CCO-LTSS Partnerships MOU Template:

MOU Period: 1/1/2025 through 12/31/2026

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 PacificSource Community Solutions- Columbia Gorge **OHA Contract #** 161736

Partner AAA/APD District (s) Names/Locations : This is a non-binding agreement between PacificSource Community Solutions ("PCS" or "CCO") Columbia Gorge and the Department of Human Services Aging and People with Disabilities District 9 hereinafter referred to as AAA/APD. AAA/APD serves the following geographical area: Hood River County, Wasco County, Sherman County and Wheeler County. PCS Columbia Gorge serves the following geographical area: : Hood River County, Wasco County, Sherman County and Wheeler County. AAA/APD has agreed to serve those counties through this Memorandum of Understanding (this "MOU"). The parties agree to conduct this work in accordance with Oregon Health Authority's ("OHA") CCO LTSS MOU Guidance CY2025-26 document, as that document may be amended (the "OHA Guidance"). To the extent that there is any language in this MOU that conflicts with the OHA Guidance, the OHA Guidance shall supersede the language in this MOU.

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

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s): PCS Care Management	APD/AAA Lead(s): APD/AAA Case Management

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

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	1. All PCS members are screened for risk level. Members who are receiving Medicaid-funded LTSS are stratified as Moderate or High Risk based on critical risk factors. Each of these members receives outreach by PCS regardless of Risk level. When the member is reached and opts to engage in Care Coordination, PCS staff contacts APD/AAA to coordinate care, invite to and schedule IDT meetings, and establish ongoing communication. 2. Members receiving Medicaid-funded LTSS who have experienced a Hospital event or been discharged to an SNF are reported via the HIE system. This report is shared with APD/AAA via secure email. 3. PCS initiates discharge planning and includes APD/AAA when a member receiving Medicaid-funded LTSS services is experiencing a transition in levels of care. Additionally, PCS notifies APD/AAA of all PHEC	APD/AAA will provide the CCO with a report of service plans and Risk levels for the prior month renewals and new completed LTSS intakes. At the bi-monthly IDT CCO and APD will review the LTSS members prioritizing high care and high/medium risk members with care coordination needs. APD/APD will make referrals to CCO for members with potential need for Care Coordination risk assessments as APD/AAA staff identify concerns or gaps or changes in health status. APD will make referrals to CCOs or community partners for any Health-Related Social Needs (HRSN).	Event communication with APD/AAA POC problem of Needs APD/AAA assessment Referral source of APD/AAA	# 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]

	stays and includes the date the member is expected to be discharged. 4. PCS contacts Members who are not receiving Medicaid-funded LTSS but are considered to have ongoing Special Health Care Needs (excluding OHP Bridge members) and refer to APD/AAA for assessment. 5. PCS and APD/AAA meet twice monthly to discuss any discharge barriers, ADL barriers, and overall Care Coordination for members receiving Medicaid-funded LTSS services. These meetings also provide the opportunity to discuss members referred to APD/AAA for evaluation of needed services and discussion of LTSS members that APD/AAA refers to PCS for Care Coordination services. *See LTSS Workflow			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	1. PCS shares member Care Plans with APD/AAA for LTSS members.	APD/AAA will assign appropriate Case workers including Case Managers and/or Diversion	PCS maintains records of members discussed in regularly	# of members with LTSS that are addressed/staffed via IDT meetings monthly.

	2. PCS and APD/AAA schedule and hold at least two (2) Interdisciplinary Team (IDT) Meetings per month to coordinate care for high-risk members/consumers receiving LTSS or who are potentially eligible for LTSS. PCS provides a list of members to be discussed prior to scheduled IDT meetings. PCS and APD/AAA collaborate as a team during those meetings to ensure a holistic Care Plan for that member. 3. PCS requests APD/AAA provide a list of consumers to be discussed at scheduled IDT meetings. 4. PCS invites members and/or their representatives or guardians to attend IDT meetings. 5. PCS invites PCPs and relevant providers or agencies to attend IDT meetings.	Transition coordinators, to attend IDT bi-weekly meetings to jointly coordinate plans for high need members. coordinator, for members needing routine and care coordination. Assignments are generated from monthly LTSS, risk reports provide by APD/AAA to PCS. APD/AAA caseworkers will encourage LTSS members and/or representatives to participate in IDT meetings after their renewal or new intake is completed. Member will have the have the choice to decline. APD/AAA will participate in quarterly meeting to review coordination and MOU processes and adjust processes as needed to best serve members.	scheduled IDT meetings with APD/AAA. PCS uses a medical management system to capture IDT meetings for LTSS members. PCS captures attendees of IDT meetings in the medical management platform. PCS documents whether the member was invited and attended the IDT meeting.	% 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).

	6. PCS includes PS Medicare and DSNP to attend IDTs as indicated. 7.PCS invites relevant MA plan representation as able. 8.PCS updates and revises the member Care Plan as indicated from feedback in IDT meetings with APD/AAA. 9. PCS and APD/AAA also meeting quarterly for system level coordination and to ensure MOU processes and agreements are being met.			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	1. PSC develops a member-focused care plan that considers evidence-based practices, member preferences and goals, and timely service access in collaboration with the member's care team, including but not limited to LTSS service providers. This care plan will be embedded in the member's Care Profile. 2. Per HIPAA regulations, PCS will jointly share care plans with	•APD/AAA will share LTSS service plans and risk assessments to PCS. PCS/APD will coordinate during IDT meetings to integrate PCS and APD/AAA care plans. •APD/AAA will actively engage individuals in the design, and where applicable, implementation of their LTSS service plan, in coordination with CCO where relevant to	% of PSC person-centered care plans for LTSS members when possible, documenting member preferences and goals, tracked through a data pull from PCS's population health management platform. % of PSC person-centered care plans for LTSS members that are updated ate least every 90 days and shared with relevant	% 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.

