you that are nonvoting members, do you have
any comments or additions that you want to
add to that? Ms. Pennington?

MS. PENNINGTON: No.

MS. GORTON: All right, then. Then, we
will consider that we are closed on the
appendectomy. We have a written advisory
statement with recommendations from you on
what to do with that policy.

All right. Moving right along, the
next item which is "Uncomplicated Pediatric
Pneumonia" is the orange tab. All right.
Here we go.

Ms. Blankenship, on the line, before we
go to the pneumonia, I'm sorry, do you have
any comments or anything you want to add to
the appendectomy discussion?

MS. BLANKENSHIP: No. I'm good. Thank
you.

MS. GORTON: All right. Thank you, ma'am.

All right. "Uncomplicated Pediatric
Pneumonia". Look at items "A", "B", and
"C", episode subtypes, trigger, and
duration.
THE COMMITTEE: (Reviews document.)

MS. GORTON: The one thing I would like to point out that's different with the pneumonia versus the other two is that this is driven by a primary diagnosis of pneumonia as opposed it's not procedural, there is not a surgical intervention. It is diagnosis-driven. Also, on "Episode duration", it begins on the date of admission to the facility, the ED or the hospital, and it ends 30 days after discharge. So, when you go to Section "D", under "Episode services" that are included, and if you will remember from the previous episodes, this particular section is what identifies your episode windows. So, take a look at Section "D". You will notice there is no pre-trigger or pre-procedure window. This episode begins with a trigger of a diagnosis of pneumonia.

Any questions, comments, or discussion items for "A", "B", "C", and "D" related to pneumonia?

MR. DEATON: You said it begins with a diagnosis of pneumonia, or it begins with
the hospital services?

MS. GORTON: The date of admission to
the facility.

MR. DEATON: All right. Because you
can have a diagnosis before a patient is
hospitalized.

MS. GORTON: The trigger is in the
facility where that diagnosis occurs.

MR. DEATON: Okay.

DOCTOR GOLDEN: So, if they are
admitted from an office to the hospital with
pneumonia, it would still be a pneumonia
event.

MR. DEATON: Oh, I understand that.

DOCTOR BIBB: So, the things that
happen in the office wouldn't count yet. It
would be the date they are admitted is when
the clock starts, in the hospital.

MR. DEATON: All right.

DOCTOR GOLDEN: And that will probably
be a minority of events.

MS. GORTON: Any other questions or
comments or discussion about "A", "B", "C",
and "D"?

THE COMMITTEE: (No response.)
MS. GORTON: Ms. Blankenship?
MS. BLANKENSHIP: No. I'm good.
MS. GORTON: All right.

DOCTOR HENDERSON: I like the way you define the re-admissions on day one through three, and then relevant complications on day four through 30. So, if the week after they are discharged from the hospital with the pneumonia they get hit by a car and have a broken leg, they are not a re-admission for the pneumonia?

DOCTOR GOLDEN: That's correct. We have done that for almost all our episodes. We have cleaned it up to where, 72-hour window count, and after that --

DOCTOR HENDERSON: Have you talked to Medicare about that?

DOCTOR BIBB: It's much more fair.

MS. PENNINGTON: Yes, sure is.

MS. GORTON: Yes. And this is outlined in each of the four episodes. Cur post-procedure window is separated day one through three. So, we are looking at those causes for admissions in a small window separate from the remaining period of time
so that we are not capturing broken legs and
car wrecks and things like that.

DOCTOR GOLDEN: The ray of sunshine is
that Medicare is very aware of us developing
episodes. So, they are taking notes. Now,
whether it translates into the rest of their
program, I don't know. I think they are
paying attention.

MS. GORTON: The next section has to do
with the Principal Accountable Provider.
The PAP for this episode is the facility.
So, it would be the ED or the inpatient
facility. It would not be the physician
where the guy came from the office to your
hospital. It's the facility.

The next section, 300, are exclusions
that are specific to pneumonia. So, again,
you have the list that we read earlier that
are global exclusions. Then, you have items
"A", "B", "C", but then "C" is one through
12. So, it follows over to the next page.
So, take a few minutes and look at the
exclusions that are specific for pediatric
pneumonia.

DOCTOR GOLDEN: I will say, we still
have Parkinson's disease, which is a geriatric condition. So, it probably doesn't matter, but it probably was a hold-over from some other work. We are basically looking for fairly ambulatory normal kids to be part of the episode.

MS. GORTON: And so, it is item "A" that indicates the age range for this episode, six months through age 12.

DOCTOR GOLDEN: And we are targeting that, because most of these cases are going to be viral. They are not your typical bacterial pneumonias you get in older patients. So, particularly in the pre-school category.

DOCTOR BIBB: So, on the -- DOCTOR GOLDEN: Yeah. It is usually a milder disease than older kids and older adults.

DOCTOR BIBB: So, on the trigger, is it just the specific code for pneumonia for the diagnosis, or would it be like RSV? Because if they had RSV first and they had pneumonia second, would that still trigger this episode?
DOCTOR GOLDEN: Yes. Pneumonia is pneumonia.

DOCTOR BIBB: It has to be the primary diagnosis that goes in on the claim for it to trigger it, is how it's written here. As the primary.

DOCTOR GOLDEN: Help me out there, James. You know how that was --

MR. GALLAHER: Yes. Pneumonia is the primary diagnosis.

DOCTOR BIBB: So, if RSV was the primary, then pneumonia, then this technically wouldn't qualify?

MS. GORTON: The way we have this written, we are looking what the primary diagnosis is. We are looking what would be in DX one versus DX two through nine.

MR. GALLAHER: Right.

MS. GORTON: So, DX one, that would be, then RSV, two through nine.

DOCTOR BIBB: So, that would miss almost every RSV patient, which is part of the goal of this, I would think.

DOCTOR GOLDEN: RSV would obviously be a complicating factor, yes, that's correct.
DOCTOR BIBB: So, we would -- I mean, a lot of these things that you are looking for, I mean --

DOCTOR GOLDEN: Well, a lot of the RSV pneumonia also is in the younger category, that's right.

MS. GORTON: So, RSV -- if you have beneficiaries that are less than the age of six months, they have an RSV diagnosis, they are going to be excluded because they are too young.

DOCTOR BIBB: Yes. But you're going to have a lot of people with RSV that are over six months.

DOCTOR THOMAS: There are a bunch of your toddlers with RSV.

DOCTOR GOLDEN: Yes. So, everybody with RSV would not be counted in this, technically.

DOCTOR GOLDEN: If that's the primary diagnosis, then the answer is that's correct.

DOCTOR BIBB: But was that your intent of it?

DOCTOR THOMAS: I mean, they are the
viruses. That's one of the big viruses.

MS. GORTON: We may have to go back and
look at our specifics as it relates to those
diagnoses discussions, because, I'm sorry, I
can't tell you off the top of my head the
specifics of our discussions about RSV.

DOCTOR BIBB: It seems like it should
be pneumonia-related diagnosis, I mean, if
you are going to use the primary.

DOCTOR GOLDEN: We will take a look at
that.

MS. GORTON: All right.

DOCTOR GOLDEN: I don't know the answer
to that.

MS. GORTON: All right.
Pneumonia-related. Okay.

DOCTOR HENDERSON: So, a 14-year-old
would be excluded?

DOCTOR GOLDEN: From this episode, that
is correct. BlueCross is looking at doing
an episode on pneumonia, but they'll be
doing it in adults, because that's their
primary population.

DOCTOR BIBB: I'm just afraid that, how
it's written, there won't be hardly anybody
who qualifies. Because every hospital wants you to put the most specific cause of the episode.

DOCTOR GOLDEN: Sure.

DOCTOR BIBB: And so, then, if that happens, then --

DOCTOR GOLDEN: There are still a fair amount of non-RSV diagnoses.

DOCTOR BIBB: Yes. But even if you put staph pneumonia, and you put staph first, then pneumonia would be second.

DOCTOR GOLDEN: Well, no, no. It would still be a pneumonia. It's a pneumonia diagnosis. So, if they wrote "RSV pneumonia", then that would be -- that would be in the episode.

DOCTOR BIBB: Okay.

DOCTOR THOMAS: Influenza?

DOCTOR BIBB: Yes. You put influenza first, and then pneumonia second --

DOCTOR GOLDEN: If you wrote "influenza pneumonia", that would be in the episode.

DOCTOR BIBB: Is there a code for influenza pneumonia, specifically?

DOCTOR GOLDEN: Yes.
DOCTOR BIBB: Or is it just influenza?

