

**Tri-County Medicaid Collaborative / Medicaid Long-Term Care  
Long Term Care Coordination Agreement  
Multnomah County**

This Long Term Care Coordination Agreement is entered into by and between the Tri-County Medicaid Collaborative (TCMC) and the Multnomah County Aging and Disability Services Division.

**PURPOSE:**

To implement and formalize system and care coordination between the TCMC, in its role as a Coordinated Care Organization (CCO) and Multnomah County, in its role as the Area Agency on Aging (AAA) and as the Long Term Care Agency for Multnomah County. In addition, the purpose of this agreement is to identify the roles and responsibilities of the TCMC and the County.

**RECITALS:**

1. 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).
2. Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services.
3. 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.
4. The 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.
5. This Agreement will be considered part of a system of coordination between the CCO and the LTC network in Multnomah, Clackamas and Washington Counties that also includes the Aging and People with Disability (APD) Medicaid Programs in Clackamas and Washington Counties and Clackamas County Social Services and Washington County Disability, Aging and Veterans Services, the AAAs for Clackamas and Washington Counties.

The parties agree to support health care transformation as follows:

**1. Prioritization of high needs Members in LTC**

TCMC and the County will establish a standard definition of high needs Members and criteria for assessing individuals by November 1, 2012. TCMC and the County will collaborate to establish this process, to promote: sharing of information regarding risk criteria for health system and long-term care system; education regarding critical risk factors for each system of care.

The partners will share initial information about potentially high risk Members by March 15, 2013. The parties will revisit by June 15, 2013 whether these agreements have been effective in identifying high risk Members and make adjustments to the definition and processes as needed.

### **Tri-County Medicaid Collaborative / Medicaid Long-Term Care**

TCMC and the County will establish a process for using information available, including data provided by OHA/DHS central office, to identify a list of individuals each has in common.

TCMC and the County shall share key information pertinent to each entity's risk assessment:

- County LTC staff will share key information, listed below, for its highest needs individuals served by the TCMC, such as those identified as having the most needs for assistance with activities of daily living - (service priority levels 1-3). County staff will also share this information for Members that are known to have other complex conditions, high Emergency Department (ED) usage, or other complicating circumstances on an ad hoc or individual basis. The County will share with TCMC available and relevant LTC client information which may include:
  - Case manager contact information
  - Service Priority Level
  - LTC provider contact information
  - Member's LTC goals/preferences
  - Service Plan, including Contract RN involvement
  - Risks
  - Natural Supports
  - Last assessment date
  - Monitoring frequency

TCMC agrees to share key information, listed below, from individual risk assessments for individuals defined as high needs, as well as relevant information from community health assessments with designated County staff. Key information that the TCMC will share with County includes:

- Key risk factors;
- Treatment and care plan; and
- Interdisciplinary Team lead, members.

Methods of information sharing:

- Information will be shared according to a schedule established by the County and TCMC.
- Information will be shared electronically if available, by fax or email to the designated contact person or back-up.
- As TCMC, the County and State data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing.
- TCMC and the County will periodically review the data sharing content and process to ensure the information shared is useful and the process is timely and efficient.
- An updated contact list for designated staff to be liaison for problem-solving, information sharing and other key communication will be shared between TCMC and County programs at least quarterly.

In recognizing the importance of continual dialogue and learning, the TCMC and County programs will do the following to enable a Plan Do Study Act (PDSA) cycle:

- By March 15, 2013, develop a mutually agreed upon list of high risk Members; and
- By June 15, 2013, the parties meet to review and assess whether the parties have successfully identified and prioritized high risk Members; identify the strengths of the work to date, any challenges or barriers to achieving the Triple Aim, and any unexpected opportunities. The parties will document any insights and will update and amend this Agreement, as necessary; and will determine measures and timeframes for future accountability and evaluation efforts, in

### **Tri-County Medicaid Collaborative / Medicaid Long-Term Care**

coordination with OHA/DHS metrics and accountability efforts. By July 1, 2013, partners to this Agreement will begin to explore considerations for developing clinical, financial and data structures that include shared savings and incentive payments for care coordination and health care navigation by the County's LTC program for individuals identified as high need who are receiving eligibility determination through the County program but are not receiving care coordination by any health or social service system.

