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 of Josephine County (CCO or PrimaryHealth), the Rogue Valley Council of Governments (AAA/APD) and Douglas County Senior and Disability Services (AAA/APD). "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 of Josephine County, Rogue Valley Council of Governments and Douglas County Senior and Disability Services 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	• AAA/APD will provide CCOs with access to information needed to identify members with high health care needs.	AAA/APD, PrimaryHealth and Options for Southern Oregon have developed a shared definition of high needs individuals that encompasses social, medical and behavioral risk factors.

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.		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. PrimaryHealth 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 AAA. AAA agrees to make evidence-based services and other supports available to CCO members. Designated contact staff: • CCO Case Management team: ○ Jo Russell, jfr@ohms1.com, 541-471-4207 ○ Patti Wilson, pattiw@ohms1.com, 541-471-4207 AAA/APD: • 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, 541-440-3608 • Rogue Valley Council of Governments ○ Carol Terry, carol.a.terry@state.or.us, Community Living Program Manager, 541-471-2863

		○ Karen Kahl, APD Co-manager, Josephine County, karen.k.kahl@state.or.us

Shared Accountability

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

- Information on Josephine County members is shared at a bi-weekly care team conference call attended by case management staff from AAA/APD, PrimaryHealth and Options for Southern Oregon. Individual cases may be brought forward at the meetings both reactively and proactively to respond to or prevent health or placement issues.
- The bi-weekly care team conference call will be held whether or not cases have been put on the agenda creating a reliable, regular time for partners to communicate about specific cases, ongoing issues and new ideas for coordination.
- Information on Douglas County members will be shared on as needed basis through telephone or secure email between designated contact staff.
- The interagency care coordination referral process and form will be updated to reflect current agencies and contact people.
- AAA/APD will provide a spreadsheet report of CCO members receiving Medicaid long term care services monthly.
- PrimaryHealth and AAA/APD will meet in January, 2016 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.

AAA/APD will report annually to the PrimaryHealth Clinical Advisory Panel on activities surrounding this Memorandum of Understanding.

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	• 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	AAA/APD, PrimaryHealth and Options for Southern Oregon will share information from their care plans as needed or as new care plans are developed. • AAA/APD works with consumers receiving long term care services to create individualized, person-centered care plans. • AAA/APD will also share a report monthly of CCO

goals captured in AAA/APD service plans as appropriate. ○ Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD and with LTC providers.	members with intensive care coordination needs.	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 ○ APD case manager contact information ○ LTC provider contact information • PrimaryHealth develops care plan information from health risk assessments and from ENCC and community outreach worker notes • Options of Southern Oregon works with its clients to create individualized, person-centered care plans.

Shared Accountability

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

- Information from individualized care plans will be shared at care team conferences attended by case management staff from AAA/APD, PrimaryHealth and Options for Southern Oregon. Care team conferences for Josephine County members are held bi-weekly and for Douglas County members on an as needed basis.
- The action items resulting from the care team conference will be merged into a collaborative care plan.
- By October 31, 2015, CCO and AAA/APD will create and implement a template for the collaborative care plan.
- PrimaryHealth and AAA/APD will meet in January, 2016 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.
- During that meeting, AAA/APD and PrimaryHealth will evaluate the implementation and usefulness of the collaborative care plan template.

  AAA/APD will report annually to the PrimaryHealth Clinical Advisory Panel on activities surrounding this Memorandum of Understanding.

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.	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. 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 LTSS and medical providers and CCOs. PrimaryHealth agrees to notify appropriate AAA/APD branch offices when members who are receiving or who need to be assessed for long term services and supports are being discharged from hospital to skilled nursing. AAA/APD Transition Coordinators agree to notify PrimaryHealth when working with CCO members. PrimaryHealth agrees to coordinate directly with AAA/APD Transition Coordinator when one is assigned. In Jackson and Josephine Counties, PrimaryHealth 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 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

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

- Information on Josephine County CCO members receiving transition services from AAA/APD will be shared at the bi-weekly care coordination meeting and as needed.
- Information on Douglas County CCO members receiving transition services from AAA/APD will be shared as needed.
- Changes in caregivers will be reflected on the report of CCO members receiving long term care services sent by AAA/APD to CCO monthly.
- CCO will share information on discharges from hospital to skilled nursing at biweekly care coordination meetings and as needed.
- RVOG will report progress, completion and outcomes of Coleman Care Transitions at least quarterly.
- PrimaryHealth and AAA/APD will meet in January 2016 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.
- AAA/APD will report annually to the PrimaryHealth Clinical Advisory Panel on activities surrounding this Memorandum of Understanding.

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.	PrimaryHealth 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. PrimaryHealth provides opportunities for member engagement through care coordination, community outreach, educational opportunities and the Community Advisory Council. 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 PrimaryHealth 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. AAA/APD agrees to assist CCO in recruiting consumers to serve on the CCO Community Advisory Council upon request.

