CCO-LTSS Partnerships MOU Template:

MOU Period: January 1, 2025 -December 31, 2025.

Please submit your CCO's CCO-LTSS MOU(s) by March 31, 2025 through the CCO portal at via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/. This report content is subject to public posting and redaction. It will be shared without redaction with the Centers for Medicare and Medicaid Services (CMS) and with the Oregon Department of Human Services. Final MOUs will be posted at https://www.oregon.gov/oha/hsd/ohp/pages/cco-ltss.aspx

CCO Name: Advanced Health_____OHA Contract # 1617546_____

Partner AAA/APD District (s) Names/Locations: Oregon Department of Human Services: Aging and People with Disabilities: District 7

_____

_____

If more than one AAA/APD office in your CCO Geographic Region Please Circle or X Whichever Applies: **X** Single Combined MOU ☒ Multiple MOUs ☐

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
CCO will clearly articulate in this section: --How CCO governance structure will reflect the needs of members receiving Medicaid funded Long-Term Services and Supports (LTSS), for example through representation on the governing board, community advisory council or clinical advisory panel. --How Affiliated MA or DSNP plan participates in the MOU work for FBDE.	**AAA/APD will clearly articulate in this section:** --How AAA/APD governance Lead(s) for participation at the community level in the board / Advisory panel for LTSS perspective/Care Coordination. --AAA/APD will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of members served by the regional CCO(s).

Advanced Health's governance structure is designed to meet the needs of our LTSS members, incorporating community input through the participation of a Community Advisory Council (CAC), the Board of Directors, a Clinical Advisory Panel, and collaboration with our Affiliated Wellcare MA plan. The CAC plays a crucial role in ensuring the healthcare needs of the community are addressed. Most of the council members are residents of Coos County, enrolled in the Oregon Health Plan, while others represent local community organizations. The council's responsibilities include advocating for preventing care practices, overseeing the Community Health Assessment (CHA), guiding the adopting of a Community Health Improvement Plan (CHIP), and publishing an annual report on CHIP progress.	APD governance Lead(s) actively participate in the Coos and Curry Advisory Councils to guide and support services for LTSS consumers in the community. Their involvement allows for direct responses to consumer needs, education, and alignment of staff and services with local LTSS priorities. Additionally, APD governance Lead(s) attend weekly interdisciplinary meetings with Bay Area Hospital, CCO, and mental health representatives to review processes and ensure timely, appropriate responses to LTSS consumers. They also provide education on LTSS services, eligibility, prioritization, and community resources to support Care Coordination. As local providers for the Southcoast Aging and Disability Resource Connection (ADRC), APD Lead(s) work within the statewide framework to meet staffing, resource, and LTSS consumer needs, particularly for CCO members. On a local level, APD Lead(s) collaborate with community organizations, such as Bay Cities Ambulance and local emergency services, to offer ongoing education and support for LTSS consumers. They also manage contracted RN services for LTSS consumers in Coos and Curry counties, ensuring the appropriate services are in place to meet local needs. In representing APD, local governance Lead(s) work to address LTSS consumer needs and actively engage in new advisory boards or councils that serve both CCO members and the broader community.

CCO-LTSS APD/AAA MOU(s): See MOU Worksheets for additional detail on MOU expectations in each domain

MOU Service Area:				
Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success**	**Annual Report on Specific Statewide Measures of Success (provide data points*) — monthly & annual [REQUIRED data points at minimum}**
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members	After the adoption of the new care coordination OARs in 2025, Advanced Health's Customer Service department contacts members who are stratified at no/low risk, while Care coordination reaches out to moderate to high-risk members. Each department attempts to complete the Health Risk Assessment (HRA). This assessment can identify those who may require Care coordination and/or LTSS services. Members are assessed annually, offered Care Coordination services at the beginning of the year by mail and later contacted by a Care coordinator at least two times by telephone. A care coordinator may also contact a member whenever they experience a	APD will provide the 834 Report to the CCO identifying enrollment data for LTSS consumers. APD utilizes risk assessment data, service priority levels (updated at least annually), and case manager concerns (ex: ED utilization, hospitalization, at- risk of losing housing) to identify high-risk members who may benefit from ICC. APD case managers share their LTSS member concerns at the hospital complex case meeting, monthly CCO/APD meeting, call the AH Customer service and/or email the Intensive Care coordination referral email inbox with a completed ICC referral screen. Furthermore, APD also emails the most recent LTSS list for Advanced Health/APD consumers once a month to	Advanced Health has continued our monthly collaborative meeting at the administrator level. This meeting serves as a platform to strengthen partnerships, review MOU requirements, design new processes, exchange staff contact information, address inter-agency challenges, and promote collaboration. During these our monthly meetings, CCO care coordinators, APD case managers, county mental health, and our MA Advantage partners, come together to discuss shared cases under the oversight of the CCO Care Coordination Director. Staff members share pertinent information about each member and identify areas requiring prioritization for follow-up care. The Care Coordination	# of members with LTSS that prioritization data was shared during each month/year Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]— calculated by OHA from data submitted. # 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 # of completed referrals for care

