

Child Core Set Dental Sealant Measure Webcast November 12, 2015

Hello everyone and thank you for attending today's Technical Assistance Webinar on the Dental Sealant Measure in the Child Core Set. Before we begin, we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget by clicking on the "Maximize" icon at the top right of the widget or by dragging the bottom right corner of the widget panel.

If you have any questions for presenters during the webcast you can click on the Q&A widget at the bottom and submit your question there. We will try to address as many questions as possible during this event, but if a fuller answer is required or we run out of time, your question will be answered later via email. We do capture all questions. A copy of today's slide deck and the technical assistance resources mentioned in today's presentation are available in the resource list widget that looks like a green folder at the bottom of your screen.

If you have any technical difficulty, please click on the help widget. It has a question mark icon and covers common technical issues. An on-demand version of the webcast will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you earlier. Now I'd like to pass it over to Margo Rosenbach of Mathematica Policy Research. Margo, you now have the floor.

Thank you, Brice. And I'd like to add my welcome to everyone on the phone, listening in to this webinar. We have a very exciting panel assembled for today starting with Dr. Lynn Mouden who is the Chief Dental Officer at CMS, who is going to be talking about CMS' Oral Health Initiative and the Dental Sealant Measure. We have several people assembled from the Dental Quality Alliance of the ADA to talk about the Dental Sealant Measure specifications. They are the measure stewards, and speaking on behalf of the DQA is Krishna, and then two people talking from Alabama and Texas about their experiences in calculating the Dental Sealant Measure. And then, finally, I'll wrap up with some technical assistance resources that are available to help states on behalf of the Technical Assistance team at Mathematica Policy Research. And then we'll conclude with some next steps and additional information. Next slide, Brice. So now I'd like to turn it over to Dr. Mouden to talk about the Oral Health Initiative and the measure.

Okay. Thank you, Margo. And I'd like to add my welcome and thank you for all who are participating. I have kind of looked through the attendee list and see that we have a nice mix of folks today from public health to Medicaid to private affairs to advocates. And we're obviously glad to see so much interest in what we're talking about today. I've got just a few minutes to try and kind of frame what we're going to talk about later. And then we'll turn it over to Dr. Aravamudhan for more detail. So next slide, please.

Just to make sure we do things formally here, we do have learning objectives. And what we're going to talk about are the motivation for the new Dental Sealant Measure, and including why it's important to include caries risk element; describe the specifications for the measure and the technical assistance resources that are going to be available to help you calculate the measure; and then when we turn it over to the states, we'll learn about two states' experiences with calculating the new Dental Sealant Measure.

So, as I'm sure most of you know, we've had an Oral Health Initiative at CMS since 2010. We've just finished the first five years of that effort, and it has all focused on dental prevention strategies. And as you also probably know, we have set baseline and been reporting on the prevention measure, which includes dental sealants, but not so much specifically on just the sealant measure itself.

In the last three years that states have been working under the oral health initiative we've seen about a 3% increase nationally. We do know that several states are on track to reach the ten-percentage-point goal over the five-year period of the Oral Health Initiative. Some states are very much on track. We actually have some states that have kind of dropped by the wayside and their numbers are not as good as where we started. We continue to work with all the states on these measures.

So why do we focus on dental sealants? Well, obviously we do know that sealing all permanent first molars, at least according to one study, can save Medicaid about \$53 per child in just the first two years after the sealant is placed. But we have much room for improvement as we're trying to increase access,

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not just for dental care in total but also specifically for getting access to these dental sealants as they're needed.

So just to talk a little bit about the Child Core Set, the Child Core Set is an initiative that was given to CMS under the CHIPRA statute, the Child Health Insurance Program Reauthorization Act. And it gave a couple of directives to HHS, and therefore to CMS. First of all, HHS was required to identify and publish measures. And then what's also left to us each year is to publish what we call the Secretary's Report. We provide the information to the HHS secretary to talk specifically about the Child Core Set measures. Excuse me.

Since sealants are one of the most effective preventive oral health services for children, we feel it's important to represent them in the Child Core Set. So changing the Child Core Set slightly, we took out the TDENT, the Treatment for Dental Services measure, which had some methodological flaws, and replaced it with the SEAL measure, starting in 2015. So this is the first reporting year. One of the benefits of using the SEAL measure is it is a validated feasibility and reliability tested measure from the Dental Quality Alliance and is part of the set of the Pediatric Oral Health Quality Measures. It's important to those who work in the quality arena that a measure be endorsed by the National Quality Forum. And the SEAL measure, along with others in starter set, have been endorsed by the NQF.

