NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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Adeela Kahn: Hi everyone. This is Adeela Kahn from NQF. I'm here with my colleagues Elisa Munthali, Ashley Morsell, Kaitlynn Robinson-Ector and our consultant Robyn Nishimi.

This is the Health and Well-Being Workgroup III Call. We'll be going over the preliminary evaluations for the measures in scientific workgroup.

The way the call is structured is that we'll introduce the measure and then we'll have the lead discussants go over some of their comments which we've compiled and we'll be showing on the Webinar.

We have six measures so I'd like to stick to about 20 minutes of discussion per measure. We can start off by doing a quick roll call. I'll read off the names of the workgroup members first.

Sarah Sampsel?

Sarah Sampsel: I'm here.

Adeela Kahn: OK. Chisara Asomugha?

Chisara Asomugha: Here.

Adeela Kahn: OK. Renee Frazier? Ron Inge?

Ronald Inge: Here.

Adeela Kahn: David Krol?

David Krol: Here.

Adeela Kahn: Mike Stoto?

Michael Stoto: I'm here too.

Adeela Kahn: And Rob Valdez?

OK. Are there any workgroup members that I haven't called? Or any other committee members who maybe on the call?

Amy Minnich: Hi. Amy Minnich is here.

Adeela Kahn: OK.

Catherine Hill: And Catherine Hill.

Robert Valdez: Hi. This is Robert Valdez. I wasn't sure whether you can hear me or not.

Adeela Kahn: OK. Thanks, Rob. I'm sorry. Who was the other one? We have Amy Minnich and?

Catherine Hill: Catherine Hill.

Adeela Kahn: OK. Great.

(Tom McEnery): (Tom McEnery).

Adeela Kahn: OK. OK. I just want to check that our developers on the call also the Dental Quality Alliance. Do you guys have an open line area here?

It should be Krishna and or Manessa.

Krishna Aravamudhan: Manessa will not be joining us but we do have two other people from my committee. Jill Herndon and Jim Krol, are either of you there?

Jill Herndon: Hi. This is Jill.

Adeela Kahn: Great. OK. Let's get started. The first measure is going to be 2508 Prevention …

Michael Stoto: Excuse me. Before we start, I can't get through to the web link. I don't know whether other people having that problem or not.

Adeela Kahn: Are you – is it just not showing up or you …

Michael Stoto: It says "Access Denied", "Access to this page is denied" when I go through.

Adeela Kahn: Let me see. It's nqf.commpartners.com

Michael Stoto: That's right. Now, I …

Adeela Kahn: You would have …

Michael Stoto: … have different e-mails about this today's call and that's the later one. The earlier one goes through but there's nobody there.

Adeela Kahn: Yes. So if you go to the main site, the nqf.commpartners.com.

Michael Stoto: Yes.

Adeela Kahn: You should see a box that says "Enter a Meeting".

Michael Stoto: OK. Funny they didn't even let me go there.

Adeela Kahn: Right there.

Michael Stoto: OK.

Adeela Kahn: And then just type in 317524. And you should be able to get in.

Michael Stoto: I still get this access denied. It comes back to the same screen.

Adeela Kahn: That's very strange.

Elisa Munthali: Mike, this is Elisa. I'll send you the link again.

Michael Stoto: OK.

Elisa Munthali: OK.

Adeela Kahn: Sorry about that. So we can go ahead and get started though. 2508 Prevention, Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk. And the leads for this are Sarah and David. So Sarah if you'd like to start first.

Sarah Sampsel: Sure. So, you know, this is a measure that is a percentage of enrolled children from 6-9 years of age at elevated risk, moderate or high who receive a sealant and permanent for similar tooth within the reporting year and, you know, the basis and the rationale behind the measure really is that, you know, there's a timing issue regarding placing sealants on children's teeth but that they are a preventive mechanism. So this is a process measure.

But putting the sealants on permanent teeth will prevent, you know, other health issues decay et cetera down the road. And therefore, you know, there is, you know, put up guidelines behind this as well as, you know, I felt enough evidence behind to support the measure concept as a whole. I think that, you know, the measure seems to, you know, if you're thinking about it in a framework of the (US PSDF) or otherwise, you know, there seems to be more, definitely more benefit than harm.

I would say that my only, you know, kind of concerns about the measure would be, you know, the age groups. And I know there are other measures that look at, you know, in the series that we'll be talking about with other age groups and really being able to specifically define what is the right time to do this and, you know, is there really a need for multiple measures or is there a way to do it with one measure and but then have age stratifications where you look at where it makes the most sense.

But otherwise, you know, I really feel the opportunities for improvement here. I think that anybody involved in, you know, child health quality realizes that this is an area that tends to get overlooked a lot. You know, just because it's not ingrained into typical medical practice but, you know, there are some

opportunities for education, you know, no matter where you are in the system. You know, there also seemed to be variation between though not all of testing sites were able to provide breakdowns and disparities, there does seem to be evidence behind the disparities in dental care overall and then in sealants and certainly there's room for improvement across board in this area.

Adeela Kahn: Thanks, Sarah. David, do you want to add anything?

David Krol: Not a lot. Just going through all of my different sections, the things that I can add and not repeat was that – it's important to note that this is focused on a specific age group – the measure is focused on a specific age group with a specific risk status focused on a specific tooth.

The evidence that supporting the measure, the ADA guideline doesn't give, Elisa, I couldn't find a specific age or a specific molar but does says that – it does say that sealants should be placed on pits and fissures of children than adolescents' permanent teeth when it's determined that the tooth or the patient is at risk for developing caries.

So that's just a slight twist on what was already provided. I don't have anything to necessarily add to performance gaps, there are definitely performance gaps there, it's definitely high priority.

Some questions that I had in the specifications area around – again, because it's a specific tooth and not knowing well enough what the array of CDT codes stand for as far as an accurate definition of what elevated risk is. It's hard for me to determine if those truly are those CDT codes are adequate evidence for elevated risk.

