Quality Measurement 105

Measurement in Action
Oral Healthcare Quality Reports – State Profiles

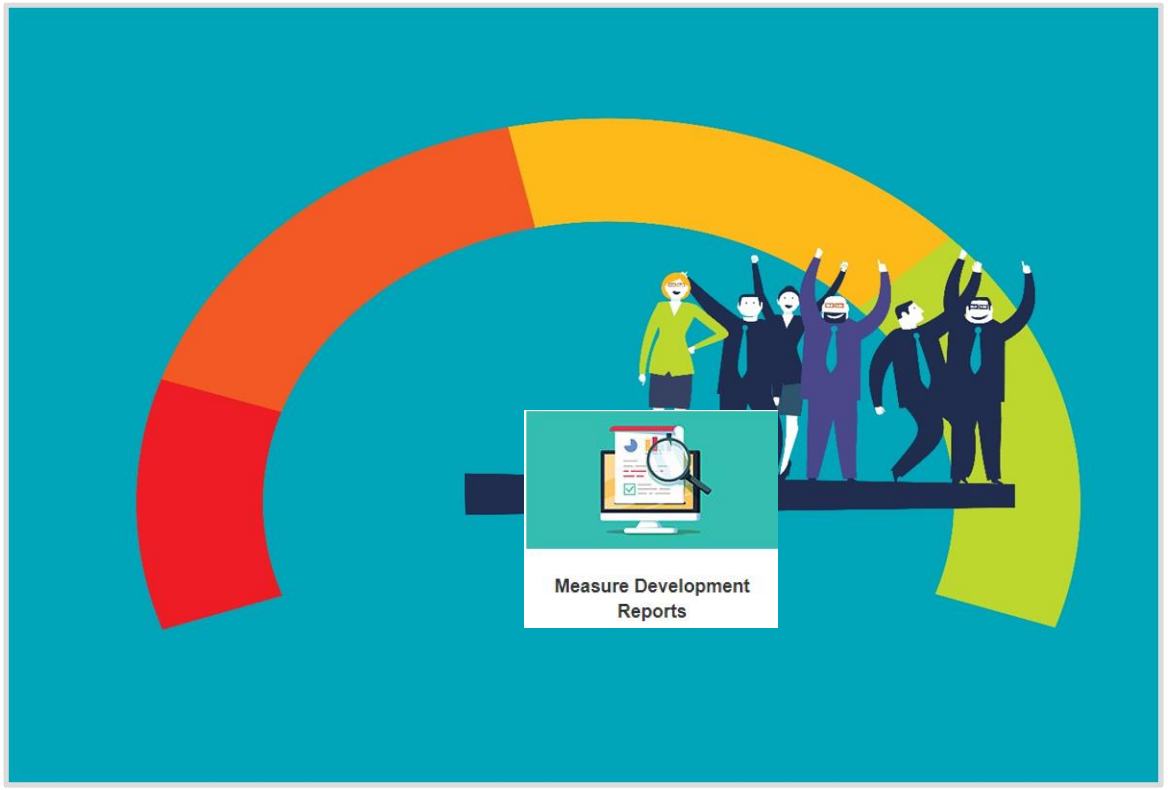
How to interact during the webinar

Use the Chat function for questions for the Technical Team

Use the Q&A function for questions for the presenter(s)

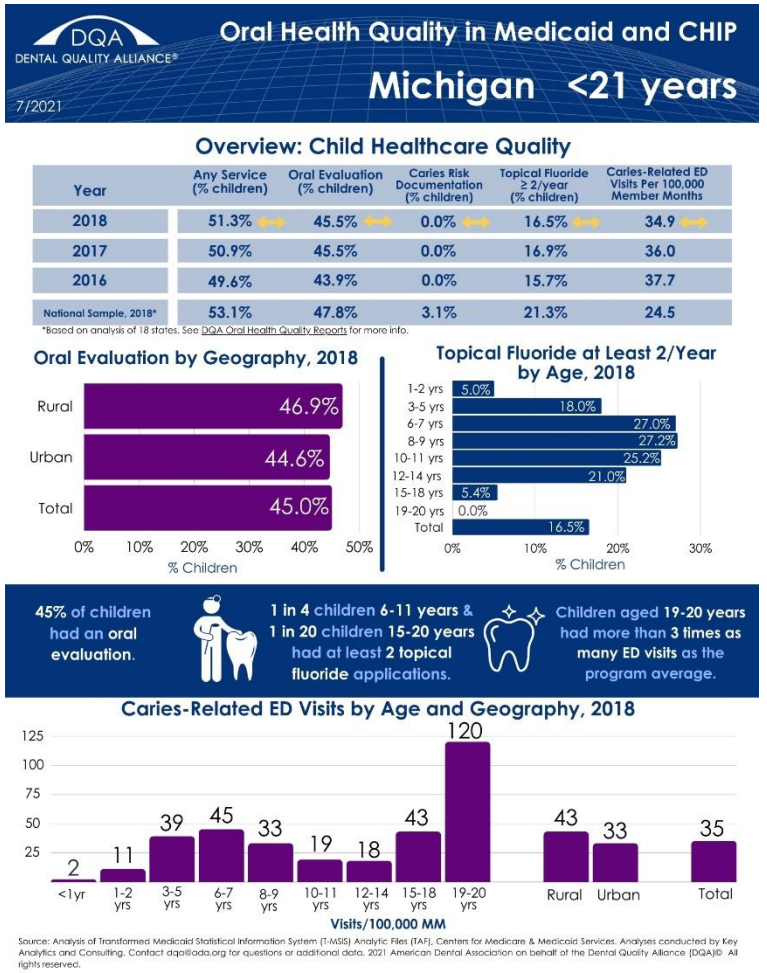
Dr. Marie Schweinebraten, DMD

Chair, DQA Education Committee



MEASURE and IMPROVE

MEASURE and IMPROVE



Learning Objectives

By the end of this webinar, participants will be able to:

- Gain familiarity with how data are reported and compiled at the state and plan levels for Medicaid and CHIP.
- Learn how the DQA is using national data for Medicaid and CHIP programs contained within the Transformed Medicaid Statistical Information System (T-MSIS) to conduct research that supports systems-level improvement.
- Understand how measurement can be used to identify disparities in care.

Speaker

Dr. Jill Herndon, owner and principal consultant with Key Analytics and Consulting.

Disclosures

Dr. Herndon is presenting in her capacity as a methodology consultant to the Dental Quality Alliance.

Measurement in dentistry: where we were

IOM (2011), *Advancing Oral Health In America*, Key Findings and Conclusions

"Oral health lags significantly behind the remainder of the health care system in developing quality measures, and as a result, little is known about the quality of oral health care."

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

2008 NATIONAL DENTAL SUMMARY

January 2009

Dental Quality Alliance: CMS is interested in forming a Dental Quality Alliance (DQA) and is currently in discussions with the American ~~Dental Association~~ (ADA) to begin this process. The DQA would bring together parties from many aspects of oral health fields including national dental organizations, Federal and State partners, payers and consumers to begin working together on measurements that could be used by States for purposes of improving the delivery of oral health services and the development of quality measures. These measures could ultimately be used to enhance reporting on the CMS form 416 or through state-based value based purchasing initiatives. While children eligible for Medicaid will be the primary area of concern, the DQA will also address dental services for the adult population.