So one of the things that differs this from what is reported in the 416 line 12D, those of you who work in Medicaid are familiar with the 416 form, two differences. First of all, the period of continuous enrollment is 180 days, while in the form 416 it's 90 continuous days of enrollment, and the caries risk is represented in the DQA measure. So, as Krishna will be talking about, this isn't just sealants provided to any patient. It's those who are at higher risk. And she will talk about how those are identified. So that's the basis of what we're going to talk about today. So I think that takes care of my part for now. So I'd like to turn it over to Dr. Krishna Aravamudhan who is the director of the Council on Dental Benefit Programs at the American Dental Association. Krishna.

Thank you. Dr. Mouden. Hello everybody and thank you for inviting us to speak today. I'd like to start with a very quick introduction about the Dental Quality Alliance and the process we follow, therefore spending the bulk of the time on the measure itself. So the DQA, or Dental Quality Alliance, is formed at the request from CMS in 2008 to bring the dental community together to talk about, you know, what is quality in dentistry and how can we move the needle, and what sort of measures are really required. We're seeing a lot of anxiety in medicine right now in terms of so many measures, we need to harmonize, and so on and so forth. So, although we started late, it gives us an opportunity to think about really what we need and then drive towards that goal.

So the DQA started with conducting an environmental scan, and we looked at all the measures that were out there. We found a lot of measures, and you can see the report there on the website. But, you know, the heart of the measure is the specification. And as we work through this webinar, we'll sort of understand the importance of that specification. It's really that tool that allows us to calculate the measure the same way and compare entities across each other.

So we spent a couple of years kind of learning about the measurement process, benchmarking against what others are doing, and 2011 is the first when we started actually putting our measures together. In 2014, we had our first set of measures endorsed by the NQF. And today we're very, very proud to say seven measures are actually endorsed by the National Quality Forum. When the measure development process starts, we start by conceptualizing what we need to measure, why we want to measure that, and then we go through very, very rigorous testing, which almost took us, I think, 18 months to complete the first start set.

And the testing, as Dr. Mouden mentioned, really looks at, okay, is this measure feasible? Is it reliable? Is it valid?, and kind of working through and developing that specification. I have to say that the process as we went through it, the realization, and it's a very, very important realization, that there is no perfect measure and there is no magic measure. So using, you know, one measure or saying, okay, this is the

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measure, it's all about doing everything uniformly so then we can compare and learn and then improve. Again, the purpose of this endeavor is to improve, and so we never want to lose sight of that goal.

We contracted with the University of Florida, and I know we have presenters from there as well to talk to you today. And we used data from Texas Medicaid, Texas CHIP, Florida Medicaid, Florida CHIP, and some commercial data to actually pull together these measures and pull together specifications. So that's an overview of why we are here or how we came here today.

For the rest of the presentation, I will sort of go over the measure itself and we'll talk a little bit about why we're measuring sealants, why it's a measure structured that way, what do you need to do this measure, and then how you're going to actually compute the data. So, with that, can we move to the next slide, please?

All right, for those who can see the screen, this slide basically gives you the measure description, the numerator and the denominator. So this is sort of your overview, the executive summary of the measure, if you will. Now, as we look at this, the first question is, okay, why are we measuring sealants and why are we focusing on this measure? So anyone who knows dental data, Medicaid, you know, claims, et cetera, et cetera, outcomes are very, very difficult to measure in dentistry, given the data limitations that we have.

So if we cannot measure outcomes directly, the question becomes, okay, what can we measure next? And so that is where processes of care become hugely important. And in order to identify the right process of care to measure, we have to go back to our roots in science. We have to say, okay, where is the evidence? What do we know that works? So we can see if we are providing that, so that then we can make sure that we are actually moving the needle towards a healthy population.

So every measure has to be grounded in evidence. And the structure of the measure, because it's so precise, is using -- we're not simply counting services. We're not simply counting the number of sealants. We're now changing this, using the same data to actually measure quality. And that's the reason why you see things like elevated risk, you see a very specific age range, you see a very specific tooth number. All of these pieces of the measure are built in because we have to tie it back to the evidence. So it's hugely, hugely important, as any implementer is implementing this measure, to very, very, very closely follow the specifications.

Like I began by saying, you know, the roles here is to improve, so you don't want to measure everybody and everything, but you're trying to target and focus the population, and say, "Okay, if we want to move this population, who needs to be moved, and then how can we move them?" So that's sort of the overview of the dental sealant measure. As Dr. Mouden mentioned, this is endorsed by NQF, and you see the definitions for the denominator and numerator on the slide. We'll go into more detail on each of these as we move through the presentation. Next slide, please.

So here we're going to talk about -- so we talked a little bit about, you know, why we're measuring sealants. So let's talk a little bit about what do you need to measure sealants. So hopefully, by now, you're all onboard about, okay, this is an important topic, we have a performance gap, sealants are important. Let's measure it. Okay.