It's also not clear to me how a child with one of four of these permanent molar teeth sealed is of how you determine whether the quality versus someone who has 404, 204 or 104 because all of those would satisfy the measure. So not – I have a little challenge there.

Also, the question of whether is it the child that's at elevated risk or the tooth that's at elevated risk but not necessarily the child and I asked that only

because one of the evidence sources, the Bosham, gives either as the determination of risk if I understand it correctly.

And the only other question I had was about some of the taxonomy and I'm sorry if I'm going to too much detail on this. But some of the logic regarding the rendering provider taxonomy code and it's not clear to me. It says that any of those listed in the table can be included in the denominator but there's one code that's listed that says, it sounds like if it's done by dental hygienist doesn't qualify but has the notations – would qualify but has a notation that says it's not applicable for this measure. So I'm not quite – it doesn't really quite make sense to me.

Let's see if there's anything else I have. Not necessary a reliability testing but validity testing not an issue there, its administrative data. I don't think that's a problem.

Again, the question of what's the difference between moderate and high risk and is it the number of CDT codes that they have, that determines – is it an issue of low risk versus moderate of higher or no risk versus moderate or high. It's a little bit challenging in implying CDT code to determine risk.

Let's see, I think that was probably it. The feasibility was fine. It looks like there's some usability right now in Texas although there's not yet clear evidence that it's being shown to improve care or quality but it's probably just too early to be implemented.

So that's about – that's all I have. Thanks.

Adeela Kahn: Thank you very much. Is there any other committee members wants to add any comment?

Ronald Inge: This is Ron Inge. So I'd like to comment on a couple of things if I can remember them. David went through quite a bit.

The age range has to do with the typical eruption pattern of the first molars. I agree with David in that. It should not be – or it should at least be stratified by the number of first molars and not just be qualified by one.

The purpose is to identify patients at risk. Risk is defined by the ADA guidelines in regards to risk which has to do with both socioeconomic as well as the presence of caries, cavities beforehand or potential lesions, also a family history.

So there are risk factors that the healthcare provider, the dentist, would be taking into account to determine risk. Moderate risk and high risk should be treated the same because the same protocol is relevant for each one of those. So in that regard, that would work very good in that instance.

In regards to using claims data. You substitute the incidents of decay. So a restoration or a filling that's been done on the child previously for an incipient lesion. And again, you can capture a concept of risk, high or low risk. I think that no risk does not exist. There is always a risk of caries just simply because of the oral cavity and it's whether or not there are more or multiple risk factors in place that will move it from low to high or moderate.

Let's see. What else did he touch on? That's as much as I can remember right now.

Elisa Munthali: Thank you.

Robert Valdez: This is Rob Valdez. I also had – and this goes across the number of measures actually but these are issues that were raised for me that was identifying elevated risk whether it's moderate or high or any using service codes. I mean, there are CDT codes that are evaluations of those issues which are included in the logic here. But then adding the service codes is somewhat strange.

The other thing that struck me was also the exclusion of service providers who were in fact doing sealants and it doesn't at all seem to make any sense to include who the provider is if the service is in fact provided. And in fact that it – for Medicaid, it limits the kind of programs they can begin to define and design that exists in some parts whether particularly a girl in frontier country.

David Krol: I agree. That was the point I missed.

Michael Stoto: This is Mike Stoto. Like Bob, these issues are going to run across all of these different measures that we're talking about today.

Robert Valdez: Right.

Michael Stoto: It's clear that this group had the marching orders to only work with billing data. And, you know, there's just so much that you can do with that.

I agree with the left point Bob said and about the problems with particular providers. But I guess I wonder does anybody – and I don't know enough about the substance to know whether or not the risk measures are at least reasonable. I mean, they clearly not going to be perfect if they're going to be working with these billing data. But they provide a reasonable way of getting something close to a proxy for risk.

Adeela Kahn: Thanks everyone. If no one has anything to say, I'd like to turn it over to the developers.

Robert Valdez: Well, I do have one other thing to say. This is Robert Valdez. The initial exclusion of children by issues that can't be determined by these kinds of data that have to do with how Medicaid programs are structured in CHIP programs are structured in states, and states and territories have the option of covering children who aren't normally covered by federal activities through state initiatives. So some of the exclusions that are identified about whether or not children immigration is one thing or another has no place in this.

The question is only, are they covered for dental services or not?

Krishna Aravamudhan: Can I speak, Adeela?

Adeela Kahn: Yes, please.

Krishna Aravamudhan: Thank you. Thank you all for your time. This is Krishna from the Dental Quality Alliance. I probably lead out the comments and ask my friends here Dr. Krol and Jill Herndon to speak to certain elements that I'm not able to address.

In terms of the age and tooth, the guidelines like Dr. Krol noted is that it is the patient or the tooth at risk and the guidance as the sealants and as the toot erupts.

Six to nine as Dr. Inge noted is the tooth eruption timeline for the permanent molars. We have – there is a lot of data out there in terms of how resources can best be impacted and where you get the most of. In fact, in terms of better outcomes, lower cost et cetera and what time the sealants are placed. And so the age six to nine is attached to that tooth eruption pattern. And that's why this measure is written the way it is.

In terms of the risk, I think one of you noted that there are CDT codes and then the question also was, why do we have those additional codes? As you look at the measure logic, it as an 'or' clause, meaning if you have the CDT codes that are coming being reported from the providers and you can use that. If you don't have the CDT codes then you can go ahead and look for past history. Past history of caries is the best or the most important, most valid predictor for future caries risk. So, all the other codes that you see are markers for caries – treated caries from the past.

These risk codes are relatively new. They've been in the system for about two years now. So there are places that providers may not still be using it. So to allow those systems, the mechanism to still apply this measure, we have a couple of different ways that that risk can be captured.

The risk is not captured at the tooth level. The risk is captured at the patient level.

