CCO-LTSS Partnerships MOU Template:

MOU Period: **January 1, 2025 through December 31 2025**

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 **Umpqua Health Alliance, LLC** **OHA Contract #** **161767**

Partner AAA/APD District (s) Names/Locations - **DHS Aging and People with Disabilities District 6 office (APD) and Douglas County Senior Service (AAA)**

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): Keala Meyer, RN, BSN, Care Coordination Director	APD/AAA Lead(s):
UHA has a robust CCO membership on its Community Advisory Council that is broadly representative of the members served. UHA has a CCO member and community member on its board of directors to represent the voice of the healthcare consumer. UHA meets quarterly with APD/AAA LTSS partners to discuss member needs and activities related to care coordination and the provision of LTSS services. UHA works in collaboration with its affiliated Dual-Eligible Special Needs Plan (DSNP), ATRIO, to provide care coordination and transitional care to Full Benefit Dual Eligible (FBDE) members. Referrals are made by UHA to ATRIO Case Managers to provide medical support for FBDE members. ATRIO sends referrals to UHA Care Coordination to assist with services not provided by ATRIO. The teams hold an interdisciplinary team meeting twice a month to collaborate care for the FBDE LTSS members.	**AAA/APD will clearly articulate in this section:** --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	UHA is responsible for sharing LTSS member data to assist APD/ AAA with prioritization. UHA created a report sourced from the OHA's 834 eligibility file to identify members receiving LTSS services. This report includes data such as program eligibility, disabilities, accessibility, language, and ethnicity. The report assists with screening for risk or high needs and helps identify and ensure individuals who are traditionally under served are included as the highest priority group for care coordination. This report is shared via secure email with the APD supervisor or delegated staff	APD/AAA will participate in bi-monthly IDT meetings to coordinate planned care for UHA members. APD/AAA will report out on status of referrals received at bi-monthly IDT meeting. The following information will be shared at each meeting as needed: provider information, care supports in place, Medicare plans, assessments, treatment and care plans, care transitions, discharge follow-up care, referrals, caseworker contact information and any other necessary information to assist in the coordination of care for the UHA member such as legal guardian information. APD will identify members who have a health condition or are	Health Risk Screening (HRA) completed by LTSS members per month	# 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

	member once per month. Additionally, UHA's population health platform, Arcadia, uses automation to identify high-risk members through claims data, diagnoses, and eligibility rate group. The Health Risk Screening Assessment (HRA) is UHA's primary tool used for assessing a member's needs, identifying special healthcare needs, functional needs, screening for health equity and Social Determinants of Health (SDoH) disparities, and identifying members at high risk for hospitalizations and avoidable ER utilization. Members identified through the HRA as meeting the criteria for LTSS are referred internally to a Case Manager for completion of a CM assessment to determine needs. Members that need assistance performing Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) and are agreeable to receiving LTSS are referred for eligibility screening by the UHA Case Manager to ADP/AAA through phone contact with the screener of the day. Referrals for UHA case management sent from APD/AAA	considered high risk to refer for case management to UHA. APD will review reporting of members that declined case management and determine if outreach from APD caseworker may support member in accepting or identify a barrier to being able to participate. APD Caseworkers assist members in accessing Health-Related Social Needs (HRSN) benefits by providing guidance and making referrals on their behalf for services they may qualify for to support improved health outcomes.		coordination review [Monthly/Year Total]

	Caseworkers are submitted via secure email to CaseMangement@umpquahealth.com. Within 30 days from referral, the assigned Case Manager reaches out to the member or designated caregiver to complete a case management assessment and develop a care plan which is shared with the member and with member approval, with the member's ADP/AAA Caseworker as well as the member's care team. UHA will provide educational materials and presentations to APD/AAA partners to increase awareness of the services provided by the UHA Care Coordination Department, Case Managers, and Community Health Workers (CHWs), to ensure APD/AAA is appropriately referring members for case management and other services, and to reduce duplicative efforts. UHA Case Managers and ADP/AAA Caseworkers work collaboratively to ensure a member's LTSS needs are met without duplication of services. Information is shared via bi-monthly IDT meetings or secure email. This includes but is not limited to the member's Health Risk Screening, case management			

	assessment, integrated care plan, and APD/AAA service plan. Coordination during IDT meetings help minimize duplicative services by assigning responsibility for action items and interventions. UHA's Case Managers are accountable for tracking interventions and following up on outcomes discussed during IDT for their assigned members. This includes making referrals to other departments or teams as necessary to address potential safety, or high-risk concerns. For example, members with medication-related problems are referred to UHA's clinical pharmacy team for medication therapy management. ATRIO Case Managers participate in UHA's bi-monthly Interdisciplinary Team (IDT) meetings to enhance collaboration in coordinating care for DSNP members, including those with Special Health Care Needs and Medicaid-funded LTSS or LTSS needs. As part of the member's care team, ATRIO CM contributes to the development and implementation of the integrated care plan. This plan is shared among care team members to reduce duplication of efforts and ensure the member receives the necessary services to			

