Proposed New Measures for HEDIS®[1] Measurement Year (MY) 2023: Oral Evaluation, Dental Services (OED) Topical Fluoride for Children (TFC)

NCQA seeks comments on proposed new measures for potential inclusion in the HEDIS measure set for MY 2023:

- *Oral Evaluation, Dental Services:* The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the MY.
- *Topical Fluoride for Children* (formerly *Topical Fluoride for Children at Elevated Caries Risk*)*:* The percentage of members 1–20 years of age who received at least two topical fluoride applications during the MY.

Good oral health is a vital component of a child's overall health. A primary goal of dental or oral health care is to prevent tooth decay, also known as cavities, caused by dental caries. Dental cavities are one of the most common chronic conditions in children in the United States.

NCQA is set to retire the long-standing Annual Dental Visit (ADV) measure for HEDIS MY 2023. Stakeholders urged NCQA to identify an appropriate replacement measure, to avoid a gap in measuring dental quality in HEDIS. NCQA and the Dental Quality Alliance (DQA), the performance measure development organization established by the American Dental Association (ADA), worked to determine if one or more existing DQA pediatric measures could be adapted for inclusion in HEDIS, and concluded that both OED and TFC are robust replacements. NCQA desires for the adapted measures to align as much as possible with the original DQA measures. Therefore, NCQA is prioritizing alignment with both DQA measures.

NCQA seeks general feedback and specific feedback on the following questions:

1. Do you support alignment of the proposed HEDIS measures with the DQA measures? Or do you support proposed differences in the HEDIS measures identified below.
2. Oral Evaluation, Dental Services:
    a. This DQA measure focuses solely on services provided by dental providers. Should the HEDIS measure recognize evaluations provided by other types of medical providers, such as pediatricians or family physicians?
    b. The DQA measure specifications includes nine age stratifications. NCQA proposes four age stratifications and a total rate for the HEDIS measure. Do you support fewer stratifications?
3. Topical Fluoride for Children:
    a. The DQA measure specifications includes three indicators that delineate type of provider (dentists, other medical providers, either type of provider). NCQA proposes to assess only the combined indicator (either type of provider). Should NCQA include more indicators by provider type in the HEDIS measure?
    b. The DQA measure captures fluoride varnish. Should this measure capture all types of fluoride applications, not just fluoride varnish?
    c. The DQA measure specification includes eight age stratifications. NCQA proposes four stratifications and a total rate. Do you support fewer stratifications?
    d. The DQA measure specifies an allowable gap of 31 days. NCQA proposes an allowable gap of 45 days to align with other HEDIS measures. Do you support 45 days vs. 31 days?

Supporting documents include the draft measure specifications and evidence workup.

NCQA acknowledges the contributions of the Dental Expert Work Group and the Technical Measurement Advisory Panel.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Oral Evaluation, Dental Services (OED)

SUMMARY OF CHANGES TO HEDIS MY 2023

- First-year measure.

Description

The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Eligible Population

Product line	Medicaid.
Ages	Under 21 years as of December 31 of the measurement year. Report four age stratifications and a total rate: • 0–2 years • 3–5 years. • 6–14 years. • 15–20 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	180 days during the measurement year.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator	The eligible population.
Numerator[1]	A comprehensive or periodic oral evaluation with a dental provider during the measurement year (Oral Evaluation Value Set ***with*** NUCC Provider Taxonomy Value Set).

[1] The NCQA Value Set Directory includes Current Dental Terminology (CDT) codes, © 2022 American Dental Association. All rights reserved.
Use of the CDT codes by NCQA, including inclusion in HEDIS, is contingent on NCQA and the ADA/DQA entering into an appropriate license agreement.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table OED-1: Data Elements for Oral Evaluation, Dental Services

Metric	Age Stratification	Data Element	Reporting Instructions
OralEvaluationDentalServices	0-2	Benefit	Metadata
	3-5	EligiblePopulation	For each Stratification
	6-14	ExclusionAdminRequired	For each Stratification
	15-20	NumeratorByAdmin	For each Stratification
	Total	Rate	(Percent)

Oral Evaluation, Dental Services (OED)
Topical Fluoride for Children (TFC)
Measure Workup

Measure Descriptions

- *Oral Evaluation, Dental Services (OED):* The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation by a dental provider during the measurement year.
- *Topical Fluoride for Children (TFC):* The percentage of members 1–20 years of age who received at least two topical fluoride applications.

Topic Overview

Prevalence and Importance

Oral examinations include physical examination, review of appropriate images and evaluation for risk of tooth decay. Examination visits may also include the application of topical fluoride. Topical fluoride plays an important role in preventing dental decay (cavities) caused by dental caries in children. Dental caries is the most common chronic disease in children in the United States. From 2015–2016, prevalence of total (untreated and treated) caries-related tooth decay was 46% for children 2**–**19 years (Fleming, 2018). As children age, the prevalence increases from 21% (2–5 years) to 51% (6–11 years), to 54% (12–19 years). Overall, the prevalence of untreated caries was 13.0%. If untreated, dental caries can lead to difficulties with eating, speaking and learning (Griffin, 2016).

