

**Memorandum of Understanding for LTC Coordination between Cascade Health Alliance and Klamath District DHS APD**

**Memorandum of Understanding**

Medicaid-funded long term care (LTC) services are legislatively excluded from Coordinated Care Organization (CCO) budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability for individuals receiving Medicaid-funded long term care services.

This is a non-binding agreement between Cascade Health Alliance, (CHA)(CCO) and the Klamath District DHS Aging and People with Disabilities Office (AAA or DHS-APD district office). The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system.

Based on the good faith description of the roles and responsibilities of the entities participating in the proposed agreement to coordinate care and share accountability for Medicaid funded long term care, Cascade Health Alliance (CCO) and Klamth District DHS APD office agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	AAA/APD Expectation	CCO/AAA/APD agreements:
<ul style="list-style-type: none"> <li>• CCOs will define universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs members receiving Medicaid funded LTC services.                             <ul style="list-style-type: none"> <li>○ CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers.</li> <li>○ CCOs will define how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will provide CCOs with access to information needed to identify members with high health care needs.</li> <li>• AAA/APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA/APD offices into CCOs' individualized care plans for members with intensive care coordination needs.</li> </ul>	<p>1. Prioritization of high needs member in LTC:</p> <ul style="list-style-type: none"> <li>• APD Will provide copies of CAPS assessments for service or care setting changes.</li> <li>• Work towards cross training</li> <li>• Obtain information from eligibility case loads</li> <li>• Case Manager will ask addition questions regarding health provider usage.</li>   <li>• CHA/CM staff will develop an acuity system which takes into consideration all information received from the APD CAPS assessment, eligibility information, care setting changes, chronic condition diagnosis scoring, utilization score and all evaluations/reports received from CCO partners such has Mental Health and A&amp;D workers.</li> </ul>

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1. Prioritization of high needs members in LTC		
CCO Expectation	AAA/APD Expectation	CCO/AAA/APD agreements:
<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations.</li> </ul> <p><b>***CHA and APD staff will meet monthly for the 1<sup>st</sup> three months and as needed thereafter to review data sharing experiences and make adjustments to the program.</b></p>		<ul style="list-style-type: none"> <li>CHA staff will provide and receive training with the APD staff on each agencies policies and procedures.</li> <li>Preliminary expectation is that CHA will provide all Care/Treatment Plans on a (to be determined) time frame to the staff at APD. APD will be provided updated Care/Treatment Plans as they are revised.</li> <li>CHA plans to communicate with the APD staff through a secure email system, fax and phone contact.</li> </ul>

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2. Development of individualized care plans		
CCO Expectation	AAA/APD Expectation	MOU activities
<ul style="list-style-type: none"> <li>CCOs' individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTC services and supports needs.                             <ul style="list-style-type: none"> <li>Plans will reflect member or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate.</li> <li>Individualized person-centered care plans will be jointly shared</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>AAA/APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA/APD offices into CCOs' individualized care plans for members with intensive care coordination needs.</li> </ul>	<p>2. Development of Individualized care plans:</p> <ul style="list-style-type: none"> <li>APD Provide copies of Client Assessment Planning System ( CAPS) anytime a new assessment is completed</li> <li>Future discussions/dialogue with client around risk assessments</li> <li>CHA Care/Treatment Plans will include a history and physical, identification of all care providers, any DME and or therapy requirements, referral/services being provided for the Member, a list of interventions along with both short and long term goals and</li> </ul>

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<b>2. Development of individualized care plans</b>		
and coordinated with relevant staff from AAA/APD and with LTC providers.		outcomes. CHA will also supply APD with updated care conference notes as they occur. The CHA ENCC/Case Managers will develop the care plans with assistance from the Member/Caregiver, APD staff and all Providers involved in the Members care.
<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. ***</li> </ul>		

<b>3. Transitional care practices</b>		
<b>CCO Expectation</b>	<b>AAA/APD Expectation</b>	<b>MOU activities</b>
<ul style="list-style-type: none"> <li>CCO will demonstrate how it will coordinate and communicate with AAA/APD to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650.</li> </ul>	<ul style="list-style-type: none"> <li>AAA/APD will demonstrate how it will coordinate and communicate with CCO to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650.</li> </ul>	<b>3. Transitional care practices:</b> <ul style="list-style-type: none"> <li>include CCO in weekly nursing home meetings</li> <li>Invite CCO to potential problem solving meetings</li> <li>Staffing with CCO as needed</li> <li>CHA will attend weekly Facility based (SLMC and PRCC) meetings with the APD staff.</li> <li>Meet with APD staff to develop new systems for tracking transitions and assure continuity of care for high risk Members.</li> </ul>
<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. ***</li> </ul>		