So now that we have bought into the concept, let's go on and see what we need in order to make this measure happen. So this measure, one of the very important things as far as testing goes is to test for feasibility, which basically means, look, we know there's no perfect database, we don't have everything that we need, but, based on what we have, can most people measure or put this measure in place? So that's a part of the testing.

And so the specifications that you have in front of you are the critical data elements. The table in this slide lists for you all the data elements that are crucial to this measure. And you will see that these are very, very similar to what you have programmed or what you use to get data for your 416. Data quality is hugely important, as always. You have to make sure you have robust data, otherwise the measure score that you get really wouldn't mean much.

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CMS error rates of 5% studied element error thresholds are probably a good rule of thumb to follow for all of these measures. Important, just like the 416 new instructions, we are including all claims, whether they are paid or pending, suspended, and so on, because the intent here is to see whether the service was provided, and we're using claims data to do that. We're not looking at whether the service was paid for. So, very, very important.

In terms of the amount of data or the year, the reporting year for this particular effort is 2014. So, obviously you will need all the claims data for 2014. But there is another set of data which we call the "lookback period" of up to three years, not three years, it's up to three years that you will require to calculate the elevated risk piece. Again, I'll go over this when we start talking about the denominator in a few minutes.

So you need 2014 data and you need up to three years lookback data, and you need all the claims data. Now, an important note for states that are using the managed care model, you know, if all the enrollees in your state are really belonging to one or the other managed care, it's not correct to simply kind of get the MCOs to calculate the scores and add it up, that is not how the measure works. If an enrollee sort of switches plans and doesn't have a gap in continuity, you really want to make sure you're measuring at the program level. So make sure we're measuring at the program level, make sure you're including fee-for-service, managed care, prepaid dental, everything. So all of those -- all the populations really need to be included. Next slide, please.

So, like I just said, this is basically all children eligible for EPSDT benefits need to be included in your population. And this is the same as what is done for the 416. Next slide, please. We'll go one more slide. Okay.

So now we're going to start talking about really how this measure is going to be calculated. So a measure has two components, right? It has the denominator and then it has a numerator. The denominator is basically -- the numerator is basically a subset of the denominator. And then the denominator is a subset of your entire population that's in your Medicaid database. So how do you go through this case-finding process?

So once you have your entire data place, your enterprise of all the kids in your program, how do you come to the denominator? You get there by applying three basic filters. The very first filter is the age filter. So we are interested, for this measure, to look at kids between ages six to nine years. Again, I cannot repeat this enough, the specifications are hugely important. Programming something, just reading the numerator/denominator statement, would not be sufficient.

For example, how do you know whether a child is six years belongs or falls in this range? Well, so the specification tells you that you use the labs data with the measurement year, that is December 31st, 2014, as your marker, you use date of birth data element as your source data for this, and you figure out if the child is greater than or equal to six years and less than or equal to ten years. So that's how the programming needs to be done to get this cohort of kids who belong in the six to nine years. Throughout the specifications you'll also see places; okay, there it's missing or invalid data, you need to kind of throw out this record. So that's, again, very important to make sure we're all measuring the same way.

Okay, so from your enterprise data, you have now pooled the kids who are six to nine years old. What's the next filter? The next filter we put in is the enrollment filter. The enrollment filter, as Dr. Mouden mentioned, is 180 days continuous enrollment. This is one place where we differ from the 416 reporting. And I can go into more detail of why we picked 180 days, if anyone has questions, but for now I'll just leave it that, you know, we're using the 180 days and it has to be a continuous enrollment.

This slide also has some very important information, so hopefully you will get to read this after and when you're trying to make your program. The gap is counted at the program level. Again, if an enrollee moves between managed care carriers within the state but didn't have a gap, you know, the child should be included. If there were multiple spells within the year, again, you take the longest spell. So check with the

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specification to make sure you have all of these nuances programmed in as you're trying to use the enrollment filter. So that takes us through the first and second step of the denominator. Next slide, please.

Okay. Now, the third filter to get to the denominator is this application of elevated risk, and I'll go a little bit slow here because this is the piece that we get the most questions on. If you look at the specification, there are two methods to find the kids who are at elevated risk. Now, the very first question that we get asked is why can't we just use all Medicaid kids as high risk and why do we need to do this? Again, you're kind of trying to go through a sampling, a case-finding procedure where you're identifying children who can be successfully identified through claims data who absolutely need sealants. So past history of restoration is the most significant marker. There's a lot of evidence that says it's a predictor of future disease, so that is conceptually what drives this methodology for risk assessment.

