Chair Greenlick and Members of the Health Care Committee:

We write today to express our support for oral health integration into Oregon's Coordinated Care Model. The undersigned organizations understand that one of the guiding principles recognized in the establishment of Coordinated Care Organizations (CCOs) was the need to integrate physical, behavioral, and oral health. While the 16 CCOs have experienced varying levels of successful integration, the CCOs have also experienced obstacles to integration specific to the communities that the CCO serves.

While we disagree that board representation of dental plans or providers is a pervasive barrier to oral health integration, we are all committed to moving integration forward within the Coordinated Care Model. **CCO's are generally willing to assign one board seat to an oral health provider or DCO representative so long as the CCO has the ability to pick the representative in the same manner that all other board members are picked**.

The undersigned CCO's have several concerns about proposed amendments that would place the responsibility with DCO's to nominate individuals to be considered for CCO Boards including the following:

- There is no process in place for DCOs to convene themselves
- There are no requirements that DCOs nominate a person based in the community
- There is no direction for how the nomination process would function - Who would be responsible for establishing a process for DCOs to determine nominees? Who would be responsible for determining nominees? What if DCOs disagree on nominees? How would those nominees be given to CCOs? How would CCOs know if all DCOs agreed on nominees? What would the timeframe be for nominations to be made?

ORS 414.625 sets out the process for CCOs to determine their governing bodies. It states:

Each coordinated care organization has a governing body that includes:

(A) Persons that share in the financial risk of the organization who must constitute a majority of the governing body;
(B) The major components of the health care delivery system;
(C) At least two health care providers in active practice, including:
  (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375 (Nurse practitioners), whose area of practice is primary care; and
  (ii) A mental health or chemical dependency treatment provider;
(D) At least two members from the community at large, to ensure that the organization's decision making is consistent with the values of the members and the community; and
(E) At least one member of the community advisory council.

It would be inconsistent with current statute to establish separate criteria for nomination of a DCO to a CCO Board. Further, it is unprecedented for the state to establish a standard of requiring separate organizations to determine the candidate pool for a position on the Board of a private entity.

The undersigned CCO's do not all agree about placing a statutory requirement for a DCO position on a CCO Board. Some would prefer the position be more general and focus on an oral health provider. For the purposes of HB 2882, however, we would accept a statutory requirement to assign one CCO board seat to an organization that bears financial risk for dental care provided to CCO members, so long as the CCO has the ability to select the representative in the same manner that all other board members are selected. If the legislation advances with a DCO nomination provision, we will be forced to oppose HB 2882 in its current form.

Many CCOs already have dental care representation on their boards with significant variability in integration often attributable to the infinite differences present within different communities

throughout the state. The undersigned organizations do not believe that a statutory change to the CCO boards will be a "silver bullet" to integration. However, we stand ready to take the next steps towards integration, and would like to do this in collaboration with the oral health community. We believe our recommended approach would be acceptable to a majority of DCOs and others in the oral health community.

We look forward to continuing this conversation as this legislation develops.

Sincerely,

AllCare Health
Cascade Health Alliance
Columbia Pacific CCO
Eastern Oregon CCO
FamilyCare Health
Health Share of Oregon
InterCommunity Health Network CCO
Jackson Care Connect
Primary Health of Josephine County
Western Oregon Advanced Health
Willamette Valley Community Health
Yamhill Community Care Organization
Coalition for a Healthy Oregon