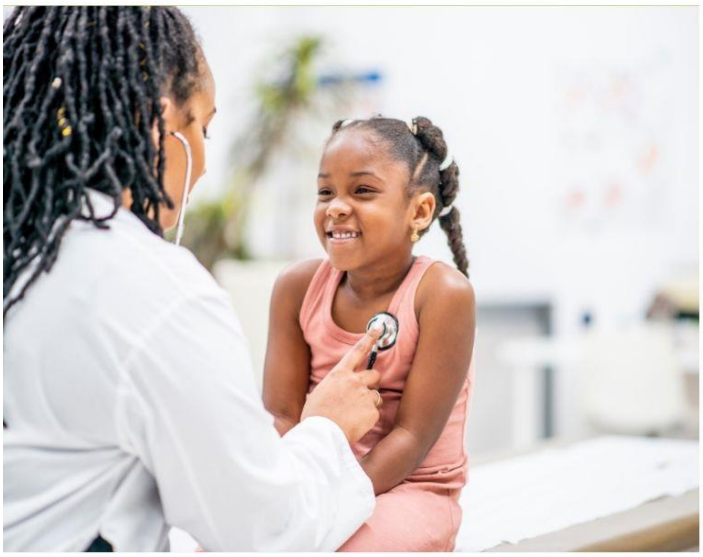

CONNECTICUT DENTAL HEALTH PARTNERSHIP

the dental plan for HUSKY Health

2024 Connecticut Medical / Dental Integration

REPORT

The Connecticut Dental Health Partnership is the Dental Plan for HUSKY Health and is administered by BeneCare Dental Plans under a contract with the Connecticut Department of Social Services (DSS).

Our mission is to enable all HUSKY Health members to achieve and maintain good oral health. We work to ensure all members have equitable access to oral health services.

JUNE 2024

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The Connecticut Dental Health Partnership is the Dental Plan for HUSKY Health and is administered by BeneCare Dental Plans under a contract with the Connecticut Department of Social Services (DSS).

The Connecticut Dental Health Partnership is committed to achieving Oral Health Equity. Our mission is to enable all HUSKY Health members to achieve and maintain good oral health. We work to ensure all members have equitable access to oral health services.

Medical-Dental Integration and Its Importance

Medical-Dental Integration (MDI) is a model of care that emphasizes the connection between one's oral health and systemic health. It is an approach to care that integrates dental medicine into primary care and behavioral health and encourages providers to incorporate comprehensive care plans for the whole person.[1] MDI creates a system that enables coordination and collaboration among a variety of providers regardless of physical location.[2]

Medical-Dental Integration is an important model of care for four main reasons:

1. **The link between oral and overall health is scientifically proven.** Research has proven that oral health problems, especially the long-term inflammation related to gum disease, can contribute to a variety of health problems, including heart disease, diabetes, Alzheimer's disease, pregnancy complications, and rheumatoid arthritis."[1,3] Cancer is also included; researchers found that men with gum disease were 49% more likely to develop kidney cancer, 54% more likely to develop pancreatic cancer, and 30% more likely to develop blood cancers.[4]

Pneumonia is also linked to oral health. Bacteria in the human mouth is directly connected to the respiratory system. Nurses in one study improved pneumonia outcomes by providing oral health interventions to all adult patients admitted to the hospital, which reduced overall hospital costs, length of stay, and patient mortality.[5]

Signs and symptoms occurring in the mouth can even act as an early warning sign to systemic health problems.

2. **MDI improves outcomes in the patient care experience.** Medical-dental integration can improve the healthcare experience for patients.[6] Patients deserve quality care that includes a wholistic approach, incorporating oral health into the rest of the body. Medical-dental integration relies on high-quality providers who understand the importance of oral health as related to overall health and can educate their patients on the importance of oral health as it relates to their entire bodies.
   a. 63% of adults say their primary medical doctor "never" or "rarely" asks about their oral health.
   b. 30% of adults would be more likely to seek dental care if their dentist and doctor were located in the same place.

The survey results showed that consumers understand the connection between oral health and overall health and are eager for changes to the system.[6]

3. **MDI reduces healthcare costs.** Medical-dental integration reduces costs to the entire health care system. Integration between oral health and chronic disease prevention programs benefits patients and saves money.[7]

According to the Centers for Disease Control and Prevention (CDC), the health care system could save up to $100M each year if dental offices performed screenings for diabetes, high blood pressure, and high cholesterol.[7]

In another example within the Medicare program, $520 million is spent annually on dental emergency department visits; the exacerbation of other conditions means increased expenditures and negative outcomes in other areas of health care as well. If these issues were caught and managed early, many expenditures could be avoided.[1]

Some dentists are providing screenings for chronic diseases such as diabetes, high blood pressure, and cholesterol. These services (screenings) have been shown to provide substantial cost savings to health systems as well as benefits to patients.[8]

4. **MDI increases access to care for vulnerable populations.** Medical-dental integration is an important strategy for increasing access to care for vulnerable populations. As patients visit their primary care office for medical treatment, for example, primary care providers have the opportunity to assess oral health risk and reinforce home care messaging, creating an access point for patients who might not otherwise seek dental care.[1]

   As medical-dental integration gains traction, patients will notice more primary care services in the dental treatment room. Dental assistants and hygienists will measure patients' vital signs. Medical providers will start providing more services that are traditionally performed in a dental office.

