

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

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 the CCO for Clackamas, Multnomah and Washington Counties, the Tri-County Medicaid Collaborative (TCMC), and the local Aging and People with Disabilities offices (APD) for Clackamas and Washington Counties. 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, **Tri-County Medicaid Collaborative and Aging and People with Disabilities for Clackamas and Washington Counties** agree to participate in the following activities:

The parties agree to support health care transformation as follows:

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

TCMC and APD will establish a standard definition of high needs Members and criteria for assessing individuals by November 1, 2012. TCMC and APD will collaborate to establish this process, to promote educating and sharing of information regarding risk criteria for health and long-term care service systems.

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.

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

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- APD 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). APD 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. APD 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, non-Medicaid services such as Older American Act funded services
  - 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 APD staff. Key information that the TCMC will share with APD 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 APD and TCMC.
- Information will be shared electronically if available, by fax or email to the designated contact person or back-up.
- As TCMC, APD and State data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing.
- TCMC and APD 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 APD programs at least quarterly.

In recognizing the importance of continual dialogue and learning, the TCMC and APD 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

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- 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 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 APD's LTC program for individuals identified as high need who are receiving eligibility determination through the APD 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 APD 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 APD according to individual need or as new care plans are developed.

By June 30, 2013, APD 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). APD will share this information with TCMC as new care plans are developed and existing plans are updated. Key LTC client information will include:

- APD 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**

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APD 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, APD 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 APD 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.
- 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, safe and transition.
- TCMC will work with its Affiliates and delivery system partners to integrate APD 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.

#### **4. Member engagement and preferences**

By March 15, 2013 TCMC and APD will identify the roles, responsibilities and scope for TCMC care coordinators, partner organization case managers and APD 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.

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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 APD will amend this Agreement to identify roles, responsibilities and scope for TCMC and APD 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 (PCPCHs), encouraging and setting standards to promote that appointed lead providers or care teams will confer with all providers responsible for a Member's care, including LTC providers and APD LTC case managers and diversion coordinators.

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

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

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

By June 30, 2013, APD 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.

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

Data sharing agreements will be established no later than March 15, 2013 with APD 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**

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By February 2013 TCMC and APD 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 APD'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.

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

- TCMC to communicate with APD 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 APD 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 APD LTC program to solicit applications for LTC Medicaid consumer participation on the CAC.

**TCMC CMO Workgroup:**

- TCMC will include representatives from APD 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 APD 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 APD 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.

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TCMC and APD LTC program will develop a schedule of training and education of each others systems of care and ensure attendance of interdisciplinary 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

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

By January 2014 TCMC will coordinate with APD to pursue the option of co-location of APD 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 APD Medicaid LTC program will share contact information and protocols for referring Member complaints and grievances pertaining to their plan or coverage in either system. (NOTE: see OHA/DHS MOU Guidance, pg 17 which calls out expectation for coordinating member complaints and grievances across the 2 systems)

TCMC, APD, and partner agencies in Multnomah, 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.

**Signatures and Contacts**

Tri-County Medicaid Collaborative / Medicaid Long-Term Care

Tri-County Medicaid Collaborative

By: \_\_\_\_\_  
Title: \_\_\_\_\_ Date: 7/17/12

The designated contact person is:

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First name Last name  
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Email Phone

Department of Human Services, Aging and People with Disabilities

By: Jessica Soltetz  
Title: Interim District Manager Date: 7/23/12

The designated contact person is:

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Reviewed:

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

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

The designated contact person is:

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<u></u> Authorizing Signature - Signed as to form	<u>8/1/12</u> Date