Measurement in dentistry: where we are

Validated measures in use

Validated Measures

Utilization of Services
Preventive Services for Children
Treatment Services
Caries Risk Assessment Documentation
Oral Evaluation
Topical Fluoride for Children
Receipt of Sealants on First Permanent Molars
Receipt of Sealants on Second Permanent Molars
Care Continuity
Usual Source of Services
Oral Evaluation – Adults with Diabetes
Topical Fluoride for Adults at Elevated Caries Risk
Periodontal Evaluation in Adults with Periodontitis
Non-Surgical Ongoing Periodontal Care in Adults with Periodontitis
Follow-Up after ED Visit by Children/Adults
Per Member Per Month Cost of Clinical Services

Used for Quality Improvement, Public Reporting, and Payment Programs: Example

Centers for Medicare & Medicaid Services: Medicaid and CHIP Child Core Set
Health Resources & Services Administration: Uniform Data System Reporting
Covered California – Health Benefit Exchange, Plan Contracts
Massachusetts Delivery System Reform Incentive Payment
Oregon Health Authority (Payment Program, Public Reporting, QI)
Michigan Healthy Kids Dental, Dental Plan Request for Proposals (RFP)/Contract
Florida Medicaid, Dental Plan RFP/Contract
Texas Medicaid and CHIP, Plan Contracts

Who's measured: different levels

% of patients in the practice, clinic, health center who received recommended care

HRSA UDS reporting
eCQMs
ADA DERE

% of patients enrolled in the health plan who received recommended care

DQA Program/
Plan level measures

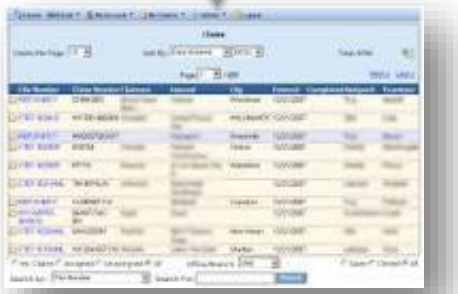
% of patients enrolled in the program (e.g., Medicaid) who received recommended care

CMS Core Set
DQA State Profiles

How's it measured: different data sources

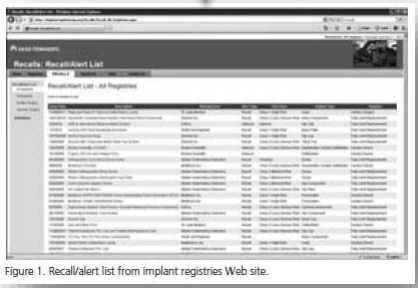
Health Records

HRSA UDS reports



Administrative Database
(enrollment, claims and encounters)

CMS Core Set
DQA State Profiles

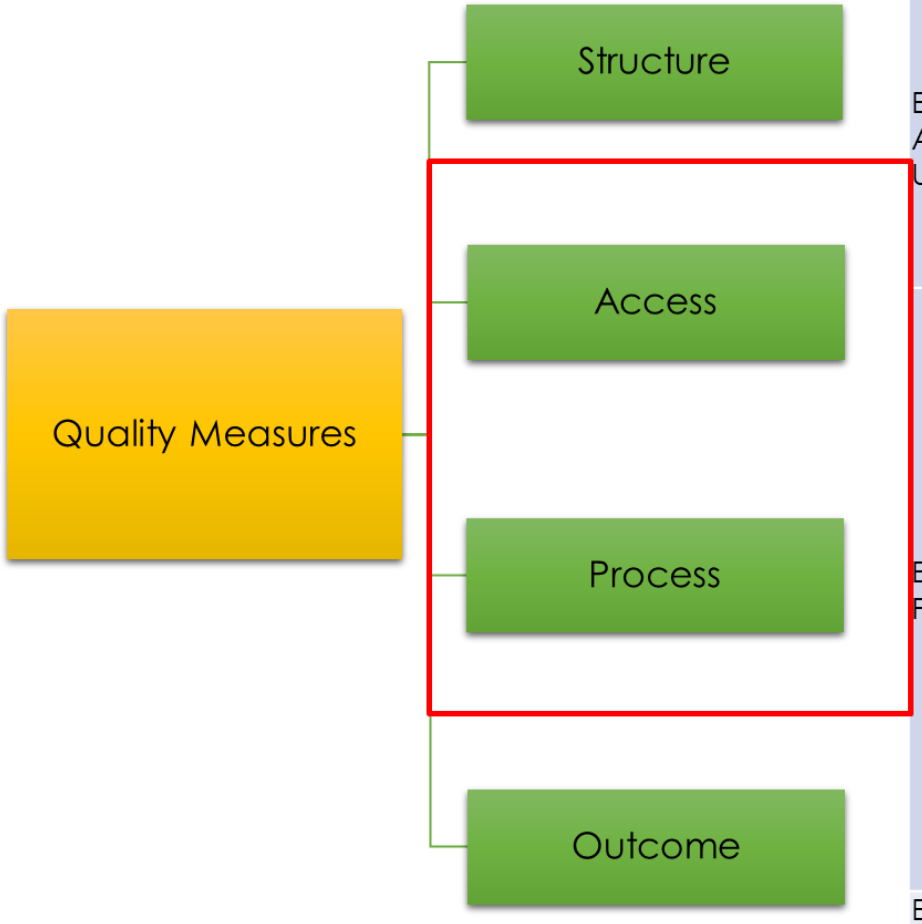


Registries

ADA DERE

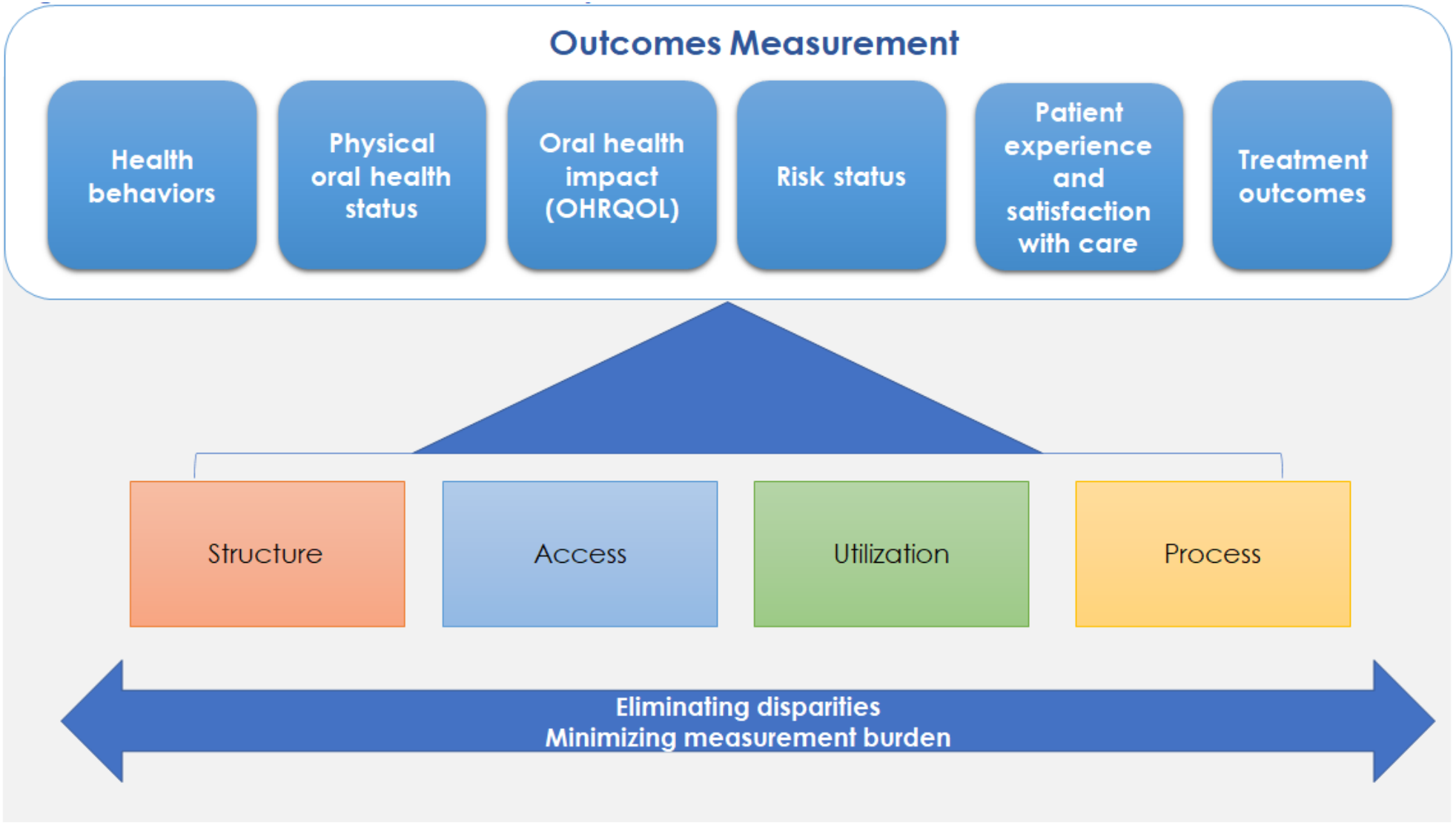
Patient surveys (patient reported outcomes, satisfaction, experience with care and health status)

