CCO-LTSS Partnerships MOU Template:

MOU Period: January 2025 **through** December 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 Trillium Community Health Plan **OHA Contract #**161766

Partner AAA/APD District (s) Names/Locations:

Aging and People with Disabilities Branch 1017

738 W. Harvard Ste. 180

Roseburg, Oregon 97470

If more than one AAA/APD office in your CCO Geographic Region Please Circle or X Whichever Applies: Single Combined MOU X Multiple MOUs: N/A

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s): Angela Hastings-Director, Care Management	**APD/AAA Lead(s): Tom Maloney, APD, District Manager**
	APD CM, located in Reedsport, will coordinate with CCO on membership on agreed upon processes in domains.

CCO will clearly articulate in this section:	AAA/APD will clearly articulate in this section:
Trillium's governance structure captures the needs of its members receiving Medicaid funded Long-Term Services and Supports (LTSS) through members who provide representation through the Board of Directors, Community Advisory Council (CAC) and Prevention Workgroup. Trillium's affiliated DSNP and MA plans participate in the LTSS MOU work for FBDE. All affiliated plans are within the same electronic platform which supports seamless management of the membership with ease of monitoring and reporting.	APD has advocacy staff members that 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				

DOMAIN 1 Goals: Prioritization of high needs members. CCO and APD will establish routine communication pathways to share information on mutual members that have been identified and prioritize as having high needs to support timely access to referral and resources. Improved communication will support in decreasing duplicative effort, while identifying opportunities "to go upstream" with prevention and implementation of care coordination activities that reduce unnecessary ER visits or hospitalizations	CCO conducts Health Risk Screenings (HRS) within 30 days of identifying a member with LTSS, or part of a prioritized population*, traditionally underserved **, or have a health condition or received a referral. (*older adult, hard of hearing, blind, or have other disabilities; complex or high health care needs, multiple or chronic conditions, SPMI, or receiving LTSS. ** @ risk for inpatient psychiatric hospitalization, receiving intensive mental health services, or transitioning from Oregon State Hospital) CCO will provide a list of members that could not be reached through all available means to APD/AAA for assistance on other contact information. CCO will provide monthly reporting that combines data from authorizations and claims for physical/behavioral/dental and other key shared initiatives (Hot Spotter) to APD.	APD will review list of unable to reach to determine if any other information is available for CCO outreach.	Monthly CCO and APD will review # of members identified as high needs with LTSS. Also will capture # of members per route identified (risk screening/reporting/referral) for opportunities. Monthly (twice a month) CCO and APD will review # of members referred to SDS/ODDS/MH agencies for new LTSS service assessments and # of members referred for service plan hour increase/change.	# 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]
DOMAIN 2: Interdisciplinary care teams				

DOMAIN 2 Goals: Interdisciplinary care teams CCO and APD will establish and maintain on-going interdisciplinary care teams, consisting of representation from CCO, APD/AAA/ODDS/MH, PCP, LTSS, Specialist and other agencies/service providers working with the member. The interdisciplinary care teams will coordinate care and develop individualized care plans for identified high needs, mutual members. Identify processes and resources to support best practices to build care plans and integrated approaches for member supports	CCO will request Interdisciplinary Care Team (IDT) meetings when identified as needed. CCO will monitor for changes of condition, transitions of care and other opportunities for care plan updates. CCO will work with the member in identification of their preferred Interdisciplinary Care Team members. This should include member, member rep, primary care, specialists, and APD/AAA/ODDS/MH and community agencies working with the member. CCO will coordinate formal invitation and set up to the meeting. Capture of attendees/notes/CP update. CCO will encourage and support member engagement in the care planning process to ensure member preference and success of plan. CCO will ensure review of preventive screenings, early intervention, management of chronic conditions and wellness	APD will participate in interdisciplinary care team meetings to support their member. APD will request ICT meetings when identified as needed, especially during LTSS transitions of care. (i.e. ICF to AFH, RCF to in home)	Bi-monthly - CCO and APD/AAA will meet to review # of members with LTSS due for IDT meeting, and review for opportunities to reduce duplication of actions and services.	# 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).

