Health Share of Oregon Care Coordination and Long-Term Care Services & Supports Memorandum of Understanding

This Amended and Restated Memorandum of Understanding (MOU) is entered into as of January 1, 2025, by and between Health Share of Oregon (Health Share) and the Multnomah County Aging, Disability and Veterans Services Division (ADVSD) and the ODHS offices for Aging and People with Disabilities (APD) in Clackamas and Washington counties, collectively referred to herein as "LTSS agencies."

Memorandum of Understanding Definitions

"Aging and People with Disabilities (APD)" has the meaning provided for in OAR 410-141-3500
"Area Agency on Aging (AAA)" has the meaning provided for in OAR 410-141-3500
"Care Coordination" has the meaning provided for in OAR 410-141-3500
"Care Plan" has the meaning provided for in OAR 410-141-3500
"Health Risk Assessment" has the meaning provided for in OAR 410-141-3500
"Medicaid-Funded Long-Term Services and Supports (LTSS)" has the meaning provided for in OAR 410-141-3500
"Long-term Care" has the meaning provided for in OAR 410-141-3500
"Special Health Care Needs" has the meaning provided for in OAR 410-141-3500
"Treatment Plan" has the meaning provided for in OAR 410-141-3500

Purpose of Memorandum of Understanding

Medicaid-funded long-term services and supports (LTSS) are legislatively excluded from Coordinated Care Organization (CCO) budgets and will continue to be paid for directly by the Oregon Department of Human Services (ODHS).

To share responsibility for delivering high quality, person-centered care, improve health, and reduce costs, the parties to this MOU work together to:

- Coordinate care across the healthcare continuum
- Share accountability for individuals receiving Medicaid-funded LTSS
- Increase communication between Health Share and LTSS Agencies regarding individuals receiving Medicaid-funded LTSS to ensure care coordination
- Improve health outcomes
- Deliver high quality, person-centered care
- Reduce costs in healthcare delivery and long-term care systems
- Improve care experience and quality of life
- Address social determinants of health
- Reduce health disparities
- Prevent or delay need for LTSS

Agreements of the Parties

Based on a good faith description of the roles and responsibilities, the parties to this MOU agree to participate in this MOU during the period from January 1, 2025, through December 31, 2026.

Core Memorandum of Understanding Elements

I. Governance Structure and Accountability
   A. The Health Share Medicaid LTSS Sub-Committee meets at least quarterly to review and discuss the activities included in this MOU as well as other topics of mutual interest, including any issues or barriers which may be impacting the LTSS population, and to review and improve processes.
   B. Membership on the LTSS Sub-Committee includes at least one representative from each of the following:
      1. Health Share of Oregon
      2. Multnomah County Aging, Disability and Veterans Services Division (ADVSD)
      3. Clackamas County ODHS-APD District 15
      4. Washington County ODHS-APD District 16
      5. Clackamas County Social Services (CCSS)
      6. Washington County Disability, Aging and Veterans Services (DAVS)
      7. CareOregon, Inc
      8. Kaiser Permanente
      9. Legacy Health – PacificSource
      10. OHSU Health Services
      11. Providence Health Assurance
   C. Additional stakeholders identified by the LTSS Sub-Committee may also be invited to attend quarterly meetings, as needed.
   D. Health Share designates staff to support the work of the LTSS Sub-Committee, including, but not limited to: scheduling and planning meetings, preparing agendas and supporting documentation for meetings, and documenting and disseminating meeting notes.

II. Data and Reporting
   A. Health Share maintains data sharing platforms which shall remain accessible to all LTSS agencies.
   B. LTSS agencies are required to track and report all data requested in the monthly reporting form.
   C. LTSS Agencies shall monthly report requested data to Health Share via Bridge.
   D. Health Share maintains an LTSS Care Coordination Teams Contact Information document which includes contact information for all LTSS Agencies and Health Share Plan Partner staff. Document is audited and updated regularly and shared via Bridge.

Memorandum of Understanding Domains

This Memorandum of Understanding includes the five required domains set forth by Oregon Health Authority.

