

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 **Columbia Pacific, LLC (CCO)** and the **Aging and People with Disabilities District 6 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, **Columbia Pacific, LLC (CCO)** and the **Aging and People with Disabilities District 6 Office (AAA or DHS APD district office)** agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	APD/AAA Expectation	CCO/APD/AAA agreements:
<ul style="list-style-type: none"> • CCOs will define a screening process that assesses high needs members receiving Medicaid funded LTC services. • CCO will factor in relevant referral, risk assessment and screening information from local APD/AAA offices and LTC providers. • CCOs will define how it will communicate and coordinate with APD/AAA when assessing members receiving Medicaid-funded LTC services. 	<ul style="list-style-type: none"> • APD/AAA will provide CCOs with information needed to identify members with high health care needs receiving LTC services. • APD/AAA will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid APD/AAA offices. 	<p>Beginning on October 30, 2012 partners will share initial information (as outlined below) about potentially high risk members, and will revisit in January, 2013 whether these agreements have been effective in identifying high risk members.</p> <p>CCO and APD/AAA will use information available, including data provided by OHA/DHS central office, to identify a list of individuals each has in common.</p> <p>Share key information pertinent to each entity's assessment:</p> <ul style="list-style-type: none"> • APD/AAA staff will share key information, listed below, for its highest needs individuals served by the CCO, such as: <ol style="list-style-type: none"> 1. Those identified as having the most needs for assistance with activities of daily living - (service priority levels 1-3).

1. Prioritization of high needs members in LTC

CCO Expectation	APD/AAA Expectation	CCO/APD/AAA agreements:
		<ul style="list-style-type: none"> • By September 30, 2012, meet to review the processes that have been outlined and to further define implementation details in this MOU. • By February 28, 2013, meet to assess whether these MOU agreements have been carried out, identify strengths of the MOU, any challenges or barriers to meeting MOU agreements, unexpected opportunities, informal/anecdotal outcomes, and revise MOU to adjust for this new information, and • To determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.

2. Development of individualized care plans

CCO Expectation	APD/AAA Expectation	MOU activities
<ul style="list-style-type: none"> • The CCO will develop individualized person-centered care plans when deemed necessary and may include information about the supportive and therapeutic needs of each member, including LTC services and supports needs. <ul style="list-style-type: none"> o Plans will reflect member or family/caregiver preferences and goals captured in APD/AAA service plans as appropriate. o Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from APD/AAA and with 	<ul style="list-style-type: none"> • APD/AAA will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid APD/AAA offices into CCOs' individualized care plans for members with intensive care coordination needs. 	<p>By October 30, 2012, the CCO will share individual care plans for members also served by the APD/AAA office, for those with CCO individual care plans. CCO will share this information with APD/AAA. The above information will be shared in a manner and interval as agreed upon in the August coordination/planning meeting. CCOs will include APD/AAA contact information for each individual's care coordinator and/or primary care home for purposes of care coordination.</p> <p>By October 30, 2012, APD/AAA /AAA will share key client information with the CCO for individuals that the CCO has developed an individual care plan, including information documented in the long term care client assessment and planning system (CAPS). APD/AAA will share this information with the CCO in a manner and interval as agreed upon in the September coordination/planning meeting. Key</p>

2. Development of individualized care plans

LTC providers

- o MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations.

client information will include:

- Client choice of living situation and preferences
- APD/AAA case manager contact information
- LTC provider contact information

CCO and APD/AAA will hold each other accountable in the following ways:

- By February 28, 2013 meet to review the processes that have been defined in this MOU to assess whether these MOU agreements have been carried out, identify strengths of the MOU, any challenges or barriers to meeting MOU agreements, unexpected opportunities, informal/anecdotal outcomes, and revise MOU to adjust for this new information, and
- Meet to determine measures and timeframes for future accountability and evaluate efforts in coordination with OH/DHS metrics and accountability efforts.

3. Transitional care practices

CCO Expectation	APD/AAA Expectation	MOU activities
<ul style="list-style-type: none"> o CCO will demonstrate how it will coordinate and communicate with APD/AAA 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. 	<ul style="list-style-type: none"> o APD/AAA 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. 	<p>In the September Coordination and Planning Meeting the APD/AAA and CCO will reach agreements on how they will coordinate and communicate to incent and monitor improved transitions in care for members receiving LTC services and supports. These agreements will address the following:</p> <ul style="list-style-type: none"> • How information and documentation will be in the community wide Electronic Health Record so that access is available to providers in the community as well as CCO staff. This will facilitate direct communication between the CCO care coordinators and the providers. • How transitions will be addressed on individual case needs. How to achieve the goal of, when notified of a transition, assuring that each case will be reviewed for services or additional assistance needed. • How coordination with mental health and physical health providers will be facilitated by the ENCC to maintain an appropriate plan of care. • How care will be managed by the CCO Geriatrician on staff - and achieving the goal of Type B AAA and/or APD case managers becoming regularly a part of CCO care coordination meetings to address any issues or concerns and to assist where possible with any transitions the ENCC may need assistance with. <p>The CCO will assure the following:</p> <ul style="list-style-type: none"> • Policy and procedures will be developed to outline care plan requirements, as appropriate for members identified as needing intensive care coordination. Our mental health partners will continue to share their plans with our ENCCs for members with persistent mental illness receiving services. We also plan to
<ul style="list-style-type: none"> o MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. 		