The simplest, most easiest method is, of course, if you have caries risk code 0602 and 0603. But the problem is these codes were introduced only in 2014, and if you're using the 2014 data, the likelihood that you're going to find these codes and people report these codes to you on the claim is very, very low. So I would be very surprised if any states actually have these codes in their system, especially for 2014 data. However, the important point to remember is as we go to the future, if we can get these codes implemented, get these codes in a system, it would make a calculation of measures like this measure and measures like this very, very much simpler.

Okay. So what is the second method, which is probably the method that you all are going to need to program to calculate the measure today? That measure is, again, grounded by the fact that we're going to look for past history of restorations as a predictor of future risk. So how do we look for past history of restorations? Well we have all a list of restoration codes that is included, both in the slide deck as well as the resources Mathematica has put together and in our specification. It's a list of D codes that should be in your claims form.

You look for these restorations and past history is basically where you are using the last three years as a lookback period. Very, very important to emphasize that you do not look for any kind of enrollment over these past three years: you're simply looking back. You have the children who are six to nine, who are currently enrolled in the measurement year, you're taking those kids and then you're looking back through their claims history to see whether any of them had restorative history. You might have some kids where you have data only for the last year, some kids where you might have two-year history, some kids who have three years history, but whatever you can find positively to identify the child as elevated risk, that's what you include. So that is really, really important.

Important, as you get this data, don't interpret this as this is the prevalence of high-risk kids in my program, because, again, remember, it's a sampling strategy, it's a case-finding process. You're not going to identify all the kids at elevated risk. You're going to identify a core set that you know are at elevated risk. I hope this is really clear in terms of how the elevated risk piece is programmed into the measure.

So once you have your denominator -- so you did the age, you did the continuity and enrollment, and then you did the elevated risk -- you really have your denominator population. So then we come to calculating the numerator, and the numerator is very simple. It says, "Okay, now you have this cohort of kids. Look and see whether these kids received a sealant." The code for the sealant is D1351. So you look to see whether those codes are there -- that code is there.

Now you want to see whether the sealant has been provided as a dental service. In our user guide, as well as resources Mathematica has put together from there, you will see, again, a table of the NUCC codes. Some states use the NUCC codes. Some states map to it. Some states have a separate file. But whichever way you're doing it, the definition for dental service is exactly adopted from CMS. So whatever you're doing for the 416, you can do the same thing and determine whether the sealant was provided as a dental service.

The very, very last step is looking to see if that sealant was placed in the permanent molar tooth. Now, for those non-dental folks on this call, we all have four first permanent molars. It has to be the first permanent

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molar. That's the tooth that erupts between six to nine. Again, like I said, we want it to stay grounded in evidence. So the evidence says that, you know, put that sealant as soon as that tooth erupts, so that is when you see the outcomes improve.

There is a lot of evidence in terms of getting sealants on kids to reduce the incidence of decay, and that is the health outcome we're trying to reach. So the last step in the process is to find that tooth number, to make sure it's the permanent first molar tooth, and see if the sealant was placed on that. Next slide, please. Go one more after that. Thank you.

So once you have that, you found your denominator, then you found your numerator, you have to now make sure that you don't have any duplicate records, so you un-duplicate it. The numerator divided by the denominator is going to give you the measure rate. So that's pretty much a walkthrough of how the measure is calculated. As part of your resource materials, I believe Mathematica also has a fact sheet and sample SAS code that can serve as a starting point for programmers. The architecture of the databases might be quite different. So the programmers, you need to kind of look through the code and through the specifications. We have a very, very detailed user guide that can also serve as a reference. So, hopefully, all these resources will help you kind of program this. So, with that, I think I am done with my portion of the presentation.

That's great, Krishna. That was a really wonderful presentation about the measure. We do have a few questions to start off with. The first question is -- I think it's an interesting one about since the sealant on the tooth is usually a one-time thing, why wouldn't a patient stay numerator-compliant from one year to the next?

So that's a very, very interesting question, and I hope I'm understanding it correctly. The thing is we all have four permanent molars, right? And then we did a lot of testing where we saw, do all the kids get all the sealants done on the same year? is there -- you know, as we look year to year, how many kids? and it's very variable between programs. One is the program that we had -- you had only 50% of the kids getting it in the first -- in one year. And then you had 30% getting it over two years. So tooth eruption patterns vary. Again, there's no perfect measure, but you want to make sure that as the teeth erupt you're able to capture the child and then make sure that the sealant is applied. So I hope that helps explain as to why we have a broader range. All the four molars won't come in at the very same time.

