

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 ("Agreement") between Jackson Care Connect (CCO) and the Rogue Valley Council of Governments (AAA/APD). "Entities" represented by Jackson Care Connect may include the Community Mental Health Program (CMHP), Primary Care Provider Clinics, and others providing care or services to Jackson Care Connect members. 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. This MOU will be reviewed by the entities on an annual basis and will be updated as necessary based on process development and evolution. Any updates to this document will be mutually agreed upon by the entities. Any disputes related to the terms of this MOU will be resolved to the mutual satisfaction of both parties.

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

1. Prioritization of high needs members in LTC		
CCO Expectation	AAA/APD Expectation	CCO/AAA/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 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. 	<ul style="list-style-type: none"> • AAA/APD will provide CCOs with access to information needed to identify members with high health care needs. • AAA/APD will define how it will integrate key health-related 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. 	<p>CCO and AAA/APD will use information available, including data provided by OHA/DHS central office, to identify a list of individuals each has in common.</p> <ul style="list-style-type: none"> • AAA/APD agrees to share key information on individuals receiving Medicaid-funded long-term care services at scheduled meetings as well as on an as needed/requested basis. • CCO agrees to factor in relevant risk assessment and screening information from AAA/APD in its case management of high needs members who are receiving Medicaid-funded long-term care services. <p>Designated contact staff:</p> <p>CCO:</p> <ul style="list-style-type: none"> • Peggy Loveless, Care Management Team Supervisor, lovelessp@careoregon.org, 503-416-5734

1. Prioritization of high needs members in LTC		
		<ul style="list-style-type: none"> • Maria Morales, Nurse Case Manager, mmorales@careoregon.org, 503-416-4930 <p>Rogue Valley Council of Governments:</p> <ul style="list-style-type: none"> • Liz Bardon, LTSS Innovator Agent, lbardon@rvcog.org, 541-423-1379 • Julie Ormand, Field Office Manager, Medford Disability Services Office, julie.ormand@state.or.us, 541-734-7508 • Silvia Ceron, Field Office Manager, Medford Senior Services Office, silvia.e.ceron@state.or.us, 541-776-6222
Shared Accountability		
<p>CCO and AAA/APD will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> • AAA/APD agrees to provide CCO with a report (currently, the "CCO report") containing data on all CCO members who are receiving Medicaid-funded long-term care services. This report will be provided monthly in an electronic format via secure email to CCO contact. • AAA/APD agrees to continue to explore ways to improve or refine the data provided to CCO. • CCO will share information about its members at care team meetings to take place at least monthly. • By August 31, 2015, the parties will explore processes to merge their data using relevant risk measures, SPL ratings and other agreed upon measures into a report of high needs members who may benefit from care coordination. • By October 31, 2015, procedures will be developed on how to select high needs members for care coordination. • By January 31, 2016, meet to evaluate effectiveness of procedures developed to identify individuals for care coordination. 		
2. Development of individualized care plans		
CCO Expectation	AAA/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 AAA/APD service plans as appropriate. ○ Individualized person-centered care plans will be jointly shared 	<ul style="list-style-type: none"> • AAA/APD will define how it will integrate key health-related 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. 	<p>CCO and AAA/APD agree to develop and document a shared care plan at case staffing meetings for each member discussed. In order to develop the shared care plan:</p> <p>CCO agrees to share its individual care plans for members who are being cared for jointly at case staffings.</p> <p>AAA/APD will also share its key information with CCO for members who are being cared for jointly at case staffings. Key client information will include the member's choice of living situation and preferences and most cost effective option to meet member care needs.</p>

2. Development of individualized care plans		
and coordinated with relevant staff from AAA/APD and with LTC providers.		<p>The goal of both entities is member involvement in care planning. Input from the member or their representative will be sought prior to case staffing meetings and acceptance of the shared care plan will be sought from the member or their representative.</p> <p>The shared care plan will document four items: problem, goal, intervention and outcome. The outcome will be updated in follow up meetings.</p>
Shared Accountability		
<p>CCO and AAA/APD will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> • Each case staffing will result in a shared care plan. A designated note taker will complete a shared care plan form developed by CCO and AAA/APD. The form will document the problem, goal, intervention and outcome. • Care plans will be distributed electronically to CCO and AAA/APD staff and any other providers (ADRC, primary care physician, behavioral health, etc.) attending each staffing and each agency will store a copy in their own record system. • The care plan will be updated with outcomes as needed and redistributed. 		