DOCTOR GOLDEN: Influenza tends to be a tracheal/bronchial episode, and it can be parenchymal. Pneumonia is technically a parenchymal infection.

DOCTOR BIBB: Yes.

DOCTOR GOLDEN: So, there are separate codes for that.

DOCTOR HENDERSON: So, would you code that patient out as influenza number one, number two, pneumonia secondary to number one?

DOCTOR GOLDEN: Not everybody codes -- not every child that shows up in an ER has influenza pneumonia.

DOCTOR HENDERSON: Right.

DOCTOR GOLDEN: Lots of folks would be diagnosed with influenza --

DOCTOR HENDERSON: Right.

DOCTOR GOLDEN: -- and won't have a pneumonia.

DOCTOR HENDERSON: Right.

DOCTOR GOLDEN: Influenza pneumonia is a very specific category. We will have to look to see whether we use secondary
diagnoses. I don't know the answer.

MS. GORTON: We can certainly take that recommendation under advisement --

DOCTOR GOLDEN: Yes.

MS. GORTON: -- where if the wording of primary diagnosis is pneumonia is too specific, then we can certainly provide that information to you and get you a response back.

DOCTOR BIBB: I know 99 percent of the time I get a discharge summary from Children's, it's going to have RSV, then it may have pneumonia. It doesn't say "RSV pneumonia". It has pneumonia as a separate diagnosis. So, how this is written, almost every one I get back, assuming they bill what's on their discharge summary, would not qualify, technically.

DOCTOR GOLDEN: We will take that under consideration.

MS. GORTON: Fair point. We will take that and take a look at that information.

All right. Any other -- so, we were down talking through our exclusions. So, we are down through the 225.300.
Any other questions or comments related to those sections through Exclusions?

THE COMMITTEE: (No response.)

MS. GORTON: Ms. Blankenship, any comments, questions?

MS. BLANKENSHIP: No, not so far.

MS. GORTON: All right. Great. All right.

Then, let's look at Section 400, which are the adjustments to the cost based on risk factors. So, take a look at items "A", "B", "C", and "D".

THE COMMITTEE: (Complies.)

MS. GORTON: Any questions or comments related to the identified risk factors?

THE COMMITTEE: (No response.)

MS. GORTON: All right. The next section is --

DOCTOR HENDERSON: Since this is a protocol for pediatric pneumonia, do we want to leave seven and eight in there?

DOCTOR THOMAS: Right. I was wondering about that.

MS. GORTON: Oh, under Section 300?

DOCTOR HENDERSON: Yes. Under the
"Exclusions".

MS. GORTON: The Parkinson's and multiple sclerosis?

DOCTOR HENDERSON: Right.

DOCTOR GOLDEN: We can take them out.

MS. GORTON: Thank you, sir.

DOCTOR RODGERS: Can I ask a question?

MS. GORTON: Yes, absolutely.

DOCTOR RODGERS: I’m not a committee person.

MS. GORTON: Oh, absolutely.

DOCTOR RODGERS: Was cystic fibrosis considered as an exclusion?

DOCTOR GOLDEN: I think it already is in the globals.

DOCTOR HENDERSON: Number four also says, "Clinically pertinent respiratory disorders."

DOCTOR GOLDEN: We would not include cystic fibrosis.

MS. LASOWSKI: Yes. That's in the globals.

MS. GORTON: I will have to look back at the list in order to know that for a fact. I'm sorry, I won't know that until I
look at it.

DOCTOR HENDERSON: There's a three and a four. There's "structural and lung disorders", and "pertinent respiratory disorders".

DOCTOR RODGERS: Right.

DOCTOR GOLDEN: Yes. Number three would cover cystic fibrosis, under number three.

MS. GORTON: Okay.

DOCTOR RODGERS: Okay. We had some specific ones here, so I --

DOCTOR GOLDEN: Yes. It's available on request. I think we got rid of bronchiectasis, also.

MS. GORTON: Any other questions?

THE COMMITTEE: (No response.)

MS. GORTON: All right. So, the next section after the risk factors and adjustments has to do with the quality measures to pass. And this is a very specific metric. "This metric addresses inappropriate use of antibiotics in children ages six months through four years of age."

So, noting that six through four is a subset
of your total included age group in this episode, which was the six months through 12. And, "A PAP must have at least five valid episodes of which three must be within the age bracket of children ages six months through four years. The maximum threshold is 80 percent." So, we will open that to discussion.

DOCTOR BIBB: My question is, what percent of these hospitalized pneumonia patients are viral?

DOCTOR GOLDEN: Doesn't have to be hospitalized.

DOCTOR BIBB: Okay. What percent of these are viral?

DOCTOR GOLDEN: In this category, supposedly all of -- most of them are viral. There are some exceptions.

DOCTOR BIBB: So, everyone who is admitted for a bacterial pneumonia would need antibiotics, and that would not --

DOCTOR GOLDEN: That is correct. In this age category window, pre-school window, the literature says most of these cases are viral. The practice standard -- the
practice variation here is fairly significant. So, that's why we have chosen a very high number. But again, generate some discussion.

DOCTOR BIBB: So, does that mean up to 80 percent can get antibiotics and it's still compliant?

DOCTOR GOLDEN: That is correct. That is correct.

DOCTOR BIBB: Okay.

DOCTOR GOLDEN: That is correct. So, the metric is to try to promote some thought and some judgment about the use of antibiotics in this age category.

MS. GORTON: Other questions and comments about that specific metric?

MR. DEATON: I'm not for sure if I understand that.

MS. GORTON: Well, all right. So, the part about -- okay. Can you -- which part?

MR. DEATON: Yes. It just says, you know, basically, no more than 80 percent of the cases can have antibiotics?

DOCTOR GOLDEN: That's correct.

MR. DEATON: Okay.
DOCTOR GOLDEN: And again, the practice community ranges from 40 to 50 percent to 100 percent.

MR. DEATON: Okay. And it's really not dependent on what type of pneumonia, just the fact that it's pneumonia?

DOCTOR GOLDEN: In this case, it's really the age of the patient with the diagnosis.

MR. DEATON: Right.

DOCTOR HENDERSON: And you have eliminated all of these other systemic diseases, so you are talking about a healthy kid in that age bracket?

DOCTOR GOLDEN: That is correct.

DOCTOR HENDERSON: It's most likely to be viral.

DOCTOR GOLDEN: Yes, that's correct.

MS. GORTON: Any other questions or comments about that?

THE COMMITTEE: (No response.)

MS. GORTON: All right. The second measure is a measure to track, which is the rate of chest imaging. So, that is utilization and informational purposes only,
not tied to gain-share.

DOCTOR GOLDEN: And like appendectomy, the rate of chest x-rays in this category is all over the place. So, we are just going to see if people -- get feedback as to what they are doing or not. There may be a lot of variation, also, in the diagnosis of -- the use of the diagnosis of pneumonia. So, we are going to be looking at that, also, tracking.

MS. PENNINGTON: So, are you wanting it or not?

DOCTOR GOLDEN: At this point, we are just trying to let people look it over.

MS. PENNINGTON: Should they or should they not?

DOCTOR GOLDEN: I think, technically, if you think somebody has pneumonia -- a lot of literature will say it's very difficult to make a diagnosis of pneumonia without an x-ray.

DOCTOR HENDERSON: That's right.

MR. DEATON: I can't imagine you doing that.

DOCTOR HENDERSON: So, using the
percussion and palpation and all that stuff
that people don’t do --

DOCTOR GOLDEN: Or do well.

DOCTOR RODGERS: And that age group is
really hard to do what you could do in an
adult exam. I mean, kids can’t do
inspiratory and expiratory that adults can
do. So to make sure that it’s accurate,
that’s real important.

DOCTOR GOLDEN: I think once we get the
information -- we want to track it, and we
will get the information out, at some point
there could be a quality metric. At this
point, we just want to track the data.

DOCTOR THOMAS: Have you found any
utilization of CT in this episode?

DOCTOR GOLDEN: I would have to go
look. I’m not sure we track that, but I can
take a look and we can ask our --

DOCTOR THOMAS: Just interested.

DOCTOR HENDERSON: And again, we are
talking about kids.