	health-related circumstance change (HRCC) such as an emergency hospitalization or significant new health diagnosis. Depending on the member's risk level, follow-up may be initiated by Customer Service, Care Coordination, or APD, depending on the member's status of care. When Customer Service receives a HRA indicating that a member has high needs or self-identifies as part of a prioritized population (e.g., those with disabilities, chronic conditions, or those receiving LTSS services), a care coordination referral screen is completed by a customer service representative and submitted to the Care Coordination team at ICCreferrals@advancedhealth.com. The Care Coordination team responds to these requests within one business day. To facilitate the coordination of Care Coordination services, Advanced Health uses the Activate Care software tool, which helps track and manage member goals, tasks, contacts, and care coordination outreach notes. Activate care also	the ICC Director. Internal discussion is currently underway at the CCO to determine the best approach to systematically review the 800+ identified CCO/APD consumers for potential referral to intensive care coordination. As of 2022, APD now has access to Activate Care and is working towards uploading summary of SPL assessment to the ICC members' care plans.	Director monitors the progress of LTSS members monthly. Case notes, service planning, risk assessments, and care plans are tracked in an Excel spreadsheet, helping prioritize high-needs members for timely follow-up care, which now includes the member's individual risk score. The tracking sheet includes details such as the assigned CCO coordinator, LTSS case manager, and the status of the member. APD case managers have access to Activate Care, allowing them to upload their LTSS assessments directly to the member's care plan.	coordination review [Monthly/Year Total]

	receives Point Click Care (PCC) hospital event (HEN) and skilled nursing facility notifications (SNF) to help the Care coordinators monitor the member's admissions and discharges. Care coordinators know to follow up with the member after seeing a HEN or SNF notification, within a few days, to check in on the member's health status. Members are encouraged to self-refer to Customer Service if they wish to be reassessed for care coordination services. For members in care coordination for a year or more, Activate Care will prompt care coordinators to complete an annual HRA. LTSS members are discussed weekly at Bay Area Hospital's complex care coordination meetings.			

DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	IDT (Interdisciplinary Team) meetings are held five times a month: weekly at the hospital for complex care, and monthly between CCO and APD staff. These meetings include LTSS supervisors and case managers, CCO nurses, traditional health workers, and a licensed mental health practitioner. In addition, APD and CCO administrators meet once a month to focus on process development, continue relationship building, and collaboratively address interagency challenges. Integrated care plans are developed through a person-centered approach in Activate Care, incorporating input from the member during the standard enrollment and intake process for care coordination, as outlined in our policies and procedures. Additional insights from IDT discussions are also used to create these plans. LTSS members are notified of their care coordination enrollment within ten days of their initial assessment through a phone call from their	The APD CM lead worker acts as the point of contact for the CCO care coordinator. APD case managers routinely contact CCO nurses and traditional health workers to problem-solve cases outside of standard meetings. LTC supervisors are also present at the IDT meeting for support, guidance and direction to staff. APD routinely updates the CCO on their case manager staff roster and assignment to LTSS members for improved communication and in preparation for our monthly IDT meeting and for sharing of Activate Care records. Members are given the opportunity to participate in ad- hoc meetings between APD and CCO staff, as appropriate, outside of the regularly scheduled weekly meetings, due to lack of time and other LTSS members being discussed. According to APD, it should be noted that LTSS members with a SPL 1 to 3 are the highest need members with significant cognition and/or mobility issues are most likely not even able to meet for care coordination meetings.	Advanced Health uses Microsoft Outlook to track the CCO/APD monthly meeting schedule and Microsoft Teams to host the virtual meetings, facilitate chat communication, and record staff attendance. To better track ad-hoc IDT meetings between CCO and APD staff, additional checkboxes have been added to Activate Care. While individual meetings take place between the Member, APD case manager, and CCO Care coordinator, Members have not requested participation in the all-staff meetings that include APD/CCO/County Mental Health and/or APD/CCO/Bay Area Hospital. The Care Coordination Director monitors the outcomes of the monthly IDT meetings and sends an encrypted Excel file listing each LTSS member, their assigned CCO/LTSS staff, the member's current health status to the APD administrator team for distribution and review, and the member's risk score. APD and CCO administrators periodically exchange updated staff rosters, and any changes to LTSS staff are reflected in the monthly calendar invites and access to Activate Care.	# of members with LTSS that are addressed/staffed via IDT 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/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO).