1. Prioritization of high needs members
2. Interdisciplinary care teams (IDT)
3. Development and sharing of individualized care plans
4. Transitional care practices
5. Collaborative communication tools and processes

Exhibit A – Required Domain Details is attached to, and by this reference incorporated in, this MOU. Exhibit A provides additional information regarding the five required domains including:

- Processes and Activities agreed to by the CCO
- Processes and Activities agreed to by the LTSS Agency
- Process Monitoring and Measurement
- Requirements for Reporting

Exhibit B – Required Domain Reporting, is attached to, and by this reference incorporated in, this MOU.

Signatures and Contacts

This MOU may be signed in counterparts. Delivery of an executed signature page of this MOU by electronic signature software or by electronic transmission of a PDF file will be effective as delivery of a manually executed counterpart of this MOU. At the request of a party, each other party will confirm a PDF transmitted signature page by delivering an original signature page to the requested party.

[***signature pages follow***]

Health Share of Oregon

[redacted] Date: 3/20/2025

Name: [redacted] Title: CEO

Designated Contact Person

Name: [redacted] Title: Clinical Operations Manager

Email: [redacted] Phone: [redacted]

Clackamas County Department of Human Services, Aging and People with Disabilities

By [redacted] Date: 3/18/2025

Name: [redacted] Title: D15 APD District Program Manager

Designated Contact Person

Name: [redacted] Title: PEMD – APD Deputy District Manager

Email: [redacted] Phone: [redacted]

Multnomah County Aging, Disability, and Veterans Services Division

By: [redacted] Date: 2/26/25

Name: [redacted] Title: Department Director

Designated Contact Person

Name: [redacted] Title: Quality Assurance Coordinator

Email: [redacted] Phone: [redacted]

Washington County Department of Human Services, Aging and People with Disabilities

By: [redacted] Date: 3/3/25

Name: [redacted] Title: APD District Manager

Designated Contact Person

Name: [redacted] Title: Deputy District Manager, Washington and Columbia Counties APD

Email: [redacted] Phone: [redacted]

Exhibit A

Required Domains Details

MOU Service Area: Clackamas, Multnomah, and Washington Counties				
DOMAIN 1: PRIORTIZATION OF HIGH NEEDS MEMBERS				
Shared Accountability Goals	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Local Measures of Success**	**Annual Report on Specific Statewide Measures of Success**
DOMAIN 1: Prioritization of high needs members	High Needs Members are identified by Care Coordinators via an initial Health Risk Assessment (as defined in OAR 410-141-3500) conducted within 90 days of enrollment or sooner if member's health status requires it. Health Share and its Subcontractors work with APD/AAA to update and improve processes to identify high needs members and share prioritization data with APD/AAA. These processes will be reviewed by the LTSS Sub-Committee quarterly to ensure appropriate prioritization of member needs. Health Share provides Subcontractors with a list of their LTSS members monthly, based on the LTC flag in the 834 file from OHA (Attachment A: Standard Operating Procedure_LTSS Data Upload).	APD/AAA staff shares prioritization data with Health Share Subcontractors via phone and email. Health Share provides APD/AAA with a list of their LTSS members monthly, based on the LTC flag in the 834 file from OHA. (Attachment A: Standard Operating Procedure_LTSS Data Upload).	Track usage of Bridge by Health Share Subcontractors and APD/AAA per month and discuss issues/barriers at Care Coordination Advisory Workgroup within the LTSS Sub-Committee.	# 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 coordination review [Monthly/Year Total]

	Subcontractors communicate with APD/AAA regarding high needs members using the process created in collaboration with Health Share, its Subcontractors, and the APD/AAA as outlined in Attachment B: LTSS IDT_ Desk Procedure To facilitate communication and coordination across systems, Health Share maintains and shares a document titled "LTSS Care Coordination Contact Info" which contains pertinent Subcontractor LTSS and/or care coordination staff. Subcontractors review the contact information at least quarterly and will notify Health Share of any corrections or updates as soon as they are known. Health Share will also conduct a bi-annual audit of the LTSS Care Coordination Contact Info document to ensure all data is accurate. (Attachment C: LTSS Care Coordination Contact Info) Referral process document,(LTSS IDT_ Desk Procedure) for Health Share Subcontractors and APD/AAA are housed on Bridge. Health Share Subcontractors notify Health Share of any referral process updates as needed.	APD/AAA staff follow the process outlined in Attachment B: LTSS IDT_ Desk Procedure To facilitate communication and coordination across systems, Health Share maintains and shares a document titled "LTSS Care Coordination Contact Info" which contains pertinent APD/AAA staff. APD/AAA staff review the contact information at least quarterly and will notify Health Share of any corrections or updates as soon as they are known. (Attachment C: LTSS Care Coordination Contact Info) APD/AAA staff notify Health Share of any referral process updates as needed.		