DOCTOR GOLDEN: I will say that --
well, you will see in the next episode, we
have some interesting CT data.
DOCTOR THOMAS: All right.
DOCTOR GOLDEN: But that's the next episode.
MS. GORTON: Any questions -- any other questions or discussion up to this point?
THE COMMITTEE: (No response.)
MS. GORTON: And I will say, I took a look back, Doctor Rogers, in the global exclusions, and cystic fibrosis is listed in the global exclusions.
DOCTOR RODGERS: Okay.
MS. GORTON: Ms. Blankenship, anything to add?
MS. BLANKENSHIP: No.
MS. GORTON: All right.
MR. GALLAHER: I reached out to our clinical staff, and RSV is not a trigger, but pneumonia caused by RSV is.
DOCTOR GOLDEN: And I guess the question is, it has to be a primary diagnosis, as opposed to pneumonia as a secondary diagnosis would not be counted, which is, I think, the question on the table. So, the question is, do you want to make pneumonia in the secondary field to be
considered?

MR. GALLAHER: We will have to think about that.

DOCTOR GOLDEN: Yes.

MS. GORTON: So, what you said, James, RSV is not a trigger, but pneumonia caused by RSV is? Is that what you said?

MR. GALLAHER: Yes.

MS. GORTON: Okay. That's how it currently stands?

MR. GALLAHER: Yes.

MS. GORTON: All right. So, the next section are your thresholds. So, you can take a minute and read those dollar figures there.

THE COMMITTEE: (Complies.)

MS. GORTON: Your PAP curve break-out is that we anticipate 40 percent of the PAPs in acceptable, 35 percent in gain-share, 25 percent in risk-share. And as we discussed in hysterectomy, and I didn't make this comment when we were talking about appendectomy, but it applies there, as well as here, and that was your -- what we are, I think, calling a global recommendation about
what you had said in hysterectomy related to
thresholds and changing prices, et cetera,
will apply here, as well.

Any questions or comments related to
these thresholds?

THE COMMITTEE: (No response.)

MS. GORTON: And again, this was off of
the 2014 data. The last statement is, case
volume of five valid episodes per 12-month
performance period.

Ms. Blankenship, do you have anything
to add that is related to pediatric
pneumonia?

MS. BLANKENSHIP: No, I do not. Thank
you.

MS. GORTON: All right. So, let's open
it for general discussion across the
episode. Any comments or questions of
concern that we need to address?

DOCTOR HENDERSON: I have got one
comment. And again, this reflects my age, I
guess. But we are going to require 75
percent -- or we are going to look for 75
percent imaging on appendices. I understand
that. In a young child with pneumonia, as
you pointed out, it's very difficult to do
these other techniques to examine. You
know, why not ask for 75 percent imaging for
a diagnosis of pneumonia?

DOCTOR GOLDEN: The practice variation
was so substantially significant that -- I
think that's why we wanted to track it. If
you want to make that a quality metric, I
think we could make that under your
advisement.

DOCTOR HENDERSON: Maybe the next time
around, or the next revision.

DOCTOR GOLDEN: David, I mean, would
that cause us grief if we made it into a
quality metric?

MR. WALKER: I don't think so.

DOCTOR GOLDEN: If that's your
recommendation, we certainly can --

DOCTOR BIBB: Do we want to keep the
antibiotic?

DOCTOR HENDERSON: To make the
diagnosis of pediatric pneumonia, do you
think that's unreasonable to expect that
three-fourths of them are going to have a
chest x-ray?
DOCTOR RODGERS: I think that's a good practice. I still have difficulty with this one just -- because I know we are trying to drive some good quality and reduce variation, but I think almost any child -- I mean, just in my general practice -- I'm curious about the statewide data. Because, I mean, if I was going to admit a child to the hospital for pneumonia, it would be an x-ray diagnosed focal lobar pneumonia, and that child would get antibiotics. Another child would be like bronchiolitis or viral pneumonitis or something like that, hypoxia, those sort of things. And then, you know, I think there is also a big quality measurement around the appropriate antibiotics being chosen. But I don't know if there is any way to track that, you know, because, I mean, most people --

DOCTOR GOLDEN: Actually, we were looking at that. Or was that the UTI?

MS. GORTON: That is -- it's the inappropriate use of antibiotics in those young children. So, we are looking at appropriate versus inappropriate use of

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antibiotics.

DOCTOR RODGERS: I think what we see is there is an overuse of Macrolides and not enough use of Ampicillin or --

DOCTOR HENDERSON: Well, what you're saying is, the chest x-ray not only is important for diagnosis, but in helping you decide about therapy?

DOCTOR RODGERS: Right. I mean, after the diagnosis, what I was admitting them with, you know.

DOCTOR BIBB: Well, I would rather have the x-ray as a quality metric and have the antibiotic as a tracking, just myself. And I think some of this, I think in the ER especially, we are seeing more people give a diagnosis of pneumonia, maybe without an x-ray, or even -- I see normal x-rays as a diagnosis.

DOCTOR RODGERS: Right.

DOCTOR BIBB: Because people don't want to put URI, because that's an episode, and they want to justify antibiotics. So, there has been some change in coding, I think. There is a gray area. How else do you know?
DOCTOR GOLDEN: I'm listening.

DOCTOR BIBB: So, that's --

DOCTOR RODGERS: Like I look at this the way I practice, and I would think, you know, the only time I would be using antibiotics is if I thought they had a focal lobar pneumonia that was diagnosed on x-ray. And that would be 100 percent of those kids. The other ones, I would probably diagnose as bronchiolitis or hypoxia -- or not hypoxia. But bronchiolitis, they are not going to need antibiotics.

DOCTOR GOLDEN: Well, I think a lot of people are treating and diagnosing bronchiolitis or streaky looking pneumonia --

DOCTOR RODGERS: Right.

DOCTOR GOLDEN: -- as opposed to lobar pneumonia.

DOCTOR RODGERS: Right.

DOCTOR GOLDEN: Right. And I think that's really what we're looking at.

DOCTOR RODGERS: And those are viral.

DOCTOR GOLDEN: Yes. That's what is on the table.
DOCTOR RODGERS: These people just have a very low threshold to put these kids on antibiotics, and so they do push for that diagnosis, and they don’t want to go with a URI diagnosis.

DOCTOR GOLDEN: Right. I mean, we would be happy to make this a quality metric, and start to push the -- that might drive away some of the diagnoses, as well.

MS. GORTON: So, your recommendation is to -- for us to consider switching these two measures, switching the antibiotics to a track and moving the rate of chest imaging to a metric to pass? Did I get that correct?

DOCTOR GOLDEN: That would be my recommendation.

MS. GORTON: We can take that under advisement and bring -- we will look at the information and bring it back and give you our response to that request.

DOCTOR GOLDEN: And we might do that by phone so we can keep this thing on track, or we can send you the distribution and give you a recommendation and go from there.
DOCTOR HENDERSON: And the rate, 75 percent for chest x-ray?

DOCTOR RODGERS: Yes, I think that's reasonable.

DOCTOR GOLDEN: Yes. We will take a look.

MS. GORTON: All right. Are there any other points of discussion related to the pediatric pneumonia?

THE COMMITTEE: (No response.)

MS. GORTON: All right. So, to summarize this in order to develop your written advisory statement, I think I see there are three issues. So, one issue that we need to provide additional information on has to do with either primary diagnosis of pneumonia or a pneumonia-related diagnosis as the trigger. Am I correct?

DOCTOR BIBB: Yes. Or using a secondary diagnosis of pneumonia to act as a trigger, either way.

MS. GORTON: All right. So, take a look at a way for us to further define the episode trigger?

DOCTOR BIBB: Correct.
MS. GORTON: All right.

DOCTOR BIBB: To capture the episodes you are trying to capture.

MS. GORTON: We will take a look at that. The second issue has to do with the recommendation of the removal of Parkinson’s disease and multiple sclerosis from the list of exclusions based upon the fact that this is a pediatric episode.

And the third recommendation is for us to look at the switching of the two quality measures and switching the antibiotic to a track and the rate of chest imaging to the pass, setting a rate -- a recommended rate of 75 percent. Is that correct? Did I capture those three recommendations correctly?

DOCTOR BIBB: I agree.

MS. GORTON: Ms. Blankenship, do you have anything to add to that?

MS. BLANKENSHP: No, I do not.

MS. GORTON: All right. So, if the committee feels like that that summary is correct and accurate, then I will go to the four voting members for a "yea" or "nay" on
that summary of your written advisory statement.

Doctor Bibb?

DOCTOR BIBB: Yes.

MS. GORTON: Doctor Henderson?

DOCTOR HENDERSON: Yes.

MS. GORTON: Doctor Thomas?

DOCTOR THOMAS: Yes.

MS. GORTON: Mr. Deaton?

MR. DEATON: Yes.

MS. GORTON: All right. Great.

DOCTOR GOLDEN: And throw Dawn on the list.

MS. GORTON: Oh, I'm sorry. And Dawn says "yes".

