DENTAL QUALITY ALLIANCE®

Improving Oral Health Through Measurement

DENTAL QUALITY ALLIANCE: 2024 Annual Measure Review Call for Public Comment

FREQUENTLY ASKED QUESTIONS

February 2024

Contents

PURPOSE

The purpose of this FAQ is to serve as a resource for those reviewing and considering commenting on DQA Measures during the 2024 Annual Measure Review public comment period. This document provides responses to many previous questions as well as summarizing changes to the measure specifications over time. The more detailed Annual Measure Review reports from prior years can be found on the DQA website, along with the detailed measure specifications and user guides.

FAQ for Pediatric Measures

These FAQs can also be found in the Pediatric Measures User Guide.

1. Topical Fluoride for Children

A. Why were 2 fluoride applications selected to qualify for the numerator?

Evidence suggests that professionally applied topical fluoride, starting as early as six months of age and applied at least every 3 – 6 months in children at increased caries risk, is beneficial in preventing dental caries.[1] Thus, the minimum recommended frequency of 6 months would be equivalent to two fluoride applications per year for children. Even at this minimum requirement, significant performance gaps have been observed with the percentage of children receiving at least two topical fluoride applications ranging from 18%-37% in original testing data that was restricted to children at elevated risk for dental caries[2] and from 17%-29% in more recent analyses of state Medicaid programs for children regardless of caries risk.[3] Programs and plans that wish to further explore receipt of topical fluoride among their enrollees to inform quality improvement efforts may find it useful to evaluate the number and percentage of children who received 0, 1, 2, 3, or 4 or more topical fluoride applications.

B. For the "oral health" and "dental or oral health" versions of the measure Topical Fluoride for Children, can CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional) be counted in the numerator?

Yes, the measure specifications include CPT code 99188 in the oral health and dental or oral health numerators.

C. Why is CDT code D1208 (topical application of fluoride – excluding varnish) included in the measure regardless of age?

Both fluoride varnish and fluoride gel are recommended for children 6-18 years of age and fluoride varnish is recommended for children younger than 6 years of age in evidence-based

guidelines. There are two CDT codes used in the measures to identify topical fluoride application: D1206 (topical application of fluoride varnish) and D1208 (topical application of fluoride – excluding varnish). Consequently, D1208 does not allow one to distinguish between fluoride gel versus other forms of topical fluoride, such as foam. This limitation is noted in the measure specifications.

Other forms of topical fluoride besides fluoride varnish are not recommended in evidence-based guidelines for children younger than age 6 years because of concerns that the potential risks of adverse events, specifically nausea and vomiting, from swallowing these agents outweighs the potential benefits. Although other forms are not recommended, the guidelines additionally state that "practitioners may consider the use of these other agents on the basis of their assessment of individual patient factors that alter the benefit-to-harm relationship." The overall intent of the measures is to assess and promote the use of professionally applied topical fluoride. Because evidence-based guidelines allow for the possibility of using other forms of professionally applied topical fluoride for children under age 6, the DQA's measures capture all forms of professionally applied topical fluoride.

Measure users who are interested in understanding the proportion of professionally applied topical fluoride that is applied in the form of fluoride varnish versus other agents may wish to prepare additional reports that include: (1) only D1208 in the numerator and (2) only 1206 in the numerator for the age stratifications of interest (age stratifications: 1-2; 3-5; 6-7; 8-9;10-11;12-14;15-18;19-20). Alternatively, a simple frequency report of all D1208 and all D1206 codes reported by age stratification could be generated. Such reports could be used to identify educational opportunities to encourage providers who are using other forms of topical fluoride for children younger than age 6 years to switch to topical fluoride varnish.

2. Sealant Measures: Current and Retired

A. How do the current sealant measures differ from the retired sealant measures?

The current sealant measures, Sealant Receipt on Permanent 1st Molars and Sealant Receipt on Permanent 2nd Molars, went into effect on January 1, 2020. The current measures are population-based measures that assess whether children have ever received sealants — by the 10th birthday for permanent first molars and by the 15th birthday for permanent second molars. The original DQA sealant measures that were validated and approved in 2013 focused on annual receipt of sealants; these measures were retired effective January 1, 2020. The retired specifications will not be reviewed and updated on an annual basis. Program that are interested in assessing annual application of sealants to a subset of enrollees inferred to be at elevated risk for dental caries related lesions may continue to use the 2019 versions of these measures.