   For example, pediatricians provide oral health assessments on children as well as fluoride varnish treatments. The United States Preventive Services Task Force recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.[8]

As providers increasingly acknowledge the link between oral and overall health, as well as the effect medical-dental integration has on vulnerable patient populations, MDI will continue to be a model of care that encourages providers to create comprehensive care plans for the whole person.[9]

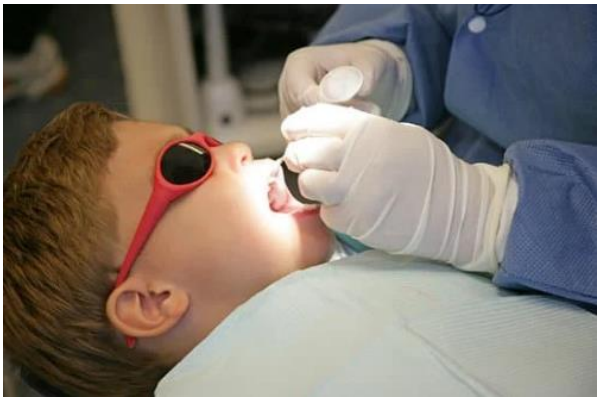
Current Medical-Dental Integration Efforts within Connecticut

A. Efforts within the Connecticut Dental Health Partnership

Access to Baby Care (ABC) Program

Early education and prevention are key to reducing the prevalence of oral disease in all populations. The Connecticut Dental Health Partnership's (CTDHP) Access to Baby Care (ABC) Program is a crucial component of its medical-dental integration efforts. It allows children and families to interact with a medical provider regarding oral health much sooner than they would usually visit a dentist. With ABC, pediatricians and family practitioners have a unique opportunity to support the prevention of dental caries and promote good oral health habits, including establishing a dental home for the child by their first birthday.[9]

The primary goal of ABC is to train, support, and reimburse primary care pediatric medical practitioners who provide oral health assessment and fluoride varnish application for their HUSKY members, ages 7 and younger.



Oral health services, including assessment, fluoride varnish, fluoride supplementation and anticipatory guidance are recommended by the American Academy of Pediatrics and required by Medicaid's EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) Guidelines.

ABC trains providers using a national oral health curriculum known as Smiles for Life.[10] Training can be provided online or in-person, at the convenience of the medical office and focuses on identifying early childhood caries, performing oral health assessments, and providing fluoride varnish to patients in their medical home.

Once training is complete and certification documented, providers are reimbursed $25 per oral health assessment and $20 per fluoride varnish treatment at well-child visits.

CTDHP also provides essential support to medical offices through the ABC Program Practice Specialist who develops ongoing relationships with practices to set data-driven quality improvement goals and identifies opportunities to replicate best practices.

CTDHP designed and developed reporting and analytic capabilities to enhance its ABC Program model with a Utilization and Revenue Report. Using the report, the ABC Program Practice Specialist provides offices with follow-up support at 30-, 90- and 180-day intervals, with a Utilization and Revenue Report for the latter two periods (see **Appendix A** for example).

In the report, CTDHP calculates the rate of oral health assessment and fluoride varnish applications at the practice and provider level at monthly intervals, as well as the lost revenue opportunity when oral health services are not provided. The report is now embedded into recruiting, training, and providing ongoing performance improvement with practices to increase their rates. For one prominent Connecticut pediatric organization, the Utilization and Revenue Report was able to show **$900,000** in potential unbilled services.

In 2023, trained providers across Connecticut missed out on **$2,909,150** by not providing oral health assessment and fluoride varnish to eligible HUSKY children under the age of 7.

By executing the ABC program, the Connecticut Department of Social Services and CTDHP have recognized the importance of reimbursing providers for early oral health assessments and fluoride varnish for its youngest and most vulnerable population without usurping billing and reimbursement codes from dental providers.

Table 1. Number of Trained ABC Providers in Connecticut, by year

ABC Year	Billing Providers*		Ancillary Providers**		All Providers
	# Newly Trained	Running Total	# Newly Trained	Running Total	
2021	70	523	5	48	571
2022	35	558	11	59	617
2023	51	609	33	92	701***

*Billing Providers include physicians, physician assistants, advanced practice nurse practitioners.
**Ancillary Providers include registered nurses, licensed practical nurses, certified medical assistants and billing staff.
***Total reflects attrition of 18 billing providers no longer actively certified for ABC services due to retirement, death or moving out of state, as of April 2024.

