

Memorandum of Understanding

Eastern Oregon Coordinated Care Organization (EOCCO) and Aging and People with Disabilities
(APD) Districts 9, 11, 12, 13 & 14

I. Background

Medicaid funded long term service and supports (LTSS) are legislatively excluded from the 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 long term care services. To reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCO's and the long term care system must coordinate care and share accountability for individuals receiving Medicaid funded long term care services.

II. Purpose

The purpose of this Memorandum of Understanding (MOU) is to clarify agreements between Eastern Oregon Coordinated Care Organization and Aging and People with Disabilities (Districts 9, 11, 12, 13 & 14). This Agreement forms the basis to provide comprehensive and integrated services for EOCCO members receiving long term care through APD. The MOU is a one year agreement, however, the work plan (Attachment A) lays out a two year vision to track progress toward long term goals. The shared goal of this 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. The following are guiding principles in the joint delivery of services and activities outlined in this Agreement:

- Creating a better experience for the individual
- Lowering costs and preventing/avoiding cost shifting
- Providing better care and services
- Reducing disparities
- Creating better health outcomes
- Pursuing innovative approaches to care

III. Roles and Responsibilities:

The following is a good faith description of roles and responsibilities of the entities participating in the proposed Agreement to coordinated care and shared accountability for Medicaid funded long term care. Both entities are bound by more exhaustive responsibilities outlined in statute but for the purposes of this Agreement fundamental roles include:

<i>EOCCO</i>	<i>APD</i>
<ul style="list-style-type: none"> ▪ Medical primary care ▪ Hospital services ▪ Mental/Behavioral health ▪ Medicaid home health ▪ Durable medical equipment ▪ Emergency transportation ▪ Nutrition and IV services ▪ Rehabilitation services <i>(such as physical occupational and behavioral/mental health)</i> 	<ul style="list-style-type: none"> ▪ LTSS eligibility ▪ LTSS authorization and placement (homes and community based/ nursing facility except when Medicare skilled) ▪ LTSS case management coordination and troubleshooting, ▪ Adult protective services ▪ Contacting for Medicaid LTC providers ▪ Foster Home Licensing and Quality

<p><i>therapies)</i></p> <ul style="list-style-type: none"> ▪ Medical surgical services ▪ Pharmaceutical services (<i>including Medicare Part D; excluding psychiatric medications that are yet to be transferred to the role of EOCCO</i>) ▪ Speech language pathology ▪ Audiology, hearing aid services, ▪ Transplant services ▪ Hospice and other palliative care 	<p>Assurance</p> <ul style="list-style-type: none"> ▪ LTC ombudsman ▪ Eligibility and enrollment for Medicaid ▪ Medicaid low income co pay.
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EOCCO agrees to the following responsibilities to support the goals of this Agreement:

- Deliver high quality, person-centered health care to its members, including members receiving Medicaid-funded Long Term Care (LTC).
- Share individualized care plans per individualized high needs member.
- Engage with APD when necessary on case management and coordination to ensure member care needs are met with the most cost effective and appropriate options.
- Actively engage members in the design and implementation of their treatment and care plans and work towards development of joint plans.
- Work to ensure APD Case Managers or Transition Coordinators are notified if a member may transition from hospital to LTC.

APD (Districts 9, 11, 12, 13 & 14) agrees to the following responsibilities to support the goals of this agreement:

- Authorize, manage and monitor Medicaid-funded LTC services.
- Share information on LTC service plans.
- Provide EOCCO with access to information to identify members with high health care needs.
- Collaborate with EOCCO to ensure wrap around services are utilized.
- Coordinate with EOCCO regarding post placement needs regarding diversion/transition.
- Work to ensure that EOCCO providers are notified of EOCCO members receiving LTC.

IV. Goals, Agreements and Measures of Accountability

Each party has reviewed and agrees to the joint responsibility in meeting the elements in the MOU work plan (Attachment A). Both parties will hold the other accountable by monthly meetings that will rotate domain focus and report on the related data elements and progress. Additionally, there will be an in-person reevaluation meeting in September to review all measures of accountability and plan for the next steps and any modifications. Other means of accountability will include workgroup meetings and utilization of an issues tracker where both entities can identify and track issue resolutions and outcomes. Progress toward the goals will be measured by reaching the desired outcome of the measure of accountability as stated below and in the work plan and through resolutions of issues identified through the issues tracker. Below is a summary of the overarching goals, agreements and respective measures of accountability each party agrees to work towards through this agreement.

Domain 1: Identification of High Needs Members in LTC

Goal: There will be Intensive Care Coordination for high needs members to prevent duplication and improve overall health of patient.

Agreement: APD & EOCCO agree to work together to identify high needs members and develop appropriate plans and processes to intervene with services when appropriate.