The table below summarizes the key differences between the retired measures and the current measures.

Comparison of Retired and Current Sealant Measures

Version	**RETIRED** **Sealants for Children (6–9 or 10–14) at Elevated Risk** **CLAIMS-BASED PROGRAM /PLAN LEVEL MEASURE**	**CURRENT** **Sealant Receipt on Permanent 1st and 2nd Molars (by age 10 or by age 15)** **CLAIMS-BASED PROGRAM/PLAN LEVEL MEASURE**
Status	**Retired, effective January 1, 2020** (specifications are no longer updated; previous versions may be used at the program's discretion)	**Approved for use, effective January 1, 2020**
Purpose	Assesses the number of children with at least one sealant placed in the reporting year. Encourages the provision of sealants to children inferred to be at elevated risk.	Assesses the number of children in the program who ever received sealants (regardless of caries risk). Population-based measure that promotes sealing all molars by specified age for the enrolled population.
Population assessed	Patients enrolled in the program who are inferred to be at elevated risk through provider assessment or prior claims history of caries-related treatment. (Thus, the measures only capture patients who have accessed the dental care system.)	All patients within the specified age ranges, regardless of caries risk status or prior access to the dental care system.
Age	Within the age range of 6–9 years / 10–14 years in the reporting year.	Children who have their 10th birthdate/15th birthdate in the reporting year.
Intervention assessed	At least one sealant in reporting year	(1) At least one sealant in the 48 months prior to the birthdate and (2) All four molars ever sealed in the 48 months prior to the birthdate
Exclusions	No specific exclusions; however, children who have had no contact with the dental care system or have not received dental care used to identify elevated risk are not included in the measure.	Excludes children when claims data indicate that all four molars (1st or 2nd, depending on the measure) have been previously treated and the child likely has no sealable molars.

B. The current sealant measures have several changes to the denominator. How will these changes affect measure interpretation and comparisons between programs?

48-month look-back period to identify sealant placement and denominator exclusions

Reporting entities (Medicaid/CHIP programs and plans) may experience significant differences in enrollment duration for individual enrollees, which could affect the availability of complete claims and associated treatment history (due to not having claims data for treatment rendered outside of program enrollment). The lack of claims data related to treatment that may have been provided outside of program enrollment may reduce the ability to consistently identify children who should either be included in the numerator (looking back 48 months for sealant receipt) or excluded from the denominator (looking back 48 months for all four molars being previously treated). The extent of variation in enrollment duration across reporting entities and the potential impact on measure scores should be considered if making comparisons between programs. However, this consideration is not unique to dental measures.

Inclusion of children who have not accessed the oral healthcare system

As a population-based measure, the denominator includes all children meeting the age and enrollment criteria, including those who have not had contact with the care system. Consideration should be given to interpreting the measure scores in a context that is informed by a review of complementary measures, such as measure scores related to oral health care access (e.g., Oral Evaluation) and treatment (Treatment Services).

Exclusion of children from the denominator who are identified as having no sealable molars

The measure denominator excludes children who can be identified with administrative claims data as having no sealable permanent molars. Thus, differences in measure scores between programs/plans may reflect significant differences in access to treatment services or significant differences in population health. Consequently, before making comparisons between programs (or between plans), measure users should consider evaluating differences in exclusion rates between reporting entities and their impact on measure scores in order to evaluate and address such potential confounding factors.

Removal of elevated caries risk criteria from denominator

The original sealant measures focused on children who could be inferred to be at elevated caries risk based on procedure codes within administrative claims data. The current sealant measures do not restrict the denominator to children identified as being at elevated caries risk. Programs that are interested in understanding the percentage of children receiving sealants by

caries risk status, can stratify the current sealant measures by elevated caries risk status using the methodology outlined in the User Guide.