Sarah Sampsel: Can I interrupt right there? This is Sarah Sampsel. Just for a question on that.

Krishna Aravamudhan: Sure.

Sarah Sampsel: So, you know, I will admit I'm more used to health plan medical data. But what – do you know the typical length of past history that reporters of this measure would have on children because, you know, if we're using that type of data to look for past history and that helps predict risk then my immediate question is how much data is typically available?

Krishna Aravamudhan: So the way the logic is specified is a look back period of the enrollment continuities and for enrollment is required only for the reporting period. And then if you have look back for about three years then you can look whether the child was in the system and whether the child received any treatment.

The three-year time span is again based on evidence and all the risk assessment tools also use that same time span in terms of even asking the provider to see well in the past three years that this child gets treated for caries so you would bump them up in terms of the risk status.

So that's the sort of data we're looking for in terms of classifying risk. Now, we also want to make the point that the intent of the measure is not to be sort of shoot for that perfect place where you're able to identify all the children at risk and see if they get sealant. We're still seeing a performance gap even for those kids that can be identified at risk to claims data.

It would be a wonderful world if we are at this place where all the kids that we can identify through claims data got the necessary prevention. Then we can ask ourselves the question, "OK, what about the others whom we're not able to capture through claims data but still might be at risk." But we aren't even there yet.

And so the intent of this measure if those who are identifiable can we at least push them because they are the core group. Most at risk, can we move them into this prevention around?

Michael Stoto: So this is Mike Stoto. To me, that raises the question about comparability across the different plans to the extent that they have different amounts of data that they've retained and different ways of recording this in the past and so on. Do you have any information of that?

Krishna Aravamudhan: Is Dr. Krol on there? Jim Krol? He could have addressed this more effectively but I will do my best here. And Jill, please step in on this one as well.

But when we did the comparisons and we did both commercial sector as well as the Medicaid programs and plans. The message that is used, it's pretty consistent even across the commercial sector and many commercial plans actually use this measure as well. And the Medicaid sector in terms of having the data over the past three years to get the denominator population. The rates are comparable.

Jill, do you want to add anything to that?

Ronald Inge: Actually, this is Dr. Inge. Can I add?

Krishna Aravamudhan: Sure.

Ronald Inge: So in a commercial environment. We utilize data between three and five years. We have a population that's been fairly stable of over half a million children within our database and that's what we use to establish this measure in our own company, so in a commercial environment.

So much of the work was done initially in a commercial environment where there has been continues coverage so that you can track the delivery of the sealants overtime and also then track whether or not there are future restorations. So that's where most of the measure was developed at.

Krishna Aravamudhan: And overtime, we do hope that the CDT codes that are there for risk will catch up to a point where we can remove the second part of the logic that actually requires the look back period.

So that's why we have the 'or' clause in terms of use of CDT risk codes and if they are not there then go ahead and use the past history of it (more).

The other questions that had come up that I can then go on and address. If anyone else had any questions on this risk and then I can address the oral health providers.

OK. In terms of the oral health providers, all of these measures when we first have looked at the DQA have much more expanded specifications in terms of the same concept applied to dental providers, the same concept applied to oral

health providers and then dental oral health providers. Those specifications for all three relations are available at the DQA website because of time constraints and what we could submit and the need to follow NQF processes. We only chose to submit the dental services for endorsement.

Having said that, the reason why we parse out between these provider types is the finance existent can be vastly different between states. And in order to be able to compare across states then you would need to sort of look at that, some states use the medical money to finance some of the sealants that are placed by – fluoride that is placed by pediatricians and so on some of the services provided.

The definition for dental versus oral health tends from the CMS definition that is in the books for decades now and that is how CMS classifies all these metrics they use and therefore succeed in form.

So there's a separate line item in the (for 16 form) for dental services, a separate line item for oral health services and these definitions the providers types of this on CMS's requirements.

Robert Valdez: But isn't web matters of whether or not the kids got the service?

Male: Right.

Krishna Aravamudhan: So that is very true. Ultimately, everything has to be patient centered and whether the patient got the service, but these measures or performance measures for the plans and the programs.

So we are taking the same concepts and building e-measures out of them which will mind data from the electronic health record. And in that case, this distinction really doesn't matter. It really matters that the patient get it and do we have data of the electronic health record that the patient receive the service.

So the e-measure recreations go away from all these definition but for the programmatic measures because the nature of the financing system is the way it is, we had to parse it out.

Robert Valdez: I would challenge that because there are – it's more important that the child receive the services, not who provided it because there are several states around the country where a hygienist practice independently. And so they will be able to provide those services and it will be build under the hygienist tax ID number or whatever their MPI is. So I would really lobby to include services provided by any healthcare provider.

Krishna Aravamudhan: We did look into that. Colorado is one state that allows independent hygiene practice. No other state at least as much as I know.

The other data that is emerging right now …

Robert Valdez: Alaska and Minnesota.

Michael Stoto: Washington also.

Krishna Aravamudhan: OK. That's why I wanted Dr. Krol on this question but I am personally also aware of other outcomes data that is coming in terms of, you know, retention of sealants and based on different provider types as we are looking more into outcome measures. This is something that is also sort of data when this is coming through.

So that is something that, you know, if Dr. Krol is able to join, he can address a little bit more. But this is as much – these were the discussions on our end when we started parsing it out between different systems.

Michael Stoto: It's like, you know, the issue was not of whether or not they can practice independently. The issue like we were all saying whether or not the kids get the service.

Ronald Inge: Right.

Michael Stoto: That's what the measure needs to be with them but …

Krishna Aravamudhan: But if you have a Medicaid program which has, you know, separate medical dental financing and I guess with the independent practicing

hygienic it'll still come out from the dental money. So on that end, we should be OK.

Jill Herndon: Can I say something? This is Jill.

