

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 Eastern Oregon Coordinated Care Organization and the Aging and People with Disabilities District 13 and 14. 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, and Aging and People with Disabilities District 13 and 14 agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	APD Expectation	CCO/APD agreements:
<ul style="list-style-type: none"> • 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"> ○ CCO will factor in relevant referral, risk assessment and screening information from local APD offices and LTC providers. ○ CCOs will define how it will communicate and coordinate with APD when assessing members receiving Medicaid-funded LTC services. 	<ul style="list-style-type: none"> • APD will provide CCOs with access to information needed to identify members with high health care needs. • APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid /APD offices into CCOs' individualized care plans for members with intensive care coordination needs. 	<p><i>Beginning on Sept 1, 2012, partners will share initial information (as outlined below) about potentially high care needs members, and will revisit by April 1, 2013 whether these agreements have been effective in identifying and prioritizing high needs members.</i></p> <p><i>Effective December 1, 2012 CCO and APD will use information available, including data provided by OHA/DHS central office, to identify high needs individuals.</i></p> <p><i>Share key information pertinent to each entity's risk assessment:</i></p> <ul style="list-style-type: none"> • <i>APD staff will share key information, listed below, for its highest needs individuals served by the CCO, such as: those identified as having the most needs for assistance with activities of daily living - (service priority levels 1-3). APD/ staff will also share this information for members that are known to have other complex conditions, high ER utilization, or other</i>

1. Prioritization of high needs members in LTC

CCO Expectation	APD Expectation	CCO/APD agreements:
<ul style="list-style-type: none"> MOU will address how CCO and APD will hold themselves mutually accountable to meeting these expectations. 		<p><i>complicating circumstances on an as needed basis.</i></p> <p><i>Key information that APD will share with CCO includes:</i></p> <ul style="list-style-type: none"> • <i>Service Priority Levels of identified high needs members in LTC including service planning and assessment information.</i> • <i>APD will notify CCO when a LTC member experiences a change of condition resulting in higher level of care or multiple failed placements.</i> • <i>APD will notify CCO about LTC member hospitalizations and known ER visits.</i> • <i>APD will provide CCO with LTC Medicaid service eligibility dates.</i> • <i>APD will contact non LTC Medicaid members regarding LTC services and eligibility as referred by the CCO.</i> • <i>APD will follow up with CCO contact staff on status of LTC service referrals initiated by CCO.</i> <p><i>CCO agrees to share key information, listed below, for individuals defined as high needs, as well as relevant information from community health assessments with designated APD staff. Key information that CCO will share with APD includes:</i></p> <ul style="list-style-type: none"> • <i>Designated CCO contact staff (see below).</i> • <i>CCO will notify APD of additional care or support services provided to identified high need LTC members.</i> • <i>High need LTC members may include: clients with multiple chronic illnesses resulting in multiple ER visits or hospital observation/admissions</i>

1. Prioritization of high needs members in LTC

CCO Expectation	APD Expectation	CCO/APD agreements:
		<p><i>CCO/APD agreements:</i></p> <ul style="list-style-type: none"> • <i>APD and CCO agree to collaborate with identifying high needs members and developing appropriate LTC plans.</i> • <i>CCO will communicate with APD when identified high need member may transition from hospital to LTC</i> • <i>CCO will share individualized care plans per individualized high needs members.</i> <p><i>Methods of information sharing:</i></p> <ul style="list-style-type: none"> • <i>Information will be shared on a daily basis or as determined by need.</i> • <i>Information will be shared electronically if available; by phone, fax or email to the designated contact person or back-up.</i> <ul style="list-style-type: none"> • <i>As CCO and APD data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing.</i> • <i>Designated contact staff:</i>

1. Prioritization of high needs members in LTC		
CCO Expectation	APD Expectation	CCO/APD agreements:
		<p>APD will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> • Beginning in February 1, 2013, APD and CCO will establish monthly status check in meetings for the purpose of updating status of coordination efforts. • By April 1, 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 • By Sept 1, 2013, meet 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 Expectation	MOU activities
<ul style="list-style-type: none"> • 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"> ○ Plans will reflect member or family/caregiver preferences and goals captured in APD 	<ul style="list-style-type: none"> • APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid APD offices into CCOs' individualized care plans for members with intensive care coordination 	<p>Beginning February 1, 2013, CCO will share individual care plans for members also served by the APD office. The above information will be shared as needed or as new care plans are developed. CCOs will include APD contact information for each individual's care coordinator and/or primary care home for purposes of care coordination.</p> <p>Beginning February 1, 2013, APD will share key member information with the CCO for individuals that the CCO has</p>

2. Development of individualized care plans	
<p>service plans as appropriate.</p> <ul style="list-style-type: none"> ○ Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from /APD and with LTC providers. 	<p>needs.</p>
<ul style="list-style-type: none"> ● MOU will address how CCO and APD will hold themselves mutually accountable to meeting these expectations. 	<p><i>developed an individual care plan, including information documented in the LTC member assessment and planning system (CAPS). APD will share this information with CCO as needed or as new care plans are developed. Key member information will include:</i></p> <ul style="list-style-type: none"> ● <i>Member choice of living situation preferences and most cost effective option to meet member care needs.</i> ● <i>APD case manager contact information.</i> ● <i>CCO contact information.</i> ● <i>LTC provider contact information.</i> ● <i>Primary care physician/Patient Centered Primary Care Home (PCPCH) contacts information.</i> ● <i>Care plan will be agreed upon by member/or representative.</i> <p><i>CCO and APD will hold each other accountable in the following ways:</i></p> <ul style="list-style-type: none"> ● <i>Beginning in February 2013, APD and CCO will establish monthly status check in meetings for the purpose of updating status of coordination efforts.</i> ● <i>By April 30, 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</i> ● <i>By September 30, 2013, meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.</i>