	LTSS service providers within 10 days of completing the member assessments using secure email when possible and postal mail when not. 3. PCS will discuss any needed updates to the care plan, including, but not limited to, ways to reduce readmission and avoidable ED utilization and improve depression screening and follow-up plans for LTSS members at the twice-monthly scheduled IDT Meetings and no less than every 90 days. 4. As part of the care planning process, Advance Care Planning or End-of-Life Decision making will be addressed with the member and medication reconciliation will be provided for members with complex medication concerns. 5. Additional information on PCS care plan guidance can be found in the Medicaid Care Management Policy.	health care treatment and care planning. •APD/AAA will contact CCOs when they have referrals for care coordination or otherwise have identified gaps or concerns about health care needs of members with LTSS	parties, tracked through a data pull from PCS's population health management platform.	
DOMAIN 4: Transitional care practices/Care Setting Transitions				

DOMAIN 4: Transitional care practices Goals	1. PCS develops a member-focused care plan considering evidence-based practices, member preferences and goals, and timely service access in collaboration with the member's care team, including but not limited to LTSS service providers. This care plan will be embedded in the member's Care Profile. 2. Per HIPAA regulations, PCS will jointly share care plans with LTSS service providers within 10 days of completing the member assessments using secure email when possible and postal mail when not. 3. PCS will discuss any needed updates to the care plan at the twice-monthly scheduled IDT Meetings and no less than every 90 days. 4. When PacificSource is aware that an LTSS member is transitioning to another CCO, PCS will notify the APD office.	•APD case workers will participate in IDT meetings when appropriate. D/T workers will participate and coordinate with PCS to discuss ongoing transition members and coordinate with PCS. Monthly member service plans from APD/AAA will include preferences and goals. PCS and APD/AAA D/T caseworkers will coordinate service plans to meet member medical and social goals during transitions. •Once PCS contacts the local office with LTSS referrals, APD/AAA will follow its current LTSS new intake process per local protocol. •APD/AAA will work with CCO, OHA and medical providers on durable medical equipment and environmental modifications needed for successful transitions.	IP stay and have a Plan of Care outcome of "Coordination of care with APD/AAA" or the appropriate agencies have been notified within the IP stay. IP stay and a Facility Discharge Assessment where the question was this discharge delayed because DME, Medications or transportation were not arranged timely? CM event with engagement level of Redirected to "Transition to other CCO" and warm handoff completed = yes Quarterly meetings	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge? % CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)? # of Debrief meetings held quarterly to post-conference transitions where transitions wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4].

	5. PCS will notify APD via fax, mail, phone, or portal regarding inpatient LTSS members before discharge.			
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	1. PCS receives HIE HEN notifications that identify all Hospital Events for members receiving Medicaid Funded LTSS members. PCS also receives HIE SNF notifications identifying admits and discharges to/from a Skilled Nursing Facility (SNF). These notifications serve as a referral for Care Coordination if there is an identified risk for readmission or a need for ongoing care coordination needs. It also serves as a notification for ED visits, hospital admissions, and discharges, which are treated as a Health Related Circumstance Change for those members. 2. PCS Care Coordinators use the information in the notification to initiate outreach to members and to update the member's Individualized Care Plan.	•APD/AAA will ensure communication processes are clear and reflect capabilities and expectations to build cross-system collaboration to improve outcomes and reduce duplication. •APD/AAA will ensure communication methods are detailed and specific to enable regular communication and information sharing across all required domains. •APD/AAA uses Point Click Care to monitor LTSS consumers admittance for ER services, inpatient hospital admits and medical appointments. Point Click Care also identifies any known health professionals engaged with the consumer for current or past care. APD will review and engage the CCO for	Referral source Referral source LTSS DTR	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments. # of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments. MOU includes written process documents (prioritization, IDT, care planning, transitions) that clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).

	3. These notifications also prompt PCS Care Coordinators to collaborate with APD/AAA about discharge planning and reducing barriers to discharge for the member. 4. PCS schedules an IDT meeting within 14 days of a transition between levels of care identified within the HIE HEN or SNF notification and invites the member, their caregiver, any relevant providers, and <APD/AAA>. 5. PCS will send <APD/AAA> a HEN notification report weekly so they can identify hospital events for any members that they are currently managing	wrap around care needs identified using this platform. •APD/AAA will participate in discussions as appropriate on any APD/AAA use or monitoring new SNF information (Post-Acute Care) in PointClick Care. APD/AAA will check PointClick Care daily and weekly and enter information into Oregon Access for ongoing Case Management monitoring. Case Managers monitor for high risk indicators and transitions. They will participate in discussion as appropriate on any APD/AAA use or monitoring new SNF information in PointClick Care.		
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals				
OPTIONAL DOMAIN B: Health Promotion and Prevention				

OPTIONAL DOMAIN B: Safeguards for Members Goals				
OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals				

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.

CFO 3/25/25

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

David Brehanst Dist Manager Dist 9 APD. 3/20/2025

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

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