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 Lane **OHA Contract #161764**

Partner AAA/APD District (s) Names/Locations This is a non-binding agreement between PacificSource Community Solutions ("PCS" or "CCO") Lane and the Lane Council of Governments (LCOG), Senior and Disability Services (the Area Agency on Aging for Lane County) hereinafter referred to as AAA/APD. AAA/APD serves the following geographical area: Lane County, Oregon. PCS Lane serves the following geographical area: Lane County. AAA/APD has agreed to serve Lane County 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/AAALead(s):** Stephanie Sheelar, LCOG Deputy Director and Marisa Andrews, Contracts Manager

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.	AAA has an Advocacy Council made up of Advisory Council members. The Advocacy Council and AAA leadership will continue to advocate for Medicaid services, LTSS, and Care Coordination in collaboration with the CCOs. This will be accomplished through education and training which results in letters, meetings, and conversations with local, state, and federal legislatures regarding these topics.

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				

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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	AAA Expectations: •AAA will provide CCOs with access to information needed to identify members with LTSS with high health care needs. •AAA will provide monthly report of member – (includes assessment scores, SPL, service plan, case worker, and other prioritization data) to CCO. •AAA 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. •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]

	<APD/AAA> of all PHEC 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. 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.	•AAA will participate in interdisciplinary care team meetings to support their members. •AAA will ensure that CCO providers/care teams are notified of which CCO members are receiving LTSS services, the relevant local AAA/APD office contact, and contact for relevant LTSS provider. •AAA will have knowledge of and actively participate in CCO team-based care processes when appropriate.	PCS maintains records of members discussed in regularly 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 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).

	5. PCS invites PCPs and relevant providers or agencies to attend IDT meetings. 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	•AAA will provide consumer preference from CA/PS to ensure alignment with care plan. •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 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

	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, 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.	health care treatment and care planning. •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.	% of PSC person-centered care plans for LTSS members that are updated ate least every 90 days and shared with relevant parties, tracked through a data pull from PCS's population health management platform.	90 days/quarterly and shared with all relevant parties.

	5. Additional information on PCS care plan guidance can be found in the Medicaid Care Management Policy.			
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.	• AAA will communicate and collaborate on transitions of care identified within LTSS/Home and Community Based Care supporting the lease restrictive consumer choice. This is managed through a Transition and Diversion team and/or case managers who review and update through assessment. They will reach out weekly to CCO staff to communicate consumers preparing for transition to ensure that discharge order are in place. • AAA will provide detail on best way to contact staff for LTSS assessments. • AAA will work with CCO, OHA and medical providers on durable medical equipment and environmental modifications	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].

	4. When PacificSource is aware that an LTSS member is transitioning to another CCO, PCS will notify the APD office. 5. PCS will notify APD via fax, mail, phone, or portal regarding inpatient LTSS members before discharge.	needed for successful transitions.		
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. 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.	•AAA Transition and Diversion team monitor hospital event and skilled nursing facility notifications through PointClickCare and will notify CCO on members noted as having a change of condition or change to their service plan. •Participate in discussions as appropriate on any AAA use or monitoring new SNF information (Post-Acute Care) in PointClickCare.	Referral source Referral source LTSS DTR	# of CCO PointClickCare 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 PointClickCare 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

	2. PCS Care Coordinators use the information in the notification to initiate outreach to members and to update the member's Individualized Care Plan. 3. These notifications also prompt PCS Care Coordinators to collaborate with APD 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			responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).
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.

M F Dir CFO 3/25/25

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

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

Transaction ID: CBJCHBCAABAAatd3dEmtlCMKkEHJH4-IDNg-OpnMWl4u

Stephanie Sheeler | Stephanie Sheeler, LCOG Deputy Director, Senior & Disability Services | 03/24/2025

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

Transaction ID: CBJCHBCAABAAatd3dErntlCMKkEHJH4-IDNg-OpnMWl4u