DOCTOR GOLDEN: Dawn says "yes", too.

MS. GORTON: I'm sorry. Thank you, Doctor Golden. I apologize for that. All right.

And I guess this would be a good place to point out, even though I think I was going to do it at the end, but as we look at your written advisory statements, the information as is outlined in Act 1266 indicates that we receive your written
advisory statements today as they have been voted on, and then we will research those and we will provide a response back to you if there are any of those recommendations within which we disagree or have some variability to. So, we will be getting written statements back to you -- or written responses to you on that.

All right. Any other questions about pneumonia?

THE COMMITTEE: (No response.)

MS. GORTON: All right. Then, we can consider that one closed. Look at us, quarter until 1:00.

All right. The last of the four is "Urinary Tract Infection". This is the yellow tab in your notebook. All right.

So, we will start with Urinary Tract Infection. Looking at items "A", "B", and "C", which is -- the subtypes, of which there are none, a description of the episode trigger, and the duration. Pointing out, for this one, in the duration, it is only 14 days after discharge from the ED. So, it is shorter in duration than the other episodes.
DOCTOR GOLDEN: And to make it clear, this is not for people who get admitted to the hospital. These are people who are seen in the ER and discharged. This is not inpatient UTI. Our feeling was that if you get admitted for UTI, it gets into sepsis and all sorts of other less than consistent kind of events. So, this is just almost an ambulatory UTI seen in the ER. And there are a lot of them.

DOCTOR HENDERSON: Would you include pyelonephritis, then?

DOCTOR GOLDEN: Pyelonephritis can be treated on an ambulatory basis, especially if it’s mild, as long as you give sufficient amount of antibiotics. Obviously if you have a high fever and you can’t -- you’re throwing up, you can’t swallow, you can’t drink, you get admitted.

DOCTOR BIBB: So, if you are admitted, the trigger doesn’t count, then?

DOCTOR GOLDEN: If you are admitted, you are out, it’s not a valid episode.

MS. PENNINGTON: Okay.

MS. GORTON: Any other discussion about
items "A", "B", and "C"?

THE COMMITTEE: (No response.)

MS. GORTON: All right. Item "D", Episode services, this is again a
description of the Medicaid services that
are considered covered and included in the
episode. And again, there is no pre-episode
window. It starts with when the episode is
triggered in the ED and a post-period. And
again, we have -- again, it's short, 14
days.

DOCTOR BIBB: I have a question, just
in general. Some of these are things that
would not be emergent. So, if someone comes
to the ER and it's deemed nonemergent and
they want a referral from the primary care
provider, does that affect the trigger at
all, if it's deemed nonemergent versus
emergent?

DOCTOR GOLDEN: This would be based --
I guess we have to look at this. I think
it's going to based on a physician bill, is
that the triggering?

MS. GORTON: Yes.

DOCTOR GOLDEN: So, there are episodes
where -- and I believe, you know, while the hospital might have not billed for the event because it was nonemergent, the doc still sees the patient, can be seen, and can bill.

DOCTOR BIBB: Okay. I just thought that the hospital billed a screening code or something.

DOCTOR GOLDEN: They do do that. But this is going to be based, I think, on the physician bill. The hospital could screen. The hospital may not bill for the ER visit, but sometimes the doc sees the patient.

DOCTOR BIBB: So, this will incentivize the hospital, if it's nonemergent, to not see them, do the screening as opposed to seeing them?

DOCTOR GOLDEN: Well, yes and no. Yes and no. And you will see, as we talk about the practice variation, you know, an ambulatory UTI can be -- it's usually a woman. Okay? There are a few men, but that's usually more complicated, especially in the Medicaid population, as opposed to the Medicare population.

But, you know, you can see somebody
come in, get a urine specimen, dip the
urine, see the positive dip stick, prescribe
an antibiotic, and for many cases, you are
done. The practice variation here is, urine
cultures, CBCs, CAT scans, onward and
onward, choice of antibiotics. So, it's not
necessarily the visit itself. It's what
happens during the visit that's actually the
driver of cost.

DOCTOR BIBB: So, the lack of referral
or not referral from the primary care --
because a lot of these are going to be
nonemergent. So, if I give the referral,
that will allow the hospital to bill more?
Or explain to me how that would work, then.
I don't understand.

DOCTOR GOLDEN: The referral is based
on just, you know, you have given the
referral for them to see the patient so they
can bill a facility charge for the ER visit.
Okay?

DOCTOR BIBB: Okay.

DOCTOR GOLDEN: On the other hand,
again -- you know, it gets complicated.
I'll have to go check with our coding
people. If an ER doc bills his services, while the ER visit, itself, hasn't been approved, I believe those get paid. And I'm not sure that needs a referral. There is a little different coding in our billing process. We have never clamped down on physician bills for ER visits that are not approved for the facility.

DOCTOR BIBB: Okay. It was my understanding that if I didn't make a referral, the ER -- the doctor couldn't put a claim through. Just like if someone comes to my office and I don't have a referral, I can't bill.

DOCTOR GOLDEN: I would have to look into that. The answer is -- you are asking, now, a nuance of our system that I have never been asked before.

DOCTOR BIBB: Okay. Because it would make a big difference on what is allowable under certain circumstances.

DOCTOR GOLDEN: Because I know that, you know, ER visits are not considered part of the allowable outpatient visits. That's separate. And if the doc can bill, even
though the facility is not billing, it may be an allowable charge that doesn’t count against total visit counts. But I will have to look into that.

MS. GORTON: All right.

MR. GALLAHER: I think we allow the bill. I think other carriers probably do a better job of that than we do.

DOCTOR GOLDEN: Yes.

MS. TRITT: As a non-member, may I ask a question?

DOCTOR GOLDEN: Sure.

MS. GORTON: Yes.

MS. TRITT: Okay. Then, why would you want the Principal Accountable Provider in this particular case to be the facility, when you are going off the physician bill?

DOCTOR GOLDEN: Well, at some point, because we do -- because the ER providers are so potentially difficult to track, ER groups that are hired, et cetera, that it’s very often either an employee or a contract with the ER group, or somebody that has been hired to cover the ER, there is a -- usually, a relationship between the ER
providers and the hospital. So, the
hospital could have some influence over the
ER provider.

DOCTOR THOMAS: They do.

DOCTOR GOLDEN: We can look at that.

MS. TRITT: David, do you want to laugh
out loud? Do we have influence?

DOCTOR HENDERSON: I'm confused.

Because we are talking about people who have
an uncomplicated urinary tract infection, we
think we can treat them as an outpatient and
we're not going to admit -- if they are
admitted to the hospital, they wouldn't fall
under this.

DOCTOR GOLDEN: Right.

DOCTOR HENDERSON: Well, that patient
could just as easily be treated in my
office.

DOCTOR GOLDEN: Well, some of them are
coming in at midnight. But that's true,
yes.

DOCTOR HENDERSON: So, this is going to
apply only to these urinary tract
infections, this Episode of Care, if they
come to the ED?
DOCTOR GOLDEN: That is correct.

DOCTOR HENDERSON: If they come to a physician’s office, none of this applies?

DOCTOR GOLDEN: That’s usually in the medical home, total cost of care in the medical home.

DOCTOR BIBB: I mean, I guess, from our perspective, if someone -- if it’s not emergent, if the hospital deems it is not emergent, we don’t give the referrals, ever. Because, I mean, if you come in at midnight and you’ve got this, and you don’t need to be in the hospital, you can wait until eight hours later.

DOCTOR GOLDEN: You know, over time, with 24/7 live voice access, some of these will be handled by phone.

DOCTOR BIBB: Yes. That’s what we do.

DOCTOR GOLDEN: So, down the road, that’s correct. There are still a couple thousand of these visits. There are thousands of these visits. And --

MS. PENNINGTON: You are just trying to get the hospital not to do CT scans and all this elaborate expensive stuff.
DOCTOR GOLDEN: Payment reform is, "What are we doing out there?"

DOCTOR THOMAS: Right.

DOCTOR GOLDEN: And then, you start looking at the data, and you say, "Well, why are we doing this?" Well, this is a way of getting your hands around it. Are these avoidable visits? Sure. Can the medical homes manage it? Sure. Should these be even going to urgent care centers? Some of them are. Practice variation is going to happen there, too. So, over the long run, I would hope -- or we would hope that a lot of these visits could be managed by the medical home, either through the after-hours coverage, protocols, patient phone-in, management.

DOCTOR THOMAS: Over the phone, yes.

DOCTOR GOLDEN: But right now, the state of the art is that we have a couple thousand visits going on for relatively straightforward ambulatory UTIs.