Adeela Kahn: Sorry. Sorry. Can I just say something really quickly? This is Adeela. I think James Krol is actually on the Webinar. Amy, has he called in?

Amy Minnich: No ma'am, not yet.

Adeela Kahn: OK. All right. Well, he is on the Webinar so I guess that doesn't make a difference. So you guys can continue.

Krishna Aravamudhan: Jill wanted to say something.

Robert Valdez: Having to run programs, it really didn't matter if the provider was because the financing ultimately comes out of the same pot, comes out of the programmatic pot. And it may come out of different pockets but it all comes out of the same Medicaid programmers as CHIP program.

Jill Herndon: Hi. This is Jill. So one of the things that we found was a number that the Medicaid programs and CHIP programs that we've worked about this that they like to understand that utilization that's coming from the dental services side and then from some of these other sides like physicians providing oral health services fluoride varnish and so forth.

And I think that that was part of the motivation to apply CMS had actually specified these separately as well as having a combined measure which is also the DQA had done with having a dental and oral and a combine dental oral which are all available but they were not all submitted for endorsement because that would have tripled the number of applications and it just wasn't feasible.

But we do see that there is an interest in kind of understanding not only the collective but the vehicles through which these services are getting provided and impacts of these some other provider types.

And then there's also …

Ronald Inge: This measure won't do it (Jill), as you've provided taxonomy basically collapses everybody together who falls within your taxonomy. So you can't even tell who among the taxonomy that you provide is providing this service.

David Krol: And isn't this ultimately, you know, a measure intended for Medicaid as opposed to the providers?

Jim Krol: This is Jim Krol. I'm sorry I was late dialing in. I was listening to the whole conversation. I agree with Jill.

Our intent here is really just to understand the various ways that this procedure actually can be provided and lumping at it altogether in one sense does give you an aggregate measure of the number of children that are actually receiving the services. But it certainly at the program level and perhaps depending on how benefits are structured at a plan level would not in the lump to aggregate mechanism allowed for assessing the performance of different providers groups or perhaps even covered under this type of benefit plans.

So we're – again, our DQA measure includes the gamut of providers that segments them according to the CMS taxonomy of dental providers and all health providers and, you know, if we are, you know, fully behind capturing the information from all the streams. But as Krishna indicated in the time and resources allotted to submit measures, to NQF, this is the first measure we picked and that relates to sealants.

Michael Stoto: But, you know, there's really a fundamental question here that I think we need to address and that is whose performance are we trying to assess when we use this measure? I mean, is it the individual providers that might have responsibility for these kids or is it the whole Medicaid system in state or something in between?

Jim Krol: Krishna can jump on this but up to this point, our focus is on the entire Medicaid system or, you know, the commercial sector or a CHIP plan, you know, regardless of how it segment it out. And then the plans with whom

programs like contract. We fully see the value of using this measure at a provider level, in a quality improvement level but so far our testing is based on program level using the data from the two states and with whom those states (contract).

Michael Stoto: So if that's the case, if the goal is to assess of how Medicaid as a whole is doing in a state, it really doesn't matter which provider provides the services.

Jim Krol: Well, I mean I guess we'll discuss this but the point is that made me aware that Jill tried to make earlier that if you already interested if the needle go up, you know, the measure gives you a basic measure of that but if you are interested in line with a toolkit that just was put out by Mathematica under a contract with CMS in helping states understand to look beyond the aggregate measure and to try to determine where opportunities for performance lie. We believe that the measure – this measure with the complementary measure, the oral health service provider measure that would be a complementary measure but again because of resources and time that takes to submit measures to the NQF process, we only have this piece now. But clearly, our DQA measure supports the use of both and we believe it provides a better level of understanding for actual programmatic improvement.

Adeela Kahn: Is there isn't any more discussion then I actually like to move on to the next measure which is 2509 Prevention Dental Sealants for 10 to 14 Year-Old Children at Elevated Caries Risk. And again, the lead discussants for this are Mike Stoto and Ron Inge.

Michael Stoto: So this is Mike and I think that we can repeat exactly the same discussion we just had with nearly difference between 08 and 09 is the age and the tooth that it's involved. And …

Ronald Inge: I agree completely -- it's the same discussion. I think we should continue that. The biggest challenge is not including providers – so to me the real question is, "What is this measure trying to capture?" So if it's in a programmatic level for the patient. So we're looking at a quality improvement for the patient then it's more about whether the sealant is placed. If we want to look at a measure

that's going to stratify or measure the performance of the healthcare provider, I don't think this measure gets to that.

Krishna Aravamudhan: This is Krishna. I don't want to reiterate. These measures that were submitted to NQF are for measuring the performance of the program or the plan. Ultimately, the goal is to improve the health of the patient. So I get that. So we need to keep that in mind that it is our programmatic measures that e-measures, provider level measures are – will be it depends. But given that, the argument about …

Ronald Inge: Given that? What that means is that these don't work for that purpose if they only deal with one provider. It's like …

Jim Krol: It is obviously a misunderstatement because Krishna just stated the purpose of the measures and then I heard the comment that they don't work at the level of the provider. We're not submitting them.

Michael Stoto: I'm sorry -- they don't work at the level of the plan. From the plan's point of view, from Medicaid's point of view and the state, the question is whether the kids got the service, not who did it.

Jim Krol: Well, again at one level at the aggregate level so what the measure would give you but if you want to understand the original differences or you have differences from one plan to the next, some of the factors that might lead to opportunities for improvement, gaps in performance whatever you want to call them only having the aggregate measure and argue that will provide as much information as having a measure that actually does the segmentation because of the way that the markets are currently structured and at the way that the services in the program you're currently structuring and operate.

Krishna Aravamudhan: And just to kind of also reiterate that again as part of our measure set we do have the measure that is dental or oral health services which means is not going to parse it out by either way you can just stratify by provider type if needed. And we could simply substitute that iteration of the measure for endorsement but we take this one for our application form.