Great. So now we have a couple questions about the continuous enrollment requirement of 180 days. And so I'll try and paraphrase them as much as possible. So this question says, "Continuous enrollment is 180 consecutive, uninterrupted days, is that correct, as opposed to 180 days cumulative, spanning one enrollment spell?"

Oh, yes, it is a continuous 180 days. And let me take a moment here to explain why it's 180 days, so then it will make sense to the programmers on this call to help you implement this measure. So we had the option of, you know, any enrollment or one-month enrollment or the 90-day enrollment or the HEDIS type 11 out of 12 months. And the balance was, okay, how do we include as many kids as possible? As we did the testing with the HEDIS type enrollment phase where we looked at 11 out of 12 months, with a break of 45 days, what we found that in some of the programs you'd lose two-thirds of the population. And this is right at step one, right? And if you lose two-thirds of the population right there, and then you're applying more and more filters, your sample size really becomes so small that it is not then reflective of the population you're trying to analyze. But if you limit it to, like, 30 days or 90 days, then you're thinking about, practically speaking, does the child have the time to get the enrollment card, go make an appointment, get the needed care, and then get into a preventive schedule? So it's a balance between the reality of the current delivery system as well as the need to include as many children in the population. So that's just the reasoning behind the 180 days. So in order to have that, you know, part where they can actually get the card, see the dentist, et cetera, that continuity is very, very important.

Great. Thank you. And we are getting a lot more questions. I will answer -- a couple people asked where can we find the SAS code, and that code will be ready in the next week or so. We will be putting it up -- we will send it out to people on the webinar who request it, and then also be making it available through

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Medicaid.gov. But it's not quite ready yet, but will be soon. So we had a question about the tooth number code. "Why do we need the tooth number, and if we don't have that variable, can we skip this step? How does that impact the results?"

Good question. So tooth number code is important because we want to make sure that it is the permanent first molar tooth. Now, I will say, and I hope that I can confirm through Mathematica after this call, after talking to a few people, but the age six to nine, if you definitely have the permanent molars, which is what you report on 12D of the CMS416, I think it should be okay the way you do it for the 12D because the second molars don't really erupt, third molars don't really erupt, but it's hugely important that you are able to identify that it's the permanent tooth and it's the molar tooth. So, for that, you might really need the tooth number. We found that there were a lot of sealants being applied, even in that age range, on the primary teeth for sometimes, you know, premolars that have erupted and things like that, and we don't want that. So we want to stick to the evidence and make sure that we are actually looking for permanent molar teeth. And if you can confirm it's a first molar, then that's great.

Thank you, Krishna. We have another question asking for a bit more about the motivation or justification for this measure, and particularly using the high-risk definition. Why not evaluate performance based on all kids enrolled, not just a subset? And then asking, talking about limiting the sample size, how many kids in this population are enrolled six months and coded correctly?

Okay, for the first part -- I didn't quite understand the second part, but let me answer the first part first, and then we'll go to the second part. So, like I said, you know, we're using claims data and we're calling this quality. So we cannot be counting services. We have to actually ground it in evidence in order to actually say this is a health care quality measure. For that purpose, we have to kind of stay true to the evidence and what the current evidence-based guidelines say. If there is any evidence in dentistry, there is evidence for sealants. That is the strongest we have. And so, if you look at the Cochrane reviews, if you look at the ADA guidelines, all of those resources kind of tell you that the current best evidence is that for those who are moderate or high risk, sealants really do reduce the incidence of decay. So that is why you have the elevated risk piece.

Now, one thing in the measurement space that we all need to understand, that this is not standard of care, this is not establishing policy, this is not saying, "Okay, the other kids should not get sealants," none of that. The measure is simply asking the question, "What kids who absolutely need sealants, are they getting it?" as an indication of quality of the system. So that is why we're kind of doing or limiting it to that kids at elevated risk and then going through this case-finding process. So, Margo, if you could kind of repeat that second question.

I think at this point, why don't we move on to some other questions related to elevated risk. I think we do have a number of questions, one coming from a state asking if elevated risk codes are unavailable, should the program not report any rate or should the program modify the measure to exclude the elevated risk criteria?

Okay, so I will tell you 100% -- or let me say 99.9%, you're not going to have the elevated risk code, or at least the CDT code 0602 or 03. You will need to use the specifications. The specifications describe methodology by which you can case find for those at higher risk, that is completely feasible. So I hope that all of you can follow that methodology which says, okay, look back at the claims history, find those kids who have a restorative code, and then use that subset of the population. Again, if we are going to learn from each other, then we have to kind of measure the same way. The measure score is just a data point. It has to be interpreted. If everyone kind of does their own thing just for the sake of reporting, we will not be able to learn from each other. So it's really important to stay consistent, stay true to the measure. So use the lookback period, use the restorative history codes, and then you will be able to find your subset. Some states will have a smaller subset. Some states are going to have a larger subset, just a sampling saying, because it is going to be influenced by how many people had a touchpoint with the system in the last three years and so on, but it is feasible.