	<p>evaluate case management software solutions that will help risk stratify our population to identify those who may need intensive care coordination from an ENCC.</p> <ul style="list-style-type: none"> o APD will continue to use the continuity of care referral form for care coordination when members apply for the plan. Dual members will continue to receive a yearly HRA from our local Medicare Advantage plan for evaluation. This will be shared with the community partners and used by our care coordinators to coordinate care plans between agencies. Additional needs assessment surveys will be determined by the ENCC members with the assistance of technology services. We will continue to review the form and work with our local social service agency, APD. Communication will be through the usual channels (telephonic, secure email) with the ENC coordinating relevant information from these sources in generating member care plans when needed. o At the time of a transition the ENCC care manager will facilitate to address any higher level needs. Care plans are considered living and fluid documents that will be updated with any changes to ensure members receive the right care and resources at the right time based on their changing health needs and goals completion.
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4. Member engagement and preferences		
CCO Expectation	APD/AAA Expectation	MOU activities

<ul style="list-style-type: none"> • CCO will encourage members to engage in the design and, where applicable, implementation of their treatment and care plans, in coordination with APD/AAA where relevant to LTC service planning. 	<ul style="list-style-type: none"> • APD/AAA 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. 	<p>Member engagement will be achieved by:</p> <ul style="list-style-type: none"> • Assuring that all members are assigned a Primary care provider when they become enrolled with our CCO. Our local providers have contracts that define the timeliness of access required. This information is available to the member and provider in the member and provider handbook. Our team of ENCCs will be the "hub" in coordinating services to ensure the member and the member's PCP are linked to appropriate members and resources. • Assuring educational materials are developed for distribution with member enrollment packets. The population of Douglas County is homogeneous with less than 1% of our population being non English speaking. (CAHPS 2007) Letters will be sent to members and providers with information about how to get alternate formats. Our (CCO) website will be updated and provider and member handbook will contain such information. Where appropriate, our ENCCs will involve cultural experts and translation services to ensure member care plans are created in a culturally competent manner. • Assuring that our provider network is culturally diverse with highly skilled providers to assess member health needs. Our ENCC nurses are available to help coordinate care and support these providers and members with their needs. Where appropriate, our ENCCs will involve cultural experts and translation services to ensure member care plans are created in a culturally competent manner
<ul style="list-style-type: none"> • MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. 		

5. Establishing member care teams

CCO Expectation	APD/AAA Expectation	MOU activities
<ul style="list-style-type: none"> • CCO will support the flow of information to APD/AAA. • The CCO-appointed lead provider or care team will encourage all providers responsible for a member's care, including LTC providers and APD/AAA to participate. • To support care teams, CCO will 	<ul style="list-style-type: none"> • APD/AAA 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. • APD/AAA will ensure that CCO 	<p>In the September Coordination and Planning Meeting the APD/AAA and CCO will reach agreements on how CCO providers/care teams will work with APD/AAA. This agreement will address:</p> <ul style="list-style-type: none"> • How ENCC nurses and support staff will continue work with the Interdisciplinary Care Team (IDCT) to manage member needs: IDCT consists of PCP, social services and mental health professionals. Additional IDCT members may be invited based on needs identified. • Plans to work with affiliates to expand and further develop

5. Establishing member care teams

CCO Expectation	APD/AAA Expectation	MOU activities
<ul style="list-style-type: none"> o Work with APD/AAA to identify members receiving LTC services. o Include LTC providers and APD/AAA case managers as part of the team based care approach. • Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services. 	<p>providers/care teams are notified of which CCO members are receiving LTC, the relevant local APD/AAA office contact, and contact for relevant LTC provider.</p> <ul style="list-style-type: none"> • APD/AAA will have knowledge of and actively participate in CCO team based care processes when appropriate. • DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams. 	<p>community prevention and self-management programs based on the needs of our population. (Currently crisis management is available from our community partner Douglas County Mental Health.)</p> <p>The CCO will assure that:</p> <ul style="list-style-type: none"> • A team approach is used as our model for coordinating these services. Each member who experiences a transition to a setting where Medicaid-funded long term care services will be utilized will be assigned a care coordinator. Once alerted of a transition the CC will begin reaching out to the member. A care plan will be developed, when deemed appropriate, with the assistance of an interdisciplinary care team that will include the CC, the member, the member's PCP, necessary specialist provider(s), case managers from the APD office and other appropriate non-traditional healthcare workers. This will allow best practices to be shared among the care team to ensure the member's care is coordinated during transitions. • The care plan may contain, and is not limited to, both medical and non-medical information (e.g. a current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, benefit information, contact information for professional care providers or practitioners and informal care providers). The care plan may include long term and/or short term goals that take into account the patient's goals and preferences, identify barriers to meeting their goals or compliance with the care plan, and have a process to assess progress.
<ul style="list-style-type: none"> • MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. 		

Signatures and Contacts

For Columbia Pacific CCO (CCO)
The designated contact person is:

First Name _____ Last Name _____
Email _____ Phone _____
Authorizing Signature _____ Date 8/20/12

For DHS / Aging and People with Disabilities (APD District Office)
The designated contact person is:

First Name Merry Last Name Bayly
Email merry.t.bayly@state.or.us Phone 541-957-3013
Authorizing Signature Merry T Bayly Date 8/29/2012

For DHS, Aging and People with Disabilities Division, Central Office (DHS, Aging and People with Disabilities Division, Central Office)
The designated contact person is:

First Name Patricia Last Name Baxter
Email Patricia.E.Baxter@state.or.us Phone (503) 945-5858
Authorizing Signature Patricia Baxter Date 10/5/12

For Peggy Madison, Administrator
The t Douglas County Health & Social Services

BOARD OF COUNTY COMMISSIONERS OF DOUGLAS COUNTY (vices Division)

First Name _____ Last Name _____ By Susan Chair
Email _____ Phone _____ By Lang Kallstrom Commissioner
Authorizing Signature _____ Date _____ By Joseph Kallstrom Commissioner
Date 9/5/12

REVIEWED AS TO FORM _____
By _____
Office of County Legal Counsel
Date: 9/4/2012