October 15, 2018

Dear Metrics and Scoring Committee Members:

Thank you for your continued support of fully integrating dental and oral health into the coordinated care model and overall whole-person health. Untreated oral disease can have significant adverse health impacts across the lifespan, both within the health care delivery environment and related to the social determinants of health. Oral health issues may cause chronic pain that negatively affects daily activities, such as speech or sleep, and longer-term effects, such as chronic oral infections and diabetes, heart and lung disease, stroke, and poor birth outcomes.

CCO Oregon is a statewide nonprofit with members from across Oregon that work within the coordinated care model. Our membership includes providers, community-based organizations, social service agencies, hospitals, clinics, payers, and coordinated care organizations. CCO Oregon convenes these members in discussions on a regular basis to share best practices, draft recommendations, and consider how the coordinated care model may be moved forward. Today's remarks result from conversations in our Dental and Oral Health Work Group over the past few months.

The CCO Oregon Dental and Oral Health Work Group was pleased to see the steps taken by the Metrics and Scoring Committee (MSC) at the August 2018 meeting to move towards the inclusion of adult oral health in the 2019 CCO Quality Pool and discussion of the State Quality measurements related to the 1115 Waiver. While we appreciate this move, we also recognize the inherent challenges organizations and stakeholder groups will face with these new and transformative measures. The CCO Oregon Dental and Oral Health Work Group present the following recommendations:

Dental sealants on permanent molars for children

1. We support keeping the benchmark for the dental sealant metric at 23% for 2019. At this time, we do not support the proposal to increase the benchmark from 23% to 26% in 2020.
    a. The MSC increased the benchmark for 2018 from 20% to 23%; yet, in doing so, opted for no change to specifications including the issue of the rolling denominator.
    b. In August 2018, MSC decided to switch to risk-based criterion in 2020, but leave as is for 2019. We think it is important to note that the move to risk-based specifications will reset baselines and targets and thus keep the benchmark as-is during this change.

Assessment for children in DHS custody (changes slated for 2020)

1. We recommend keeping this benchmark as-is because decreasing the days allotted for dental [and physical health] assessments is significant.
    a. The percentage of children in foster care who received a mental, physical, and dental health assessment within 60 days of placement increased from 27.9% in 2014 to 82.8% in 2017.

    b. Despite the fact that 15 CCOs improved in 2017 and 13 CCOs met the target, we are still not meeting the statewide benchmark of 90%.
    c. The proposed timeline changes will further exacerbate challenges in acquiring accurate data and when metric specifications aren't based in the "on the ground" reality, it can make measures unattainable and adversely affect impact.
2. We support ongoing discussion and operational advancements to improve the ability of DHS (and specifically Child Welfare) to provide timely information to coordinated care stakeholders that may help us attain the statewide benchmark.

Oral Evaluation for Adults with Diabetes

1. We recommend that, for the purposes of establishing denominator specification, the involved metrics committees strive to mitigate definitional variation of "diabetics", specifically differences between claims-based definitions versus EHR-based understanding as this may have an impact on care coordination efforts.
2. Overall, we support the inclusion of the diabetes/dental measure even if the denominators cannot be aligned.

State Quality Set (Any dental service; CAHPS: Access to dental care; Follow-up after ED visit for non-traumatic dental reasons; and Topical fluoride varnish)

1. Ensure specifications span and stratify the age continuum of CCO membership:
    a. Adults to children
    b. Children based on CHIP or Medicaid
    c. Age banding cohorts within child and adult cohorts
2. Ensure specifications span and stratify the continuum of covered services:
    a. Prevention and non-prevention
    b. Categorical code groupings
3. Determine whether or not a risk-based approach will be retained, per DQA measures and specifications therein.
4. Acknowledge inherent administrative and operational lift of "Follow-up after ED visits for non-traumatic dental reasons" metric, including:
    a. Days to follow-up and defining follow-up
    b. Defining "non-traumatic dental reasons"
5. Inform how the CAHPS: Access to dental care will be administered.

We look forward to continued discussions to ensure the dental and oral health metrics are not only meaningful and relevant, but also promote alignment of patient care and improved population health.

Thank you,
Matt Sinnott, Willamette Dental
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CCO Oregon Board of Directors Co-Chair