Table 2. Percentage of HUSKY Health Population receiving ABC Services at Well-Child Visits since 2021

Year	Children Continuously Enrolled in HUSKY up to Age 7*	Unique Children with ABC Services	% Rate	Fluoride Varnish Claims	Oral Health Assessment Claims
2021	108,193	14,179	13%	11,844	14,891
2022	103,518	14,860	14%	11,807	16,833
2023	110,580	17,702	16%	12,834	20,503

*Children, up to age 7, who have enrolled continuously in Medicaid for 3 months

Additionally, CTDHP engaged in a joint effort with Connecticut Children's Care Integrated Network (CIN). Statistical analysis conducted by their Program Business Consultant, Laura Marin Ruiz, DDS, MHA, shows results after five CIN primary-care practices received in-person trainings with the ABC program:

Table 3. Connecticut Children's Care Integrated Network - ABC Training Results

	Before Training	After Training
Oral Health Assessment Rate	14.3%	26.9%
Fluoride Varnish Rate	17.0%	23.2%

Dental referrals are also highly encouraged as part of the ABC Program. In 2023, a total of 35,575 HUSKY members under the age of 21 who had no prior dental history had a primary care provider well-child visit in their prior year and then had at least one dental visit for non-emergency reasons.

The Association of State and Territorial Dental Directors (ASTDD) recognized the Access to Baby Care Program as a best practice in its report: Best Practice Approach - Early Childhood Caries - Prevention and Management.[11]

ABC was also featured by the Centers for Medicare and Medicaid Services - Oral Health Affinity Group, whose goal was to support state Medicaid and Children's Health Insurance Program oral health quality improvement teams to improve the delivery of fluoride varnish to beneficiaries ages 0-5 years by primary care providers. CTDHP presented nationally for the State Spotlight Webinar in June 2023, and will continue to be recognized in 2024 with a "State Story" video on the Utilization and Revenue Report.

The Connecticut Dental Health Partnership works closely with our sister administrative service organizations, Community Health Network (CHN-CT) and Carelon. The ABC Practice Specialist

collaborates closely with CHN's Practice Transformation Specialists who meet quarterly with primary care providers. The collaboration emphasizes to providers the importance of incorporating dental services into primary care appointments.

Table 4. Dental Utilization Data on Patient Centered Medical Home (PCMH) Practices, 2023

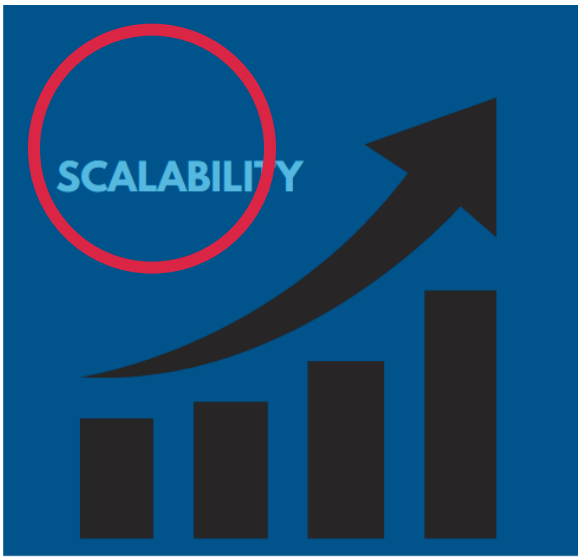
	All Offices Participating in ABC	Non-PCMH Offices	PCMH Offices
Fluoride Varnish Rate	14%	14%	15%
Oral Health Assessment Rate	24%	19%	25%

Coordinating Care with HUSKY Health's Medical Administrative Service Organization - The Community Health Network of Connecticut

The Community Health Network of Connecticut (CHN-CT), the Medicaid Medical Administrative Service Organization, and CTDHP have implemented programs and pilots which seek to reinforce coordinated care for HUSKY Health Members and emphasize the importance of a medical and dental home.

In 2021, CHN-CT and CTDHP implemented a pilot to co-manage members with a diabetes or sickle cell diagnosis who had not been to the dentist in the prior 12 months.

Members are co-assigned a CHN Intensive Care Management Registered Nurse and a CTDHP Oral Health Navigator to reinforce good oral health care and support the member in obtaining a dental home. The nurse care manager and oral health navigator coordinate patient information and update on activities via case consult and case conference. The pilot goals are for the member to utilize preventive services. In pilot year 1, 36 members were co-managed with 56% of members utilizing preventive dental services.



Building upon the success of pilot year 1, the criteria was changed to include members with diabetes or sickle cell, with no prior dental utilization in the previous 12 months, e.g., no dental home, *and* members without a primary care physician (PCP). Targeting this population would presumably yield greater oral health and

medical impacts to the patient. Also, the goal was to increase the number of members in the pilot to test scalability. In pilot year 2, 81 members were co-managed under the new criteria, with 36% of the members utilizing preventive dental services.

In pilot year 3, operational changes were made to reduce administrative burden and to test systematizing the process. The goal is to work with 100 members with chronic medical diseases who have not utilized dental services in the prior 12 months nor have an attributed PCP. Outcome data is forthcoming.

As both teams continue to work and coordinate member care, CTDHP realized a significant increase in referrals from CHN-CT generally. In state fiscal year 2023, 35% of all referrals to the Oral Health Navigation team were from CHN-CT.