DOCTOR BIBB: So, the problem is, the ones where they are either emergent, deemed emergent, or they're nonemergent and the
doctor gives the referral. And then, the hospital, there is a big variation on what they do. So, if you don’t give a referral, then nothing is billed by the hospital, so that should be excluded.

DOCTOR GOLDEN: No. The docs can -- no. The docs are still --

DOCTOR BIBB: The hospital is responsible for that?

DOCTOR GOLDEN: Well, it is happening in the ER. I mean, let’s face it. Right now, I would say -- I can’t give you numbers, but my guess is there will be a fair number of cases where the hospital will deem it nonemergent, but the doc may submit a bill for seeing the patient. It may be a level two, may be a level three, you know, but the facility fee for the hospital ER, I think, will not be charged. And I can get you -- I can go in more detail. But I’m looking now at just the process of a bill was generated for a UTI and there are some ancillary services being charged, and the ancillary service fees are all over the place. I think I have shown that slide on a
webinar, where the rate of use of urinary tract infections -- urinary cultures ranges from ten percent on average in one ER to 90 percent on another ER, and it is all gradations in between. We have ERs where 40 percent of these patients get CT scans, you know.

DOCTOR BIBB: I will agree, there's a problem. My point is, in the trigger, are we making sure the trigger is defined in a way that identifies the episodes correctly?

DOCTOR GOLDEN: We will take that under advisement.

(WHEREUPON, Ms. Gorton left the meeting room.)

DOCTOR GOLDEN: We are losing people here. Do we need to take a break?

MS. LASOWSKI: She is coughing, so she went outside.

MR. WALKER: Why don’t we take a short break?

DOCTOR GOLDEN: Let’s take a little break.

MS. LASOWSKI: We will take a short break here.
(WHEREUPON, a break was taken.)

MS. GORTON: All right. We are back.

DOCTOR GOLDEN: So, you know, again, what we were trying to focus on here was the practice variation. And there are bills being generated. And so, we were trying to capture as many of the episodes where bills are being generated.

Now, it may create some secondary discussions about appropriateness and so forth and so on, and who should be seen and who shouldn’t be seen. And that’s all healthy. But one of the big drivers here is not necessarily the fact that the patient was seen, but the fact that all sorts of stuff is going on, and -- you know, and a lot of it for uncertain rationale.

MS. GORTON: All right. So, since I did have to step out, is the item that’s at discussion here is the impact of nonemergent visits in the ED on the trigger? Was that the discussion?

DOCTOR GOLDEN: Yes. You know what we will do is -- I think I would recommend that we will give the committee further
information about the details on that.

MS. GORTON: Okay.

DOCTOR GOLDEN: But again, I want to --

MS. GORTON: Okay.

DOCTOR GOLDEN: But the episode itself
is based on what happens during the moment
of service.

MS. GORTON: In the ED. Okay. Good.

All right. So, we are through items "A",
"B", "C", and "D".

Any other questions or comments for
those issues?

THE COMMITTEE: (No response.)

MS. GORTON: All right. The next
section, 200, identifies the PAP as the
facility where the UTI is diagnosed. I
suppose it's possible that there may be a
potential impact on that based upon what we
are looking at, at the ED. But that's where
that stands now.

Next section has to do with exclusions.
So, these are the episode-specific
exclusions for UTI. The global exclusions
from Section 200.300 apply here. So, take a
look at items "A", "B", "C", and then it
goes for -- you have items one through nine on those comorbidities. So, take a look at those.

DOCTOR GOLDEN: We also had looked at things like, especially for kids, you know, previous visits to a urologist in the previous year, again, there weren't many of them, as an exclusion, as well as the use of urinary catheters would be an exclusion. And I think -- what else did we use, anybody in diapers after the age of like four or five or something like that?

MS. GORTON: Yes. I think those are outlined in the -- let me see. In the code set, whether we can indicate that those are actually addressed in how things are written, then we need to take a look at that.

DOCTOR GOLDEN: Yes. But we are excluding people who, you know, have clearly chronic urinary system issues, and all those folks are gone. So, kids -- anybody who has seen a urologist in the previous couple of months are out.

DOCTOR THOMAS: Pregnancy, is that out?
DOCTOR GOLDEN: Yes. Pregnancy, I think, would be out, because that's in the pregnancy Episode of Care where we take a look at that.

MS. PENNINGTON: Someone with a -- that maintains a Foley?

DOCTOR GOLDEN: Yes. Urinary catheters would be removed. Or even chronic self-catheterization, or home catheterization, they would be out.

MS. PENNINGTON: Okay.

DOCTOR GOLDEN: And again, we were trying to focus on relatively healthy, ambulatory people.

MS. GORTON: Any other questions or concerns about Section 300?

THE COMMITTEE: (No response.)

MS. GORTON: Ms. Blankenship?

MS. BLANKENSHIP: No.

MS. GORTON: Section 400 are the adjustments in the cost made as a result of risk factors. Any comments or questions related to the three risk factors that are listed?

THE COMMITTEE: (No response.)

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MS. GORTON: Section 500 are the quality measures. So, we have one measure to pass, "Percent of valid episodes in which clinically inappropriate antibiotics," and they are listed there, "are prescribed. Must be below a maximum threshold of 25 percent."

DOCTOR GOLDEN: So, here we are talking about Ampicillin which all the med quality guidelines say you should avoid because of very high rates of resistance. Augmentin would be acceptable. We have actually had to do some magic with our claim sets to be able to distinguish between the two. Third generation Cephalosporins are generally considered overkill. And Quinolones usually should not be considered your first line.

So, you know, they are still talking about Bactrim would be acceptable, Augmentin would be acceptable. In kids, Keflex is acceptable. Second generation Cephalosporins are acceptable. And so, we are saying, you know, if you are using -- if more than 25 percent of your prescriptions are one of these others, that you would fail
the metric.

MS. GORTON: Any questions or
discussion about that information?

THE COMMITTEE: (No response.)

MS. GORTON: The next one is the
quality measure to track, of which there are
two. Tracking percent of episodes,
including a CBC, and percent of episodes
that include a urine culture.

DOCTOR GOLDEN: Don’t we have a CT
scan, too? I know I have that data. I
thought we had the CT.

MS. GORTON: I will have to look, sir.
I don’t know.

DOCTOR GOLDEN: Abdominal CT scan.

MS. LASOWSKI: It was originally on
there.

DOCTOR RODGERS: May I make a comment?

MS. GORTON: Yes, absolutely, please.

DOCTOR RODGERS: Just on the urine
culture, I’m glad you’re tracking it, and I
just wondered why it wasn’t a quality
measure. I think in practice it’s so
difficult when they go to the ER and they
have been diagnosed with a UTI because
they've had a few white cells of one plus positive esterase, and they get diagnosed with a UTI and they don't do a culture, and they come back two days later and they're still having fever and you have no culture to know if it's a resistant bug or if something else is going on. I just would think a urine culture would be a much -- would be a good quality measure, if not now, in the future. I mean, I know you're tracking it.

DOCTOR GOLDEN: Well, here is the issue. Maybe in kids.

DOCTOR THOMAS: In children.

DOCTOR GOLDEN: You know, but in a 17-year-old or a 25-year-old woman.

DOCTOR RODGERS: Not that big of a deal?

DOCTOR GOLDEN: It's not that big of a deal. You know, most UTIs in older folks, you know, it's -- it's not particularly -- most folks don't get a culture.

DOCTOR RODGERS: And my only other question was, too, about ultrasounds. They don't get the VCUGs, for kids, they are
usually not done within the two-week period, I think it's a 14-day period, but sometimes they do. And would y'all look at the effective VCUGs on cost?

DOCTOR GOLDEN: Yes. We actually looked and we are actually surprised how little they are being done. And that should be -- that was something we were thinking about, and we would be happy to chat with you about, should that be a quality metric that some of these kids in the right age category should get these. And as far as we can see, they are not getting them.

DOCTOR RODGERS: Because I think it has been so controversial for so long, and now there are much clearer guidelines about in what group they should be done.

DOCTOR GOLDEN: Yes. We have kind of kicked it out of the -- and again, if it becomes a problem in terms of -- we could make a risk adjustment down the road, and in the age category where that would be appropriate.

DOCTOR RODGERS: Could you do a urine culture based on -- do a VCUG based the age
category? Is that a possibility to track it within a certain age group?

DOCTOR GOLDEN: I would have to look.

DOCTOR RODGERS: Okay. I'm just curious.

DOCTOR GOLDEN: You know, we can look -- we can also run -- I could go back to our data people and see whether age categories conferred a higher cost risk.

