Prevention and Population Health, Fall 2017 Cycle: CDP Report

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

Contents

Prevention and Population Health, Fall 2017 Cycle

Executive Summary

Traditionally, efforts to improve the health and well-being of individuals and populations have focused on medical care. As a result, nearly all national health spending has been attributed to healthcare services. However, medical care has a relatively small influence on health outcomes when compared to interventions that address smoking, lower educational attainment, poverty, poor diet, and physical environmental hazards (e.g., unsafe housing and polluted air).[1] There is growing recognition of the influence of social determinants of health (SDOH) on health outcomes. Maintaining and improving the health and well-being of individuals and populations will require a multidisciplinary, multifactorial approach to address SDOH.

Performance measures are needed to assess improvements in population health, as well as the extent to which healthcare stakeholders are using evidence-based strategies (e.g., prevention programs, screening, and community needs assessments). To support this effort, the National Quality Forum (NQF) endorses and maintains performance measures related to prevention and population health through a multistakeholder consensus development process. The fall 2017 Prevention and Population Health cycle reviewed prevention and population health measures undergoing maintenance of endorsement.

Although this project focused on measure endorsement, NQF's work on prevention and population health extends to efforts to reduce disparities in health outcomes and promote the coordination of communities to improve local population health. For example, NQF commissioned a report to identify opportunities to align health improvement activities and measurement across the healthcare and government public health systems. Most recently, NQF developed an action guide that provides practical guidance for communities to make lasting improvements in population health.

NQF's prevention and population health portfolio of measures includes measures for health-related behaviors to promote healthy living; community-level indicators of health and disease; modifiable social, economic, and environmental determinants of health; primary prevention and/or screening; and oral health (see Appendix B).

For the fall 2017 cycle, the Prevention and Population Health Standing Committee evaluated seven measures for maintenance of endorsement using NQF's standard evaluation criteria; two screening measures and five measures related to pediatric dentistry. The Committee expressed some concerns about how well the specifications of some measures aligned with the evidence, appropriateness of exclusions, and missing data on disparities. All measures had been previously endorsed. Ultimately, five measures are endorsed and two measures did not maintain endorsement.

The five endorsed measures are:

- 0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (National Committee for Quality Assurance)
- 0034 Colorectal Cancer Screening (COL) (National Committee for Quality Assurance)

- 2511 Utilization of Services, Dental Services (American Dental Association on behalf of the Dental Quality Alliance)
- 2517 Oral Evaluation, Dental Services (American Dental Association on behalf of the Dental Quality Alliance)
- 2528 Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services (American Dental Association on behalf of the Dental Quality Alliance)

The two measures that are no longer endorsed are:

- 2508 Prevention: Sealants for 6-9 Year-Old Children at Elevated Caries Risk (American Dental Association on behalf of the Dental Quality Alliance)
- 2509 Prevention: Sealants for 10-14 Year-Old Children at Elevated Caries Risk (American Dental Association on behalf of the Dental Quality Alliance)

The body of this report briefly summarizes the measures under review; Appendix A offers detailed summaries of the Committee's discussion and ratings on the criteria for each measure.

Introduction

The United States continues to lag behind other nations in key population health indicators like infant mortality, obesity, and life expectancy, despite spending more on healthcare than any other nation in the world.[2] Population health describes the "health outcomes of a group of individuals, including the distribution of such outcomes within the group."[3] Both medical care and social determinants of health (SDOH) influence medical outcomes. SDOH includes factors like availability of safe housing and local food markets, access to healthcare services, and culture. Nearly 60 percent of deaths in the United States have been attributed to SDOH,[4] yet less than 5 percent of national health expenditures have been attributed to prevention services[5]. However, healthcare systems are increasingly expanding their roles to collaborate with patients and communities to better address SDOH.

Performance measurement is necessary to assess whether healthcare stakeholders use strategies to increase prevention and improve population health. Strengthening measurement of prevention and population health will require joint efforts from communities, public health entities, and other nonhealthcare stakeholders (e.g., education, transportation, and employment) that influence health outcomes. Growing evidence demonstrates that targeted programs and policies can prevent disease, increase productivity, and yield billions of dollars in savings for the U.S. healthcare system. The United States can reduce the incidence of morbidity and premature morality by identifying the right measures and implementing evidence-based interventions.

To support this goal, the National Quality Forum (NQF) maintains a portfolio of measures endorsed through a multistakeholder consensus development process and has developed best practices for prevention and population health. NQF's prevention and population health portfolio includes measures that assess the promotion of healthy behaviors, community-level indicators of health, oral health, and primary prevention strategies. For example, NQF has endorsed several measures related to immunizations and screenings that are widely used in public reporting and accountability programs. In August 2016, NQF released an action guide to help multisector groups work together to improve population health. The guide includes a range of resources, practical examples, and recommendations.

This project sought to identify and endorse measures that can be used to assess prevention and population health in both healthcare and community settings. It also focused on the assessment of disparities in health outcomes. Measures reviewed in the fall 2017 cycle focused on oral health and screening.

NQF Portfolio of Performance Measures for Prevention and Population Health

The Prevention and Population Health Standing Committee (see Appendix C) oversees the majority of NQF's portfolio of prevention and population health measures (see Appendix B). The Committee's portfolio contains 36 measures: 25 process measures and 11 outcome and resource use measures. Currently, it does not include any composite measures (see table below).

Table 1. NQF Prevention and Population Health Portfolio of Measures

	Process	Outcome/Resource Use
Immunization	9	0
Pediatric Dentistry	6	1
Weight/BMI	3	0
Diabetes-Related Measures	0	4
Admission Rates	0	5
Cancer Screening	4	0
Cardiovascular/Pulmonary	1	1
Colonoscopy	2	0
Total	25	11

Additional measures related to prevention and population health are assigned to other projects. These include various diabetes assessment and screening measures (Behavioral Health project), well-child care (Pediatrics project), HIV viral load (Primary Care and Chronic Illness project), ACEI/ARB medication measures (Cardiovascular project), perinatal immunization (Perinatal and Women's Health project), gastrointestinal and asthma admission rates (All-Cause Admissions and Readmissions project), and one cost and resource use measure (Cost and Efficiency project).

Measure Evaluation

On February 9, 2018, the Prevention and Population Health Standing Committee evaluated seven measures undergoing maintenance review against NQF's standard evaluation criteria.

Table 2. Prevention and Population Health Fall 2017 Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	7	–	7
Measures endorsed	5	–	5
Measures not recommended for endorsement	2	–	2
Measure recommendation deferred	4	–	4
Measures withdrawn from consideration	1	–	1
Reasons for not recommending	Importance – 0 Scientific Acceptability – 2 Overall – 0 Competing Measure – 0	Importance – N/A Scientific Acceptability – N/A Overall – N/A Competing Measure – N/A	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from December 11, 2017 to February 1, 2018, for all seven measures under review. Three pre-evaluation comments were received (Appendix F) and shared with the Committee prior to its initial deliberations during the in-person meeting.

Post-Evaluation Commenting Period

The 30-day post-evaluation period was open from March 14 to April 12, 2018. During this commenting period, NQF received 12 comments from four member organizations. NQF received public comments on all seven measures under review, and NQF staff requested responses from measure developers where necessary. The Committee discussed these comments and took action on measure-specific comments as needed during the post-comment conference call on April 30, 2018. Overall, comments received on the draft report supported the Committee's recommendations.

Overarching Issues

Several overarching issues emerged during the Standing Committee's discussion of the measures. These issues factored into the Committee's ratings and recommendations, but the measure evaluation summaries in the next section do not detail these considerations for each individual measure.

Linking Evidence to Measure Specifications

The Committee expressed concerns about the link between the evidence and specifications for several measures. For example, the measure on weight assessment and counseling (measure 0024) included an age group that was not included in the guideline upon which it was based. The Committee also noted issues with how the pediatric dentistry measures identify individuals who are "high-risk" and how the approach corresponded to the evidence.

Appropriate Exclusions

The Committee noted issues with the exclusions for several measures. Exclusions are critical to ensure that the right population is being captured in a measure. For example, Committee members shared a concern that the colorectal cancer screening measure (measure 0034) does not exclude individuals with limited life expectancy. Other concerns regarded children captured in the denominator of several of the dental sealant measures, such as the lack of an exclusion of children with previously sealed molars.

Lack of Data on Disparities

The Committee raised the issue of a lack of performance data for measures where there are known disparities. For example, racial and ethnic disparities in obesity, counseling on healthy eating and exercise, colorectal cancer screening, and the use of dental services have all been documented in the literature. Yet, the screening measures submitted for review did not include recent performance data stratified by race and ethnicity.

Summary of Measure Evaluations

The following brief summaries of the measure evaluations highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

Weight and BMI

0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (NCQA): Endorsed

Description: Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: body mass index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Records, Paper Medical Records

This maintenance measure—first endorsed in 2009 and most recently maintained (reviewed and approved for continued endorsement) in 2014—assesses the percentage of children age 3-17 years who received weight assessment and counseling for physical activity. The measure cites the U.S. Preventive Services Task Force (USPSTF) guideline for body mass index (BMI) screening and intervention as evidence for the measure. However, the Committee noted that the measure does not fully align with the USPSTF's guideline, which recommends that physicians offer or refer children and adolescents to comprehensive intensive behavioral interventions to promote improvements in weight status. Further, the guidelines address patients beginning at age 6. The developer cites additional recommendations from the American Academy of Pediatrics' "Bright Futures" to supplement the USPSTF's recommendation for patients ages 3-5. Following discussion of the lack of direct evidence supporting the impact of screening and counseling, the Committee did not reach consensus on whether the measure meets the evidence criterion during the measure evaluation meeting. The Committee discussed and re-voted on the Evidence criterion during the post-comment web meeting. During the web meeting, the Committee focused on the lack of evidence that supports the level of counseling specified in the measure. The Committee voted >60 percent Insufficient on the Evidence criterion, which prompted a vote on an Exception to the Evidence, which passed (Yes-13; No-2).

To assess construct validity, the Developer assesses the correlation between this measure and a similar measure of adult BMI assessment. The Committee questioned whether assessing this pediatric measure with the adult measure was appropriate, and several members believed that the measure's moderate correlation with adult BMI assessment was not sufficient justification for the measure's validity. The Committee recommended that the developer assess construct validity using either a similar measure of screening in the pediatric population (e.g., lead screening) or a measure of recent obesity, diabetes, or metabolic disorder diagnoses. The Committee did not reach consensus on whether the measure meets the validity criterion during the measure evaluation meeting. The Committee discussed and re-voted on the Validity criterion during the post-comment web meeting. During the web meeting, the Committee questioned the validity of the codes that correspond to counseling in the medical record, raising concern over whether the therapies included in the codes would be considered a comprehensive, intensive behavioral intervention, as the USPSTF guidelines recommend. Ultimately, the Committee agreed that

NQF measure 0024 is valid (H-0; M-10; L-3; I-2). The measure was recommended for continued endorsement.

Screening and Prevention

0034 Colorectal Cancer Screening (COL) (NCQA): Endorsed

Description: The percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Paper Medical Records

This maintenance measure—first endorsed in 2009 and most recently maintained in 2014—assesses the percentage of patients age 50-75 years who received appropriate screening for colorectal cancer. This measure aligns with the A-rated 2016 USPSTF guideline recommending screening for colorectal cancer starting at age 50 and continuing until age 75. The developer updated the evidence for the measure to reflect the 2016 USPSTF guidelines, which added two additional tests to satisfy the screening requirement. The measure now includes the sigmoidoscopy, colonoscopy, and colonography, as well as the two new tests, FIT DNA and the fecal occult blood test. The Committee discussed the measure's lack of exclusions for individuals with limited life expectancy and noted the potential harms of including those patients in the measure. The developer noted that the exclusion for patients in hospice is intended to address this issue. The measure received broad agreement through Committee discussion and voting on all evaluation criteria. The Committee recommended the measure for continued endorsement.

Dental Services

2508 Prevention: Sealants for 6-9 Year-Old Children at Elevated Caries Risk (American Dental Association on behalf of Dental Quality Alliance): Not Endorsed

Description: Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This maintenance measure, first endorsed in 2012, assesses whether children age 6-9 years who are at moderate or high caries risk received sealants on a first permanent molar during the reporting year. The developer provided updated information from a Cochrane Review on the effectiveness of sealants; the results directionally support the recommendations from the American Dental Association (ADA) Sealant Guideline, which is being updated. Evidence-based clinical recommendations note sealants should be placed on pits and fissures of children's primary and permanent teeth once it has been determined the tooth, or the patient, is at risk of experiencing caries. Committee members asked for clarity about whether the measure specifications align with the evidence—specifically, a child who has received sealants on a permanent first molar in the target year does not necessarily assess whether the child has received the recommended sealants, which may have occurred in a prior year. The developer provided a performance range of 20 percent to 30 percent from CY 2010, indicating variation in sealant placement across programs. Although the Committee recognized that the measure is only now being widely implemented, they took note of the large gap, but requested that the developer provide more recent

performance data as soon as possible. The Committee decided to forgo re-voting on the reliability of the measure because new testing information was not provided, which NQF's endorsement of maintenance policy permits. Instead, Committee members agreed to accept the votes for evidence, performance gap, and reliability from their previous evaluation of the measure. Committee members reiterated the need to clarify whether a child who has received the sealants has met the recommended guidelines. The Committee had concerns that the measure does not exclude children with previously sealed molars. Ultimately, the Committee did not recommend the measure for endorsement during the February 9 in-person meeting. Following the evaluation, the measure developer submitted a request for reconsideration. However, during the post-comment call on April 30, the Committee voted not to reconsider the measure.

2509 Prevention: Sealants for 10-14 Year-Old Children at Elevated Caries Risk (American Dental Association on behalf of Dental Quality Alliance): Not Endorsed

Description: Percentage of enrolled children in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This maintenance measure, first endorsed in September 2014, assesses whether children age 10-14 years who are at moderate to high risk of developing dental caries receive sealants on a permanent second molar during the reporting year. The developer provided updated information from a Cochrane Review on the effectiveness of sealants. The results directionally support the recommendations from the American Dental Association (ADA) Sealant Guideline, a guideline that is currently being updated. One Committee member noted that the placement of sealants in the measure is competing with another procedure within the health plan, single surface restorations. Health plans see an increase in single surface restorations on first and second molars because most of them include this service in their packages; if a patient receives a single surface restoration on a permanent tooth, this doesn't allow for that tooth to receive a sealant. Committee members agreed to accept the votes for evidence, performance gap, and reliability from their previous evaluation of the measure. As with NQF measure 2508, Committee members reiterated the need to clarify whether a child who has received the sealants has met the recommended guidelines. During the initial vote on the validity criterion, the Committee did not reach consensus because of its concern about the measure's exclusions. Following the February 9 measure evaluation meeting, the measure developer submitted additional information regarding the measure's exclusions, as requested by the Committee. During the post-comment web meeting on April 30, the Committee discussed the measure's validity. Committee members continued to assert that the underlying quality concept of interest, supported by the ADA guidelines, is whether sealants are placed by the appropriate age, rather than during the measure's reporting year. On the re-vote, the Committee again did not reach consensus on Validity, and, therefore, the measure was not recommended for continued endorsement.

