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 ***Umpqua Health Alliance – DCIPA, LLC*** (CCO) and the ***Aging and People Disabilities District 6 office*** (AAA or DHS-APD district office). 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, ***Umpqua Health Alliance – DCIPA, LLC*** (CCO) and ***Aging and People Disabilities District 6 office*** (APD/AAA) agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	APD/AAA Expectation	CCO/APD/AAA agreements:

• CCOs will define a screening process that assesses high needs members receiving Medicaid funded LTC services.
  ○ CCO will factor in relevant referral, risk assessment and screening information from local APD/AAA offices and LTC providers.
  ○ CCO will define how it will communicate and coordinate with APD/AAA when assessing members receiving Medicaid-funded LTC services.
	• APD/AAA will provide CCO with information needed to identify members with high health care needs receiving LTC services.
	• APD/AAA will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid APD/AAA offices.
		Share key information pertinent to each entity's assessment:
		• APD/AAA staff will share key information, listed below, for its highest needs individuals served by the CCO, such as:
		  1. Those identified as having the most needs for assistance with activities of daily living - (service priority levels 1-3).
		  2. APD/AAA staff will also share this information for members identified by the CCO as having other complex conditions, high ER usage, or other complicating circumstances on an ad hoc or individual basis.
		• CCO agrees to share key information, for individuals defined as high needs, as well as relevant information from community health assessments with designated APD/AAA staff. Key information that CCO will share with APD/AAA includes:
		  1. Any care plans developed on member's behalf
		  2. Provider treatment plans shared with the CCO
		  3. Coordination of care issues
		
		Methods of information sharing:

1. Prioritization of high needs members in LTC		
CCO Expectation	APD/AAA Expectation	CCO/APD/AAA agreements:
		• APD/AAA will share information on its long-term care consumers served by the CCO quarterly if deemed useful. This information, named "CCO Report" is available on a spreadsheet and will be delivered via secure email to CCO's designated contact person. • CCO will share information on its members who are receiving Medicaid-funded longer term care services at an interval determined by mutual agreement. • Both parties will share information on individuals with specific or immediate needs electronically via secure email, fax or share point . Cases shared on this site are reviewed at regularly scheduled interdisciplinary care team meetings. • As CCO and APD data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing. Designated contact staff: • CCO: Kristi DePriest, kdepriest@architravehealth.com,541-673-1462 • APD: Merry L. Bayly, APD District 6 Manager merry.l.bayly@state.or.us 541-957-3013 • Aging and Disabilities Resource Connection: Jeanne Wright, AAA Director, jlwright@co.douglas.or.us, 541-400-3608

2. Development of individualized care plans		
CCO Expectation	APD/AAA Expectation	MOU activities
• The CCO will develop individualized person-centered care plans when deemed necessary and may include information about the supportive	• APD/AAA will define how it will integrate key health-related information, including risk assessments	The CCO may share individual care plans, for members that have been identified as being served by the APD/AAA office. CCO will share this information with APD/AAA via a secure email or fax solution.

2. Development of individualized care plans		
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 APD/AAA service plans as appropriate. o Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from APD/AAA and with LTC providers.	generated by LTC providers and local Medicaid APD/AAA offices into CCO's individualized care plans for members with intensive care coordination needs.	CCOs will provide APD/AAA contact information for the ENCC nurse and support staff. When deemed appropriate, primary care home information will be shared for purposes of care coordination APD /AAA will share key client information with the CCO when appropriate for individuals that the CCO has developed an individual care plan, including information documented in the long term care client assessment and planning system (CAPS). Key client information will include: • Client choice of living situation and preferences • APD/AAA case manager contact information • LTC provider contact information AAA/APD will share information on individuals with new or changed long term care plans electronically via fax or secure email. Cases may be reviewed at regularly scheduled interdisciplinary care team meetings if concerns are identified.

3. Transitional care practices		
CCO Expectation	APD/AAA Expectation	MOU activities
• CCO will demonstrate how it will coordinate and communicate with APD/AAA 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.	• APD/AAA 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.	The CCO will assure that: • A team approach is used as the model for coordinating transition services. Once alerted of a transition the ENCC will begin reaching out to the transition coordinator to coordinate transition efforts. A care plan will be developed, when deemed appropriate. • The care plan may contain, and is not limited to, both medical and non-medical information (e.g. a current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, benefit information, contact information for professional care providers or practitioners and

		informal care providers). The care plan may include long term and/or short term goals; identify barriers to meeting their goals or compliance with the care plan.
		• APD/AAA will assure that:
		  • Complex transitions for Medicaid-funded long-term care consumers will be brought to CCO for planning and coordination of consumer's medical and social needs.
		  • To achieve continuity of care and successful handoffs, transitions into or out of Douglas County will receive special attention due to the required coordination between two APD offices and two CCOs.