3. Stratifications: Classifying Children at Elevated Caries Risk

A. Why did the DQA remove children at elevated caries risk as criteria for inclusion in the denominator for the topical fluoride and sealant prevention measures and change elevated caries risk to an optional stratification?

Although the DQA used a validated methodology to identify children who could be inferred as being at elevated risk based on procedure codes contained within administrative claims data, the stakeholder community expressed concern about the limitations of this approach. The measure specifications previously limited the denominator-eligible population to a subset of children who could be inferred to be at elevated risk based on caries risk assessment (CRA) CDT codes and caries-related treatment codes. The frequency of reporting and documenting CRA CDT codes in claims data is limited. As a result, children who are actually at elevated risk, but without a caries-related treatment code nor documented CRA CDT codes, were not included in the prevention measures' denominators. Specifically, many children at elevated risk may not be captured in the measures' denominators because they are not accessing the dental care system, and lack of access to care itself is a risk factor. Furthermore, it is likely that children may have caries-related lesions that have not progressed to the point of requiring treatment which is a pre-requisite for being considered to be at "elevated risk." The DQA also identified primary prevention as an overriding objective of these measures. Consequently, after testing and validating an alternate methodology for identifying the measures' denominators without the elevated risk criteria, the DQA removed these criteria from the denominators and instead allows for optional stratification by elevated caries risk. The DQA recognizes that removing the elevated risk criteria from the measure denominator could potentially create the perception of moving away from individualized, risk-based care. This is not the intent. The DQA emphasizes that measurement specifications are not care delivery guidelines. Removal of the elevated risk criteria should **not** be construed as a recommendation to move away from caries risk assessment and the development of individualized care plans.

B. Why does the elevated risk stratification methodology not consider all Medicaid-enrolled children as being at "elevated risk"?

Within the care delivery system, evidence-based guidelines recommend that **patient-level risk assessment** should drive treatment planning and care delivery. Accordingly, the DQA's approach to performance measurement within the care delivery system is based on these patient-centered decisions instead of using broad population level indicators such as socio-economic status. Not every child enrolled in Medicaid is at elevated caries risk. While social determinants play a significant role in influencing outcomes, their impact on each patient needs

to be carefully assessed. Encouraging individualized risk-based care, in itself, is a quality improvement activity.

The findings of an American Dental Association - American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel, which reviewed the current state of science on caries risk assessment and developed guidance on risk categorization, found that current caries risk assessment tools share many common elements to assess risk and affirmed that they have at least dichotomous predictive ability to quantify "low risk" and "elevated risk." The findings note: "Current tools have derived various methods to categorize risk based on expert consensus. The categorization of risk differs between the tools. However, all tools appear to qualify 'low risk' in a similar manner: lack of disease and presence of protective factors. Current CRA tools could be effectively used in identifying 'low risk' patients." This review affirms the ability of current CRA tools to distinguish elevated risk from low risk.

C. Why use methodologies that require prior years' data to identify elevated risk, which may impact feasibility?

Based on the best current evidence, the National Institute for Health and Care Excellence (NICE) suggests that "clinical judgment of the dentist and his or her ability to combine risk factors, based on their knowledge of the patient and clinical and socio-demographic information is as good as, or better than, any other method of predicting caries risk."[4] Therefore, the DQA risk-based measures specifications include the caries-risk assessment CDT codes introduced in 2014. However, these CDT codes are not consistently and widely reported. Therefore, additional methodology to identify children at elevated risk was included that is based on prior caries experience, which is an established risk factor that can be identified using caries-related treatment codes in administrative claims data.

Evidence from a systematic review indicates that previous caries experience is an important predictor of future disease.[5] Thus, past caries history, identifiable through claims data using caries-related treatment codes, is the strongest evidence-based approach to identify children who are most susceptible to new carious lesions using historical administrative data. The DQA "look-back method" uses a tested methodology to identify children whose individual claims history is indicative of caries risk.[2]

It is important to note that the methodology used to identify elevated caries risk is not intended as a "risk assessment tool" to be used at the level of individual patients either to assess risk or to define dental benefits or qualification for services for specific groups of children. It is only a model used to identify children who can be inferred to be at "elevated risk" for caries using claims data for the purpose of evaluating program performance by enrollee risk status through measure stratification. This method is not intended to identify every child who may be at elevated risk.