#### **2. Development of Individualized care plans**

By June 30, 2013, TCMC and the County will share individual care plans for Members who are also receiving Medicaid long-term care services and who have an individual care plan with the TCMC primary care home provider. The above information will be shared on a schedule established by TCMC and the County according to individual need or as new care plans are developed.

By June 30, 2013, the County will share key client information with the TCMC for individuals for whom the TCMC has developed an individual care plan, including information documented in the long term care client assessment and planning system (CAPS). The County will share this information with TCMC as new care plans are developed and existing plans are updated. Key LTC client information will include:

- County LTC case manager contact information
- LTC provider contact information
- Service Priority level
- Member's LTC goals/preferences
- Service Plan, including Contract RN involvement, non-Medicaid services such as Older American Act funded services
- Risks
- Natural Supports
- Last assessment date
- Monitoring frequency

Additionally, the Member care plans shall include key LTC client information identified above.

#### **3. Transitional care practices**

The County has primary responsibility for supporting individuals receiving Medicaid LTC services and transitions across LTC settings, from hospital or nursing facility to home or residence of choice.

Starting September 1, 2012, the County will participate with TCMC in establishing a process for supporting individuals who transition across care settings. At a minimum the following principles will be addressed:

- TCMC, TCMC Affiliates and partner organizations to develop a consistent system to enable County LTC case managers and LTC Transition/Diversion Specialists to support transition planning, including advanced notification of hospital discharges and collaboration during discharge planning process to ensure transitions that are appropriate, safe, and person-directed.

## Tri-County Medicaid Collaborative / Medicaid Long-Term Care

- TCMC will work with nursing facilities, or other LTC providers, to develop processes and contract agreements that support effective care and transition planning, including notification of admissions, hospitalizations, and other relevant status changes; and collaboration to ensure proactive and person-centered care planning and an appropriate and safe transition.
- TCMC will work with its Affiliates and delivery system partners to integrate County LTC staff into hospital care transitions teams to identify and follow individuals who would benefit from community-based care transitions supports.
- TCMC will work with its Affiliates and delivery system partners to use an evidence-based model for care transitions of Members and will set up process and outcomes measure that ensure coordination of care across health and LTC systems.

Multnomah County, Clackamas County Social Services (CCSS) and Washington County Disability, Aging and Veterans Services (WCDAVS) will coordinate CMS-funded care transition services for Medicare fee-for-service beneficiaries with TCMC transition processes and activities.

### 4. Member engagement and preferences

By March 15, 2013 TCMC and the County will identify the roles, responsibilities and scope for TCMC care coordinators, partner organization case managers and County LTC case managers to:

- Actively engage individuals in their health and LTC service plans,
- Coordinate care/service planning processes,
- Communicate regularly with the TCMC Member and members of the care team regarding the coordinated care/service plan
- Respond to urgent situations or when care plan becomes unstable; and
- Update the care/service plan to reflect changes in the Members' needs or preferences.

By October 1, 2013, for TCMC members identified as high needs and not receiving Medicaid LTC services or care coordination (eligibility only clients) in another system, TCMC and the County will amend this Agreement to identify roles, responsibilities and scope for TCMC and County care coordination/health system navigation to:

- Engage individuals in their individual service plan,
- Coordinate care/service planning processes,
- Communicate regularly with the TCMC Member and members of the care team regarding the coordinated care/service plan
- Respond to urgent situations or when care plan becomes unstable; and
- Update the care/service plan to reflect changes in the Members' needs or preferences.

### 5. Establishing Member care teams

TCMC will include Medicaid LTC representation on work groups developing the structure and accountabilities for patient-centered primary care homes (PCPHs) and care teams, encouraging and setting standards to promote that appointed lead providers or care teams confer with all providers

### **Tri-County Medicaid Collaborative / Medicaid Long-Term Care**

responsible for a Member's care, including LTC providers and County LTC case managers and diversion coordinators.

By March 15, 2013, TCMC will work with the County programs to identify all high needs Members receiving LTC services and County programs shall provide relevant information regarding the Members' LTC services.

