CY2025 Coordinated Care Organization-Long Term Services and Supports (LTSS) Memorandum of Understanding Annual Report and Guidance

Purpose/Scope of this Guidance: This document provides an overview of the annual reporting areas aligned with annual CCO-LTSS MOUs that are CCO's responsibility for populations receiving Medicaid-funded LTSS in Oregon. This document is intended to provide guidance and technical support for the completion of CCO annual reporting, as outlined in the CCO Contract. See previously posted ***CCO-LTSS MOU guidance*** updated December 2024 for MOU specific requirements.

The purpose of the MOU is to ensure that coordination between the Oregon LTSS system and the CCO creates alignment between the two systems to provide quality care, promote coordinated care planning and care transitions, produce the best health and functional outcomes for individuals, and reduce duplication and inefficiency through better coordination across systems.

Oregon LTSS Population Definition: As set forth in OAR **410-141-3500: "Medicaid-Funded Long-Term Services and Supports (LTSS)"** means all Medicaid funded services CMS defines as long-term services and supports, including both:

(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;

(b) "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4

and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.

For additional information about the Oregon LTSS system administered through Oregon DHS please see "Overview of the Delivery System for Medicaid and Long-Term Services & Supports to Seniors and People with Disabilities" document.

Shared Accountability Goals:

Many low-income adults who need and use long-term services and supports (LTSS) have complex healthcare issues, including multiple chronic conditions to manage, and often have unmet social needs which can lead to poor health outcomes. Populations needing LTSS are among the fastest-growing populations covered by Medicaid. Oregon created a system of shared accountability between Coordinated Care Organizations (CCOs) and Oregon's Long-Term Care (LTC) system in 2013 to draw on the strengths of Oregon's medical and LTSS systems to build collaboration as part of Oregon health care transformation. The framework's intentions was developed to lead the way to greater integration and coordination between the CCO and LTSS systems while remaining consistent with and strengthening Oregon's ORS 410 values to promote health, honor, dignity, and lives of maximum independence, and Oregon's Triple Aim. Oregon also made policy decisions to exclude LTSS services from the CCO global budget and have LTSS services continue to be paid for directly by the Department of Human Services (DHS). CMS also clarified expectations for coordination with LTSS services in managed care rule updates, and now rules and contracts have been further updated to build on past successes.

CMS has also increased focus to promote integrated care, especially for dual eligibles (people eligible for both Medicare and Medicaid) and members with long-term service and support needs while reducing duplication across systems. Communication between health systems and LTSS providers were two main focuses of opportunities identified by the original Oregon framework for integration of LTSS and CCOs to address through shared accountability. Oregon's collaborative system is designed to promote CCOs use of evidence-based and, whenever possible, innovative, flexible and creative strategies at the community level to build the most integrated and coordinated care in accordance with individual member needs and goals. Intentions are to continue to build on initial success and continue to build coordinated care that promotes seamlessness for members needing LTSS services and programs. Additional expectations from the Senate Interim Committee on Health Care, Hospital Discharge Task Force continue to emphasize the importance of continued attention to improving coordination processes and communication.

Shared Accountability Goals for MOUs include the following:

- Protocols for reviewing and prioritizing members with LTSS services and sharing across systems.
- Coordinated and aligned care and services for all individuals getting long-term services and supports.
- Care and service coordination tailored to needs specific to service environments in long-term care and home and community-based settings.
- Processes for CCO referrals to APD/AAA for LTSS assessments and service planning; processes by which the Aging and People with Disabilities (APD)/ Area Agency on Aging (AAA) office or LTSS providers refer members to CCO for Intensive Care Coordination.
- Mechanisms for shared accountability –including communication, care planning, care transitions.
- Processes for addressing care transitions or addressing changes in health status or level of service, ensuring discharges receive follow-up care, assessments and monitoring.
- Ease for members in navigating and receiving care and services needed to maintain and improve health.
- Person-centered planning to address member needs, including goals to ensure health equity, language and disability access, health literacy, and promoting wellness and better health outcomes.
- Documenting success by tracking and measuring MOU activities and outcomes.

