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 AllCare, Rogue Valley Council of Governments, Aging and People with Disabilities District 7 (Curry County service area), Aging and People with Disabilities District 6 (Douglas County) and Douglas County Senior and Disability Services. 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, AllCare (CCO) and Rogue Valley Council of Governments, Aging and People with Disabilities District 7, Aging and People with Disabilities District 6 and Douglas County Senior and Disability Services (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:

• 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.
  • 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.
	• 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.
		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.
		  • AAA/APD agrees to provide CCO with relevant data on all CCO members who are receiving Medicaid-funded long-term care services.
		  • AAA/APD agrees to continue to explore ways to improve or refine the data provided to CCO.
		  • 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.
		
		CCO and AAA/APD will develop methods to proactively identify and intervene with members who are at risk of becoming high needs.

1. Prioritization of high needs members in LTC		

		• CCO agrees to share information on members who do not meet the definition of high risk but may be trending towards high risk and would benefit from evidence-based interventions provided by AAAs or other service providers in each county.
		• AAA/APD agrees to connect CCO members to evidence-based services and other supports as available within each county.
		
		Designated contact staff:
		
		AllCare CCO:
		• Claudia Pohling, Care Teams Supervisor, cpohling@mripa.org, (541) 471-4106.
		
		AAA/APD:
		• APD District 7, Curry County:
		  ○ APD Diversion/Transition team:
		  ▪ Brad Olds, brad.g.olds@state.or.us, 541-469-9299, ext. 233
		  ▪ Gayle Christiana, gayle.m.christiana@state.or.us, 541-756-2017
		  ▪ Karen Wright, karen.m.wright@state.or.us, 541-756-2017
		  ▪ Carl Fair, carl.n.fair@state.or.us, 541-756-2017
		  ○ APD Diversion/Transition support staff
		  ▪ Dena McDonald, dena.l.mcdonald@state.or.us, 541-756-2017
		• Douglas County Senior and Disability Services
		  ○ Merry Bayly, APD District Manager, merry.l.bayly.@dhsoha.state.or.us
		  ○ Jeanne Wright, AAA Director, jlwright@co.douglas.or.us, 541-400-3608
		• Rogue Valley Council of Governments
		  ○ Carol Terry, carol.a.terry@state.or.us, 541-471-2863
		  ○ Karen Kahl, Karen.k.Kahl@state.or.us, 541-471-3844 (Grants Pass Aging and People with Disabilities)
		  ○ Julie Ormand, Julie.Ormand@state.or.us, 541-734-7508

1. Prioritization of high needs members in LTC		
		(Medford Disability Services Office) o Lori Rathburn, Lori.k.Rathburn@state.or.us,- 541-618-7866 (Medford Senior Services Office)

Shared Accountability

CCO and AAA/APD will hold each other accountable in the following ways:

- 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 care team supervisors.
- CCO will share information about Jackson and Josephine County members at weekly provider partner meetings. Individual cases are brought forward at the meetings both reactively and proactively.
- CCO, its care coordination contractor, Liberty Advocacy, and APD District 7 will meet at least monthly to share information about high needs members. Meetings will include complex case staffing as well as information sharing.
- Due to the small size of the shared population in Douglas County, AllCare will share member information on an as needed basis. AllCare staff will meet in person with APD District 6 staff at least annually.
- CCO and AAA/APD will meet quarterly 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.
- By September 1, 2015, CCO and AAA/APD will develop methods to cross reference high cost, high needs CCO member lists with report of CCO members receiving long term supports and services.

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.
  • 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
	• 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.	AllCare's individualized, person-centered care plans include information about the supportive and therapeutic needs of the member including long term services and supports needs. Plans reflect member or family/caregiver preferences and goals captured in APD service plans as appropriate.
		
		AAA/APD shares key information from its person-centered care plans with CCO as needed. In addition, AAA/APD will share a report monthly of CCO members who are receiving Medicaid long term care services. Key client information will include:
		  • Member choice of living situation and preferences and most cost effective option to meet member care needs

2. Development of individualized care plans		
and coordinated with relevant staff from AAA/APD and with LTC providers.		• APD case manager contact information • LTC provider contact information
Shared Accountability		
CCO and AAA/APD will hold each other accountable in the following ways: • By December 31, 2016, CCO and AAA/APD will develop a formal, proactive process to jointly share information from individualized person-centered care plans in coordination with relevant staff and with LTC providers. • CCO and AAA/APD will meet quarterly 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		