What's measured: categories of measures



	Measure Name
Evaluating Access and Utilization	Utilization of Services
	Preventive Services for Children
	Treatment Services
	Caries Risk Assessment Documentation
	Periodontal Evaluation in Adults with Periodontitis
	ED Visits by Adults for Non-Traumatic Dental Conditions
Evaluating Process of Care	Oral Evaluation
	Topical Fluoride for Children
	Receipt of Sealants on First Permanent Molar
	Receipt of Sealants on Second Permanent Molar
	Care Continuity
	Usual Source of Services
	Follow-Up after Emergency Department Visits for Dental Caries in Children
	Non-Surgical Ongoing Care for Adults with Periodontitis
	Topical Fluoride for Adults at Elevated Caries Risk
	Oral Evaluation – Adults with Diabetes
	Follow-Up after ED Visits by Adults for Non-Traumatic Dental Conditions
Evaluating System Outcome	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
Evaluating Cost and Efficiency	Per Member Per Month Cost of Clinical Services

Measurement in dentistry: where we are headed



Outcome **measures, especially those most meaningful to patients, are essential to measuring *value*.**

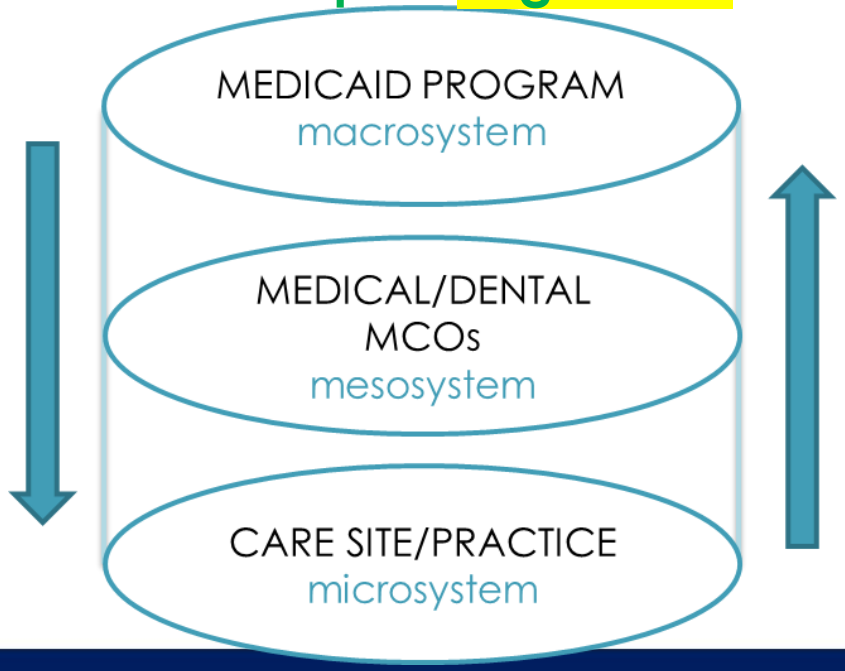
Why is measurement so focused on using administrative data at the program level, focused on access and process measures, when we ultimately want to measure patient outcomes?

Well-known challenges – we are lacking:

- Ability to integrate and aggregate EHR data
- Consistent, structured capture of diagnostic data for outcomes measurement.
- Validated patient- reported performance measures
- Data and methodologies to account for patient characteristics

Access and process drive towards outcomes

All system levels are connected and require alignment



Measurement in dentistry: where we are

Data for testing and reporting measures

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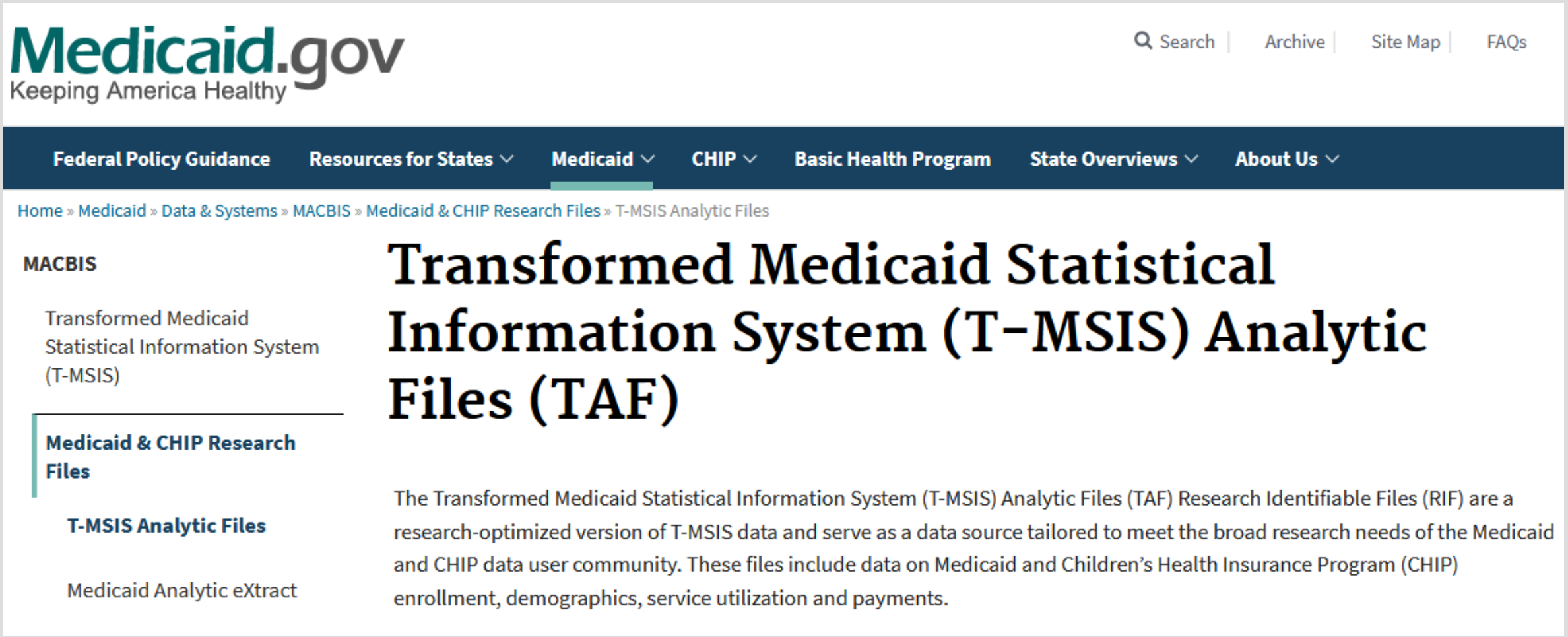
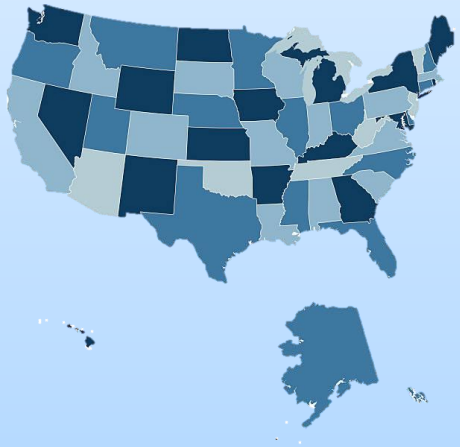


What is T-MSIS

Medicaid/CHIP eligibility and claims data for all states



DQA approved for data access:

- Calendar years 2014–2018
- Dental, Medical, Pharmacy Claims and Enrollment Data

- Includes facility and professional claims; inpatient and outpatient

Objectives:

- Develop state profiles using DQA measures
- Support ongoing evaluations of measurement reliability and validity and identify opportunities for measure development
- Develop technical assistance resources to support DQA measure implementation