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That's great, Krishna. Why don't we move on to the next segment of our presentation where we'll hear from two states, their experiences with the dental sealant measure? So the first state to present will be Alabama. And I'd like to introduce Chris McInnish.

We were in development last week to test it out for this phone call and found it pretty easy to develop. We'll concur that the D0602 AND D0603 are not found very often in our dataset. I think I found less than 50 times that we had received claims, all of which were denied. And we've checked and we currently don't cover this, don't have it as a valid code in our system, and we'll work on that. But we did find about, I think, 47 different times it was provided, but all of them were denied. We did find, though, using the table, the secondary table, this was mentioned, we did find a number of people to put in the denominator for that.

Almost all of the codes were easy to do. The hardest thing we had to do was actually the eligibility, the 180 days consecutive eligibility was not easy to do, but we were able to get it done pretty quickly. But if that was the hardest part, and that's the hardest part, then we're doing pretty well. We can respond to anything from that, but it was a fairly easy measure to calculate as we went through.

That's great. Thank you, Chris. If we have some questions, we'll come back to you. But now why don't we turn to Dr. Laccabue and Yijun Sun from Texas.

Hi. Yes, this is Dr. Marguerite Laccabue here. And I just -- I don't -- it's interesting, I've looked at a lot of these questions, it's very interesting to see all of them that have come in, so I've been reading through them. But, yeah, I just wanted to basically let everyone know that we here in Texas were actually putting into place having our providers have to supply a caries risk assessment code for all of their exams. So that's kind of what we're moving towards, basically being able to have that code available for us as we move forward 2016.

So we actually, and just a little side note, we actually had providers providing those codes for younger ages. And we definitely had the providers out there that wanted to provide that information. So we're actually very excited about moving forward and being able to get this for this age category. But I will defer to Yijun Sun over at the Institute for Child Health Policy because they're the ones that basically do all this analysis for us. So I will just defer over to Yijun.

Thank you. So, as Krishna and many people have said that in the 2014 data we haven't seen lots of providers submitted the claims with the risk assessment code. So, in that sense, we have to rely on the historical data to identify the elevated risk children. But, before that, I want to talk about the quick code data elements. So the only difference between this matter and other dental matters you have seen are the tooth number and the provider taxonomy.

So since in Texas we have DMOs to provide service to the children, so basically almost all the providers are dentists. We use NUCC identification codes to identify them. So this is not a problem for us. However, for tooth number -- actually, when we first started to test the data, like in CY13, at that time we were working with DQA to develop the measure, we found out that some providers or some dental plans, the filling rate for their tooth number is, like, less than 95%. One of the plans was even less than 90%. So then we add our monthly data process and we add the check on the tooth ID. So, from then, in CY2014, the filling rate has been improved to more than 99%. So that apparently is critical to calculate the rate.

Another point I want to talk about is that -- so, because we have both CHIP and Medicaid data, so from last year we see members switch between CHIP and Medicaid. So when looked back, the history of the children actually we combine the claims from both CHIP and Medicaid to identify the elevated risk. That's all I think about when we calculate the measure. Thank you.

Thank you to all the presenters. We do have a question that's come in that I'd like to open up to whoever can answer this, from states or DQA or even CMS. And the question is, "What are state plans to provide training and education to private dentist and sealant programs to make sure it's coded correctly?"

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What is coded correctly?

I believe -- that's actually a good question. I'll read the question again. "What are state plans to provide training and education to private dentist and sealant programs to make sure it's coded correctly?" Perhaps that would be related to the elevated risk.

Possibly so, and I might call on Texas to give us a little bit of information as they're going through the risk assessment. I think that might be the question in terms of how do you use the caries risk codes and how do you code it? From the ADA, we typically have coding resources. We offer a lot of coding assistance to dentists who call us. So that is available. But in terms of implementing the risk assessment tool and using those specific codes, I might turn to the Texas folks.

Yes, actually -- this is Marguerite Laccabue -- I actually went through this process actually from the summer into currently this fall. And we actually got some educational material out there that was available for dentists. We actually utilized case scenarios. So we gave some, you know, practical applications, giving some dental histories and various situations to help dentists identify different issues and look at them and where they would put them into different risk categories. So we actually will have an educational module that is also available for dentists to go through and look at all the case scenarios and help them in their ability to code for the different levels.

Dr. Mouden, do you have anything to add from a CMS perspective?

About the training question?

Yes.