D. Should children be enrolled in each of the three years to apply the 'look-back method' to stratify by elevated caries risk?

Children do not have to be enrolled in each of the prior three years. The past history is a look-back period for *available* claims. The stratification methodology requires looking for specified caries-indicative codes in thereporting year and three prior years. Some children who meet enrollment criteria in the reporting year may not have the enrollment and claims history with the same program or plan for prior years. The intent is to identify those children who can be inferred to be at elevated risk based on available claims data; the intent is not to identify all children at elevated risk.

E. If I am a new plan in Medicaid or am entering a new market and do not have claims from prior years, can I still stratify by elevated caries risk?

If the prior three years claims history is not available, this should be noted within the final reports with an indication of how many years (if any) of data were used. When fewer years of historical data are used, the number of children who are identified as being at elevated caries risk will decrease, which will impact the stratification denominators. Comparisons in stratifications between reporting entities or for the same entity over time may not be valid when the same look-back period is not used.

4. Age Stratifications: How were the age stratification categories identified?

The DQA standard age categories are (in years): <1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20. The DQA age stratifications were determined during measure development and testing. Detailed stratifications are used to reflect different stages of dentition development. Additional refinement was included to enable comparisons across payers that may cover different populations. For example, Marketplace coverage may only go through age 18 whereas Medicaid EPSDT benefits go through age 20. Consequently 19-20 years is included as a separate age stratification. The stratifications also were designed to be applicable across DQA measures so that comparisons can be made for the same age group across dental quality measures. Measure testing found statistically significant differences across most stratifications with variations by measure and by reporting entity. Less granular age stratifications were considered, but they were rejected for the above reasons as well as the recognition that it is relatively easy for measures users to aggregate more granular age stratifications if desired.

5. *Oral Evaluation, Dental Services: Does Oral Evaluation capture oral health screenings by non-dental healthcare professionals?*

No, this measure is not designed to capture oral health screenings by non-dental providers. The measure intent of Oral Evaluation is to capture whether children are receiving a periodic or comprehensive oral evaluation as these services are defined by the Code on Dental Procedures and Nomenclature. These oral evaluation services include diagnosis and treatment planning, extending beyond the oral health screenings conducted by non-dental healthcare professionals. Including such screenings would deviate from the measure's intent. The DQA recognizes and appreciates the important role played by medical primary care providers in promoting oral health, which includes screenings, topical fluoride application, and referrals to dental care. Consequently, there are other DQA measures, such as Topical Fluoride for Children, that capture oral healthcare services provided by non-dental healthcare professionals, such as medical primary care providers.

6. *Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children – how did the DQA handle the conversion from the ICD-9-CM to ICD-10-CM diagnosis codes for this measure?*

Ambulatory Care Sensitive Emergency Department (ED) Visits for Dental Caries in Children measures the number of ED visits among children for caries-related reasons per 100,000 member months. The DQA recognizes that diagnostic coding depends on the knowledge and appropriate documentation of the correct codes and notes that during measure testing, the DQA undertook a systematic analysis of the reliability and the validity of the codes used to identify caries-related visits. This analysis included medical record reviews that confirmed reliable identification of caries-related visits using the diagnostic code set that was contained in the measure.[1]

After the conversion from the ICD-9-CM to ICD-10-CM diagnosis codes, a comprehensive review of the ICD-9-CM to ICD-10-CM crosswalk, using the general equivalence mapping, was conducted to re-affirm and update the diagnosis codes used to identify caries-related visits. Both forward and backward mappings were conducted. Expert review of the clinical comparability of the two code systems found no concerns. A comparison of the code descriptions between the two code systems found that the main difference between the ICD-9-CM and ICD-10-CM diagnosis codes specified for this measure is that the ICD-10-CM codes provide more granularity. Because there is a collective set of codes used to identify caries-related visits, which rely on the comparable code descriptions in both the ICD-9-CM and ICD-10-CM code systems, the update to the ICD-10-CM codes did not meaningfully impact the measure scores. Additional chart validation of the caries-related diagnosis code set using ICD-10-CM codes mapped from the original ICD-9-CM code set was conducted and affirmed the continued reliability of the code set to identify caries-related visits. Pre and post ICD-10-CM

conversion performance scores from two of the programs included in the original measure testing further supported the conclusion that the conversion did not impact the measure scores.