DOCTOR RODGERS: Yes.

DOCTOR GOLDEN: So, again, I don't know if they have looked to see whether a three-year-old would be at higher risk for a higher cost UTI episode than, say, a 15-year-old or a 27-year-old.

DOCTOR HENDERSON: If you are talking about a three-year-old initial urinary tract infection, it would make a difference male versus female.

DOCTOR RODGERS: Yes. If they are male, they definitely need it.

DOCTOR GOLDEN: Well, yes. That's a whole other matter, yes.

DOCTOR RODGERS: So, say, for that older three-year-old, you don't necessarily
do it? If you didn't think they had pyelo, just clinically, you don't necessarily -- you wait until there is like a bladder infection in order to do a VCUG?

DOCTOR GOLDEN: Well, we're not -- you know, we're not saying never get a urine culture. But the variation is just all over the place.

DOCTOR RODGERS: I'm surprised they did them in adults. I don't do adults.

DOCTOR GOLDEN: They are all over the place.

MS. GORTON: Any other questions related to the quality measures?

THE COMMITTEE: (No response.)

MS. GORTON: All right. The last section is the Section 600 on thresholds. So, you can see those dollar figures listed there. PAP curves were indicative of 35 percent of PAPs would fall in acceptable, 35 percent in commendable, 30 percent in risk-share. And again, the global statement that you all made in hysterectomy about thresholds will be taken under consideration for this one, as well.
Ms. Blankenship, you have any comments, questions at this point?

MS. BLANKENSHIP: No, I do not. Thank you.

MS. GORTON: All right. So, let's open it for last general discussion before we try to summarize for the written advisory statement. Any questions or comments that we need to add at this point?

THE COMMITTEE: (No response.)

MS. GORTON: All right. If not, then let's see if we can summarize your written advisory statement related to UTI. Your first recommendation was that you are requesting further information, the impact of nonemergent visits in the ED, if I got that correct.

The second recommendation was, we need to add an exclusion somehow to address the catheters, diapers, the urologist history.

We have a recommendation for whether or not age is a risk for higher cost to be added to the adjustment. Whether or not we are going to be tracking abdominal CT scans, or abdominal imaging in general, is that
more in line with that as a track, abdominal imaging?

DOCTOR GOLDEN: I would just stick to CT scans.

MS. GORTON: Stick to CT scans?

DOCTOR GOLDEN: That, I know, we already have data that shows the variation.

MS. GORTON: All right. And the recommendation that was in hysterectomy related to the change in costs and the impact on thresholds, however we worded that before. All right. That's the summary that I have for UTI. Is there anything that I have overlooked that needs to be included in that recommendation summary?

MR. DEATON: Jackie, clarify again for me what we are going to do about this Principal Accountable Provider.

MS. GORTON: Well, thank you. Because I did not make a statement about that. I guess the clarification about the PAP would be -- a recommendation would be determined, or our response to you based upon the further information we gather on the trigger, and the impact of nonemergent
versus emergent, whether or not, I would assume, if a facility has a nonemergent and they do not file a claim and all you have is the doctor visit, an episode is not triggered if there is not a claim filed by the ED facility. Am I correct? Is that how that works, James? I mean, is that how that works? If the trigger -- if the episode is triggered by an ED visit but it's nonemergent, so there is no claim filed by the ED, there would not be an episode; is that correct?

MR. GALLAHER: No. I think, as long as the physician filed a claim, there would be, regardless of the facility claim.

MS. GORTON: Okay.

MR. DEATON: What is the effect of a medical screening exam to -- you know, if they come in, we do a medical screening exam, we have some labs, the provider says, "This is a nonemergency, you are Medicaid." If we treat, it will be -- the whole visit can be denied. If we don't treat and refer out, we get to charge for that screening. And so, there are two possibilities for what
we would be billing for.

DOCTOR GOLDEN: I would have to look.
I think that a triage fee, if I’m not
mistaken, does not have a diagnosis
connected to it. So, we will have to -- I
will have to go look here to get you the
exact information.

MR. DEATON: Okay.

DOCTOR HENDERSON: Is a medical
screened patient going to have lab work?

MR. DEATON: Yes.

DOCTOR RODGERS: They can.

MR. DEATON: Well, any patient that
walks into a hospital, the first job we have
to do is to determine, is that an emergency
or not. And the only way you can do that is
to do some diagnosis work. You know,
anything that’s considered appropriate to
decide -- I mean, if you come in with a
cough, you know, you would want to do a
chest x-ray and maybe do some labs.

DOCTOR GOLDEN: Well, see, that gets --

DOCTOR HENDERSON: That’s more than a
medical screening.

DOCTOR GOLDEN: Yes. I mean, that’s
going to get past the --

DOCTOR HENDERSON: Our triage -- our medical screening exam is done by the nurse. And I don't believe they are ordering any lab work.

DOCTOR GOLDEN: They shouldn't be.

MR. DEATON: We are required by law, for an appropriate provider, it can be a nurse, or it can be the physician, somebody has to say that's -- in our facility, only a doctor can say that's a nonemergency.

DOCTOR HENDERSON: The nurse screens at our hospital, but then she presents it to the physician, he makes the decision that this is a nonemergent patient, and then they go out. But I don't think they are getting any lab work.

DOCTOR GOLDEN: I think we are underscoring why we should collect this.

MR. DEATON: Sometimes -- I mean, there are many times you can't tell if it's a nonemergency without doing some minimal lab or an x-ray.

DOCTOR BIBB: During that scenario you're talking about, at what point do you
try to get a referral from the primary care doctor and when can you bill?

MR. DEATON: We try to -- well --

DOCTOR HENDERSON: In that situation you are describing --

DOCTOR GOLDEN: They have already been.

DOCTOR HENDERSON: -- I think they would be coded as a level three patient. They are a low acuity, but still an emergency room patient, if you can't make a decision without doing lab work. That was my understanding.

DOCTOR RODGERS: I can tell you, I mean, from AFMC's perspective, you can do a limited amount of lab work. It's just for that -- I think it's a $50.00 fee.

MR. DEATON: Yes. I mean, you are not going to get a CT.

DOCTOR RODGERS: So, that's really the difference between it being an emergent visit or nonemergent.

DOCTOR GOLDEN: Yes. Sounds like a workshop, Jodiane.

MS. TRITT: I can't wait. Thank you.

DOCTOR RODGERS: And, you know, you
have to understand that you can -- you can
do strep, you can do --

MR. DEATON: We have been doing this
for ten or 15 years.

DOCTOR RODGERS: And then, if they
don't need treatment, or they can go to
their primary care doctor the next day and
get treatment because it's determined
nonemergent. And the ER still gets paid,
but they just don't get paid that emergent
fee.

DOCTOR BIBB: So, when do they ask us
for the referral, though, that all these ERs
are sending us? If it's nonemergent and
then if they get the referral, then they can
bill for the facility fee?

DOCTOR RODGERS: They can call you
after they've done their evaluation.

DOCTOR BIBB: And if we give the
referral, then they can bill the ER fee?

DOCTOR RODGERS: Yes.

DOCTOR BIBB: Is that right?

DOCTOR RODGERS: I think it's just
whether they determine it emergent or
nonemergent. And sending a referral to be
seen -- well, wait. No, no, no. You are right. If it's termed a nonemergent, then they are not seen or whatever in the ER, then they don't have to get the referral.

MR. DEATON: If it's a nonemergent, the only way we get to be paid for it, I think -- well --

DOCTOR GOLDEN: I think what we are --

MR. DEATON: -- is if the PCP provides us with a referral.

DOCTOR BIBB: That's what we have been told.

MR. DEATON: But otherwise, we are not going to get paid for it.

DOCTOR BIBB: And the PCP, we are saying, the patient medical home, that if it's nonemergent, we're not going to sign it.

MR. DEATON: That's right.

DOCTOR BIBB: Then, the hospital is getting mad and they're having to eat it, and that has been a big point of contention, and that's where the --

DOCTOR GOLDEN: But there are still bills being generated.
DOCTOR BIBB: I know. Well, see, most doctors, and myself up until a few years ago, I just signed -- because I thought if I wasn't open at night, even if it's nonemergent, I was supposed to sign it. There's very little understanding of this. And that's where it plays into this particular episode.

MR. DEATON: It has been complicated, that's for sure.

DOCTOR BIBB: Yes. No one understands.

