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.

Purpose

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 PrimaryHealth (CCO) and the Douglas County (AAA) and DHS-APD district office. "Entities" represented by PrimaryHealth may include the Community Mental Health Program (CMHP), Primary Care Provider Clinics, and others providing care or services to PrimaryHealth 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.

Agreement

Now therefore, PrimaryHealth (CCO) and Douglas County (AAA) and DHS-APD district 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:
• 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. o CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers. o CCOs will define how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services.	• AAA/APD will provide CCOs with access to information needed to identify members with high health care needs.	*Beginning on December 1, 2012 or sooner, APD/AAA and PrimaryHealth will develop a strategy for uniform identification and prioritization of high risk members. This strategy will be built through ongoing meetings and case example analysis. Initially, prioritization and identification will be focused towards a small number of high risk cases that are known by the participating organizations. These are otherwise defined as individuals that are likely utilizing services of LTC, Physical Health, and/or Mental Health, but are not making progress towards goals, desired outcomes or appropriately utilizing the entities' services. Entities will systematically review the case examples to identify the most appropriate circumstances and process to follow for information exchange. Through the case examples, processes will be built and implemented to meet the needs of all entities.* *A primary goal of case analysis will be the identification of a common definition of what characteristics a "high risk" individual may possess. Creating a common definition of "high risk" will allow all entities to better recognize and refer when appropriate.* *APD/AAA and PrimaryHealth will discuss each organizations process in conducting risk assessments and screenings, and the usual course of action taken*

		for positive screenings. *APD/AAA and PrimaryHealth will work toward goals of a systematic process for identification and prioritization of common high needs members. APD/AAA will flag members with agreed upon indicators for "high risk" or complex circumstances on an ad hoc or individual basis to the CCO. Once flagged, AAA/APD information that may be shared includes service priority level, risk and goal information from CAPS assessments or other assessment tools.* *PrimaryHealth agrees to share information from member health risk assessments and other sources such as inpatient utilization reviews with designated APD/AAA staff for members meeting the common definition of high risk.*
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		*APD/AAA and PrimaryHealth will revisit annually whether these agreements have been effective in identifying "high risk" members, along with documenting the evolution of the strategy/process between agencies.* *Activity related to the completion of this element will begin in December, 2012. Developmental activities will take place throughout the year, with the completion date being August 31, 2013.*

2. Development of individualized care plans		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCOs' individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTC services and supports needs. o Plans will reflect member or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate. o Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD and with LTC providers.	• 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.	*APD/AAA and PrimaryHealth will share information about how individualized care plans are created by each organization.* *APD/AAA and PrimaryHealth will first address and overcome barriers to sharing information related to the HIPAA Privacy Act.* *APD/AAA and PrimaryHealth will complete confidentiality agreements and/or Business Associate Agreements necessary to share information pertinent to collaborative case management and care planning.* *Case analysis by APD/AAA and PrimaryHealth will determine a common definition of "high risk" individuals. For those that are determined to be High Risk, the individual care plan will be shared between entities. In extreme cases, care team meetings between entities may be held to develop a common care plan strategy.* *A process for sharing the individualized care plan will be developed through case analysis in early meetings. Entities may work towards a central point of contact. Strategies for sharing care plans may reflect information about the supportive and therapeutic needs of each member including member and care*

		giver preferences and be culturally sensitive. The care plan should include measureable goals and indicators of success.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		*APD/AAA and PrimaryHealth will revisit annually whether these agreements have been effective in creating and sharing individualized care plans.* *Activity related to the completion of this element will begin in December, 2012. Developmental activities will take place throughout the year, with the completion date being August 31, 2013.*

3. Transitional care practices		
CCO Expectation	AAA/APD Expectation	MOU activities
• 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.	• 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.	*Primary Health and AAA/APD will review the transition of care process and work collaboratively to enhance existing systems. To do this, Primary Health and AAA/APD will include agencies such as long-term care facilities and acute care hospitals to discuss current processes/systems for notification of needs and transition planning. Through these collaborations a process of communication pertinent to care transitions will be developed.* *Each organization will identify roles and responsibilities associated with ensuring successful transitions of care.*
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		*APD/AAA and PrimaryHealth will revisit annually whether these agreements have been effective in creating and sharing individualized care plans.* *Activity related to the completion of this element will begin in December, 2012. Developmental activities will take place throughout the year, with the completion date being August 31, 2013.*

4. Member engagement and preferences		
CCO Expectation	AAA/APD Expectation	MOU activities
• 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.	• 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.	*AAA/APD and Primary Health will work directly with the consumer and each other to develop a person centered long term care plan taking into consideration the member and care giver goals, preferences, desires, and cultural needs. The care plan should include measureable goals and indicators of success. Everyone's role, including the members, will be defined in the care plan to ensure maximum success.* *The entities will work collaboratively to implement the care plan.*
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		*APD/AAA and PrimaryHealth will meet and discuss processes and progress towards goals. The entities will indentify barriers and lessons learned to adjust business practices as needed. Will revisit annually to determine effectiveness.* *Activity related to the completion of this element will begin in December, 2012. Developmental activities will take place throughout the year, with the completion date being August 31, 2013.*

5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCO will support the flow of information to AAA/APD.	• 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.	*APD/AAA and PrimaryHealth will identify key staff to begin the initial coordination and strategic planning phase. Lead staff will be identified in each organization for participation in the CCO transition and integration project.*
• 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.	• 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.	*The lead staff identified through each agency will coordinate what information is needed for targeted consumers. As APD develops reports that identify members, information will be shared.*
• To support care teams, CCO will o Work with AAA/APD to ensure that it identifies members receiving LTC services. o Include LTC providers and AAA/APD case managers as part of the team based care approach.	• AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate.	*Through strategic planning APD/AAA and PrimaryHealth will figure out the most efficient way to share information for team based care based on the target population.*

• Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.	• DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.	*As minimum standards are provided by DHS, APD/AAA and PrimaryHealth will work towards meeting those standards of participation.*
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		*APD/AAA and PrimaryHealth will meet and discuss processes and progress towards goals. Will identify barriers and lessons learned to adjust business practices as needed. Will revisit annually to determine effectiveness.* *Activity related to the completion of this element will begin in December, 2012. Developmental activities will take place throughout the year, with the completion date being August 31, 2013.*

COORDINATED CARE ORGANIZATION: PRIMARY HEALTH OF JOSEPHINE COUNTY, LLC

Authorized Signature

Print Name

Title

11/16/12
Date

The designated contact person is:

Name

E-mail Address Phone

DOUGLAS COUNTY AAA:

Authorized Signature

Douglas County Board of Commissioners
By
Chair
By
Commissioners
By
Commissioners
Date 11·28·12

The designated contact person is:

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REVIEWED AS TO FORM
By
Office of County Legal Counsel
Date: 11/21/2012

FOR: DEPT. OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES
DISTRICT 6 OFFICE

Merry Bayly
Authorized Signature

_Merry L. Bayly_____
Print Name

__District Manager _____
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FOR: DEPT. OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES
CENTRAL OFFICE

Patricia Baxter
Authorized Signature - Signed as to form

Patricia Baxter_____
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_Chief Operating Officer_____
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12/12/12
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