CCO-LTSS Partnerships MOU Template:

MOU Period: January 1, 2025, thru December 31, 2028

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 __AllCare CCO, Inc_____ OHA Contract #___161755-9____

Partner AAA/APD District (s) Names/Locations ___Area Agency on Aging, Senior Services and People with Disabilities for Douglas County District 6__

If more than one AAA/APD office in your CCO Geographic Region Please Circle or X Whichever Applies: Single Combined MOU___ Multiple MOUs_X_

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
CCO will clearly articulate in this section: AllCare CCO will clearly articulate: Medicaid-funded long-term care (LTC) services are legislatively excluded from the budgets of Care Coordination Organizations (CCO) by law. These services will continue to be directly funded by Oregon Department of Human Services (ODHS). While Medicare covers limited coverage for post-hospital acute care, Medicaid is the primary payer for LTC services. To reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system must coordinate care and share accountability for individuals receiving Medicaid-funded long term care services. AllCare CCO Care Coordinators will involve members, and/or their authorized representatives in developing the individualized care plan (ICP). Additionally, AllCare CCO Care Coordinators will inform members and their authorized representatives about the Interdisciplinary Team (IDT) meetings and invite/engage them as appropriate. This is a non-binding agreement between AllCare CCO (Medicaid, Medicare Advantage and DSNP), and Aging People with Disabilities Douglas County. The mutual goal of the proposed agreement is to enhance person-centered care, align care and service delivery, and ensure beneficiaries receive the right amount of care at the right time across the LTC system.	**AAA/APD will clearly articulate in this section:** The regional Area Agency on Aging, and Aging and Aging and People with Disabilities is the Senior and Disability Services Department (SDS) for District 6 Douglas County. Area Agency on Aging has one office located in Roseburg, Oregon. Aging and People with Disabilities (APD) for District 6, has one office located in Roseburg, Douglas County. One advisory council assists with this advocacy. The Disability Services Advisory Council (DSAC) is being formed and will meet to advise local Aging and People with Disabilities (APD) offices on program policy and the effectiveness of services provided (such as Medicaid and SNAP) to both seniors and younger people (18-64) living with disabilities.

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	AllCare CCO utilizes a data dashboard that incorporates 834 enrollment data and other care coordination data points. This data dashboard identifies Long Term Service and Support (LTSS) members, through the utilization of filters, we can determine if members have a case open, if members have an assigned care coordinator, the date of their most recent Health Risk Assessment and if a member is identified	APD/AAA will communicate key health related information, including risk assessments created by LTC providers and local Medicaid APD/AAA offices. This can be done during scheduled IDT's, or through case consultations between AAA/APD case managers and AllCare Staff. There will also be collaborative efforts in developing, reporting and meeting metric requirements for the following: linking supportive resources,	AllCare CCO's Information Technology team has enhanced the Care Management System record to better include care plan interventions, tasks, and reports that capture data exchange, referrals and assessments. See referenced documents: Domain_1_834Report_ Domain_1a_LTSS-MOU_Staff_Training_ Guide_ Domain _1b_APD_Referal_ Domain_1c_APD_Communication_ Domain_1d_Incoming_Referral_APDAAA_ Domain_1e_Community_Partner_LTSS_Referral_pdf_ Domain_1f_Tableau_Dashboard_	# 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

	as having Special Health Care Needs (SHCN). This information allows us to quickly identify members who need outreach and engagement into care coordination. The initial outreach is essential for coordinating targeted care based on each member's individual needs, assessing potential additional unmet needs, and collaborating with the member and the member's care team. Newly enrolled members are opened for care coordination, if a member has been enrolled into AllCare and is newly LTSS, they are easily identified, and a care coordinator is assigned. The member is outreached for an initial Health Risk Assessment (HRA), and care coordinators work to	health promotion and prevention, plus safeguards for members.		assessments (for persons with unmet needs). # of APD/AAA referrals to CCO for care coordination review # of completed referrals for care coordination review [Monthly/Year Total]

	identify the members Interdisciplinary care team (ICT) to create a comprehensive person -centered care plan. If a member is not LTSS but their HRA or conditions indicate that they may be eligible for LTSS services, the member is referred to APD/AAA through the LTSS Community Partner LTSS Referral Process to connect members to APD/AAA services.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	AllCare CCO (Medicaid, Medicare Advantage, and DSNP), conducts Interdisciplinary Team Meetings (IDT) every other week or more frequently as needed. IDT meetings ensure member needs are met, and care gaps are closed. For example, transitions	APD/AAA shall support and participate in AllCare APD/AAA shall support and participate in AllCare CCO Interdisciplinary Team Meetings (IDT) if needed to coordinate planned care for CCO members. This shall include CCO members who are in the acute care setting and skilled nursing facilities and are experiencing increased complexities in	IDT meetings are documented using several methods to accurately capture collaboration, participation, and progress on care plans. Each IDT meeting is recorded in a member's Care Management System. Additionally, meetings are tracked through a sign-in sheet and an IDT case presentation form. See referenced documents: Domain_2_IDT_Meeting_Template_ Domain_2a_ Individualized_Care_Plans_with_Updates_	# 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.