Health Focused Community Engagement

CTDHP benefits from robust community-based outreach and engagement. CTDHP's Community Engagement Specialists are certified community health workers who recruit organizations trusted by HUSKY Health members to develop "*oral health champions*" to further oral health literacy and integration of oral health into their programs. This includes hospitals, primary care practices, and OB/GYN practices. In state fiscal year 2023, the team provided 495 outreach activities to health care related organizations across the state.

Moving from community engagement to community partnership is best exemplified in CTDHP's relationship with Middlesex Hospital's Cancer Center. Middlesex and CTDHP worked together in early 2021 when the oncology team identified gaps in oral health care for their prescreening oncology treatment. Since connecting, CTDHP and Middlesex Health have cross-trained staff, set up a navigation workflow for prioritization of patients due to time sensitive oncology treatment schedules, and meet to identify new collaborative opportunities.

B. Efforts within HUSKY Health

Current Dental Terminology (CDT) Codes that Promote Medical Integration within Dental

HUSKY Health supports medical-dental integration efforts by reimbursing dental providers for performing the following medical services: glucose testing and tobacco cessation.

Table 5. HUSKY Health Reimbursement for Medical Services

Dental Code	Description	Adult Reimbursement	Child Reimbursement	Number Claims Paid in SFY 2023
D0412	Blood Glucose Test	$4.38	$4.54	0
D1320	Tobacco Counseling	$4.23	$6.37	919

Within the medical administration of HUSKY Health, significant effort has been made to develop, implement, and measure oral health related outcomes relative to value-based payment programs within medical practices. The intent is to connect medical practitioners to the understanding of their influence and impact on the oral health status of their patients.

Patient-Centered Medical Home (PCMH)

The Department of Social Services (DSS) PCMH Program supports HUSKY Health pediatric and adult practices in achieving National Committee for Quality Assurance (NCQA) Patient Centered Medical Home recognition. The process to receive PCMH recognition includes measuring and meeting certain health outcome measures. DSS offers financial incentives for up to 24 months with no-cost support and guidance to achieve national recognition. Once recognized for meeting or improving on selected health performance measures, practices can receive enhanced payments.[12]

Since its inception and throughout the model and payment redesign, oral health measures either developed by NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) or by DSS have been included as elective measures, process measures, or outcome measures. They have included fluoride varnish application, annual dental visits, and oral evaluation as dental service measures. However, oral health measures have yet to be included for enhanced reimbursement to practices—the selection of enhanced reimbursement signals strategically to medical practitioners the importance of population health measures by DSS.

In a positive move nationally, the Oral Evaluation, Dental Services (OED) measure was formally adopted by HEDIS which requires all PCMH recognized practices to collect data on the

percentage of their members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider in the measurement year.[13] In Measurement Year 2023, 62.7% of patients within PCMH practices received an oral evaluation, and 61% of patients within practices receiving support to become PCMH recognized (also known as receiving Glide Path Support) received an oral evaluation. Data Received from CHN-CT, June 2024.

Patient-Centered Medical Home Plus (PCMH+)

The Patient-Centered Medical Home Plus (PCMH+) model, an evolution of the PCMH program, offers Federally Qualified Health Centers (FQHCs) and Advanced Health Networks enhanced reimbursement. This model is intended to facilitate coordinated healthcare, leading to improved quality health outcomes. The PCMH+ model strongly emphasizes the care coordination of the HUSKY Health patients, particularly the integration of primary care and behavioral health care.

It serves children and youth with special health care needs and individuals with disabilities and links the patient to community-based support.

For children ages 0-4 there are currently two oral health measures within the PCMH+ program:

- Oral Evaluation
- Annual Fluoride Treatment

However, it is important to note that these measures are for reporting purposes only.[14]

C. Other Statewide Efforts

DPH MDI Program and Funding with CHC Inc.

Entitled State Actions to Improve Oral Health Outcomes, CDC awarded funding to five states (**CT, CO, ND, SC, and VA**) to implement medical-dental integration pilot projects and other chronic disease program collaborations.[15]

With the funding from the CDC, the Connecticut Department of Public Health's Office of Oral Health and Diabetes Prevention and Control Program is working collaboratively with the state's largest FQHC. In this unique pilot program, the agencies are working together to develop bi-directional referral systems for children and adults that present with risk factors for obesity or prediabetes in the dental clinic.[15]

Connecticut Cancer Partnership

The Connecticut Cancer Partnership, a coalition of stakeholders in the state's cancer community, has developed and works to implement "a comprehensive plan to reduce the suffering and death due to cancer and improve the quality of life of cancer survivors throughout Connecticut."[16] A key focus area is to increase the vaccination rate to protect against human papillomavirus (HPV), which is linked to a staggering 70% of all oropharyngeal cancers. This underscores the urgency and importance of our mission.[17]

The dental provider community is uniquely positioned to help patients understand the value of preventing cancer and the importance of the HPV vaccine and connect patients to receiving the vaccine through their medical home or pharmacy. Through its oral health and HPV vaccination workgroups, the partnership is working to implement workforce educational interventions to increase dental providers' knowledge, skills, and abilities regarding oral and oropharyngeal cancers and the HPV vaccine.