Oregon will face increased pressure to meet the health and LTSS needs of a growing elderly population in the coming years. Effective collaboration across systems and settings of care is essential to ensuring individuals receive the most integrated, coordinated, and seamless healthcare and long-term services and supports. When systems align, it enhances cost-effectiveness, improves health outcomes, and maximizes opportunities for better care experiences. This MOU establishes clear roles, responsibilities, accountability measures, and monitoring strategies to support successful coordination and integration. For individuals to receive the most integrated, coordinated and seamless healthcare and long-term services and supports, collaboration has to be a priority across systems of care. This MOU seeks to clearly define roles, responsibilities, accountability and monitoring measures for success.

Updated 2025 MOU Reporting Documents:

This document: CY2025- CCO-Specific CCO-LTSS MOU Report Guidance	Specific guidance related to updated expectations in CCO contracts and Oregon Administrative Rules (OAR), information on definition and identifying LTSS populations, overview of timelines and due dates, summary of materials
CCO MOU Annual Report Table	Required annual report template on CCO forms page

Identifying Your LTSS Populations: 834 Report LTSS Indicator

Many CCO-APD/AAA MOUs created mechanisms to share information about high needs populations with LTSS. This process of Local APD/AAA providing lists of LTSS members has not always been complete and may have only focused on members transitioning, those being care conferenced, or having immediate needs and not all members with LTSS. CCOs are responsible per Centers for Medicare and Medicaid Services (CMS) for ensuring care coordination for members with LTSS as outlined in federal rules at 42 CFR §438.208. However, with new managed care rules, CMS identified managed care populations receiving any LTSS as high-risk populations. As part of the updated rules, CMS required a new state notification requirement to ensure that CCOs could identify CCO members receiving LTSS programs. OHA shared information via the All-Plan Technical workgroup in 2018 and released guidance to assist plans in utilizing the new notification on the 834-enrollment report. This indicator is "a yes indicator" when select LTSS programs are present at the time of the 834 data update. This information is contained in the 834 Loop 2750. This information is meant to directly assist with the new requirements to identify LTSS populations and provide required risk screening within 30 days, or to use the indicator to prioritize members with LTSS for review for care coordination, or to trigger shared care plan development or sharing as required in OARs. The indicator may still miss some LTSS services or programs that were determined at the time to not have regularly updated information available through MMIS.

Conversations are occurring to work to improve the LTSS indicator data in the 834 for CCOs to use in tracking LTSS populations. Efforts are ongoing to improve the LTSS indicator data in the 834 for CCOs to better track LTSS populations. However, because the LTSS indicator does not specify the member's specific LTSS program or services, additional coordination—such as discussions with local APD/AAA districts or direct engagement with members—remains essential for risk stratification and completing health risk assessments. Your ability to sort those who are in DD programs, but still require coordination, for example is important to work with the LTSS indicator. The type of collaboration outlined for the APD/AAA populations with LTSS is similar to processes that will assist in addressing other LTSS populations, even where an MOU requirement does not exist in statute or contract. Better collaborating across partners to serve all LTSS populations is important.

Programs included in the LTSS Indicator At Present (CHART):

T_BENEFIT_PLAN_GROUP

LOC Plan (reference only)	Plan Description (reference only)	SAK_BENEFIT_PLAN_TYPE NUMBER(9,0)	SAK_PUB_HLTH NUMBER(9,0)	DTE_EFFECTIVE NUMBER(8,0)	DTE_END NUMBER(8,0)
DDBL	Children's Intensive In-home HCBS Behavioral	6012	1041	20180101	22991231
DDCL	DD Comprehensive HCBS Waiver	6012	1042	20180101	22991231
DDEL	DD Eligible	6012	2058	20180101	22991231
DDKL	DD Comm First Choice K Plan	6012	2073	20180101	22991231
DDSL	DD In-Home Supports HCBS Waiver	6012	1044	20180101	22991231
ICPL	Independent Choices	6012	1048	20180101	22991231
KPSL	State Plan K Services for APD	6012	2076	20180101	22991231
MFNL	Medically Fragile Children non-waivered	6012	1051	20180101	22991231
MFWL	Medically Fragile Children HCBS Model Waiver	6012	1052	20180101	22991231
MIWL	Medically Involed Children's Services Waiver	6012	1053	20180101	22991231
NFCL	Nursing Home	6012	1054	20180101	22991231
NFSL	Nursing Home Short-Term	6012	1056	20180101	22991231
SPHL	Spousal Pay In-Home Services	6012	1062	20180101	22991231

MOU Required & Optional Domains: Each required and optional domain for the CCO – LTSS MOU has a domain worksheet that provides an overview of minimum requirements and highlights opportunities to build connections and sample questions that might trigger shared planning for MOU activities in that domain. MOU reporting tracks CCO completion of required MOU domain processes such as sharing prioritization with APD/AAA, tracking member engagement in IDT meetings, tracking care plan development for LTSS populations, tracking care setting transitions processes and communication around transitions. Updated CY2025-2026 MOU guidance was released December 31, 2024.