From the state Medicaid/CHIP program to T-MSIS

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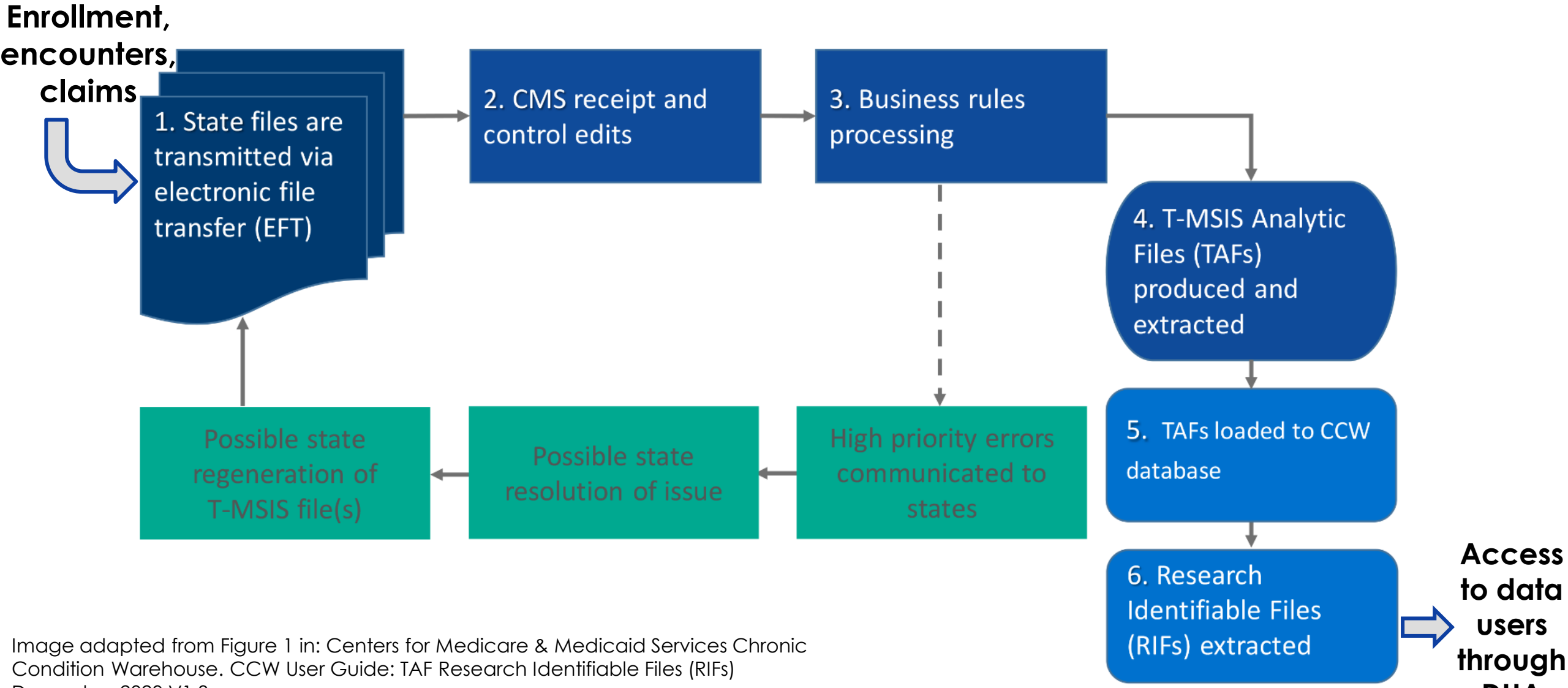

Image adapted from Figure 1 in: Centers for Medicare & Medicaid Services Chronic Condition Warehouse. CCW User Guide: TAF Research Identifiable Files (RIFs) December 2020:V1.3.

How much data are we talking about?

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75-80 million Medicaid/CHIP Enrollees per Year

Eligibility File:
188 variables

Enrollment spans, benefits, demographic/ geographic information

Hospital Inpatient Files:
>200 variables

Inpatient stay information – dates of service, diagnoses, procedures, provider and payment information

Prescription Drug Files:
>100 variables

Prescription and covered OTC drugs, NDC codes, filled dates, units, quantity supplied, provider and payment information

Other Services Files:
>150 variables

Outpatient services - dates of service, procedure codes, diagnoses, provider and payment information

Long-Term Care Files:
>150 variables

Long-care institutional claims, dates of service, diagnoses, provider and payment information

Separate set of files for each state and each year (each month for claims files).

T-MSIS: Why it is a game-changer

Where we were

Testing
2-3 programs included

Reporting
Each state programs its own measures

Where we are

Testing
Access to data for ALL state Medicaid/CHIP programs

Reporting
Centralized reporting: states can focus on quality improvement

CMS Medicaid/CHIP Child Core Set: moving from broad utilization indicators to evidence-based quality measures

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FFY 2010

- Total Eligibles who Received Preventive Dental Services (CMS - EPSDT)
- Total Eligibles who Received Dental Treatment Services (CMS - EPSDT)

FFY 2015

- Total Eligibles who Received Preventive Dental Services (CMS - EPSDT)
- **Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (DQA)**

FFY 2020

- Total Eligibles who Received Preventive Dental Services (CMS - EPSDT)
- **Sealant Receipt on Permanent First Molars (DQA)**

FFY 2021: *Recommended*

- **Sealant Receipt on Permanent First Molars (DQA)**
- **Topical Fluoride for Children (DQA)**
- **Oral Evaluation (DQA)**

Mandatory reporting in 2024

Centers for Medicare & Medicaid Services: Core Set of Children's Health Care Quality Measures for Medicaid and CHIP - Dental and Oral Health Services

T-MSIS Data: State Profiles

Why?

- Provide high level information about dental care quality
  - Support setting QI goals and monitoring progress
- Encourage viewing measures in "sets" rather than focusing on a single measure
- Provide context for measure scores

What?

- Time trends
- Contextual data
  - National average
- Stratification by demographic characteristics – e.g., age and geography (urban/rural)
  - Enable identification of disparities and where to target outreach

T-MSIS Data: State Profiles

Initial focus: CHILDREN

MEASURES

- Utilization of Dental Services
- Oral Evaluation
- Caries Risk Documentation
- Topical Fluoride
- Caries-Related ED Visits

STATES WITH COMPLETED DATA ANALYSES

- Alaska
- Connecticut
- Delaware
- Georgia
- Hawaii
- Idaho
- Louisiana
- Massachusetts
- Michigan
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Mexico
- North Dakota
- Oklahoma
- Oregon
- Washington

T-MSIS Data:
All States Summary (n=18)

MEASURE	AVERAGE	MINIMUM	MAXIMUM
Utilization of Dental Services	53.1%	37.1%	65.5%
Oral Evaluation	47.8%	33.0%	55.7%
Caries Risk Documentation	3.1%	0.0%	49.4%
Topical Fluoride	21.3%	14.3%	27.5%
Caries-Related ED Visits	24/ 100,000 MM	15/ 100,000 MM	35/ 100,000 MM

- Significant percentage of children not receiving any dental care
- Even fewer receiving recommended prevention
- Substantial variation between states
- **NOTE:** Only services for which there are claims are captured.

We are using T-MSIS data to create state profiles

Time trends – how do scores vary over time?

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Year	Any Service (% Children)	Oral Evaluation (% Children)	Caries Risk Documentation (% Children)	Topical Fluoride (% Children)	Caries-Related ED Visits/100,000 MM
2018	46.7% ↓	39.0%	2.0%	15.3%	17.7 ↓
2017	46.8%	38.3%	2.2%	15.0%	20.6
2016	49.2%	41.2%	0.0%	16.8%	23.8

GEORGIA

Year	Any Service (% Children)	Oral Evaluation (% Children)	Caries Risk Documentation (% Children)	Topical Fluoride (% Children)	Caries-Related ED Visits/100,000 MM
2018	52.0% ↓	49.5%	0.0%	21.7%	20.4 ↓
2017	53.7%	51.3%	0.0%	21.5%	21.4
2016	53.8%	51.2%	0.0%	21.2%	21.4

MICHIGAN

Year	Any Service (% Children)	Oral Evaluation (% Children)	Caries Risk Documentation (% Children)	Topical Fluoride (% Children)	Caries-Related ED Visits/100,000 MM
2018	51.3% ↑	45.5%	0.0%	16.5%	34.9 ↓
2017	50.9%	45.5%	0.0%	16.9%	36.0
2016	49.6%	43.9%	0.0%	15.7%	37.7

WASHINGTON

Year	Any Service (% Children)	Oral Evaluation (% Children)	Caries Risk Documentation (% Children)	Topical Fluoride (% Children)	Caries-Related ED Visits/100,000 MM
2018	61.1% ↑	55.3%	4.9%	27.0%	18.7 ↓
2017	60.4%	54.8%	3.4%	27.4%	20.0
2016	60.3%	54.3%	2.7%	27.4%	21.6

Why stratify? The equity-quality link

The IOM identifies **equity** as one of six attributes of high-quality care.