Elisa Munthali: And this is Elisa from NQF and we just wanted to remind the committee, you know, Krishna and your colleague. Thank you so much for being on the call and the committee as well. We just wanted to remind the committee to evaluate the measure as it's currently specified, the developers, the ADA, the AQA that said to NQF that this is specified as a health plan level. These discussions are very important.

I think for the in-person meeting, if there's anything that you'd like Krishna and the group to clarify. This is the good time to do it before we meet in just a few weeks. But we did want to just emphasize that as they came into us at NQF, they were specified at the health plan Medicare health plan.

Male: Next.

Adeela Kahn: Are there any more comments from any of the committee members?

Robert Valdez: This is Robert Valdez. It's just the same comment about the exclusion criteria as written that relates to people's immigration status that has nothing to do with this measure at all.

The real issue again is whether or not the trial is covered for dental services or not and different programs handle that issue in different ways.

Adeela Kahn: Thank you. I guess hearing no more discussion we can go on to the next measure 2517, The Oral Health Evaluation Dental Services. The lead discussants for this are Robert Valdez and Chisara Asomugha …

Robert Valdez: 2511 (DME).

Chisara Asomugha: 11 or 17?

Adeela Kahn: 2511, I'm sorry.

Male: OK.

Adeela Kahn: So, Utilization of Services and Dental Services.

Robert Valdez: Right, Utilization of Services. Again, it's the same groups, the same data, same plan. This particular measure attempts to look at the use of any services, at least one dental service for them the reporting year for anyone under the age of 21. And in fact, this measure is kind of the basis of any kind of health services research you might want to do in any kind of quality.

Male: Right.

Robert Valdez: Work that you might want to do in any world as my former teacher and mentor (inaudible) used to point out that you got to at least start by knowing whether you have access to the service or not.

The evidence for developing the measure is clear. The lack of a measure to begin either access or quality that does not work, it's extraordinarily important in this area and has been at lot for some time.

This measure, however, established some of the similar issues which is denominator exclusion that's based on the individuals characteristics rather than whether or not people are in the plan or not, whether they're coverage or not. The measure clearly demonstrates performance gaps in at this so the liability of that measure to look at these kinds of things across Florida, the commercial and (kept) these plans.

Again, we see the definition of whether or not any services provided exclude some providers and improve some providers which really had no place at some of programmatic level, if you want to know whether or not a service is provided or not to a child or a system that maybe the age of (21).

Other than that it meets all our reliability check both of the – there's the (week) scientific evidence for that's describe but there's a high concordance and recommended – from the guidelines and certainly among the logic of doing in a kind of services research or quality improvement work. (Inaudible).

Adeela Kahn: Thank you. Chisara, did you have anything to add?

Chisara Asomugha: Yes. I agree with, you know, just from a baseline or a starting point for any heath services research project. This was the beginning. I'm just – I guess I'm a little concern to the bullet points that any dental service versus a specific type of service then I guess in my mind I was thinking for young kids. You'd want something that speaks to prevention and making sure that the kids who are getting dental services are actually getting some sort of call it screening or some initial assessment as oppose to whatever other – like may it's an orthodontic service that they got. And I assume if you're getting that, you also should have had some sort of initial assessment. But anyway, that was one of the things that came up in my mind as I was reviewing this.

The second was around continuous enrollment. The period is 180 days and I know that this is typically standard for most measures like this.

But I just wonder about those individuals who might have only had the coverage for a shorter period of time. But we're still able to see or obtain some sort of dental service whether that's a significant number or not, I can't tell you. But it's just something that came to mind as I was thinking about this.

The last – I'm just sweeping through my pages here.

I think the last part was a link between access and data and as soon as I find my notes, I'll let you guys know but that's pretty much it.

Adeela Kahn: Thank you. Are there any other committee members?

Michael Stoto: This is Mike Stoto. I agree with everything that's been said but I'd like to add and maybe extend one thing. It's not clear to me that this is really a good measure of utilization for two reasons.

One is that nothing in here about whether or not these services were necessary.

Chisara Asomugha: But, that's getting – exactly.

Michael Stoto: Right. And secondly, it may will be that the kids needed the services because of a failure or prevention earlier that goes in the wrong direction. So, I'm troubled about those things.

Chisara Asomugha: Yes. I agree, thank you.

Adeela Kahn: OK. If there is no one else from the committee who'd like to make a comment, I'll turn it over to the developers.

Krishna Aravamudhan: Thank. I will start first again and then I'll ask my friends to comment here.

Again, as someone said before this is sort of the basic, you know, measure for health services research. We had a big discussion and in terms of whether this was truly indicative of quality. It should be classified as a process measure or not.

Our initial work through the DQA have been to follow the National Quality Measure Steering House stratification, classification of domains of care and this would be a use of service as measure, not a process measure based on their definitions. We classified it as process because that's how it fits into the NQF definition and also went back, you know, (inaudible) obedient folks to figure out how things work.

So, my health systems perspective, that's what this is, very, very basic and we believe in using measure sets, we believe that for quality improvement you need more than just a number, and hence our focus has been to look at these as sets, look at this in a much more comprehensive way.

Again, because we have to submit, you know, one performance measure to you, this is what we submit. This is also a very close to the HEDIS Annual Dental Visit that is NQF endorse.

In terms of the enrollment period of 180 days, again, keeping in the same with what we think a Medicaid program should do is look at data in different ways to understand what is going on and to interrupt the data into knowledge. So, we do have the 90-day, as well as the 180-day.

It takes time for a child, a parent to get enrolled, get the card, go to the dentist, set up an appointment and so on. So, while we want the system to move in the direction of get the service as soon as possible. You don't know whether the service is needed. You don't know how often it is. So, there were a lot of factors that went to develop then the 180-day requirement and you still see disparities, you still see performance gap with that.

So, let me stop there. If anyone else on my team wants to comment?