2511 Utilization of Services, Dental Services (American Dental Association on behalf of Dental Quality Alliance): Endorsed

Description: Percentage of enrolled children under age 21 years who received at least one dental service within the reporting year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims

NQF measure 2511 is a maintenance measure, initially endorsed in September 2014, which assesses whether children age 1-21 years received any dental service in the target year. Committee members acknowledged the lack of evidence of specific harm to persons who receive the services included in the measure, and also noted the difficulty in conducting systematic research to examine whether children who received any dental treatment in the reporting year were better off than those who received none at all. The developer attested that there is no new evidence or testing information, as permitted by NQF for maintenance measures. Committee members decided to accept votes from their previous evaluation of the measure. The measure is currently being used for accountability and public reporting by the Texas Health and Human Services Commission in its Texas Medicaid/CHIP Pay-for-Quality (P4Q) Program. Ultimately, the Committee recommended the measure for continued endorsement.

2517 Oral Evaluation, Dental Services (American Dental Association on behalf of Dental Quality Alliance): Endorsed

Description: Percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the reporting year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This maintenance measure was first endorsed in 2014; it is a measure of access. The developer updated the evidence with a recent Cochrane review, which corroborated previous evidence. The Committee supported the need for individuals under the age of 21 to have routine dental visits. They expressed concern, however, that the developer provided a limited set of new performance data. The developer responded that the lack of recent data is due to the start-up phase for integration of the measures into contracts and for programs and plans to prepare for reporting, in combination with a lag period for reporting measures calculated using administrative claims data. Ultimately, the Committee agreed that its previous votes on evidence and performance gap sufficed and did not revote. In addition, given that the developer did not update its previous empirical testing, as permitted by NQF, the Committee opted not to revote on scientific acceptability (i.e., reliability and validity criteria). Similarly, the Committee let stand its previous consideration of feasibility. The Committee had no concerns regarding use and usability; the developer provided data from the Texas Medicaid program that demonstrated improvement over time and indicated that Texas publicly reports performance ranges from 26 percent to 67 percent. The Committee recommended the measure for continued endorsement.

2528 Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services (American Dental Association on behalf of Dental Quality Alliance): Endorsed

Description: Percentage of enrolled children aged 1-21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This maintenance measure, first endorsed in 2014, assesses the percentage of children age 1-21 years who are at elevated risk for caries and received at least two topical fluoride applications within the reporting year. Evidence-based clinical guidelines recommend specific topical fluoride agents for people who are at elevated risk of developing dental caries, and the developer reported no new evidence since the measure's initial review. Additionally, while the Committee noted a lack of new information on performance gap, the developer responded that the lack of recent data is due to the start-up phase for integration of the measures into contracts and for programs and plans to prepare for reporting, in combination with a lag period for reporting measures calculated using administrative claims data. Ultimately, the Committee agreed that its previous votes on evidence and performance gap sufficed and did not revote. In addition, given that the developer did not update previous empirical testing, as permitted by NQF's maintenance of endorsement policy, the Committee opted not to revote on scientific acceptability (i.e., reliability and validity criteria). No concerns were raised about the use and usability criteria. The Committee recommended the measure for continued endorsement.

References

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[4] Kindig DA, Asada Y, Booske B. A population health framework for setting national and state health goals. *JAMA*. 2008;299(17):2081-2083.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Endorsed Measures

0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (WCC)

Submission | Specifications

Description: Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:

- Body mass index (BMI) percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Numerator Statement: Patients who had evidence of the following during the measurement year: a body mass index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity.

Denominator Statement: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN during the measurement year.

Exclusions: The measure excludes female patients who have a diagnosis of pregnancy and patients who use hospice services during the measurement year.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Records, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 02/09/2018

1. Importance to Measure and Report: **The measure meets the Importance to Measure and Report criteria**

(1a. Evidence, 1b. Performance Gap)

Votes from Measure Evaluation Meeting 02/09/2018

1a. Evidence: **H-0; M-9; L-1; I-5**; 1b. Performance Gap: **H-4; M-10; L-0; I-0**

Re-votes from Post-Comment Web Meeting 04/30/2018

1a. Evidence: **H-0; M-3; L-1; I-11**; Insufficient Evidence with Exception to Evidence: **Yes-13; No-2**

Rationale:

- This maintenance measure focuses on weight assessment and counseling for nutrition and physical activity for patients ages 3-17 years.
- The developer cited the USPSTF's moderate recommendation for childhood and adolescent body mass index (BMI) assessment to support the measure. The USPSTF recommendation states that there is no direct evidence on the benefits of screening; however, given the base of

evidence on lifestyle modifications to reduce excess weight, the USPSTF awarded a moderate rating.

- Some Committee members believed the measure's evidence was mostly based on a "consensus recommendation," which is reasonable for continued endorsement.
- Other committee members questioned the measure's age range, noting that the USPSTF guidelines address patients ages 6 and older. The developer responded that it used supplemental recommendations from AAP's "Bright Futures" to support the measure's inclusion of patients ages 3 and older.
- The Committee also questioned the accuracy of BMI when applied to young children, specifically that the USPSTF recommendations noted the decreased accuracy of BMI for children under six as rationale for excluding that population. A systematic review and meta-analysis of the diagnostic performance of BMI in children and adolescents (ages 4-18 years) published in 2015 concluded that BMI had high specificity, but low sensitivity, to detect excess fat and fails to identify over a quarter of children with excess body fat percentage.
- The Committee discussed the appropriateness of the nutrition and physical activity counseling included in the measure and stated that the literature suggests that more than counseling is needed. The USPSTF recommendation focuses on screening for BMI and recommends referral to comprehensive, intensive behavioral interventions to promote improvement in weigh status. The developer noted that it used supplemental recommendations from AAP's "Bright Future," which supports the inclusion of counseling. The developer also stated that this measure attempts to balance the feasibility of obtaining intervention information with making sure people get at least a minimum amount of counseling.
- Since most effective BMI interventions occur outside the clinician's office, the Committee agreed it would like to see measures that address the decision makers and institutions that can impact children and adolescent BMI (schools, communities, etc.), not just clinicians.
- The developer indicated it is developing a set of measures focused on health promotion and targeted at organizations surrounding wellness and health promotion. The developer also noted challenges defining and assessing whether referrals to more intensive weight management interventions have occurred.
- In addition to reporting performance on the measure, the developer also provided the plan with information about three separate rates for BMI screening, nutrition counseling, and physical activity counseling.
- There are known disparities in the prevalence of obesity among African American females as identified in the systematic review cited by the developer. The Committee urged the developer to improve collection of race/ethnicity data, which is often reported as unknown or refused, and to require reporting of that data to it. The developer noted that while disparities are not reported in the measure, health plans may analyze the disparities data for their own internal understanding and use.
- The Committee questioned whether it is worthwhile for NQF to endorse measures such as this, which focus only on the basic standard of care, but it ultimately agreed this was outside the scope of this particular measure evaluation.
- This measure is calculated at the plan level. Committee members discussed the appropriate attribution of the measure, noting that while plans can support activities that lead to healthy BMI, ultimately the individual clinicians will be held accountable to the measure whether appropriate or not.

- Ultimately, the Committee did not reach consensus on whether the measure meets the Evidence criterion during the measure evaluation meeting. The Committee re-voted on the Evidence criterion during the post-comment call.
- During the post-comment call, the Committee continued to express concern about the lack of evidence supporting the counseling specified in the measure. In response to a query from the lead discussant, NQF staff explained the process by which a measure would be eligible for the Exception to Evidence criterion. The Committee voted >60% Insufficient on the Evidence criterion, which prompted a vote on an Exception to the Evidence, which passed (Yes-13; No-2).
- The developer provided performance data from HEDIS for 2014, 2015, and 2016 stratified by age group and plan type. The developer characterizes the change in performance from 2014 to 2016 as "slight" improvement (3%-6%) across commercial and Medicaid plans.
- Average performance for the measure is approximately 55%-60%.
- The Committee agreed the measure meets the Performance Gap criterion that a performance gap still exists.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

Votes from Measure Evaluation Meeting 02/09/2018

2a. Reliability: **H-7**; **M-6**; **L-1**; **I-0**; 2b. Validity: **H-0; M-8; L-7; I-0**

Re-votes from Post-Comment Web Meeting 04/30/2018

2b. Validity: **H-0**; **M-10**; **L-3**; **I-2**

<u>Rationale</u>:

- The beta-binomial method was used to assess the ratio of signal to noise, where the signal is the proportion of variability in measured performance that can be explained by real differences in performance and noise is variability that is attributable to error. A reliability score of 1 implies that all the variability is attributable to real differences in performance and a score of 0 implies all variability is attributable to measurement error. The developer states a reliability score of 0.7 is considered "very good."
- Using 246 Medicaid plans and 406 commercial plans in the 2016 HEDIS dataset, the reliability statistics 0.999 in Commercial plans and 0.993 or above in Medicaid plans.
- The Committee agreed that the measure meets the Reliability criterion.
- To assess the construct validity of this measure, the developer used a Pearson correlation test to assess the correlation between this measure and a similar measure of Adult BMI assessment, hypothesizing that plans with a high performance on weight assessment and counseling for nutrition and physical activity also will have high performance on adult BMI assessment. The magnitude of correlation ranges from -1 to +1. A correlation coefficient of 1 indicates a perfect linear dependence between the measures, where increasing values on one measure are associated with increasing values of the second measure. A value of -1 indicates a perfect linear relationship, where increasing values of the first measure are associated with decreasing values of the second. A score of 0 indicates no relationship between the measures.
- The developer reported that Pearson correlation coefficients for commercial plans show a strong positive correlation with of 0.79 and higher. In Medicaid plans, results were moderate, with correlations of 0.64-0.65.

- Recent changes to the NQF measurement criteria require that maintenance measures present empiric validity testing; face validity is no longer sufficient for continued endorsement. The Committee discussed the relevance of the construct validity hypothesis, noting the weak justification that comparison to a similar adult measure provides. Rather, the Committee recommended using a related plan-level measure, such as recent diagnoses of obesity, diabetes, or metabolic syndrome in the pediatric population or a similar measure of screening (e.g., lead) in the same population.
- Because this measure used data from administrative claims, paper records, and electronic health records (EHRs), the Committee questioned the measure's sensitivity to data sources across plans. The developer responded that it audits all data and provides clear rules on how to report different data sources; it also requires a HEDIS vendor certification for data collection to further support data integrity across plans.
- The developer also purported a high degree of face validity and described its detailed method of assessment. However, the developer presented no information on the results of the face validity assessment.
- Ultimately, the Committee did not reach consensus on whether the measure meets the Validity criterion during the measure evaluation meeting. The Committee re-voted on the Evidence criterion during the post-comment call.
- The Committee requested that the developer present the results of the data collection auditing during the re-vote on the post-comment call and for its other measures in the future.
- The Committee also requested that the developer provide further construct validity testing, using a more appropriate measure for comparison during the post-comment call.
- During the post-comment call, the Committee questioned whether the codes that correspond to counseling in the medical record represent the type of counseling intended by the clinical guideline. The codes included in the measure do not specify the level of counseling that is provided, and so the Committee had concerns over whether the counseling that was provided would be considered a comprehensive, intensive behavioral intervention, as the USPSTF guidelines recommend.
- Ultimately, the Committee agreed that measure 0024 is able to measure simple screening and whether counseling took place with a moderate to high degree of validity.

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3. Feasibility: H-5; M-10; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- This measure is calculated using data from administrative claims, paper medical records, and EHRs. Data for this measure are generated or collected by healthcare personnel during the provision of care, coded by a separate individual, and abstracted from a record by someone other than the person obtaining the original information.
- The Committee noted that this measure is used in multiple programs and had no concerns regarding the measure's feasibility.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-13; No Pass-1;** 4b. Usability: **H-0; M-14; L-1; I-0**

Rationale:

- This measure is used in a variety of accountability programs, health plans, CMS programs, and Medicaid CHIP.
- Per the developer, performance data from 2014-2016 have shown modest improvement indicating that either performance or documentation is improving.
- The Committee also noted the lack of an outcome measure that addresses weight in children and adolescents.
- Following the vote, several Committee members noted their concern that the measure is "letting plans off the hook" and incentivizing interventions that show no evidence to support weight reduction. The Committee strongly recommended that during future maintenance review the measure include a component that assesses the adequacy of the counseling or meets more rigorous USPSTF guidelines.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Yes-10**; **No-5**

6. Public and Member Comment

Two comments were submitted on this measure, one pre-evaluation and one post-evaluation. The pre-evaluation comment expressed support for the measure as specified, while the other expressed concern about the lack of reliability and validity testing for the measure when collected through abstraction from the medical record. The commenter also noted that the submission does not include testing results for the testing of exclusions.

Developer Response:

- The reliability and validity testing information represents results for both administrative claims and medical record review (i.e., the measure as specified). The exclusions are identifiable in claims or by medical record abstraction; all HEDIS measures are audited in order to ensure members of the eligible population who are excluded are done so appropriately.

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7. Consensus Standards Approval Committee (CSAC) Vote (June 6, 2018): Yes-14; No-3

CSAC Decision: Approved for continued endorsement

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8. Appeals

No appeals were received.

0034 Colorectal Cancer Screening (COL)

Submission | Specifications

Description: The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

Numerator Statement: Patients who received one or more screenings for colorectal cancer according to clinical guidelines.