	of care barriers are identified, as well as additional services and supports to ensure safe transitions for members. This includes those in acute care settings and skilled nursing facilities who are facing increased complexities in the transfer process, as well as members transitioning from a home setting to a higher level of care. These IDT meetings are scheduled with APD/AAA through the end of the year and held through a secure online meeting. Members and their Interdisciplinary Care Team (ICT) are invited to attend and participate in IDT meetings. This includes, but is not limited to, the	the transfer process. The following information to be shared at each meeting as needed: provider information, care supports in place, Medicare plans, assessments, treatment and care plans, care transitions, discharge follow-up care, referrals, case worker contact information and any other necessary information to assist in the coordination of care for the CCO member such as legal guardian information.	Domain_2b_IDT_Form_Template_ Domain_2c_IDT_Meeting_Defination s_	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).

	member, the attending medical provider, and other medical professionals caring for the member, case managers from APD/AAA or other collaborative agencies and/or participants who the member identifies. Members identified for IDT meeting agenda is determined by active unmet needs, or barriers to support, care or goals, (Domain 1).			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	AllCare CCO Care Coordination works with all providers, including community and social support providers, and with the member to create a patient-centered care plan.	The following care plan information shall be coordinated between agencies to support individualized member care and ensure there is no duplication of services initially and on an ongoing basis. Care plans to include evidence-based practices with the member, family	Supervisors conduct regular case audits verifying completion of state timelines. Reports are also generated as needed from the Care Management System for reporting purposes. See referenced documents: Domain_3_Chart_Audit_Tool_ Domain_3a_Individualized_Shared_ Case_File_	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals.

	Care plan development includes the member, family and/or other individuals identified by the member, medical providers and community agencies which is documented and recorded in the AllCare CCO Care Management System and shared with the member ICT upon completion and upon any changes. Care Planning is initiated upon enrollment. Care Coordination telephonically or in person, engages with the member, attempts to complete the HRA to identify special health care needs, and care coordinators work collaboratively on the creation of the Interdisciplinary Care Plan (ICP). If a member declines completing an HRA,	and/or other individuals involved in care plan creation and completion, medical providers and community agencies which is documented and recorded. Other information to be shared pertinent in care planning shall be: member living situation preference and cost, most cost effective option to meet the member's care need, APD case worker information, LTC contact information and any other supportive individual involved in the member's care. Additionally, risk assessments generated by the LTC providers shall be integrated into the care plans shared.	Domain_3b_AllCare_Nondiscrimination_and_Language_Access_OHA_pdf_ Domain_3c_DEI_COO_006_Meaningful_Language_Access_Policy.pdf_ Domain_3d_Health_Promotion_Prevention_and_Education_Policy.pdf_	% 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.

	the care coordinator will develop an ICP with the member based on the members identified needs. If a member needs end-of-life care planning, medication reconciliation, these services are engaged through care coordination efforts, and AllCare CCOs benefit management team. If a member needs language / disability services, AllCare CCO utilizes our language access teams to assist and provide linguistically appropriate support. Collaboration with the ICT is to support the individualized member care and ensure a reduction of duplicated services as well as understanding the APD/AAA service plan for the member			

	to support member's goals with other care teams. AllCare CCO (Medicaid, Medicare Advantage and DSNP), goal for care plan creation is to ensure member centric and holistic care, coordinated between agencies and medical professionals caring for the member, this will ensure services are not duplicated. See optional domain A for process to link community resources to care plans. APD/AAA and AllCare CCO engage in IDT meetings every 2 weeks or sooner based on member needs. These are held through a secure online meeting. Care plans are shared during IDT meetings. (Domain 1)			

