

Appendix: Supplemental Materials
Measure: Care Continuity, Dental Services
NQF Measure Number 2518

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

DQA Measure Specification Sheet: Care Continuity, Dental Services

Description: Percentage of children aged 2 – 21 years 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 aged 2 – 21 years enrolled in two consecutive years
Rate: NUM/DEN

Rationale: Dental caries is the most common chronic disease in children in the United States (1). In 2009–2010, 14% of children aged 3–5 years had untreated dental caries. Among children aged 6–9 years, 17% had untreated dental caries, and among adolescents aged 13–15, 11% had untreated dental caries (2). Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. Approximately three quarters of children younger than age 6 years did not have at least one visit to a dentist in the previous year (3).

(1) National Center for Health Statistics. Healthy People 2010 Final Review. Hyattsville, MD: National Center for Health Statistics; 2012. Accessed at http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_final_review.htm on July 10 2013.

(2) Dye BA, Li X, Thornton-Evans G. Oral health disparities as determined by selected Healthy People 2020 oral health objectives for the United States, 2009–2010. NCHS data brief, no 104. Hyattsville, MD: National Center for Health Statistics. 2012.

(3) Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America's children. Acad Pediatr. 2009;9(6):415-9. PMID: 19945076

National Quality Forum Domain: Process¹

Institute of Medicine Aim: Equity, Effectiveness

National Quality Strategy Priority: Health and Well-being

Level of Aggregation: Health Plan/Program

Improvement Noted As: A higher score indicates better quality

Data Required: Two consecutive years

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

1. What is the percentage of children who have continuous care over 2 years?
2. Over time, does the percentage of children with continuous care stay stable, increase or decrease?

Applicable Stratification Variables

1. Age: 2-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

¹ **Process:** A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus. Accessed from "NQF Glossary" at http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx. Accessed January 2014.

Care Continuity Calculation

1. Run records for one reporting year for paid and unpaid claims.²
2. Check if the enrollee meets age criteria³ at the last day of the reporting year
 - 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 enrollee does not get counted in the denominator.
3. 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)⁴
 - 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 enrollee does not get counted in the denominator.

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

4. Check if subject received oral evaluation as a dental service in each year.
 - a. If [SERVICE 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, then include in **numerator**; proceed to next step.⁵
 - c. If both a AND b are not met, then the service was not a "dental service"; STOP processing. This enrollee is already included in the denominator but will not be included in the numerator.

Note: In this step, all **claims** with missing or invalid SERVICE-CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 1 should not be included in the numerator.

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

5. Report
 - a. Unduplicated number of enrollees in numerator
 - b. Unduplicated number of enrollees in denominator
 - c. Measure rate (NUM/DEN)
 - d. Rate stratified by age

² **Medicaid/ CHIP programs should apply these overall exclusions before the case finding process:**

- Undocumented aliens who are eligible only for emergency Medicaid services;
- Other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (e.g., pregnancy-related services)

The exclusion criteria should be reported along with the number and percentage of members excluded.

³ **Age:** Medicaid/ CHIP programs use age 2 - 20; Exchange quality reporting use age 2 - 18; other programs check with program officials. This criterion should be reported with the measurement score.

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 measurement 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.

⁵ **"Identifying "dental" services:** Programs and plans that do not use standard NUCC maintained provider Taxonomy Codes should use 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, consider all claims as "dental" services.