Denominator Statement: Patients 51–75 years of age

Exclusions: This measure excludes patients with a history of colorectal cancer or total colectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 02/09/2018

1. Importance to Measure and Report: The measure meets the Importance to Measure criterion

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-10**; **M-5**; **L-0**; **I-0**; 1b. Performance Gap: **H-12**; **M-3**; **L-0**; **I-0**

Rationale:

- This maintenance measure focuses on the percentage of patients ages 50-75 years who received appropriate screening for colorectal cancer. The measure aligns with the A-rated 2016 U.S. Preventive Services Task Force (USPSTF) guideline recommending screening for colorectal cancer starting at age 50 and continuing until age 75.
- The evidence for the measure was updated to reflect the 2016 USPSTF guideline, which added two tests in addition to colonoscopy to satisfy the screening requirement.
- It was noted that according to the USPSTF guideline, clinicians should engage patients to make an informed decision about the type of screening they receive. However, patient education in decision making is not addressed in the measure.
- The Committee noted that the measure does not exclude patients with limited life expectancy comorbidities, which is a critical area for stemming overuse of screening. The measure excludes hospice patients and patients in long-term care or skilled nursing facilities, but the Committee noted this does not account for additional, broader limited-life expectancy. The Committee emphasized the importance of and opportunity to move toward measures of appropriate care and encouraged the developer to consider such a change, while also acknowledging the practical concerns of defining limited life expectancy and the challenges of having known prognoses for many diagnoses.
- The developer provided performance data from HEDIS for 2014-2016 stratified by plan type. The developer stated that during this period, performance rates for the measure have shown slight decline (-1%) across commercial plans and slight improvement (+2%) in Medicare plans.

- Average performance for the measure is approximately 60% in commercial plans and 67% in Medicare plans, which the developer noted demonstrates a persistent performance gap.
- Some Committee members questioned whether a persistent gap in performance indicates a flaw in the measure itself. The developer responded that it is fair to assess the measure construct itself, but that in this case the clinical guideline supports the measure as constructed. Others pointed out that the persistent gap could be attributed to a variety of other forces in the healthcare system besides the measure itself and is not problematic if the gap is supported by evidence from additional sources.
- The developer noted that published literature has identified disparities in the rate of colorectal cancer screening based on race, ethnicity, income, education, and English language proficiency.
- The Committee requested that the developer provide a statistical test for the change in performance scores in future submissions.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-8**; **M-7**; **L-0**; **I-0**; 2b. Validity: **H-1**; **M-14**; **L-0**; **I-0**

<u>Rationale</u>:

- The beta-binomial method was used to assess the ratio of signal to noise, where the signal is the proportion of variability in measured performance that can be explained by real differences in performance and noise is variability that is attributable to error. A reliability score of 1 implies that all the variability is attributable to real difference in performance and a score of 0 implies all variability is attributable to measurement error. The developer stated a reliability score of 0.7 is considered "very good."
- Using the 2017 HEDIS dataset, the reliability statistics were 0.997 in commercial plans and 0.988 in Medicare plans.
- The Committee agreed that the measure meets the Reliability criterion.
- To assess the construct validity of this measure, the developer used a Pearson correlation test to assess the correlation between this measure and a similar measure of breast cancer screening, hypothesizing that plans with high performance on colorectal cancer screening will also have high performance on breast cancer screening. The magnitude of correlation ranges from -1 to +1. A correlation coefficient of 1 indicates a perfect linear dependence between the measures, where increasing values on one measure are associated with increasing values of the second measure. A value of -1 indicates a perfect linear relationship, where increasing values of the first measure are associated with decreasing values of the second. A score of 0 indicates no relationship between the measures.
- The developer reported that Pearson correlation coefficients for commercial plans showed a strong positive correlation of 0.711. In Medicaid plans, results were moderate, with correlation of 0.716.
- The developer purported a high degree of face validity and described its detailed method of assessment. However, the developer presented no information on the results of the face validity assessment.
- The Committee indicated some concern about reliability and validity, given the many places from which data are collected in the medical record. It requested that the developer provide a greater articulation of the data auditing process and results in future submissions.
- The Committee agreed the measure meets the Validity criterion

3. Feasibility: H-3; M-12; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- This measure is calculated using data from administrative claims, paper medical records, and EHRs. Data for this measure are generated or collected by healthcare personnel during the provision of care, coded by a separate individual, and abstracted from a record by someone other than the person obtaining the original information.
- The Committee noted it had similar objections to the collection of data from multiple sources (administrative claims, paper medical records, and EHRs) as raised in the discussion of measure measure 0024.
- Ultimately, the Committee agreed the measure meets the criterion for Feasibility.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-15; No Pass-0;** 4b. Usability: **H-6; M-9; L-0; I-0**

Rationale:

- This measure is currently in widespread use in multiple accountability programs including the Medicare Advantage Star Rating Program and the Quality Payment Program.
- The Committee noted that given that the measure numerator has changed to include additional methods of screening, measure trends over time should be assessed with caution in recognition of the expanded specifications.
- The Committee agreed that the measure meets the Use criterion.
- The Committee agreed that the measure meets the Usability criterion.

5. Related and Competing Measures

- This measure is related to:
    - 0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (American Gastroenterological Association)

Standing Committee Recommendation for Endorsement: **Yes-15**; **No-0**

6. Public and Member Comment

NQF received three post-evaluation comments from two organizations about this measure. One comment did not support the Committee's recommendation and expressed concern over the lack of exclusions for patients with limited life expectancy who are not in hospice care. The other comment expressed concern about the lack of reliability and validity testing for the measure when collected through abstraction from the medical record. The commenter also noted that the submission does not include testing results for the testing of exclusions.

Developer Response:

- The reliability and validity testing information represent results for both administrative claims and medical record review (i.e., the measure as specified). The exclusions are identifiable in claims or by medical record abstraction; all HEDIS measures are audited in order to ensure members of the eligible population who are excluded are done so appropriately.
- NCQA recognizes the hospice/living long-term in institutional care exclusion is an important step towards ensuring these patients are removed from measures that require services at an intensity and frequency that may be inappropriate. NCQA continues to assess whether there are additional ways to identify members who should be removed from these types of measures.

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7. Consensus Standards Approval Committee (CSAC) Vote (June 6, 2018): Yes-17; No-0

CSAC Decision: Approved for continued endorsement

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8. Appeals

No appeals were received.

2511 Utilization of Services, Dental Services

Submission | Specifications

Description: Percentage of enrolled children under age 21 years who received at least one dental service within the reporting year.

Numerator Statement: Unduplicated number of children under age 21 years who received at least one dental service

Denominator Statement: Unduplicated number of enrolled children under age 21 years

Exclusions: Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: American Dental Association on behalf of the Dental Quality Alliance

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STANDING COMMITTEE MEETING 02/09/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **Previous Performance Gap Evaluation Accepted**

Rationale:

- This maintenance measure captures whether children ages 1-21 years have received any dental services during the reporting year, which assesses access to oral care. The developer provided evidence that there are documented disparities in untreated dental caries and receipt of dental services. The American Academy of Pediatric Dentistry recommends that all children have a dental home established by 12 months of age.
- Committee members acknowledged the strong evidence and guidelines regarding preventive dental care/dental homes for children, but expressed concerns that the specific format of the measure does not directly address the evidence and guidelines. Particularly, "any dental service" could include extractions or other dental procedures for caries that would indicate poor or limited preventive care in previous years.
- Ultimately, the Committee chose to accept the vote on Evidence from its previous evaluation of the measure.
- The developer stated that performance range of 28% to 74% in CY 2010 is indicative of a significant performance gap. The developer did not provide more recent performance data, stating that due to the start-up phase for integration of the measures, most of the entities that have adopted the measure are just beginning implementation, so there are limited data.
- The developer stated that its findings demonstrate disparities by age, geographic location, and race/ethnicity. The developer also evaluated whether the measure could detect disparities (by income, children's health status, Medicaid program type, commercial product line, and preferred language for program communications), and noted disparities were detected for each of these factors, but data on all characteristics were not consistently available for all programs.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted;** 2b. Validity: **Previous Validity Evaluation Accepted**

<u>Rationale</u>:

- The developer provided the original testing data as previously evaluated during the measures initial review, which is permitted by NQF's maintenance of endorsement policy. Because the testing had not been updated, the Committee chose to accept its votes from the measure's prior evaluation of Reliability and Validity.

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3. Feasibility: Previous Feasibility Evaluation Accepted

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- This measure relies on standard data elements in administrative claims data, which are readily available and can be easily retrieved because they are routinely used for billing and reporting purposes. There have been no reports of feasibility issues with implementing this measure, as provided by the developer.
- Because no feasibility issues had arisen since the previous review, the Committee chose to accept the vote on Feasibility from its previous evaluation of the measure.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-12; No Pass-0**; 4b. Usability: **H-1 M-12; L-0; I-0**

Rationale:

- The measure is used for public reporting and accountability by the Texas HHS Commission: Texas Medicaid/CHIP Pay-for-Quality (P4Q) program.
- In 2016, the Dental Quality Alliance (DQA) expanded its scope of review for its measures by convening participants who shared experiences implementing DQA measures, including any challenges related to the measures specifications and use of the measures in their quality improvement programs. Participants did not have any significant issues related to the clarity or feasibility of implementing the measure.
- The developer also noted that data retrieved to date suggest a trend in improvement over time, although these are initial performance data for one program. It stated that most measure users are just now getting their quality measurement programs underway, and therefore do not have substantial data to provide.
- The Committee approved Use and Usability for measure 2511.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Yes-13**; **No-0**

6. Public and Member Comment

NQF received one comment about this measure. The comment requested clarification on whether the measure is specified for Medicaid plans only or if it is also specified for commercial plans with a dental benefit. The commenter also requested clarification on how this measure differs from the existing NCQA HEDIS measure Annual Dental Visit (NQF measure 1388), a similar measure that is no longer NQF endorsed but is currently in use in various public reporting programs.

Developer Response:

- Thank you for your comment. Measure 2511 is calculated using administrative enrollment and claims data, and it is specified for reporting at the program (e.g., Medicaid or CHIP) or plan (e.g., MCO or DBA) level. Entities that do not have dental administrative data will not be able to report this measure. Reporting on the measure for a unit (e.g., provider level) or using a data source other than that for which the measure was developed may not be reliable. A primary difference between the DQA measure- Utilization of Services and the NCQA HEDIS Annual Dental Visit (ADV) is the denominator. The enrollment requirement for the proposed measure, Utilization of Dental Services, is 6 months continuous enrollment during the reporting year as opposed to a full-year enrollment, allowing for no more than a single 45-day gap in enrollment (or one month for entities that measure enrollment on a monthly basis) for the ADV. The testing of Utilization of Dental Services included five alternative enrollment requirements, including full-

year (allowing for a one-month gap) enrollment. Our results indicated a significant decrease in the percentage of members eligible for the measure when increasing the enrollment requirement from 6 months to one year. (Data from Table 2a2.2-1. in the Measure Testing Form.) The percentage of members included with a full-year enrollment requirement ranged from only 1/3 of members up to just shy of 2/3 of members. In contrast, 2/3 – 4/5 of members were retained in the measure with a six-month enrollment requirement, which also was deemed to provide sufficient time to seek, schedule, and obtain a dental visit.

7. Consensus Standards Approval Committee (CSAC) Vote (June 6, 2018): Yes-17; No-0

CSAC Decision: Approved for continued endorsement

8. Appeals

No appeals were received.

2517 Oral Evaluation, Dental Services

Submission | Specifications

Description: Percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the reporting year.

Numerator Statement: Unduplicated number of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation as a dental service

Denominator Statement: Unduplicated number of enrolled children under age 21 years

Exclusions: Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: American Dental Association on behalf of the Dental Quality Alliance

STANDING COMMITTEE MEETING 02/09/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **Previous Performance Gap Evaluation Accepted**

Rationale:

- This maintenance measure focuses on the percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the reporting year.

- This developer cited national guidelines from the American Academy of Pediatric Dentistry (AAPD) and the American Academy of Pediatrics (AAP), which recommend that children receive oral health services by 1 year of age and have regular visits thereafter.
- The Committee supported the need for individuals under the age of 21 to have routine dental visits.
- The developer updated the evidence with a recent Cochrane Review, which was directionally the same as the previous evidence.
- Since the developer did not provide new evidence outside of the Cochrane Review, the Committee chose not to vote again and accepted its previous evaluation for the Evidence criterion.
- The developer provided plan and program level performance information from four sources: Texas Medicaid, Florida CHIP, and Florida Medicaid programs, as well as national commercial data from Dental Service of Massachusetts, Inc. The performance range of 26% to 67% in CY 2010 (year in which data were available for all five programs) indicates variation in topical fluoride application across programs. The developer did not provide more current performance data, stating that due to the start-up phase for integration of the measure, most of the entities that have adopted the measure are just implementing it and so there is limited data reporting.
- The Committee accepted the developer's rationale for the lack of updated performance gap information. Because it had not been updated since its 2014 evaluation of the measure, the Committee chose to accept the vote on Performance Gap from its previous evaluation of the measure.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted**; 2b. Validity: **Previous Validity Evaluation Accepted**

<u>Rationale</u>:

- The developer previously provided empirical reliability testing with statistical tests, but did not update the testing, as permitted by NQF's maintenance of endorsement policy.
- NQF permits data-element level validity testing to suffice for reliability testing. This previous testing focused on assessing the accuracy of dental procedure codes reported in claims data as the data elements that contribute most to computing the measure score. To evaluate data element validity, the developer conducted reviews of dental records and compared them to extracted administrative claim data, which matched more than 86% of the time.
- In addition to the data element-level validity, the developer also submitted results from a systematic assessment of the measure's face validity. The assessment used a modified Delphi method, among other activities, to assess the measure's face validity and found unanimous agreement that the calculated measure scores can be used to evaluate quality of care.
- Ultimately, given that no new testing was provided, the Committee opted to accept its previous evaluation and votes to approve the Reliability and Validity criteria.

