

September 25, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

The American Dental Association (ADA), the world's oldest and largest dental professional organization representing over 163,000 members in the United States, welcomes the opportunity to comment on the proposed rule.

Comments related to Transforming MIPS: MIPS Value Pathways Request for Information (sections III.K.3.a. (3)(a)(i) through III.K.3.a. (3)(a)(iv)):

The ADA is encouraged by the Centers for Medicare & Medicaid Services (CMS) efforts to simplify the complex MIPS program and is supportive of the move towards condition-based value pathways. We understand the need to standardize measurement using a common data source in order to compute incentive payments. However, we would like to emphasize the need for the MIPS program to remain sensitive to the needs of rural and small practices. This balance can be achieved by focusing on a limited set of relevant measures calculated using available data sources like administrative claims data.

The ADA respectfully disagrees with including a dentistry set within the MIPS program that includes the following measures:

1. Quality ID- 378: Children Who Have Dental Decay or Cavities (percentage of children aged 1–20 years have had tooth decay or cavities during the measurement year).
2. Quality ID- 379: Primary Caries Prevention Intervention as Offered by Primary Care Medical Providers, including Dentists (percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period).

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We would like to bring to your attention that the Measure 378, an outcome measure, has not been risk adjusted. To use it in an accountability application/payment program is inappropriate. Furthermore, we question the validity of the value sets included in the measure that lack specific diagnostic codes that represent sequelae of caries and associated diagnoses that stem from caries. Measure 379, even with the “substantive change” noted in the rule, does not meet the additional consideration criterion of “whether the measure reflects current clinical guidelines.” Measure 379 only tracks a single fluoride varnish applied during the measurement period. Evidence-based Clinical Recommendations suggest that efficacy of topical fluoride is dose-dependent and fluoride varnish should be applied at least every three to six months in children at elevated risk for caries.^[1] **These are significant limitations to these measures and we cannot support their use in MIPS.** We are also aware that these measures have not been widely adopted in spite of being in the MIPS program for multiple years.

Dentistry has been committed to pursuing coordinated, meaningful, and parsimonious measurement from the outset through the Dental Quality Alliance (DQA), convened by the ADA at the request of the CMS. DQA is the only comprehensive multi-stakeholder organization in dentistry that develops dental quality measures through a consensus-based process. Thirty-eight organizations with oral health experience participate in the DQA along with a public member. The ADA strongly urges the CMS to consider working with the DQA to ensure that these measures are appropriately specified to properly reflect current evidence-based clinical guidelines, be more meaningful, and encourage greater adoption among providers treating pediatric patients eligible for Medicare coverage.

We note that in the proposed rule, the agency states: “We intend to have the measures reviewed by a consensus-based entity, for example, the National Quality Forum (NQF) Measure Applications Partnership (MAP).” Our experience with this process has demonstrated the lack of inclusion of dental domain expertise within such decision-making bodies, thereby resulting in lack of any “consensus” in the dental community before these measures are adopted. The above measures provide clear example of the failure of this process. **Given that the DQA is itself a consensus based multi-stakeholder body for quality measure development formed at the request of CMS, we submit that the DQA should be the primary consensus-based entity for review of any oral health measures.**

The ADA emphasizes that the efforts to align and harmonize measures used across programs must remain a priority for the agency. In the proposed rule, the agency notes that “we should drive quality measurement towards a set of population-based outcome measures to publicly report on quality of care.” This is a laudable goal but as a healthcare system we will not succeed if different programs, even from within CMS, use different

¹ Weyant RJ, Tracy SL, Anselmo TT, Beltrán-Aguilar ED, et al; American Dental Association Council on Scientific Affairs Expert Panel on Topical Fluoride Caries Preventive Agents. Topical fluoride for caries prevention: executive summary of the updated clinical recommendations and supporting systematic review. J Am Dent Assoc. 2013 Nov;144(11):1279-91.

approaches to identify and implement measures. For example, we are aware of efforts to identify oral health measures for use within Medicaid and Children's Health Insurance Program (CHIP) Scorecard, Quality Reporting System for Medicaid Managed Care, Marketplace Quality Reporting System (QRS), and Core Set of Health Care Quality Measures for Adults and Children apart from MIPS. Through the DQA, the ADA is striving to ensure harmonization and alignment of dental measures so that measurement does not become a burden to the dental care system. In fact, we have in place a set of feasible claims-based population-focused measures for oral health.^[2] We urge CMS to support our efforts in assuring harmonization and alignment and strongly urge the agency to seek DQA input in any program engaged in implementing dental measures.

Measurement that is aligned across public and private sectors and harmonized across different settings and levels of reporting can help pave the way to improvement without being overly burdensome. The ADA encourages the use of metrics that are supported by strong scientific evidence and further tested for validity, feasibility, reliability and usability. The use of measures that are unreliable or invalid undermines confidence in measures among providers and consumers of health care.

If you would like to contact the ADA or the DQA for more information, please contact, Dr. Diptee Ojha at ojhad@ada.org.

Sincerely,

/s/

Chad P. Gehani, D.D.S.
President

/s/

Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

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² Dental Quality Measures, Dental Quality Alliance. Accessed at <https://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-development-reports/dqa-dental-quality-measures>