Measures of Accountability: Documented definition of high needs members, Analysis of high utilizer reports, summary report on APD/EOCCO services, High Risk Referral Plan, High Risk Referral form.

Domain 2: Development of Individualized Care Plans

Goal: Individual Person Centered Care plans will be developed jointly by member (and/or designated representative) EOCCO, LTC providers, PCPCH, Community Mental Health Program, APD case manager to ensure seamless experience of care.

Agreement: APD & EOCCO agree to share key information for joint care plans and to pilot the process of jointly developing person centered care plans.

Measures of Accountability: Determine process and data for developing care plans, list of PCPCH providers with care coordinators, feasibility assessment of data integration, assessment of other joint care plan models.

Domain 3: Transitional Care Planning

Goal: Members will receive coordinated transitional care, including appropriate follow-up when entering or leaving an acute care facility or long term care setting.

Agreement: EOCCO and APD will work together so that members will receive coordinated transitional care and have a seamless process for acquiring necessary coverage of durable medical equipment or specialty items.

Measures of Accountability: Barriers identified, documented process for joint transition planning, number of joint transitional care placements, documented financial coverage roles for Durable Medical Equipment and specialty items, identification of potential cost shifting areas, plans to coordinate and avoid cost shifting.

Domain 4: Member Care Coordination

Goal: Treatment and care plans will involve the member and reflect the person's goals and preferences.

Agreement: APD & EOCCO agree to actively engage member (or designated representative) in the design and implementation of the treatment and care plans.

Measures of Accountability: Client is a member of the care team and their goals and preferences are documented in the care plan.

Domain 5: Continuity of Care and Care Coordination

Goal: Identified member has a consistent relationship with a care team responsible for providing comprehensive care management in all settings.

Agreement: EOCCO and APD agree to establish member care teams.

Measures of Accountability: Cross walk of services between APD and EOCCO, issues tracker and number of cases/issues resolved at planning meetings, number of joint care team meetings.

resolved at planning meetings, number of joint care team meetings.

V. Duration

This Memorandum will be in effect for the period of one year beginning July 1, 2014, or the date on which each party has signed this agreement, whichever is later. Both parties reserve the right to renegotiate this Memorandum upon the mutual consent of the other party. This Memorandum represents the entire understanding of both parties with respect to this partnership. Any modification of this Memorandum must be in writing and signed by the parties. In the event of termination of this MOU, each party should give or be given a 30-day notice.

VI. Amendment

Given the complexity of Oregon's health care initiative, it is understood that during the term of this agreement many details regarding the partnership and funding mechanisms may be designed or altered. This agreement will be revised to reflect these changes as needed. At a minimum of quarterly, EOCCO and APD (Districts 9, 11, 12, 13 & 14) will meet to review progress related to the goals of this Agreement and to make adjustments or revisions as needed. The agreement as a whole will be reviewed annually before the anniversary of its signing. All amendments must be in writing and signed by all parties. It is the intent of APD (Districts 9, 11, 12, 13 & 14) and EOCCO that this agreement be modified as jointly agreed upon and may be renewed upon expiration.

VII. Funding

Although this MOU is not a commitment of funds both parties agree through the outlined activities in Attachment A to work towards avoidance of cost shifting and finding the most cost effective means of care without compromising integrity of care.

VII. Signatures and Contacts:

Eastern Oregon Coordinated Care Organization (Medical Management)

Dena Rossi, RN
Primary Contact Name (print)
Dena Rossi, RN
Primary Contact Signature:

Toni Olin
Authorizing name (print)
Toni Olin
Authorizing Signature

Eastern Oregon Coordinated Care Organization (Behavioral Health)

Sarah Carpenter
Primary Contact Name (print)
Sarah Carpenter

Verdi Jacobson
Authorizing name (print)
Verdi Jacobson

Aging and People with Disabilities (District 9)

Aris Bolter
Primary Contact Name (print)
Aris Bolter

CAAOCS Marson
Authorizing name (print)
CAAOCS Marson

Primary Contact Signature:

Authorizing Signature

Aging and People with Disabilities (District 11):

Gloria Peña
Primary Contact Name (print)

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Authorizing name (print)

Gloria Peña
Primary Contact Signature:

" "
Authorizing Signature

Aging and People with Disabilities (District 12):

Budget Reimick
Primary Contact Name (print)

David Brehaut
Authorizing name (print)

Budget Reimick
Primary Contact Signature:

David Brehaut
Authorizing Signature

Aging and People with Disabilities (District 13 & 14):

Sandy Hata
Primary Contact Name (print)

" "
Authorizing name (print)

Sandy Hata
Primary Contact Signature:

" "
Authorizing Signature

Aging and People with Disabilities (Central Office)

Patricia Baxter
Primary Contact Name (print)

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Authorizing name (print)

Patricia Baxter
Primary Contact Signature:

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Authorizing Signature

6/30/14