7. Follow-Up after Emergency Department Visits for Dental Caries in Children: Are the 7-day and 30-day follow up periods for visits with a dentist after a caries-related emergency department visit mutually exclusive?

No, visits that are captured in the 7-day follow-up visit also will be captured in the 30-day follow-up visit.

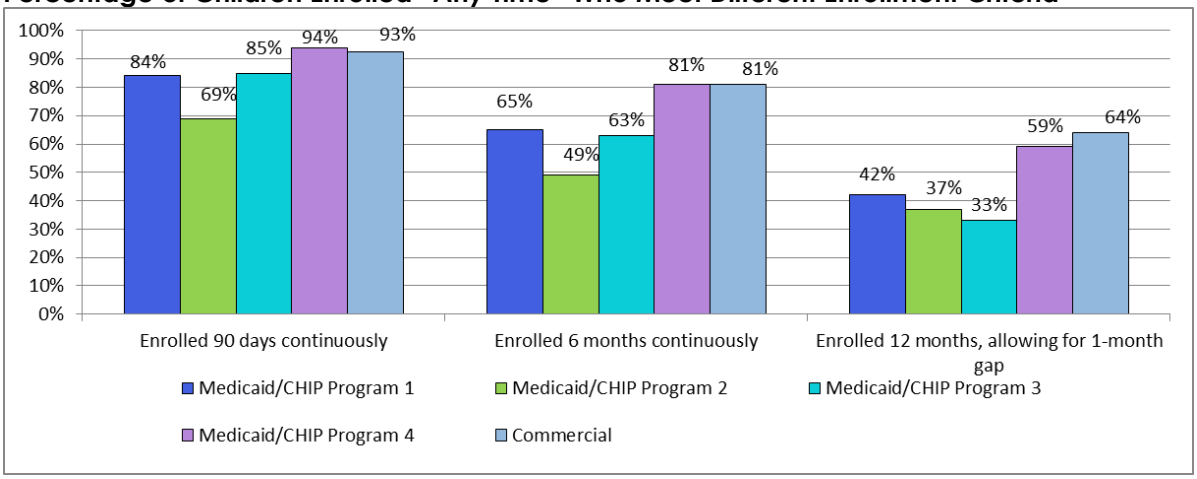
8. Enrollment Requirements: Why isn't there a 90-day enrollment denominator for the Starter Set measures to allow for comparisons to CMS EPSDT Reporting?

Applicable Measures:

- Utilization of Services
- Oral Evaluation
- Treatment Services

During measure testing, the following enrollment intervals were evaluated: a) >30 days; b) >90 days; c) >180 days; and d) 365 days, allowing a single 1-month gap. The figure below illustrates the impact of different denominator requirements on the percentage of enrolled children eligible for measure inclusion. Through evaluation of the data on the measure denominators and overall measure scores, and using a face validity consensus process, the DQA elected to use the 180-day continuous enrollment requirement in order to balance sufficient enrollment duration to allow children adequate time to access care with the number of children who are excluded from the denominator due to stricter enrollment requirements.

Percentage of Children Enrolled "Any Time" Who Meet Different Enrollment Criteria



