Capitol Dental Care, Inc.
3000 Market Street NE, Suite 228 • Salem, OR 97301 • (503) 585-5205 • Fax: (503) 581-0043

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Senate Health Care Committee

Testimony HB 2882

Chair Monnes Anderson, Vice Chair Kruse and Members of the Committee,

For the record my name is Deborah Loy. I am the Executive Director of Government Programs for Capitol Dental Care (CDC). We are a dental care organization that provides care to Oregon Health Plan (OHP) beneficiaries. Capitol Dental Care is contracted with fourteen of the sixteen coordinated care organizations (CCOs) across the state.

I am here to testify on HB 2882 and to request your support for the bill.

HB 3650 passed in the 2011 Session establishing Oregon's transformed health care delivery model. The intent of the bill was to replace siloed physical, behavioral, and oral health managed care delivery systems with newly created Coordinated Care Organizations (CCOs). This single organizational structure would consolidate and coordinate health care and lead to better patient care, improved health outcomes and lower costs.

SB 1580 passed in the 2012 Session and gave Oregon Health Authority (OHA) approval to move forward with this integrated delivery system model. The legislation did not require CCOs to immediately contract with dental care organizations (DCOs). Rather it stated, "on or before July 1, 2014, each CCO must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside." This reprieve, while allowing DCOs additional time to contract with multiple CCOs

across the state, also has in many cases made it a challenge for DCOs to become meaningfully engaged in CCO governance structures.

The current statutory CCO governance structure requirements are: "***persons that share in the financial risk*** of the organization; ***major components of the health care delivery system***; at least two health care providers in active practice, including: a physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and a mental health or chemical dependency treatment provider; at least two members from the community at large, to ensure that the organization's decision-making is consistent with values of the members and the community; as well as having at least one member from the CCO's community advisory council."

Both HB 3650 and SB 1580 speak to requirements for CCO governance structure and are consistent in language; except with passage of SB 1580, the Legislature recognized that persons important to include in CCO governance had been left off the original requirements. It added those persons to the governance structure requirements.

If HB 2882 passes, it would add the requirement of a DCO as a member of each CCO's governance structure. The bill states each DCO contracted with the CCO (if they elect to) may put forth a candidate. The CCO would then select from the resulting candidate pool.

One of the statutory requirements for governance referenced above is to include "major components of the health care delivery system." Dental is one of the major components of the health care delivery system. This legislative intent was reinforced by more than one legislator during SB 1580 floor speeches. Even with this verbal reinforcement of legislative intent, only a few CCOs have included a DCO in governance.

Another requirement is to include "persons who share in the financial risk." The DCOs share substantial risk with CCOs. DCOs are at risk to not only provide dental care to CCO members, but to hold dental reserves. We are not only at risk for DCO performance measures, but also for CCOs meeting their OHA contract requirements. One such requirement is timely submission of encounters. Should a CCO not meet this requirement, OHA can assess a sizable penalty. Whether or not a DCO contributed to the reason for the penalty, we are risk to share in its payment. Additionally, DCOs are potentially at risk for dental related to CCOs medical loss ratios and other financial impacts to global budgets.

During the 2015 Session, Capitol Dental Care introduced a bill for a DCO to be on each CCOs board. We ourselves requested the bill be pulled back to allow more time for CCOs to address this without legislation. In the past two years, there has been some movement in regard to addressing the issue, but still many of the CCOs governance structures lack a DCO representative.

Some CCOs have suggested rather than a DCO representative, it should be a dental provider. While a dental provider can be a voice for oral health at the governance level, few have integral knowledge on dental risk bearing or managed dental plan operations. The DCOs have a deep understanding and years of experience in managing the care and financing for OHP beneficiaries. This level of knowledge would be difficult for most dental providers to replicate. There may be situations where a DCO puts forth a dental provider candidate, but we should not be limited in our options for selection of the best person to represent us.

One CCO has suggested the governance representative must be from the local community. Oregon's CCOs have a strong community foot print. Several DCOs contract with multiple CCOs and operate in various communities throughout Oregon. The fact our administrative offices may not be located in a local community does not mean we are disconnected from the communities we serve. Capitol Dental Care has affiliated dental clinics located in most of our CCOs service areas who are constituents of these communities. We are a strong believer in community based care and actively engaged in our communities. Some examples are: operating school based sealant programs, dental sponsor of a school based health center, visiting Head Start sites multiple times a year to deliver prevention services, and being co-located within medical clinics to name a few.

As a Capitol Dental Care administrator, I personally attend CCO meetings throughout our service areas. In addition either I or other Capitol Dental Care staff persons participate in county or regional oral health coalitions. Capital Dental Care is very much a citizen and part of the communities we serve. Although there may be situations where a DCO puts forth a local representative, we should not be limited to do so.

Recently OHA commissioned an environmental scan and recommendations from Health Management Associates (HMA). Their report is publically available. In the executive summary it states, 'The vision for Oregon's health system transformation includes an intention to

integrate oral health, physical health, and behavioral health across the delivery system… Most of the DCOs, while included as part of the CCO policy development, were not initially involved in the formative efforts of the regional CCOs, but their networks currently deliver oral health services for most of the CCO enrollees across the state. It has been a period of transition over the last two years since the oral health funding stream has become the responsibility of the new CCOs, with full integration not yet achieved."

An additional statement, "Oral health integration is just beginning. It lags behind efforts on behavioral health integration in Oregon, but more and more activities are underway, and relationships are developing and evolving across the delivery system… Achieving further success will require a common message, **aligned leadership**, smoothing processes, and **overcoming barriers**… Oral health matters and focusing on oral health integration is critical to attaining better health, better care, and lower costs."

As indicated in the HMA report, oral health integration will require leadership. The request in HB 2882 is to have a DCO representation as part of the CCO governance structure. It is not meant to be disruptive to CCO governance but for a DCO representative to be a member and partner in their leadership. Full integration of dental, physical and behavioral health will require managed care delivery systems, including DCOs, working together under the CCO umbrella to transform care. DCOs are looking forward to working with our CCOs as a member of their governance structures to help in achieving oral health integration as one of these goals.

We would appreciate your support for HB 2882. Thank you for allowing me to testify today and for your support.