DOMAIN 2: INTERDISCIPLINARY CARE TEAMS				
Shared Accountability Goals	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Local Measures of Success**	**Annual Report on Specific Statewide Measures of Success**
DOMAIN 2: Interdisciplinary care teams	Health Share Subcontractors shall work with APD/AAA to schedule and hold Interdisciplinary Team (IDT) meetings as often as necessary, to coordinate care for mutual members receiving LTSS. IDTs are scheduled via email. Purpose of IDTs: To gather all care team members from all disciplines (healthcare, long term services and supports, mental/ behavioral health, other social service, and community partners) that are currently involved with a member receiving LTSS to: • Understand the member's health and welfare related needs, including the member's goals, preferences, and any concerns about access to needed services; • Understand each care team member's scope and role in assisting and supporting the member; • Communicate consistently with the member about what they can expect from their care team; and • Work collaboratively to address gaps and unmet needs of the member while respecting the member's right to self-determination and the least restrictive intervention.	APD/AAA staff work with Health Share Subcontractors to schedule and hold Interdisciplinary Team (IDT) meetings as often as necessary to coordinate care for mutual members receiving LTSS. IDTs are scheduled via email. Purpose of IDTs: To gather all care team members from all disciplines (healthcare, long term services and supports, mental/ behavioral health, other social service, and community partners) that are currently involved with a member receiving LTSS to: • Understand the member's health and welfare related needs, including the member's goals, preferences, and any concerns about access to needed services; • Understand each care team member's scope and role in assisting and supporting the member; • Communicate consistently with the member about what they can expect from their care team; and • Work collaboratively to address gaps and unmet needs of the member while respecting the member's right to self-determination and the least restrictive intervention.	Track usage of Bridge by Health Share Subcontractors and APD/AAA per month and discuss issues/barriers at Care Coordination Advisory Workgroup within the LTSS Sub-Committee.	# 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).

	IDTs should strive to include care team members from all disciplines (physical health, long term services and supports, behavioral health, other social service, and/or community partners) that are currently involved with a member. Members or their representatives are also invited to attend their IDT meeting. Health Share Subcontractors shall engage LTSS members in their IDT meetings as often as possible or desired by members. Health Share Subcontractors will continue to use and refine the IDT process.	IDTs should strive to include care team members from all disciplines (physical health, long term services and supports, behavioral health, other social service, and/or community partners) that are currently involved with a member. Members or their representatives are also invited to attend their IDT meeting. AAA/APD staff shall engage LTSS members in their IDT meetings as often as possible or desired by members. APD/AAA staff will continue to use and refine the IDT process		

DOMAIN 3: DEVELOPMENT AND SHAREING OF INDIVIDUALISED CARE PLANS				
Shared Accountability Goals	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Local Measures of Success**	**Annual Report on Specific Statewide Measures of Success**
DOMAIN 3: Development and sharing of individualized care plans	Health Share hosts a Care Coordination Advisory Group every month which brings together care coordination staff from across the continuum to share best practices and processes on all aspects of care coordination and to support a culture of integration. Representatives from each Health Share Subcontractor participate in these meetings. Health Share and Health Share Subcontractors maintain policies, procedures, and/or processes regarding the following: • Development of individual, integrated treatment and person-centered care plans with member and/or member representative input; • Development and implementation of processes for sharing information, coordinating care, and monitoring results, and creating the most comprehensive care plan to address member needs and how often care plans are reviewed and updated; • Support of the appropriate flow of relevant information and a standardized approach to effectively plan, communicate, and implement care planning and follow-up; and	APD/AAA staff attend and participate in the Care Coordination Advisory Group hosted by Health Share. APD/AAA staff maintain policies, procedures, and/or processes regarding the following: • Development of individual, integrated treatment and person-centered care plans with member and/or member representative input; • Development and implementation of processes for sharing information including LTSS care plans, coordinating care, and monitoring results, and creating the most comprehensive care plan to address member needs and how often care plans are reviewed and updated; • Support of the appropriate flow of relevant information and a standardized approach to effectively plan, communicate, and implement care planning and follow-up; and	Track usage of Bridge by Health Share Subcontractors and APD/AAA per month and discuss issues/barriers at the Care Coordination Advisory Workgroup within the LTSS Sub-Committee.	% 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.