<b>4. Member engagement and preferences</b>		
<b>CCO Expectation</b>	<b>AAA/APD Expectation</b>	<b>MOU activities</b>

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<ul style="list-style-type: none"> <li>• CCO will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with AAA/APD where relevant to LTC service planning.</li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will actively engage individuals in the design, and where applicable, implementation of their LTC service plan, in coordination with CCO where relevant to health care treatment and care planning.</li> </ul>	<p>4. Member engagement and preferences:</p> <ul style="list-style-type: none"> <li>• APD will solicit information from clients and share with CCO</li> <li>• CHA ENCC/Case Managers will involve the Member/Caregiver in all care plan development and at least one long term goal will be Member driven.</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. ***</li> </ul>		

<b>5. Establishing member care teams</b>		
CCO Expectation	AAA/APD Expectation	MOU activities
<ul style="list-style-type: none"> <li>• CCO will support the flow of information to AAA/APD.</li> <li>• The CCO-appointed lead provider or care team will confer with all providers responsible for a member's care, including LTC providers and AAA/APD.</li> <li>• To support care teams, CCO will               <ul style="list-style-type: none"> <li>○ Work with AAA/APD to ensure that it identifies members receiving LTC services.</li> <li>○ Include LTC providers and AAA/APD case managers as part of the team based care approach.</li> </ul> </li> <li>• Adapt team-based care</li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will define roles, responsibilities and process for assignment of and participation in the CCO care team, including coordination with CCO lead care coordinator, for members needing routine and intensive care coordination.</li> <li>• AAA/APD will ensure that CCO providers/care teams are notified of which CCO members are receiving LTC, the relevant local AAA/APD office contact, and contact for relevant LTC provider.</li> <li>• AAA/APD will have knowledge of and actively participate in</li> </ul>	<p>5. Establishing member care teams.</p> <p>First part:</p> <ul style="list-style-type: none"> <li>• Case managers or diversion transition, whoever is taking the lead will participate in the care planning</li> <li>• APD will work on having good communication</li> </ul> <p>Second part</p> <ul style="list-style-type: none"> <li>• APD will provide copies of assessments when there are changes</li> <li>• Communicate when cases open or change in care settings.</li> </ul> <p>Third part</p> <ul style="list-style-type: none"> <li>• Same as above (second part)</li> </ul> <p>Fourth part</p> <ul style="list-style-type: none"> <li>• Case managers or diversion transition will encourage</li> </ul>

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5. Establishing member care teams		
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<p>approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.</p>	<p>CCO team based care processes when appropriate.</p> <ul style="list-style-type: none"> <li>DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.</li> </ul>	<p>provider participation</p> <p>APD and CCO will meet at least annually, review progress, identify barriers and adjust processes accordingly.</p> <ul style="list-style-type: none"> <li>CHA will provide the APD staff with Care/Treatment Plans on a routine schedule and as changes occur.</li> <li>The flow of information from CHA to other agencies will be by secure email, fax or phone contact.</li> <li>CHA ENCC/Case Managers will meet with APD staff and other LTC providers as needed to ensure that a comprehensive Care Plan is developed and implemented.</li> <li>CHA will work with APD and LTC providers to develop a meeting schedule to address Members needs and community concerns for this high risk population.</li> </ul>
<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. ***</li> </ul>		

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**Signatures and Contacts**

For Cascade Health Alliance (CCO)

The designated contact person is:

_____	_____
First name	Last name
_____	_____
Email	Phone
_____	_____
Authorizing Signature	Date <u>6/22/12</u>

For Klamath District DHS APD (AAA/APD District Office)

The designated contact person is:

Gloria	Pena
_____	_____
First name	Last name
Gloria.pena@state.or.us	541-851-8922
_____	_____
Email	Phone
<u>Gloria Peña</u>	<u>6/22/12</u>
Authorizing Signature	Date

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For DHS, Aging and People with Disabilities Division, Central Office

The designated contact person is:

Patricia Baxter  
First name Last name

patricia.e.baxter@state.or.us 503-945-5858  
Email Phone

Patricia Baxter 7/2/12  
Authorizing Signature Date  
-Signed as to form