	are addressed as indicated at each care plan meeting.			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans CCO and APD are both required to ensure person centered care planning processes are in place to address member's needs. The expectation is to reduce duplication of services, assessments and improving member experience and outcomes through more integrated approaches to care planning while maintaining member's self-defined quality of life, choice, control, and self - determination.	CCO will provide support in determination of underutilization of routine medications or services through reporting. (i.e. no fills on chronic condition meds or lag fills on diabetes supplies) When underutilization is noted, TCHP CM will outreach practitioner to coordinate discussion. CCO will review and update the ICP at least annually for members, or when condition/need requires. CCO will support member's access to specialist through coordination assistance, if needed.	AAA will provide consumer preference from CA/PS to ensure alignment with care plan.	Bi-monthly - CCO and APD/AAA will meet to review # of care plans that document member preferences and goals. # of CCO ICPs updated every 90 days for relevant parties.	% 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.
DOMAIN 4: Transitional care practices/Care Setting Transitions				
DOMAIN 4: Transitional care practices Goals CCO and APD will develop coordinated transitional care practices that incorporate timely information-sharing when	CCO monitors for transitions of care through Collective reporting for inpatient and emergency room. Members are outreached and assessed with each transition to ensure current and new needs are	APD will communicate and collaborate on transitions of care identified within LTSS/Home and Community Based Care supporting least restrictive consumer choice. This is managed through a Transition and Diversion team and/or case	Bi-monthly -CCO and APD will meet to review % of discharges communicated from APD prior to CCO discharge/transition. % of transitions where discharge orders were arranged before discharge and did not delay	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME, medications,

transitions occur, minimal crosssystem duplication of effort, and effective deployment of care coordination and connection to behavioral, psycho-social or social determinant of health resources at any time members experience a transition in their care setting. Identify resources to support evidence-based care transition best practices. Transitions include when member's need or wish to change settings of care, service levels, or have an event that changes health status or result in unexpected hospitalizations or emergency room visits.	quickly addressed. CCO will collaborate on APD transitions of care to support timely coordination of DME, medications and transportation before discharge date. CCO will monitor members that are relocating to another CCO region and collaborate with local APD on a warm hand off to the receiving APD agency. CCO will support member in navigating the social systems with referral to community health workers within the CCO to assist with housing, food insecurity, and other social determinant of health needs.	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 orders are in place. APD will assist in warm hand off to a receiving APD agency.	discharge. % CCO region to CCO region transfers that were communicated to the appropriate receiving APD agency. CCO and APD will hold debrief meetings when transitions demonstrated opportunities for quality improvement . (i.e. medications, equipment, Home Health, caregiver)	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].
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals The CCO and APD MOU will support two-way collaborative communication through agreed upon modalities at times of key events, changes in health status, service priority levels, or changes in location of LTSS service	CCO monitors hospital event and skilled nursing facility notification through Collective. CCO will ensure communication of transition to primary care provider and APD/AAA agencies to collaborate in the reducing hospitalizations, support transitions and to trigger reassessment of needs, if a change of condition.	APD Transition and Diversion team monitor hospital event and skilled nursing facility notifications through Collective and will notify CCO as needed if member may require more assistance via care coordination, such as an IDT.	Monthly CCO and AAA will review # of hospital and skilled nursing event notifications from Collective or other means that involved APD for consultation or were recognized as a referral potential for a new LTSS assessment.	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with 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 AAA teams for members with

delivery, or other transitions in member's need or level of care.	CCO has implemented a clinical review process to assess the quality and appropriateness of care furnished to members using LTSS with the goal to share the audit results with the APD agencies based on findings in order to enhance collaboration and improve identifiable care gaps.		# of members who return to hospital within 30 days (IP or ED). # LTSS members who trigger for • All Cause Readmission • Avoidable emergency department utilization • Emergency department utilization among members with mental illness • Screening for depression and follow up. • Alcohol and Drug Misuse: SBIRT •Poor control A1c •Diabetes short term complication admission rates •COPD or asthma in older adults admission rate •Congestive health failure admission rate •Asthma in younger adults admission rate	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).
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.

Sarah K. B Sarah Brewer, Plan President & CEO, Trillium Community Health Plan, 3/21/2025

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

Tom Maloney Distict Manager District 6 Douglas County

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

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