	Each care plan is reviewed at least every 90 days or more frequently and after every IDT meeting, allowing for care plan amendments to meet the needs and care of all members. Care Plans are shared with the members ICT upon completion, when changes occur, and are also available electronically to members on the AllCare secure member portal.			
DOMAIN 4: Transitional care practices/Care Setting Transitions				
DOMAIN 4: Transitional care practices Goals	AllCare CCO has processes written into various policies and procedures outlining specific transitions of care for members. These policies provide state guidelines and specific timelines while working with the members.	For CCO members in residential, inpatient, long-term care, home to a higher level of care, or other similarly licensed care facility, APD/AAA will support and participate in discharge meetings as follows: • The transition meeting may be held 30 days prior to the member entering the CCO's service area if at all possible; and/or	AllCare CCO's Care Management System automates system triggers for all TOC cases to contact agencies involved in the member's care. The system triggers specific tasks to coordinate medication, DME, transportation and other TOC needs as identified by the Centers for Medicare and Medicaid Services (CMS) Transitions of Care. All completed actions are reportable and shall be submitted upon request. See referenced documents: Domain_4_Pop_Health_Audit_Tool_ Domain_4a_Transition_of_Care_Program_Policy_.pdf_	% 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

	Through PointClickCare, AllCare CCO Care Coordinators monitor member hospitalizations, emergency department usage, and skilled nursing facility discharge events in real time. These events may prompt updates to care planning, referrals to APD/AAA, or other necessary support and engagement. AllCare CCO has interdepartmental systematic guidelines to map the coordination and care for members transitioning between care settings. This provides decision-making processes for clinical and non-clinical staff reviewing behavioral, physical, and oral	• If applicable to another facility or program or as soon as possible if CCO is notified of impending discharge with less than 30 days of notice of discharge. This information may be informational only if care coordination is needed or outlined in current CCO-LTSS state guideline requirements.	Domain_4b_Transitions_of_ Care_ Case_ File_ Example.docx_ Domain_4c_Point_Click_Care_Medical_Cohorts_Including_SNF_and_Daily_Hospital.pdf	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].

	health service requests. Upon identification of a member with special healthcare needs or LTSS (long-term services and supports), various qualified staff are available to assist in the transition, this includes resources needed for Social Determinants of Health (SDOH). Such qualified staff may include, but is not limited to, Health Related Services, Non-Emergent Medical Transportation (NEMT) Liaison, Register Nurses, Licensed Practical Nurses, Behavioral Health Specialists, Respiratory Therapists, Intensive Care Coordinators, Maternal Child			

	Health Advocates, Traditional Health Workers and Pharmacists. AllCare CCO also has a dedicated team that focuses on Transitions of Care within Care Coordination, the Behavioral Health team and the Benefit Management and Utilization team. Staff attend in-person facility meetings and meet with members face to face. Dedicated Transitions of Care staff work to ensure key post-discharge planning begins at the time of admission, including ensuring follow-up appointments are made, as well as requests for DME,			

	medications, home health services, and the entirety of discharge orders follow the member from one care setting to another or to home. This includes additional benefits such as face to face interactions, Advance Care Planning and home meal delivery.			
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	When an AllCare CCO member is identified for a referral to APD/AAA, AllCare CCO will utilize the Community Partner LTSS referral process to initiate this referral. (Domain 1) AllCare CCO has various reporting mechanisms in place notifying multiple internal departments of hospital events	Both entities will continue to expand, improve and utilize communication resources available. APD/AAA shall continue to receive CCO referral requests which includes request for assessment of services. AllCare CCO communication between entities shall be documented and supplied to OHA reporting requirements.	AllCare CCO's Care Management System allows all completed actions within a member's case to be reportable and shall be submitted upon request. AllCare also utilizes external HIE platforms to produce HEN reports. Additionally, claim data reports are utilized for monitoring, potential referrals, collaboration of care and care coordination as needed. See referenced documents: Domain_5_Point_Click_Care_Medical_Cohorts_Including_SNF_and_Daily_Hospital.pdf__ Domain_5a_Community_Parnter_LTSS_Referral_ Domain_5b_Transitions_of_Care_Case_File_Example_	# 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

	and services obtained by members. This includes claims review AllCare CCO Benefit Management team. Through the use of PointClickCare, AllCare CCO Care Coordinators can monitor, in real time, member hospitalization, emergency department utilization and SNF discharge events. These events can trigger care planning updates, referrals to APD/AAA or other supports/engagement as needed. AllCare CCO Staff also utilize Health Information Exchange (HIE) platforms to obtain further information that results in the need to collaborate			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).

