

****Please read the DQA Measures User Guide prior to implementing this measure.****

DQA Measure Technical Specifications: Administrative Claims-Based Measures

Care Continuity, Dental Services

Description: Percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years
Numerator: Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service in both years
Denominator: Unduplicated number of children enrolled in two consecutive years
Rate: NUM/DEN

Rationale: Dental caries is one of the most common chronic diseases in children in the United States (1). For 2015–2016, prevalence of total caries (untreated and treated) was 45.8% and untreated caries was 13.0% among youth aged 2–19 years (2). Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. In 2014, 52% of all children and 60% of poor children (FPL<100%) did not have a dental visit during the year (3).

- (1) Centers for Disease Control and Prevention. Oral Health Conditions: Cavities (Tooth Decay). Available at: <https://www.cdc.gov/oralhealth/conditions/index.html>. Accessed July 19, 2023.
- (2) Fleming E, Afful J. Prevalence of total and untreated dental caries among youth: United States, 2015–2016. NCHS Data Brief, no 307. Hyattsville, MD: National Center for Health Statistics. 2018.
- (3) Nasseh K, Vujicic M. Dental care utilization steady among working-age adults and children, up slightly among the elderly. Health Policy Institute Research Brief. American Dental Association. October 2016. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1016_1.pdf. Accessed July 19, 2023.

National Quality Measures Clearinghouse: Access;¹ Process²

IOM Aim: Equity, Effectiveness

Level of Aggregation: Health Plan/Program

Improvement Noted As: A higher score indicates better quality.

Data Required: Administrative enrollment and claims data; two consecutive years. When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

Measure purpose: Examples of questions that can be answered through this measure at each level of aggregation:

¹ **Access (Clinical Quality Measure):** "Access to care is the attainment of timely and appropriate health care by patients or enrollees of a health care organization or clinician. Access measures are supported by evidence that an association exists between the measure and the outcomes of or satisfaction with care." National Quality Measures Clearinghouse. Available at: <https://www.ahrq.gov/gam/summaries/domain-definitions/index.html>. Accessed July 19, 2023.

² **Process:** "A process of care is a health care-related activity performed for, on behalf of, or by a patient. Process measures are supported by evidence that the clinical process—that is the focus of the measure—has led to improved outcomes. These measures are generally calculated using patients eligible for a particular service in the denominator, and the patients who either do or do not receive the service in the numerator." NQMC Measure Domain Definitions. Available at: <https://www.ahrq.gov/gam/summaries/domain-definitions/index.html>. Accessed July 19, 2023.

1. What is the percentage of children who have continuous care over 2 years?
2. Does the percentage of children with continuous care vary by the stratification variables?
3. Are there disparities in continuous care among different groups based on the stratification variables?
4. Over time, does the percentage of children with continuous care stay stable, increase or decrease?

Applicable Stratification Variables (Optional: Contact Program Official to determine reporting requirement):

1. Age (e.g., 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20)
2. Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)
3. Program/Plan Type (e.g., traditional FFS; PPO; prepaid dental/DHMO)
4. Geographic Location (e.g., rural; suburban; urban)
5. Race
6. Ethnicity
7. Socioeconomic Status (e.g., premium or income category)

Care Continuity (Dental Services) Calculation

1. Check if the subject meets age criteria at the last day of the reporting year:³
 - a. If child is ≥ 1 and < 21 ,⁴ 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 subject does not get counted.
2. Check if subject is continuously enrolled for at least 180 days in each year (i.e., 180 days in reporting year AND 180 days in prior year):⁵
 - a. If subject meets continuous enrollment criteria, then include in **denominator**; proceed to next step.
 - b. If subject does not meet enrollment criteria, then STOP processing. This subject is not counted in the denominator.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: All subjects who meet age and enrollment criteria in each year

3. Check if subject received oral evaluation as a dental service in each year:
 - a. If [CDT CODE] = D0120 or D0150 or D0145 in the reporting year AND in the prior year, AND
 - b. If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 1 below.⁶
 - c. If both a AND b are met, then include in **numerator**; proceed to next step.
 - d. If either a OR b is **NOT** met, then a dental service was not provided; STOP processing. This subject is already included in the denominator but will not be included in the numerator.

³ **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.

⁴ **Age:** Medicaid/CHIP programs use under age 21 (< 21) as upper bound of age range; Exchange quality reporting use under age 19 (< 19) as the upper bound of the age range; other programs check with program officials. The age criteria should be reported with the measure score.

⁵ **Enrollment in "same" plan vs. "any" plan:** At the **state** program level (e.g., Medicaid/CHIP) a criterion of "**any**" plan applies versus at the **health plan** (e.g., MCO) level a criterion of "**same**" plan applies. The criterion used should be reported with the measure score. While this prevents direct aggregation of results from plan to program, each entity is given due credit for the population it serves. Thus, states with multiple MCOs should not merely "add up" the plan level scores but should calculate the state score from their database to allow inclusion of individuals who may be continuously enrolled but might have switched plans in the interim.

