## CCO-LTSS Partnerships MOU:

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

**CCO Name** PacificSource Community Solutions – Marion-Polk **OHA Contract #** 161765

**Partner AAA/AAA District (s) Names/Locations: This is a non-binding agreement between PacificSource Community Solutions ("PCS" or "CCO") Marion-Polk and Northwest Senior and Disability Services (the Area Agency on Aging for Marion and Polk Counties) ("AAA"); hereinafter referred to as AAA. AAA serves the following geographical area: Marion, Polk, Yamhill, Clatsop, and Tillamook Counites. PCS Marion-Polk serves the following geographical area: Marion and Polk counties. AAA has agreed to serve Marion and Polk 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/AAA 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 | AAA Lead(s): AAA Case Management |
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| **CCO will clearly articulate in this section:**<br>--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.<br><br>--How Affiliated MA or DSNP plan participates in the MOU work for FBDE. | **AAA will clearly articulate in this section:**<br>--How AAA governance Lead(s) for participation at the community level in the board / Advisory panel for LTSS perspective/Care Coordination.<br><br>--AAA 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). |

| MOU Service Area: | | | | |
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| **Shared Accountability Goals with 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.<br><br>When the member is reached and opts to engage in Care Coordination, PCS staff contacts AAA to coordinate care, invite to and schedule IDT meetings, and establish ongoing communication.<br><br>2. Members receiving Medicaid-funded LTSS who have experienced a hospital event or are being discharged to a SNF are reported via the HIE system. | 1. AAA provides PCS a monthly service report via secure email of all CCO LTSS members served to assist in identifying those with high health care needs.<br><br>2. AAA utilizes referrals, screenings and assessments to identify and prioritize CCO members with high health care needs. Additionally, AAA uses status change updates from hospitals to prioritize<br><br>3. AAA identifies LTSS members receiving:<br><br>• In-home services that staff believe are at risk due to accepting/receiving | Event communication with AAA<br><br>POC problem of Needs AAA assessment<br><br>Referral source of AAA | # of members with LTSS that prioritization data was shared during each month/year<br><br>Annual Average monthly # of members with LTSS for whom prioritization data was shared [ monthly #/total in year]— calculated by OHA from data submitted.<br><br># of CCO referrals to AAA for new LTSS service assessments (for persons with unmet needs).<br><br># of AAA referrals to CCO for care coordination review<br># of completed referrals for care coordination review [Monthly/Year Total] |

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| | This report is shared with AAA via secure email.<br><br>3. PCS initiates discharge planning and includes AAA when a member receiving Medicaid-funded LTSS services is experiencing a transition in levels of care. Additionally, PCS notifies AAA of all PHEC (Post-Hospital Extended Care) stays and includes the date the member is expected to be discharged.<br><br>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 AAA for assessment if indicated.<br><br>5. PCS and 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 AAA for evaluation | lower than authorized care plan.<br>• LTSS consumers receiving involuntary move-out notices and/evictions.<br>• LTSS consumers whose biopsychosocial needs are impacting their care planning.<br><br>4. AAA shares key health-related information with the CCO via the monthly service report which includes consumer service priority level (SPL), type of LTC care being received, LTC provider, and a count of ED and IP events in the last year.<br><br>5. AAA will bring relevant updates and gaps in care coordination needs to twice/monthly meetings with CCO in order to create comprehensive individualized care plans for | | |

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| | of needed services and discussion of LTSS members that AAA refers to PCS for Care Coordination services.<br><br>*See LTSS Workflow | CCO members with care coordination needs. | | |
| **DOMAIN 2: Interdisciplinary care teams** | | | | |
| DOMAIN 2 Goals:<br>Interdisciplinary care teams | 1. PCS shares member Care Plans with AAA for LTSS members.<br><br>2. PCS and 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 | 1. AAA agrees to the following processes and activities to ensure individualized person-centered care plans:<br><br>2. Support PCS by:<br>• Invite the member and/or their authorized representative to attend the IDT meeting.<br>• AAA notifies the CCO which members receive LTSS | PCS maintains records of members discussed in regularly scheduled IDT meetings with AAA.<br><br>PCS uses a medical management system to capture IDT meetings for LTSS members. | # of members with LTSS that are addressed/staffed via IDT meetings monthly.<br><br>% of months where IDT care conference meetings with CCO and AAA occurred at least twice per month.<br><br>total annual IDT meetings completed by CCO-AAA teams. |

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| | list of members to be discussed prior to scheduled IDT meetings. PCS and AAA collaborate as a team during those meetings to ensure a holistic Care Plan for that member.<br><br>3. PCS requests AAA provide a list of consumers to be discussed at scheduled IDT meetings.<br><br>4. PCS invites members and/or their representatives or guardians to attend IDT meetings.<br><br>5. PCS invites PCPs and relevant providers or agencies to attend IDT meetings.<br><br>6. PCS includes PS Medicare and DSNP to attend IDTs as indicated.<br><br>7.PCS invites relevant MA plan representation as able and appropriate.<br><br>8.PCS updates and revises the member Care Plan as indicated | supports via the monthly service report<br><br>3. Develop and verbally share individualized person-centered care plans with relevant care team members during IDT meetings.<br><br>4. AAA invites relevant providers or agencies to attend IDT meetings.<br><br>5. If participation in biweekly IDTs present a resource constraint, an alternative plan may be agreed upon between the parties to remain compliant to the minimum expectations of twice a month. | PCS captures attendees of IDT meetings in the medical management platform.<br><br>PCS documents whether the member was invited and attended the IDT meeting. | % of times consumers participate/attend the care conference (IDT) by month/year.<br><br>% of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO). |