CCOs should be striving to build activities and processes with APD/AAA districts to address the following in the MOU. REQUIRED DOMAINS:

1. Prioritization of high needs members

2. Interdisciplinary care teams

3. Development and sharing of individualized care plans

4. Transitional care practices

5. Collaborative Communication tools and processes

Optional Domains: These domain areas are optional based on local partnership goals (for more detail on each domain see domain worksheets pages) and do not have statewide metrics

reporting, however CCOs are encouraged to set local goals and measures to build comprehensive processes.

A: Linking to Supportive Resources
B. Health Promotion and Prevention
C: Safeguards for Members

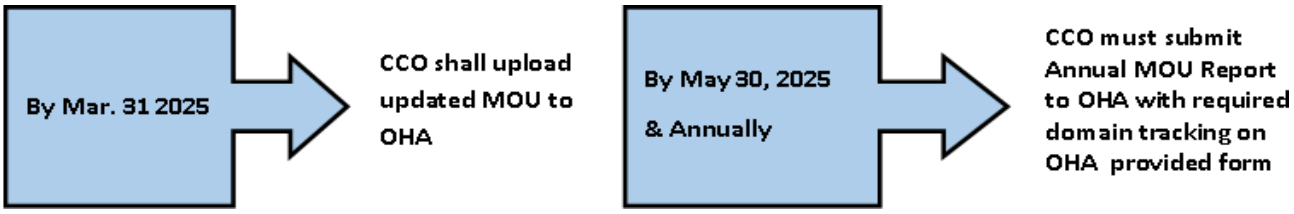
Deliverable Requirement:

2025-2026 MOU & Reporting Process: The CCO-LTSS MOU addresses the core elements in each domain of CCO-LTSS MOU guidance. **The annual reporting for CY2024 due May 30, 2025 includes the data fields that CCOs have been asked to track since 2020.** The goal is to monitor processes outlined as core expectations in MOUs are happening for the existing LTSS population and new referrals for members who need LTSS are happening. A few fields have been removed for CY2024 data reporting to simplify to the most essential of these fields. CCO-LTSS MOU and required data points collected and provided to OHA in annual reports on Report Template by the CCO.

Annual Report Submission: CCO shall submit annually no later than May 30th an annual report to OHA that have been agreed to in a MOU or in Subcontract between the Contractor and the Type B AAA or State APD district office(s) in its Service Area on the report template provided by OHA. **Annual Report for CY2024 data is due May 30, 2025.** OHA will post annual reports, but additional details will be provided at a later date regarding specifics.

What is due when?

CCO Submits New MOU to OHA:	March 31, 2025
CCO Submits Annual Reports to OHA:	May 30, 2025



CCO Care Coordination Rules & Linkages to MOU Domains:

This table highlights sections of updated OARs that relate to core required domains for the CCO-LTSS MOU.

CCO Care Coordination OARs (Updated 2024)	Oregon Administrative Rule Requirements: What is required for CCO Members with LTSS	Related Shared Accountability Domains (*there may be other domains impacted in your MOU based on specific CCO activities*)
OAR 410-141-3860 **Care Coordination: Administration, Systems and Infrastructure**	Coordinated Care Organizations (CCOs) must coordinate services for members in accordance with 42 CFR §438.208 and as outlined in detail in this rule. CCOs must develop and continuously improve the infrastructure (e.g., **systems, technology solutions, processes, relationships, and agreements**) needed to support, enable, and uphold their responsibility to coordinate services for their members. • **410-141-3860 (8)(a)(A)** Implementing and utilizing a care management platform to track and monitor care coordination activities (e.g., **document, track, and report care planning activities, goals and outcomes**, Members' care team, **communication to/from care team**, community resources, completed assessments, **identified needs, change in health-related circumstances**, communication with individual Members, and timeliness of activities) • **410-141-3860 (8)(a)(B)** Implementing and utilizing member data to develop a risk stratification model and mechanism to stratify members by the following risk levels, at a minimum: no- or low-risk, moderate-risk, high-risk. The Oregon Health Authority (Authority) must approve CCOs' risk stratification mechanisms and algorithms before implementation.	**Relates to requirements in CCO-LTSS MOU Guidance:** DOMAIN 1: Prioritization of High Needs Members DOMAIN 2: Interdisciplinary care teams DOMAIN 3: Development and sharing of individualized care plans DOMAIN 4: Transitional Care Practices DOMAIN 5. Collaborative Communication tools and processes

