

## 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 Willamette Valley Community Health LLC (CCO) and NorthWest Senior & Disability Services (NWSDS). 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.

### Agreement

Now therefore, CCO and NorthWest Senior & Disability Services agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	Area Agency on Aging (AAA)/Aging and People with Disabilities (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</li></ul>	<ul style="list-style-type: none"><li>• AAA/APD will provide CCOs with access to information needed to identify members with</li></ul>	<p>In order to assist with selection of members designated as "high risk", NWSDS agrees to share with CCO the service priority level and information from standardized risk assessment in the Client Assessment and Planning</p>

<p>intensive care coordination for high needs members receiving Medicaid funded LTC services.</p> <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>	<p>high health care needs.</p>	<p>System (CA/PS), of individuals with service priority level 1-4 living in their own home or community based setting. Effective date for sharing of this information is dependent upon necessary report(s) from DHS, Aging and People with Disabilities (APD). It is expected that necessary reports would be available to NWSDS not later than December 2012.</p> <p>Additionally, NWSDS agrees to share with CCO information regarding in-home service clients the Case Manager believes to be at risk due to accepting lower than authorized care plan, anyone with a notice for eviction or involuntary move out. Since this information is not dependent on outside reports, NWSDS agrees to begin relaying this information to the CCO in September 2012.</p> <p>CCO agrees to share information from community health assessments and individual risk assessments of individuals and communities defined as high risk with designated NWSDS staff.</p> <p>As CCO and APD data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing.</p>
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		<p>Methods of information sharing:</p> <ul style="list-style-type: none"> <li>Information will be shared monthly by the 15<sup>th</sup> of the month. Information will be shared electronically if available, by fax or email to the designated contact person or back-up.</li> </ul> <p>CCO and NWSDS agree to coordinate and mutually agree upon final number of high need members that will receive intense care coordination as defined in this document. Additionally, it is agreed that either CCO or NWSDS may offer up individual members for consideration of intensive care coordination outside of the specific parameters listed here.</p> <p>Both entities agree to revisit these criteria in June 2013, and annually thereafter, to determine whether these agreements have been effective in identifying high risk/need members.</p>
<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations</li> </ul>		<p>CCO and NWSDS agree to conduct regular meetings to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization.</p>

## 2. Development of individualized care plans

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 goals captured in AAA/APD service plans as appropriate.</li> <li>○ Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD and with LTC providers.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <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>By August 2013, the CCO will share information with NWSDS on individual health goals, annually or as determined.</p> <p>Beginning January 1<sup>st</sup>, 2013 NWSDS will share with CCO information for designated members regarding their choice of living situation as noted on DHS client choice form. Additionally, stated client preferences and goals as documented in CA/PS will be relayed as appropriate. Contact information for surrogate decision makers will also be provided (conservator, legal guardian, and health care power of attorney) as Agency is aware.</p> <p>Also beginning January 1<sup>st</sup>, 2013 for members other than those receiving care in their own home; current care provider type and contact information will be relayed by NWSDS to CCO.</p> <p>CCO will provide NWSDS information regarding member's health goals to be included in NWSDS long term care file.</p> <p>Information will be integrated into individual service or care plans by January 2014.</p>

<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations</li> </ul>		CCO and NWSDS agree to conduct regular meetings to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization
<b>3. Transitional care practices</b>		
<b>CCO Expectation</b>	<b>AAA/APD Expectation</b>	<b>MOU activities</b>
<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>NWSDS will notify CCO within 7 days of receipt of information regarding member move. Including; date of move, new address, type of LTC setting, member contact number, provider contact number. CCO to reciprocate if they are aware of move first.</p> <p>NWSDS and CCO will work collaboratively to develop agreements around post hospital/skilled placement and roles that are most efficient, yet prevent cost shifting or increases to LTC nursing home case load.</p>

<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations</li> </ul>	<p>NWSDS will continue to monitor ICF Nursing Home Count.</p> <p>Additionally, CCO and NWSDS will specifically address degree to which entities are collaborating on care transitions to ensure positive outcomes for members.</p>
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<b>4. Member engagement and preferences</b>		
<b>CCO Expectation</b>	<b>AAA/APD Expectation</b>	<b>MOU activities</b>
<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>Beginning January 1<sup>st</sup>, 2013 NWSDS agrees to share with CCO pertinent details of individual member barriers to achieving health goals that staff are aware of. This includes; homelessness, misuse of medications, no phone, lack of accessible transportation, minimal or insufficient social supports.</p> <p>CCO will share with NWSDS similar barriers to achieving health goals; member routinely does not follow up with scheduled appointments, does not have primary care provider, known gaps in provider capacity in the community.</p>