	• Processes for coordination with social and support services and resources to address social determinants of health that support care plans and ensure access to language and disability services to ensure access. • Process for incorporating Advance Care Planning or End-of-Life Decision Making/POLST into comprehensive care planning when appropriate. • Process for medication reconciliation for patients with complex or high-risk medication concerns.Per OAR 411-004-0030, care team members will develop the person-centered service plan with the individual Member and, as applicable, the legal or designated representative of the Member. Care plans will strive to incorporate Member preferences and goals whenever possible. Health Share Subcontractors have strategies to reduce all-cause readmissions and avoidable ED utilization, and to improve depression screening and follow-up plans for members with LTSS. Health Share Subcontractors will monitor for changes of condition, care transitions, and other opportunities for care plan updates.	• Processes for coordination with social and support services and resources to address social determinants of health that support care plans and ensure access to language and disability services to ensure access. • Process for incorporating Advance Care Planning or End-of-Life Decision Making/POLST into comprehensive care planning when appropriate. • Process for medication reconciliation for patients with complex or high-risk medication concerns. • Per OAR 411-004-0030, care team members will develop the person-centered service plan with the individual Member and, as applicable, the legal or designated representative of the Member. Care plans will strive to incorporate Member preferences and goals whenever possible. APD/AAA staff develop and use strategies to reduce all-cause readmissions and avoidable ED utilization and will work with Subcontractors to improve depression screening and follow-up plans for members with LTSS.		

	As all LTSS Members are required to have care plans, Health Share Subcontractors will create a care plan for all new LTSS Members and update care plans as necessary. When care plans are updated, Health Share Subcontractors share updated care plan with all members of the care team, including the member in LTSS. LTSS Members (and, as applicable, their legal or designated representative) are treated fairly, are informed of their choices, and have a strong and respected voice in decisions about their care and support services.	APD/AAA staff will assist the Health Share Subcontractors with creating and update care plans as necessary. LTSS Members (and, as applicable, their legal or designated representative) are treated fairly, are informed of their choices, and have a strong and respected voice in decisions about their care and support services.		

DOMAIN 4: TRANSITIONAL CARE PRACTICES				
Shared Accountability Goals	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Local Measures of Success**	**Annual Report on Specific Statewide Measures of Success**
DOMAIN 4: Transitional care practices	Health Share and Health Share Subcontractors maintain policies, procedures, and/or processes regarding how transitions and transition resources are coordinated for members receiving LTSS, and to support the appropriate flow of relevant information within Health Share and with APD/AAA, including: • Processes to coordinate appropriate discharge planning and ensure that services are in place prior to discharge per OAR 410-141-3860. • Scheduling for key follow-up appointments, planning for transportation needs, medication reconciliations and durable medical equipment needs before transition happens. • Communication strategies and expectations. • Appropriate use of cross system resources during transitions. Health Share Subcontractors support appropriate planning for different types of transitions including transitions to and from hospitals from in-home, community-based facility, long term nursing facilities and post-acute settings (skilled nursing facility care) as well as transitions between these settings. These processes	APD/AAA staff maintain policies, procedures, and/or processes regarding how transitions and transition resources are coordinated for members receiving LTSS, and to support the appropriate flow of relevant information within APD/AAA and with Health Share and Health Share Subcontractors, including: • Processes to coordinate appropriate discharge planning and ensure that services are in place prior to discharge per OAR 410-141-3860. • Assisting Health Share Subcontractors with follow-up for key appointments, planning for transportation needs, and durable medical equipment needs before transition happens. • Communication strategies and expectations. • Appropriate use of cross system resources during transitions. APD/AAA staff support appropriate planning for different types of transitions including transitions to and from hospitals from in-home, community-based facility, long term nursing facilities and post-acute settings (skilled nursing facility care) as well as transitions between these settings. Examples of planning supports may include:	Track usage of Bridge by Health Share Subcontractors and APD/AAA per month and discuss issues/barriers at Care Coordination Advisory Workgroup within the LTSS Sub-Committee.	% 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 weren't smooth (improvement process approach)? [Q1, Q2, Q3, Q4].