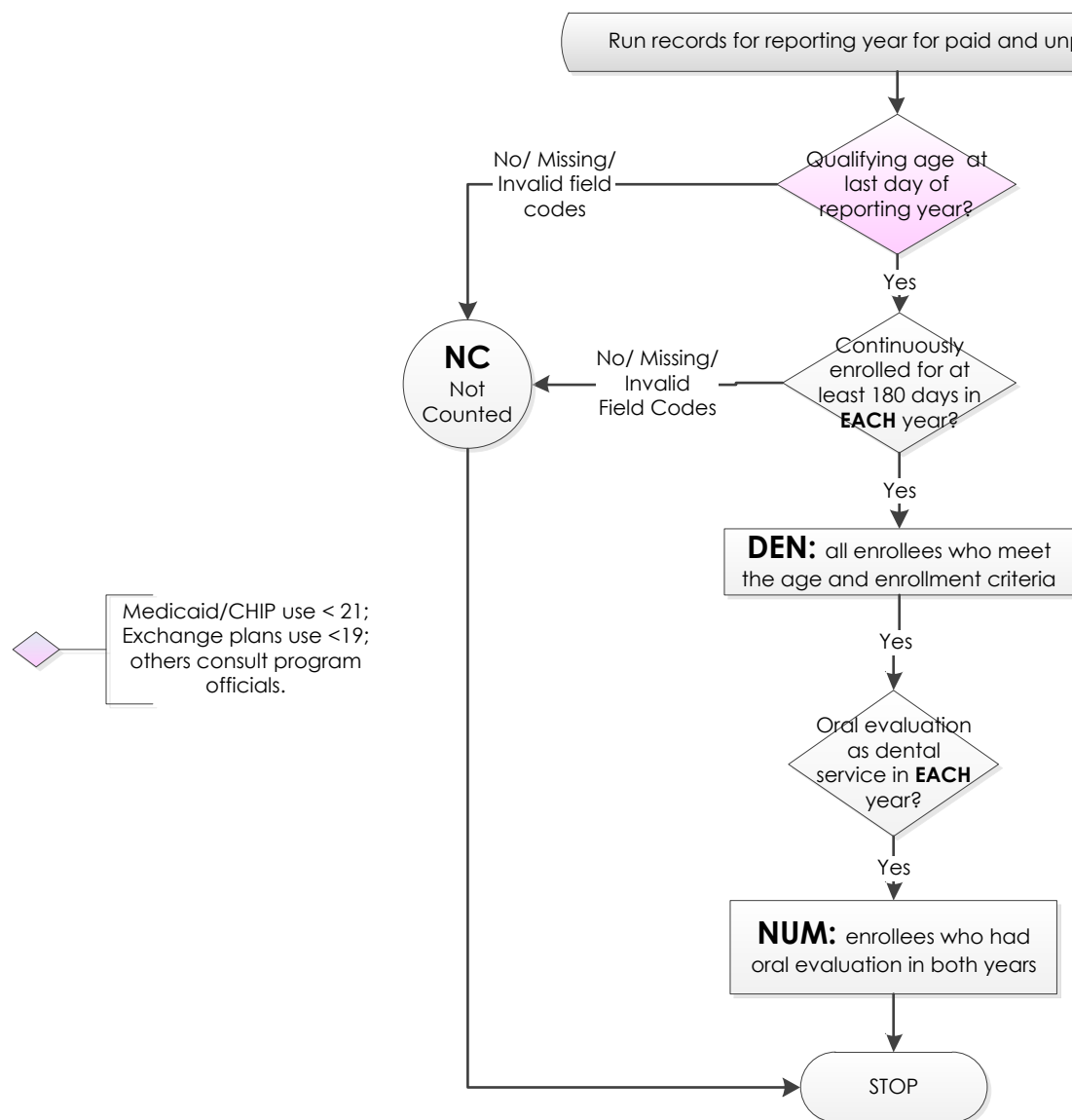
Table 1: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”*

122300000X	1223P0106X	1223X0008X	261QF0400X
1223D0001X	1223P0221X	1223X0400X	261QR1300X
1223D0004X	1223P0300X	124Q00000X+	
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

*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 for this measure.

*** Note: Reliability of the measure score depends on the quality of the data that are used to calculate the measures. The percentages of missing and invalid data for these data elements 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, records with missing or invalid SERVICE-CODE will be counted in the “all enrollees” but not in “all enrollees who received service.” These records are assumed to not have had a visit. In this case, a low quality data set will result in a low utilization score and will not be reliable.***



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Dental Quality Alliance Measures (Measures) and related data specifications, developed by the Dental Quality Alliance (DQA), are intended to facilitate quality improvement activities.

These Measures are intended to assist stakeholders in enhancing quality of care. These performance Measures are not clinical guidelines and do not establish a standard of care. The DQA has not tested its Measures for all potential applications.

