DQA
DENTAL QUALITY ALLIANCE®
Improving Oral Health Through Measurement

DENTAL QUALITY ALLIANCE: 2017 ANNUAL MEASURES REVIEW

REPORT FROM THE DQA MEASURES DEVELOPMENT AND MAINTENANCE COMMITTEE

MAY 2017

Contents

INTRODUCTION AND PURPOSE

The purpose of this report is to summarize the outcomes of the 2017 annual review of the Dental Quality Alliance's (DQA's) quality measures for pediatric and adult populations. DQA measures address prevention and disease management of oral health diseases for both children and adults, including measures of utilization, access, cost, and quality of dental services for individuals enrolled in public (Medicaid, CHIP) and private (commercial) insurance programs. Seven DQA measures are endorsed by the National Quality Forum (NQF).

The detailed specifications can be found on the DQA website at:

http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/measures-medicaid-and-dental-plan-assessments

PROCESS

In order to comply with the NQF's endorsement agreement, the DQA has established an annual measure maintenance process. This measure review process is overseen by the DQA's Measures Development and Maintenance Committee (MDMC) which is comprised of five subject matter experts, a member of the DQA Executive Committee and DQA Chairs. (Appendix A).

The DQA released a call for comments to its members and the broader oral health community in February 2017. Following a 30-day comment period, the MDMC addressed the comments.

COMMENTS ADDRESSED

The DQA's MDMC would like to thank all of the stakeholders who submitted comments to the measures. The following paragraphs summarize the review of the comments as addressed by the MDMC. The detailed public comments are contained in Appendix B.

Periodontal Measures

One commenter (a) noted the use of the same treatment procedure codes to determine "history of periodontitis" for denominator inclusion as well as to qualify patients for inclusion in the numerator.

The MDMC noted that measure development in dentistry is currently challenged by the lack of diagnostic codes in administrative claims data and consequent reliance on procedure codes as proxies. The measure examines whether patients who have a history of periodontitis (denominator - identified during the three years prior to the measurement year) are receiving ongoing periodontal care (numerator – identified during the reporting year). The time frame for identifying denominator inclusion is different than that for identifying numerator inclusion. Procedure codes for treatment of periodontitis are used to both identify historical treatment and ongoing care.

The same commenter (a) also suggested removing D4910 from the denominator and limit the numerator inclusions to only D1110 or D4910. The MDMC notes that inclusion of D4910 (Periodontal Maintenance) in the denominator was carefully considered and evaluated during the testing process. Based on DQA testing data, expert opinion, and stakeholder feedback on which procedure codes were reliable indicators of a history of periodontitis, the DQA was in favor of including individuals with a history of D4910 because this service, by definition, is indicated for individuals with a history of periodontitis. In addition, testing data demonstrated a significant proportion of the population had ONLY D4910 in the three years prior to the measurement year. Thus, removing D4910 would exclude a significant portion of the target population from measurement. Restricting the numerator to only D1110 or D4910 also was considered. Periodontal maintenance (D4910) as a procedure includes "site specific scaling and root planing." Anecdotally, in some Medicaid programs that do not cover D4910 or have frequency limitations, providers use D4341/D4342 to document limited scaling and root planing in patients being maintained following comprehensive periodontal therapy. Inclusion of D4341/D4342 did not substantially increase the numerator values in two of the programs used for testing. However, there was a pronounced increase in the numerator for one Medicaid program. Based on these considerations, the DQA was in favor of including D4341/D4342 in the

definition of ongoing care to include patients being cared for through the provision of limited scaling and root planing to address recurrent disease.

Care Continuity Measure

The Care Continuity measure examines whether a child received a comprehensive or periodic oral evaluation in each of two consecutive years. One commenter (a) inquired about limiting the measure to only dental providers and not including oral evaluations performed by a pediatrician and other providers "given the fact that currently most private health insurers must cover an oral health risk assessment by a pediatrician and other DQA measures recognize the role of medical providers in delivering oral health care, it seems prudent to expand the scope of the continuity of care measure to include evaluations such as oral health risk assessments that might be performed outside of a dental office. This is especially important for young children who are still very unlikely to be seen by a dentist and, even in Medicaid, quite likely to be seen for a well-child visit". The MDMC appreciates this comment and notes that this is an important variant of the current Care Continuity measure that addresses "oral health services" (per Centers for Medicare and Medicaid definition for services other than those provided by or under the supervision of a dentist). The Starter Set, of which Care Continuity is part, was reviewed and modified as part of the 2016 Annual Measure Review. The Care Continuity Measure for oral health services was removed from the formally maintained measurement set as part of the 2016 review. However, guidance for calculating the Care Continuity measure to include "oral health" services is available from the DQA. To view the complete list of the DQA measures and multiple reporting options/versions please access:

http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/measures-medicaid-and-dental-plan-assessments

Usual Source of Services Measure

Usual Source of Services examines whether a child visited the same practice or clinical entity in each of two consecutive years. A commenter requested that DQA consider revising the measure to be specific to the main dentist/ rendering provider instead of the same clinical practice (e). The MDMC notes that the intent of the measure is to align with the concept of continuous care within a dental home. Evidence suggests

that a usual source of dental care is a strong and consistent predictor of dental visits.[1] The MDMC determined that if a patient is seen regularly in the same practice that continuity of care falls within the intent of the measure. The MDMC additionally noted challenges in reliably identifying the same individual rendering provider especially in cases of multi-provider settings such as a dental school clinics where claims may be submitted through one clinical faculty.

