Q#	Workgroup Member Name	Jim Schowalter	Todd Stivland	John Marty	Rose Roach	Larry Schulz	*Average score (4=Str Ag; 1=Str Dis)*	*Total score (max=20)*	Sen. Marty Notes	Rose Notes
2	Encourage or incentivize partnership and care coordination with broad range of community organizations.	4	4	4	4	4	*4*	*20*		
21	Ensure that measures include risk adjustment methodology that reflects medical and social complexity.	3	4	4	4	4	*3.8*	*19*	Again, I do not accept the premise that this is possible to accurately accomplish in a manner that doesn't significantly increase health care spending.	
1	Use community standard risk adjustment models in all measurement, with continued development of risk adjustment models for predicting cost and measuring quality that reflect complexity and social determinants.	3	3	4	4	4	*3.6*	*18*	However, I am not sure that this can be adequately accomplished. Certainly not accurately enough to base payments on the results.	agree we should do it but how?
3	Encourage or incentivize participation of diverse patients in leadership or advisory teams.	4	3	4	4	3	*3.6*	*18*		
18	Use system wide utilization measures (such as preventable ED visits, admissions, or readmissions) to assess impact of care coordination.	4	4	3	3	3	*3.4*	*17*	This is part of what we should measure – not just reduction in undesirable utilization, but also measure increase in desired utilization. We want appropriate utilization, not inappropriate utilization.	
22	Ensure that tiering and billing processes do not pose a barrier to reimbursement, and payment sufficient for patients with complex medical and non-medical needs.	2	4	4	4	3	*3.4*	*17*	Not sure that this is workable under various alternative payment systems.	
7	Fund innovative grants to providers that meet specific requirements (i.e. tied to group's agreed upon priorities).	3	3	3	3	4	*3.2*	*16*	Depends what "requirements" and priorities we are discussing.	
10	Patients choose a provider through a prospective, enrollment based method (for example, the patient selects principle care management provider or clinic); if the patient doesn't choose, then they are attributed via an alternate mechanism (e.g. regionally, prior year's history, etc.).	4	3	1	3	4	*3*	*15*	I do not believe we should be rewarding or punishing providers for patients that are not seeing them. What kind of care coordination are they providing if the patient doesn't even understand that they are connected?	I really wasn't comfortable choosing an answer because I strongly agree that patients should choose their provider and can agree to attribution if they don't but only if both the patient and provider are connected to each other and made aware of the relationship. Seems nuts to hold providers accountable for patients who don't even know that provider is supposed to be their provider. For those reasons I did choose agree.

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6	Provide prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for patients with complex medical and non-medical needs and tied to TCOC savings and performance.	3	4	1	2	4	*2.8*	*14*	I chose not to respond but survey would not allow, so I marked it as strongly disagree but my real answer is: Not sure how to respond to this one: yes, we should prospectively pay for care coordination, and non-medical services and "infrastructure" for patients with complex needs, but strongly disagree with tying it to a system with measurements that don't work.	
8	Tie alternate payments to cost measures that reward for reduction vs. provider's previous year (cost savings) and performance vs. peer group, to incentivize both lower and higher performing, efficient providers. Ensure that measure is risk adjusted.	4	4	1	1	4	*2.8*	*14*	I don't think we have the ability to measure this accurately, so we will spend enormous amounts for administrative expenses that might make the situation worse.	Disagree because I don't have any idea how you do it without significantly increasing administrative costs? Who bares that cost? The provider? They're already putting out a ton of money to get these models up and running and it's my understanding that their investment in starting an ACO or IHP isn't netted out of any savings produced meaning there may or may not be actual savings realized.
16	Establish an aligned payment approach for care coordination across all payers.	3	4	1	3	3	*2.8*	*14*	I chose not to respond but survey would not allow, so I marked it as strongly disagree but my real answer is: If we have a good system, everyone should participate in it.	

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20	Incentivize coordination of care with broad range of non-medical and community providers within care coordination models.	2	4	1	3	4	*2.8*	*14*	I chose not to respond but survey would not allow, so I marked it as strongly disagree but my real answer is: Let's just pay for care coordination, not "incentivize" it.	I agree but don't understand all this need to "incentivize". Find out what's needed to improve the health of the patient and community and provide the resources to do so. This is health, it shouldn't be treated like a commodity wherein we incent the system to do what they system is supposed to do in the first place which is provide care and improve people's health.
9	Tie alternate payments to quality and patient experience performance vs. peer group or improvement vs. prior year.	4	3	1	1	4	*2.6*	*13*	I don't think we have the ability to measure this accurately, so we will spend enormous amounts for administrative expenses that might make the situation worse.	
19	Integrate non-medical services into TCOC calculation.	3	4	1	3	2	*2.6*	*13*	I chose not to respond but survey would not allow, so I marked it as strongly disagree but my real answer is: I am very skeptical of TCOC, and am not sure how it can be accomplished without increasing disparities, but in such a system, non-medical services should be included.	
11	Require participation across Medicaid and commercial payers in arrangements that meet the proposed standards and recommendations.	1	4	1	3	3	*2.4*	*12*	I chose not to respond but survey would not allow, so I marked it as strongly disagree but my real answer is: Depends upon the standards we are talking about.	Hard to know if I agree or disagree since I don't know what standards and recommendations we're talking about here but synchronizing the commercial payers with government payers so everyone is held to the same standard seems something that I can agree to in general.
5	Directly incent the elimination of health disparities by tying payment (e.g. prospective PMPM payments, TCOC shared savings, etc.) to closing gaps for specific populations.	3	4	1	1	2	*2.2*	*11*	Because of the inherent inaccuracy of our quality measurement system I believe this may produce results that increase disparities.	

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15	Provide enhanced incentive to payers that have X% of lives covered in alternative delivery or payment arrangements.	2	3	1	1	4	*2.2*	*11*	Until we know that these alternative arrangements save money and improve quality, we should NOT expand use of them.	
17	Include a broader set of population health measures in quality measurement methodology.	3	2	1	2	3	*2.2*	*11*	I chose not to respond but survey would not allow, so I marked it as strongly disagree but my real answer is: We should be measuring population health, but I'm not clear how this relates to quality measurement methodology.	I struggled with this one and chose disagree only because I can't help but wonder just how many things are we to measure? Who determines? Where does it end? Will we ever measure enough things to achieve an agreed upon definition of quality? Sounds like more money spent on administrative tasks when what's needed is more money spent on direct care and care coordination.
4	Directly incent the elimination of health disparities through incentive payments tied to closing gaps for specific populations.	2	3	1	1	3	*2*	*10*	I am skeptical that incentive payments are a reasonable means of closing gaps. Why not simply pay the providers to do what we want them to do?	disagree but not with eliminating health disparities, we need to find out what's needed to eliminate them and provide the resources necessary to close the gap
13	Provide enhanced incentives to providers that have X% of revenue in alternative delivery or payment arrangement across contracts.	2	3	1	1	2	*1.8*	*9*	Until we know that these alternative arrangements save money and improve quality, we should NOT expand use of them.	
14	Require payers to have X% of lives covered in alternative delivery or payment arrangements.	1	2	1	1	3	*1.6*	*8*	Until we know that these alternative arrangements save money and improve quality, we should NOT expand use of them.	
12	Require providers to have X% of revenue in alternative delivery or payment arrangement across contracts.	1	2	1	1	1	*1.2*	*6*	Until we know that these alternative arrangements save money and improve quality, we should NOT expand use of them.	