OHA has determined that it will not renew the DCO contracts when they expire on December 31, 2022.

Please noted, that these are general responses and are based on OHA's FFS contracts with DCOs as managed care entities (i.e., as PAHPs under Medicaid rules). They do not consider each DCO's internal structure and relationship with its providers.

1. ***If a member needs emergency and/or urgent dental care soon after the CCOF transition, how might this be handled?***

It will be handled according to the CCO process for emergency and/or urgent dental care, including any CCO arrangements with subcontracted DCOs. DCO will have no obligation after Jan.1,2023.

DCOs have no obligation to provide services to OHP member under the FFS contract after Jan.1,2023.

2. ***Does OHA have suggested communication language to use with dental providers (especially since many dental providers often overlap DCOs and/or CCOs?)***

OHA does not have such a resource. However, DCOs may wish to refer to Provider Matters for examples.

3. ***OHA has shared DCOs 'will this year' have a chance to review/comment on the CCO contract's (especially related to dental due to the transition). What might this look like in future years going forward?***

OHA works with CCOs and OHA SMEs on the contract for the upcoming year. OHA will not directly engage dental entities in this process since the contract is between OHA and CCOs. OHA relies on the CCOs to consult with parties within their organizations, which may include

dental entities, about the contract during the process. OHA SMEs may engage with internal and external stakeholders at a high-level about particular contract content; these stakeholders may include dental entities.

4. ***Encounter submissions typically goes from DCO to OHA, or will CCO have responsibility for DCO encounters?***

The ultimate responsibility is for the CCO. The CCO may utilize the DCO as a "submitter" so its staff can send the encounter claims (containing the CCO Plan ID#) to OHA, but the responsibility for submission, completeness, and accuracy stays with the CCO. It's the CCO's decision how to handle this.

5. ***Besides member communications, will OHA also be sending any provider communications?***

OHA will continue to utilize the Provider Matters newsletter to share updates with providers. We recommend that DCOs share updates with their provider networks as well.

6. ***Will DCO receive ways guidance on language to provide to members on this transition?***

Letter templates were shared via email with DCOs on September 7. DCOs can choose to use the sample language provided or use their own language. All letter templates must meet OHA Material Review requirements and letters must be submitted for approval. Using OHA template language will help ensure an expedited review process. For more information about material reviews, please visit the QA Material Submission and Review page or contact the Quality Assurance team at HSD.QualityAssurance@odhsoha.oregon.gov

7. ***When is the Dental Care Organization (DCO) Member Transition & Contract Close - Out Plan Due?***

October 1, 2022.
As described in the CY 2022 DCO contract (Exhibit D, Sections 10-11) and OAR 410-141-3710 – Contract Termination and Close-Out Requirements, each DCO must submit a member transition and contract close-out plan to OHA.

OHA will review the plan. If approved there will be monthly progress reports submitted to OHA until the contract is closed

8. ***How often will the Contractor provide status reports to OHA?***

During the Transition Period Contractor shall be required to provide to OHA status reports every thirty (30) days detailing Contractor's progress in carrying out the Transition Plan.

9. ***How long will DCO's need to continue obligations under the Transition Plan including an explanation of how it will resolve any responsibilities?***

No less than 18 months, (contract Exhibit D, sections 10-11)

10. ***Does OHA have written document of what the transition process that will be taking place at a local and plan level for the DCO transition plan?***

OHA does not have such a resource. However, DCOs may wish to refer to Provider Matters for examples.

11. ***Can DCO's still access MMIS post end contract?***

Yes, for up to 18 months or until OHA provides written release agreeing that all continuing obligations of the FFS contract have been fulfilled, whichever is earlier. After that, the DCO would need to work with the CCO that has a subcontract with the DCO to get access to MMIS under the CCO's account.

12. ***Compact of Free associations (COFA) fact sheet.***

Please see link for further information.

13. ***Has the health equity reporting requirement been finalized for 2022?***

July 22nd, 2022, Health Equity Assessment Tool memo was sent to the DCO.

14. ***Are DCO's expected to maintain a website?***

Yes, DCOs are expected to continue to have websites. The DCO must maintain certain operations for 18 months after the FFS contract ends. What type of content makes sense for the DCO's website depends on the DCO and its operations, including its relationship with one or more CCOs. The DCO may need to review each section of its website to determine what content makes sense prior to the transition, for the early part of the close-out period, and then later in the close-out period.

For illustration: The DCO should consider putting information on their member-facing and provider-facing webpages about the upcoming FFS transition. Around January 1st, the content should be adjusted to give members and providers direction for matters that are still the DCO's responsibility during the close-out period, such as appeals and grievances and claims processing and direct them to the appropriate CCO resources for matters governed by any CCO that has a subcontract with the DCO.

15. What deliverable associated with training and education has been waved for the deliverables for 2022 contract?

OHA expects DCOs to continue to support and promote health equity, and to actively develop their health equity infrastructures. OHA's Office of Equity and Inclusion will work with DCOs to develop a meaningful way to assess DCO infrastructure and capacity to advance health equity as an organization and in its Service Area(s). In 2021, this work will include DCO participation in developing the health equity assessment that will be a required deliverable for Contract Year 2022.

16. Will OHA capture each CCO's process and share it with DCOs?

No, this is a CCO process and is not captured by OHA.

17. If a member needs emergency and/or urgent dental care soon after the CCOF transition, how might this be handled?

It will be handled according to the CCO process. DCO will have no obligation after Jan.1,2023.

18. What will be the process/timeline for a member to change DCO assignment (under a CCO) following the transition?

This would be handled through each CCO's internal process. OHA does not have information about this.