"the goal of a health care system is to improve health status . . . in a manner that reduces health disparities among particular subgroups"

"the quality of care should not differ because of such characteristics as gender, race, age, ethnicity, income, education, disability, sexual orientation, or location of residence"

Measure Stratifications help us identify:

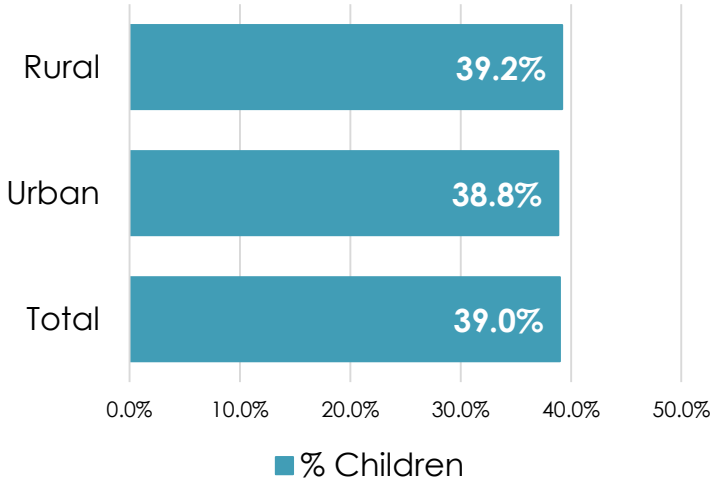
- Which populations are we having the most success reaching?
- Which populations have the biggest care gaps?

Institute of Medicine (U.S.). Committee on Quality of Health Care in America. Crossing the Quality Chasm : a new health system for the 21st century. Washington, D.C.: National Academy Press; 2001.

State Profiles: Stratifications

Oral Evaluation by Geography, 2018

ALASKA



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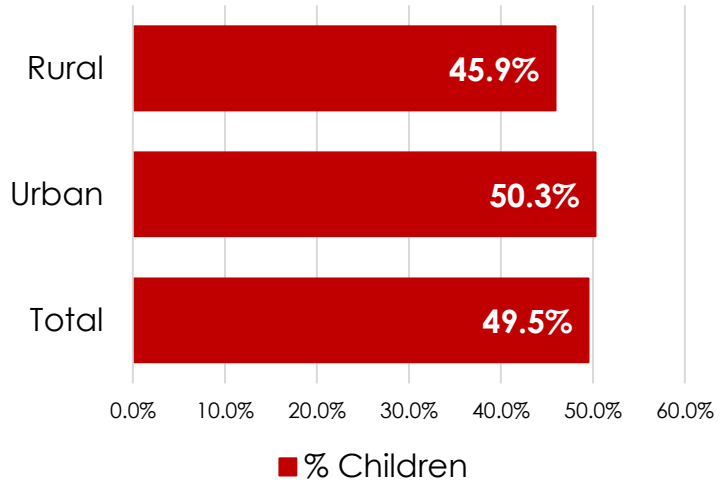

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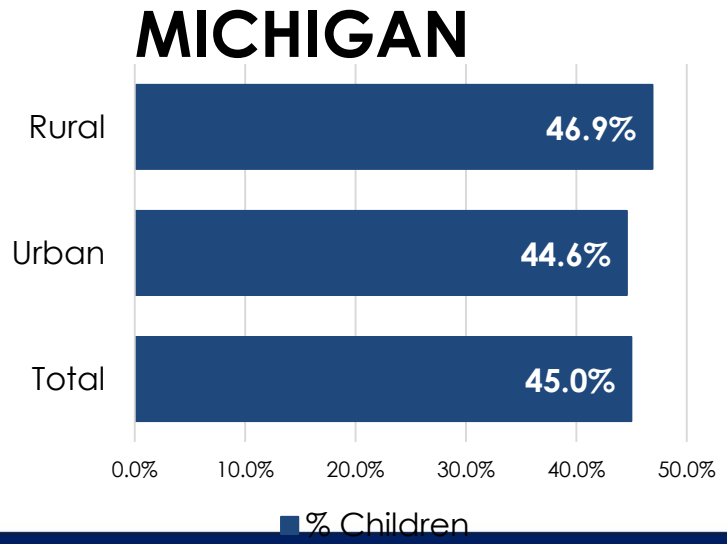

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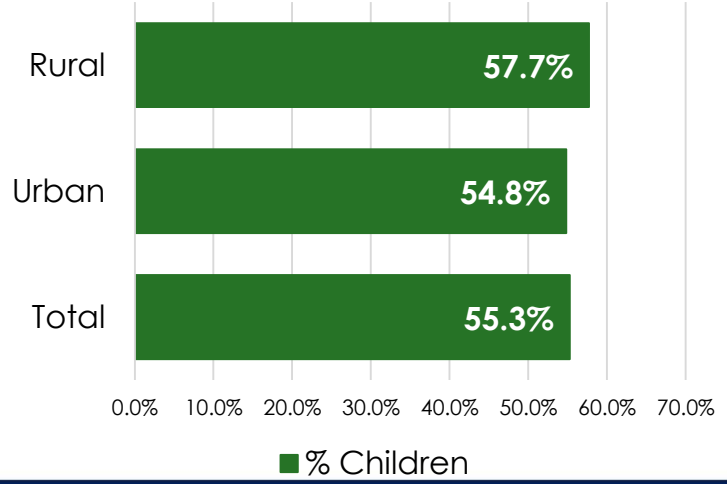

State Profiles: Stratifications

Topical Fluoride by Age, 2018

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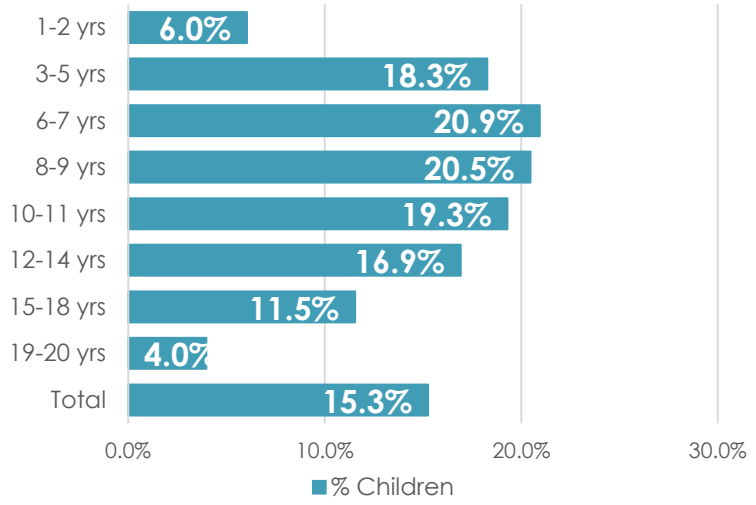

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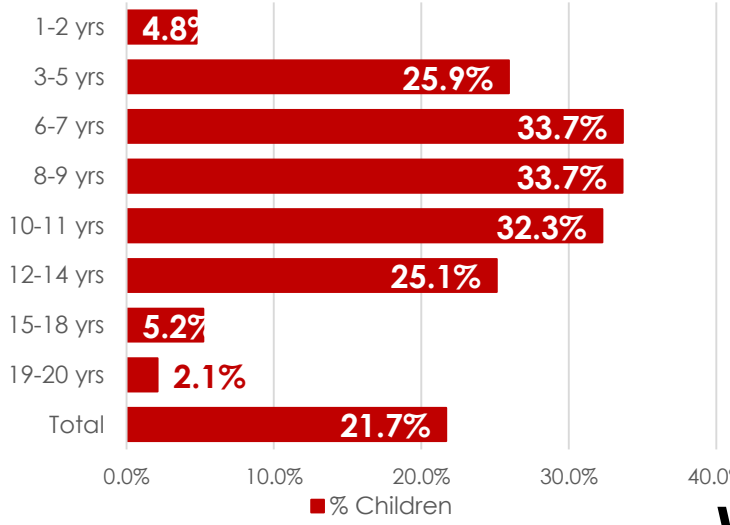

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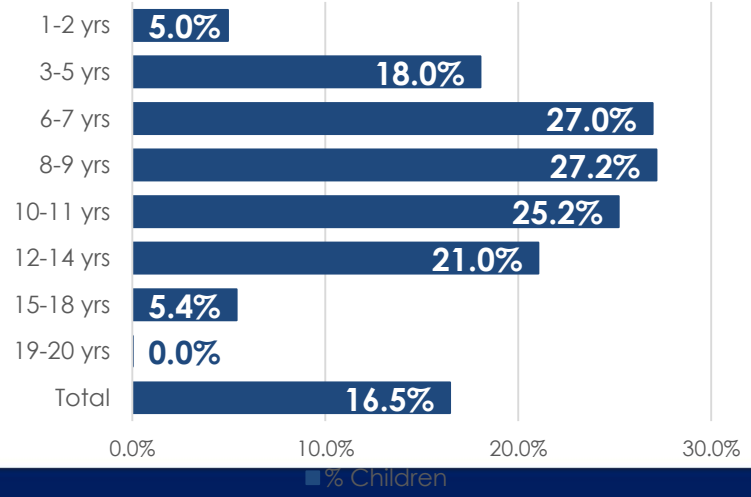