⁶ **Identifying "dental" services:** Programs and plans that do not use standard NUCC maintained provider taxonomy codes should use a valid mapping to identify providers whose services would be categorized as "dental" services. Stand-alone dental plans that reimburse **ONLY** for services rendered by or under the supervision of the dentist can consider all claims as "dental" services.

Note: At least one claim for oral evaluation in the reporting year AND at least one claim for oral evaluation in the prior year must be with a provider whose [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 1.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Subjects who received an oral evaluation as a dental service in each year

4. Report
 - a. Unduplicated count of subjects in numerator
 - b. Unduplicated count of subjects in denominator
 - c. Measure rate (NUM/DEN)

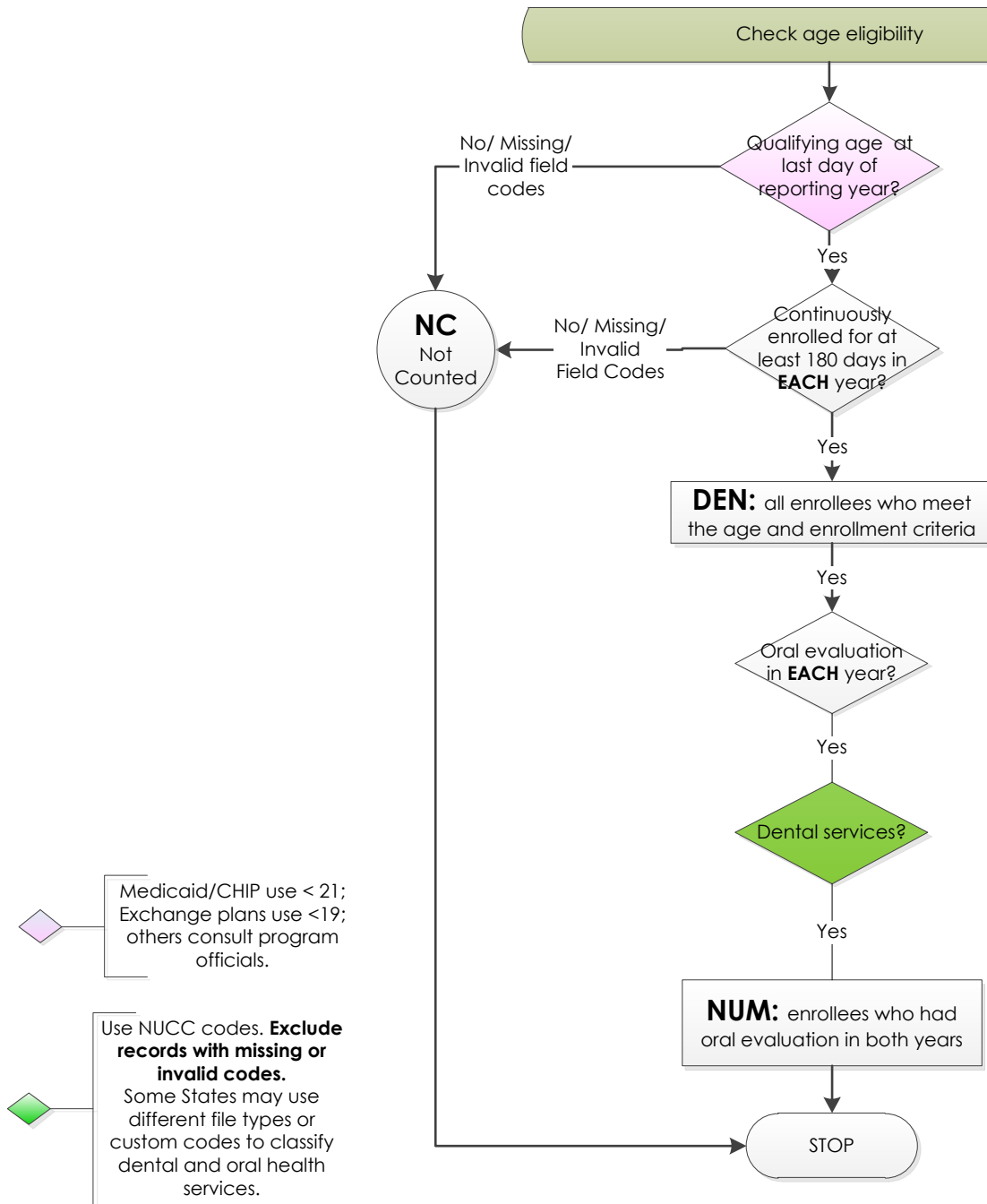
Table 1: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”*

122300000X	1223P0106X	1223X0008X	125Q00000X	126800000X
1223D0001X	1223P0221X	1223X0400X	261QF0400X	261QD0000X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X	204E00000X
1223E0200X	1223P0700X	125J00000X	1223X2210X	261QS0112X
1223G0001X	1223S0112X	125K00000X	122400000X	

*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 to this measure.

Reliability of the measure score depends on the quality of the data elements that are used to calculate the measure. The percentages of missing or invalid data for each data element used to calculate the measure must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, subjects who have records with missing or invalid CDT CODE may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low-quality data set will result in a measure score that will not be reliable.



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