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Coordinated Care Organizations Implementation Proposal

The January 24, 2012 CCO Implementation Proposal outlines criteria for the newly forming Coordinated Care Organizations (CCOs) that they must meet to be certified. Capitol Dental Care sees the following as concerns related to a dental care organization (DCO).

1) CCO criteria on 'Governance': Each CCO has a governance structure that includes: A majority interest consisting of the **persons that share the financial risk** of the organization; the **major components of the health care delivery system**; and the **community at large**, to ensure that the organization's decision making is consistent with the values of the members of the community.

Financial risk can have different meanings. It can be capitalizing the new company, putting up reserves, or being capitated for member care. Does a person need to meet all or one? The answer will help determine if a DCO shares risk. A dental plan can meet reserves and member care risks, but it is uncertain due to resources whether capitalization of the new company will be an option. Clarification of intent of share financial risk would allow a dental plan and others to have a better understanding.

Major components of health care delivery system is not defined, HB3650 calls out integrating physical health, mental and oral health, but the criteria does not indicate if oral health is or isn't a major component. Clarification of intent of major components of health care delivery system as to whether oral health is or isn't included would set forth a clear pathway.

Community at large and values consistent with community, dental providers are a part of their communities. It will be easy for oral health to be lost in a medical model having a voice that states it is an important component of the community model being designed. Clarification oral health providers are indeed part of the community. Also that oral health is an important part of overall health.

2) CCO criteria on dental care organizations: On or before 7/1/14, each CCO will have a formal contractual relationship with **any** DCO in its service area.

Some newly evolving CCOs have interpreted 'any' as one but not necessarily all. Interpreting any as one has the potential to create delivery system monopolies and shut out much needed oral health access. Recently during a committee meeting legislative counsel interpreted 'any' as 'all'.

A newly evolving CCO with some dental capacity through counties, community health centers, and/or schools of dental higher education has not necessarily envisioned including DCOs who have been serving members in the area they intend to serve. Many of CDC's community panel providers have provided care to OHP patients for years. These providers are important to the community's access, and continuity of care relationships between patients and dental providers.

The 7/1/14 date should not be the ultimate goal with no effort on the part of the newly evolving CCO to contract with any DCO before that date.

The RFA for prospective CCOs should require a robust response to these criteria questions. How does the applicant intend to move forward and contract with all DCOs? What specific actions and timelines are to be taken? How will DCOs and oral health be integrated into the CCO? How will the transition of DCO members and providers be handled? What steps will be used to encourage a DCO to contract earlier than 7/1/14?

The CCO implementation proposal has transition strategies, and transitional provisions, but none that speaks to dental. Leaving this up to wide interpretation of the newly evolving CCOs set up the likelihood of dental failing to integrate successfully. DCOs should contract directly with Oregon Health Authority (OHA) until a plan is in place to allow for successful integration of dental into a CCO. Whether contracting with OHA or a CCO CDC is willing to engage in transformation measurable Triple Aim goals of better health, better care, and lower costs.