

## GLOSSARY: MOU GUIDANCE

This Glossary is a communication tool which attempts to provide informal explanations of terms which may be used in discussions regarding the MOU. These terms should *not* be considered as alternatives to the legal or statutory definitions which are used in contract or regulatory processes.

**Addictions Services** – Refers to alcohol and other drug treatment and recovery services.

**Aging and People with Disabilities (APD)** – A division in the Department of Human Services (DHS) that runs programs for seniors and people with disabilities. The name was recently changed from “Seniors and People with Disabilities” (SPD). APD is not the primary agency for services to individuals with developmental disabilities or mental health issues.

**Area Agency on Aging (AAA)** (Type B) – Locally governed and managed offices responsible for both Medicaid-funded long term Care (LTC) and Older American Act services in the following counties: Clatsop, Tillamook, Polk, Yamhill, Marion, Multnomah, Linn, Benton, Lincoln, Lane, Douglas, Jackson, Josephine Counties. These offices will be required partners in the development of Memo of Understanding (MOU). Area Agencies on Aging (Type A) exist in other areas of the state who do not provide Medicaid services and who therefore will not be required partners in development of MOUs.

**Behavioral Health** – Refers to the full range of Mental Health and Addictions Services.

**Chronic Conditions** – A medical disease or condition, such as diabetes, arthritis, congestive heart failure or asthma that persists over time is marked by frequent recurrence and which requires proactive outpatient treatment to prevent or minimize deterioration. This term is not used for behavioral health diagnoses.

**Coordinated Care Organizations (CCO)** – Business responsible for integrated, comprehensive medical care envisioned by Health Systems Transformation and which will have a contract with Oregon Health Authority to provide Medicaid funded medical and behavioral health services using a capitated model of financing.

**Centers for Medicare and Medicaid Services (CMS)** – Federal agency responsible for Medicaid and Medicare.

**Dually Eligible Individuals, or Individuals who are Dually Eligible** – Dually eligible individuals refers to individuals who are eligible and receive both Medicare and Medicaid behavioral health and medical benefits. Persons who also have Medicaid long term care benefits might be referred to as individuals who are ‘triple eligible.’ “Duals” is a short cut term for ‘dually eligible individuals’ and its use should be avoided as it can be considered objectionable.

**Department of Human Services (DHS)** – Department within the State of Oregon which provides many programs designed to assist Oregonians to be independent, healthy, and safe. Aging and People with Disabilities is one of five program areas within this Department.

**Developmental Disability** – A medically diagnosed condition that starts before age 18 (or 22 in the case of Traumatic Brain Injury) and which prevents normal adaptive and/or intellectual functioning.

**Evidence Based or Best Practices Approaches** – Approaches identified through empirical research or practice which can achieve desired, verifiable health or service outcomes.

**Fee for Service** – A method of paying an established fee for a unit of service after it has been delivered.

**Flexible Service** – A service that is provided as an alternative or in addition to a more traditional type of medical or behavioral health service. Flexible Services may include, but are not limited to: respite care, partial hospitalization, sub-acute psychiatric care, family support services, parent psychosocial skills development, peer services and non-traditional workforce activities including peer wellness specialists, personal health navigators, community health workers and other healthcare workers who might be identified in a contract or by a person’s care team.

**Flexible Service Approach** – means the delivery of any medical or behavioral health service provided by the Coordinated Care Organization in a manner or place different from the traditional manner or place of service delivery. A Flexible Service Approach may include delivering traditional or non-traditional services at alternative sites such as schools, residential facilities, nursing facilities, members' homes, emergency rooms, offices of DHS, OHA, other community settings; offering flexible clinic hours and using peers, paraprofessionals, community health workers, peer wellness specialists, or personal health navigators who are culturally competent to strengthen engagement efforts with members.

**Health Services** – Services obtained through a person’s medical provider or health insurance.

**Health Systems Transformation (HST)** – A range of programs and initiatives activated by state and federal legislation developed to improve access to healthcare, improve health outcomes and lower healthcare costs. Development of CCO’s is a critical part of this effort.

**Home and Community Based Services Waiver (HCBS)** – Within broad Federal guidelines, states can develop home and community-based services programs to meet the needs of people who prefer to get long-term care services and supports in their home or community rather than in an institutional setting.

**Individualized Care Plan** – See also **Person-Centered Care**. A plan developed by the individual and the individual’s inter-disciplinary care team to provide services and supports to meet the individual’s medical, behavioral, and social needs.

**Interdisciplinary Care Team (IDT)** – A team that develops the individualized, person-centered care plan and/or coordinates services across medical, behavioral and long term care systems. Ideally an IDT includes the individual, the individual’s primary care physician, long term care provider, case manager, non-traditional health care worker, other health professionals as well as family members.

**Learning Collaboratives** – A jointly developed event or process for sharing knowledge between health care providers and community organizations serving mutual clients.