Jim Krol: A quick and I'll just address the comment or the question about enrollment duration as well. You know, we had – we tested various enrollment periods during our testing process of the measures. We do know from some previous work, as well as our testing.

Krishna mentioned the HEDIS Annual Dental Visit measure which basically requires continuous enrollment for 11 out of 12 months.

So, and we know that in other states where we've tested the – that data and it's actually published in the peer reviewed literature that that will exclude up towards to a 45 percent or so of children from the analysis. The history of all of measures like this the original (inaudible) 16 measure actually included identified subset of services, some diagnostics unpreventive.

The CMS later moved around the year 2002 to annual dental visit measure and not annual dental visit measure but utilization of services measure complemented by the percent of children or number of children getting preventive services and the number of children who got something beyond a diagnostic or preventive service. And so, that was done back in 2000 and they at that time it was enrollment period of even for one month, it would be accounted in the denominator.

CMS has subsequently increased that enrollment period in the last, I believe 2010, starting with the 2010 reporting. But we looked again at multiple enrollment periods and looked at and try to include as many children as possible but also still allowing for a period after enrollment where an individual would become aware that they had the benefits and then be able to

contact the provider and actually receive a service. So, that's the rationale for our 180 days but 90-day period is the current approach use by CMS.

Krishna Aravamudhan: I do want to also address the exclusions concern. The intent for exclusions definitely was to only exclude those without dental benefit.

I understand, you know, where it might cause some confusions so we would be happy to provide the language if we were given the opportunity to do so. We're also checking into the HEDIS Annual Dental visit measure as it stands to the original specifications only as for dentist which is even more narrower than what our measures seek to do but we're seeing what the latest guidance is on that and others.

Another measure fluoride varnish that was again endorsed by NQF that only looks at oral health or primary care providers providing the service. So this thing about looking at different providers and the way the financing system structured is pervasive, you know, all kind of quality measures that's going on in dentistry.

Adeela Kahn: If there are no more comments, we can go on to the next measure. 2517 Oral Evaluation Dental Services and the lead discussants are Renee Fraizer and Ron Inge. Renee, are you on the line? OK. Ron, let's turn it over to you.

Ronald Inge: This is a process measure and I think it's a fundamental in regards to access. So from a programmatic level, you do want to see whether or not you have access and what percentage. I was looking for its – in references, comprehensive and periodic exams but it's for children zero through 20.

So that leaves out the oral evaluation or I'm not sure if it was being thought off. The oral evaluation for children under three is different from the definition that's given for a comprehensive or a periodic. So I would ask the developers if that was included but just not called out specifically.

Krishna Aravamudhan: Sorry. Can I answer that Adeela?

Ronald Inge: Sure.

Krishna Aravamudhan: Sorry.

Adeela Kahn: Go ahead.

Krishna Aravamudhan: I didn't know what I was thinking of. It's his turn. I'm sorry. But yes, it's comprehensive or periodic and also for the youngest children would be zero, one, four, five is included.

Ronald Inge: OK. That was my only concern there. So from a process measure, you know, I think this is a very standard approach at a programmatic level. It would identify the efforts that are being provided by a plan to observe access by the population being served. That was my only concern about it was to make sure that everything from an oral evaluation was covered for the children in question.

Adeela Kahn: It is. Krishna, you can go ahead and …

Krishna Aravamudhan: Yes it is. It is. Everything in terms of a comprehensive or periodic oral evaluation, all the three codes that are there in the CDT book is covered.

Ronald Inge: OK.

Adeela Kahn: Great. Are there any other comments from the committee members?

All right, well that was a quick one. Let's go on to the next one 2518 Care Continuity and Dental Services. The lead discussants for this measure are Mike Stoto and David Krol.

Michael Stoto: So this is Mike. What this measure is to find out basically the previous measure two years in a row. And so although I like the previous measure, I don't like this one very well at all because it really doesn't get at the concept of continuity.

It doesn't say whether or not the kids have had the same services, I mean, services provided by the same provider or the same office or anything like that. And it really doesn't have to say anything about other dental services that the kids received whether they got that from the same ones either.

So, you know, they refer to the phase validity of work done by the – using the (range) UCLA (inaudible) a process but it doesn't seemed, at least I can't find that there's events that this particular one was considered as a measure of phase validity and should be a care continuity.

Krishna Aravamudhan: Can I respond?

Adeela Kahn: Yes, Krishna. Please respond.

Krishna Aravamudhan: Thank you. So again, with the DQM measure set, we have two different measures. One is care continuity which is as you said evaluation over two years. We have another measure called the usual source of services which gets to what you're talking about whether they went to the same provider.

What we get got stuck with that measure is unlike medicine whether there is a lot of evidence to support the fact that visiting the same provider actually improve health outcomes, there is zero literature in dentistry to that effect. So we would not have been able to complete the forms of NQF passage to support that measure.

The second thing if our commercial partners and we are looking at broad-based measures thinking about the patient. And so our commercial partners would argue that it is not necessary for the patient to go back to the same clinic or such into improve health outcomes.

So there was a lot of conversation. We do have to measures, but this measure is only looking at the continuity aspect of versus the usual source of services, we still have that measure but haven't submitted to NQF because the concern would have been the lack of evidence.

Michael Stoto: Well, we have to evaluate the one that before us and my …

Krishna Aravamudhan: Yes. And to change this – the reason why this does not include that same source of service component is because that's not evidence based.

Michael Stoto: OK. Is there any evidence that will having two oral evaluations two years in a row actually represents continuity of care?

Krishna Aravamudhan: There are nice guidelines in terms of how the child needs to come, you know, half of – well visit if you will in dentistry to have better outcomes. So that is available in terms of a guideline recommendation.

We could have gone beyond two years but it's really to attract ear over-ear and if you tract the measure overtime, then the kids enroll in your plan and really getting the service you need.