DOCTOR GOLDEN: Yes. And again, the point of these episodes is to --

MR. DEATON: But at the end of the day, if it's determined to be a nonemergency, and my doctor writes a prescription, we're not going to get paid for any of our services, the lab, the radiology, or nothing. But if we do the screening, and we do some lab, and we do a chest x-ray, I mean, I'm just saying a cough, for example, you do some basic stuff, CBC, chest x-ray, it rules out an emergency, then that's nonemergency. If we were to do something because of that, we get paid zero. If we say, "This is a
nonemergency, you need to go see your
primary care," we can bill the screening and
the ancillaries and get paid for that, but
we don't get to charge for an ED visit.

DOCTOR RODGERS: Right.

MR. DEATON: There is a difference
between the level of service.

DOCTOR HENDERSON: Well, in that
situation where you have seen that patient,
you have done this basic lab work and
screened out that it's nonemergent, and you
have done a strep screen, it's not strep --

MR. DEATON: Right.

DOCTOR HENDERSON: -- you are telling
them, "You to go to your primary care doctor
tomorrow," what is he going to do, take
Tylenol? You could have told him that.

What are you going to do for him the next
day when he comes in?

DOCTOR GOLDEN: I think it would be a
good column for a journal article.

DOCTOR RODGERS: I think you should
remind the patient of the fact that they
should have gone to their PCP first rather
than the ER.
MR. DEATON: As a humanitarian, any physician that they think that patient needs a prescription, they're going to go ahead and write it, and the hospital is not going to get paid, you know, because that's the right thing to do for the person.

DOCTOR BIBB: What we are having, though, is the hospital is pressuring us to write the referral so they can get paid.

MR. DEATON: Yes. Because we, you know -- and I tell my docs, I say, "Look" -- especially if it's on a, you know, Sunday morning and they are not going to be able to see their doctor for the next 24 hours. I mean, we do it all the time.

MS. PENNINGTON: Well, I went in for a UTI like 41 years ago, and I thought it was an appendicitis attack. I really thought I was going to have surgery, and I had it in my head, because it was so awful. If they had turned me away and didn't give me antibiotics, I would have been mad.

DOCTOR RODGERS: I think if the patient truly thought it was really an emergency, then that, also -- if they documented that
that patient truly thought it was an emergency, then it is, they can count it as an emergency.

DOCTOR THOMAS: Prudent lay person.

DOCTOR GOLDEN: Yes, prudent lay person.

MR. DEATON: But this is why I think we need to be very clear on what triggers the hospital being accountable and not accountable. That’s all I’m saying here, you know. Because if we come in and just do screening and maybe we don’t -- maybe we don’t do anything, other than the doctor does a physical. Says, "I don’t think this is an emergency." And then the primary care doctor orders some of these high level antibiotics that’s on the hit list, then it affects our, you know, overall payments at the end of the year.

DOCTOR GOLDEN: Now you are seeing some of the complexity we face in looking through all the codes and how to make the codes make sense in a logical framework.

MR. DEATON: Yes. I’m not being critical of what you have done so far.
DOCTOR GOLDEN: No. I understand.

MR. DEATON: I don't know how you have even got it distilled down to this. But I'm just saying, it is so complex.

DOCTOR GOLDEN: We appreciate your input. In fact, this is actually exceeding our expectations in terms of value in terms of helping us become smarter. So, we will take this feedback, and let us talk to our -- we have a number of -- we have coding people, we have data people, and James lives this all the time where the intent is one thing and then you find gremlins in the coding and the algorithms, you can see how easy it is for little nuances to start to cause issues when you put it in operation. So, we appreciate the conversation, and it will help us get a little more clarity and we will get back to you on that.

DOCTOR RODGERS: I'm sorry. I just thought of one more question, but this is going back a little bit. But the Ceftriaxone that's used in the ER that's often used for patients with a bad UTI that are vomiting or whatever, just so they can
go home and not necessarily be hospitalized, does that get excluded? Since it's third
generation Cephalosporins, that says a
prescription for a third generation
Cephalosporin. But this would be like an IM
injection of Ceftriaxone in the ER.

DOCTOR GOLDEN: You know, if that's not billed, if it's part of the ER visit fee, I
don't know. But it is, it would be covered.
There are other things they could give. But again, it's just a matter of the percentage of times you do that.

DOCTOR RODGERS: Yes. Good point.

MS. GORTON: Any other discussion or questions?

DOCTOR HENDERSON: You got all that down, Jackie?

MS. GORTON: Well, I'm getting ready right now to re-summarize.

MR. DEATON: Do you want us to repeat that?

MS. GORTON: To re-summarize.

MS. PENNINGTON: Can I --

MS. GORTON: Yes, ma'am. Go ahead.

MS. PENNINGTON: It's not the

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hospital's fault that the patients come in. You know, sometimes it seems like our hospital is punished and having to pay -- I mean, I know those that order all that junk that's extra. But you want the patient taken care of.

DOCTOR GOLDEN: I understand. But again --

MS. PENNINGTON: And so, it's like, for him, in his situation, and trying to get the doctor to sign off. I mean, it's not --

DOCTOR GOLDEN: We are not counting how many times the patient gets seen, we are not counting that. We are counting -- what's going to drive the variation here is all the testing and the practice style. It's not necessarily that the patient was seen.

MR. DEATON: I mean, I need to get rid of the knuckleheads in my Emergency Department that has been ordering all these CTs for simple things.

MS. PENNINGTON: Right.

MR. DEATON: I mean, that's really what it boils down to.

DOCTOR BIBB: Or at least tell folks,
you know.

MR. DEATON: That’s right. Jodiane, don’t tell them I called the ED doctors knuckleheads.

MS. TRITT: Oh, I have called them worse.

MR. DEATON: Because I love our docs. But I’ve had that over the years. They certainly over-kill sometimes. All it takes is one out of 20 or 50. Yes.

DOCTOR GOLDEN: Sometimes conversations like that don’t happen until you have to have them.

MS. GORTON: So, let me go back to the written advisory statement upon which you all have to vote and see if I’ve got this summarized correctly. So, in relation to us looking further into the episode trigger itself, we also need to look into how that information that we discover is actually impacting whether the PAP should be the facility or not. There is a connection between the trigger and the PAP. Did I get that correct?

THE COMMITTEE: (No response.)

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MS. GORTON: And that we also have these exclusions to look at, we have the age as a risk factor for higher cost, abdominal CT scans. Did I get all that correct?

THE COMMITTEE: (No response.)

MS. GORTON: Any additions or corrections to those recommendations as your advisory statement?

THE COMMITTEE: (No response.)

MS. GORTON: Ms. Blankenship, anything to add?

MS. BLANKENSHIP: Not at this time.

MS. GORTON: All right. Well, then, if there are no corrections or changes to that summary of an advisory statement, then I’m going to take it to the voting members. Doctor Bibb, yes or no or if that meets your need?

DOCTOR BIBB: Yes.

MS. GORTON: Doctor Henderson?

DOCTOR HENDERSON: Yes.

MS. GORTON: Ms. Stehle?

DOCTOR GOLDEN: She’s a "yes".

MS. GORTON: Doctor Thomas?

DOCTOR THOMAS: Yes, ma’am.
MS. GORTON: Mr. Deaton?

MR. DEATON: Yes.

MS. GORTON: All right. So, there were five "yeses", no "nos". So, we have that as your statement.

All right. Well, that’s the end of the four episodes. Does everybody want to stand up and cheer, "Yea, we are done with those four." And I think we are going to be done on time by 2:00 o’clock.

So, let’s take a look at the agenda. There’s a couple of things I want to say about other business, then I want to open it up to you.

So, I wanted to tell you under other business that the written advisory opinion from the February 12th meeting has been posted on the website. So, if you haven’t taken a look, I just want to let you know that that was out there, and that the two recommendations that you made in February were accepted and put into operation on those policy recommendations for the general policy for our episodes.

A public hearing as it related to those
general section changes was held on March
the 25th. There were no comments received
as a result of that public hearing. So, the
APA process is continuing being ready to go
through your legislative subcommittees, on
its way to full Legislative Council in order
for those to be effective by July 1st. That
was the anticipated effective date for that.
So, as far as we know, things are moving
right along.

And ther, the last thing is to say, as
it relates to these four episodes, a public
hearing is scheduled for July the 11th from
5:00 p.m. to -- is it 6:30 or 7:30?
MS. MURPHY: 5:30 to 7:00.
MS. GORTON: 5:30 to 7:00 at the
Central Arkansas Library downtown. And all
the necessary public notices will be put in
place for that July 11th public hearing.
So, that was my other business.