Sealant Measures

Applying exclusions: The DQA periodically receives questions from implementers about whether tooth level exclusions can be applied to the program- and plan-level sealant measures. The DQA considered whether to incorporate exclusions (e.g., teeth that have been previously sealed, restored or extracted) for its program/plan-level measures. In general, the ability to reliably identify children who are candidates for exclusions is challenging for measures calculated using administrative claims data in the absence of tooth-level clinical findings and diagnoses. Some of MDMC's considerations when determining whether to incorporate exclusions were:

- A look-back time frame would need to be established to capture past history of sealants, restorations or extractions to identify enrollees eligible for exclusion. To do so, a determination is needed about whether to use a uniform look back period for all children or whether to take into account the child's age. If a uniform look-back period is used, the appropriate length of time to look back must be determined as well as the appropriateness of the length of time for each age cohort. If age is accounted for, then questions such as the following must be addressed: Is there no look-back required for children who are six years old, but a minimum of three years look-back is necessary for 9 year olds? In this case, there is an assumption that all measured entities have a similar distribution of 6 year olds (needing no look-back) versus 9 year olds (needing at least a 3-year look back), which may not be the case.
- To enable accurate comparisons between measured entities (e.g., dental managed care organizations), an enrollment period for the designated look-back period would need to be specified and required in order to avoid measurement distortions when removing children from the denominator. DQA

testing indicates that when additional enrollment requirements are applied, the number of children in the denominator for this measure may become too small to adequately represent the program/plan. Quality measurement outcomes become questionable. In essence, there is a validity issue.

- Program/plan measures are system-level measures and if at-risk children have molars extracted/restored after they erupt instead of being sealed, that in itself is a system failure and excluding those children from measurement may mask the quality issue being addressed. Scores may improve in this case when population health does not. It is important to determine how many of the exclusions are due to restorations, extractions or previously sealed teeth, respectively.
- There also may be the situation where one plan has a "sicker" population (i.e., more enrollees with teeth extracted/restored) which makes the proportion of children who are excluded different. The additional validity issues that arise from this consideration need to be addressed.
- The measure only looks for at least one sealant. Resealing is very common and is important to ultimately prevent disease.
- Because certain reasons for exclusions are not identifiable in claims data (e.g., unerupted or missing teeth), children who would be eligible for these reasons (all or in combination with other reasons) will not be identified.

Considering these challenges, along with expert opinion and stakeholder feedback, the DQA developed the program and plan-level sealant measure without exclusions. The DQA also developed detailed guidance, which is incorporated in the User Guide and measures specifications, on how the results should be interpreted. Note that the DQA's practice level measure for quality improvement available at the DQA website provide detailed specifications for exclusion criteria to allow practices with more detailed electronic patient records to calculate the measure.

CODE UPDATES

Upon review of both the 2017 CDT Manual and National Uniform Code Committee Health Care Provider Taxonomy code updates, no new codes were identified as being relevant to the measures.

MISCELLANEOUS: CARIES RISK ASSESSMENT

One commenter noted a need for a measure of receipt of a caries risk assessment (c). The MDMC notes that it is currently working on developing a measure on caries risk documentation. Additionally the MDMC would like to inform the community that there are other measures in the pipeline including dental-related ED visits by adults and follow-up after a dental-related ED visit by adults. For more information on the DQA's current and anticipated projects, please visit the DQA current measure activities page- http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities

And finally, the MDMC notes to the commenter of a specific comment (d) regarding DQA advancing implementation and adoption of a measure developed by the Centers for Medicare and Medicaid Services — CMS75v: Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period. The MDMC notes that the comment is very timely given the measure's incorporation in the CMS's Quality Payment Program through Merit-Based Incentive Programs (MIPS). The DQA agrees there is an opportunity to update and improve this outcome measure, including establishing a valid value set and addressing risk adjustment. The MDMC on behalf of the DQA would assume stewardship if given the opportunity to do so.

Appendix A: MDMC

Measures Development and Maintenance Committee:

Craig W. Amundson, DDS, General Dentist, HealthPartners, National Association of Dental Plans. Dr. Amundson serves as chair for the Committee.