Michael Stoto: Well, I guess my understanding is that there are – that there are guidelines, you know, that they are cited in 2517 that relate to routine oral exams and that certainly seems very plausible to me as being important and we've just discuss that one.

But I'm wondering, you know, what evidence is there that this is current one basically getting those services two years in a row is an important thing to measure. It doesn't relate to continuative care or what does it relate to and what's the evidence that this is of importance on this one.

Krishna Aravamudhan: Dr. Krol, do you want to add anything?

Jim Krol: Well, the only thing I would add is that whereas, you know, let's say the general guidelines will help supervision for children, you know, do include actually developmental sort of milestones incorporated in to the timing of those visits.

The guidelines that at least at present that are basically endorsed by the American Academy of Pediatric Dentistry the AAPD and some others to speak to establishing a dental home or having a child assessed ideally by one year of age and at particular they are identified high risk. And then a periodicity services that in the current AAPD guidelines say every six months or – I would modify it based upon the child's risk and they don't know the specific sort of mantle or, you know, specifying a hard periodicity between those visits.

So the continuity piece, you know, as Krishna explained, we look to differentiate from the usual source of care but didn't – weren't able to get that guideline submitted. And so we have just the continuity measure as – and to try to differentiate situations where children might have an evaluation but then the care is – it's an episodic form of care as opposed to what is the sort of routine within a dental home where a child is being seen on regular, some sort of regularity of basis although, you know, it might – the number of whether it take every six months, every 12 months, et cetera, might vary but than a two year period is generally a wide range of the recommendations for the period in which the child would be seen for periodic examinations.

Ronald Inge: Would it be more effective if you also connected preventive services within that time period? Because if you look at the previous measures so they would have had an evaluation so the continuity of care would be from that evaluation, something would have been determined in regards to their risk status or their need for services.

And if you're looking at a continuum of care, you would expect that if there is a subsequent visit that there should be some preventive services being offered.

Krishna Aravamudhan: The argument that we would have gotten against that Ron, especially from the commercial sector would have been that the prevention, the evidence base if you kind of tie yourself to the concept of evidence-based industry if prevention is tied to risk while every child needs to get that evaluation, not every child needs to get the prevention. We would have gotten the arguments to that end.

Jim Krol: Yes. I don't what the arguments might have been but we do have the topic of fluoride measure which, you know, is meant to get at. I think what you're suggesting here but again as with all of our measures, you know, consistent with the current approach, you know, taken by the CMS, you see an array of measures that each individual measure tells you something but when you look at aggregations or I don't know of composites is the right technical but if you look at multiple measures, you get a better sense that of – or meetings to assess the performance of a program, oral plans.

So all of these measures are not the be all end all measures. They're meant to individually to assess one aspect of performance and intellectually to allow for assessment in a more robust way.

Krishna Aravamudhan: And the problem that we were stuck with is the need to use administrative claims data and the lack of any diagnostic coding in the system and so that's why we have to rely on process measures right now.

And again, the thinking was when you're looking at process measures, that becomes even more important than looking at the other measures that of different aspects coming together to paint a larger picture to get at, you know, whether you're really moving the outcomes needle, because we're coming back to if the guideline says you will improve outcomes, so let's try doing this so we hope the outcome improved. We cannot measure that outcome yet because of the lack of the data source.

Adeela Kahn: Are there any more comments from the committee members.

David Krol: Just – this is (David). Just to get my second opinion of what was presented from the second reviewer. The only thing that I'll add is and it's interesting, I apologize I didn't go into reading in as much detailed of 3517 as I did – I'm sorry 2517 as I did 2518.

But one of the things that sticks out is that there's – and one of the things that we're asked to review as far as quality is the evidence that the process contributes to a health outcome. And in this one at least there's not – there's limited evidence that's provided to show that the process – what the processes contribution is to the health outcome and then the AAPD guideline states, "That early detection and management in oral conditions can improve a child's oral health."

And perhaps I'm reading too much into the word, "can" but it doesn't say, "does" and that maybe purposeful based on the quality of evidence that supports the process to the outcome. And we see that in the UK nice review, there are grades of the evidence, the AAPD review doesn't provide that but

they provide a grade of D or GPP for the evidence time to process to the outcome at least that's how I understand it.

There's no – as far as I can tell, there's no grading of the quality or definition of the grading of the quoted evidence provided in either of the systematic review. The UK review does state that there's a lack of high quality evidence across studies, although they do point out and it is important to point out that it may not reflect the importance in professional agreement that exist around at least the to you or the intervals for recall visits.

So and in the more recent systematic review that was done by Cochrane, they point out that that include only RCTs and that's important to point out. That they'd only concluded one study and it was very low quality.

So it's important to point out although it may not necessary change the way we approach this measure that the evidence that ties the process, the dental visit to a health outcome is pretty lacking although that may not reflect the importance of a dental visit nonetheless.

Adeela Kahn: Krishna, do you want to response?

Krishna Aravamudhan: No. Thank you.

Adeela Kahn: OK. If there are no more comments from the committee members, we can finish up early and just do a mass measure, it's 2528 Prevention:

Topical Fluoride for Children at elevated Caries Risk, Dental Services and lead discussants for this measure are Sarah Sampsel and Rob Valdez.

Sarah Sampsel: OK. So I guess if it doesn't matter who is first, you know, I think this is another example of a measure that's fairly similar to the first couple that we spoke about the difference in this measure would be at the wider age group of looking at all children that seems to be conceivably enrolled in a Medicaid or CHIP plan.

I'd be concerned about the higher age range in the commercial population and that definition, but I don't think that's, you know, important consideration at this moment.

But basically this is looking at different from the sealants, it's looking for fluoride application and often seems to be an area where, you know, those guidelines are important for the fluoride application and, you know, this is not only of the general guidelines but also the Cochrane review supported this as well.