The final measure specifications originally included an additional 90-day continuous enrollment denominator for three measures (Utilization of Services, Oral Evaluation, and Treatment Services) to allow for historical comparisons to the CMS EPSDT data. The 90-Day enrollment denominator option was eliminated from the NQF-endorsed Utilization of Services and Oral Evaluation measures because the NQF did not permit multiple denominators within a single measure in order to ensure standardization and consistency in quality measure reporting. In keeping with this approach, the 90-day enrollment denominator option also was eliminated from the Treatment Services measure. CMS and other stakeholders (e.g., state Medicaid programs and state Marketplaces) have adopted DQA measures. The 180-day enrollment interval has not been cited as a barrier to implementation although it has been recognized as a distinction from the CMS EPSDT data reporting requirements. The DQA has and will continue to work with the oral healthcare stakeholder community to promote the development and adoption of validated quality measures and alignment in oral healthcare performance measurement across stakeholder groups. Plans and programs interested in continuing to make comparisons to CMS EPSDT data or that are interested in further evaluating the impact of enrollment requirements can conduct their own sensitivity analyses using different enrollment lengths. However, these alternative enrollment lengths should not be reported as the official DQA measure scores.

9. *Miscellaneous*

Additional context for understanding the distinctions between Care Continuity, Dental Services and Usual Source of Services, Dental Services can be found in the 2023 AMR Report.

FAQ for Adult Measures

These FAQs can also be found in the Adult Measures User Guide.

1. *Classifying Individuals at Elevated Caries Risk*

Applicable Measure:

- Topical Fluoride for Adults at Elevated Caries Risk

A. Why did the DQA not consider all Medicaid-enrolled individuals as being at "elevated risk"?

The DQA has focused measurement of topical fluoride receipt on adults at elevated risk for dental caries to focus on a priority population where evidence of effectiveness is greatest and there is the least uncertainty about the appropriateness of the intervention. The evidence-based guidelines regarding topical fluoride developed by the American Dental Association

recommend that these services be provided for individuals "at-risk" for dental caries. Testing data found that significant performance gaps existed within elevated caries risk populations.[2,6]

Within the care delivery system, evidence-based guidelines also recommend that **patient-level risk assessment** should drive treatment planning and care delivery. Accordingly, the DQA's approach to performance measurement within the care delivery system is based on these patient-centered decisions instead of using broad population level indicators such as socio-economic status to measure performance. Not every person enrolled in Medicaid is at elevated caries risk. While social determinants play a significant role in influencing outcomes, their impact on each patient needs to be carefully assessed. Encouraging individualized risk-based care, in itself, is a quality improvement activity.

Creation of a "performance" measure should not be construed as a policy statement or as a basis for altering benefit design. For example, a performance measure focusing on preventive services for individuals ***at elevated risk*** does not imply that only individuals at elevated risk should receive the services; the measure is simply a means of assessing to what degree preventive services are being provided to a particular group of individuals for whom guidelines have established good evidence for recommending the services.

B. Why use methodologies that require prior years' data to identify elevated risk, which may impact feasibility?

Based on the best current evidence, the National Institute for Health and Care Excellence (NICE) suggests that "clinical judgment of the dentist and his or her ability to combine risk factors, based on their knowledge of the patient and clinical and socio-demographic information is as good as, or better than, any other method of predicting caries risk."[4] Therefore, the DQA risk-based measures specifications include the caries-risk assessment CDT codes introduced in 2014. In addition, evidence from a systematic review indicates that previous caries experience is an important predictor of future disease.[5] Therefore, additional methodology to identify individuals at elevated risk was included that is based on prior caries experience, which can be identified using caries-related treatment codes in administrative claims data. The DQA "look-back method" uses a tested methodology to identify individuals whose claims history is indicative of caries risk. Measure implementers should use both caries risk assessment codes and the caries-related treatment codes to identify individuals at elevated caries risk.

It is important to note that the methodology used to identify elevated caries risk is not intended as a "risk assessment tool" to be used at the level of individual patients either to assess risk or to define dental benefits or qualification for services for specific groups of individuals. It is only a model used to identify individuals who can be inferred to be at "elevated risk" for caries using claims data for the purpose of measuring program performance. This method is not intended to identify every person who may be at elevated risk.

C. Should individuals be enrolled in each of the three years to apply the 'look-back method'?

There is no enrollment requirement during the three years prior to the reporting year. The past history is a look-back period for *available* claims. The reporting year remains a single year and is the only year during which minimum enrollment length must be verified.

D. What should I do if I do not have 3 years of claims history prior to the reporting year for some individuals meeting the enrollment criteria in the reporting year?

