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.

Purpose

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 ("Agreement") between Columbia Pacific Coordinated Care Organization, LLC (CCO), and the AAA office of NorthWest Senior & Disability Services (NWSDS-AAA), and the local APD offices for Columbia County (Columbia-APD), Douglas County (APD-District 6), and Coos County (APD-District7). The mutual goal of the 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. In order to achieve these goals, the parties to this Agreement desire to set forth their respective roles and responsibilities to coordinate care and share accountability for Medicaid funded long term care.

Agreement

Now therefore, CCO and AAA/APD agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	Area Agency on Aging (AAA)/Aging and People with Disabilities (APD) Expectation	CCO/AAA/APD agreements:
• CCOs will define universal screening process that assesses individuals for critical	• AAA/APD will provide CCOs with access to information needed to	In order to assist with selection of members designated as "high care needs", AAA/APD agrees to share with CCO the service priority level and information from

risk factors that trigger intensive care coordination for high needs members receiving Medicaid funded LTC services. ○ CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers. ○ CCOs will define how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services.	identify members with high care needs, as requested.	standardized risk assessment in the Client Assessment and Planning System (CA/PS), of individuals with service priority level 1-13 living in their own home or community based setting. Additionally, AAA/APD agrees to share with CCO, as requested, information regarding in-home service clients the AAA/APD Case Manager believes to be at risk due to accepting lower than authorized care plan, and anyone with a notice for eviction or involuntary move out. CCO agrees to share information from community health assessments and individual risk assessments of individuals and communities defined as high risk or high utilizer with designated AAA/APD staff. By January 2015, CCO and AAA/APD staff will work together to develop processes to identify individuals with high care needs or with the potential for high care needs that may be avoidable with proactive management. As CCO and APD data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing. Methods of information sharing: • Information will be shared monthly by the 15th of the month. Information will be shared electronically if available, by fax or email to the

		designated contact person or back-up. CCO and AAA/APD agree to coordinate and mutually agree upon final number of high care need members that will receive intense care coordination as defined in this document. Additionally, it is agreed that either CCO or AAA/APD may offer up individual members for consideration of intensive care coordination outside of the specific parameters listed here. Both entities agree to revisit these criteria annually, to determine whether these agreements have been effective in identifying high care need members.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD agree to conduct regular meetings, meeting at least quarterly, to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization.

2. Development of individualized care plans		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCOs' individualized person-centered care plans will include information about the	• AAA/APD will define how it will integrate key health-related	AAA/APD and other community partners (as needed) will develop with the CCO, individual care plans for designated members, stating their choice of living

supportive and therapeutic needs of each member, including LTC services and supports needs. o Plans will reflect member or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate. o Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD and with LTC providers.	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.	situation, client preferences and goals as appropriate. Contact information for surrogate decision makers will also be provided (conservator, legal guardian, and health care power of attorney) as agencies are made aware. For NWSDS and Columbia County APD, all information will be brought to the Interdisciplinary Care Team (ICT) meetings to coordinate care for joint clients, and then will be integrated into individual service or care plans. Douglas County APD (District 6) and Coos County APD (District 7) agree to work with CCO to develop care team processes by August 1, 2014.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD agree to conduct regular meetings, meeting at least quarterly, to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization

3. Transitional care practices		
CCO Expectation	AAA/APD Expectation	MOU activities

• 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.	• 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.	AAA/APD will notify CCO within 7 days of receipt of information regarding ICT member move. Including; date of move, new address, type of LTC setting, member contact number, provider contact number. CCO to reciprocate if they are aware of move first. AAA/APD and CCO will work collaboratively to develop agreements around post hospital/skilled placement and roles that are most efficient, yet prevent cost shifting or increases to LTC nursing home case load.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		AAA/APD will continue to monitor ICF Nursing Home Count. Additionally, CCO and AAA/APD will specifically address degree to which entities are collaborating on care transitions to ensure positive outcomes for members.

4. Member engagement and preferences

CCO Expectation	AAA/APD Expectation	MOU activities
• 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.	• 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.	AAA/APD agrees to share with CCO pertinent details of individual ICT member barriers to achieving health goals that staff are aware of. This includes; homelessness, misuse of medications, no phone, lack of accessible transportation, minimal or insufficient social supports. CCO will share with AAA/APD similar barriers to achieving health goals; member routinely does not follow up with scheduled appointments, does not have primary care provider, known gaps in provider capacity in the community. All individualized care plans developed by the ICT will be discussed with and approved by the member involved.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD are each committed to establishing and maintaining effective communication through regularly scheduled meetings, meeting at least quarterly.

5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities

• CCO will support the flow of information to AAA/APD.	• 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.	With regard to members identified as having "high care needs" as outlined in number 1 of this document, AAA/APD and CCO agree to; develop efficient processes for Interdisciplinary Care Team (ICT) meetings, identify contacts for ICT meetings, and convene ICT meetings on a regular basis (at least quarterly).
• 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.	• 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.	Please see numbers 2 and 3 of this document.
• To support care teams, CCO will o Work with AAA/APD to ensure that it identifies members receiving LTC services. o Include LTC providers and AAA/APD case managers as part of the	• AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate.	CCO and AAA/APD recognize the importance of providing team-based care. The organizations will work towards utilizing health information technology that enables members of the interdisciplinary care team to assess patient information that is accurate and up to date. Both organizations agree that team-based care is essential to improving patient outcomes and are committed towards continuously enhancing the performance of the interdisciplinary care teams. CCO and AAA/APD partners will

team based care approach.		use appropriate secure systems when sharing information electronically, thus facilitating the ready exchange of information identified in this document.
• Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.	• DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.	CCO and AAA/APD agree to work towards integrating appropriate staff into the interdisciplinary care team. Work has already begun to identify LTC providers that provide care for potentially "high care need" clients. This integration will enable both organizations to provide care that reflects the unique needs of each member.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD agree to conduct regular meetings, meeting at least quarterly, to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization.

Signatures and Contacts:

For Columbia Pacific Coordinated Care Organization, LLC (CCO)

The designated contact person is:

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Email: Phone:

[signature]
Authorizing Signature

June 24, 2014
Date

For NorthWest Senior & Disability Services (AAA Office)

The designated contact person is:

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[signature]

6/25/14

For Douglas County (APD Office-District 6)

The designated contact person is:

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Merry L Bayly 6-13-2014
Authorizing Signature Date

For Douglas County Senior and Disability Services

The designated contact person is:

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Peggy Madison 6-16-14
Authorizing Signature Date

For Columbia County (APD Office)

The designated contact person is:

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Jessica Soltesz 6/19/14
Authorizing Signature Date

For Coos County (APD Office-District 7)

The designated contact person is:

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Michael Marchant 6/30/14
Authorizing Signature Date

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

The designated contact person is:

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Patricia Baxter

Authorizing Signature

6/30/14

Date