	assigned coordinator, followed by a mailed enrollment letter that includes the care team's contact information and an overview of the care coordination program. Care coordination members, or their authorized representatives, can access Activate Care to view and contribute to the development of their care plan. Care Coordinators are also responsible for coordinating resources and supports to address Social Determinants of Health (SDOH). During the IDT meetings, several guiding questions are consistently applied to all cases, including: • What are the primary healthcare goals and progress in care coordination? • What APD services is the individual receiving? • Are there any significant changes in physical and/or behavioral health symptoms? • Is the individual able to manage their activities of daily living?		Bay Area Hospital maintains the schedule for weekly IDT meetings and tracks the patient list. These hospital meetings involve participation from nursing case managers, discharge planners, hospital physicians, LTSS case managers, and CCO nurses. Every week, the hospital sends an encrypted email of their caseload to CCO and APD staff. The weekly hospital IDT meeting focuses on addressing the needs of members to ensure smooth transitions between care settings or levels of care. Topics discussed include discharge planning, follow-up scheduling, medications, durable medical equipment (DME), NEMT transport, home environment, and any barriers to care or treatment plans. A primary goal of these meetings is to reduce avoidable hospitalizations and shorten length of stay.	

	• Are there any potential safety concerns in the home? • Are there any acute/high-risk medical conditions or concerning medications? • Is there a lack of access to care or durable medical equipment? • Is there a risk for readmission to the emergency department? • Is there a risk of harm to themselves or others? • Is the individual struggling with their treatment plan? • Are there any health equity, language, or cultural considerations? • Is there a need for POLST (Physician Orders for Life-Sustaining Treatment), Advanced Directives, or End-of-Life Care Planning? • Could HRS flex funds be used to assist the member with SDOH needs or non-covered durable medical equipment (DME)?			

DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	Advanced Health follows a structured process, in line with the 2025 administrative rules, for developing individualized care plans. The process begins with either a referral screen and/or health risk assessment completed by the LTSS member or their representative. This screen and/or assessment captures the member's current medical, behavioral, and social needs, as well as their motivation to participate in their own care. Afterward, the member is assigned to the most appropriate care coordinator, either a Nurse (LPN/RN) or Traditional Health Worker (CHW/PN), based on their needs. The assigned coordinator then conducts a HRA to better understand the member's situation and to guide the creation of their personalized care plan. The care plan is reviewed and discussed with either the Care Coordination Program Manager or the THW state liaison before being presented to the member. The entire process of care coordination and planning is organized through Activate Care, our cloud-based care	As of the beginning of 2022, LTSS staff have access to the LTSS members care plans in Activate Care and are currently working towards uploading their assessment information to the Activate Care shared care plan. APD shares assessment, care plan, other known and relevant information, either by telephone, secure email and/or potentially Activate Care. Care plan development can occur in the IDT meeting and/or by consultation with CCO care coordinators. As of 2022, APD continues to increase their referral rate for LTSS members for care coordination as indicated by our recent MOU activities report submission.	Activate Care is used to document and track the care of LTSS members. This software system enables the creation of automated workflows, including embedded enrollment and intake tasks for our care coordination program. One key feature of these workflows is an automated reminder for care coordinators to update member care plans at least every 90 days. In addition to utilizing Activate Care, the Care coordination Director conducts a monthly case review to assess the status of each LTSS member. During this review, the Care Coordination Director expects care coordinators to provide updates on the current healthcare plan goals. APD staff upload completed LTSS assessments to the protected Care Profiles and/or Care Plans maintained by the CCO, facilitating the sharing of information for coordinated care.	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals. % of CCO person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties.