	• **410-141-3860 (8)(a)(B) (i)** Data sources used to identify risks, risk level and care gaps must include but are not limited to the following sources: claims and utilization data, Health Risk Assessments, **functional needs assessments**, , **referrals**, **event notifications**, and other available resources to inform physical, developmental, behavioral, oral and social needs (including Health-Related Social Needs (HRSN) and Social Determinants of Health and Equity (SDOH-E)) **410-141-3860 (8)(a)(H)** Abide by, or enter into as needed, any agreements or Memoranda of Understanding (MOUs) governing coordination with other entities described in (2) of this rule, including at minimum but not limited to, Aging and People with Disabilities (APD) or Type B Area Agency on Aging (AAA) for Long Term Services and Supports.	
OAR 410-141-3865 **Care Coordination: Identification of Member Needs**	**OAR 410-141-3865(3)** This section specifies details for types of information CCOs shall consider relevant information from a variety of sources to inform the development or update of a Member's Care Profile, and/or Care Plan, if applicable, as described in **OAR 410-141-3865(4) and (5) and (6) below**. This includes things like change in health status or discharge/change in care settings or receiving information or referral from APD/AAA (4) CCOs must implement mechanisms, including but not limited to the HRA and any additional relevant assessments described above, to identify the risk level and needs for: (a) Members with Special Health Care Needs (SHCN) as defined in OAR 410-120-0000 and (b) Members requiring Medicaid Funded Long Term Services and Supports (LTSS) as defined in OAR 410-141-3500.	**Relates to requirements in CCO-LTSS MOU Guidance:** DOMAIN 1: Prioritization of High Needs Members DOMAIN 2: Interdisciplinary care teams DOMAIN 3: Development and sharing of individualized care plans

	(5) If at any time the Member is identified as potentially eligible for, or requiring LTSS, or having a Special Health Care Need, the CCO must also ensure those members are comprehensively assessed, per 42 CFR 438.208(c)(2), as soon as their health condition requires, to identify those members who have an ongoing special condition that requires either a course of treatment or regular care monitoring. (6) CCOs must ensure appropriate and prompt referral of Members identified in (5) of this rule to the Oregon Department of Human Services (ODHS), including Aging and People with Disability (APD) programs, the Office of Developmental Disabilities Services (ODDS), Local Mental Health Authorities (LMHA) or other service programs where appropriate for completion of a comprehensive assessment and potential service planning	DOMAIN 4: Transitional Care Practices DOMAIN 5. Collaborative Communication tools and processes
OAR 410-141-3870 **Care Coordination: Service Coordination**	CCOs shall consider the Member's identified risk level to determine if a Care Plan is required. **410-141-3870 (4)(c) –subsections (B) (D) below:** (B) Members within the moderate-risk and high-risk levels, **or who require Long Term Service and Supports (LTSS) must have a Care Plan developed.** (D) For Members receiving Long Term Services and Supports (LTSS), the CCO shall have access to or integrate any service or Care Plans developed by entities listed in OAR 410-141-3865(6) into the Member's Care Profile or Care Plan.—Note this requires communication with the LTSS provider or case manager or member to fully understand and incorporate service plan detail and member goals and preferences into the larger CCO comprehensive care plan. **Care plans:** The Care Plan is developed or revised as required in **410-141-3870 (5)(d)**	DOMAIN 2: Interdisciplinary care teams DOMAIN 3: Development and sharing of individualized care plans DOMAIN 4: Transitional Care Practices DOMAIN 5. Collaborative Communication tools and processes