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| | from feedback in IDT meetings with AAA.<br>9. PCS and 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.<br><br>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.<br><br>3. PCS will discuss any needed updates to the care plan, including, but not limited to, | 1. AAA actively engages individuals in the design, and where applicable, implementations of their LTSS service plan. LTSS partners bring relevant LTSS member information to the IDT meetings to coordinate care for joint consumers. LTSS partners will factor in relevant referral and case management information from PCS staff in development of collaborative care plans.<br><br>2. AAA notifies PCS of identified barriers to achieving goals related to service plans such as<br>• Homelessness<br>• Misuse of medications | % 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.<br><br>% 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. | % of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals.<br><br>% 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. |

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| | 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.<br><br>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.<br><br>5. Additional information on PCS care plan guidance can be found in the Medicaid Care Management Policy. | • Lack of accessible transportation<br>• Insufficient social supports<br>• No mode of communication<br>• Gaps in health care needs<br><br>3. IDT discussion outcomes/plans to address identified barriers are integrated into the service care plans. Plans of action are followed up on at subsequent IDT meetings.<br><br>4. Any data exchange must comply with HIPAA and state confidentiality laws. CCO shall provide AAA with reciprocal access to data related to members' health status, risk screenings, and care transitions to ensure equitable information flow. | | |
| **DOMAIN 4: Transitional care practices/Care Setting Transitions** | | | | |

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| 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.<br><br>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.<br><br>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.<br><br>4. When PacificSource is aware that an LTSS member is transitioning to another CCO, PCS will notify the AAA office. | 1. AAA coordinates post-placement needs, care preferences, goals and most cost-effective options to meet the members' needs.<br>2. AAA follows up as appropriate to any referrals made by PCS for LTSS and completes LTSS assessments and re-assessments as defined by the state. Reassessments are done in coordination with the member. Any relevant findings are shared with PCS.<br><br>3. AAA participates in IDT meetings and, as appropriate, care planning related to LTSS members. The IDT scheduling process and standing agenda items ensure clear and effective cross-system collaboration for LTSS members. | 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.<br><br>IP stay and a Facility Discharge Assessment where the question was this discharge delayed because DME, Medications or transportation were not arranged timely?<br><br>CM event with engagement level of Redirected to "Transition to other CCO" and warm handoff completed = yes<br><br>Quarterly meetings | % transitions where CCO communicated about discharge planning with AAA office prior to discharge/transition?<br><br>% transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge?<br><br>% CCO region to CCO region transfers that communication was made to appropriate AAA office(s)?<br><br># of Debrief meetings held quarterly to post-conference transitions where transitions weren't smooth (improvement process approach)? [Q1, Q2, Q3, Q4]. |

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| | 5. PCS will notify AAA via fax, mail, phone, or portal regarding inpatient LTSS members before discharge. | 4. AAA reviews the CCO's monthly Transitions Report to identify if the LTSS members may require additional information sharing or care planning.<br>• AAA will assist with care coordination within the scope of its funded programs but shall not assume responsibility for unfunded care coordination tasks assigned to CCO<br>• AAA participation in care transitions shall be limited to its statutory and contractual obligations. This MOU shall not be used to shift costs or responsibilities to AAA without prior agreement and funding | | |
| **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 | 1. AAA follows up as appropriate to any referrals made by PCS for | Referral source | # of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with |

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| | 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 (HRCC) for those members.<br><br>2. PCS Care Coordinators use the information in the notification to initiate outreach to members and to update the member's Individualized Care Plan.<br><br>3. These notifications also prompt PCS Care Coordinators to collaborate with AAA about discharge planning and reducing barriers to discharge for the member. | LTSS members by completing LTSS assessments and reassessments as defined by the state rules. AAA shares any relevant findings with PCS.<br><br>2. AAA participates in IDT meetings and, as appropriate, care planning related to LTSS members. The IDT scheduling process and standing agenda items for joint meetings ensure clear and effective cross-system collaboration for LTSS members.<br><br>3. AAA reviews the CCO monthly transition reports and uses it to identify LTSS members who require additional information sharing or care planning. | Referral source<br><br>LTSS DTR | AAA teams for members with LTSS or new in-need of LTSS assessments.<br><br># of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with AAA teams for members with LTSS or new in-need of LTSS assessments.<br><br>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). |

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| | 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 AAA.<br><br>5. PCS will send AAA a HEN notification report weekly so they can identify hospital events for any members they are currently managing | | | |
| **OPTIONAL DOMAIN A: Linking to Supportive Resources** | | | | |
| OPTIONAL DOMAIN A: Linking to Supportive Resources Goals | | 1. AAA shares what types of resources are available to support members through ODHS (ADRC, SNAP, Older American Act Services)<br>2. AAA shares process by which additional LTSS supports can be authorized (e.g. transportation, safety devices, funds for specific items, special needs, K-Plan ancillary services). | | |
| **OPTIONAL DOMAIN B: Health Promotion and Prevention** | | | | |

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

**Term:** The understanding and commitments made by the parties pursuant to this MOU shall be in effect as of January 1, 2025 and shall terminate on December 31, 2026, unless earlier amended or terminated by either party.

**Liability:** No liability will arise or be assumed between the parties as a result of this MOU.

**Governing Law:** This MOU shall be governed by and construed in accordance with the laws of the State of Oregon, without regard to conflict of laws principles.

**Counterparts:** This MOU may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

**SIGNATURES: Include Name, Job Title, Agency, Signature, Date**

Signatures of All MOU parties (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.

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In Witness Whereof, the parties have executed this MOU as of January 1, 2025

CCO Authorized Signature

Peter Davidson, Executive VP and Chief Financial Officer,

AAA Office Authorized Signature

Charlene Gibb

Charlene Gibb, Executive Director of Programs/Medicaid,