	are maintained by and specific to each Health Share Subcontractor. Examples of planning supports may include: • Identify current long term and post-acute Medicaid residents that have potential for transition. • Monitor individuals that are either Post Hospital Extended Care (PHEC) or Medicare Skilled for transition potential prior to potential LTSS application. • Support the individual's choice of placement options. • Identify and address barriers to placement. • Verify supports and additional need to create a safe transition/placement • Hold a post-transition meeting of the IDT (with the member, their representative or guardian when possible) within 14 days of transition between levels, settings, or episodes of care. Health Share and its Subcontractors work with APD/AAA to define a quality improvement process approach for transitions that are not smooth. Health Share and its Subcontractors meet at least quarterly with APD/AAA to review current processes, identify and resolve service or process gaps, and address any issues.	• Identify current long term and post-acute Medicaid residents that have potential for transition. • Monitor individuals that are either Post Hospital Extended Care (PHEC) or Medicare Skilled for transition potential prior to potential LTSS application. • Support the individual's choice of placement options. • Identify and address barriers to placement. • Verify supports and additional need to create a safe transition/placement • Participate in a post-transition meeting of the IDT (with the member, their representative or guardian when possible) within 14 days of transition between levels, settings, or episodes of care. APD/AAA staff work with Health Share and its Subcontractors to define a quality improvement process approach for transitions that are not smooth. APD/AAA staff meet at least quarterly with Health Share and its Subcontractors to review current processes, identify and resolve service or process gaps, and address any issues.		

DOMAIN 5: COLLABORATIVE COMMUNICATION TOOLS AND PROCESSES				
Shared Accountability Goals	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Local Measures of Success**	**Annual Report on Specific Statewide Measures of Success**
DOMAIN 5: Collaborative Communication tools and processes	Health Share Subcontractors share process documents for communication and will maintain key contacts for receiving communications on Bridge. Health Share Subcontractors use PointClickCare information to track current LTSS members receiving care coordination services. PointClickCare information is also used to determine if LTSS members may require more assistance with care coordination. Health Share and its Subcontractors work with APD/AAA to continue to identify ways to use PointClickCare to improve communication and care coordination.	APD/AAA staff share process documents for communication and will maintain key contacts for receiving communications on Bridge. APD/AAA staff use PointClickCare information to track current LTSS members receiving care coordination services. Collective Platform information is also used to determine if LTSS members may require more assistance with care coordination.	Track usage of Bridge by Health Share Subcontractors and APD/AAA per month and discuss issues/barriers at Care Coordination Advisory Workgroup within the LTSS Sub-Committee.	# of CCO PointClickCare 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 PointClickCare 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).

Exhibit B

Required Domain Reporting

<table>
<tr><th colspan="4">DOMAIN 1: PRIORTIZATION OF HIGH NEEDS MEMBERS</th></tr>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td>DOMAIN 1 MOU Goals: Prioritization of high needs members</td><td></td><td></td><td>
# of members with LTSS that prioritization data was shared during each month [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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# of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) [Monthly/Year Total]
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<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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# of APD/AAA referrals to CCO for Care Coordination review [Monthly/Year Total]
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# of completed referrals for Care Coordination review [Month and Year Totals]
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<tr><th colspan="4">DOMAIN 2: INTERDISCIPLINARY CARE TEAMS</th></tr>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td>DOMAIN 2 Goals:
Interdisciplinary care teams</td><td></td><td></td><td>
# of members with LTSS that are addressed/staffed via IDT meetings monthly [Monthly/Year Total]
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<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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____% of months in year 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
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<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
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% of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO) [Monthly/Year]
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<tr><th colspan="4">DOMAIN 3: DEVELOPMENT AND SHAREING OF INDIVIDUALISED CARE PLANS</th></tr>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) –monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td>DOMAIN 3 Goals: Development and sharing of individualized care plans</td><td></td><td></td><td>% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals [month/year]
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<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
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____% 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 [Annual]
<table>
<tr><td colspan="3">Quarter 1</td><td colspan="3">Quarter 2</td><td colspan="3">Quarter 3</td><td colspan="3">Quarter 4</td><td>Annual</td></tr>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg</td></tr>
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<tr><td>DOMAIN 4: Transitional care practices Goals</td><td></td><td></td><td>
% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? [Monthly/Year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
% transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge? [Monthly/Year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
% CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)?
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
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</table>
____# of Debrief meetings held quarterly to post-conference transitions where transition wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4]
<table>
<tr><td colspan="3">Quarter 1</td><td colspan="3">Quarter 2</td><td colspan="3">Quarter 3</td><td colspan="3">Quarter 4</td><td>Annual</td></tr>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr>
<tr><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td></td></tr>
</table>
</td></tr>
<tr><td colspan="4">DOMAIN 5: COLLABORATIVE COMMUNICATION TOOLS AND PROCESSES</td></tr>
</table>