Identifying caries early on 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 children below the federal poverty level did not have a dental visit during the year.

Financial importance and cost-effectiveness

Between 1996 and 2013, more than $26 billion was spent on dental care for children and adolescents. Every year, more than 34 million school hours are lost due to unplanned (emergency) dental care. In 2017, there were 2.1 million dental-related ER visits (both children and adults); Medicaid paid for about 69% of these visits for children (CDC, 2021). States are obligated to provide dental benefits to children covered by Medicaid and the Children's Health Insurance Program (CHIP) (Medicaid.gov, 2010). Coverage includes dental services for children as part of the Early and Periodic Screening, Diagnostic and Treatment benefit (Medicaid.gov, 2010). States that have a separate CHIP program can provide a package of dental benefits that meet CHIP requirements or provide a benchmark dental benefit package (Medicaid.gov, 2010).

There can be significant payoffs to investing in oral health. In one simulation study conducted in Virginia for Medicaid eligible children younger than 3 years, the authors estimated that receiving fluoride varnish would reduce the percentage of 7½ year old children with tooth decay from 63% to 40%. Primary care physicians applying fluoride varnish would save Medicaid more than $75 per child, totaling almost $2 million/year for Virginia Medicaid (Scherrer & Naavaal, 2019).

Underscoring the importance of topical fluoride application, it has been estimated that providing fluoridated water to communities for 1 year could save $6.5 billion in future dental treatment costs. Persons in communities with

fluoridated water have fewer cavities than persons in those without it (NIHCM, 2021).

Supporting Evidence for Examination and Topical Fluoride Application

The American Academy of Pediatric Dentistry (AAPD) recommends that children receive their first clinical oral examination at the time of their first tooth eruption and no later than their first birthday (AAPD, 2018). Thereafter, it is recommended that the frequency of examinations be based on the child's individual needs and susceptibility to disease. Recommendations from the National Institute for Health and Care Excellence (NICE) also support an individualized approach to determining the frequency of dental checks (NICE, 2004). NICE recommends that that shortest interval between visits for children younger than 18 be no less than 3 months and no greater than 12 months (NICE, 2004). AAPD and NICE recommendations are not graded. AAPD recommendations were developed from an evaluation of more than 40 articles from published literature, as well as expert consensus opinion by experienced researchers and clinicians. The NICE guideline development process includes relevant literature review, expert committee review and stakeholder feedback.

The U.S. Preventive Services Task Force (USPSTF) recommends that primary care clinicians prescribe oral fluoride supplementation for children younger than 5, starting at 6 months for those whose water supply is deficient in fluoride, and apply varnish to the primary teeth of all infants and children, starting at the age of primary tooth eruption (USPSTF, 2021). The AAPD recommends that topical fluoride treatments be provided every 6 months, or at an interval appropriate to the child's individual needs, starting at 12–24 months and continuing into adolescence (AAPD, 2018). A Cochrane systematic review to determine the effectiveness of fluoride varnishes in children and adolescents (up to 16 years) found an association between fluoride and a decreased risk of caries (Marinho et al., 2013). In a systematic review conducted by a panel of experts convened by the American Dental Association, the authors recommend fluoride be administered (in varying forms and concentrations) to all children, to prevent dental caries (Weyant et al., 2013).

Adverse outcomes associated with untreated dental cavities can be numerous; they include pain, infection, increased ER visits and decreased quality of life (Çolak et al., 2013;USPSTF, 2021).

Health care disparities

Health care disparities in oral health range from income based to racial and ethnic disparities. The National Institute for Health Care Management found that low-income children are twice as likely to have untreated dental cavities than higher-income children (NIHCM, 2021). When examining the percentage of children with caries-related lesions based on data from 2011–2016, Black and Hispanic children are more likely to have cavities than White children (NIHCM, 2021). Historically, the Native American population has had less access to dental care. American Indian or American Native children have the highest level of tooth decay—more than 4 times higher than White children (NIHCM, 2021). By age 5, 75% have experienced tooth decay (NIHCM, 2021).

Gaps in care

The barriers to achieving optimal oral health include provider shortage, lack of access to fluoridated water and financial barriers (NIHCM, 2021). More than 62 million people live in a health professional shortage area (HRSA, 2021). There are also approximately 100 million Americans without access to fluoridated tap water. Lack of transportation and childcare or work leave issues are also barriers (NIHCM, 2021).

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Specific Guideline Recommendations

Clinical Practice Guidelines: Screening and Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years

Organization, Year	Target Population	Recommendation	Grade
USPSTF, 2021	Children younger than age 5 years	Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.	B
		Primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	B
		Routine oral screening examinations: No recommendation	I

Clinical Practice Guidelines: Dental Caries in Children from Birth Through Age 5 Years: Screening

Organization, Year	Target Population	Recommendation	Grade
USPSTF, 2014	Children from Birth Through Age 5 Years	Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.	B
		Primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	B
		Routine oral screening examinations: No recommendation	I