The measure specifications require looking for specified caries-indicative codes in the reporting year and in the three prior years for available claims. Some individuals who meet enrollment criteria in the reporting year may not have the claims history with the same plan for prior years. The intent is to identify those individuals who can be confirmed as being at elevated risk; the intent is not to identify all individuals at elevated risk. The measure includes the subset of individuals who can be identified as being at elevated risk using claims data.

E. If I am a new plan in Medicaid or am entering a new market and do not have any claims from prior years, what can I do?

If the prior three years claims history is not available, this should be noted within the final reports with an indication of how many prior years (if any) of data were used. When fewer years of historical data are used, the number of individuals who qualify for the denominator will decrease and the measure rates may be impacted. Comparisons between plans may not be valid unless all plans use the same look-back period.

2. *Topical Fluoride for Adults at Elevated Caries Risk: Why were 2 fluoride applications selected to qualify for the numerator?*

Evidence-based guidelines for adults suggest that professionally applied topical fluoride every 3-4 months is effective in preventing caries in adults at elevated risk for dental caries.[1] Programs and plans that wish to further explore receipt of topical fluoride among their enrollees to inform quality improvement efforts may find it useful to evaluate the number and percentage of individuals at increased caries risk who received 0, 1, 2, 3, or 4 or more topical fluoride applications.

3. *Identifying Individuals with a History of Periodontitis*

Applicable Measures:

- Periodontal Evaluation in Adults with Periodontitis
- Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis

A. Do the measures distinguish between aggressive and chronic periodontitis?

No, due to lack of diagnostic codes in claims data, these measures do not distinguish between aggressive and chronic periodontitis. CDT procedure codes indicative of periodontal treatment or maintenance are used to identify "history of periodontitis."

B. Why use methodologies that require prior years' data to identify individuals with periodontitis, which may impact feasibility?

Both measures are designed to evaluate whether individuals who have a **history of periodontitis** continue to receive care. Therefore, the denominator population is comprised of individuals with periodontal treatment or maintenance in the three prior years.

C. Should individuals be enrolled in each of the three years to identify "history of periodontitis"?

There is no enrollment requirement during the three years prior to the reporting year. The past history is based on *available* claims. The reporting year remains a single year and is the only year during which minimum enrollment length must be verified.

D. What should I do if I do not have a full 3 years of claims history prior to the reporting year for some individuals meeting the enrollment criteria in the reporting year?

The measure specifications require looking for specified periodontitis-indicative codes in the three prior years. Some individuals who meet enrollment criteria in the reporting year may not have the claims history with the same plan for all three prior years. The intent is to identify those individuals who can be identified as having periodontitis; the intent is not to identify all individuals with periodontitis. The measure includes the subset of individuals who can be identified as having periodontitis.

E. If I am a relatively new plan in Medicaid or recently entering a new market and do not have claims history in that program/market for 3 prior years, what can I do?

When three years claims history in the program or market is not available, this should be noted within the final reports with an indication of how many years of data were used. When fewer than three years of historical data are used, the number of individuals who qualify for the denominator will decrease and the measure rates may be impacted. Comparisons between plans may not be valid unless all plans use the same look-back period.

F. If I am a new plan in Medicaid or am entering a new market and do not have any claims from prior years, what can I do?

If there is **no** claims history in prior years, it will not be possible to identify individuals with a history of periodontitis and, therefore, this measure cannot be calculated.

4. *Why is Periodontal Evaluation in Adults with Periodontitis considered a "utilization" measure and Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis considered a "process quality measure"?*

Utilization measures are identified by the National Quality Measures Clearinghouse as "related health care delivery measures" that "can assess encounters, tests, or interventions that are not supported by evidence for the appropriateness of service for the specified individuals."[7] A process of care quality measure 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."[7] There currently is an insufficient evidence base for associating oral evaluations with improved outcomes for patients with a history of periodontitis. However, oral evaluations can be used to identify the extent to which adults with a history of periodontitis are being seen for care. The measure *Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis* identifies specific dental care services indicative of ongoing care associated with successful long-term management of periodontal disease.[8-11] The two measures provide complementary information. *Periodontal Evaluation* indicates the percentage of enrollees with a history of periodontitis who are seen for care, whereas *Ongoing Periodontal Care* identifies the percentage of individuals with a history of periodontitis who receive ongoing care. *Periodontal Evaluation* measure scores can provide context for interpreting *Ongoing Periodontal Care* scores by enabling programs to identify what percentage of patients with a history of periodontitis are accessing care. Additional information and context for these two measures is included in the 2022 AMR Report.

