DENTAL QUALITY ALLIANCE™
Improving Oral Health Through Measurement

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

DQA Measure Technical Specifications: Administrative Claims-Based Measures

Utilization of Services, Dental or Oral Health Services

"Dental" OR "Oral Health" Services
Description: Percentage of enrolled children under age 21 who received at least one dental OR oral health service within the reporting year
Numerator: Unduplicated number of children who received at least one dental OR oral health service
Denominator: Unduplicated number of enrolled children under age 21
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). This measure allows assessment of whether a child received any dental services during the year and, therefore, also measures access to oral health care. The Institute of Medicine identified improving access to oral health care as a "critical and necessary first step to improving oral health outcomes and reducing disparities (4)."

Rationale for "Dental or Oral Health" Services Specification:
Apart from routine quality reporting, researchers and policy makers may wish to seek additional information regarding whether certain services were provided to a population. In such cases, a "dental OR oral health" specification of the measure may be applicable. The "dental OR oral health" measure is **NOT** a sum of the "dental" and "oral health" Utilization of Services measures but represents the unduplicated count of children who received a dental or oral health service. The DQA Measures User Guide provides additional information on categorization of "dental" and "oral health" services.

Note: Not all state Medicaid programs reimburse for "oral health" services up to age 21. Age stratifications may be used when interpreting this measure.

(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 27, 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 27, 2023.
(4) Institute of Medicine and National Research Council. Improving access to oral health care for vulnerable and underserved populations. Washington, D.C.: National Academies Press; 2011.

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AHRQ Domain: Use of Services[1]

Institute of Medicine Aim: Equity

National Quality Strategy Priority: Health and Wellbeing

Level of Aggregation: Health Plan/Program

Improvement Noted As: This measure should be interpreted in conjunction with the DQA measures: (1) Utilization of Services, Dental Services (CBE #2511[2]) and (2) Utilization of Services, Oral Health Services. In general, a higher percentage of children who receive a dental or oral health service during the reporting year indicates better performance. Contextual information relating to the overall health status of the population is also useful in interpreting measure scores. The measure can also be very useful longitudinally to monitor change over time for a particular program or plan.

Data Required: Administrative enrollment and claims data; single year. 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. What percentage of children received at least one dental or oral health service during the reporting period?

2. Over time, does the percentage of children who receive at least one dental or oral health service stay stable, increase, or decrease?

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

1. Age (e.g., <1; 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)

[1] **Use of Services (Related Healthcare Delivery Measure):** Use of services is the provision of a service to, on behalf of, or by a group of persons identified by enrollment in a health plan or through use of clinical services. Use of service measures can assess encounters, tests, or interventions that are not supported by evidence for the appropriateness of the service for the specified individuals. National Quality Measures Clearinghouse. Available at: https://www.ahrq.gov/gam/summaries/domain-definitions/index.html. Accessed July 27, 2023.
[2] Measure is endorsed by the Centers for Medicare and Medicaid Services (CMS) Consensus-Based Entity (CBE), formerly the National Quality Forum. Endorsed measures can now be found at https://p4qm.org/measures.

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Utilization of Services (Dental or Oral Health Services) Calculation

1. Check if the subject meets age criterion[3] at the last day of the reporting year:[4]
    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 subject is not counted in the denominator.

2. Check if subject is continuously enrolled for at least 180 days during the reporting year:[5]
    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 subject is not counted in the denominator.

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

3. Check if subject received any **dental or oral health** service during the reporting year:
    a. If [SERVICE CODE] = CDT D0100 – D9999 OR [SERVICE CODE] = CPT 99188[6]
    b. If a is not met, then a "dental or oral health" service was not provided; STOP processing. This subject is already included in the denominator but will not be included in the numerator.

    Note 1: Some states may use additional codes to reimburse for oral health services provided by non-dental providers.[6] These codes should be included in the [SERVICE CODE] codes in addition to the CDT codes.
    Note 2: In this step, all **claims** with missing or invalid SERVICE CODE should be excluded.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Subjects who received a dental or oral health service

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

[3] **Age**: Medicaid/CHIP programs use under age 21 (< 21); Exchange quality reporting use under age 19 (<19); other programs check with program officials. The age criterion should be reported with the measure score.
[4] **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] **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] **Services provided by medical providers**:
CPT 99188 is a dedicated code for "application of topical fluoride varnish by a physician or other qualified health care professional."