Shared Accountability

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

- Information regarding member preferences and needs will be shared at between CCO and APD/AAA at biweekly care coordination meetings in Josephine County and via telephone or secure email for Douglas County members.
- If the care team is unable to develop a plan that is acceptable to the member, a full interdisciplinary team meeting will be called. The interdisciplinary team will include the member or their delegate plus behavioral health, home care workers, primary care providers and others as needed.
- RVOG will report member usage of evidence-based self-management programs including completion and outcomes to PrimaryHealth at least quarterly.
- PrimaryHealth and AAA/APD will meet quarterly 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.
- AAA/APD will report annually to the PrimaryHealth Clinical Advisory Panel on activities surrounding this Memorandum of Understanding.

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. • 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.	• 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 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.	PrimaryHealth and AAA/APD agree to establish care teams that meet regularly to respond to or prevent member health or placement issues. • Information on Josephine County members is shared at bi-weekly care team meetings. Individual cases are brought forward at the meetings both reactively and proactively. Meetings are attended by case management staff from AAA/APD, PrimaryHealth and Options for Southern Oregon. • Care team conference calls will be scheduled as needed with Douglas County AAA/APD. • PrimaryHealth community outreach workers will coordinate home visits with AAA/APD case workers as needed. • Care team members will include the contact people listed in Domain 1 as well as others involved in the member's care such as case workers, transition coordinators or community outreach workers. • Care teams may be expanded to a full interdisciplinary team to include behavioral health, home care workers, primary care providers, the member or others to assist is resolving more complex issues. • Information may be shared outside of scheduled meetings on an as needed basis through telephone or secure email between designated contact staff. The current interagency care coordination referral process and form will be updated to reflect current agencies and contact people. • CCO and APD/AAA agree to initiate interdisciplinary care conferences when issues arise that that are outside of the general rules or boundaries of individual organizations. The goal of the care conference will be to develop cross-boundary innovative solutions, avoid inappropriate cost shifting and meet member needs.

Shared Accountability

PrimaryHealth and AAA/APD will hold each other accountable in the following ways:
• Care team members will report on their activities at biweekly care coordination meetings in Josephine County and via telephone or secure email for Douglas County members.
  ○ The bi-weekly care team meeting will be held whether or not cases have been put on the agenda creating a reliable, regular time for partners to communicate about specific cases, ongoing issues and new ideas for coordination.
  ○ If the care team is unable to successfully resolve the health or long term care issues, a full interdisciplinary team meeting will be called.
• PrimaryHealth and AAA/APD will meet in January, 2016 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.
• AAA/APD will report annually to the PrimaryHealth Clinical Advisory Panel on activities surrounding this Memorandum of Understanding.

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.	PrimaryHealth and Rogue Valley Council of Governments have entered into an agreement to provide non-traditional, Flexible Services and Flexible Approaches to PrimaryHealth CCO members in Josephine County. • PrimaryHealth agrees to refer members to AAAs services and to compensate AAA for the services per an agreed upon fee schedule. • AAA agrees to provide fee schedule services at no cost to the PrimaryHealth member and to share the outcome of each referral with PrimaryHealth. • For services not currently covered by a fee schedule, Rogue Valley Council of Governments agrees to share information with PrimaryHealth regarding class schedules and new or changed services. • PrimaryHealth agrees to share information regarding services with its membership and case management team. • RVOG will report member usage of evidence-based self-management programs including completion and outcomes to PrimaryHealth at least monthly. Douglas County AAA and Rogue Valley Council of Governments both provide information and referral services through the Aging and Disability Resource Connection of Oregon (ADRC). PrimaryHealthPrimaryHealth agrees to share ADRC contact information with its case management staff and members.
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.	The Governance Board of PrimaryHealth authorizes and sponsors a Clinical Advisory Panel (CAP). The purpose of the CAP is the engage providers in the PrimaryHealth service area to build networks that enhance the Triple Aim. AAA/APD agrees: • to serve on PrimaryHealth's Clinical Advisory Panel • to report annually to the Clinical Advisory Panel on activities surrounding this LTC/CCO Memorandum of Understanding PrimaryHealth agrees : • That the Clinical Advisory Panel will report MOU activities to the PrimaryHealth Governance Board.

Signatures and Contacts

For PrimaryHealth of Josephine County CCO
The designated contact person is:

Roylene	~~Dalike~~ Dalke
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Email	**Phone**
Roylene Dalke	6/30/2015
Authorizing Signature	**Date**

For Douglas County Senior and Disability Services (AAA/APD District Office)
The designated contact person is:

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Merry L Bayly	6-29-2015
Authorizing Signature	Date

Additional contact people:

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Jeanne L. Wright	6/29/2015
Authorizing Signature	Date

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

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Phone

Authorizing Signature

6/25/15
Date

Additional contact person:

Kathie
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Young
Last name

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Authorizing Signature

6-26-15
Date

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

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Phone

Authorizing Signature

6/30/15
Date