5. *Pregnancy-Related Measures: Why are the Measures limited to Beneficiaries with Live-Birth Deliveries?*

Applicable Measures:

- Utilization of Services During Pregnancy
- Oral Evaluation During Pregnancy

Because the intent is to measure oral healthcare services received *during pregnancy*, it is necessary to identify the pregnancy episode (i.e., the period prior to the delivery date). To identify the pregnancy period, an "event" – a procedure or encounter – relative to which the pregnancy episode can be defined must be identified. Live-birth deliveries are commonly the basis for defining pregnancy episodes in other quality measures examining care received during pregnancy[12,13] as well as for other oral healthcare performance metrics focused on pregnant beneficiaries.[14] The pregnancy episode can be defined as the period prior to the delivery date. Because different pregnancy outcomes (e.g., stillbirths, ectopic pregnancies, and terminations) have pregnancy episodes with different durations, each outcome requires identification of an event that forms the basis for reliably identifying the pregnancy episode. Published research

validating identification of pregnancies using claims data demonstrate the complex logic required to capture pregnancy episodes across multiple types of outcomes.[15-17] Research also estimates that live births represent more than 70% of pregnancy episode outcomes (when an outcome can be identified)[16,17] and tend to be more reliably identified than other pregnancy outcomes.[15,16] With these feasibility and reliability considerations, live-birth deliveries were selected as a starting point for developing oral healthcare measures for pregnant individuals.

6. *Dual Eligibles: Why are beneficiaries dually eligible for Medicaid and Medicare excluded from some medical-dental measures?*

Applicable Measures:

- Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults
- Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults
- Adults with Diabetes – Oral Evaluation

These measures require medical administrative claims data as well as dental. Medicaid programs frequently do not have access to complete Medicare claims data for dual eligible beneficiaries. Thus, the measure cannot be reliably calculated. A program that does have access to complete Medicare claims data may want to additionally run these measures for its dual eligible population. If a program elects to do this, measure scores for the dual eligible population should be reported separately from the non-dual eligible population. In addition, the program should clearly indicate how it is identifying and defining "dual eligibles" because not all dual eligibles are fully eligible for Medicaid benefits (i.e., some dual eligible beneficiaries may only be eligible for limited Medicaid coverage). The definition for "dual eligible" and the extent of Medicaid benefits coverage for those individuals should be included in reports of measure scores for the dual eligible population.

7. *Why are inpatient admissions excluded from Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults and Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults?*

The intent is to measure access by evaluating the proportion of the population that seeks care in the emergency department for ambulatory care sensitive non-traumatic dental conditions and who are subsequently discharged from the ED. Patients who are admitted for hospitalization represent a different category of healthcare needs and a different episode of care. Patients who receive care in the ED typically do not receive definitive care and are referred to a dental provider. Consequently, the measure of follow-up care focuses on those patients discharged from the ED. Measure testing found that ED visits resulting in inpatient admissions represent fewer than 2% of ED visits. Consequently, exclusion of these visits will not materially affect relative

comparisons between programs or evaluation of within-program trends over time. It is important that measure implementers recognize that this measure is ***not designed to measure resource use***. The DQA recognizes that non-traumatic dental condition ED visits that result in inpatient admissions are significant in terms of both health consequences and system resources. Consequently, the measure specifications include reporting the number of visits excluded because they resulted in inpatient admissions so that programs and other stakeholders are aware of the magnitude of these visits and can monitor trends over time.

8. *Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults: Are the 7-day and 30-day follow up periods for visits with a dentist after a non-traumatic dental condition emergency department visit mutually exclusive?*

No, visits that are captured in the 7-day follow-up visit also will be captured in the 30-day follow-up visit.

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