Not really. We obviously are going to rely on not only our friends at Mathematica but also on the dental team here to help the states figure out how best to get the message out on what dentists are supposed to be coding, and that's no different than any other compliance and documentation issue. Good documentation is necessary for claims as well as these measures.

That's great. So another question has come in that's a more general question. Will CMS or ADA name a preferred risk assessment tool for 2016?

I will answer the question from that princely gentleman. CMS will not be specifying a risk assessment tool, and as you look at the 601, 602, 603's, it also does not specify a particular risk assessment tool. I think that states will probably be endorsing -- I'll put that in quotes -- one form or another the risk assessment that they think the dentists should be using, but I'll leave it to the states to determine that.

Krishna, do you have anything to add to that?

Nothing. I think I would completely agree with Dr. Mouden.

Terrific. Okay, well why don't we move on to the next slide then. So on behalf of the TA team at Mathematica, I wanted to give you some further information about technical assistance resources. Next slide, Luke. Many of these resources are actually available through the webinar in the "Resource" part of your console, but they also are available electronically. Information on the CMS Oral Health Initiative is available on medicaid.gov, at this particular link. Also, the technical specification and resource manual for the Child Core Set measures are available, and then also is CMCS informational bulletin to the 2015 updates to the Child and Adult Core Set. And that's actually where the new sealant measure was introduced.

And we did have a question from one of the attendees about which measure was replaced. And the measure that was replaced the measure from the 416 report, based on dental treatment services. So the Preventative Dental Service Measure was kept, the new Dental Sealant Measure was added, and the Dental Treatment Measure was excluded, was retired. Next.

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Okay, so as Krishna referred to, there's an extensive DQA User Guide that's available. We have that in your resource console, and available also on ada.org. And we've actually been referring to it quite a bit to understand the codes and think you'll find it useful as well. And then as Krishna mentioned, the goal here is to calculate state-level rates at the program level. But we do recognize that some states work closely with their managed care plans or have some children in deeper service and other managed care plans. So we do also have guidance on calculating state-level rates based on data from multiple reporting units, and that's also available on medicaid.gov. And we can provide guidance through the TA mailbox if people have questions about how to do that.

We've also mentioned some forthcoming TA resources on the Dental Sealant Measure. We're in the process of developing the TA brief on calculating the measure that presents a lot of the information that you've heard here today in more narrative and reference form. And I think it's been really helpful to hear the questions that have come in through the Q&A, because I think that will help us to frame some of the guidance that we'll give through the TA brief. And we also are in the process of developing sample SAS code.

As Krishna mentioned, we also recognize that this will just be sample code because different states use different kinds of -- have different variables and different ways of coding up the key data elements, but we hope that that will also be useful.

And then as we've mentioned, if you want TA related to the dental sealant measure -- and I would add to any other Core Set Measure -- please submit your questions to the TA mailbox, and we give the address here, macqualityta@cms.hhs.gov, and we will be more than happy to provide TA, and set up a call if that would be helpful, whatever you would find useful.

Okay, so we have a question that says, "TA?," and I have a feeling that's because people are wondering what is technical assistance. And technical assistance is where we can just help you answer your questions about the measures, kind of like we're doing today. So if you have a question about interpreting the code, please do feel free to ask questions, and we will get back to you.

Okay. So I think we can open it up to some more general questions as well now, before we go into the final section with the wrap up. So I think this probably is for Krishna. If states are using different assessment codes, for example, AAPD versus ADA, how accurate is the data that is being collected?

So, you know, there are many, many commonalities between all the risk assessment tools, so at the end of the day, if the provider has used a tool, whatever tool they're using and says, okay, this child really is at moderate to high risk, then the sealant should have been provided. So what we are looking at is a sealant being provided for those children who are identified as elevated risk. I don't think it will matter in terms of, you know, comparing it between states. There are lots more differences in terms of utilization and access that would also impact the measure scores and measure rates. So using different tools, in my opinion, is not going to impact the data that much.

Okay, thank you. So now we have a question for Texas. The question is, what challenges did you face in identifying children continuously enrolled, and were the challenges different from the ones that states face in identifying children enrolled for 90 days for the CMS 416 reporting?

Hi. So from our data warehouse, the enrollment was flagged at, like, a monthly enrollment, so we discount six continuous enrollment. So for that part, I don't think it's as difficult. So we just count any six continuous enrollments. That's it.

Hello?

Hello.

Yes.

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Chris, is there anything that you wanted to add from Alabama's perspective about the differences between 416 continuous enrollment and this one?

