"Oral health for all"

Connecticut Oral Health Initiative

Comments on Health Care Cabinet Recommendations for the Health Care Cost Strategies

November 15, 2016

Please accept these comments in regard to the recommendations of the Health Care Cabinet on Health Care Cost Strategies.

The Connecticut Oral Health Initiative (COHI) works to increase a public conscience that results in oral health for all. COHI has actively engaged in discussions around health, health care delivery and population health to both increase the integration of oral health care in health systems and to work towards the Triple Aim for healthcare improvement, through participation the State Innovation Model, the State Health Improvement Plan and other avenues available in Connecticut and nationally.

COHI acknowledges the effort that the members of the Healthcare Cabinet in conjunction with Bailit Consulting for over a year, but we have only become aware of this process over the last couple months. During that time, we have tried to learn and know we are still inadequate to comment fully on the report, but will try to address some of the issues of which we may agree or not agree, for your consideration.

First and foremost, we request that oral health care, both provided by medical and dental providers be integrated from the start. There is volumes of evidence that disease in the mouth have a great impact on overall health and the ability to live heathy, active lives. Oral health cannot be kept in a silo. It is often said that the mouth is the gateway to the body, yet treating as if apart from the body.

The care of disease in the mouth related to infection and inflammation can cost much less than the associated high costs of medical care in persons with diabetes, heart and lung disease, pregnancy and adverse birth outcomes, and the list can go on.

The Early and Periodic Screening, Diagnostic and Treatment, Connecticut's SIM Advanced Medical Home and Community and Clinical Integration Plan Standards, and the State Health Improvement Plan have the start to integrating oral health care into health systems. We recommend the cabinet look at these programs and ones in other states to use a basis for implementing care to include oral health care.

The concept of Consumer Care Organizations (CCOs) is attractive. Coordinating care is one of its strongest suits. We wish the Cabinet will look at the CCO program in Oregon with a focus on the integration of oral health in the model.

The current Medicaid program, especially in regards to the Person-centered Medical Home and Dental Medicaid have performed very well in regards to increasing quality of care and lowering the costs per patient. Dental has experienced a care cost trend from just under $30 per

member of month (PMPM) in 2009 to just under $20 PMPM in 2015. In 2005, Connecticut had about 300 dentists participating in Medicaid and that has increased to over 1500. These are dental figures that are likened to Medical ones I hear reported. Will this be able to continue in this trajectory if new payment models with downside risks are introduced?

The State Innovation Model looked at best practices and tries to implement them. We wonder if it will continue, and be able to make improvements as it does an evaluation of its impact. We recommend working more in conjunction with SIM program to result in the best model for improving quality of care, impacting population health while lowered costs.

You have received many comments from others who are more involved in this process and have a better understanding, and we hope you will follow their recommendations.

Please contact us for further discussions and requests for information that we may be able to provide you in taking the correct direction with the cost-containment plan.

Regards,

Mary Moran Boudreau,
Executive Director