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3. Feasibility: Previous Feasibility Evaluation Accepted

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- This measure relies on standard data elements in administrative claims data (e.g., patient ID, patient birthdate, enrollment information, CDT codes, date of service, and provider taxonomy). These data are readily available and can be easily retrieved because they are routinely used for billing and reporting purposes.
- Because no feasibility issues had arisen since the previous review and the specifications remained the same, the Committee chose to accept the vote on Feasibility from its previous evaluation of the measure.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-12; No Pass-0**; 4b. Usability: **H-1; M-12; L-0; I-0**

Rationale:

- This measure is currently in use for public reporting in the Texas Medicaid/CHIP Pay for Quality Program (P4Q).
- In 2016, the Dental Quality Alliance (DQA) expanded its scope of review of its measures by convening conference calls for two user groups – one comprised of representatives from six state Medicaid programs (Alabama, Florida, Kentucky, Oregon, Nevada, and Pennsylvania) and the other comprised of representatives from eight dental plans. Participants shared their experiences implementing DQA measures in their respective programs, including any challenges related to the DQA measures specifications and use of these measures in their quality improvement programs. The developer reports that participants did not have any significant issues related to the clarity or feasibility of implementing the measure specifications.
- The developer also noted that data retrieved suggest a trend in improvement over time, although these are initial performance data for one program. It stated that most measure users are just now getting their quality measurement programs underway.
- Ultimately, the Committee voted unanimously that the measure meets the NQF Use criterion. Additionally, the Committee raised no concerns regarding the measure's usability and voted that the measure meets NQF's Usability criterion.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Yes-13**; **No-0**

6. Public and Member Comment

NQF received one comment about this measure. The commenter requested clarification on whether the measure is specified for Medicaid plans only or if it also is specified for commercial plans with a dental benefit. The commenter also asked the Committee to look for opportunities for harmonization with existing Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSTD) reporting requirements. The commenter further noted that, conceptually, any visit that satisfies measure 2511

would also satisfy measure 2517, and vice versa; and recommend that the Committee consider the value of having both measures in the Prevention and Population Health portfolio.

Developer Response:

- Thank you for your comment. Measure 2517 is calculated using administrative enrollment and claims data, and it is specified for reporting at the program (e.g., Medicaid or CHIP) or plan (e.g., MCO or DBA) level. Entities that do not have dental administrative data will not be able to report this measure. Reporting on the measure for a unit (e.g., provider level) or using a data source other than that for which the measure was developed may not be reliable.

  There is no counterpart on the CMS-416 EPSDT data for the DQA's Oral Evaluation measure. The DQA was formed at the request of CMS and maintains regular communication with CMS about its measure development activities in order to promote alignment and harmonization in dental quality measurement. Measure 2511, Utilization of Services, is an access measure – whether children are able to access the dental care system. Measure 2517 is a process measure – whether children are receiving regular oral evaluations, including diagnostic services that are critical to evaluating oral disease and dentition development and to developing an appropriate oral health prevention regimen and treatment plan.

7. Consensus Standards Approval Committee (CSAC) Vote June 6, 2018): Yes-17; No-0

CSAC Decision: Approved for continued endorsement

8. Appeals

No appeals were received.

2528 Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services

Submission | Specifications

Description: Percentage of enrolled children aged 1-21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.

Numerator Statement: Unduplicated number of enrolled children aged 1-21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications as a dental service

Denominator Statement: Unduplicated number of enrolled children aged 1-21 years who are at "elevated" risk (i.e., "moderate" or "high")

Exclusions: Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: American Dental Association on behalf of the Dental Quality Alliance

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STANDING COMMITTEE MEETING 02/09/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **Previous Performance Gap Evaluation Accepted**

Rationale:

- This maintenance measure assesses the percentage of enrolled children ages 1-21 years who are at elevated risk for caries who received at least two topical fluoride applications within the reporting year.
- The developer attested there was no new evidence since the last evaluation. Previously, the submission cited a systematic review of 71 controlled clinical trial studies. The evidence received a grade of moderate by an expert panel, which is second on a three-point scale and denotes that evidence statements "are based on preliminary determination from the current best available evidence, but confidence in the estimate is constrained by one or more factors."
- Ultimately, given that the evidence had not changed since the measure's previous endorsement, the Committee opted not to re-vote on the Evidence criterion. The votes from the Committee's previous review will carry over to this maintenance evaluation.
- The developer provided plan and program level performance information from four sources: Texas Medicaid, Florida CHIP, and Florida Medicaid programs, as well as national commercial data from Dental Service of Massachusetts, Inc. The performance range of 18% to 35% in CY 2010 (year in which data were available for all five programs) indicates variation in topical fluoride application across programs.
- The developer reported improvement of approximately 2% in Texas Medicaid and approximately 4% in Texas CHIP. The developer attributes improvement on the measure's performance to the stimulus that measurement itself provides.
- The Committee noted the lack of new information on performance gap; the developer responded that the lack of recent data is due to the start-up phase for integration of the measures into contracts and for programs and plans to prepare for reporting, in combination with a lag period for reporting measures calculated using administrative claims data.
- The Committee accepted the rationale for the lack of updated performance gap information. Because it had not been updated since its 2014 evaluation of the measure, the Committee chose to accept the vote on Performance Gap from its previous evaluation of the measure.

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2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted**; 2b. Validity: **Previous Validity Evaluation Accepted**

Rationale:

- Elevated risk is captured and defined in three new CPT caries risk assessment codes (high, moderate, low) that can be submitted as an indication of risk. Given that the codes are new and use is still growing, the measure also uses a "look back" methodology that looks back three years to determine if a child has undergone any restorative procedure that would indicate tooth decay to include in the measure.
- The developer submitted critical data element testing to satisfy requirements for reliability and empiric validity testing. The developer reviewed dental records for the Texas Medicaid program to evaluate the agreement between the claims data and dental charts by calculating the sensitivity, specificity, positive predictive value, and negative predictive value, as well as the kappa statistic.
- Agreement (concordance) for topical fluoride application was 89.9%. Sensitivity was 90.7% and specificity was 88.4%. The positive predictive value was 93.5% and negative predictive value was 83.9%. The kappa statistic value was 0.782, which indicates "substantial agreement" between the claims data and the dental charts.
- The developer also submitted results from a systematic assessment of the measure's face validity. The assessment used a modified Delphi method, among other activities, to assess the measure's validity and found unanimous agreement that the calculated measure scores can be used to evaluate quality of care.
- The measure excludes those children enrolled in Medicaid or CHIP who do not have dental coverage or whose coverage does not include the two fluoride applications called for in the measure. However, there is no similar exclusion for children on commercial insurance who may have the same lack of or gap in coverage. Because this measure is assessed at the plan level, the developer stated it is unlikely that its use will unduly penalize providers who do not meet the measure's requirements as a result of a patient's lack of coverage. Additionally, the developer noted that more and more dental insurers are expanding coverage to include the evidence-based recommendation for two or more fluoride treatments per year. Committee members, nevertheless urged the developer to make the same exclusion for commercial plans as is provided for Medicaid/CHIP.
- The Committee noted that while pediatric dentists often perform a risk assessment, most children receive dental services from general dentists who show variation in their understanding and documentation of risk assessments. Additionally, young children will not have had a restorative procedure in order to be captured via the look-back method. The developer responded that these children would most likely still receive the preventative fluoride treatment but would not be documented as at-risk, and therefore not included in the measure, unless the dentist used the new CDT codes. Further, the developer noted that plans have begun to incentivize the use of the new risk assessment CDT codes and that the inclusion of the CDT codes in the measure can promote further adoption.
- One Committee member noted that children insured under Medicaid or CHIP tend to change plans frequently. Risk assessment information does not follow a patient across plans and can therefore be lost when a child switches to a new dental plan.
- Ultimately, given that no new measure testing was provided, as permitted by NQF for maintenance consideration, the Committee opted to carry over the votes for the Reliability and Validity criterion from the measure's previous endorsement evaluation.

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3. Feasibility: Previous Feasibility Evaluation Accepted

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- This measure relies on standard data elements in administrative claims data (e.g., patient ID, patient birthdate, enrollment information, CDT codes, date of service, and provider taxonomy). These data are readily available and can be easily retrieved because they are routinely used for billing and reporting purposes.
- Given that no new feasibility information was provided, the Committee opted to carry over the votes from the measure's previous endorsement evaluation for the Feasibility criterion.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-14; No Pass-0;** 4b. Usability: **H-1; M-12; L-0; I-1**

Rationale:

- This measure is currently used in Texas Medicaid and CHIP, as well as the Florida Statewide Medicaid Prepaid Dental Health Program.
- The Committee voted unanimously that the measure meets the NQF Use criterion. Additionally, the Committee raised no concerns regarding the measure's usability and voted in support on the Usability criterion.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-14**;** No-0

6. Public and Member Comment

NQF received one comment on this measure. The commenter requested clarification on whether the measure is specified for Medicaid plans only or if it is also specified for commercial plans with a dental benefit. The commenter supported the Standing Committee's request for clarification of how to identify individuals who are at "high" or "moderate" risk.

Developer Response:

1. Thank you for your comment. Measure 2528 is calculated using administrative enrollment and claims data, and it is specified for reporting at the program (e.g., Medicaid or CHIP) or plan (e.g., MCO or DBA) level. Entities that do not have dental administrative data will not be able to report this measure. Reporting on the measure for a unit (e.g., provider level) or using a data source other than that for which the measure was developed may not be reliable.

   The focus of this measure is on children inferred at being elevated caries risk as a priority population to focus quality measurement. Testing data found that significant performance gaps existed within the elevated caries risk populations. During initial measure development, it was recognized that the ability to make reliable distinctions between at-risk levels (e.g., between "moderate" and "high" risk) was not well established. Consequently, the measure adopted a

clearer cut dichotomous distinction of “low” risk and “elevated” risk. (The measure does not require distinguishing “moderate” risk from “high” risk.) The recent findings of an American Dental Association – American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel (available upon request), which reviewed the current state of science on caries risk assessment and developed guidance on risk categorization, found that current caries risk assessment tools share many common elements to assess risk and affirmed that they have dichotomous predictive ability to quantify “low risk” and “elevated risk”: “Current tools have derived various methods to categorize risk based on expert consensus. The categorization of risk differs between the tools. However, all tools appear to qualify “low risk” in a similar manner: lack of disease and presence of protective factors. Current CRA tools could be effectively used in identifying “low risk” patients.” Consequently, the MDMC continues to support the focus of the measure on the priority population of children at elevated risk for developing dental caries.

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7. Consensus Standards Approval Committee (CSAC) Vote (June 6, 2018): Yes-17; No-0

CSAC Decision: Approved for continued endorsement

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8. Appeals

No appeals were received.

Measures Not Recommended

2508 Prevention: Sealants for 6-9 Year-Old Children at Elevated Caries Risk

Submission

Description: Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.

Numerator Statement: Unduplicated number of enrolled children age 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth as a dental service.

Denominator Statement: Unduplicated number of enrolled children age 6-9 years who are at "elevated" risk (i.e., "moderate" or "high")

Exclusions: Medicaid/ CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded.

There are no other exclusions.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: American Dental Association on behalf of the Dental Quality Alliance

STANDING COMMITTEE MEETING 02/09/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **Previous Performance Gap Evaluation Accepted**

Rationale:

- The developer provided an update to the evidence in the form of a recent Cochrane Review on the effectiveness of sealants. The results of the review continue to support the recommendations of the American Dental Associations Sealant Guideline, which is currently being updated.
- The developer provided program- and plan-level information from five different sources: Texas Medicaid, Texas Children's Health Insurance Plans (CHIP), Florida CHIP, and Florida Medicaid programs, as well as national commercial data from Dental Service of Massachusetts, Inc.
- Committee members agreed the data source and sample sizes are sufficient to assess the gaps in performance, which ranged from 20% to 30% in CY 2010. The developer noted this is indicative of variation in sealant replacement across the programs, but Committee members expressed concern that the current performance gap is based on broad low performance and not a variation in sealant placements.

- The developer did not provide more recent performance data, stating that due to the start-up phase for integration of the measures, most of the entities that have adopted the measure are just beginning implementation and so there is limited data reporting.
- The developer provided disparities data and showed statistically significant differences for both race and ethnicity were detected for the two programs for which such data were available. Additionally, the developer evaluated whether the measure could detect disparities by income (within a given program), children's health status (based on their medical diagnoses), Medicaid program type, CHIP dental plan, commercial product line, and preferred language for program communications.
- Although the developer detected disparities based on all the differing factors, data on all the characteristics were not consistently available, so it presented disparities data just on those characteristics most consistently available and had the greatest standardization (i.e. race/ethnicity and geographic location).
- Committee members acknowledged the Medicaid data are captured differently and will have different disparities, but wonder if this conclusion will have an impact on the performance gap.
- The Committee agreed to accept its votes on Evidence and Performance Gap from its prior review.

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2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted**; 2b. Validity: **H-0**; **M-5**; **L-8**; **I-0**

<u>Rationale</u>:

- The developer previously provided empirical reliability testing using statistical tests, but did not update with new testing, as permitted by NQF's maintenance of endorsement policy. NQF permits data-element level validity testing to suffice for reliability testing. This previous testing focused on assessing the accuracy of dental procedure codes reported in claims data as the data elements that contribute most to computing the measure score. To evaluate data element validity, the developer conducted reviews of dental records and compared them to extracted administrative claim data, which matched more than 90% of the time.
- For Validity, Committee members questioned whether children that received a sealant on a permanent first molar, within the target year, also means that they specifically have received the recommended sealants.
- One Committee member also expressed concerned that the exclusion of children without dental benefits is not taken into account when the measure is being computed. Developers noted that the number of children enrolled in Medicaid without dental benefits is minimal, but that the exclusion does apply to the Medicaid plans
- Committee members also questioned the ambiguity of elevated risk and suggested that improved coding is a technique that could improve performance without any unintended consequences arising.
- While the Committee generally supported the concept and direction of the measure, concerns remained regarding the measure's exclusions and questions about sealants generally vs. specific sealants recommended. Ultimately, the measure failed the Validity criterion.
- The developer submitted a request for reconsideration for this measure. The Committee voted not to reconsider the measure following deliberations on a similar measure, measure 2509,

which was consensus not reached and was ultimately not recommended. The Committee agreed that the issues with measure 2509 also exist in this measure.

5. Related and Competing Measures

No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **N/A**

6. Public and Member Comment

NQF received five post-evaluation comments on this measure. All five comments raised concern over the measure's specifications, specifically the lack of exclusions for individuals with zero sealable molars. One comment disagreed with the measure's inclusion of individuals with "elevated" risk in the denominator, noting there is evidence that current tools to assess caries risk are not reliable. One comment also requested the creation of implementation guidelines.

Developer Response:

- Thank you for your comment.
  The intent of Measure #2508 is to compare program (e.g., Medicaid) and plan performance over time related to the application of sealants for a population at inferred risk for caries by measuring the percentage of enrolled children 6-9 years of age, at elevated caries risk, who received a sealant on a permanent first molar tooth during the reporting year.