**Long Term Care Services and Providers** – Services and supports provided to assist persons who are aged, blind or have disabilities for long periods of time. In Oregon, long term care providers include nursing facilities, assisted living facilities, residential care facilities, specialized living facilities, adult foster homes, and in-home services and supports provided by Home Care Workers or in-home service agencies. Services are funded through state and federal Medicaid programs. Long term care services also exist for medically fragile children and persons with intellectual and developmental disabilities.

**Medicaid** – A federal and state funded portion of the medical assistance programs also referred to as Title XIX or the Oregon Health Plan (OHP). Medicaid has a range of programs with differing eligibility standards.

**Medicaid State Plan** – The State Plan is the official statement describing the nature and scope of Oregon State's Medicaid program.

**Medicare** - A federally administered program offering health insurance benefits for persons aged 65 or older and persons who have been determined by Social Security to have long term disabilities.

**Medicare Advantage Plans** - Known as Medicare Part C, Advantage plans provide Medicare-covered benefits to members and may in addition to Part A and B benefits and Part D pharmaceutical benefits, offer extra benefits that Medicare does not cover, such as vision or dental services.

**Memorandum of Understanding (MOU)** – A written agreement between a CCO and a Type B AAA or DHS/APD District office defining the roles and services that will be provided to ensure that CCO and Medicaid long term care services for shared clients are coordinated. Type A AAAs may also be party to these agreements but are not mandatory participants.

**Mental Health Services** – Refers to outpatient and in patient mental health services ranging from prevention, crisis intervention and planning for children and adults. Services delivered will not include state hospitalization. Residential services funded under behavioral health Medicaid have been phased into the CCO responsibilities.

**Metrics** –Data or performance measures which describe health care experiences which can be quantified or compared. Information can be collected from structures, process or outcomes. While outcomes are the ultimate measurement goal, in the early phases of system transformation most of the metrics gathered will be focused on structure and process measures to create baselines and identify reasonable benchmarks.

**Non-Traditional Health Workers** – Refers to the use of certified and/or qualified health care interpreters, personal health navigators, peer wellness specialists and community health workers who meet competency standards established by the OHA.

**Oregon Health Authority (OHA)** – The authority that administers the funds for Medicaid and which will execute contracts with Coordinated Care Organizations.

**Oregon Health Policy Board** – The nine-member Oregon Health Policy Board (OHPB) which serves as the policy-making and oversight body for the Oregon Health Authority.

**Older Americans Act-** A federal program separate from Medicaid which provides funding for a range of services for elderly persons which are administered **through** Aging and People with Disabilities and delivered locally by Area Agencies on Aging (AAA's). These social support services include; prevention and wellness programs, information/assistance/outreach, in-home assistance, family caregiver supports, respite, transportation, home and congregate meals, legal assistance and caregiver counseling/support. The AAA's which provide these services are important community partners for CCO's.

**Person-Centered Care** – A practice of identifying what is important to and for an individual and the social, health, behavior and financial supports they will need. Person-centered care is always provided in a manner that balances issues of risk and safety with the person's goals and preferences.

**Patient-Centered Primary Care Home (PCPCH)** – The Patient-Centered Primary Care Home is a new model of primary care that focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs. PCPCHs are expected to provide person centered care with attention to the person's social, physical and behavioral health care needs.

**Physical Health Services** – Refers to medically necessary services including the care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem. Oregon prefers to use the more inclusive "health services" term noted above when referring to the comprehensive services are envisioned to provide.

**Program for All Inclusive Care for the Elderly (PACE)** – The Program for all Inclusive Care for the Elderly (PACE) is provided by a managed care entity that provides medical, dental, mental health, social services, transportation and long-term care services to persons age 55 and older on a pre-paid capitated basis in accordance with a signed agreement with the state and CMS. PACE programs may be provided as an alternative to CCOs.

**Shared Accountability** – Medicaid funded long-term care services are legislatively excluded in HB 3650 from CCO global budgets and will continue to be paid for directly by the state through the Department of Human Services. This exclusion is called a 'carve out' and creates the possibility of misaligned incentives between the CCO's and the long-term care (LTC) system. In order to reduce costs and assure shared responsibility for delivering high quality, person-centered care CCO's and the LTC system will need to share accountability for the services provided to mutual clients.

Accountability will be measured in early years through reporting methodologies which will inform the development of performance measures. Financial incentives and penalties may be created in the future. A memorandum of understanding between the local CCO and APD/AAA is a mandatory method of shared accountability.

**Special Needs Plans** – The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) coordinated care plan (CCP) that was specifically designed to provide targeted care to individuals with special needs. Some special needs plans target dually eligible persons and provide coordinated Medicaid and Medicare services.

**Transitional Care** – General term to identify the activities and coordination that must occur as individuals with health and long term care needs move between locations and/or different service programs. The goal of transitional care is to have the communication and continuity of service needed to support the individuals health, preferences and goals. Transitional Care is usually required when persons move between hospitals, sub acute and post acute nursing facilities, the individual's identified home, primary and specialty care.

**Waiver or 1115 Waiver** – A waiver granted by CMS which allows a state to use federal funds to support a demonstration that promotes the objectives of Medicaid while providing services in new manner. Services provided under the Oregon Health Plan's Standard and Plus programs are examples of an 1115 Waiver.