	Subsections (A) – (E) below of this rule and in alignment with: (A) The Member's identified needs and risk level; and (B) With identification of the Member's goals and preferences, when available, to the extent the Member desires or is able to participate; and (C) **By incorporating information from any relevant assessments, treatment and service plans from providers or community partners involved in the Member's care, to the maximum extent feasible**; (D) **In consultation with any other provider, case manager, or entity providing services to, or coordinating care for, the Member;** (E) In consultation with a clinician that has the appropriate clinical qualifications and expertise to review and revise the Care Plan considering the Member's complex physical, developmental, behavioral or oral health care needs including clinical subjectivity. **410-141-3870 (5)(a) --**Section (D) For Members receiving Long Term Services and Supports (LTSS), the CCO shall have access to or integrate any service or Care Plans developed by entities listed in OAR 410-141-3865(6) into the Member's Care Profile or Care Plan. Please note, there is no automatic access to LTSS service plans, CCOs must connect with members or LTSS case managers or programs to incorporate this information into the larger comprehensive CCO care plan. **410-141-3870 (5)(a) and (b) sections below: The Care Plan** is developed or revised as	

	required in (5)(d) of this rule and in alignment with: **G. Member engagement in Care Planning:** Care plans should be developed: "With the Member, their representative or guardian's participation to the extent they desire or are able to participate. The Member, their representative or guardian shall be satisfied with and understand the Care Plan, including any of their own roles and responsibilities." **410-141-3870 (5) (c) (A) – (B)** as follows: (c) After development of the Care Plan, CCOs must make it promptly available to the Member, the Member's representative or guardian and to all relevant providers rendering services to the Member who shall coordinate and provide services according to it: (A) After development of the Care Plan, CCOs must make it promptly available to the Member, the Member's representative or guardian and to all relevant providers rendering services to the Member who shall coordinate and provide services according to it: (B) The Member, the Member's representative or guardian must be provided immediate electronic access, or a copy in the Member's preferred method of communication and in the Member's preferred language. Auxiliary Aids and Services and Alternate Formats must be made available upon request of the member at no cost within five (5) business days of the request. **410-141-3870 (5) (d)**: Open Care Plans must be reviewed and revised at least annually, or (B) Upon a change in health-related circumstances as described in OAR 410-141-3865(3)(g)—which includes change in care settings, or discharge from a hospital, PHEC or SNF to new setting	

	such as home. Event notifications (HEN and SNF) can help trigger need for communication with LTSS programs to request assessment for LTSS services at discharge or transition. (D) If the associated risk level of a Member remains a moderate, high or LTSS and the Member no longer wishes to participate the CCO must close the Care Plan and transition to a CCO directed Care Plan as outlined in (5)(a)(B) and (5)(a)(C) of this rule. (a) **If members experience a Care Setting Transition CCOs must ensure**: (A) Members are transitioned into the most appropriate independent and integrated community settings and provided follow-up services as medically necessary and appropriate prior to discharge to facilitate successful handoff to community providers; Details on coordination with **Post Hospital Extended Care (PHEC)** are in this rule in section **410-141-3870 (6)(e) (A) (B) (C) (D).** **410-141-3870 (7) In addition to the care planning requirements above, for LTSS or Special Health Care Needs Members as defined in OAR 410-120-0000 that are assessed according to OAR 410-141-3865(5) to have an ongoing special condition that requires a course of treatment or regular care monitoring or identified as high risk**: (a) CCOs must consider the above members, according to their needs, during Interdisciplinary Team Meetings which are convened and facilitated as needed according to the Member's Care Plan, **including a post-transition meeting of the interdisciplinary team within fourteen (14) days of a transition**	

	between levels, settings or episodes of care. These meetings must: (A) **Include the Member, their representative or guardian,** unless the Member declines or the Member's participation is determined to be significantly detrimental to the Member's health, in accordance with (5)(b)(G) of this rule; (B) Invite and consider relevant information from all providers and other entities serving the Member including but not limited to those listed in OAR 410-141-3860(2); and (C) Provide a forum to: (i) Describe the clinical interventions recommended to the treatment team and identify the frequency of necessary Interdisciplinary Team Meetings appropriate to meet the Care Plan needs; (ii) **Create a space for the Member to provide feedback on their care, self-reported progress towards their Care Plan goals, and their strengths exhibited in between current and prior meeting**;	
Referral for LTSS Screening/Assessment to partners/agencies when CCO identifies member need	**OAR 410-141-3865(6) CCO must have a referral process** to the appropriate partners agency (AAA/APD or ODDS) for members thought to benefit from Medicaid LTSS services to receive intake or transition assessment. This is critical for ensuring all members receive Medicaid benefits they may be entitled to that will assist them in meeting needs with Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) that are coordinated out of existing LTSS programs in ODHS and the 1915i benefit. Communication at times of care setting transitions or hospital or post-hospital extended care (PHEC) or Skilled Nursing Facility stays are	DOMAIN 1: Prioritization of High Needs Members DOMAIN 4: Transitional Care Practices DOMAIN 5: Collaborative Communication tools and processes