- The DQA thanks the DentaQuest for their comments.
  The intent of Measure #2508 is to compare program (e.g., Medicaid) and plan performance over time related to the application of sealants for a population at inferred risk for caries by measuring the percentage of enrolled children 6-9 years of age, at elevated caries risk, who received a sealant on a permanent first molar tooth during the reporting year.
- Thank you for your comment.
  This measure is calculated using administrative enrollment and claims data, and it is specified for reporting at the program (e.g., Medicaid or CHIP) or plan (e.g., MCO or DBA) level. Entities that do not have dental administrative data will not be able to report this measure. Reporting on the measure for a unit (e.g., provider level) or using a data source other than that for which the measure was developed may not be reliable.
  The focus of this measure is on children inferred at being elevated caries risk as a priority population to focus quality measurement. Testing data found that significant performance gaps existed within the elevated caries risk populations. During initial measure development, it was recognized that the ability to make reliable distinctions between at-risk levels (e.g., between "moderate" and "high" risk) was not well established. Consequently, the measure adopted a clearer cut dichotomous distinction of "low" risk and "elevated" risk. (The measure does not require distinguishing "moderate" risk from "high" risk.) The recent findings of an American Dental Association – American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel (available upon request), which reviewed the current state of science on caries risk

assessment and developed guidance on risk categorization, found that current caries risk assessment tools share many common elements to assess risk and affirmed that they have dichotomous predictive ability to quantify "low risk" and "elevated risk": "Current tools have derived various methods to categorize risk based on expert consensus. The categorization of risk differs between the tools. However, all tools appear to qualify "low risk" in a similar manner: lack of disease and presence of protective factors. Current CRA tools could be effectively used in identifying "low risk" patients." Consequently, the MDMC continues to support the focus of the measure on the priority population of children at elevated risk for developing dental caries.

- The DQA appreciates the support of the National Association of ACOs and its recognition of the importance of this measure for improving quality of care and oral health outcomes. The DQA would like to address the comment regarding accounting for the previously sealed molars as the same comment was also expressed by the NQF Standing Committee.
  Measure Intent: The intent of Measure #2508 is to compare program (e.g., Medicaid) and plan performance over time related to the application of sealants for a population at inferred risk for caries by measuring the percentage of enrolled children 6-9 years of age, at elevated caries risk, who received a sealant on a permanent first molar tooth during the reporting year.
  Intended to evaluate relative performance. The measure specifications note that:
  - This measure will not delineate those whose teeth have not erupted, those who have already received sealants in prior years, and those with decayed/filled teeth not candidates for sealants.
  - This measure is not designed to provide the absolute percentage of children who have ever had a sealant on a permanent second molar.
  - The measure is intended to be used for monitoring variations in sealant placement between reporting entities and disparities in sealant placement.

  Many of these limitations stem from lack of critical data within administrative claims including lack of ability to identify unerupted teeth, lack of diagnostic codes to identify decayed teeth, and lack of surface level data in many program level databases.
  Valid process measure. Testing indicated that the measure enables program and plan level process-of-care comparisons. Performance gaps and disparities in performance at a point in time can be identified. Face validity assessments by the MDMC as well as the stakeholder community at large affirmed that the measure is a valid process measure with a higher score signifying higher quality.
  Consequently, the measure provides the information it claims to, and measure guidance explicitly clarifies what it is not designed to do in order to avoid mistaken interpretations of the measure score. The measure enables sound conclusions about the quality of care provided.
  In addition, among all of the DQA measures, this measure has enjoyed the greatest adoption, which speaks to the measure's ability to serve as a valid quality indicator, including adoption by the Centers for Medicare & Medicaid Services in the CHIPRA Core Set of Child Quality Measures, with reporting by 34 states in 2016, and inclusion in the Covered California State Marketplace quality reporting.
  Rationale for not accounting for prior sealant placement. Feasibility, reliability and validity concerns were identified. To accurately capture prior sealant data, a child's complete dental treatment history during the tooth eruption years would need to be captured in administrative

claims data. Due to enrollment churn, these historical data are frequently not available. The lack of historical data could be addressed by requiring continuous enrollment in prior years during the tooth eruption period; however, the consequent substantial decrease in the denominator-eligible population raised significant face validity concerns about the representativeness of the resulting sample. Additionally, excluding children with prior sealants could create potentially biased measurement when there are variable observation windows across reporting entities for capturing prior sealant placement. A plan with more historical data will be able to identify more exclusions with a consequent increase in its measure score that is not reflective of improved quality but merely of having more historical data available.

Re-examination of lack of denominator exclusions. The MDMC reviewed data offered by two Dental Benefit Administrators (DBAs) that participate in the one of the same Medicaid and CHIP programs included in original testing to lend insight into the impact on measure performance when exclusions for prior sealant placement are incorporated. Data without incorporating enrollment criteria in years prior to the reporting year were provided.

Table 1 compares the measure scores provided by the two DBAs for the current measure and for the measure with prior sealants excluded, using a 3-year look-back period. (Note: Plan 1 did not have data available prior to 2013, so the 3-year look back could only be used for 2016.) As expected, the measure scores increased, ranging from an increase of 1.8 percentage points to 5.1 percentage points. The differences in the measure scores were statistically significant (based on non-overlapping 95% confidence intervals) in both programs.

Table 1: #2508 (Sealants, 6-9 years) Measure Score Comparisons with and without Exclusions for Previously Sealed Teeth

	Denominator	Measure Score	95% CI, Lower Bound	95% CI, Upper Bound
Plan 1				
Medicaid 2016-DQA Current Measure	321038	24.49%	0.2434	0.2464
2016-Exclude Previously Sealed	263981	28.77%	0.2860	0.2895
CHIP 2016-DQA Current Measure	46767	22.97%	0.2259	0.2335
2016-Exclude Previously Sealed	38947	26.74%	0.2630	0.2718
Plan 2				
Medicaid 2014-DQA Current Measure	161553	27.00%	0.2678	0.2722
2014-Exclude Previously Sealed	141771	30.00%	0.2976	0.3024
2015-DQA Current Measure	220022	25.70%	0.2552	0.2588
2015-Exclude Previously Sealed	184174	29.80%	0.2959	0.3001
2016-DQA Current Measure	243165	25.10%	0.2493	0.2527
2016-Exclude Previously Sealed	198213	29.70%	0.2950	0.2990
2017-DQA Current Measure	215350	24.30%	0.2412	0.2448
2017-Exclude Previously Sealed	171338	29.40%	0.2918	0.2962
CHIP 2014-DQA Current Measure	21092	25.10%	0.2451	0.2569
2014-Exclude Previously Sealed	18870	27.60%	0.2696	0.2824
2015-DQA Current Measure	17376	24.70%	0.2406	0.2534
2015-Exclude Previously Sealed	15617	27.10%	0.2640	0.2780
2016-DQA Current Measure	25147	23.10%	0.2258	0.2362
2016-Exclude Previously Sealed	23085	24.90%	0.2434	0.2546

2017-DQA Current Measure 23931 22.80% 0.2227 0.2333
2017-Exclude Previously Sealed 21894 24.60% 0.2403 0.2517
Impact of exclusions on relative performance: electronic patient record-level validation. We had detailed patient record-level data available from 77 dental practice these practices locations representing more than 60,000 children <21 years of age (>14,000 6-9 years). We used these data to compare the relative rankings of the 77 practices based on their measure scores calculated without any exclusions with the relative rankings based on their measure scores calculated excluding children with no sealable molars for any reason (prior sealants, restorations, extractions, unerupted teeth, missing teeth, and active caries). We used Kendall's tau correlation coefficient, a statistical test of associations based on ranks of data, to compare the relative rankings. This correlation coefficient is a more conservative measure of correlation than Spearman's rho. Values >0.70 indicate high correlation. The Kendall's tau correlation coefficient between the two approaches was 0.83 ($p<0.001$), signifying high positive correlation in the relative rankings for the two approaches (with and without exclusions) in calculating the measure scores. [Spearman's rho=0.94, $p<0.001$] These results further supported the conclusion that the measure scores calculated without exclusions enable comparable distinctions in performance.
Based on these evaluations, it appears that not accounting for exclusions does not compromise the measure's ability to distinguish performance between reporting entities.

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7. Consensus Standards Approval Committee (CSAC) Vote: Yes-13; No-4

CSAC Decision: Did not approve for continued endorsement

2509 Prevention: Sealants for 10-14 Year-Old Children at Elevated Caries Risk

Submission | Specifications

Description: Percentage of enrolled children in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year.

Numerator Statement: Unduplicated number of enrolled children age 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth as a dental service.

Denominator Statement: Unduplicated number of enrolled children age 10-14 years who are at "elevated" risk (i.e., "moderate" or "high")

Exclusions: Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: American Dental Association on behalf of the Dental Quality Alliance

STANDING COMMITTEE MEETING 02/09/2018

1. Importance to Measure and Report: **The measure meets the Importance criteria**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **Previous Performance Gap Evaluation Accepted**

Rationale:

- This maintenance measure captures the percentage of children ages 10-14 years who are at elevated risk of dental caries and who have received a sealant on a permanent second molar within the reporting year.
- The measure mirrors evidence-based guidelines regarding effective caries prevention, as well as the specific tooth (second permanent molar) for which the evidence is the strongest and the timing (shortly after eruption) of sealant placement to maximize effectiveness.
- The measure received a Grade B, which is defined as directly based on category II evidence or extrapolated recommendation for category I evidence.
- A recent Cochrane Review on the effectiveness of sealants encapsulated all the evidence, which support the recommendations of the American Dental Association (ADA) Sealant Guideline. This guideline is currently being updated.
- Since the developer did not provide new evidence outside of the Cochrane Review, which was directionally the same as previous evidence, the Committee chose not to vote again and accepted its previous evaluation for the Evidence criterion.
- The performance range of 8% to 13% in CY 2010 is indicative of low prevalence in sealant placement and across programs. The developer also provided 2011 CMS performance data from state Medicaid programs, which ranged from 6% to 22% of children ages 10-14 years who received a sealant on a permanent second molar tooth.
- The developer did not provide more recent performance data, stating that due to the start-up phase for integration of the measures, most of the entities that have adopted the measure are just beginning implementation and there are limited data.
- The developer provided disparities data and showed statistically significant differences for both race and ethnicity were detected for the two programs for which such data were available. Additionally, the developer evaluated whether the measure could detect disparities by income (within a given program), children's health status (based on their medical diagnoses), Medicaid program type, CHIP dental plan, commercial product line, and preferred language for program communications.
- The developer also evaluated whether the measure could detect disparities (by income, children's health status, Medicaid program type, commercial product line, and preferred language for program communications), and disparities were detected for each of these factors, but data on all characteristics were not consistently available for all programs.
- Since the developer did not provide new performance gap information, the Committee chose not to vote again and accepted its previous evaluation for the Performance Gap criterion.

2. Scientific Acceptability of Measure Properties: The measure did not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

Votes from Measure Evaluation Meeting 02/09/2018

2a. Reliability: **Previous Reliability Evaluation Accepted**; 2b. Validity: **Previous Validity Evaluation Accepted**

Re-votes from Post-Comment Web Meeting 04/30/2018

2b. Validity: **H-0**; **M-8**; **L-6**; **I-1**

Rationale:

- The developer previously provided empirical reliability testing using statistical tests, but did not update with new testing, as permitted by NQF's maintenance of endorsement policy. NQF permits data-element level validity testing to suffice for reliability testing. This previous testing focused on assessing the accuracy of dental procedure codes reported in claims data as the data elements that contribute most to computing the measure score. To evaluate data element validity, the developer conducted reviews of dental records and compared them to extracted administrative claim data, which was >88% for the second molar, if sealant applied and >95% for application of sealant.
- For validity, Committee members expressed concern that children who received sealants on their second molars might not have met the recommended clinical guidelines. Specifically, Committee members questioned whether a child has a sealant on a permanent second molar in the target year actually meant that they had received the recommended sealant that year, since it could have happened in a prior year.
- The Committee did not reach consensus on the Validity criterion during the measure evaluation meeting. The Committee re-voted on the measure's Validity during the post-comment web meeting.
- During the post-comment call, Committee members agreed the updated information provided by the developer explained the Dental Quality Alliance's intended use of the measure. Some Committee members, however, maintained their previous concerns regarding sealants being placed at the appropriate age, and not whether the sealants were placed during the target year. Ultimately, the measure did not receive sufficient votes to meet the Validity criterion.

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3. Feasibility: Previous Feasibility Evaluation Accepted

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- This measure relies on standard data elements in administrative claims data (e.g., patient ID, birthdate, enrollment info, CDT codes, date of service, and provider taxonomy), which are readily available and can be easily retrieved because they are routinely used for billing and reporting purposes. There have been no reports of feasibility issues with implementing this measure, as provided by the developer.
- The Committee opted to accept its previous vote on Feasibility.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-13; No Pass-0**; 4b. Usability: **H-0; M-11; L-0; I-1**

Rationale:

- The measure is used for public reporting and accountability by the Texas HHS Commission: Texas Medicaid/CHIP Pay-for-Quality (P4Q) program.
- In 2016, the Dental Quality Alliance (DQA) expanded its scope of review for its measures by convening participants who shared experiences implementing DQA measures, including any challenges related to the measures specifications and use of the measures in their quality improvement programs. The developer reports participants did not have any significant issues related to the clarity or feasibility of implementing the measure.
- The developer noted that the data retrieved suggest a trend in improvement over time, but that these are initial performance data for one program. It stated that most measure users are just now getting their quality measurement programs underway, and therefore do not have substantial data to provide.
- The Committee voted to approve both the Use and Usability criteria.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **N/A**

6. Public and Member Comment

NQF received two comments on this measure. One comment agreed with the Committee's concern about the need for an exclusion of patients with previously sealed molars. Additionally, however, the commenter noted support for the measure's endorsement. The second comment called for clarification as to whether the measure is specified exclusively for Medicaid plans or if it also applied to commercial plans with a dental benefit. The commenter also agreed with the Committee's request for clarification on how individuals are classified as "high" or "moderate" risk.

