

## 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 PacificSource Community Solutions and the District 10 APD Office. 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, PacificSource Community Solutions and District 10 APD office 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"> <li>• 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"> <li>○ CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers.</li> <li>○ CCOs will define how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will provide CCOs with access to information needed to identify members with high health care needs.</li> <li>• 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.</li> </ul>	<p>Beginning on August 1, 2012, PSCS CCO and APD will share information about potentially high risk members, and will revisit in 6 months whether these agreements have been effective in identifying high risk members. Prior to August 1, 2012 agreement will be reached by both organizations regarding how this population will be defined.</p> <p>PSCS CCO and APD office will use information available, including data provided by OHA/DHS central office, to identify individuals each organization has in common.</p> <p>PSCS CCO and APD office will share key information as appropriate from each entity's risk assessment. Recognizing that this process will be evolutionary, PSCS and APD office will work together to develop a process to share the information that includes the following elements:</p> <ul style="list-style-type: none"> <li>• APD staff will share key information for its highest needs individuals served by the PSCS CCO, such as: those identified</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations.</li> </ul>		

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

CCO Expectation	AAA/APD Expectation	CCO/AAA/APD agreements:
		<p>as having the most needs for assistance with activities of daily living - (service priority levels 1-3). APD office staff will also share this information for members that are known to have other complex conditions, high ER usage, or other complicating circumstances on an ad hoc or individual basis.</p> <ul style="list-style-type: none"> <li>• CCO agrees to share key information from assessments such as individual risk assessments for individuals defined as high needs, as well as relevant information from community health assessments.</li> </ul> <p>Methods of information sharing:</p> <ul style="list-style-type: none"> <li>• Meet monthly regarding shared members with representation from both organizations.</li> <li>• Information will be shared as appropriate.</li> <li>• Information will be shared electronically if available, by fax or email to the designated contact person or back-up.</li> <li>• As CCO and APD data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing.</li> </ul> <p>Designated contact staff</p> <ul style="list-style-type: none"> <li>• PSCS CCO: [Signature]</li> <li>• [Signature]</li> </ul>

1. Prioritization of high needs members in LTC		
CCO Expectation	AAA/APD Expectation	CCO/AAA/APD agreements:
		<ul style="list-style-type: none"> <li>• To...</li> <li>• ...</li> <li>• ...</li> </ul> <p>PSCS CCO and APD will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> <li>• PSCS CCO and APD will meet quarterly with the first meeting scheduled for February, 2013 , 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</li> <li>• 3 months after effective date, PSCS CCO and APD will meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.</li> </ul>

2. Development of individualized care plans

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CCO Expectation	AAA/APD Expectation	MOU activities
<ul style="list-style-type: none"> <li>• 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"> <li>○ Plans will reflect member or family/caregiver preferences and if possible, goals captured in APD service plans as appropriate.</li> <li>○ Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from APD and with LTC providers as appropriate.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local APD offices into CCOs' individualized care plans for members with intensive care coordination needs as appropriate.</li> </ul>	<p>Within 3 months after implementation of CCO, the CCO and APD office will share individual care plans as appropriate for members that are shared between the organizations. A process will be developed to share the above information as needed or as new care plans are developed. PSCS CCO and APD will develop a process to include APD and PSCS contact information for each individual's care coordinator and/or primary care home for purposes of care coordination.</p> <p>PSCS CCO and APD will share key client information for individuals that the CCO 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 CCO as new care plans are developed. Key client information will include:</p> <ul style="list-style-type: none"> <li>• Client choice of living situation and preferences</li> <li>• APD case manager contact information</li> <li>• LTC provider contact information</li> </ul> <p>CCO and APD/AAA will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> <li>• By February 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</li> <li>• In 3 months after effective date, PSCS CCO and APD will meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with</li> </ul>
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2. Development of individualized care plans	
OHA/DHS metrics and accountability efforts.	

3. Transitional care practices		
CCO Expectation	AAA/APD Expectation	MOU activities
<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<p>PSCS CCO and APD will coordinate and communicate regarding transitions in care for shared members receiving LTC services. A process will be developed to monitor improvement in transitions in care once communication pathways are established. The goal of these communication pathways will be to ensure members receive comprehensive transitional care as required by HB 3650.</p> <p>CCO and APD/AAA will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> <li>By February 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</li> <li>In 3 months after effective date, PSCS CCO and APD will meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.</li> </ul>
<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations.</li> </ul>		

4. Member engagement and preferences		
CCO Expectation	AAA/APD Expectation	MOU activities

<ul style="list-style-type: none"> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>	<p>PSCS CCO and APD will actively engage individuals in the design and implementation of their LTC service plan where relevant to health care treatment and care planning. A process will be developed to mutually engage members in the treatment and care planning as appropriate. This process will include relevant information solicited from the client by either PSCS CCO or APD organization. It will also include documentation included in the CAPs system. A communication process will be developed between PSCS CCO and APD to include members as appropriate.</p>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations.</li> </ul>		<p>CCO and APD/AAA will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> <li>• By February 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</li> <li>• In 3 months after effective date, PSCS CCO and APD will meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.</li> </ul>

5. Establishing member care teams		
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<ul style="list-style-type: none"> <li>• CCO will support the flow of information to APD for appropriate members.</li> <li>• The CCO-appointed lead provider or care team will confer with all providers responsible for a member's care, including identified LTC providers and APD staff.</li> <li>• To support care teams, CCO will               <ul style="list-style-type: none"> <li>○ Work with APD to ensure that it identifies members receiving LTC services.</li> <li>○ Include LTC providers and APD case managers as part of the team based care approach as needed.</li> </ul> </li> <li>• Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate.</li> <li>• DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.</li> </ul>	<p>PSCS CCO and APD will share information for appropriate members as identified by PSCS CCO or APD. PSCS CCO and APD will develop a process for joint participation in member care teams as appropriate.</p> <p>PSCS and APD will work together to develop processes around sharing member information. This could include expanded access to systems that have information of shared members.</p> <p>CCO and APD/AAA will hold each other accountable in the following ways:</p> <ul style="list-style-type: none"> <li>• By February 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</li> <li>• In 3 months after effective date, PSCS CCO and APD will meet to determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations.</li> </ul>		

Signatures and Contacts

For Pacific Service Community Solutions (CCO)

The designated contact person is:

First name \_\_\_\_\_ Last name \_\_\_\_\_  
 Email \_\_\_\_\_ Phone \_\_\_\_\_  
 Authorizing Signature \_\_\_\_\_ Date 6/20/12

For APD District 10 (AAA/APD District Office)

The designated contact person is:

Douglas \_\_\_\_\_ Brewer \_\_\_\_\_  
 First name Last name  
douglas.s.brewer@state.or.us \_\_\_\_\_ (541) 693-8694 \_\_\_\_\_  
 Email Phone  
[Signature] \_\_\_\_\_ 6/20/12 \_\_\_\_\_  
 Authorizing Signature Date

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

The designated contact person is:

<u>Patricia</u> First name	<u>Baxter</u> Last name
<u>patricia.e.baxter@state.or.us</u> Email	<u>503-945-5858</u> Phone
<u>Patricia Baxter</u> Authorizing Signature -Signed as to form	<u>7/2/12</u> Date