	with agency partners such as APD/AAA. The HIE can also provide additional information regarding members care team. AllCare CCO will review annually with the APD/AAA team our unique and varied utilization of community-based tools, like the HIE and PointClickCare, to increase collaboration and share workflows that improve quality of care.			
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	AllCare CCO continues to collaborate with medical care teams and community partners in implementing a CIE (Unite Us) platform for resource utilization, this closed-loop referral system will be made available to multiple entities	AAA will continue to refer members as appropriate to AllCare CCO. This will support shared members who may have assessment requests, social service supports and other needs. Linking to Support Services: AAA programs may include:	All entities will have independent reporting access for various data elements to meet individual metric outcomes, state requirements or other information needed for reporting.	

	without cost or fees.	• PEARLS: Program to Encourage Active and Rewarding Lives for Seniors • OPAL: Options for People to Address Loneliness • Powerful Tools for Care givers classes • Aging and Disability Resource Connection (ADRC) is available to assist any consumer, family member, or friend of senior or person with disability. ADRC will refer to other health promotion and prevention programs such as (but not limited to) those named above. These services are available through individual referral or through specific contract with AllCare CCO to support its membership. APD is actively exploring the utilization of the CIE and are engaging with community partners in this process.		
OPTIONAL DOMAIN B: Health Promotion and Prevention				

OPTIONAL DOMAIN B: Health Promotion and Prevention	AllCare CCO will abide by OHA guidelines in facilitating Interdisciplinary team meetings (IDT). Such meetings include invitations to the following: the member, family/support, medical care team, AllCare CCO Care Coordination team, LTSS, APD/AAA and/or any other individual involved in the member's care. AllCare CCO will continue collaborating with the Health and Wellness team to support members on their wellness journeys. • Tobacco Cessation • Preventative Wellness Program • Lose It AllCare CCO supports members with	APD attends AllCare Population Health Staff meetings at least annually or more often to provide education regarding APD programs. AAA will additionally attend Population Health Staff meetings to provide education to our team regarding health promotion and prevention services. AAA office will additionally provide tangible or electronic flyers for community sharing regarding workshops offered. AAA offices offer supportive education and classes as outlined in section A.	AllCare CCO will have an identified liaison communicating with APD/AAA's liaison to evaluate processes and safeguards while evaluating necessary changes needed to meet a member's goal. Communication will be a combination of electronic and face-to-face collaboration at least quarterly.	

	Advance Directives, including providing community-based education, provider network training, as well as community provider support in assisting members with Advance Directive education and support with completion of their Advance Directives. AllCare provides referrals to the AAA programming that is outlined in section A. Crisis protocols will remain in effect, and ongoing collaboration will continue with AllCare CCO's Behavioral Health (BH) team, Medical Directors, Quality and Compliance departments, and any other relevant internal policies or departments to ensure the safety and well-being of members, in line with AllCare CCO obligations.			

	Additionally, AllCare CCO collaborates with state entities, such as the Oregon Health Authority (OHA) Ombuds Program.			
OPTIONAL DOMAIN C: Cross-System Learning Goals				
OPTIONAL DOMAIN C: Cross-System Learning Goals	AllCare CCO, when requested, will provide CCO education and presentations to APD/AAA outlining the following: • CCO Capabilities • Processes • Language and terminology • Limitations within each required domain • Prioritization of high needs members • Interdisciplinary team meetings (IDT) • Development and sharing of individualized care plans (ICP)	APD/AAA will, when requested, provide agency education and presentations to AllCare CCO outlining the following: • APD/AAA Capabilities • Program availability • APD/AAA Processes • Language and terminology • Limitations within each required domain • Prioritization of high needs members • Interdisciplinary teams • Development and sharing of individualized care plans	Both entities agree to keep records of education documentation and attendance for all training sessions. Training will be conducted at least annually to assist in employee turnover, program changes, and or other potential barriers that may prevent members from achieving their care plan goals.	

	• Transition of care practices • Collaborative communication tools and processes • Phone /email contact lists of Care Coordinators	• 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

Max Janasik
max.janasik@allcarehealth.com Max Janasik, CEO, AllCare CCO, Inc. 03/10/2025

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

Tom Maloney
tom.j.maloney@odhs.oregon.gov Thomas Maloney, District Manager, Roseburg APD, District 6, 03/12/2025

AAA Office Authorized Signature, Name, Job Title, AAA Office Name, Date

Jeanne Wright
jlwright@co.douglas.or.us Jeanne Wright, Director, Douglas County Senior and Disability Services (DCSDS), AAA, 03/18/2025