Developer Response:

- Thank you for your comment. This measure is calculated using administrative enrollment and claims data, and it is specified for reporting at the program (e.g., Medicaid or CHIP) or plan (e.g., MCO or DBA) level. Entities that do not have dental administrative data will not be able to report this measure. Reporting on the measure for a unit (e.g., provider level) or using a data source other than that for which the measure was developed may not be reliable.
  The focus of this measure is on children inferred at being elevated caries risk as a priority population to focus quality measurement. Testing data found that significant performance gaps existed within the elevated caries risk populations. During initial measure development, it was recognized that the ability to make reliable distinctions between at-risk levels (e.g., between "moderate" and "high" risk) was not well established. Consequently, the measure adopted a clearer cut dichotomous distinction of "low" risk and "elevated" risk. (The measure does not require distinguishing "moderate" risk from "high" risk.) The recent findings of an American Dental Association – American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel (available upon request), which reviewed the current

state of science on caries risk assessment and developed guidance on risk categorization, found that current caries risk assessment tools share many common elements to assess risk and affirmed that they have dichotomous predictive ability to quantify “low risk” and “elevated risk”: “Current tools have derived various methods to categorize risk based on expert consensus. The categorization of risk differs between the tools. However, all tools appear to qualify “low risk” in a similar manner: lack of disease and presence of protective factors. Current CRA tools could be effectively used in identifying “low risk” patients.” Consequently, the MDMC continues to support the focus of the measure on the priority population of children at elevated risk for developing dental caries.

- The DQA appreciates the support of the National Association of ACOs and its recognition of the importance of this measure for improving quality of care and oral health outcomes. The DQA would like to address the comment regarding accounting for the previously sealed molars as the same comment was also expressed by the NQF Standing Committee.
  Measure Intent: The intent of Measure #2509 is to compare program (e.g., Medicaid) and plan performance related to the application of sealants for a population at inferred risk for caries by measuring the percentage of enrolled children 10-14 years of age, at elevated caries risk, who received a sealant on a permanent second molar tooth during the reporting year.
  Intended to evaluate relative performance. The measure specifications note that:
  - This measure will not delineate those whose teeth have not erupted, those who have already received sealants in prior years, and those with decayed/filled teeth not candidates for sealants.
  - This measure is not designed to provide the absolute percentage of children who have ever had a sealant on a permanent second molar.
  - The measure is intended to be used for monitoring variations in sealant placement between reporting entities and disparities in sealant placement.

  Many of these limitations stem from lack of critical data within administrative claims including lack of ability to identify unerupted teeth, lack of diagnostic codes to identify decayed teeth, and lack of tooth surface level data in many program level databases.
  Valid process measure. Testing indicated that the measure enables program and plan level process-of-care comparisons. Performance gaps and disparities in performance at a point in time can be identified. Face validity assessments by the MDMC as well as the stakeholder community at large affirmed that the measure is a valid process measure with a higher score signifying higher quality.
  Consequently, the measure provides the information it claims to, and measure guidance explicitly clarifies what it is not designed to do in order to avoid mistaken interpretations of the measure score. The measure enables sound conclusions about the quality of care provided.
  Rationale for not accounting for prior sealant placement. Feasibility, reliability and validity concerns were identified. To accurately capture prior sealant data, a child’s complete dental treatment history during the tooth eruption years would need to be captured in administrative claims data. Due to enrollment churn, these historical data frequently are not available. The lack of historical data could be addressed by requiring continuous enrollment

in prior years during the tooth eruption period; however, the consequent substantial decrease in the denominator-eligible population raised significant face validity concerns about the representativeness of the resulting sample. Additionally, excluding children with prior sealants could create potentially biased measurement when there are variable observation windows across reporting entities for capturing prior sealant placement. A plan with more historical data will be able to identify more exclusions with a consequent increase in its measure score that is not reflective of improved quality but merely of having more historical data available.

The MDMC reviewed data offered by two Dental Benefit Administrators (DBAs) that participate in the one of the same Medicaid and CHIP programs included in original testing to lend insight into the impact on measure performance when exclusions for prior sealant placement are incorporated. Data without incorporating enrollment criteria in years prior to the reporting year were provided.

Table 1 compares the measure scores provided by the two DBAs for the current measure and for the measure with exclusions for children who already had all four molars previously sealed, using a 3-year look-back period. (Note: Plan 1 did not have data available prior to 2013, so the 3-year look back could only be used for 2016.) As expected, the measure scores increased, but the increases were less than 1 percentage point, ranging from 0.30% percentage point to 0.76% percentage point. The differences in the measure scores were statistically significant (based on non-overlapping 95% confidence intervals) in the Medicaid program, but not in the CHIP program.

Table 1: #2509 (Sealants, 10-14 years) Measure Score Comparisons with and without Exclusions for Previously Sealed Teeth

	Denominator	Measure Score	95% CI, Lower Bound	95% CI, Upper Bound
Plan 1				
Medicaid 2016-DQA Current Measure	347260	17.04%	0.1691	0.1716
2016-Exclude Previously Sealed	327778	17.79%	0.1766	0.1792
CHIP				
2016-DQA Current Measure	46110	17.24%	0.1690	0.1759
2016-Exclude Previously Sealed	43823	17.94%	0.1758	0.1829
Plan 2				
Medicaid 2014-DQA Current Measure	157734	17.70%	0.1751	0.1789
2014-Exclude Previously Sealed	151899	18.20%	0.1801	0.1839
2015-DQA Current Measure	215113	17.60%	0.1744	0.1776
2015-Exclude Previously Sealed	204487	18.30%	0.1813	0.1847
2016-DQA Current Measure	260807	17.00%	0.1686	0.1714
2016-Exclude Previously Sealed	248681	17.70%	0.1755	0.1785
2017-DQA Current Measure	264111	16.70%	0.1656	0.1684
2017-Exclude Previously Sealed	248829	17.40%	0.1725	0.1755
CHIP 2014-DQA Current Measure	29510	14.60%	0.1420	0.1500
2014-Exclude Previously Sealed	28687	15.00%	0.1459	0.1541
2015-DQA Current Measure	22175	15.00%	0.1453	0.1547
2015-Exclude Previously Sealed	21493	15.30%	0.1482	0.1578

2016-DQA Current Measure 31012 15.00% 0.1460 0.1540
2016-Exclude Previously Sealed 30308 15.30% 0.1489 0.1571
2017-DQA Current Measure 30835 15.00% 0.1460 0.1540
2017-Exclude Previously Sealed 29990 15.30% 0.1489 0.1571

Impact of exclusions on relative performance: electronic patient record-level validation. We had detailed patient record-level data available from 77 dental practice locations representing more than 60,000 children <21 years of age (>19,000 10-14 years). We used these data to compare the relative rankings of the 77 practices based on their measure scores calculated without any exclusions with the relative rankings based on their measure scores calculated excluding children with no sealable molars for any reason (prior sealants, restorations, extractions, unerupted teeth, missing teeth, and active caries). We used Kendall's tau correlation coefficient, a statistical test of associations based on ranks of data, to compare the relative rankings. This correlation coefficient is a more conservative measure of correlation than Spearman's rho. Values >0.70 indicate high correlation. The correlation coefficient between the two approaches was 0.96 ($p<0.001$), signifying nearly perfect positive correlation in the relative rankings for the two approaches (with and without exclusions) in calculating the measure scores. [Spearman's rho=0.996, $p<0.001$] These results further supported the conclusion that the measure scores calculated without exclusions enable comparable distinctions in performance.

Based on these evaluations, it appears that not accounting for exclusions does not compromise the measure's ability to distinguish performance between reporting entities.

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7. Consensus Standards Approval Committee (CSAC) Vote: Yes-13; No-4

CSAC Decision: Did not approve for continued endorsement

Measure Withdrawn from Consideration

One measure previously endorsed by NQF was not re-submitted for maintenance of endorsement. Endorsement for this measure will be removed.

Measure	Reason for withdrawal
2020 Adult Current Smoking Prevalence	Developer is no longer able to support the measure.

Appendix B: Prevention and Population Health Committee Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized or Implemented as of December 12, 2017
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Merit-Based Incentive Payment System (MIPS) Program; Qualified Health Plan (QHP) Quality Rating System (QRS)
0032	Cervical Cancer Screening (CCS)	Merit-Based Incentive Payment System (MIPS) Program; Qualified Health Plan (QHP) Quality Rating System (QRS)
0034	Colorectal Cancer Screening (COL)	Medicare Part C Star Rating; Medicare Shared Savings Program; Merit-Based Incentive Payment System (MIPS) Program; Qualified Health Plan (QHP) Quality Rating System (QRS)
0038	Childhood Immunization Status (CIS)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals; Merit-Based Incentive Payment System (MIPS) Program; Medicare Physician Quality Reporting System; Physician Feedback/Quality Resource Use Report; Physician Value-Based Payment Modifier; Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
0039	Flu Vaccinations for Adults Ages 18 and Older	Medicare Part C Star Rating; Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
0041	Preventive Care and Screening: Influenza Immunization	Medicare Shared Savings Program; Merit-Based Incentive Payment System (MIPS)
0226	Influenza Immunization in the ESRD Population (Facility Level)	N/A
0272	Diabetes Short-Term Complications Admission Rate (PQI 01)	Medicaid
0273	Perforated Appendix Admission Rate (PQI 2)	N/A
0274	Diabetes Long-Term Complications Admission Rate (PQI 03)	N/A
0275	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	N/A
0277	Congestive Heart Failure Rate (PQI 08)	Medicaid
0279	Community-Acquired Pneumonia Admission Rate (PQI 11) (Previously named "Bacterial Pneumonia Admission Rate")	N/A
0280	Dehydration Admission Rate (PQI 10)	N/A

NQF #	Title	Federal Programs: Finalized or Implemented as of December 12, 2017
0281	Urinary Tract Infection Admission Rate (PQI 12)	N/A
0283	Asthma in Younger Adults Admission Rate (PQI 15)	Medicaid
0285	Lower-Extremity Amputation among Patients with Diabetes Rate (PQI 16)	N/A
0431	INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL	Hospital Compare; Hospital Outpatient Quality Reporting; Prospective Payment System-Exempt Cancer Hospital Quality Reporting; Ambulatory Surgical Center Quality Reporting; Hospital Inpatient Quality Reporting; Inpatient Psychiatric Facility Quality Reporting; Inpatient Rehabilitation Facility Quality Reporting; Long-Term Care Hospital Quality Reporting; Home Health Value Based Purchasing
0509	Diagnostic Imaging: Reminder System for Screening Mammograms	Medicare Physician Quality Reporting System; Physician Feedback/Quality Resource Use Report; Physician Value-Based Payment Modifier; Merit-Based Incentive Payment System (MIPS) Program
0638	Uncontrolled Diabetes Admission Rate (PQI 14)	N/A
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Ambulatory Surgical Center Quality Reporting; Hospital Compare; Hospital Outpatient Quality Reporting; Medicare Physician Quality Reporting System; Physician Feedback/Quality Resource Use Report; Physician Value-Based Payment Modifier; Merit-Based Incentive Payment System (MIPS) Program
0659	Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	Ambulatory Surgical Center Quality Reporting; Hospital Compare; Hospital Outpatient Quality Reporting; Medicare Physician Quality Reporting System; Physician Feedback/Quality Resource Use Report; Physician Value-Based Payment Modifier; Merit-Based Incentive Payment System (MIPS) Program
0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	Nursing Home Quality Initiative; Inpatient Rehabilitation Facility Quality Reporting; Long-Term Care Hospital Quality Reporting
0681	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	Nursing Home Quality Initiative

NQF #	Title	Federal Programs: Finalized or Implemented as of December 12, 2017
1407	Immunizations for Adolescents	Medicare Physician Quality Reporting System; Physician Feedback/Quality Resource Use Report; Physician Value-Based Payment Modifier; Merit-Based Incentive Payment System (MIPS) Program; Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
2372	Breast Cancer Screening	Medicare Part C Star Rating; Merit-Based Incentive Payment System (MIPS) Program; Medicare Shared Savings Program; Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
2511	Utilization of Services, Dental Services	N/A
2517	Oral Evaluation, Dental Services	N/A
2528	Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	N/A
2689	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	N/A
2695	Follow-Up after Emergency Department Visits for Dental Caries in Children	N/A
2828	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	N/A
3039	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	N/A
3070	Preventive Care and Screening: Influenza Immunization	N/A

Appendix C: Prevention and Population Health Standing Committee and NQF Staff

STANDING COMMITTEE

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Rochester, New York

Amir Qaseem, MD, PhD, MHA (Co-Chair)
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Appendix D: Measure Specifications

0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:

- Body mass index (BMI) percentile documentation
- Counseling for nutrition
- Counseling for physical activity

TYPE

Process

DATA SOURCE

Claims, Electronic Health Records, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan, Integrated Delivery System

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients who had evidence of the following during the measurement year: a body mass index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity.

NUMERATOR DETAILS

ADMINISTRATIVE:

BMI Percentile: Patients with a BMI percentile* (BMI Percentile Value Set) during the measurement year

*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value

Counseling for Nutrition: Patients with counseling for nutrition (Nutrition Counseling Value Set) during the measurement year

Counseling for Physical Activity: Patients with counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year

---

MEDICAL RECORD:

BMI Percentile:

Patients with documentation in the medical record of a BMI percentile during the measurement year. Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile:

• BMI percentile documented as a value (e.g., 85th percentile).

• BMI percentile plotted on an age-growth chart.

The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

Only evidence of the BMI percentile or BMI percentile on an age-growth chart meets criteria.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

Counseling for Nutrition:

Patients with documentation in the medical record of counseling for nutrition or referral for nutrition education during the measurement year. Documentation must include a note indicating the date and at least one of the following:

• Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).

• Checklist indicating nutrition was addressed.

• Counseling or referral for nutrition education.

• Patient received educational materials on nutrition during a face-to-face visit.

• Anticipatory guidance for nutrition.

• Weight or obesity counseling.

Counseling for Physical Activity:

Patients with documentation in the medical record of counseling for physical activity or referral for physical activity during the measurement year. Documentation must include a note indicating the date and at least one of the following:

• Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).

• Checklist indicating physical activity was addressed.

• Counseling or referral for physical activity.

• Patient received educational materials on physical activity during face-to-face visit.

• Anticipatory guidance specific to the child's physical activity.

• Weight or obesity counseling.

DENOMINATOR STATEMENT

Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN during the measurement year.

DENOMINATOR DETAILS

Patients 3-17 years of age as of December 31 of the measurement year with an outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.

EXCLUSIONS

The measure excludes female patients who have a diagnosis of pregnancy and patients who use hospice services during the measurement year.

EXCLUSION DETAILS

Exclude female patients who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

Exclude patients who use hospice services any time during the measurement year (Hospice Value Set).

