9 124:3 138:13  
 154:11,12 155:9  
 156:3,17 162:19  
 166:20 178:10 179:1  
 199:7,15 200:3 207:3  
 219:9 265:11,21  
 266:2 267:21,22  
 272:4 301:18 304:8  
 304:10 305:14,22  
 327:10 328:11 329:22  
 331:21 333:17 352:4  
**20-40** 273:3  
**20-44** 123:5 150:8  
**20-year-old** 141:18  
**2000-when-ever** 294:3  
**2012** 174:6 175:6  
**2015-2016** 174:19  
**2017** 1:6 69:5 175:5  
 295:12  
**2018** 260:9  
**20s** 142:1  
**21** 56:1 168:12 176:15  
 265:11 266:2,9  
**21%** 361:22 362:1  
**2152** 367:7,17 369:14  
 369:14 381:3 385:4  
 388:22  
**216** 4:12  
**217** 4:13  
**22** 265:11 266:4,9  
**23** 266:3,9 356:19  
**2371** 259:14 260:14,19  
**24** 60:9 265:11 269:15  
 270:5 381:9,14  
 382:13,14,17 383:4  
 383:14  
**24-month** 381:7 382:1  
 382:19  
**2456** 241:14 261:4  
**2483** 181:5,7 198:21

**25** 4:4 57:9 80:17  
 219:10 264:6,15,16  
 265:11,12  
**25%** 178:12 200:5 207:4  
 330:1 333:17  
**250** 355:12  
**2597** 384:15,15  
**2599** 385:5 388:12  
 390:1  
**26** 163:14 164:5,11,21  
 166:6 167:1 271:12  
**26%** 362:11,11  
**2600** 389:18  
**2605** 262:4,10,15 390:9  
 390:10,12  
**2631** 207:11 218:21  
 265:15  
**27** 55:5 323:1  
**2806** 342:13 347:12  
**2940** 395:4  
**2950** 350:12 395:12  
 396:3  
**2951** 361:3 363:22  
**2957** 369:15  
**2a** 398:10 399:2,14

---

**3**


---

**3** 79:10 110:6 150:19  
 151:2 154:10,16  
 155:5,22 162:18  
 166:13 272:8,9 273:5  
 273:6,9,12 274:16  
 278:13 362:2 402:18  
**3:10** 302:8  
**3:15** 307:9  
**3:25** 307:10  
**30** 80:16 138:13 172:22  
 240:19 261:20 352:18  
**30-** 172:19  
**30%** 200:16 328:12  
**300** 355:12  
**306** 4:15  
**307** 4:16  
**31** 124:4  
**32%** 362:21  
**3225** 402:19,21 404:8  
**35** 4:5 162:20  
**35%** 199:16  
**394** 4:19  
**3M** 266:8 267:1 268:21  
 320:7

---

**4**


---

**4** 80:8 110:6 301:22  
 302:1 339:7,8,10  
**40%** 179:3 200:4  
**406** 4:21  
**43** 116:12 225:4 311:11

**44** 377:9  
**45** 179:2 378:10  
**45-64** 123:5 150:9 273:3  
**46** 315:8 316:17 322:15  
 326:22  
**47** 379:2  
**48** 4:7 400:12  
**49** 402:1

---

**5**


---

**5** 4:2 81:5 86:16,19  
 247:19 248:21,22  
 249:1 339:1  
**5:09** 406:15  
**5:30** 27:6  
**50** 117:7 162:21 166:20  
 168:14 353:9 397:1  
**51** 398:4  
**52** 379:19 383:19  
**53** 381:3  
**54** 384:16  
**55** 219:11 388:14  
**55%** 178:11  
**56** 389:17  
**57** 390:11  
**58** 342:13 347:12  
**59** 395:5

---

**6**


---

**6** 54:5 86:14,20 241:10  
 247:18  
**60** 65:21 89:10,10 100:8  
 100:18 102:21 105:21  
 201:14,20 202:4  
**60%** 179:18,19 303:2  
 332:1  
**6060** 396:2  
**61** 348:10 361:3  
**62** 402:22  
**63** 61:2  
**65** 123:6 150:9 273:3  
**66** 55:21  
**69** 55:2 58:22 116:10

---

**7**


---

**7** 1:6 246:19  
**70** 116:10  
**700** 146:11  
**74%** 347:22  
**75** 4:8 78:4

---

**8**


---

**8** 252:14 272:18  
**8:45** 405:1,5  
**80** 206:8  
**80%** 279:18  
**85%** 301:14

---

**9**


---

**9** 254:21 271:22 272:19  
 272:21 280:17 296:5  
**9:00** 1:9  
**9:02** 5:2  
**90** 19:20 269:7,13 270:6  
 270:7,17 348:13,20  
 353:9 355:13  
**90,000** 134:20  
**91** 60:16  
**94** 375:21  
**9th** 1:8

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Medicaid Innovation Accelerator  
Project Coordinating Committee

Before: NQF

Date: 06-07-17

Place: Washington, DC

was duly recorded and accurately transcribed under  
my direction; further, that said transcript is a  
true and accurate record of the proceedings.

*Neal R Gross*  
-----  
Court Reporter

**NEAL R. GROSS**

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701