By June 30, 2013 TCMC and County programs shall include County LTC case managers as part of the team based care approach and shall encourage and set standard to promote that all providers confer with County case managers.

#### **6. Use of best practice**

By June 30, 2013, the County will incorporate information from the CCO into the care planning of the individual. Information will include best practice approaches, and other health-related, evidence-based practices that support the individual in a LTC setting.

By January 1, 2014, TCMC and the County and partner agencies in Clackamas and Washington Counties will explore formal agreements and establish a plan for the provision and expansion of evidence-based chronic disease self-management programs, which may include:

- Living Well with Chronic Conditions/Tomando programs based on the Stanford Chronic Disease Self-Management Program
- STAR-Caregiver and/or REACH programs that train families caring for individuals with Alzheimer's disease and related dementias.
- Evidence-based fall prevention and health promotion classes, such as: Tai Chi for Better Balance, Arthritis Foundation Exercise Classes, and others.

TCMC and the County will explore opportunities to expand availability of the County Aging & Disability Resource 24-Hour Access call center service for shared Members across the 3 counties.

#### **7. Use of health information**

Data sharing agreements will be established no later than March 15, 2013 with the County LTC program to facilitate cross-system communication and protocols for using information to coordinate care across settings and systems.

#### **8. Member Access and Provider Responsibilities**

By February 2013 TCMC and the County will establish a process to include Medicaid LTC program in their comprehensive communication approach with Medicaid LTC beneficiaries to ensure maximum impact to engage beneficiaries in their health care. Specific aspects may include:

- Link to TCMC web-site and calendar of wellness events on the [ADRCofOregon.gov](http://ADRCofOregon.gov) and on the County's Aging & Disability Services web-site and
- TCMC making printed and translated education materials regarding member access to CCO services available to County LTC programs to share with members and family caregivers.

## **Tri-County Medicaid Collaborative / Medicaid Long-Term Care**

TCMC will engage the TCMC Community Advisory Council to monitor and measure patient engagement and activation.

- TCMC to communicate with County LTC offices regarding feedback sessions/focus groups to solicit Member feedback.

### **9. Outcome and quality measures**

As guidance is made available by OHA/DHS, TCMC and the County LTC program will coordinate to establish shared accountability performance measures.

### **10. Governance Structure**

TCMC Community Advisory Council:

- A majority of the CAC representation is made up of consumers and older adults and people with disabilities will be represented.
- TCMC will coordinate with the County LTC program to solicit applications for LTC Medicaid consumer participation on the CAC.

TCMC Governing Board: Area Agencies on Aging and Disability from the 3 counties will be represented on the Governing Board by the designated representative from each County.

TCMC CMO Workgroup:

- TCMC will include representatives from the County Medicaid LTC programs on the Chief Medical Officer (CMO) Workgroup, in the appropriate sub-committees, to represent the clinical and health needs of Medicaid LTC beneficiaries.

TCMC IT Oversight Committee

- TCMC will include representatives from the County on the IT Oversight Committee, in the appropriate sub-committees, to represent the clinical and health needs of Medicaid LTC beneficiaries and establish protocols and mechanisms for data sharing across care settings.

### **11. Learning Collaborative**

TCMC and the County will coordinate regarding opportunities to increase staff and community partner education in the areas of health literacy, motivational interviewing, person-centered/directed planning, practices to promote Member engagement.

TCMC and the County LTC program will develop a schedule of training and education of each others systems of care and ensure attendance of inter-disciplinary staff from health and LTC systems.

Topics may include:

- LTC assessment and planning processes
- Elder abuse reporting and prevention
- Primary health homes
- Health Literacy
- Other topics to be developed

## Tri-County Medicaid Collaborative / Medicaid Long-Term Care

### 12. Role of patient centered primary care home (PCPCH)

By January 2014 TCMC will coordinate with the County to pursue the option of co-location of County LTC care coordination staff in health home settings to facilitate integrated approach to care for individuals needing long-term services and supports and explore the expansion of providing matching funding for the co-location of LTC care coordination staff in hospital and provider settings.

### 13. Safeguards for Members

By September 1, 2012, TCMC and the County Medicaid LTC program will share contact information and protocols for referring Member complaints and grievances pertaining to their plan or coverage in either system.