CTDHP has recently joined the Connecticut Cancer Partnership and looks forward to collaborating with them on elevating HPV vaccination information.

HPV Vaccination within Dental

Currently, there is no Current Dental Terminology (CDT) coding or CT Medicaid reimbursement on the dental fee schedule for dental providers to administer the HPV vaccine.

Emerging Trends Outside of Connecticut

Funding Opportunities

Medical-dental integration models are at the forefront of the national and statewide stages for healthcare policymakers and practitioners.

The United States Centers for Disease Control and Prevention's (CDC) Division of Oral Health awarded funding to the National Association of Chronic Disease Directors (NACDD) in 2020 for medical-dental integration.

The goal of the MDI funding was to find and promote successful models of integrated medical and dental services in a variety of settings such as: dental public health, clinical dentistry, primary medical care settings, and public health settings to support populations with unmet oral health needs and associated chronic diseases.[18]

Workforce Education

Workforce education, a critical component of a successful MDI model, is an emerging trend in several states.

Virginia's Department of Health Dental Program is partnering with internal and external stakeholders to broaden their knowledge about the connection between oral and overall health with a focus on individuals with chronic conditions who have unmet oral health needs. The Adult Oral Health and Chronic Disease Program there focuses on integrating medicine and dentistry through training and educational programming for adult oral health and its relationship to chronic disease.[19]

Virginia also boasts a Special Health Care Needs Oral Health Program that improves access to dental services for individuals with special health care needs (ISHCN) by providing education to health professionals, caseworkers, educators, direct support professionals, students training for the dental profession, and other individuals working with ISHCN.[19]

Iowa offers its residents access to the I-Smile program, run by the Iowa Department of Health and Human Services (IDHHS). I-Smile coordinators exemplify a successful MDI model by working with families, dental offices, medical providers, schools, businesses, civic organizations, and social service organizations to provide oral health, medical and community resources to help ensure a lifetime of health and wellness.[20]

South Carolina's Oral Health and Diabetes Medical-Dental Integration (OHD-MDI) project is focused on partner education and training to improve the consistency, accuracy, and timeliness of oral health messaging in primary care settings for adults with diabetes.[21]

Co-Location of Services

Co-location of medical and dental services, another example of a successful MDI model, is evidenced in Colorado's Diabetes, Cardiovascular Disease, and Oral Health Integration (DCVDOHI) project.

This clinical quality improvement model, funded by the CDC, was designed to ensure better care coordination in the clinical setting for patients with co-morbid conditions. This whole-person integrated approach is a promising practice where medical and dental services are either co-located or where bi-directional referral agreements are in place.[22]

Medical Services in Dental Settings

Medical services performed in a dental setting provide another example of a successful MDI program and emerging trend.

The North Dakota Department of Health's Oral Health Program, also funded through the CDC grant, has partnered with private dental practices and several federally qualified health centers and safety net clinics to implement hypertension screening and referral protocols in dental settings.[23]

Dental Services in Medical Settings

The incorporation of dental services into medical settings is the final example of emerging MDI trends around the country.

The Colorado Medical-Dental Integration (CO MDI) project, funded by Delta Dental, integrated registered dental hygienists (RDHs) into medical care teams to increase access to oral health care for marginalized populations, improve people's oral health, and build sustainable medical-dental integration models. Twenty-eight RDHs within 16 healthcare organizations provided more than 67,000 hygiene visits, expanding access to oral health care and improving oral health outcomes for historically underserved Coloradans of all ages.[24]

Acknowledging the critical role oral health plays in a healthy pregnancy, the Michigan Initiative for Maternal and Infant Oral Health (MIMIOH) includes dental hygienists at obstetric / gynecologic (OB/GYN) clinics in federally qualified health centers to improve oral health outcomes. Presenting oral health care as part of prenatal care and having co-located OB/GYN and dental clinics were essential to the success of the program.

The state of Ohio provides a similar program in which prenatal healthcare professionals are trained to provide oral health assessments, referrals and case management as part of a complete prenatal program.[20]

Barriers to Medical-Dental Integration

Significant barriers to medical-dental integration efforts include:

1. Healthcare Delivery Settings

Care settings are often siloed by location.[25] In non-integrated care settings, dental care is provided in one physical location and medical care in another. Patients must negotiate individual practices and sites on their own with varying degrees of success.[26]

2. Billing and Funding Structure

Payment and insurance processes are separate and distinct, making integration difficult.[25] Medical and dental practices often receive separate funding, have little to no sharing of resources, and conduct separate billing practices.[25] Billing systems for medical providers and dental providers are independent of each other. Dental providers, whose billing is heavily procedural, bill for services using current dental terminology (CDT) codes that are developed and updated by the American Dental Association.

Medical providers, in contrast, use current procedural terminology (CPT) codes that were developed and maintained by the American Medical Association.