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.	CCO Transitions of Care nurses follow members as they move from hospital to skilled nursing to home. • CCO shares information about members in transition with AAA/APD in Josephine County. AAA/APD agrees to share information with CCO regarding member transitions from skilled nursing to Medicaid home and community-based services • This may be informational-only if coordination is not needed • Coordination needs will be determined on a case by case basis AAA/APD agrees to share information regarding changes in caregivers for CCO members receiving Medicaid-funded long term care. • This information will be reflected on the monthly report of CCO members receiving long term care services. CCO and AAA/APD agree to coordinate all 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. In Jackson and Josephine Counties, CCO agrees to refer members

		transitioning from hospital or skilled nursing facility to home to Rogue Valley Council of Government's (RVCOG) Coleman Care Transitions program
		• RVCOG agrees to initiate Coleman Care Transitions interventions with members in Jackson and Josephine Counties who are referred by the CCO.
		  ○ RVCOG will communicate the progress and outcome of each Coleman Transition to CCO
		  ○ RVCOG agrees to contact the CCO if at any time they may be of assistance with case management, authorizations, potential provision of flexible services, or other matters.

Shared Accountability

CCO and AAA/APD will hold each other accountable in the following ways:

- CCO and AAA/APD agree to develop a process for coordination in discharge planning throughout the CCO service area by December 31, 2016, with a goal of creating a team-based approach to discharge and transition planning.
- RVCOG will collect data and report on Coleman Care Transitions referral activity and program outcomes.
  - Referral volumes will be reported to AllCare monthly
  - Program outcomes will be reported to AllCare at least quarterly.
- CCO and AAA/APD will meet quarterly 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

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.	AllCare actively engages 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 service delivery model is based on member care preference and individual choice.
		• APD LTC case managers and diversion/transition specialists will
		  ○ Actively engage member and their supports in LTC service planning
		  ○ APD case managers will choice counsel potential LTC member

		regarding LTC service criteria and options ○ APD will collaborate with member, their supports and AllCare for LTC planning purposes. ○ AAAs agree to continue to offer evidence-based practices that engage CCO members in their own care. ○ APD case management agrees to provide information about AAA services to its clients. Rogue Valley Council of Governments agrees to provide services designed to improve self-management skills and reduce the need for medical interventions to AllCare members. AAA/APD agrees to assist CCO in recruiting consumers to serve on the CCO Consumer Advisory Council upon request.

Shared Accountability

CCO and AAA/APD will hold each other accountable in the following ways:

- By December 31, 2016, CCO and AAA/APD will develop a formal, proactive process to jointly share information regarding member preferences and choices for inclusion in individualized person-centered care plans.
- CCO and AAA/APD will meet quarterly 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

5. Establishing member care teams

CCO Expectation	AAA/APD Expectation	MOU activities
• 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 ○ Work with AAA/APD to ensure that it identifies members receiving LTC services.	• 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	CCO agrees to include AAA/APD staff in its care team process • CCO holds weekly provider partner meetings to coordinate care for Jackson, Josephine and Curry County members. Josephine and Curry counties comprise one meeting and Jackson County another meeting. Individual cases are brought forward at the meetings both reactively and proactively. • CCO agrees to work with APD District 6 in Douglas County on an as needed basis. • Ad hoc care teams are assembled when CCO identifies an individual as needing routine or intensive care coordination. • Designated contact staff is the same staff as listed in Domain 1

5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities
• 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.	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.	above. AAA/APD agrees to participate in CCO care teams including weekly provider partner meetings and ad hoc care teams assembled as needed when a member has immediate needs. • Due to the small size of the shared population in Douglas County, member care teams will be assembled on a case by case basis. • AAA/APD provides information to the care team regarding: o Member choice of living situation and preferences o APD case manager contact information o LTC provider contact information o Supports and services provided to member by AAA/APD • Designated contact staff is the same staff as listed in Domain 1 above.
Shared Accountability		
CCO and AAA/APD will hold each other accountable in the following ways: • CCO will share information about Curry, Jackson and Josephine County members at weekly provider partner meetings. Individual cases are brought forward at the meetings both reactively and proactively. AAA/APD case managers will attend the meetings as needed to share information about their clients. • CCO, its care coordination contractor, Liberty Advocacy, and APD District 7 will meet at least monthly to share information about high needs members shared by the three entities. Meetings will include complex case staffing as well as information sharing. • Due to the small size of the shared population in Douglas County, AllCare will share member information on an as needed basis. AllCare staff will meet in person with APD District 6 staff at least annually. • CCO and AAA/APD will meet quarterly 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		