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td rowspan="4">DOMAIN 5: Collaborative Communication tools and processes Goals</td><td rowspan="4"></td><td rowspan="4"></td><td># 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. [Monthly/Year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td># 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. [Monthly/Year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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</table></td></tr>
<tr><td>__X__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). Documentation: Attached 3 written process documents</td></tr>
</table>

Attachment A
LTSS Standard Operating Procedure

Project or Process Name: Long-Term Service and Supports (LTSS)
Version Effective Date: December 16, 2024; March 8, 2023; December 27, 2021
Prepared By: [redacted]
Modified By: [redacted]

Project or Process Purpose
Health Share is required to report metrics to the Oregon Health Authority on the following domains:
1.Prioritization of high needs members
2.Interdisciplinary care teams (IDT)
3.Development and sharing of individualized care plans
4.Transitional care practices
5.Collaborative communication tools and processes

Health Share's IDS/ICN partners need to know which members are in Long-Term Care (LTC) or those who need Long-Term Service and Supports (LTSS). They have requested that Health Share send a file each month of their members so they can target outreach to their most critical and vulnerable members.

SOP Scope
To outline the process of uploading members lists to the SFTP.

HSO Business Contact Names & Titles
[redacted] IS Sr. Business Systems Analyst
[redacted], Operations Specialist

Partner Organizations
All IDS/ICN partners (CareOregon, Kaiser, LHPS, OHSU, and Providence)
APDs within our service area's three counties (Multnomah, Washington, and Clackamas)

Roles & Responsibilities

Title	Responsibilities	Name
Operations Specialist	Communicates with partner organizations, manages MOU data and deliverables	[redacted]
Sr. IS Data Analyst	Implemented automation of member lists	[redacted]
IS Sr. Business Systems Analyst	Liaison between HSO IT and partner organizations	[redacted]

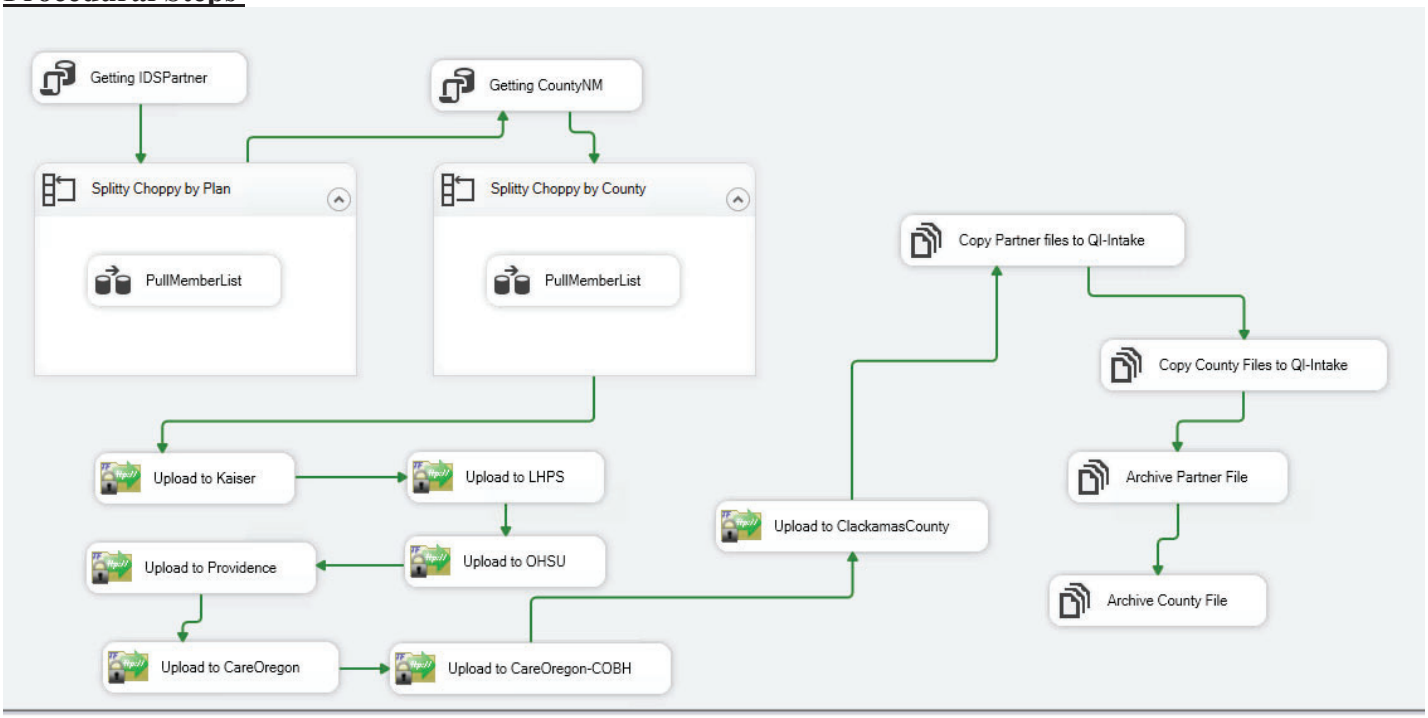
Timelines/SLAs
Heath Share will automatically upload the member lists to the respective SFTP folders for all IDS/ICN partners and Multnomah County on the 28th of each month.
Operations Specialist will manually extract and upload the member lists to the LTSS Bridge page for Clackamas and Washington Counties on the 28th of each month or the next closest business day.