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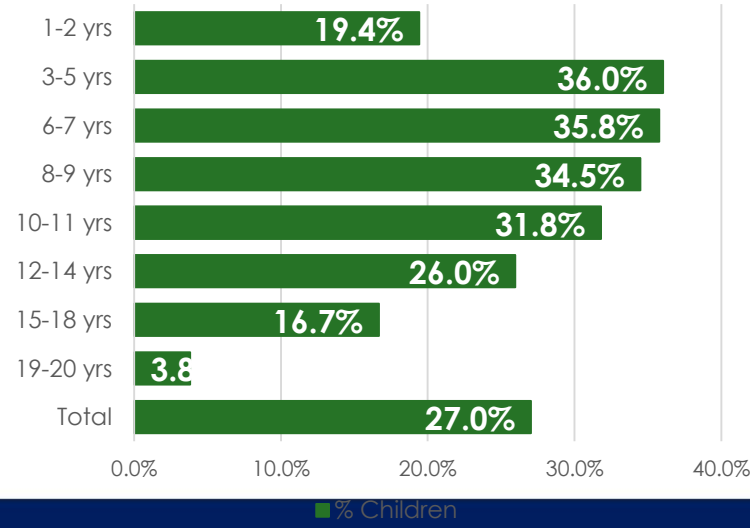
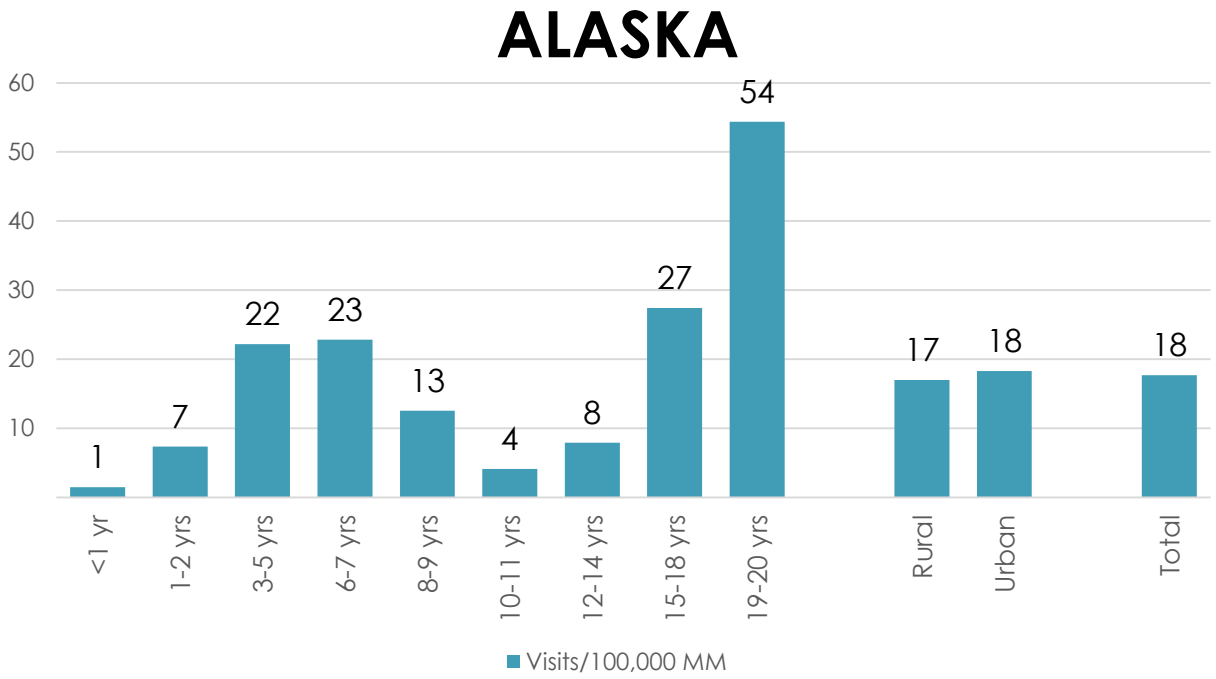
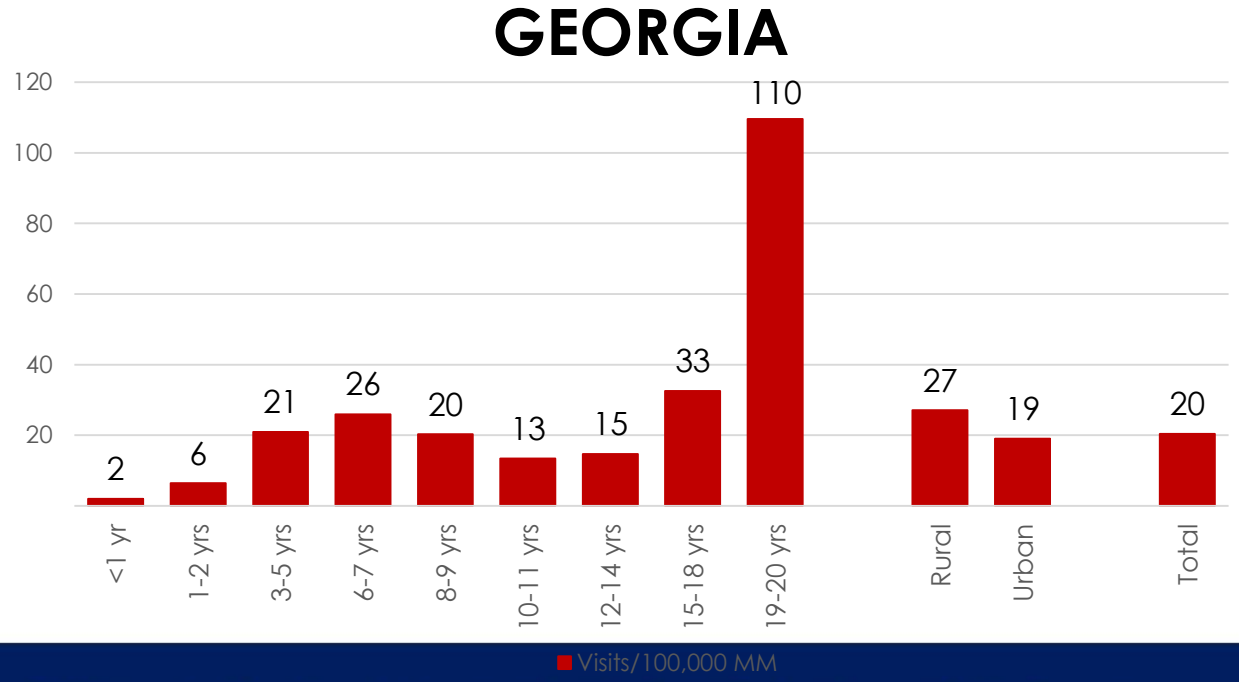