So, do you all, as committee members,
have any other business or concerns that you
want to bring to the attention of the group?
THE COMMITTEE: (No response.)
MS. GORTON: None? All right.
Wonderful. Of course, you know that communication is always open to David Walker. If you have any concerns or questions in the interim between meetings, you can always contact him or me. So, that line is always open.

All right. So, the next thing that we want to talk about, Doctor Bibb, is a date and time of the next meeting. The recommendations from the committee in the past have been to meet at least quarterly, which would then be the month of August. And so, behind what is the -- maybe the last tab in your notebook, and I didn't write a color down, I'm sorry, but there should be an August calendar right at the back of your -- no. Kind of where you are. Go -- yes. Keep going. There should be a calendar right after the UTI. All right. So, there is an August calendar. You can take a look -- your recommendations had been the first or second Friday.

At this point, I do not know that we have policy that we would be bringing to you in August. I'm not sure. There may be a
perinatal policy that would be in a position
to be presented to the committee in August.
But at this point, I don't know that we have
any other. It doesn't mean that there
wouldn't be something, but I'm not -- I'm
pretty sure if we were going to be
presenting something else, we would be far
enough along with it we would know. But
anyway, I think we may just only have a
piece of perinatal policy.

So, Doctor Bibb, I will turn it over to
you for y'all to discuss your next meeting
in August.

DOCTOR BIBB: Personally, I'm going to
be gone the 5th and 12th, but I could
probably participate via phone. So, the
19th works better for me, but I will defer
to the majority of the group.

MS. GORTON: And the 19th being the
third Friday; is that correct?

DOCTOR BIBB: Yes, ma'am.

MR. DEATON: I'm out of the office on
the 19th.

MS. GORTON: Okay. I don't know if I
have the -- we will have to take a look at
the impact on the implementation date of that.

MS. MURPHY: November 1.

MS. GORTON: I'm sorry?

MS. MURPHY: 11-1.

MS. GORTON: 11-1. All right. Hang on. I didn't bring that.

DOCTOR RODGERS: What about on those two Thursdays, Doctor Bibb?

DOCTOR BIBB: I could make -- or I can do the 26th, on that Friday, if that would be an option.

DOCTOR THOMAS: I'm good any time.

MS. GORTON: The later we go into a month will have a significant impact on our ability to meet our deadlines to have that in place by November the 1st. If it's possible, Doctor Bibb, to meet on the 5th or 12th, for you to call in would be much more preferable --

DOCTOR BIBB: Yes, that's fine.

MS. GORTON: -- in a timely manner than postponing it later in the month.

DOCTOR BIBB: How about the 12th?

Because there is a 50 percent chance that I
think I will be here the 12th. I've got a
trip. It's either going to be that weekend
or the next. Sorry I can't be sure. But I
can call in, either way.

MS. GORTON: Okay. So, the 12th --
DOCTOR BIBB: The 12th would be the
most likely day.

MS. GORTON: How does August the 12th
work for everyone?

DOCTOR THOMAS: Yes.
MR. DEATON: That works for me.
MS. GORTON: David, works for you,
works for Doctor Thomas, call in. Doctor
Henderson?

DOCTOR HENDERSON: Yes.

MS. GORTON: Ms. Pennington?

MS. PENNINGTON: I can.

MS. GORTON: Ms. Blankenship, how does
August the 12th for the next meeting impact
you?

MS. BLANKENSHIP: That looks good for
me.

MS. GORTON: All right. Always knowing
that this call-in number is available. If
appearing in person is difficult, this is
the call-in number to be able to participate by phone. It would certainly be a two-hour meeting at this point. I don't anticipate it being any different than -- it would be 10:00 to noon like we had previously. It would not be an extended meeting like today.

So, does 10:00 to noon work?

MR. DEATON: Yes.

DOCTOR BIBB: Yes.

MS. GORTON: The actual place would be determined upon room availability. We will certainly try our best to be back over in South, but it will depend on room availability for that day.

All right. So, is that agreeable, 10:00 to noon on August the 12th?

MR. DEATON: Yes.

DOCTOR THOMAS: Yes.

DOCTOR BIBB: Yes, ma'am.

MS. GORTON: And it will probably be only a piece of perinatal policy that we will be presenting.

(WHEREUPON, the phone connection was terminated.)

MS. GORTON: We have ended the phone
call for this. All right. Any remaining
questions or concerns? I know you have a
question about your TR1. I may need to get
Donesta to come over, because I don’t know
the answer to your question. And I am
sorry.

DOCTOR BIBB: Okay.

MS. GORTON: Yes, ma’am?

MS. PENNINGTON: I believe I’m a
one-year member.

MS. GORTON: Let me look. I just
happen to have that list.

MS. PENNINGTON: All right.

MS. GORTON: You are a two-year term.

MS. PENNINGTON: Oh, I am? Okay.

MS. GORTON: We will go through these.

Doctor Bibb was elected for a two-year term.
Now, some of these I have term limit dates
on them, and some I do not. So, that is
something we have to look at. But Doctor
Bibb is a two-year term, Mr. Joyner, who was
not able to be here today, is a two-year
term. Mr. Deaton is a two-year term. Ms.
Pennington is two years. Doctor Richey, who
also was not able to be here, is a two-year
term. Doctor Henderson is a two-year term with an expiration date on that term of October 31st, 2017. So, that's all into next year.

We have a vacant position representing hospitals -- oh, Jodiane has already gone. Voting hospitals with more than 100 beds, that position is still vacant. That expires in August. Doctor Thomas, a term expiring, two-year term, in 2017. Mr. Norsworthy, two-year term ending August of '17. Mr. Pritchett, two year term, in October. Everybody in '17. So, we are good. It looks like they were all two-year terms with staggering dates.

MR. DEATON: Did we have some one-year terms?

DOCTOR HENDERSON: Yes, I thought we did.

MS. PENNINGTON: Yes, I thought I did.

MS. GORTON: Well, then, you know, okay. Maybe I have a typo in my list. So, thank you for pointing that out.

MR. DEATON: I'm not trying to get out of it.
MS. GORTON: Yes, you are.

MS. PENNINGTON: Because I thought like some of y'all drew and then the rest of us were one year.

MS. GORTON: Thank you for making that -- thank you. I will take a look.

DOCTOR HENDERSON: I was two.

DOCTOR BIBB: And I was two.

DOCTOR HENDERSON: And you were two.

MS. GORTON: I will take a look back at that. I'm sorry. I may have that as an error.

Any other questions or concerns that were raised?

THE COMMITTEE: (No response.)

DOCTOR GOLDEN: I thank everybody for their input. It was very helpful.

MS. GORTON: Absolutely. Thank you so very much. This has been -- so, we have had three meetings. You can tell by all three meetings that they were entirely differently structured based upon the policy that we had or whether we had policy and how much of that we had. So, today's process, if you have any feedback on good or bad or
indifferent, I would appreciate hearing that from you. Because with this being the process of the policy, this is how I anticipate going forward, whether we have one or two or four or six. So, any feedback you have about how today went will be greatly appreciated, because it will be this that we will use as our format for future meetings. So, anything you have, that would be great.

Any last questions or concerns?

THE COMMITTEE: (No response.)

MS. GORTON: Doctor Bibb, anything from you?

DOCTOR BIBB: No.

MS. GORTON: Then, I will leave it to you to adjourn the meeting.

DOCTOR BIBB: Do I have a motion to adjourn?

DOCTOR HENDERSON: So move.

DOCTOR BIBB: Second?

DOCTOR THOMAS: (Indicated.)

DOCTOR BIBB: All those in favor say "Aye".

THE COMMITTEE: "Aye." (Unanimous.)
DOCTOR BIBB:  Okay.  All opposed say "Nay".

THE COMMITTEE:  (No response.)

DOCTOR BIBB:  Meeting adjourned.

(WHEREUPON, at 1:30 p.m., the taking of the above-entitled proceeding was concluded.)

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CERTIFICATE

STATE OF ARKANSAS    )
COUNTY OF PULASKI    ) ss.:  

I, DEBBYE L. PETRE, Certified Court Reporter and notary public in and for the County of Pulaski, State of Arkansas, duly commissioned and acting, do hereby certify that the above-entitled proceedings were taken by me in Stenotype, and were thereafter reduced to print by means of computer-assisted transcription, and the same truly, and correctly reflects the proceedings had.

WHEREFORE, I have subscribed my signature and affixed my notarial seal as such notary public at the City of Little Rock, County of Pulaski State of Arkansas, this the 5th day of June, 2016.

DEBBYE L. PETRE, CCR
NOTARY PUBLIC IN AND FOR PULASKI COUNTY, ARKANSAS

My Commission Expires:

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