Special Requirements or Restrictions
None

Supportive Documentation
Health Share LTSS Tri-County MOU
OHA LTSS MOU Guidance Documentation

Prerequisites and Related SOPs
None

Procedural Steps



Attachment B

TITLE: Long-Term Services and Supports Interdisciplinary Care Teams (IDT) Procedure

PROCEDURE:

I. APD/AAA or Health Share Plan Partner staff receives or initiates the IDT referral.
   A. Referrals can be received or initiated from the LTSS case manager, CCO case manager, medical provider, or by the client meeting specific quantifiable criteria (ER visits, etc.).
II. Staff enters client information into LTSS tracking document/system.
III. Staff responds to the referring party for information gathering.
IV. Determine current and future state.
   A. Define current state and presenting concern for the client.
   B. Define desired future state or resolution for the client.
   C. Capture the client's perspective whenever possible.
V. Establish IDT participants.
   A. IDT participants can include the client, client representatives, family members or client supports, the LTSS case manager, the CCO case manager, medical providers, social workers, and points of contact for the clients housing.
   B. APD/AAA and Health Share Plan Partner staff should engage with LTSS Members in their IDT meetings as often as possible or desired by members.
VI. Collect the ROI.
   A. Use form MSC 3010 "Authorization for Disclosure, Sharing and Use of Individual Information."
VII. Establish IDT deliverables.
VIII. Schedule the IDT with all participants
   A. Find a time that accommodates all participants.
   B. Select date and time for the IDT.
   C. Send IDT invitation to participants.
IX. Hold IDT
   A. Draft the IDT agenda.
   B. Distribute the IDT agenda and meeting materials.
   C. Complete IDT and the IDT deliverables.
   D. Record the resulting IDT decisions.
   E. Capture open IDT action items.
   F. Reassign uncompleted deliverables for a future IDT.
   G. Track IDT Meeting for reporting purposes.
X. Communicate IDT results and meeting notes to participants and stakeholders.

REFERENCES:

MSC 3010: Authorization for Disclosure, Sharing and Use of Individual Information

Department: Operations and Integration	Author: [redacted], Operations Specialist
Effective Date: June 2021	Review Frequency: As needed
Revision Date(s): February 2022; January 2025	

Attachment C

Health Share LTSS Care Coordination Teams Contact Info

New Referral for LTSS Members Needing Care Coordination

When there is a New Referral for an LTSS Member who needs Care Coordination, contact the **Primary Contact for LTSS Members New to Care Coordination** noted below for each organization. Requests should include the *member's name, DOB, and the requester's name and contact information* along with reason for referral. Contact the **Secondary Contact** below if you don't receive a timely response (within **5** business days).

