



*Improving Oral Health Through Measurement*

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# DENTAL QUALITY ALLIANCE: 2018 ANNUAL MEASURES REVIEW

REPORT FROM THE DQA MEASURES  
DEVELOPMENT AND MAINTENANCE  
COMMITTEE

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JUNE 2018

## Contents

INTRODUCTION AND PURPOSE.....	3
PROCESS.....	3
CODE UPDATES .....	4
COMMENTS ADDRESSED .....	4
Comments to DQA Annual Measure Review .....	4
Comments to NQF Measure Maintenance Review.....	4
Utilization of Services, Dental Services.....	5
Oral Evaluation, Dental Services.....	5
Topical Fluoride for Children at Elevated Caries Risk, Dental Services.....	5
Appendix A: Measures Development and Maintenance Committee .....	7
Appendix B: Public Comments .....	8

## INTRODUCTION AND PURPOSE

The purpose of this report is to summarize the outcomes of the 2018 annual review of the Dental Quality Alliance's (DQA's) quality measures for pediatric and adult populations. DQA measures address prevention and disease management of oral health diseases for both children and adults, including measures of utilization, access, cost, and quality of dental services for individuals enrolled in public (Medicaid, CHIP) and private (commercial) insurance programs.

The detailed specifications can be found on the DQA website at:

<http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/measures-medicaid-and-dental-plan-assessments>

## PROCESS

The DQA has established an annual measure review and maintenance process. This measure review process is overseen by the DQA's Measures Development and Maintenance Committee (MDMC) which is comprised of six subject matter experts, a member of the DQA Executive Committee, and DQA Chairs. ([Appendix A](#)).

The DQA released a call for comments to its members and the broader oral health community in February 2018. Following a 30-day comment period, the MDMC carefully considered and addressed the comments.

In addition, the following five DQA measures underwent a three-year continuing review by the National Quality Forum, which also included public comment periods:

- 2508: Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk, Dental Services
- 2509: Prevention: Sealants for 10-14 Year-Old Children at Elevated Caries Risk, Dental Services
- 2511: Utilization of Services, Dental Services
- 2517: Oral Evaluation, Dental Services
- 2528: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services

**[The DQA's MDMC undertook an intensive review of the DQA's two sealant measures for children 6–9 years and 10–14 years, respectively; the sealant measures review is described in a separate report.](#)**

The DQA's MDMC would like to thank all stakeholders who submitted comments to both the DQA and NQF review processes to allow for thorough review of its measures. The DQA reviewed and reaffirmed its measures by approving this report at its meeting on June 29<sup>th</sup>, 2018.

## CODE UPDATES

Review of the 2018 CDT Manual and National Uniform Code Committee Health Care Provider Taxonomy code updates did not identify new codes relevant to the measures.

## COMMENTS ADDRESSED

The following paragraphs summarize the review of the comments as addressed by the MDMC. The detailed public comments are contained in [Appendix B](#).

### Comments to DQA Annual Measure Review

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One commenter appreciated the DQA's consideration of the measure concept of "**improved caries risk status** as a means of evaluating the success of care delivery mechanisms for both pediatric and adult populations." The MDMC is actively engaged in identifying ways to measure health status and outcomes in the absence of routine structured capture of diagnostic codes in commonly used data sources. The DQA has a systems-level outcome measure of caries-related ED use among children and is currently testing an adult counter-part measure. At the practice level, the DQA has developed a measure of new carious lesions at visit recall ([Caries at Recall](#)) for use in quality improvement applications.

The same commenter encouraged the DQA to seek stewardship of CMS75v: "Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period." The MDMC notes that the comment is timely given the measure's incorporation in the CMS's Quality Payment Program through Merit-Based Incentive Programs (MIPS). The DQA could update and improve this outcome measure, including establishing a valid value set and addressing risk adjustment. The DQA would likely assume stewardship if given the opportunity to do so.

### Comments to NQF Measure Maintenance Review

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There was one organization that provided comments on the three non-sealant measures (2511: Utilization of Services, Dental Services; 2517: Oral Evaluation, Dental Services; 2528: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services). The commenter requested clarification on whether these DQA measures are specified for Medicaid plans only or if they are

also specified for commercial plans with a dental benefit. The DQA clarified that the measures are calculated using administrative claims data, and they are specified for reporting at the program (e.g., Medicaid or CHIP) or plan (e.g., MCO or DBA) level.

### Utilization of Services, Dental Services

The commenter also sought clarification on how the DQA Utilization of Services measure differs from the NCQA Annual Dental Visit measure. The DQA clarified that Utilization of Services requires a 6-month continuous enrollment requirement compared with the NCQA requirement of full-year enrollment (allowing for no more than a 45-day gap). The DQA's measure testing found a significant decrease in the percentage of members eligible for the measure with the longer enrollment criterion.

### Oral Evaluation, Dental Services

The commenter requested that opportunities to harmonize this measure with Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) reporting requirements be considered. The commenter also asked whether there was sufficient distinction between Utilization of Services and Oral Evaluation to merit having both measures in the NQF portfolio. The DQA noted that there is no counterpart to the Oral Evaluation measure in the CMS-416 EPSDT data. The DQA was formed at the request of CMS and maintains regular communication with CMS about its measure development activities to promote alignment and harmonization in dental quality measurement. The DQA also clarified that Utilization of Services is an access measure – whether children are able to access the dental care system, whereas Oral Evaluation is a process measure – whether children are receiving regular oral evaluations, including diagnostic services that are critical to evaluating oral disease and dentition development and to developing an appropriate oral health prevention regimen and treatment plan.