Additionally, the International Classification of Diseases – 10th revision (ICD-10) is a medical coding system by the World Health Organization that includes over **70,000 codes** for varying diagnoses and symptoms.

To promote integration, stakeholders have collaborated to develop innovative and flexible solutions. For example, in 2015, the American Medical Association approved a CPT code (99188) for the application of fluoride varnish by primary care health professionals.

3. Providers

The transition to medical-dental integration can also be hindered by the providers themselves. Some established providers might be unwilling to change their methods or routines for the transition of their practices toward MDI.[26] For providers who are ready and willing to incorporate MDI efforts, their education and specialty training may not have prepared them fully for interdisciplinary care.

4. Time

Time and effort are absolute necessities for the high-level collaboration required with MDI. This may affect practice productivity or cadence of care. Relationships need to be developed between providers who share patients but may have never met in person. [26]

5. Lack of Effective Information Sharing

Lack of effective information sharing is the largest barrier to effective medical dental integration. Despite innovation in the care delivery system, the exchange of electronic patient data between dental and medical providers to facilitate collaboration remains inadequate. [27] Most dental and medical EHRs are not fully integrated and interoperable and do not allow for the exchange of data and other information, nor do they allow data to be stored in a mutually accessible manner. This creates a barrier to coordinating care and expanding the integration of oral health care in primary care. [20] Patients' physical and dental needs are treated as separate issues, with separate treatment plans. Inefficiencies in operations also result.

6. Communication Hurdles

Reliable communication is at the core of effective medical-dental integration between providers as well as provider to patient, and patient to provider.

In typically siloed healthcare settings, communication between providers is rare and only occurs under compelling circumstances, usually driven by provider need or a specific patient issue. [26] Whether between providers of different specialties, or between provider and patient, offices have unique communication preferences and referral processes. [25] Creating effective referral networks can be challenging, and offices' capacity to accept new patients must be considered. Primary care health professionals may not know whether the referral has been completed. [20] If unable to reach a fellow provider, patients are not always a reliable source of their health histories and prescription medication lists and are often unsure of when and how to access care. [25]

Policy & Program Recommendations

	Progression Towards Greater Integration →			
MDI Category	**Health Focused Community Preventive Care**	**Coordinated Care**	**Co-Located Care**	**Integrated Practice Care**
Description	Preventive oral health care is provided in community-based settings whose focus is oriented to health, well-being, and prevention but are not necessarily delivering oral or medical care. Referral pathways and coordination of care are systematized in the establishment of a dental and medical home. Community preventive care acts as a "spoke" to a "hub" of medical and dental providers.	Medical and dental providers work in separate facilities with separate systems. Communication between providers is ad-hoc and specific to a mutual patient via a consult or limited information sharing. If screening is occurring on dental or medical needs, the information stays in respective patient chart and is not shared nor acted upon.	Medical and dental providers are co-located in the same facility or staff are "embedded" within the respective facilities. Separate systems may be used or some shared systems are utilized e.g., scheduling or medical records. Face to face collaboration and information sharing occurs routinely. Screening occurs and coordinated referrals between medical and dental is standard work.	High levels of collaboration between dental and medical providers. Care team definition includes both dental and medical providers. Providers are consulted, conferenced, and sought out as part of standard practice. Workflows and protocols are standardized in scheduling, screening, and referrals. Performance indicators are established in protocols. An integrated medical-dental health record exists for the exchange of health information.
Example Policies to Enable progression towards integration.	Establish a dental code set and reimbursement process or prospective payment system (PPS) for FQHCs in which qualified RDHs deliver preventive care in expanded community-based settings to adults and children.	Develop an incentive payment bundle for dental providers to conduct health screenings (blood pressure, blood sugar), assessment of primary care attribution, and	Authorize a form of PPS reimbursement for caries risk assessment, prophylaxis, fluoride varnish, and/or silver diamine fluoride to be provided by dental providers co-located in the medical	Akin to the Value Based Payment Contract to Home and Community-Based Services, enable supplemental infrastructure payments to dental providers to connect with and meaningfully use
	Inclusive of the coding and reimbursement is to coordinate active referrals to medical and dental providers. Example of settings: Head Start Programs, The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics, homeless shelters, senior congregate meal sites, group homes. Consider an incentive payment structure to providers whose members have had preventive care and a referral is completed to a dental or medical home evidenced by claims. Expand the Access to Baby Care Program to community and home-based care settings and enable Registered Nurses to assess for oral health and apply fluoride varnish. Pilot RDHs performing preventive care in the home to Community Options participants.	effectuated referral to primary care evidenced by claim. Add oral health measures and effectuated referrals to dental providers into payment models for PCMH, PMCH+, or Primary Care Redesign efforts. Pilot use of electronic health record (EHR) prompts to medical practices to make referrals to dental clinics. Akin to the Value Based Payment Contract to Home and Community-Based Services, enable supplemental infrastructure payments for dentists to transition to ICD-10 diagnosis coding to update their coding software and skillsets.	setting at federally qualified health centers. Encourage and promote financial and operational pathways for pediatric medical homes, adult primary care, and OB/GYN practices to co-locate independent registered dental hygienists into their practice.	(Connecticut's Health Information Exchange) CONNIE. CONNIE to operationalize dental provider use cases in empanelment, (admission-discharge-transfer) ADT feed, and e-consult recognizing that electronic dental records are distinct from electronic medical records.