Primary Contact for LTSS Members New to Care Coordination	Secondary Contact
CareOregon - Primary Email: [redacted]	**CareOregon - Secondary** Name: [redacted] Email: [redacted] Phone: [redacted]
Kaiser - Primary Name: [redacted] Email: [redacted] Phone: [redacted]	**Kaiser - Secondary** Name: [redacted] Email: [redacted]
OHSU - Primary Email: [redacted]	**OHSU- Secondary** Name: [redacted] Email: [redacted] Phone: 5[redacted]
PacificSource - Primary Name: [redacted] Email: [redacted] Phone: [redacted]	**PacificSource - Secondary** Name: [redacted] Email: [redacted] Phone: [redacted]
Providence- Primary Name: [redacted] Email: [redacted] Phone: [redacted]	**Providence- Secondary** Name: [redacted] Email: [redacted]
Clackamas County- Primary Name: [redacted] Email: [redacted] Phone: [redacted]	**Clackamas County - Secondary** Name: [redacted] Email: [redacted] Phone: [redacted]
Multnomah County- Primary Name: [redacted] Email: [redacted] Phone: [redacted]	**Multnomah County - Secondary** Name: [redacted] Email: [redacted]
Washington County - Primary Name: [redacted] Email: [redacted] Phone: [redacted]	**Washington County - Secondary** Name: [redacted] Email: [redacted]

LTSS Members in Care Coordination

If an LTSS member is currently engaged with a care coordinator, they should be contacted directly. If a response is not received within 5 business days, the **Care Coordinator Secondary Contact** (listed below) for the organization can be contacted to escalate the request.

Secondary /Escalation Contacts

CareOregon
Name: [redacted]
Email: [redacted]
Phone: [redacted]

Kaiser
Name: [redacted]
Email: [redacted]

Name: [redacted]
Email: [redacted]

OHSU
Name: [redacted]
Email: [redacted]
Phone: [redacted]

PacificSource
Name: [redacted]
Email: [redacted]
Phone: [redacted]

Providence
Name: [redacted]
Email: [redacted]

Name: [redacted]
Email: [redacted]

Clackamas County
Name: [redacted]
Email: [redacted]
Phone: [redacted]

Multnomah County
Name: [redacted]
Email: [redacted]

Washington County
Name: [redacted]
Email: [redacted]
Phone: [redacted]

All Counties and Plan Partners are contractually required to keep this contact information current. To make updates to this list, contact the Health Share Operations Specialist, [redacted] *at* [redacted] *as soon as the changes occur.*

Certificate Of Completion

Envelope Id: 0BC3BF31-2ED4-45EE-960C-0E4F185A2CB5
Status: Completed
Subject: Sign 2025 Medicaid LTSS MOU - Sign by 3/27
Source Envelope:
Document Pages: 27
Signatures: 1
Certificate Pages: 2
Initials: 0
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-08:00) Pacific Time (US & Canada)

Envelope Originator:
[redacted]
2121 SW Broadway
Ste 200
Portland, OR 97201-3181
[redacted]
IP Address: 75.164.135.253

Record Tracking

Status: Original
3/18/2025 | 12:48 PM

Holder: [redacted]

Location: DocuSign

Signer Events	Signature	Timestamp
[redacted] CEO Health Share of ORegon Security Level: Email, Account Authentication (None)	DocuSigned by: [redacted] Signature Adoption: Pre-selected Style Using IP Address: 50.53.45.20	Sent: 3/18/2025 | 12:59 PM Resent: 3/20/2025 | 11:14 AM Viewed: 3/20/2025 | 11:44 AM Signed: 3/20/2025 | 11:44 AM

Electronic Record and Signature Disclosure:
Not Offered via Docusign

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
[redacted] Contracts Manager Health Share of Oregon Security Level: Email, Account Authentication (None)	COPIED	Sent: 3/18/2025 | 12:59 PM
[redacted] Contracts Manager Health Share of Oregon Security Level: Email, Account Authentication (None)	COPIED	Sent: 3/20/2025 | 11:44 AM

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	3/18/2025 | 12:59 PM
Certified Delivered	Security Checked	3/20/2025 | 11:44 AM
Signing Complete	Security Checked	3/20/2025 | 11:44 AM
Completed	Security Checked	3/20/2025 | 11:44 AM

Payment Events	Status	Timestamps