3. Transitional care practices		
CCO Expectation	AAA/APD Expectation	MOU activities
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<p>CCO and APD/AAA agree to share information on members in transition between hospital, skilled nursing and home, collaborate to ensure wrap around services are utilized based on availability and coordinate regarding post-placement needs supporting the member's health needs, care preferences, goals and most cost effective option to meet member care needs. Particular attention will be given to transitions into or out of the CCO service area for members receiving long term care services to ensure continuity of services between the old and new LTC and medical providers and CCOs.</p> <p>Information will be shared at case staffings that take place during care team meetings. Immediate need transitions will be coordinated via telephone or secure email outside of regular meeting schedules with outcomes reported during regular care team meetings.</p> <p>Members not served by APD Diversion/Transition may participate in Coleman Care Transitions Interventions provided by AAA. A work plan for</p>

		program implementation including referral protocols and workflow procedures will be developed.
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Shared Accountability		
CCO and AAA/APD will hold each other accountable in the following ways:		
<ul style="list-style-type: none"> • CCO and APD/AAA staff will complete a request for case staffing form for transitions requiring coordination between parties. The form will include all pertinent details about the transition including timeframe, locations and specific member needs. • If a transition is imminent and falls outside of regular meeting schedules, the parties will reach out to each other via telephone or secure email for coordination. The outcome will be shared at the next care team meeting for documentation in meeting notes or a shared care plan. • A work plan leading to implementation of the Care Transitions Intervention program will be developed by August 1, 2015. • Care Transitions Interventions will be fully implemented by September 1, 2015. • AAA will report Care Transitions Intervention activity and outcomes to CCO monthly beginning October 1, 2015. 		

4. Member engagement and preferences		
CCO Expectation	AAA/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 AAA/APD where relevant to LTC service planning. 	<ul style="list-style-type: none"> • 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. 	<p>CCO and AAA/APD will actively engage individuals in care coordination activities and development of a shared care plan.</p> <p>Prior to submitting a case staffing request, the CCO or APD case manager will reach out the member, inform them of the case staffing process and solicit their input regarding their goals, preferences and needs. The member will be given the opportunity to attend the staffing in person or via teleconference.</p> <p>Whether or not the member attends the staffing, their input will be included in the discussion and the final care plan will reflect the member and care giver goals, preferences, desires, and cultural needs.</p> <p>Jackson Care Connect and AAA/APD agree to explore ways to proactively identify individuals who would benefit from services designed to improve self-management skills and reduce the need for medical interventions.</p>
Shared Accountability		
CCO and AAA/APD will hold each other accountable in the following ways:		
<ul style="list-style-type: none"> • The member's goals, preferences and needs will be documented in the shared care plan developed at case staffing. The care plan form will be distributed electronically to all attendees and each agency will store a copy in their own record system. The care plan will be updated with outcomes as needed and redistributed. • AAA will educate CCO on available services and the parties will develop referral procedures by September 30, 2015. 		

5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities
<ul style="list-style-type: none"> • CCO will support the flow of information to AAA/APD. • 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. • To support care teams, CCO will <ul style="list-style-type: none"> ○ Work with AAA/APD to ensure that it identifies members receiving LTC services. ○ Include LTC providers and AAA/APD case managers as part of the team based care approach. • Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services. 	<ul style="list-style-type: none"> • 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. • 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. • AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate. • DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams. 	<p>CCO and APD/AAA will attend regularly scheduled multi-disciplinary team meetings on at least a monthly basis. At these meetings, CCO and APD/AAA will staff cases upon request from either CCO or APD/AAA.</p> <p>The process for requesting a staffing and developing a care plan will generally be:</p> <ul style="list-style-type: none"> • Party requesting the staffing will complete a request form at least one week prior to care team meeting. The form will be distributed via secure email. • Whichever agency is responsible for the info/assistance being requested will share the form with case managers, ADRC staff, care coordinators, etc. to prepare for the staffing. • In cases where an issue can be resolved without a full multidisciplinary team, the responsible party will simply report on the resolution at the meeting and the requestor will determine if that resolution is enough or if the case needs to be revisited at a later date. • Party requesting the staffing will notify the member of the meeting and talk about their goals and needs. The member will be invited to attend or participate by phone if they wish. • Primary care provider, behavioral health or other providers may be invited to attend the meeting • Staffing meeting structure: <ul style="list-style-type: none"> ○ Provide details on the case, expand on the intake summary from the request form ○ Identify the issues to be addressed by each organization ○ Identify goals of the member and their care team ○ Develop interventions to address issues and meet goals ○ Determine follow up date to report on outcomes • Care plan will be documented by the meeting's note taker • Outcomes will be added to the plan when follow up meeting occurs. <p>Members who are not receiving long term care services may also be</p>

5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities
		brought forward for consultation. AAA/APD will provide consultation on CCO members who are not receiving long term care to the extent possible.
Shared Accountability		
CCO and AAA/APD will hold each other accountable in the following ways:		
<ul style="list-style-type: none"> • Meetings will be held at least monthly • Requests for case staffing will be documented on a request form • Individualized care plans developed at care team meetings will be documented in writing and distributed to all parties • The care plans will be updated and redistributed as outcomes are reported at follow up meetings. 		

Signatures and Contacts

For Jackson Care Connect (CCO)

The designated contact person is:

Jennifer

Lind

First name

Last name

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503-416-3683

Email

Phone

Authorizing Signature

Date

18 May 2015

For Rogue Valley Council of Governments (AAA/APD District Office)

The designated contact person is:

Dave

Toler

First name

Last name