Medical-Dental Integration RECOMMENDATIONS

1. **Prioritize oral health policies within the MDI framework.** Utilizing this framework can assist the Department of Social Services and policy stakeholders to focus their efforts along the continuum of integration.

2. **Develop incremental policy and reimbursement opportunities that can enable moving providers along the levels of integration.**[26] This includes actions DSS can take with Federally Qualified Health Centers (FQHCs) that are well-positioned to integrate care given their usual co-location of medical and dental providers and deep relationships with community-based organizations to further preventive care in the community.

3. **Utilize the framework to consider developing an enhanced reimbursement or outcomes-based payment model** and administration akin to the Patient Centered Medical Home (PCMH) model deployed by DSS and Community Health Network of Connecticut (CHN-CT) for dental practices to incorporate health screening and primary care referrals.

4. **Evaluate the status of HUSKY Health providers' integration efforts along the framework's continuum.** The framework can enable assessment of where practices are along the continuum to evaluate the progress towards integrated practice.

SUGGESTED NEXT STEPS:

1. DSS endorsement/approval of the framework and commitment to prioritizing MDI for future oral health efforts.

2. If approved by DSS, CTDHP to conduct stakeholder feedback on the framework to assess its viability, identify policy changes that can be effectuated, and evolve the framework to meet the needs of providers and members. Examples of stake holder organizations to gather feedback to include the DSS Dental Policy Advisory Committee, CHN-CT colleagues, Connecticut State Dental Association (CSDA), Connecticut Dental Hygienist Association, Department of Public Health (DPH) Office of Oral Health, Community Health Center Association of Connecticut (CHC-ACT), Connecticut Oral Health Initiative (COHI), Connecticut Chapter of American Academy of Pediatrics (AAP), Connecticut State Medical Society.

3. CTDHP to update the draft framework for DSS submission (as part of SFY 25 Medical-Dental Integration Report) reflective of the feedback and evolution of policy suggestions.

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Appendix

A. Utilization and Revenue Report

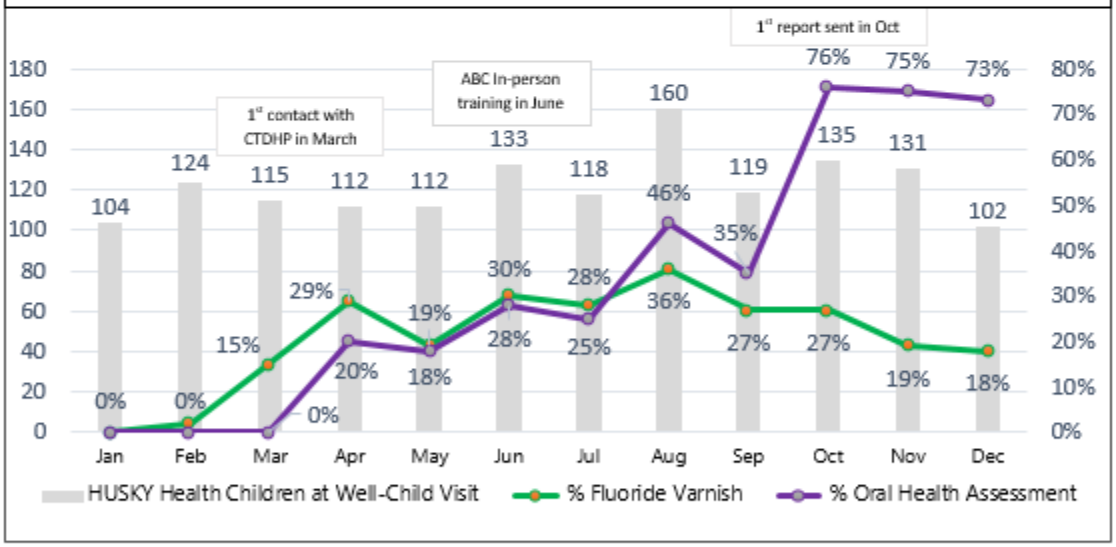
Access to Baby Care Program (ABC Program)
Utilization and Revenue Report: *East Lyme Pediatrics*

Provider List *Based on CT Dental Health Partnership records and claims analysis as of January 22, 2024, the providers identified below have either been trained and certified to bill for ABC Services or have not and are likely resulting in denied reimbursement claims. If there are errors or omissions please contact Jessica McMullin, RDH, MPH, ABC Program Practice Specialist at (860) 507-2309 or email at Jessica.McMullin@ctdhp.com to rectify.*

Providers Trained/Certified	Providers **Not** Trained/Certified
Shawn Binns Jessie Brutus Stephanie Carper Sajda Malik Tina Taylor	

ABC Service Rate by Practice *Based on claims analysis from 2023, average fluoride varnish rates have increased from **16% to 26%** and average oral health assessment rates have increased from **11% to 55%** for HUSKY Health children after completion of in-person ABC training.*