	critical times for members with conditions that may require additional LTSS supports.	
Process to receive and respond to Referral to Care Navigation or Care Coordination from AAA/APD or ODDS partners	CCO must have a process to ensure LTSS program case managers can connect in a timely way to request support for a member with care navigation or a referral to care coordination. The MOU process should establish open channels of communication that ODHS partners feel are able to gather a response and support for members or they may not reach out. Tuning up communication channels is a must. Care-setting transitions are a particularly important time to consider referrals for LTSS assessments.	DOMAIN 1: Prioritization of High Needs Members DOMAIN 4: Transitional Care Practices DOMAIN 5: Collaborative Communication tools and processes
Comprehensive Transition Care & Planning: -- transitioning from Hospital or Skilled Nursing Facility care, transitioning from institutional or residential care, transitioning to Home and Community Based Services **OAR 410-141-3860, OAR 410-141-3865, OAR 410-141-3870**	Care setting transitions should reflect goals to address needs of members to ensure a successful transition from one setting or level of care to another; including where necessary to ensure the community and home supports are in place prior to transition; methods to share discharge planning; ensure follow-up scheduling; Non-emergency Medical Transportation (NEMT,) etc. Members should receive comprehensive care setting transition support, including appropriate follow-up, when such Member entered and left and Acute care facility or a long-term care setting. --CCO contract --reference Exhibit B, Part 4, Care Integration Reassessment for events listed in OAR 410-141-3865. Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings or episodes of care as noted in **410-141-3870 (7)**. CCO is responsible for holding Hospitals and specialty service Providers accountable for achieving successful transitions of care. If	DOMAIN 4: Transitional Care Practices DOMAIN 2: Interdisciplinary care teams DOMAIN 5. Collaborative Communication tools and processes

	discharge planning is subcontracted, CCO is still responsible for monitoring discharge planning completeness. Follow up to hospitalization measures also follow national recommended standards for how quickly those with emergency department or hospitalization should receive follow-up services. CCO's primary care teams are responsible for transitioning Members out of Hospital settings into the most appropriate, independent, and integrated care settings, including home and community-based as well as hospice and other palliative care settings.	
HIT and Collective (Use of Event Notifications) for Hospital Event Notifications (HEN) or Skilled Nursing Facility (SNF) Notifications: This includes addressing increasing provider use of event notifications (HIE roadmap) via Collective tools **CCO Contract: Exhibit J**	CCOs should outline how they will use Event Notifications to foster collaborative care processes [AAA/APD partners are also subscribed to Collective via State Medicaid funds but use the data differently via reports and not notifications]. HEN and SNF PointClick event notifications are a tool for collaboration and a trigger for CCOs to know that members are experiencing some sort of event that may include a major care-setting transition or event that triggers a need for reassessment as noted in 410-141-3865. To accurately respond to requirements to communicate and request LTSS assessments for members who are experiencing any care setting transition such as hospital, PHEC or SNF discharge or transition. How will entities enhance use of SNF notifications in care coordination processes?	DOMAIN 5. Collaborative Communication tools and processes
Wellness/ Prevention: The CCO responsible to enhance Implementation integrated Prevention, Early Intervention, and wellness activities such as chronic disease management or medication	Monitor/ensure members are receiving preventive screenings, early intervention and wellness (i.e. Depression screening, flu/shingles/pneumonia shots, medication reconciliation, falls prevention programs, home modifications, HRSN services)	DOMAIN 2: Interdisciplinary member care teams DOMAIN 3: Development and sharing of individualized care plans