Measures are subject to review and may be revised or rescinded at any time by the DQA. The Measures may not be altered without the prior written approval of the DQA. Measures developed by the DQA, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and DQA. Neither the DQA nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The DQA, American Dental Association (ADA), and its members disclaim all liability for use or accuracy of any terminologies or other coding contained in the specifications.

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NOV 04 2013

Robert A. Faiella, D.M.D., M.M.Sc.
President
American Dental Association
211 E. Chicago Avenue
Chicago, IL 60611-2637

Dear Dr. Faiella:

Thank you for your letter concerning the dental quality measures recently tested and validated by the Dental Quality Alliance (DQA). As you mentioned, the DQA was formed at the behest of Centers for Medicare & Medicaid Services (CMS) and we continue to be vitally interested in the group's efforts. We are pleased that Dr. Lynn Mouden, the CMS Chief Dental Officer, serves on the DQA to provide CMS input into the DQA's collaborative efforts.

The dearth of tested quality measures in oral health has been a concern to CMS and other payers of oral health services for quite some time. The DQA-funded testing for feasibility, reliability and validity of the ten measures in the DQA Starter Set is truly a step forward in quality measurement.

The changing landscape of health care, in light of CHIPRA, the Patient Protection and Affordable Care Act, and other factors, continues to drive efforts in CMS to improve health and health care quality. Along with these changes, implementing new quality measures within Medicaid and CHIP will be important.

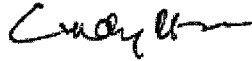
I, Dr. Mouden, and the CMS dental team are now focused on how we can best use these new DQA quality measures. We will consider how the measures could be used within CMS' data collection systems and/or how they could be used in states' data collection and quality improvement efforts. We encourage you to explore endorsement from the National Quality Forum as a means to move these measures forward.

We look forward to our continuing work with the DQA and our joint efforts to measure and improve the quality oral health services for all the beneficiaries served in our programs.

Page 2 – Robert A. Faiella, D.M.D., M.M.SC.

Please feel free to contact Dr. Mouden at 410-786-4126 at any time.

Sincerely,

A handwritten signature in black ink, appearing to read "Cindy Mann", with a stylized flourish at the end.

Cindy Mann
Director

cc:

Dr. Kathy O'Loughlin, Executive Director, ADA
Dr. Ron Hunt, Chair, DQA
Dr. Krishna Aravamudhan
Dr. Lynn Douglas Mouden, Chief Dental Officer, CMS
Laurie Norris, JD, Coordinator, CMS Oral Health Initiative



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

January 27, 2014

Krishna Aravamudhan
Senior Manager, Office of Quality Assessment and Improvement
American Dental Association
211 E. Chicago Ave
Chicago, IL 60611

Krishna:

This letter is to inform you that HHSC is currently using the Dental Quality Alliance measures as part of its quality assurance program in both Medicaid and the Children's Health Insurance Program (CHIP). These are included in Texas' Uniform Managed Care Manual for dashboard reporting. Please see the below information in response to your questions:

- Name of program and sponsor: HHSC Quality Assurance Division
- URL:
 - Medicaid--<http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10-1-10.pdf>
 - CHIP--<http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10-1-9.pdf>
- Purpose: Quality Improvement
- Geographic area and number and percentage of accountable entities and patients included: Statewide
- Measures in use:
 - Utilization of Services
 - Preventive Services
 - Treatment Services
 - Oral Evaluation
 - Topical Fluoride Intensity
 - Sealant use in 6-9 years
 - Sealant use in 10-14 years
 - Care Continuity
 - Usual Source of Services
 - Per member per month Cost

Total enrollment statistics for both the Medicaid and CHIP programs are posted on a monthly basis on the HHSC website here:

<http://www.hhsc.state.tx.us/research/index.shtml>

The latest figures available show a total Medicaid Enrollment of 3,644,992 during the month of June, 2013.

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751 • (512) 424-6500

Please let me know if you need any additional information.

Very truly yours,

A handwritten signature in black ink, appearing to read "JR Roberts DDS". The signature is stylized with a large, looping "R" and "DDS" written in a separate, more legible script to the right.

John "JR" Roberts, DDS
State Dental Director
Texas Medicaid and CHIP
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