East Lyme Pediatrics - HUSKY Health Children, Oral Health Assessment and Fluoride Varnish at Well Child Visits 2023. Source: CMAP Claims Data

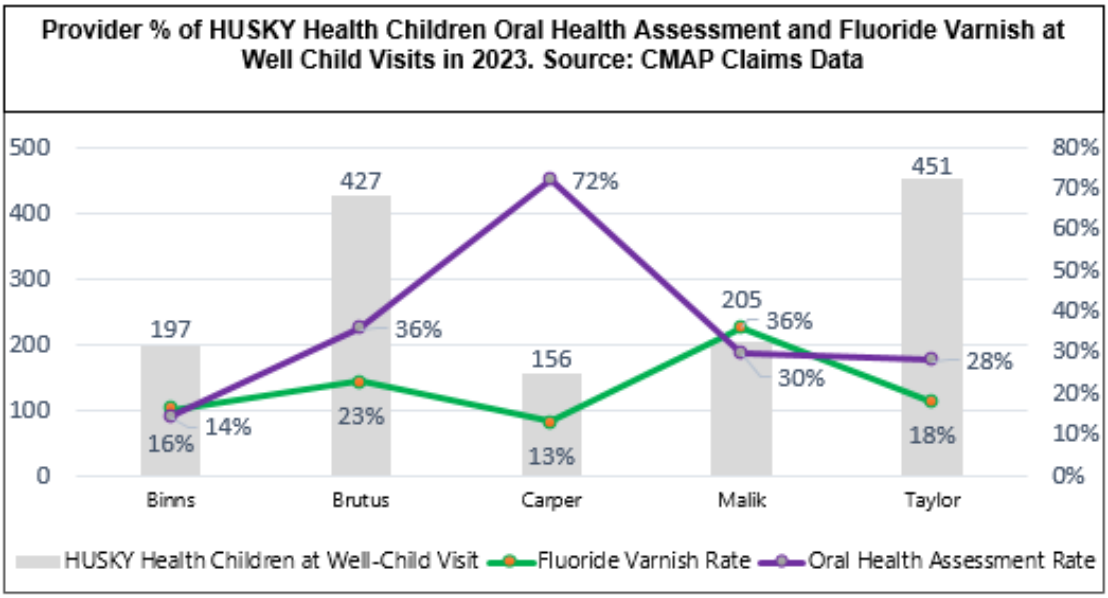


Well Child Codes: 99381, 99382, 99383, 99391, 99392, 99393
Oral Health Assessment Codes: All Codes with a D/A Modifier- 99381-99383 for Prevention-New, 99391-99393 for Prevention-Established.
Fluoride Varnish Code: 99188

Utilization and Revenue Report developed by Kate Parker-Reilly, LMSW, Connecticut Dental Health Partnership
The Dental Plan for HUSKY Health, 2022.

Access to Baby Care Program (ABC Program)
Utilization and Revenue Report: *East Lyme Pediatrics*

Individual Provider Rates *The following analysis of the number of children who have received well-child visits and the percentage who received an oral health assessment and fluoride varnish service by provider. Any provider missing from table likely did not have any claims submitted.*



Well Child Codes: 99381, 99382, 99383, 99391, 99392, 99393
Oral Health Assessment Codes: All Codes with a D/A Modifier- 99381-99383 for Prevention-New, 99391-99393 for Prevention-Established.
Fluoride Varnish Code: 99188

Missed Revenue Opportunity *The following analysis of missed revenue is based on the number of well-child visits without oral health assessment or fluoride varnish (or both) services for 2023. Analysis concludes that a missed revenue opportunity of $47,145 existed during this time frame.*

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Fluoride Varnish ($20 per Visit)	$2,080	$2,440	$1,960	$1,600	$1,820	$1,860	$1,700	$2,060	$1,740	$1,960	$2,120	$1,680
Oral Health Assessments ($25 per Visit)	$2,600	$3,100	$2,875	$2,250	$2,300	$2,400	$2,200	$2,150	$1,925	$800	$825	$700
Total Missed Revenue Opportunity	$23,020 (fluoride treatments) + $24,125 (oral health assessments) = **$47,145**											

Access to Baby Care Program (ABC Program)
Utilization and Revenue Report: *East Lyme Pediatrics*

Connecticut Dental Health Partnership can help you complete the next steps:

- ☐ Congratulate the providers and staff on their tremendous effort and increase in oral health assessment rates!
- ☐ Review resources available for providers, parents and patients at www.ctdhp.org/abc-program/.
- ☐ Take a close look at provider data on page 2 of this report. Consider whether a simple billing barrier could be preventing providers from using the oral health assessment modifier.
- ☐ Fluoride rates in the last quarter of 2023 became considerably lower than oral health assessment. At the next team meeting, raise awareness of fluoride varnish as a clinical standard of care recommended by the American Academy of Pediatrics.
- ☐ Assign a fluoride champion to keep track of training and supplies for each operatory.