<ul style="list-style-type: none"> <li>MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations</li> </ul>	<p>CCO and NWSDS are each committed to establishing and maintaining effective communication through regularly scheduled meetings.</p>
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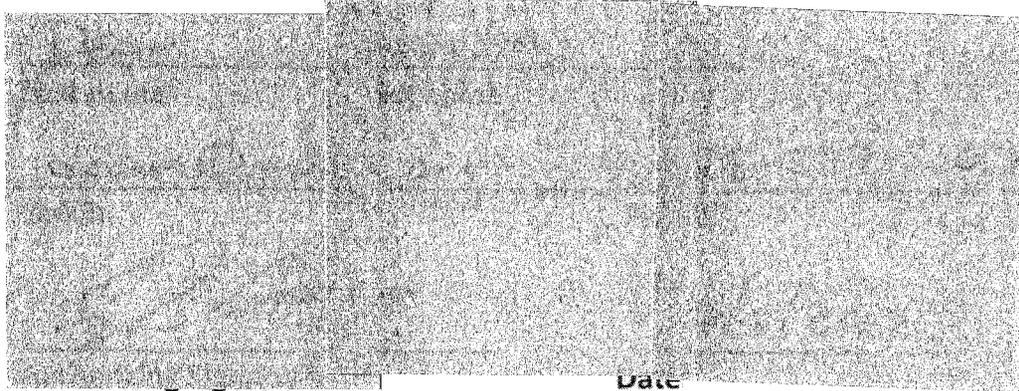
5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities
<ul style="list-style-type: none"> <li>CCO will support the flow of information to AAA/APD.</li> </ul>	<ul style="list-style-type: none"> <li>AAA/APD will define roles, responsibilities and process for assignment of and participation in the CCO care team, including coordination with CCO lead care coordinator, for members needing routine and intensive care coordination.</li> </ul>	<p>With regard to members identified as “high need” as outlined in number 1 of this document, effective January 2013, NWSDS and CCO agree to; develop efficient process for interdisciplinary team (IDT) meetings, identify contacts for IDT and convene IDT monthly.</p>
<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<p>Please see numbers 2 and 3 of this document.</p>

<ul style="list-style-type: none"> <li>• To support care teams, CCO will <ul style="list-style-type: none"> <li>○ Work with AAA/APD to ensure that it identifies members receiving LTC services.</li> <li>○ Include LTC providers and AAA/APD case managers as part of the team based care approach.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate.</li> </ul>	<p>CCO and NWSDS recognize the importance of providing team-based care. The two organizations will work towards utilizing health information technology that enables members of the interdisciplinary care team to assess patient information that is accurate and up to date. Both organizations agree that team-based care is essential to improving patient outcomes and are committed towards continuously enhancing the performance of the interdisciplinary care teams. We anticipate having access to secure electronic e-mail in September 2012, thus facilitating the ready exchange of information identified in this document.</p>
<ul style="list-style-type: none"> <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>• DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.</li> </ul>	<p>CCO and NWSDS agree to work towards integrating appropriate staff into the interdisciplinary care team. Work has already begun to identify LTC providers that provide care for potentially "high need" clients. This integration will enable both organizations to provide care that reflects the unique needs of each member. Both organizations will attempt to identify case management software that facilitates the documentation and provision of care provided by the interdisciplinary care team.</p>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations</li> </ul>		<p>CCO and NWSDS agree to conduct regular meetings to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization.</p>

**Signatures and Contacts**

For Willamette Valley Community Health, LLC (CCO)

The designated contact person is:



For NorthWest Senior & Disability Services (AAA/APD District Office)

The designated contact person is:

Rodney Schroeder  
First name                      Last name

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Email: Rodney.Schroeder@nwscds.org Phone: 503 304-3655

Rodney Schreder

Authorizing Signature

8/9/12

Date

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

**The designated contact person is:**

Patricia

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Baxter

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Email

(503) 945- 5858

Phone

Patricia Baxter

Authorizing Signature - Signed as to form

9/5/12

Date