You know, I think the measure has the same issues in the specifications especially the coding for high and moderate risk as previous measures that we've discussed but it is the broader based measure and seems to lead to, you know, a process of care that would improve outcomes i.e. the fluoride treatment.

You know, it seems like the testing implications are very similar in the room for improvement, it's also similar and that they're definitely are gaps here and, you know, it seems to tie together some of the issues of going beyond just looking for a visit or continuity of care but actually that something happens if those visits occur that are in line with guidelines.

Robert Valdez: OK, Sarah. I guess you're handing it over to me.

Sarah Sampsel: Sorry.

Robert Valdez: All right. I have the – as would all of the previous ones, I have problems with the inclusion criteria that are focused on individuals characteristics rather than whether they're covered or not. And I also continue to have some difficulty with identifying elevated risk whether alliance on services delivered even though there are diagnostic codes that have been identified in this effort.

The exclusion of providers again makes no sense but this is actually a programmatic level specimens. And last week the testing and certainly works across programs and it's been identified here but the evidence of validity is fairly weak even though we have decades of the use of fluoride and water supply one with the NQF that the extension would make sense. And certainly, you know, there's great professional agreements after that in fact that the use of this kind of regular treatment is important. But it is my reading in this application is that the evidence is fairly weak at this point.

Adeela Kahn: Are there any other committee members who like to add anything?

(Tom McEnery): Hi, this is (Tom). There's another complicating factor for this measure and that sometimes pediatricians and maybe I don't know family physicians will provide topical fluoride in their offices. And so you may – if you're just looking at the dental side of things, you may miss children who have had topical fluoride applied because they were done in a physician's office.

Krishna Aravamudhan: Can I respond, Adeela?

Adeela Kahn: Yes.

Krishna Aravamudhan: OK. So again back in the providers. I think all the arguments, I mean we put in front of you are the same. This particular measure in terms of the physician's offices, there is currently NQF endorsed measure that talks about the same thing in physicians' offices.

So this is sort of a sister measure, the complementary measure to that. I don't know whether these issues about provider types were raised when those measures where endorsed but were sort of just following the system here with that. So there will be measures for both the financing systems.

So there's a comment on the age that I do want to clarify. The age does remain the same across commercial versus (Medicaid/SHIP). The distinction we have drawn in all the measures, if (Medicaid/SHIP) should use 21 and the exchanges when the marketplaces plans uses for marketplace reporting potentially they should do with under 19 and it is only because that's how the regs are of whatever the child is defined as, that that would apply.

Are the exclusion coming again? We can certainly change the language to reflect the intent which was to exclude any child who doesn't have a dental benefit.

I do want to also go ahead and point out that there are significant differences between medicine and dentistry. Apart from the data limitations that we have

diagnostic coding and such Medicaid, Medicare does not cover dentistry at all, very, very small oral surgery component.

Medicaid covers dental benefits, varies across dates in terms of what's covered as well as it makes up only ten percent of the market, 40 percent of the market is a commercial factor and then the 30 percent is out of pocket.

So vastly different financing systems between medicine and dentistry certainly measure quality and target, you know, the measures for specific systems, I think we need to be aware of that as well.

Adeela Kahn: Thanks, (Krishna). Were there any last comments from the committee members? OK. I'm hearing none. I'd like to open up the call for NQF public and member comment, so (Amy)?

Operator: At this time, if you would like to ask a question, please press star one on your telephone keypad, we'll pause for just a moment to compile the Q&A roster.

We have no public comments or questions at this time.

Adeela Kahn: OK. Anyone on the committee want to make a public comment? OK. So our next step will be our in-person meeting, it's scheduled for April 29th and 30th. You should have all received some travel information – the committee member should have all received a travel e-mail with all the logistics on how to book flights in hotel. If you haven't gotten that, then please e-mail me and we'll get back to you as soon as possible.

We're going to be compiling today's discussion and a meeting summary and we'll have the meeting summaries available to in about two weeks. We're going to try and give them to in advance of the meeting so that it will have all of the workgroup discussions just as a primer for you if, you know, want a quick overview of how the workgroup discussions have gone.

I'd like to thank the committee members and the developers for their time and for a really productive discussion. Today is our actually last day of public and member comment on our website. If you'd like to go and submit a comment,

we'll be discussing those comments at the in-person meeting so it's a great opportunity for anyone who is listening on the call to have the committee members discuss any issues you might see with the measures.

If there are no other announcements – did you want to make announcement on (inaudible)?

Elisa Munthali: Yes, this is Elisa. We also just wanted to announce that we have two additional population health projects. The one we wanted to talk about today is on population health framework. This project is a test with developing a community action guide that communities and the federal governments and other partners that is working to include population health (inaudible) can use to do so.

The guide has been posted for public comments today and will be available for a 15-day public comment period that ends on April 16 at 6 p.m. So we'd love your input on the guide and we're trying to make sure that the work that we're doing around population health and other topics is aligned. So we want to make sure as much as possible that we're sharing information about the other projects. Thank you.

Male: Can you e-mail that to us?

Elisa Munthali: Absolutely. Actually I'm e-mailing it to the entire committee today.

Male: Great.

Male: Great. Thank you.

Elisa Munthali: Yes.

Male: And for the – will the – our written comments also be made available to us at the in-person meeting? I just want to make sure I don't need to bring anything.

Elisa Munthali: Yes. Your written comments will be included in the meeting materials.

Male: OK. Great thanks.

Catherine Hill: I haven't received the travel information on the April 29th meeting. Is it possible that others might be missing that information as well? This is Catherine Hill. I wonder if you could send that.

Elisa Munthali: OK. We'll follow up with our meetings department.

Catherine Hill: Thank you.

Elisa Munthali: Yes.

Adeela Kahn: OK, everyone. Thank you very much. You got a pretty …

Male: Thank you very much have a great day.

Male: Thank you.

Male: Bye.

Adeela Kahn: Bye.

Operator: Thank you. This concludes today's conference call. You may now disconnect.

END