management; including outreach to increase preventive screenings/ behavioral health assessments **OAR 410-141-3860**		DOMAIN 4: Transitional Care Practices
OAR 410-141-3835 **Authorization of services:** Recognize unique needs of members with chronic conditions/LTSS services in the way authorization for services occurs	Per 42 CFR §438.208 and CCO Contract: Contractor shall ensure the services supporting Members with ongoing or chronic conditions, or who require Long-Term care and Long-Term Services and Supports, are authorized in a manner that reflects the Member's ongoing need for such services and supports and do not create a burden to Members needing medications or services to appropriately care for chronic conditions. CCOs shall protect Members against underutilization of services. (c) For members with special health care needs (including LTSS) as determined through an assessment requiring a course of treatment or regular care monitoring, each MCE shall have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs	DOMAIN 3: Development and sharing of individualized care plans
Building Community Resource Linkages CCO builds support links/addresses social determinants of health, health equity, or navigating to social service agency supports **OAR 410-141-3860**	Provide assistance in navigating the social systems and in accessing community and social support services such as Oregon Food bank, housing vouchers, etc.	DOMAIN 3: Development and sharing of individualized care plans DOMAIN 4: Transitional Care Practices Optional Domain A: Linking to Supportive Resources
No Wrong Door: Beneficiary Support	Develop assistance to provide member support with understanding and navigating system,	ANY DOMAIN WHERE

Mechanisms Provide assistance with and links to grievance, appeals and hearings for any Medicaid covered service; navigation assistance	including appropriate parties for services outside CCO scope Ensure safety issues are addressed for high-risk members. Link members to any SDOH resources or HRSN programs such as housing supports, home modifications or climate supports, etc.	APPLICABLE GOALS OUTLINED
CCO Metrics: How is your CCO-LTSS partnership contributing to targets for key metrics?	**Statewide Quality Metric for CCO: All-cause readmissions** **Other Metrics:** SDOH: Social Needs Screening and Referral Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control; Substance Use Disorder Screening: Screening, Brief Intervention and Referral to Treatment (SBIRT) Screening for Depression and Follow-Up Plan Initiation and Engagement of Substance Use Disorder Treatment Controlling High Blood Pressure Follow-Up Measures: Follow-Up After Emergency Department Visit for Mental Illness Follow-Up After Hospitalization for Mental Illness	Examples of some metrics that can be impacted for populations with LTSS through your MOU work. (OHA data shows a high comorbidity of LTSS with other chronic conditions, SPMI and Chemical Dependency so CCOs may be able to impact the current metrics by ensuring LTSS populations are receiving supports in these areas). Reporting asks if you are using care coordination staff, THWs or using Event Notifications (HEN and SNF) to assist in improving your CCO metrics for LTSS populations

Required MOU Data Points for Annual Reporting: CCO should develop systems to ensure data is being tracked to be reported annually for annual periods. Many of these are not new metrics, however OHA is now collecting and collating reporting to CMS on the CCO – LTSS MOU. See highlighted items for items added based on new OARs adopted for CY2024. Some reporting items were removed that are no longer requirements in OARs as of CY2024.

Please complete the data fields (denoted by _) in the column titled "Annual Report on Specific Statewide MOU Data Points."

Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed	**Annual Report on Specific Statewide MOU Data Points**
DOMAIN 1: Prioritization of high needs members	____# of members with LTSS that prioritization data was shared during each month _____Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year] ____# of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) ____# of APD/AAA referrals to CCO for care coordination review
DOMAIN 2: Interdisciplinary care teams	____# of members with LTSS that are addressed/staffed via Interdisciplinary team meetings monthly ____% of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month ____Total annual IDT meetings completed by CCO-APD/AAA teams ____% of times consumers participate/attend the care conference (IDT) by month/year ____% of consumers that are care conferenced/percentage of LTSS recipients served by CCO
DOMAIN 3: Development and sharing of individualized care plans	___% of CCO care plans for CCO members with LTSS that incorporate/document member preferences and goals

	____% of CCO care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties
DOMAIN 4: Transitional care practices	**A. # of transitions** where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? [Monthly/Year] **B.** # total number of transitions tracked per month (baseline) **C.** ____% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? (A divided by B = C) ____% transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge? ***Per new CY2024 OARS**: #of members receiving post-transition meeting of the interdisciplinary team (IDT) within fourteen (14) days of a transition between levels, settings or episodes of care. ***Per new CY2024 OARS:** % of these post-transition IDT meetings that included the member or member's representative in the meeting
DOMAIN 5: Collaborative Communication tools and processes	____# of CCO Collective Platform HEN notifications monthly result in CCO follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments ____# of CCO Collective Platform SNF notifications monthly that result in CCO follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments ____MOU includes written process documents (prioritization, IDT, care planning, transitions) that clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).

Technical Assistance:

If you have questions on CCO-LTSS reporting detail, contact Jennifer Valentine at Jennifer.B.Valentine@oha.oregon.gov or Janet Herb janet.herb@oha.oregon.gov.