The denominator for all rates must be the same. An organization that excludes these patients must do so for all rates.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

The total population is stratified by age: 3-11 and 12-17 years of age.

Report two age stratifications and a total rate for each of the three indicators.

The total is the sum of the age stratifications.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the eligible population. To do so, identify all patients 3-17 years of age who had an outpatient visit (Outpatient Value Set) with a PCP or OB/GYN during the measurement year.

Step 2: Exclude patients with pregnancy diagnosis (Pregnancy Value Set) or who used hospice services (Hospice Value Set) from the eligible population.

Step 3: Determine numerator events. To do so, identify the number of patients in the eligible population who had evidence of BMI percentile documentation (BMI Percentile Value Set), counseling for nutrition (Nutrition Counseling Value Set), and counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.

Step 4. Calculate the three rates. 123834| 140881

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0034 Colorectal Cancer Screening (COL)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan, Integrated Delivery System

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients who received one or more screenings for colorectal cancer according to clinical guidelines.

NUMERATOR DETAILS

ADMINISTRATIVE:

Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria:

-Fecal occult blood test (FOBT Value Set) during the measurement year.

-Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.

-Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.

-CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.

-FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two years prior to the measurement year.

MEDICAL RECORD:

Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria:

-Fecal occult blood test during the measurement year.

-Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.

-Colonoscopy during the measurement year or the nine years prior to the measurement year.

-CT colonography during the measurement year or the four years prior to the measurement year.

-FIT-DNA test during the measurement year or the two years prior to the measurement year.

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this

is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures:

--Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.

--Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

--If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.

--If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.

--FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.

--If the medical record indicates that a gFOBT was done, follow the scenarios below.

–If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.

–If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.

–If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

DENOMINATOR STATEMENT

Patients 51–75 years of age

DENOMINATOR DETAILS

Patients 51–75 years of age as of the end of the measurement year (e.g. December 31).

EXCLUSIONS

This measure excludes patients with a history of colorectal cancer or total colectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.

EXCLUSION DETAILS

Exclude patients with either of the following any time during the patient's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set)

- Total colectomy (Total Colectomy Value Set)

Exclude patients who use hospice services any time during the measurement year (Hospice Value Set).

Exclude patients 65 and older who are enrolled in an institutional SNP or living long-term in an institution at any time during the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

None

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the eligible population: identify patients 51-75 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: history of total colectomy or colorectal cancer. Exclude these patients from the eligible population.

Step 3. Determine numerator: the number of patients who have been screened for colorectal cancer by any of the included screening methods, within the associated time interval.

Step 4. Calculate the rate. 123834| 140881

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2511 Utilization of Services, Dental Services

STEWARD

American Dental Association on behalf of the Dental Quality Alliance

DESCRIPTION

Percentage of enrolled children under age 21 years who received at least one dental service within the reporting year.

TYPE

Process

DATA SOURCE

Claims Not applicable.

LEVEL

Health Plan, Integrated Delivery System

SETTING

Outpatient Services

NUMERATOR STATEMENT

Unduplicated number of children under age 21 years who received at least one dental service

NUMERATOR DETAILS

Please see section S.14

DENOMINATOR STATEMENT

Unduplicated number of enrolled children under age 21 years

DENOMINATOR DETAILS

Please see section S.14

EXCLUSIONS

Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded.

EXCLUSION DETAILS

There are no other exclusions than those described above.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

This measure is stratified by age using the following categories:

<1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

No new data are needed for this stratification. Please see attached specifications for complete measure details.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Utilization of Services Calculation

1. Use administrative enrollment and claims data for a single year. When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).
2. Check if the enrollee meets age criteria at the last day of the reporting year:

a. If age criterion is met, then proceed to next step.

b. If age criterion is not met or there are missing or invalid field codes (e.g., date of birth), then STOP processing. This enrollee does not get counted in the denominator.

3. Check if subject is continuously enrolled for at least 180 days during the reporting year:

a. If subject meets continuous enrollment criterion, then include in denominator; proceed to next step.

b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted in the denominator.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: All enrollees who meet the age and enrollment criteria

4. Check if subject received any dental service:

a. If [CDT CODE] = D0100 – D9999, and;

b. If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes or their equivalent in Table 1 below, then include in numerator; STOP processing

c. If both a & b are not met, then service was not provided or not a dental service; STOP processing. This enrollee is already included in the denominator but will not be included in the numerators.

Note: In this step, all claims with missing or invalid CDT CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 1 should not be included in the numerator.

YOU NOW HAVE NUMERATOR NUM COUNT: Enrollees who received a dental service

5. Report

a. Unduplicated number of enrollees in numerator

b. Unduplicated number of enrollees in denominator

c. Measure Rate (NUM/DEN)

d. Rate stratified by age

Table 1: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”*

122300000X	1223P0106X	1223X0008X	261QF0400X
1223D0001X	1223P0221X	1223X0400X	261QR1300X
1223D0004X	1223P0300X	124Q00000X+	125Q00000X

1223E0200X 1223P0700X 125J00000X

1223G0001X 1223S0112X 125K00000X

*Services provided by County Health Department dental clinics may also be included as “dental” services.

+Only dental hygienists who provide services under the supervision of a dentist should be classified as “dental” services. Services provided by independently practicing dental hygienists should be classified as “oral health” services and are not applicable for this measure. 135987

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2517 Oral Evaluation, Dental Services

STEWARD

American Dental Association on behalf of the Dental Quality Alliance

DESCRIPTION

Percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the reporting year.

TYPE

Process

DATA SOURCE

Claims Not applicable.

LEVEL

Health Plan, Integrated Delivery System

SETTING

Outpatient Services

NUMERATOR STATEMENT

Unduplicated number of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation as a dental service

NUMERATOR DETAILS

Please see Section S14.

DENOMINATOR STATEMENT

Unduplicated number of enrolled children under age 21 years

DENOMINATOR DETAILS

Please see Section S14.

EXCLUSIONS

Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded

EXCLUSION DETAILS

There are no other exclusions than those described above.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

This measure will be stratified by age using the following categories:

<1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

No new data are needed for this stratification. Please see attached specifications for complete measure details.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Oral Evaluation Calculation

1. Use administrative enrollment and claims data for a single year. When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

2. Check if the enrollee meets age criteria at the last day of the reporting year:

a. If age criterion is met, then proceed to next step.

b. If age criterion is not met or there are missing or invalid field codes (e.g., date of birth), then STOP processing. This enrollee does not get counted in the denominator.

3. Check if subject is continuously enrolled for at least 180 days:

a. If subject meets continuous enrollment criterion, then include in denominator; proceed to next step.

b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted in the denominator.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: All enrollees who meet age and enrollment criteria

4. Check if subject received an oral evaluation as a dental service:

a. If [CDT CODE] = D0120 or D0150 or D0145, and;

b. If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 1 below, then include in numerator; proceed to next step.

c. If both a AND b are not met, then the service was not provided or not a "dental service"; STOP processing. This enrollee is already included in the denominator but will not be included in the numerator.

Note: In this step, all claims with missing or invalid CDT CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 1 should not be included in the numerator.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees who received an oral evaluation as a dental service

5. Report

a. Unduplicated number of enrollees in numerator

b. Unduplicated number of enrollees in denominator

c. Measure Rate NUM/DEN

d. Rate stratified by age

Table 1: NUCC maintained Provider Taxonomy Codes classified as "Dental Service"*

122300000X	1223P0106X	1223X0008X	261QF0400X
1223D0001X	1223P0221X	1223X0400X	261QR1300X
1223D0004X	1223P0300X	124Q00000X+	125Q00000X
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

*Services provided by County Health Department dental clinics may also be included as "dental" services.

+Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services. Services provided by independently practicing dental hygienists should be classified as "oral health" services and are not applicable for this measure. 135987

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2528 Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services

STEWARD

American Dental Association on behalf of the Dental Quality Alliance

DESCRIPTION

Percentage of enrolled children aged 1-21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.

TYPE

Process

DATA SOURCE

Claims Not applicable.

LEVEL

Health Plan, Integrated Delivery System

SETTING

Outpatient Services

NUMERATOR STATEMENT

Unduplicated number of enrolled children aged 1-21 years who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications as a dental service

NUMERATOR DETAILS

Please see section S14.

DENOMINATOR STATEMENT

Unduplicated number of enrolled children aged 1-21 years who are at “elevated” risk (i.e., “moderate” or “high”)

DENOMINATOR DETAILS

Please see Section S14.

EXCLUSIONS

Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded.

EXCLUSION DETAILS

There are no other exclusions than those described above

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

This measure is stratified by age using the following categories:

1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

No new data are needed for this stratification. Please see attached specifications for complete measure details.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Topical Fluoride Intensity Calculation for Children at Elevated Caries Risk

1. Use administrative enrollment and claims data for a single year. When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

2. Check if the enrollee meets age criteria at the last day of the reporting year:

a. If child is >=1 and < 21, then proceed to next step.

b. If age criteria are not met or there are missing or invalid field codes (e.g., date of birth), then STOP processing. This enrollee does not get counted.

3. Check if subject is continuously enrolled for the reporting year (12 months) with a gap of no more than 31 days (one month gap for programs that determine eligibility on a monthly basis):

a. If subject meets continuous enrollment criterion, then proceed to next step.

b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted.

YOU NOW HAVE THE COUNT OF THOSE WHO MEET THE AGE AND ENROLLMENT CRITERIA

4. Check if subject is at "elevated risk":

a. If subject meets ANY of the following criteria, then include in denominator:

i. the subject has a CDT Code among those in Table 1 in the reporting year,

OR

ii. the subject has a CDT Code among those in Table 1 in any of the three years prior to the reporting year, (NOTE: The subject does not need to be enrolled in any of the prior three years for the denominator enrollment criteria; this is a "look back" for enrollees who do have claims experience in any of the prior three years.)

OR

iii. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year.

b. If the subject does not meet any of the above criteria for elevated risk, then STOP processing. This enrollee will not be included in the measure denominator.

YOU NOW HAVE THE DENOMINATOR (DEN): Enrollees who are at "elevated risk"

5. Check if subject received at least two fluoride applications as dental service during the reporting year – at least two unique dates of service when topical fluoride was provided. Service provided on each date of service should satisfy the following criteria:

a. If [CDT CODE] = D1206 or D1208 , and

b. If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 1 below, then include in numerator; proceed to next step.

c. If both a AND b are not met, then the service was not a "dental service"; STOP processing. This enrollee is already included in the denominator but will not be included in the numerator.

Note 1: No more than one fluoride application can be counted for the same member on the same date of service.

Note 2: All claims with missing or invalid CDT CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 2 should not be included in the numerator.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees at "elevated risk" who received fluoride as a dental service

6. Report

a. Unduplicated number of enrollees in numerator

b. Unduplicated number of enrollees in denominator

c. Measure Rate (NUM/DEN)

d. Rate stratified by age

Table 1: CDT Codes to identify "elevated risk"

D2140	D2394	D2630	D2720	D2791	D3120
D2150	D2410	D2642	D2721	D2792	D3220
D2160	D2420	D2643	D2722	D2794	D3221
D2161	D2430	D2644	D2740	D2799	D3222
D2330	D2510	D2650	D2750	D2930	D3230
D2331	D2520	D2651	D2751	D2931	D3240
D2332	D2530	D2652	D2752	D2932	D3310
D2335	D2542	D2662	D2780	D2933	D3320
D2390	D2543	D2663	D2781	D2934	D3330
D2391	D2544	D2664	D2782	D2940	D2941
D2392	D2610	D2710	D2783	D2950	D1354
D2393	D2620	D2712	D2790	D3110	

Table 2: NUCC maintained Provider Taxonomy Codes classified as "Dental Service"*

122300000X	1223P0106X	1223X0008X	261QF0400X
1223D0001X	1223P0221X	1223X0400X	261QR1300X
1223D0004X	1223P0300X	124Q00000X+	125Q00000X
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

*Services provided by County Health Department dental clinics may also be included as "dental" services.

+Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services. Services provided by independently practicing dental hygienists should be classified as "oral health" services and are not applicable for this measure. 135987

Appendix E1: Related and Competing Measures (tabular format)

Comparison of NQF 0034 and NQF 0658

	0034 Colorectal Cancer Screening (COL)	0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
Steward	National Committee for Quality Assurance	American Gastroenterological Association
Description	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	Percentage of patients aged 50 years to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
Type	Process	Process
Data Source	Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.	Claims, Electronic Health Data, Electronic Health Records, Other, Registry Data Not applicable.
Level	Health Plan, Integrated Delivery System	Clinician : Group/Practice, Clinician : Individual
Setting	Outpatient Services	Outpatient Services
Numerator Statement	Patients who received one or more screenings for colorectal cancer according to clinical guidelines.	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report
Numerator Details	ADMINISTRATIVE: Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria: -Fecal occult blood test (FOBT Value Set) during the measurement year. -Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year. -Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year. -CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year. -FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two years prior to the measurement year. MEDICAL RECORD: Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria: -Fecal occult blood test during the measurement year. -Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. -Colonoscopy during the measurement year or the nine years prior to the measurement year. -CT colonography during the measurement year or the four years prior to the measurement year. -FIT-DNA test during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered). A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria. For pathology reports that do not indicate the type of screening and for incomplete procedures: --Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy. --Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy. There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance. --If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator. --If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion. --FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.	Patients will be counted in the numerator if it is documented in the final colonoscopy report that the appropriate follow-up interval for the next colonoscopy is at least 10 years from the date of the current colonoscopy (ie, the colonoscopy performed during the measurement period).