State Profiles: Stratifications

ED Visits by Age and Geography, 2018





State Profiles: Stratifications

ED Visits by Age and Geography, 2018

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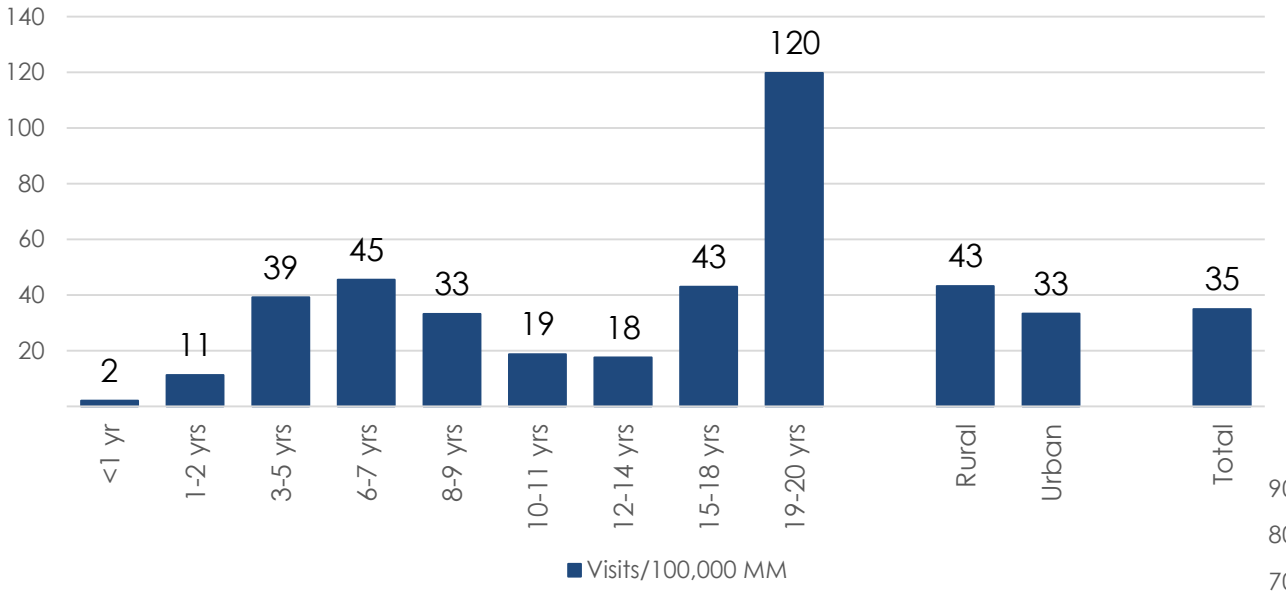

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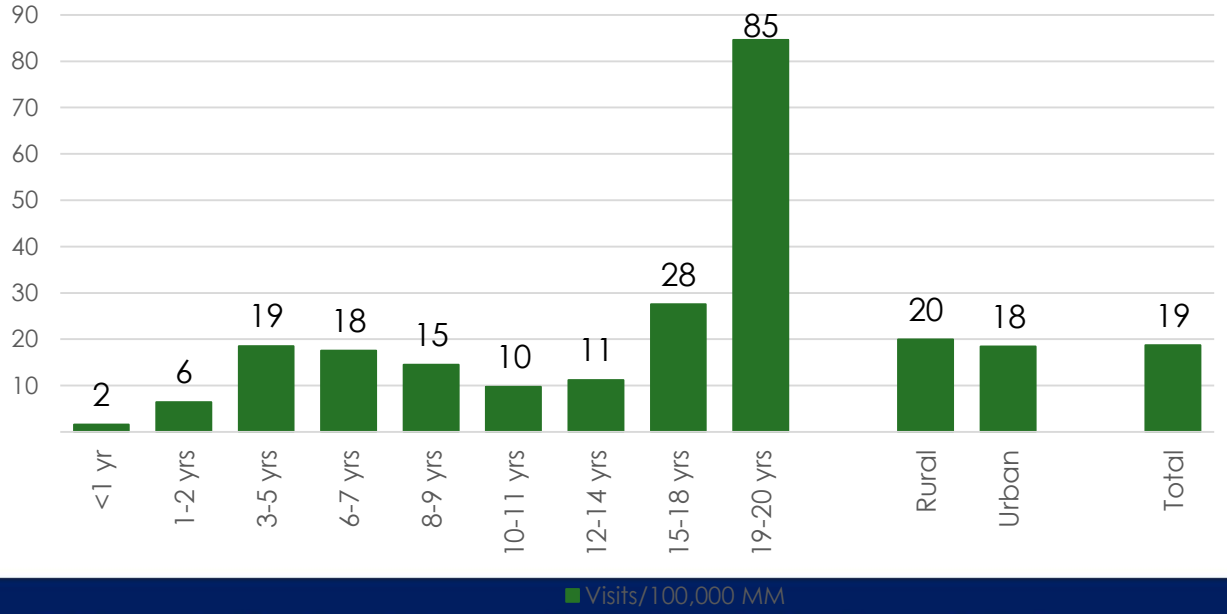
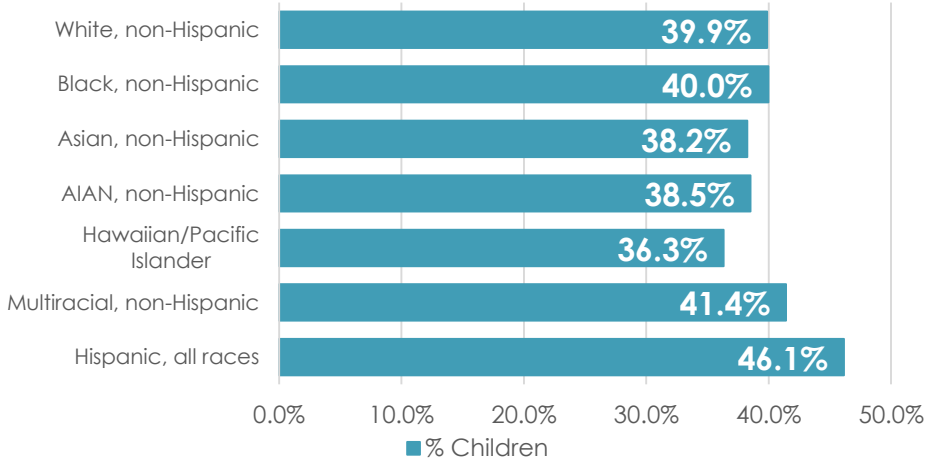


State Profiles: Stratifications

Oral Evaluation by Race/Ethnicity, 2018

ALASKA



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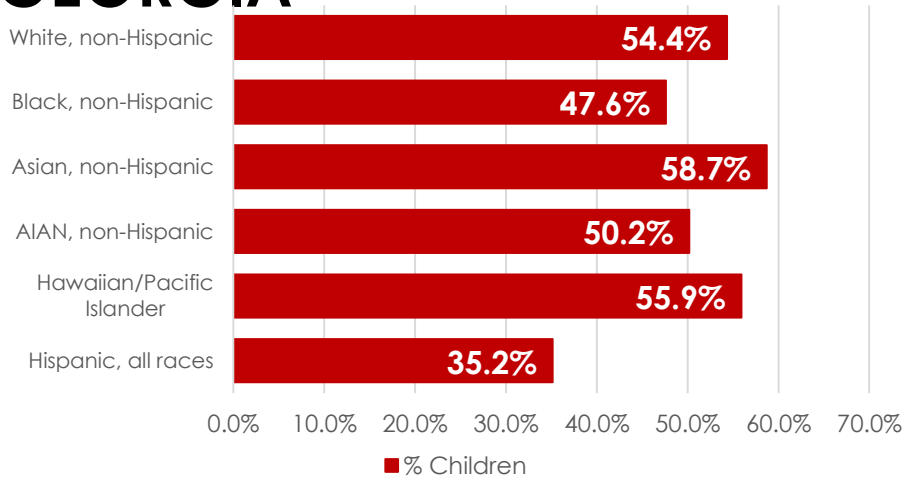

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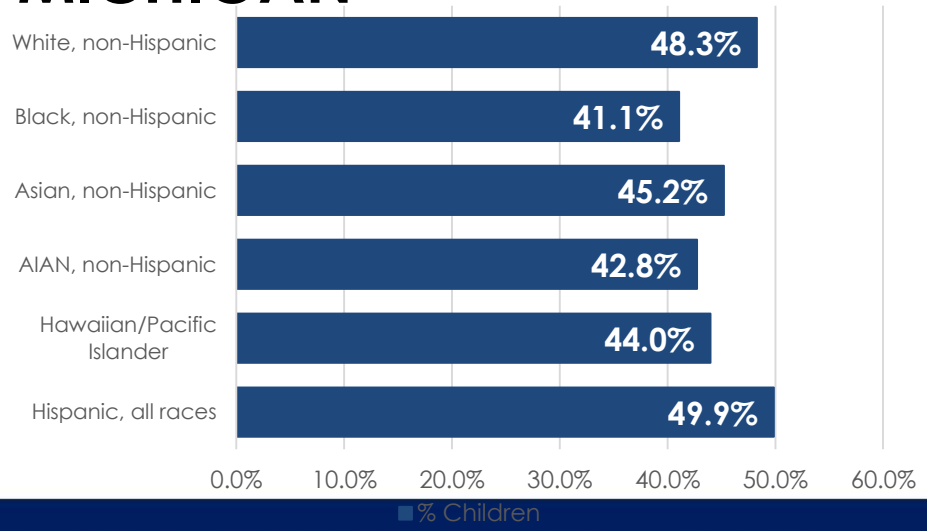