4. Member engagement and preferences		
CCO Expectation	APD/AAA Expectation	MOU activities
• CCO will encourage members to engage in the design and, where applicable, implementation of their treatment and care plans, in coordination with APD/AAA where relevant to LTC service planning.	• APD/AAA 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.	CCO will achieve member engagement by: • Assuring that all members are assigned a Primary care provider when they become enrolled with the CCO. CCO's local providers have contracts that define the timeliness of access required. This information is available to the member and provider in the member and provider handbook. CCO ENCCs will be the "hub" in coordinating services to ensure the member and the member's PCP are linked to appropriate IDCT members and resources. • Assuring educational materials are developed for distribution with member enrollment packets. The population of Douglas County is homogeneous with less than 1% of the population being non-English speaking (CAHPS 2007). Letters will be sent to members and providers with information about how to get alternate formats. CCO website and provider and member handbooks contain information on how to obtain materials in other languages and formats. Where appropriate, ENCCs will

		involve cultural experts and translation services to ensure member care plans are created in a culturally competent manner. • Assure the provider network is culturally diverse with highly skilled providers to assess member health needs. ENCC nurses are available to help coordinate care and support these providers and members with their needs. Where appropriate, ENCCs will involve cultural experts and translation services to ensure member care plans are created in a culturally competent manner. APD/AAA will ensure consumer engagement by: • Developing individualized long term services and supports plans with consumers that meet the consumer's needs and preferences. • Offering supports and services through the AAA such as meal programs and Oregon Project Independence that help individuals remain in their preferred setting. • Offering information and referral through the Aging and Disabilities Resource connection to enable consumers, providers and others to identify resources and programs to assist consumers. APD/AAA will reach out to its client population to assist the CCO as requested in recruiting consumer members to the CCO's Community Advisory Council.

5. Establishing member care teams		
CCO Expectation	APD/AAA Expectation	MOU activities

• CCO will support the flow of information to APD/AAA.
• The CCO-appointed lead provider or care team will encourage all providers responsible for a member's care, including LTC providers and APD/AAA to participate.
• To support care teams, CCO will
  o Work with APD/AAA to identify members receiving LTC services.
  o Include LTC providers and APD/AAA 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.
	• APD/AAA 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 will ensure that CCO providers/care teams are notified of which CCO members are receiving LTC, the relevant local APD/AAA office contact, and contact for relevant LTC provider.
	• APD/AAA 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.
		CCO ENCC nurses and support staff will continue work with the Interdisciplinary Care Team (IDCT) to manage member needs. IDCT consists of PCP, social services and mental health professionals. Additional IDCT members may be invited based on needs identified.
		
		The CCO will assure the following:
		• Dual members will continue to receive a yearly HRA from the local Medicare Advantage plan for evaluation. Additional needs assessment surveys will be determined by the ENCC or IDCT members based on member need.
		• CCO will continue to work with APD. Communication will be through telephone, secure email and secure SharePoint web solution with the ENCC coordinating relevant information from these sources to generate member care plans when needed.
		
		APD/AAA will assure that:
		• Information regarding CCO members receiving or newly eligible for Medicaid-funded long term care services and supports is shared with CCO on an as-needed basis.
		• APD/AAA staff including case managers and transition coordinators will regularly attend interdisciplinary care team meetings to share relevant information regarding individual cases.

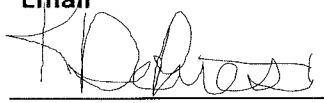
Shared Accountability	
• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations.	CCO and APD/AAA will hold each other accountable in the following ways: • Meet quarterly to assess whether these MOU agreements

	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, and • To determine measures and timeframes for future accountability and evaluation efforts.

Signatures and Contacts

For Umpqua Health Alliance **(CCO)**

The designated contact person is:

Kristi **First name**	DePriest **Last name**
Kdepriest@architravehealth.com **Email**	541-673-1462 **Phone**
 **Authorizing Signature**	6/20/2014 **Date**

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

Merry **First name**	**Bayly** **Last name**
merry.l.bayly@dhsoha.state.or.us **Email**	**541-957-3013** **Phone**

Merry J Bayly
Authorizing Signature

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Date

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

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