Mark Casey, DDS, MPH, Dental Director, North Carolina Department of Health and Human Services Division of Medical Assistance

Natalia Chalmers, DDS, PhD, Diplomate, American Board of Pediatric Dentistry, Director, Analytics and Publication, DentaQuest Institute

Frederick Eichmiller, DDS, Vice President & Science Officer, Delta Dental of Wisconsin

Chris Farrell, RDH, BSDH, MPA, Oral Health Program Director, Michigan Department of Health and Human Services

DQA Executive Committee Liaison to the MDMC:

Michael Wojcik, DDS, Periodontist, ADA/ Council on Dental Practice

DQA Leadership:

Marie Schweinebraten, DMD, Periodontist, Chair, Dental Quality Alliance

Matthew Vaillant, DDS, General Dentist, Chair-Elect, Dental Quality Alliance

The Committee was supported by:

Krishna Aravamudhan, BDS, MS, Director, Council on Dental Benefits Program, American Dental Association

Jill Boylston Herndon, PhD, Methodology Consultant to the DQA; Managing Member and Principal, Key Analytics and Consulting, LLC

Diptee Ojha, BDS, PhD, Senior Manager, Office of Quality Assessment and Improvement, American Dental Association

Appendix B: Public Comments

a) Periodontal Measures (Dr. Mark Antman, Healthcare Quality Consultant)

I appreciate the opportunity to provide comments on the DQA measures. I am limiting my comments to your two most recently-approved measures: Ongoing Care in Adults with Periodontitis (POC-A-A) and Periodontal Evaluation in Adults with Periodontitis (PEV-A-A).

Congratulations on the completion of your first measures for the adult dental population. DQA progress in measure development and implementation continues to be impressive. However, I have noted some definitional and coding inconsistencies that may hamper the implementation of these measures (particularly POC-A-A) and the prospect of gaining National Quality Forum (NQF) endorsement.

The primary issue is the redundancy of CDT codes used to specify the denominator and numerator of the Ongoing Care measure (POC-A-A). I recognize that the lack of dental diagnostic codes leaves you with no alternative to defining "history of periodontitis" with treatment codes (for scaling and root planing, etc.) as a proxy for the diagnosis (as noted in your "Measure Limitations" section). The unfortunate consequence of this limitation is that the numerator of POC-A-A is met by many of the same codes as those that qualify patients for inclusion in the denominator. Given the differences in other inclusion criteria (DEN: 1 code [claim] within 3 years prior; NUM: 2 codes [claims] in reporting year), implementation of this measure would technically still be feasible but the redundancy in coding may be confusing to implementers; NQF reviewers may also raise methodological concerns.

I encourage you to consider a few possible solutions to the issue described above:

a. Add text to the POC-A-A measure specifications document to more fully explain/justify the redundancy in numerator/denominator coding.
b. Consider removing periodontal maintenance (D4910) from the denominator specifications for POC-A-A, and limit the numerator inclusions to only D1110 or

D4910, thus eliminating the coding redundancy. Dropping D4910 from the denominator may also be more consistent with the studies you cited, which confirm the benefits of "a periodontal maintenance program following active periodontal therapy." With this change, you may also wish to consider changing the description of the denominator from "adults with a history of periodontitis" to "adults with a history of active periodontal treatment."

c. If you prefer that the denominators for measures POC-A-A and PEV-A-A remain identical, consider also revising the denominator for PEV-A-A as described in b) above.

Again, thank you for the opportunity to comment on the DQA measures. I wish you and the DQA much continued success.

b) Care Continuity (Children's Dental Health Project)

I almost forgot about this. After consulting with our staff, the primary comment I have is on the continuity of care measure which is fantastic to have but seems to be unnecessarily limited to oral evaluations performed in a dentists' office.

Given the fact that currently most private health insurers must cover an oral health risk assessment by a pediatrician and other DQA measures recognize the role of medical providers in delivering oral health care, it seems prudent to expand the scope of the continuity of care measure to include evaluations such as oral health risk assessments that might be performed outside of a dental office. This is especially important for young children who are still very unlikely to be seen by a dentist and, even in Medicaid, quite likely to be seen for a well-child visit.

c) Caries Risk Assessment (Children's Dental Health Project)

Related but not a comment on existing measures, is the need for a measure of receipt of a risk assessment. While there are risk assessment codes and existing measures that incorporate risk whether through a claims look-back or actual risk assessment, it would be good to have a formalized measure.

d) Miscellaneous (Children's Dental Health Project)

And finally, we still find ourselves without a measure of disease outside of public health surveillance mechanisms. CMS has had a sort of dummy measure sitting on the books for a few years now (CMS75v1: Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period) but there's been no movement to actualize it. We would love to see DQA champion the process to establish such a measure though I understand the challenges given the lack of widespread diagnostic codes in HIT systems. Still, as it currently stands, there's little incentive for providers to adopt a process that actually tracks disease and having an approved measure would be a huge step forward.

e) Usual Source of Care (Texas Dental Association)

"Usual source of care: percent of members with two years' continuous enrollment who visited the same clinical practice in both years." We would prefer that the measure be specific to the main dentist instead of same clinical practice.

References

1. Davidson PL, Cunningham WE, Nakazono TT, Andersen RM. Evaluating the effect of usual source of dental care on access to dental services: comparisons among diverse populations. Med Care Res Rev 1999;56(1):74-93.