### Topical Fluoride for Children at Elevated Caries Risk, Dental Services

The commenter requested clarification on how to identify individuals who are at “high” or “moderate” risk. The DQA noted that during initial measure development, it was recognized that the ability to make reliable distinctions between at-risk levels (e.g., between “moderate” and “high” risk) was not well established. Consequently, the measure adopted a clearer cut dichotomous distinction of “low” risk and “elevated” risk. (The measure does not require distinguishing “moderate” risk from “high” risk.) [The recent 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": "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."

## Appendix A: Measures Development and Maintenance Committee

### **Measures Development and Maintenance Committee:**

Craig W. Amundson, DDS, General Dentist, HealthPartners, National Association of Dental Plans. Dr. Amundson serves as chair for the Committee.

Mark Casey, DDS, MPH, Dental Director, North Carolina Department of Health and Human Services Division of Medical Assistance

Natalia Chalmers, DDS, PhD, Diplomate, American Board of Pediatric Dentistry, Director, Analytics and Publication, DentaQuest Institute

Frederick Eichmiller, DDS, Vice President & Science Officer, Delta Dental of Wisconsin

Chris Farrell, RDH, BSDH, MPA, Oral Health Program Director, Michigan Department of Health and Human Services

Gretchen Gibson DDS, MPH, Director, Oral Health Quality Group, VHACO Office of Dentistry, Veterans Health Care System of the Ozarks (VHSO)

### **DQA Executive Committee Liaison to the MDMC:**

Michael Wojcik, DDS, Periodontist, ADA/ Council on Dental Practice

### **DQA Leadership:**

Matthew Vaillant, DDS, General Dentist, Chair, Dental Quality Alliance

Allen Moffitt, DMD, Orthodontist, Chair-Elect, Dental Quality Alliance

### **The Committee was supported by:**

Krishna Aravamudhan, BDS, MS, Director, Council on Dental Benefits Program, American Dental Association

Jill Boylston Herndon, PhD, Methodology Consultant to the DQA; Managing Member and Principal, Key Analytics and Consulting, LLC

Diptee Ojha, BDS, PhD, Senior Manager, Office of Quality Assessment and Improvement, American Dental Association

Lauren Kirk, Coordinator, Office of Quality Assessment and Improvement, American Dental Association.

## Appendix B: Public Comments<sup>1</sup>

### COMMENTS TO DQA ANNUAL MEASURE REVIEW

Committer	Comment
<p>Children's Dental Health Project</p> <p>Colin Reusch, MPA</p> <p>Director of Policy</p>	<p>The Children's Dental Health Project appreciates the opportunity to comment on the substantial work of the Dental Quality Alliance in advancing meaningful quality measures to drive improved oral health outcomes. In general, CDHP supports the DQA's continued efforts to refine measures for program evaluation and practice improvement. As an organization that highly values targeting resources to high-risk populations, CDHP appreciates the DQA's advancement of measures that either incorporate caries risk as a component, measure the receipt of services likely to reduce caries risk, or track disease prevalence or oral health status over time.</p> <p>With regard to measures under development or consideration, CDHP applauds the DQA for its consideration of <b>Improved caries risk status</b> as a means of evaluating the success of care delivery mechanisms for both pediatric and adult populations. We strongly encourage the DQA to continue developing similar measures, including caries status or prevalence/severity of tooth decay. As such, we re-emphasize our previous comment that the DQA seek stewardship of CMS75v1 "Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period."</p> <p>With regard to practice-based measures, CDHP again applauds the DQA for its continued development of strong and valuable metrics for improved caries status, sealants, topical fluoride application, and dental visit after medical well child visit. We appreciate DQA's recognition of the importance of care continuity and coordination across the medical and dental domains. Of concern in the adoption and implementation of some of these measures is the general lack of ICD coding by dental professionals though we understand that the DQA and other entities are engaged in efforts to more easily map ICD codes to existing dental diagnostic systems to facilitate more robust dental HIT systems and their ability to document disease processes.</p> <p>CDHP strongly believes that the DQA's efforts are incredibly valuable to the field and necessary for achieving a more integrated oral health care delivery and financing system that places greater emphasis on oral health outcomes and facilitates system accountability. As always, please do not hesitate to contact us with questions or let us know how we can better support the DQA's efforts.</p>

<sup>1</sup> Public comments on the sealant measures are contained in a separate report on those measures.

**COMMENTS TO NQF MEASURE MAINTENANCE REVIEW**

Commenter	Comments
<p>America's Health Insurance Plans</p>	<p>AHIP would like clarification on whether the measure is specified for Medicaid plans only or if it is also specified for commercial plans with a dental benefit. If it is specified for commercial plans, the measure will be difficult for plans to report as dental benefits are usually separated from medical benefits. In these situations, the health plan may have access to dental provider information. (Applies to measures 2511: Utilization of Services, Dental Services; 2517: Oral Evaluation, Dental Services; 2528: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services)</p> <p>AHIP would also like clarification on how this measure differs from the existing NCQA HEDIS measure Annual Dental Visit (NQF #1388), a measure that is no longer NQF endorsed but currently in use in various public reporting programs. There seems to be a high degree of overlap between these two measures. (Applies to measure 2511: Utilization of Services, Dental Services)</p> <p>AHIP also asks the committee to look for opportunities for harmonization with existing Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSTD) reporting requirements. AHIP also notes that, conceptually, any visit that satisfies measure #2511 would also satisfy measure #2517, and vice versa. We recommend the Steering Committee consider the value of having both measures in the Prevention and Population Health portfolio. (Applies to measure 2517: Oral Evaluation, Dental Services)</p> <p>AHIP also agrees with the steering committee that the measure denominator requires clarification of how to identify individuals who are at "high" or "moderate" risk. (Applies to measure 2528: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services)</p>