TCMC, the County, and partner agencies in Washington and Clackamas Counties will explore potential formal agreements to establish integrated service navigation of health and LTC services and supports systems to maximize opportunities to promote person-centered care planning and divert Members from unnecessary health system and nursing facility utilization.

The following additional terms and conditions shall apply to this Agreement:

#### EFFECTIVE DATE AND TERMINATION.

1. The effective date of this Agreement shall be September 1, 2012 or the date on which each party has signed this Agreement, whichever is later. Unless earlier terminated as provided below, the termination shall be September 30, 2013.
2. This Agreement may be terminated by mutual consent of both parties at any time. Any such termination of this agreement shall be without prejudice to any obligations or liabilities of either party already accrued prior to such termination.
3. Either party may terminate this Agreement effective upon delivery of written notice to the other party or at such later date as may be established under any of the following conditions:
  - a. If funding from federal, state, or other sources is not obtained or continued at levels sufficient to allow for the purchase of the indicated quantity of services. This Agreement may be modified to accommodate a reduction in funds.
  - b. If federal or state regulations or guidelines are modified, changed or interpreted in such a way that the services are no longer allowable, appropriate for purchase under this agreement, or are no longer eligible for the funding proposed for payments authorized by this Agreement.
  - c. If any license, certificate, or insurance required by law or regulation to be held by either party to provide the services required by this Agreement is for any reason denied, revoked or not renewed.
  - d. If either party fails to provide services called for by this Agreement within the time specified herein or any extension thereof.
  - e. If either party fails to perform any of the provisions of this Agreement or so fails to pursue the work as to endanger the performance of this Agreement in accordance with its terms

**Tri-County Medicaid Collaborative / Medicaid Long-Term Care**

and after written notice from either party, fails to correct such failure(s) within ten (10) days or such longer period as the parties may authorize.

Any such termination of this Agreement shall be without prejudice to any obligations or liabilities of either party already accrued prior to such termination.

This Agreement and any changes, alterations, modifications, or amendments will be effective when approved in writing by the authorized representative of the parties hereto as of the effective date set forth herein.

**AMENDMENTS.**

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 will be designed or altered. This Agreement will be reviewed and revised periodically within its effective term. All amendments must be in writing and signed by the parties. It is the intent of the County and TCMC that this Agreement be modified as jointly agreed upon and may be renewed upon expiration.

**ADHERENCE TO LAW.** Each party shall comply with all federal, state and local laws and ordinances applicable to this agreement.

**OREGON LAW AND FORUM.** This Agreement shall be construed according to the laws of the State of Oregon. Any action regarding this agreement or work performed under this Agreement shall be filed in Multnomah County or in the United States District Court for the district of Oregon.

**NON-DISCRIMINATION.** Each party shall comply with all requirements of federal and state civil rights and rehabilitation statutes and local non-discrimination ordinances.

**SUBCONTRACTS AND ASSIGNMENT.** Neither party will subcontract or assign any part of this Agreement without the written consent of the other party.

**THIS IS THE ENTIRE AGREEMENT.** This Agreement constitutes the entire Agreement between the parties. This Agreement may be modified or amended only by the written agreement of the parties.

**Signatures and Contacts**

~~Medicaid Collaborative~~

Title: \_\_\_\_\_

Date: 7/11/12

**The designated contact person is:**

TCMC/LTC Coordinated Care Agreement Multnomah v.6

Tri-County Medicaid Collaborative / Medicaid Long-Term Care

First name

Last name

Multnomah County

By:

Title:

Date:

The designated contact person is:

Lee  
First name

Girard  
Last name

lee.girard@multco.us  
Email

503-988-3691 xt 83768  
Phone

Reviewed:

JENNY M. MORF, MULTNOMAH COUNTY ATTORNEY

By: APPROVED BY FREDRICK HENRY  
Assistant County Attorney

Date:

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

The designated contact person is:

Patricia  
First name

Baxter  
Last name

patricia.e.baxter@state.or.us  
Email

(503) 945- 5858  
Phone

Authorizing Signature - Signed as to form

Date

TCMC/LTC Coordinated Care Agreement Multnomah v.6