Quality Council Report - Second Draft:
Compendium of Public Comments Received as of 5 p.m. Tuesday, May 31, 2016

Comment	Response
The language on page 55 on what the PMO is not doing is substantial. It relates to not doing weights, attribution, etc., all major components of a value program. Accordingly, it may be helpful to bold or bullet what the PMO is not doing so it is not missed by the public.	Recommendation will be addressed in the report
The language on the dialogue with payers in the page 50 - 55 range is great, but is it all necessary, as it is largely descriptive of a current process?	Flagged for discussion at council meeting.
Much as MSSP and Core Quality Measures are mentioned early in the report in several places under the auspices of alignment; as illustrated by recent MACRA proposals, is it worth generally noting early on in the report, that the alignment will need to be revisited on an ongoing basis, given the number of evolving programs.	Recommendation will be addressed in the report
On page 12, on the topic of the issue with the US health care system, we could/should probably make a mention of the lack of social and community supports/investments (on a broad-based scale) contributing to the low-level quality outcomes, and not just point to direct health care expenditures (someone knowledgeable explained this to me after one of the early council meetings).	Recommendation will be addressed in the report
On page 14, I think it would be good to be clear that the DSS PCMH pay-for-performance model is not a shared savings/provider-risk model, as the report seems to start using the terms value-based and shared savings somewhat in the same realm/interchangeably	Regarding value-based payment, in this report we are trying to reference the achievements in Medicaid through PCMH even though this is according to some not value-based payment. That is because the cost element of the value-equation is not factored into the performance payment. SSP is generally considered value-based payment because it rewards improved value through a combination of better quality and reductions in total cost of care.
And lastly on page 59, I was wondering how providers feel about being charged a fee for the administration of the CAHPS survey beyond the third year.	Regarding CAHPS, it will be important to consider provider comments. We are making things much more cost-effective by launching a payer agnostic measure rather than requiring payer specific samples. This is good, but an even better solution would be to combine a Medicare and commercial sample. This may be where things end up evolving nationally.
Did the folks that are not part of the council/PMO and are identified in the report agree to be named?	They have not. We will reach out to them or remove the names.
The Key lessons section could do a better job at crystalizing the key points and implications to make it more easily understandable for the reader. There are also a few new concepts introduced	For discussion with the Council.

here such as contract period variation, population selection which may introduce confusion. (you may consider possibly laying this information out in a table) In the Key Lessons and Alignment process sections, the language decidedly shifts in that the PMO, rather than the Council, is recommending actions (in this case around alignment). I think I understand the rationale for this, however I wonder if we're undercapitalizing on the muscle that the consensus building process offers	
Page 3, first paragraph - "spiral out of control" seems subjective/colloquial consider different terms	Recommendation will be addressed in the report
Page 3, first paragraph - "our goals" seems non-specific. Whose goals? What goals? - addressed	Recommendation will be addressed in the report
Page 3, third paragraph - is council "proposing" or "recommending" – I prefer latter	Recommendation will be addressed in the report
Page 3, last paragraph - I don't think we met every 2-3 weeks since 2014 as language suggests addressed	Recommendation will be addressed in the report
Page 13, first paragraph - The definition of health equity is misrepresented or at least incomplete. (see CDC definition here: http://www.cdc.gov/chronicdisease/healthequity/index.htm)	Recommendation will be addressed in the report
Page 13, first paragraph - The examples of health disparities are largely outside the control of healthcare system. If point is about healthcare system then consider different examples (e.g. hypertension control, a1c testing)	Recommendation will be addressed in the report
Page 13, first paragraph - same issue with cost of disparities – forces outside the healthcare system are lead contributors	Recommendation will be addressed in the report
Page 13, first paragraph - May consider rewriting this paragraph - I can assist	Recommendation will be addressed in the report
Page 15, first paragraph - I think this should be "responsibility for the quality and total *COST* of care"	Recommendation will be addressed in the report
Page 38, 2nd paragraph	Recommendation will be addressed in the report

- This is equivalent to a prevalence rate of about 3% *in the attributed population*	
Page 40, first paragraph - suggest the specific issues regarding implementation of HIV measures be specified.	Recommendation will be addressed in the report
Page 41, second paragraph - suggest the specific concerns regarding implementation of oral health measures be specified.	Recommendation will be addressed in the report
Page 48, first paragraph - monitored because of clinical *and/or public health importance*.	Recommendation will be addressed in the report