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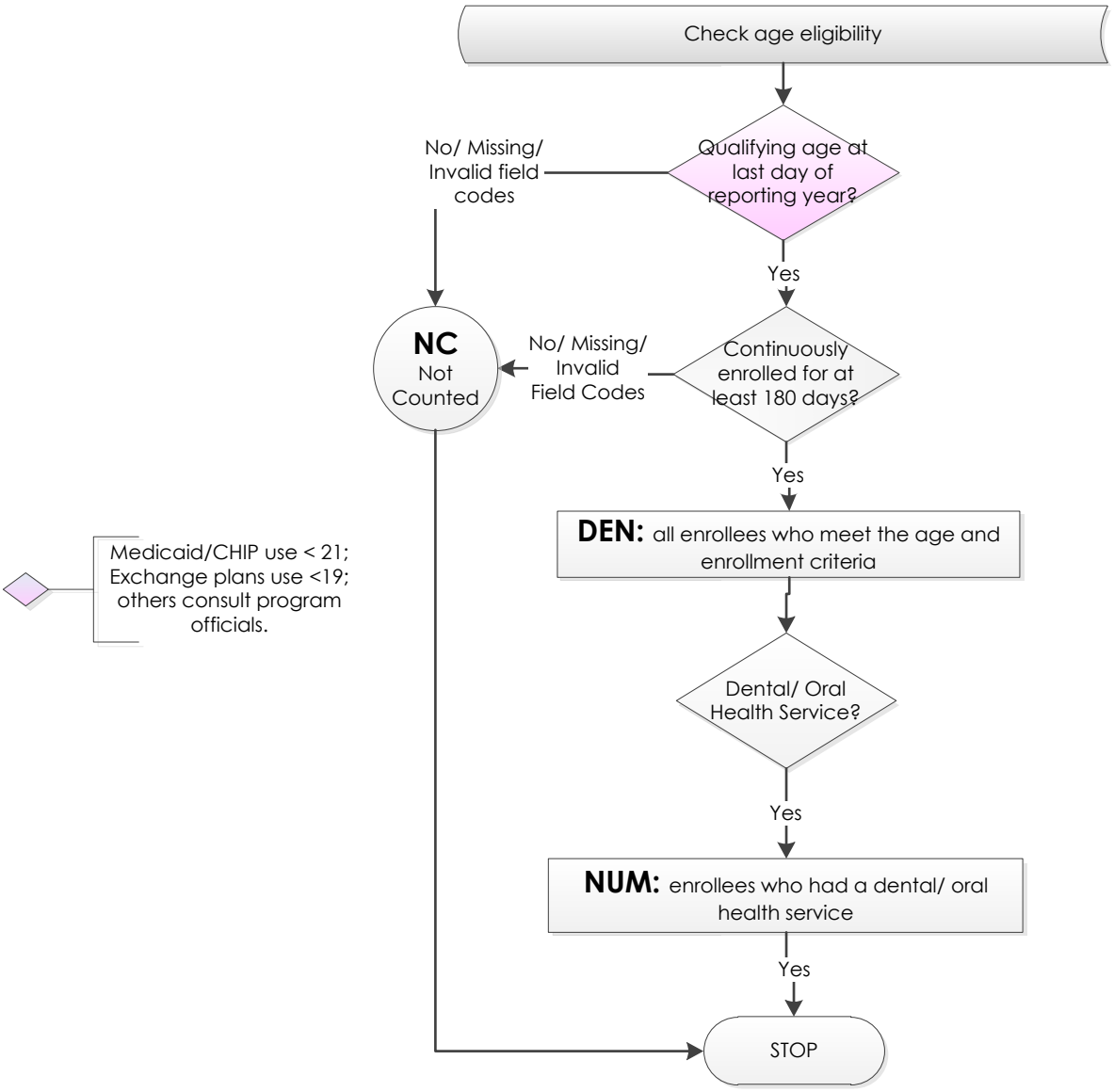
*** Note: Reliability of the measure score depends on the quality of the data elements that are used to calculate the measure. The percentage of missing or invalid data for each data element used to calculate the measure must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, subjects who have records with missing or invalid SERVICE 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 low measure score and will not be reliable.***



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