3. Transitional care practices		
CCO Expectation	APD Expectation	MOU activities
<ul style="list-style-type: none"> • CCO will demonstrate how it will coordinate and communicate with 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. 	<ul style="list-style-type: none"> • 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. 	<p>APD agrees to collaborate with CCO to ensure that wrap around services are utilized based on availability.</p> <ul style="list-style-type: none"> • Diversion/Transition will coordinate with CCO regarding post placement needs, supporting member's health needs, care preferences, goals and most cost effective option to meet member care needs. • Diversion/Transition team will coordinate with post placement (in home care, or LTC facility) and other supports (family, guardian and non CCO partners) regarding members health needs, care preferences and goals and most cost effective option to meet member care needs.
<ul style="list-style-type: none"> • MOU will address how CCO and APD will hold themselves mutually accountable to meeting these expectations. 		<p>CCO agrees to collaborate with APD to ensure:</p> <ul style="list-style-type: none"> • Member care needs are met with most cost effective and appropriate options. • CCO case management (CM) available, when deemed necessary, for continued communication with member, PCP and APD to ensure continuity of care. <p><i>CCO and APD will hold each other accountable in the following ways:</i></p> <ul style="list-style-type: none"> • Beginning in February 2013, APD and CCO will establish monthly status check in meetings for the purpose of updating status of coordination efforts • By April 30, 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

- By September 30, 2013, meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.

4. Member engagement and preferences

CCO Expectation	APD Expectation	MOU activities
<ul style="list-style-type: none"> • CCO will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with APD where relevant to LTC service planning. 	<ul style="list-style-type: none"> • 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. 	<p>APD service delivery model is based on member care preference and individual choice. APD LTC Case managers and Diversion/Transition Specialists will:</p> <ul style="list-style-type: none"> • Actively engage member and supports in LTC service planning • APD case managers will choice counsel potential LTC members of LTC service criteria and options • APD will collaborate with member, member supports and CCO for LTC planning purposes <p>CCO CM will collaborate with:</p> <ul style="list-style-type: none"> • Member, PCP/PCPCH, APD and LTC when appropriate and as needed • CCO CM will understand goals and preferences of member through communication with APD or with member as needed <p>CCO and APD will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> • Beginning February 1, 2013, APD and CCO will establish monthly status check in meetings for the purpose of updating status of coordination efforts.
<ul style="list-style-type: none"> • MOU will address how CCO and APD will hold themselves mutually accountable to meeting these expectations. 		

- *By April 30, 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*
- *By Sept 30, 2013, meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.*

5. Establishing member care teams		
CCO Expectation	APD Expectation	MOU activities
<ul style="list-style-type: none"> • CCO will support the flow of information to APD. • The CCO-appointed lead provider or care team will confer with all providers responsible for a member's care, including LTC providers and APD. • To support care teams, CCO will <ul style="list-style-type: none"> ○ Work with APD to ensure that it identifies members receiving LTC services. ○ Include LTC providers and APD case managers as part of the team based care approach. • Adapt team-based care approaches and the use of the 	<ul style="list-style-type: none"> • 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. • APD will ensure that CCO providers/care teams are notified of which CCO members are receiving LTC, the relevant local APD office contact, and contact for relevant LTC provider. • APD will have knowledge of and actively participate in CCO team based care processes when 	<p>APD has developed a single point of entry for CCO engagement, consisting of the previously described Diversion/Transition and support staff team.</p> <ul style="list-style-type: none"> • Point of entry team will triage requests and direct to the appropriate LTC case manager if needed. POE will assist the CCO with the information requested. • Diversion/Transition coordinators will assist CCO and LTC case managers with complex cases. • LTC case managers will coordinate with CCO regarding identified LTC member service planning. • LTC Diversion/Transition team or case managers will participate in ICT meetings or other person centered care coordination meetings as needed. <p>CCO CM team members are available to:</p> <ul style="list-style-type: none"> • Collaborate with APD Diversion/Transition team. • Collaborate with LTC, PCPCH/PCP as needed. • Attend ICT meetings to discuss, plan or update

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CCO Expectation	APD Expectation	MOU activities:
<p>lead coordinator to accommodate the unique needs of individuals receiving LTC services.</p>	<p>appropriate.</p> <ul style="list-style-type: none"> DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams. 	<p>members care plan.</p> <ul style="list-style-type: none"> Collaborate with all necessary parties to ensure patient centered continuity of care provided for member.
<ul style="list-style-type: none"> MOU will address how CCO and APD will hold themselves mutually accountable to meeting these expectations. 		<p><i>CCO and APD will hold each other accountable in the following ways:</i></p> <ul style="list-style-type: none"> <i>Beginning in February, 2013, APD and CCO will establish monthly status check in meetings for the purpose of updating status of coordination efforts.</i> <i>By April 30, 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</i> <i>By Sept 30, 2013, meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.</i>

Signatures and Contacts

For Eastern Oregon CCO (CCO)

The designated contact person is:

First name	Last name
Email	Phone
Authorizing Signature	Date

9/4/12

For Aging and People with Disabilities, District 13 and 14 (APD District Office)

The designated contact person is:

Sandy	Hata
First name	Last name
<u>Sandy.k.hata@dhsosha.state.or.us</u>	541-889-8592
Email	Phone

Gandy Hata
Authorizing Signature

8-31-12
Date

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

The designated contact person is:

Patricia
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Baxter
Last name

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Email

(503) 945-5858
Phone

Patricia Baxter
Authorizing Signature

1/31/13
Date