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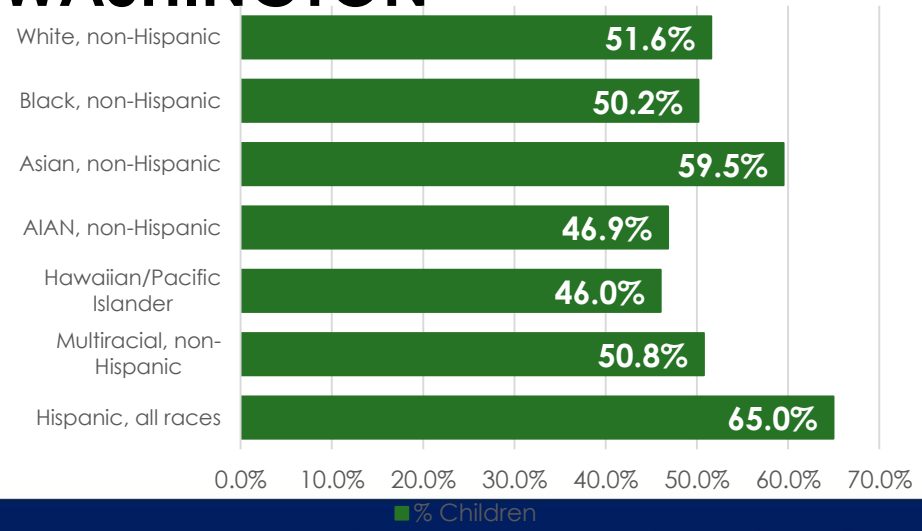


! Data Issue

Approximately **50%** of states have **inadequate race and ethnicity data** for reliable reporting.

State Profiles: Bringing it All Together

Available at: https://www.ada.org/en/science-research/dental-quality-alliance/dqa-publications

DENTAL QUALITY ALLIANCE®

Oral Health Quality in Medicaid and CHIP

Oregon <21 years

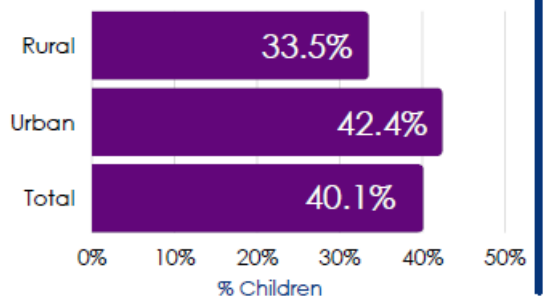
7/2021

Overview: Child Healthcare Quality

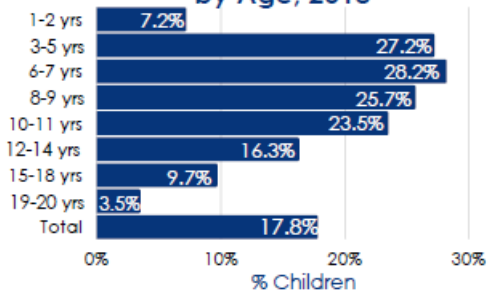
Year	Any Service (% children)	Oral Evaluation (% children)	Caries Risk Documentation (% children)	Topical Fluoride ≥ 2/year (% children)	Caries-Related ED Visits Per 100,000 Member Months
2018	51.4% ↑	40.1% ↑	21.3% ↑	17.8% ↔	29.7 ↔
2017	49.5%	39.5%	13.7%	17.6%	31.9
2016	46.5%	37.1%	7.2%	15.2%	34.5
National Sample, 2018*	53.1%	47.8%	3.1%	21.3%	24.5

*Based on analysis of 18 states. See DQA Oral Health Quality Reports for more info.

Oral Evaluation by Geography, 2018



Topical Fluoride at Least 2/Year by Age, 2018

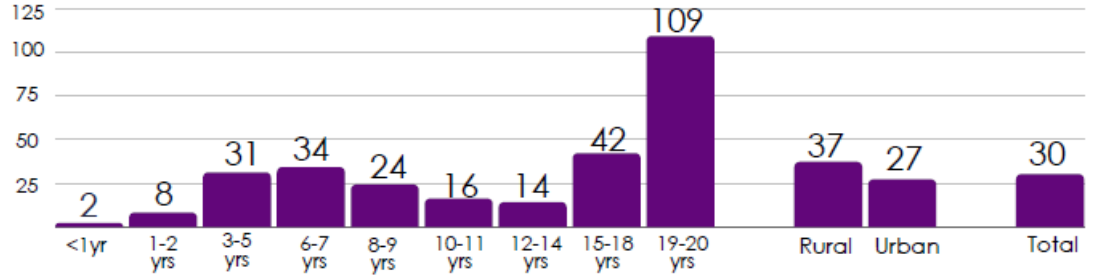


1/3 of children living in rural areas had an oral evaluation.

Fewer than 20% of children received at least 2 topical fluoride applications.

Children aged 19-20 years had more than 3 times as many ED visits as the program average.

Caries-Related ED Visits by Age and Geography, 2018



Source: Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF), Centers for Medicare & Medicaid Services. Analyses conducted by Key Analytics and Consulting. Contact dqa@ada.org for questions or additional data. 2021 American Dental Association on behalf of the Dental Quality Alliance (DQA)® All rights reserved.

State Profiles: Questions

Rather than delaying release until all states are completed, we wanted to start releasing reports in batches as they are available. States were prioritized, in part, based on data completeness and quality.

Standard delays in reporting administrative claims data to allow for claims processing and resolution – PLUS time for states to submit, CMS to process & QA, then create analytic files and make available to data users (see slide 20).

Later this month!
Please check
https://www.ada.org/en/science-research/dental-quality-alliance/dqa-publications
for updates!

T-MSIS Data Acknowledgements & Resources

- **Oral Healthcare Quality State Profile reports are part of a research project titled "The State of Oral Healthcare Use, Quality and Spending: Findings from Medicaid and CHIP Programs," made possible through Data Use Agreement (DUA) RSCH-2020-55639 with the Centers for Medicaid and Medicare Services.**

- **Centers for Medicare & Medicaid Services, T-MSIS Data: https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf/index.html**

- **T-MSIS Analytics Files (TAF) Data Quality Atlas: https://www.medicaid.gov/dq-atlas/welcome**

Concurrent efforts: practice-level measurement

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Improving Oral Health Through Measurement

Dental Quality Alliance

PRACTICE-LEVEL MEASURES FOR QUALITY IMPROVEMENT

RELIABILITY NOT ESTABLISHED. USE ONLY FOR QUALITY IMPROVEMENT

https://www.ada.org/~/media/ADA/DQA/DQA_2016_Practice_Level_Measures_for_QI.pdf?la=en

IHI Open School Online Courses

SHARE

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http://www.ihi.org/education/IHIOpenSchool/Courses/Pages/Dental-Quality-Alliance-DQA.aspx

GUIDANCE ON PRACTICE BASED MEASURES IMPLEMENTATION

The development of this guidance document has been informed by the DQA's Project on Pediatric Practice-Based Measures Testing:

Alignment and Harmonization in Reporting Quality: Establishing Reliability Across Reporting Levels

KEY RECOMMENDATIONS

- Comparisons should be made within a data source (i.e., one practice's measure score calculated using claims data should not be compared with another practice's measure score calculated using billing data or electronic dental record, EDR, data).
- Recommended minimum denominator sizes when used in accountability applications that are based on relative comparisons between practices are:

  (1) 100 when using payer claims data, (2) 50 when using practice billing data, and (3) 50 when using practice EDR data.
- When practice measure scores are clustered closely together (i.e., there is low practice-to-practice variation), accountability applications should focus on overall improvement across practices rather than relative comparisons between practices.
- Before incorporating any quality measures in accountability applications, those applications should be tested using multiple years of measure data to evaluate whether the application achieves the intended goals and whether there are unintended consequences that may undermine quality improvement efforts. It is incumbent upon the users of performance measures to carefully evaluate these impacts prior to implementing the accountability application.

https://www.ada.org/~/media/ADA/DQA/2018_PBM_Guidance_Implementation_Final20181108t102945.pdf?la=en

Use the Q&A function for questions for the presenter(s)

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Thank you!