19. Several of the PA elements are crossed out, with #28 remaining, "was the PA appropriately denied? How will OHA determine this? Administrative steps and timelines followed? Clinically?

OHA is reviewing the submitted PAs accompanying the NOABD submissions and determining whether 1) the denial is accurate according to the diagnosis and procedure code placement

and pairing/non-pairing on the Prioritized List of Health Services and 2) the rules and coverage criteria support the denial of the service.

20. In our quarterly reporting (done throughout 2022) including for Q1 we have provided OHA with information on 'any NOABDs (including as applicable copies of the notices). Is this in addition/different?

The DCO will be required to submit NOABDS for Q4 CY 2022 in February 2023 since it's in part of the Exhibit I deliverables under the FFS contract.

21. What is the process of member choice that will be offered as part of the transition of CCOF?

If members resided in a service area served by multiple CCOs, the member will be offered a choice of which CCOF they want to enroll with. Members will be notified of their CCOF options through member letters from OHA as well as from their DCO in the fall of 2022. The letters will list their CCO options and provide instructions for section their CCO, which includes calling Client services at 800-273-0557. If the members do not make a selection, OHP will select a CCOF for them. Based on their dental care member currently receives. For example., if only one of the CCO has a relation with the member's current DCO, that is the CCOF OHP will select. If multiple CCOs have the relationship with the member's current DCO, OHP will randomly assign the member to one of the CCOFs.

22. During the transition, will the monthly checks go into 2023?

Yes. OHA staff will meet with you. These monthly meetings will begin following OHA's approval of the DCO's member transition and contract close-out plan.

23. Once a transition plan is submitted, how long will it take for OHA to approve it?

OHA's goal is to approve each DCO's plan within 30 days from the 10/1 due date. It's likely that OHA will need to meet with the DCO during this period to discuss the plan and identify changes necessary for approval. OHA encourage DCOs to make any needed changes as quickly as possible and re-submit the plan.

24. Regarding the electronic health record, if the DCO does not own it, how should the information be distributed?

If the DCO is not the owner, then the DCO should make sure the actual owner of the electronic health record is aware of the DCO transition and their obligation under HIPAA (treatment, payment, or healthcare operations) to share the information with the future requestor, which may be the member's CCO or dental provider or both. The requestor will provide instructions for how to send the information to them.

25. If a member letter is submitted to OHA for review, how long will it take for OHA to review and return the letter?

For urgent requests, OHA needs up to 14 business days.

26. When the DCO submits specific deliverable regarding specific close outs, (e.g., monthly claims aging reports including IBNR), since these are not typical deliverables, is OHA going to provide templates or guidance on how to do these reports?

No, OHA will not provide a template for the monthly claims aging report including IBNR. This is a report that many managed care plans Typically produce as part of their regularly business operations. If a DCO does not already produce this report, then they can propose to OHA an alternate method for how they will determine, on a quantitative basis, when they have fulfilled all claims payment obligations to their providers.

27. Will CCO-F Members still be allowed to contact us directly for services, or will that have to go through the CCO? Is this a contract item between the CCO-DCO

It's between the CCO and the DCO. The individual is still a CCO member first and foremost and the entire CCO contract applies to them, except that they only receive dental benefits through the CCO. It's not dissimilar to CCOG, where the individual is enrolled in the CCO for dental and BH benefits only, per below.

Plan Type	*Who is responsible for payment?*		
	Behavioral health	Dental	Physical health
CCOA	CCO	CCO	CCO
CCOB	CCO	OHA or DCO	CCO
CCOE	CCO	OHA or DCO	OHA
CCOG	CCO	CCO	OHA
None listed	OHA	OHA or DCO	OHA

Plan type	*Who is responsible for payment?*		
	Behavioral health	Dental	Physical health
CCOF	OHA	CCO	OHA

28. Does the DCO have to use the member template letters provided by OHA?

No, using OHA templates is optional. However, Material Review requirements still apply to member letters. DCO-generated letters must be approved by OHA using the regular review process.

29. ***Will the DCO have to give CCO information about prior authorizations?***

Yes, prior to Jan.1st 2023, if authorizations have been done for a member.
At a minimum CCOs are required to honor services preauthorized by DCOs for the earlier of the dates of service covered by the PA or through March 31st, 2023. This requirement is based on a forthcoming temporary rule. It's each CCO's decision whether to exceed this minimum requirement.

30. Will OHA be sharing any DCO member utilization history with CCOs (for use in tracking benefit limits, continuity of care etc.)?

Yes, information will be sent to the receiving CCO once the enrollment files are updated in MMIS. Once that enrollment takes place, utilization history will be sent via SFTP to the CCO receiving the member. You can see the full rule this based on here: OAR 410-141-3850.

31. How will providers know patients are enrolled with a CCOF?

In the MMIS web portal, members enrolled in CCO-F will show "MC Program" (managed care) enrollments as CCOF-Dental.

32. Who do dental providers bill for services provided to members enrolled in a CCOF?

For billing questions related to this population, providers should contact the CCOF the OHP member is enrolled with.

33. ***Can members simultaneously enroll in a CCO-F plan type with one CCO, and a CCO-B or CCO-E plan type with a different CCO?***

No. Members can only be enrolled with one CCO and one CCO plan type at a time (e.g., CCO-A, CCO-B, CCO-E, CCO-F, or CCO-G).

34. Is the CCO responsible for the NEMT for all services for the COFA and VA dental programs?

For COFA and VA dental program members, CCO is responsible for NEMT only for dental services. For non-COFA/VA dental program members who are in a CCO-F, the CCO is responsible for NEMT for all services, same as other plan types.