	coordination platform. CCO care coordinators keep APD LTSS case managers updated on the member's care plan through individual phone calls and/or the monthly IDT meetings. Care coordinators also update their contact information in Point Click Care (PCC), as necessary, to ensure communication with APD case management and any other healthcare providers who may interact with the member in a hospital or emergency department setting. When LTSS members require assistance navigating the social support system or accessing social services, a Care coordinator is typically assigned to assist. These professionals are skilled in finding and connecting members with community resources. Flex funds, vouchers, and/or Unite Us network HRSN referrals (climate, nutrition, housing) are used to help address any identified Social Determinants of Health (SDOH) barriers.			

	For members with Special Health Care Needs (SHCN), identified through a comprehensive assessment, Advanced Health offers direct access to a specialist at no cost to the member. This access is provided for ongoing conditions that require treatment or regular monitoring. A member's Primary Care Provider (PCP) can refer the member to the appropriate specialist without requiring prior authorization. The PCP must notify Advanced Health by submitting a Physician Authorization Form, available on our website, marking the SHCN box at the top, and providing the specialist's contact information. This process allows Advanced Health to issue an authorization number for billing purposes, with pre-approved visits (e.g., 6 visits in 6 months) to ensure the member can establish care with the specialist.			
DOMAIN 4: Transitional care practices/Care Setting Transitions				

DOMAIN 4: Transitional care practices Goals	Advanced Health has designated our Care Coordination Program Manager (MSN, RN) as the primary point of contact for overseeing LTSS members. The Program Manager and staff collaborate with APD on a daily to weekly basis. Traditional Health Workers are also assigned cases by the Program Manager when Social Determinants of Health (SDOH) needs require attention. Currently, CCO and APD staff coordinate regularly through ad hoc meetings to address transitional issues. Key activities supporting care transitions—such as from hospital to home, hospital to rehab, rehab to home, or new long-term care placements—are discussed through various methods, as described above. In some cases, nursing staff and LTSS case managers meet in person to assist our most vulnerable members. An example of in-person coordination includes transitional planning at the Coal Bank Village pallet shelter.	APD case managers and CCO care coordinators attend weekly BAH meetings for discharge planning – DNS works with CM/traditional health worker. APD advises CCO care coordinators of LTSS consumers that could benefit from coordinated care and staff these individuals at our standard meetings. APD's diversion and transition (D/T) team is a specialized unit for this type of care. Through the given process, APD will notify the CCO of a transition as soon as possible. Two populations that fall in this domain are existing LTSS consumers that are hospitalized and/or new LTSS consumers. For current LTSS consumers in the hospital, the assigned APD case manager and D/T unit work with the consumer and hospital to get them stabilized in the community. Biggest obstacle is community placement capacity. APD does not provide emergent services instead addresses on following business day due to capacity for emergency services.	The Program Manager oversees transition of care activities by tracking referrals into the program. Care coordinators are assigned cases based on the strengths and abilities of each coordinator. To enhance data tracking, the Activate Care system with new checkboxes that categorize activities by type, mode, outcome, participant, and setting. Activate Care generates reports that provide insights into outreach efforts, including activities such as CCO-to-CCO transitions, SNF and HEN notifications, APD participant involvement, and skilled nursing facility settings.	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge? % CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)? # of Debrief meetings held quarterly to post-conference transitions where transitions wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4].

DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	Advanced Health and the APD District 7 office periodically exchange updated staff and contact information via email to ensure the accurate maintenance of the monthly virtual meeting IDT schedule and proper access to Activate Care. Currently, Advanced Health uses Point Click Care (PCC) to monitor LTSS and FBDE members. In some cases, care coordinators update PCC guidelines to share important information with other members of the care team, including the member's health status, special healthcare needs, and safety considerations. PCC cohorts are designed to monitor at-risk populations. Since APD case managers add themselves as providers, Advanced Health cross-references at-risk populations (identified via cohort tagging) with the provider list. Advanced Health reviews PCC cohorts periodically, including Hospital Event Notifications (HEN) for all emergency department (ED) and inpatient (IP) admissions, 7+ ED visits within 3	Both APD and CCO will continue to build on existing communication processes to share current and upcoming information for the benefit of mutual support of consumers and members. This includes referral requests and submissions, assessments, individual needs, internal and external resources, and more. Utilizing tools such as Activate Care, Monthly administrative meetings with the CCO, e-mail of shared populations, shared community meetings, and more support the ongoing communication.	Activate Care is in process this year to integrate the 834 LTSS Tag into the members' Care Profile, which will improve our awareness of this population group. In 2025, Care coordinators are contacting all the moderate to high-risk members to offer care planning services and to complete the HRS. In addition to this, a Care Coordinator RN is completing an additional LTSS assessment of each high risk member for possible referral to APD, which will greatly increase our monthly LTSS referral rate average.	# of CCO Collective Platform HEN notifications monthly result in 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 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).

	months, and skilled nursing facility (SNF) admissions.			

OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals				
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals				
OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals	CCO agrees to provide care coordination service education to the APD staff such as: • Eligibility • Relevant HRA information • Role of the RN and THW • Care coordination process • Care coordination terminology • Care coordination workflows • Care planning • Use of Activate Care	APD/AAA will, when requested, provide agency education and presentations to Advanced Health CCO outlining the following: • APD/AAA capabilities • Program availability • APD/AAA processes • Language and Terminology • Limitations within each required domain • Interdisciplinary Care teams • Development and sharing of individualized care plans • Transitional care practices		

SIGNATURES: Include Name, Job Title, Agency, Signature, Date

Signatures of All MOU parties (APD/AAA and CCO) should be included and signed prior to March 31, 2025. OHA/DHS review will occur after CCO submits the MOU. Neither OHA or DHS will require review or co-signature to the MOU.

CCO Authorized Signature, Name, Job Title, CCO Name, Date:

Ross Acker, Director of Care Coordination:

Ross Acker, MS, LPC

Ross Acker, MS, LPC (Mar 31, 2025 11:20 PDT)

APD Field Office Authorized Signature, Name, Job Title, APD Field Office Name, Date

Josh Harlukowicz, Chief Operations Officer, Oregon Department of Human Services-District 7:

Josh Harlukowicz

Advanced Health CCO-LTSS-MOU-CY2025 20250331

Final Audit Report 2025-03-31

Created:	2025-03-31
By:	Ashley Matsui (ashley.matsui@advancedhealth.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAIPr2C4arGJqyDedflSJnwmQaNnJohmzc

"Advanced Health CCO-LTSS-MOU-CY2025 20250331" History

Document created by Ashley Matsui (ashley.matsui@advancedhealth.com)
2025-03-31 - 6:15:13 PM GMT

Document emailed to ross.acker@advancedhealth.com for signature
2025-03-31 - 6:16:53 PM GMT

Email viewed by ross.acker@advancedhealth.com
2025-03-31 - 6:19:01 PM GMT

Signer ross.acker@advancedhealth.com entered name at signing as Ross Acker, MS, LPC
2025-03-31 - 6:20:46 PM GMT

Document e-signed by Ross Acker, MS, LPC (ross.acker@advancedhealth.com)
Signature Date: 2025-03-31 - 6:20:48 PM GMT - Time Source: server

Document emailed to JOSHUA Harlukowicz (joshua.z.harlukowicz@odhs.oregon.gov) for signature
2025-03-31 - 6:20:49 PM GMT

Email viewed by JOSHUA Harlukowicz (joshua.z.harlukowicz@odhs.oregon.gov)
2025-03-31 - 7:05:45 PM GMT

Document e-signed by JOSHUA Harlukowicz (joshua.z.harlukowicz@odhs.oregon.gov)
Signature Date: 2025-03-31 - 8:47:19 PM GMT - Time Source: server

Agreement completed.
2025-03-31 - 8:47:19 PM GMT