Optional Domains for MOU CCO/LTC

A. Use of best practice		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCO will describe capacity and plans for ensuring that best practices are applied to individuals in LTC settings, including best practices related to care coordination and care transitions.	• AAA/APD will support CCO efforts to implement best practices approaches, and will share promising and best practices including care coordination; care transitions and evidence based healthy aging programs related to serving individuals in LTC settings with CCOs.	AllCare and Rogue Valley Council of Governments (RVCOG) have entered into an agreement to provide non-traditional, Flexible Services and Flexible Approaches to AllCare CCO members in Jackson and Josephine County. • AllCare and RVCOG agree to collaboratively identify individuals who would benefit from services designed to improve self-management skills and reduce the need for medical interventions. • RVCOG agrees to place a referral specialist within AllCare's care team to review data and work with team members to identify AllCare members who would benefit from RVCOG's evidence-based preventive health and self-management programs. • RVCOG agrees to have their referral specialist reach out to AllCare members and enroll them in preventive health and self-management programs. • AllCare agrees to refer members to RVCOG services and to compensate RVCOG for the services per an agreed upon fee schedule. • RVCOG agrees to provide fee schedule services at no cost to the AllCare member and to share the outcome of each referral with AllCare. • For services not currently covered by a fee schedule, RVCOG agrees to share information with AllCare regarding class schedules and new or changed services. • AllCare agrees to share information regarding services with its membership and case management team. AAA/APD provides single point of entry information and referral services through the Aging and Disability Resource Connection of Oregon (ADRC). AllCare agrees to share ADRC contact information with its case management staff and members.

Shared Accountability

CCO and AAA/APD will hold each other accountable in the following ways:
• Data will be gathered and reported by RVCOG to AllCare.
  ○ Referral volumes will be reported monthly
  ○ Program outcomes will be reported at least quarterly.

E. Governance Structure		
CCO Expectation	AAA/APD Expectation	MOU activities
• How CCO governance structure will reflect the needs of members receiving LTC services and supports through representation on the governing board or community advisory council.	• AAA/APD will participate at the community level in the board / Advisory panel for LTC perspective as needed. • AAA will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of clients served by the regional CCO(s). • DHS/APD will articulate how APD will include CCO participation in their policy development structures.	APD District 7 will represent LTC programs on the AllCare Community Advisory Council in Curry County AAA/APD will encourage interested LTC members to serve on AllCare's Community Advisory Councils
Shared Accountability		
CCO and AAA/APD will hold each other accountable in the following ways: • CCO will notify AAA/APD of Community Advisory Council meeting schedules and provide agendas and meeting documents as necessary. • A representative of AAA/APD will attend CAC meetings in Curry County.		

Signatures and Contacts

For AllCare Health Plan (CCO)

The designated contact person is:

Doug	Flow
First name	Last name
dflow@mripa.org	541-471-4106
Email	Phone
Authorizing Signature	6-25-15
	Date

For APD District 6
The designated contact person is:

Merry	Bayly
First name	Last name
merry.l.bayly@dhsoha.state.or.us	541 ~~957-3013~~ 464-2443
Email	Phone
Authorizing Signature	6-29-2015
	Date

For Douglas County Senior and Disability Services
Designated contact people are:

Jeanne	Wright
First name	Last name
jlwright@co.douglas.or.us	541-440-3608
Email	Phone
Joanne L Wright	6/29/2015
Authorizing Signature	Date

For APD District 7
The designated contact person is:

Michael	Marchant
First name	Last name
michael.m.marchant@state.or.us	541-756-2017
Email	Phone
Michael M Marchant	7/1/15
Authorizing Signature	Date

For Rogue Valley Council of Governments (AAA/APD District Office)
The designated contact person is:

Dave	Toler
First name	Last name

dtoler@rvcog.org
Email

541-423-1364
Phone

Authorizing Signature

6/25/15
Date

Additional contact person:

Kathie
First name

Young
Last name

kathie.a.young@state.or.us
Email

541-423-1382
Phone

Authorizing Signature

6-26-15
Date

For DHS, Aging and People with Disabilities Division, Central Office
The designated contact person is:

DONALD
First name

ERICKSON
Last name

donald.a.erickson@state.or.us
Email

503-884-8774
Phone

Authorizing Signature

6/30/15
Date