CCO-LTSS Partnerships MOU Template:

MOU Period: January. 1, 2025 through 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 ___Rogue Valley Council of Governments and Aging and People with Disability District 8_____

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 the Oregon Department of Human Services (ODHS). Medicare covers limited post-hospital acute care, but 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 LTC services. Care Coordinators will involve members, and/or their authorized representatives, APD/AAA case managers, and any member of the members interdisciplinary care team. In developing the individualized care plan (ICP). Additionally, Care Coordinators will inform members and/or 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), Rogue Valley Council of Governments and Aging People with Disabilities District 8. 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.	**AAA/APD will clearly articulate in this section:** The regional Area Agency on Aging is Rogue Valley Council of Governments (RVCOG) for District 8 (Jackson and Josephine Counties) and is located within Rogue Valley Council of Governments (RVCOG) in Central Point, Oregon. Two advisory councils assist with this advocacy. The Senior Advisory Council (SAC) is made up of up to 21 community members, appointed by the RVCOG Board of Directors, and is mandated under the federal Older Americans Act to advise the Area Agency on Aging Program Directors. The Council provides advice and assistance with new program development and service implementation to meet the needs of seniors and people with disabilities, are advocates and sources on information to the community, and advise on key issues and emerging trends. The Disability Services Advisory Council (DSAC) is made up of up to 11 members of the community and meets monthly 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	APD/AAA will provide AllCare Health bimonthly reports and the access to identify members with high health care needs; this includes relevant data on all CCO members receiving Medicaid funded long-term care services, a change in care provider and Medicare plans. APD/AAA will communicate key health related information, including risk	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_Referral_ 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 assessments (for persons with unmet needs). # of APD/AAA referrals to CCO for care

	Assessment and if a member is identified 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	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, health promotion and prevention, plus safeguards for members.		coordination review # of completed referrals for care coordination review [Monthly/Year Total]

	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 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, and/or more frequently as needed. IDT meetings ensure member needs are met, and care gaps are closed. For example, transitions 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.	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 the transfer process. The following information to be shared at each meeting as needed: provider information, care	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_ Domain_2b_IDT_Form_Template_ Domain_2c_IDT_Meeting_Definations_	# 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

	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 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).	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.		CCO).

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. 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's 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	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 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:	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_ Domain_3b_AllCare_Nondiscrimination_and_Language_Access_OHA_pdf_ Domain_3c_Achhc_Faq_Interpreter_Services-pq_.pdf_ Domain_3c_DEI_COO_006_Meaningful_Language_Access_Policy.pdf_ Domain_3d_Health_Promotion_Prevention_and_Education_Policy.pdf	% 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.

	identify special health care needs, and care coordinators work collaboratively on the creation of the Individualized Care Plan (ICP). If a member declines completing an HRA, 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 members ICP and ensure a reduction of	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.		

	duplicated services as well as understanding 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. 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's			

	needs. These are held through a secure online meeting. Care plans are shared during IDT meetings or through secure email or fax. (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.	For CCO members in residential, inpatient, long-term care, home to a higher level of care, or other	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.	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition?

	These policies provide state guidelines and specific timelines while working with members. 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	similarly licensed care facility, APD will support and participate in discharge meetings as follows: • The transition meeting must be held 30 days prior to the member entering the CCO's service area; and/or • 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	See referenced documents: Domain_4_Pop_Health_Audit_Tool_ Domain_4a_Transition_of_Care_Program_Policy_.pdf_ Domain_4b_Transitions_of_ Care_ Case_ File_ Example.docx_ Domain_4c_Point_Click_Care_Medical_Cohorts_Including_SNF_and_Daily_Hospital.pdf__	% 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].

	provides decision-making processes for clinical and non-clinical staff reviewing behavioral, physical, and oral 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	may be informational only if care coordination is needed or outlined in current CCO-LTSS state guideline requirements.		

	Therapists, Intensive Care Coordinators, Maternal Child 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 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, ensuring follow-up appointments are made, as well as supporting 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, home meal delivery and remote patient monitoring.			
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 and services obtained by	Both entities will continue to expand, improve and utilize communication resources available. APD/AAA shall continue to receive CCO referral requests which include request for assessment of services. AllCare CCO's communication between entities shall be documented	AllCare CCO's Care Management Software 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 for members with LTSS or new in-need of LTSS assessments.

	members. This includes claims review by the 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 with agency partners such as	and supplied to OHA reporting requirements.		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).

	APD/AAA. The HIE can also provide additional information regarding members care team. AllCare CCO will review 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	RVCOG AAA currently participates in the Unite Us platform and may send or receive referrals from AllCare CCO and community partners.	All entities will have independent reporting access for various data elements to meet individual metric outcomes, state requirements or other information needed for reporting.	

	made available to multiple entities without cost or fees.	Participation in the Unite Us CIE allows for a more comprehensive referral system needed for assessment requests, social service support and other needs. This system provides a closed loop referral resource, and allows for tracking of referrals, and coordinated efforts between all involved in the member's care. Linking to Support Services: AAA programs may include: • PEARLS: Program to Encourage Active and Rewarding Lives for Seniors • OPAL: Options for People to Address Loneliness • Powerful Tools for Caregivers 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. APD is actively exploring the utilization of the CIE and are engaging with community partners in this process. These services are available through individual referral or through specific contract with AllCare CCO to support its		

		membership.		
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Health Promotion and Prevention	AllCare CCO care coordination staff complete the LTSS community referral training upon hire, and at least annually or upon identified changes. AllCare CCO will continue collaborating with the Health and Wellness team to support members on their wellness journeys. Appropriate referrals will be initiated to the Health and Wellness team for the following programs: • Tobacco Cessation • Preventative Wellness Program • Lose It AllCare CCO supports members with Advance Directives, including providing community-based education, provider network	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. APD / AAA offices support AllCare participants in ensuring they have access to Advance Directive benefits.	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.	

	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	AAA offices offer supportive education and classes as outlined in section A.		

	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, 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 • Transitional care practices • Collaborative Communication Tools and Processes • Phone / email contact lists of care coordinators	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 • Interdisciplinary Care teams • Development and sharing of individualized care plans • Transitional care practices	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.	

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. 03/04/2025

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

Jeremy Wolf
jeremy.l.wolf@odhs.oregon.gov Jeremy Wolf, APD District Manager, District 8 Jackson and Josephine Counties, 03/07/2025

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

Ann Marie Alfrey
amalfrey@rvcog.org Ann Marie Alfrey, Executive Director, Central Point Rouge Valley Council of Governments (RVCOG), 03/13/2025