	0034 Colorectal Cancer Screening (COL)	0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
	--If the medical record indicates that a gFOBT was done, follow the scenarios below. –If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator. –If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator. –If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria. Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.	
Denominator Statement	Patients 51–75 years of age	All patients aged 50 years to 75 years and receiving screening a screening colonoscopy without biopsy or polypectomy
Denominator Details	Patients 51–75 years of age as of the end of the measurement year (e.g. December 31).	All patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy during the measurement period. ICD-10-CM: Z12.11 AND Patient encounter during the reporting period (CPT or HCPCS): 44388, 45378, G0121 WITHOUT CPT Category I Modifiers: 52, 53, 73, 74
Exclusions	This measure excludes patients with a history of colorectal cancer or total colectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, inadequate prep,familial or personal history of colonic polyps, patient had no adenoma and age is >= 66 years old, or life expectancy < 10 years, other medical reasons)
Exclusion Details	Exclude patients with either of the following any time during the patient's history through December 31 of the measurement year: - Colorectal cancer (Colorectal Cancer Value Set) - Total colectomy (Total Colectomy Value Set) Exclude patients who use hospice services any time during the measurement year (Hospice Value Set). Exclude patients 65 and older who are enrolled in an institutional SNP or living long-term in an institution at any time during the measurement year.	The measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0658, exceptions may include medical reason(s) (eg, inadequate prep, other medical reasons) for not recommending at least a 10 year follow-up interval. Examples of exceptions are included in the measure language.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	None	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1. Determine the eligible population: identify patients 51-75 years of age by the end of the measurement year. Step 2. Search for an exclusion in the patient's history: history of total colectomy or colorectal cancer. Exclude these patients from the eligible population. Step 3. Determine numerator: the number of patients who have been screened for colorectal cancer by any of the included screening methods, within the associated time interval. Step 4. Calculate the rate. 123834| 140881	To calculate performance rates: 1)Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2)From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3)From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is >= 66 years old, life expectancy < 10 years, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents performance not met. 136611| 124667| 109921| 135466

	0034 Colorectal Cancer Screening (COL)	0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
Submission items	5.1 Identified measures: 0658: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Minnesota Community Measurement: These measures are harmonized but intended for different levels of accountability. --Both measures exclude patients who have had a total colectomy, a history of colorectal cancer, or who have been in hospice care. --Both measures include the same screening methods and intervals. --The Minnesota Community Measurement quality measure is intended for use at the clinician or practice-level, whereas NQF#0034 is intended for use at the health plan level. American Gastroenterological Association: These measures have different areas of focus and are harmonized where appropriate. --The American Gastroenterological Association measure focuses on only one of the available screening methods: colonoscopy. The measure assesses whether patients who have had a colonoscopy also have a recommended follow-up interval of 10 years documented in their colonoscopy report. 5b.1 If competing, why superior or rationale for additive value: Not applicable.	5.1 Identified measures: 0572: Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy 0659: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The list of measures above, includes several different populations and capture different elements in the numerator. None of them are aiming to capture the same information as measure 0658. Measures 0572, ACP-018-10, and 0392 actually aim to capture specific elements within the colonoscopy report or pathology report (after colon/rectum resection). Measure 0034 intends to capture one of four different types of colorectal cancer screening tests, instead of looking specifically at the interval between colonoscopies. Measure 0659 focuses on a different patient population, as the patients in 0659 have had a history of a prior colonic polyp(s) in previous colonoscopy findings. The patient population in measure 0659 has a different follow up interval recommendation, according to evidence based guidelines. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures.

Appendix E2: Related and Competing Measures (narrative format)

Comparison of NQF 0034 and NQF 0658

0034 Colorectal Cancer Screening (COL)
0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Steward

0034 Colorectal Cancer Screening (COL)

National Committee for Quality Assurance

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

American Gastroenterological Association

Description

0034 Colorectal Cancer Screening (COL)

The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Percentage of patients aged 50 years to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.

Type

0034 Colorectal Cancer Screening (COL)

Process

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Process

Data Source

0034 Colorectal Cancer Screening (COL)

Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Claims, Electronic Health Data, Electronic Health Records, Other, Registry Data Not applicable.

Level

0034 Colorectal Cancer Screening (COL)

Health Plan, Integrated Delivery System

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Clinician : Group/Practice, Clinician : Individual

Setting

0034 Colorectal Cancer Screening (COL)

Outpatient Services

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Outpatient Services

Numerator Statement

0034 Colorectal Cancer Screening (COL)

Patients who received one or more screenings for colorectal cancer according to clinical guidelines.

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Numerator Details

0034 Colorectal Cancer Screening (COL)

ADMINISTRATIVE:

Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria:

-Fecal occult blood test (FOBT Value Set) during the measurement year.

-Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.

-Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.

-CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.

-FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two years prior to the measurement year.

MEDICAL RECORD:

Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria:

-Fecal occult blood test during the measurement year.

-Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.

-Colonoscopy during the measurement year or the nine years prior to the measurement year.

-CT colonography during the measurement year or the four years prior to the measurement year.

-FIT-DNA test during the measurement year or the two years prior to the measurement year.

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this

is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures:

--Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.

--Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

--If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.

--If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.

--FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.

--If the medical record indicates that a gFOBT was done, follow the scenarios below.

–If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.

–If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.

–If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Patients will be counted in the numerator if it is documented in the final colonoscopy report that the appropriate follow-up interval for the next colonoscopy is at least 10 years from the date of the current colonoscopy (ie, the colonoscopy performed during the measurement period).

Denominator Statement

0034 Colorectal Cancer Screening (COL)

Patients 51–75 years of age

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

All patients aged 50 years to 75 years and receiving screening a screening colonoscopy without biopsy or polypectomy

Denominator Details

0034 Colorectal Cancer Screening (COL)

Patients 51–75 years of age as of the end of the measurement year (e.g. December 31).

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

All patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy during the measurement period.

ICD-10-CM: Z12.11

AND

Patient encounter during the reporting period (CPT or HCPCS): 44388, 45378, G0121

WITHOUT

CPT Category I Modifiers: 52, 53, 73, 74

Exclusions

0034 Colorectal Cancer Screening (COL)

This measure excludes patients with a history of colorectal cancer or total colectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, inadequate prep,familial or personal history of colonic polyps, patient had no adenoma and age is >= 66 years old, or life expectancy < 10 years, other medical reasons)

Exclusion Details

0034 Colorectal Cancer Screening (COL)

Exclude patients with either of the following any time during the patient's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set)

- Total colectomy (Total Colectomy Value Set)

Exclude patients who use hospice services any time during the measurement year (Hospice Value Set).

Exclude patients 65 and older who are enrolled in an institutional SNP or living long-term in an institution at any time during the measurement year.

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

The measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0658, exceptions may include medical reason(s) (eg, inadequate prep, other medical reasons) for not recommending at least a 10 year follow-up interval. Examples of exceptions are included in the measure language.

Risk Adjustment

0034 Colorectal Cancer Screening (COL)

No risk adjustment or risk stratification

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

No risk adjustment or risk stratification

Stratification

0034 Colorectal Cancer Screening (COL)

None

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language.

Type Score

0034 Colorectal Cancer Screening (COL)

Rate/proportion better quality = higher score

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Rate/proportion better quality = higher score

Algorithm

0034 Colorectal Cancer Screening (COL)

Step 1. Determine the eligible population: identify patients 51-75 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: history of total colectomy or colorectal cancer. Exclude these patients from the eligible population.

Step 3. Determine numerator: the number of patients who have been screened for colorectal cancer by any of the included screening methods, within the associated time interval.

Step 4. Calculate the rate. 123834| 140881

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

To calculate performance rates:

1)Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).

2)From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.

3)From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is >= 66 years old, life expectancy < 10 years, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents performance not met. 136611| 124667| 109921| 135466

Submission items

0034 Colorectal Cancer Screening (COL)

5.1 Identified measures: 0658: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Minnesota Community Measurement: These measures are harmonized but intended for different levels of accountability. --Both measures exclude patients who have had a total colectomy, a history of colorectal cancer, or who have been in hospice care. --Both measures include the same screening methods and intervals. --The Minnesota Community Measurement quality measure is intended for use at the clinician or practice-level, whereas NQF#0034 is intended for use at the health plan level. American Gastroenterological Association: These measures have different areas of focus and are harmonized where appropriate. --The American Gastroenterological Association measure focuses on only one of the available screening methods: colonoscopy. The measure assesses whether patients who have had a colonoscopy also have a recommended follow-up interval of 10 years documented in their colonoscopy report.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

5.1 Identified measures: 0572: Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy

0659: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The list of measures above, includes several different populations and capture different elements in the numerator. None of them are aiming to capture the same information as measure 0658. Measures 0572, ACP-018-10, and 0392 actually aim to capture specific elements within the colonoscopy report or pathology report (after colon/rectum resection). Measure 0034 intends to capture one of four different types of colorectal cancer screening tests, instead of looking specifically at the interval between colonoscopies. Measure 0659 focuses on a different patient population, as the patients in 0659 have had a history of a prior colonic polyp(s) in previous colonoscopy findings. The patient population in measure 0659 has a different follow up interval recommendation, according to evidence based guidelines.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures.

Appendix F: Pre-Evaluation Comments

Comments received as of February 1, 2018.

0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Sandy L. Pogones, The American Academy of Family Physicians

The American Academy of Family Physicians supports this measure as written.

0034 Colorectal Cancer Screening (COL)

Sandy L. Pogones, The American Academy of Family Physicians

This measure is consistent with the most recent USPSTF Recommendations and Evidence for Screening for Colorectal Cancer. The numerator description may need clarification as to the types of stool tests. The description under the numerator heading refers to "fecal occult blood test" and "FIT-DNA." This seems too vague. The 3 USPSTF-recommended screening tests are HSgFOBT, FIT, and FIT-DNA. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#tab.

2508 Prevention: Sealants for 6-9 Year-Old Children at Elevated Caries Risk, Dental Services

DeDe Davis, MCA Dental

MCNA is a leading Medicaid and CHIP focused dental insurer headquartered in Fort Lauderdale, Florida. We currently administer dental benefits for over 4.2 million Medicaid, CHIP, and ACA members across seven states: Texas, Louisiana, Florida, Idaho, Iowa, Nebraska and Arkansas. This makes us one of the nation's largest stakeholders with respect to utilization of the DQA's sealant measures. While we would agree that focus on sealants is an appropriate clinical area of focus for quality improvement, the measure as currently designed cannot be used to accurately measure or report on the percent of children have received clinically appropriate sealant services. The current measure maintains children in the denominator regardless of whether they have had all four first permanent molars previously sealed, restored, or extracted. The American Academy of Pediatric Dentistry's (AAPD) clinical practice guidelines recommend periodic checkups on sealants to evaluate the need for repair or replacement, and the guidelines note that the average lifespan of a sealant is five years. For this reason, most states limit Medicaid benefits for sealants on the same tooth. The current limitation for children in Texas CHIP and Arkansas Medicaid is once per lifetime. Texas Medicaid, Florida Medicaid and CHIP, and Idaho Medicaid limit the benefit to once every three years per tooth, and all other states we serve limit the benefit to once every two years per tooth. Additionally, the AAPD and ADA clinical practice guidelines note that it is clinically inappropriate to seal a tooth that has been previously restored, and it is obviously impossible to place a sealant on a tooth that has already been extracted. Yet despite these nationally recognized clinical practice guidelines, the DQA sealant measure does not remove children from the denominator who fit these criteria even though it is impossible for these children to ever be in the numerator. The impact to both states and dental benefit plans alike is statistically significant as evidenced in our 2016 calendar year results for our two largest state Medicaid contracts. Our Texas Medicaid DQA results for

high risk children ages 6-9 are as follows: 60,919/243,165 = 25.05%. In analyzing the DQA denominator, 32% (76,995) of the children included were not eligible to receive a sealant on any of the four teeth included in the measure during the reporting year due to benefit limitations and/or in accordance with ADA/AAPD clinical practice guidelines. If the DQA methodology is used to calculate the rate with these ineligible children properly removed from the denominator, the rate increases from 25.05% to 34.79% for children receiving at least one sealant during the measurement year. Using the same methodology for Louisiana Medicaid, the current DQA rate for high risk children ages 6-9 is 21.05% (20,369/96,747). In analyzing the DQA denominator, 25% (24,303) of the included children are ineligible for sealants for the reasons described above. Using the DQA methodology and removing children who are not eligible to receive the benefit produces a rate of 26.27% for children receiving at least one sealant during the measurement year. These dramatic differences are important because they provide States, dental benefit plans, academia, and public health with an accurate count of children who are eligible for sealant services and who have received them during the measurement year. States and dental benefit plans are easily able to administratively identify the majority of children who are ineligible for sealants based on the criteria cited above. Claims data typically includes procedure codes and the corresponding tooth identifier to enable removal of those who have already received a sealant, restoration, or had the tooth extracted. Currently, all dental benefit plans must identify these exclusions prior to initiating any quality improvement interventions targeted to increase those receiving sealants in order to ensure that only clinically appropriate care per the AAPD and ADA guidelines is promoted and encouraged. Additionally, inappropriate outreach to these children would result in wasted state and federal tax dollars and increase member and provider dissatisfaction rates when 11 members seek services that they are not eligible for based on the plan benefit design or nationally accepted clinical practice guidelines. As a result of this measure being included in the child core set for Medicaid and CHIP programs, states are now including penalties in contracts with dental benefit plans that hold them accountable for improving the sealant rates for the children served. The inclusion of ineligible children in the denominator makes it next to impossible to demonstrate the required improvement needed to meet these goals. Based on our analysis, 25%-30% of children in the denominators of our two largest plans are not eligible to receive the benefit in accordance with state benefit limitations or clinical practice guidelines. The medical equivalent to the current DQA sealant measure would be to keep children in the denominator for immunizations year-after-year when they previously had received the clinically recommended immunization prior to the measurement year or demonstrated a contraindication. MCNA and other dental benefit plans must negotiate on a state-by-state basis to ensure children who are not eligible to receive the sealant benefit are appropriately removed from the denominator. This has become time consuming and frustrating for states and dental benefit plans alike, and for this reason we are escalating the unintended consequences of including ineligible children to the NQF for consideration in this year's review of the Medicaid and CHIP core set. Most all of our External Quality Review Organizations have acknowledged the need for excluding members in both the CMS 416 and DQA sealant measures, Louisiana and Florida included. The Texas Pay-for-Quality program allowed for these members to be excluded from the sealant measure in calendar years 2014 – 2016, however their current stance is that if the exclusion is valid that it should be made by the NQF or the DQA and not by individual states in order to promote a uniform measure. Based on our data driven retrospective review of this measure across many state Medicaid and CHIP programs, we would strongly disagree that this measure could pass validity testing given the high volume of members in the denominator not

eligible to receive the sealant benefit. For this same reason, any statistically significant movement up or down in the overall rate does not equate to demonstrated meaningful improvement or decline in the oral health status of Medicaid and CHIP populations because the rate generated by the measure as currently designed does not produce accurate information about population health. We encourage a change to the measure to account for the three scenarios that render children ineligible for the benefit: previous sealants/benefit frequency, restorations, and extractions. MCNA appreciates the opportunity to provide feedback as a key stakeholder. It is our intention to join the National Quality Forum this year and become more active in all quality improvement activities given the increased national focus on oral health care and integrated care.

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