I don't do the 416 report, so I can't talk about changes. Normally when we look at a year's enrollment, with no more than 48 days, we can pretty much just say somebody was eligible 11 months and kind of count from there. But most of our eligibles had eligibility dates from January through December. But there were several that would have different months that were eligible throughout the year, and they change around to different aid categories or different benefit plans, and so developing the code to try to do that kind of track just kind of was a little more complicated than what we were used to, but it took a day or two for one of my guys to figure out, and we were on the road. But that was -- it wasn't unsolvable, it was just that was the biggest challenge we had with it. But the problem was that they would be an aid category this month and a 47 the next month, and then back to a 41 the next month, and mixing all those together made it a little more challenging.

That's great. Thanks, Chris. Okay. So I think another denominator question that we perhaps could come back to, Krishna. If the sealant was applied in 2013 to a seven-year-old who is in the denominator in 2014, it appears it could not be included in the numerator. Is this correct? It would appear to understate the number of individuals with sealants in 2014.

So one of the things that we have kind of made sure to include within the specifications of the DQA release are the limitations with this measure. Now we don't have diagnostic codes; we are using claims data, so there is no way for us to exclude or not count those children who have been previously sealed or who have had restorations, who have had maybe all their teeth decayed or possibly missing or unerupted. So if something had affected all those four molars to make that child kind of not sealable, if you will, there is no way with claims data that we can actually exclude them.

Now some could argue that, well, you could look at past history again and say whether the sealant was provided and start excluding those children, but then you get into nuances that, okay, that was one tooth, what happened to the other teeth, and so on and so forth. So the DQA committee, as they were looking at all of these pieces and all the practicality and feasibility and keeping this relatively simple as we are trying to go nationwide with one measure, it's really kind of trying to get all those pieces balanced. There is no perfect measure. As long as we measure the same way, we should all have comparable data.

Given these limitations that we identified, a hundred percent is not the benchmark for this measure. The highest that I have seen is around 35 percent to 40 percent. That's sort of where we are with this measure. You can compare your own self over years. The data is definitely useful, as long as everyone does it the same way, comparing it the same way between entities will be useful. So I think that's a very, very important question, and thank you for bringing that up.

Yeah. And somewhat related, we also have a question about what this means for providers who see large numbers of children that are serviced by school sealant programs and for which they may not have information about services already provided.

Again, I think it goes back to the previous answer. We're not looking to exclude kids who have already been sealed. We had sealant in one tooth. We had sealant in multiple teeth. Our testing data does indicate that there are kids who get sealants over two years and over three years, and for some programs that's very, very significant. With the school-based sealant programs, as long as Medicaid is reimbursing, and as long as that is in the claims, they all should be part of the same database and the same calculation.

Thanks. Can we go on to the next slide, Luke. Great. So I wanted to come to the wrap up part of this presentation -- next slide -- and just recap what was stated very early in the presentation, that state reporting of the new Dental Sealant Measure is a high priority for CMS. Child Core Set reporting will open in December 2015, so right around the corner. And we've had a lot of conversations today about some of the challenges and the opportunities for calculating the measure, and we do encourage states to note any

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deviations from the measure specifications, such as the measurement year or data source, as well as any eligible populations that may have been excluded from the measure. We just want to be able to better understand any of the changes that might have been made from the measure specifications that would affect the interpretation.

Again, if you have questions, please e-mail the TA mailbox, macqualityta@cms.hhs.gov. Please submit specific questions, or you may feel free to request a phone consultation for general support. And we also have an evaluation that will pop up when you logout of the webinar, and you may also request TA by filling out the webinar evaluation when you sign off. Next slide.

So now I'd like to turn it over to Dr. Mouden for the final words.

Okay, thank you very much. Well, a very interesting session, and I not only appreciate all of the presenters but all the folks that were listening so carefully that they had all those questions. I know that there's some that we didn't get to, and we'll do our best to answer those via e-mail.

As Margo was alluding to, the reporting period will start before long. Our goal is to have 25 states reporting this in the Child Core Set. That becomes kind of an important goal for us, because once 25 states are reporting, then it becomes part of the information that we share publicly. So that will get the information out there even farther and wider.

So I want to thank everybody for taking time today to be with us. I noticed we had about 300 people on, so obviously a lot of interest, and we certainly look forward to all the state's that are participating, getting us their Child Core Set SEAL Measure within the year. So with that, I think we're done for today. I need to turn it back to Brice for some final housekeeping notes.

Thanks, Lynn. This concludes the webcast for today. Please submit feedback to the presentation team using the survey in your browser window when the event concludes. You may also indicate on this evaluation if you would like to request technical assistance for calculating the Dental Sealant Measure. If you are unable to provide your feedback at this time, you can view the on-demand recording of the event and access the survey widget there. The on-demand will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration. Any questions or discussion points can also be shared with the team using the macqualityta@cms.hhs.gov mailbox. Thank you.