	meet their healthcare needs effectively. UHA provides APD/AAA staff with updated department and Case Manager contact information whenever changes occur. This information is shared via email with the APD/AAA supervisor. Additionally, UHA will educate APD/AAA staff on available Health-Related Social Needs (HRSN) benefits, the application process, and any updates or additions to benefits as they become available. **Supporting Documentation:** • DOMAIN 1 - Prioritization of High Needs Members • CE31 - Care Coordination • SOP-CE31-03 Long Term Services and Supports • Affiliated-MA-Plan-Report-2025			
DOMAIN 2: Interdisciplinary care teams				

DOMAIN 2 Goals: Interdisciplinary care teams	UHA's Care Coordination team collaborates with all providers responsible for a member's care. The care team includes the member, the member's family, caregiver, or other representative, UHA Case Manager, APD/AAA caseworker, ATRIO Case Manager, LTC providers, member's PCP, behavioral health providers, local hospital care managers, as well as other agencies/service providers working with the member. The care team meets bimonthly to coordinate care for high-risk members to create and update integrated care plans which define goals, interventions, and care team assignments. Meeting minutes are shared with attendees within 24 hours of the meeting. UHA notifies the APD District Manager when an APD representative is not in attendance at the IDT meeting. As previously discussed, UHA Case Managers are responsible for tracking outcomes, interventions, and referrals resulting from IDT discussions, as well as documenting any updates to the care plan. Updated care plans are shared with the member via mail and the care team per the agency's preferred method.	APD/AAA will participate in interdisciplinary care team (IDT) meetings to support their member. APD/AAA will define roles, responsibilities, and process for assignment of and participation in the UHA IDT team, including coordination with the UHA Case Manager, for members needing care coordination. APD/AAA will ensure that UHA providers/care teams are notified of which UHA members are receiving LTSS services, the relevant local AAA/APD office contact, and contact for relevant LTSS provider.	APD/AAA attendance at IDT meetings	# 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.

	Supporting Documentation: • DOMAIN 2 - Interdisciplinary Care Teams.pdf • SOP-CE31-04 Interdisciplinary Care Teams • SOP-CE31-03 Long Term Services and Supports • Affiliated-MA-Plan-Report-2025 • Interdisciplinary Case Staffing Form _2025 1			

				% 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).
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	For UHA members eligible for, or receiving, LTSS services, the assigned Case Manager reaches out to the member to engage in care coordination and complete the HRA and CM assessment. Members will be asked by the case manager to identify the individuals they would like to be involved to establish their preferred care team to assist in achieving optimal health and wellness outcomes. This may include but is not limited to family member representative(s), PCP, Specialist(s), caregiver(s), LTC provider(s), CBOs, MA Plans, APD Caseworkers. Each are encouraged to participate and/or consult in designing member care plans. Care team participation may include engaging in member's HRA, CM	LTSS member's care plans and service plans will be exchanged between UHA and APD via secure email. APD will share consumer preference from Client Assessment and Planning System (CA/PS) with UHA Case Manager to ensure alignment with LTSS members' care plans. APD/AAA will actively engage individuals in the design, and where applicable, implementation of their LTSS service plan, in coordination with UHA where relevant to health care treatment and care planning. UHA Case Managers and APD/AAA will communicate with all care team members about LTSS members via secure email, telephone, or through IDT meetings to discuss: new referrals to UHA case management		% 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.

	assessment, sharing existing care/service plans, IDT meeting representation, as well as ongoing communication to monitor and share information related to care needs. UHA Case Manager facilitates the development of an integrated, person-centered care plan with the member and their identified care team. UHA ensures members are treated fairly, are informed of their choices, and have a voice in decisions about their care and support services. Individualized care plans integrate the member's problems, goals, and care needs identified by all individuals involved in their care. It includes information about the supportive and therapeutic needs of the member including LTSS services and support needs. At minimum, this includes the APD service plan as well as the preferences and goals expressed by the LTSS member, family/caregiver, and/or any other individuals engaged in their care team. The care plan includes: 1. Frequency of provider appointments. 2. Preventative care to maintain or improve health.	or APD, assessments and screenings, member preferences and goals, triggering events, gaps in care, barriers to engagement, and/or concerns about health care needs.		

	3. Screenings and strategies to reduce unnecessary hospitalizations or ER visits, prevent hospital readmission, and improve depression screening. 4. Social and support services. 5. Identified SDoH needs and referrals made to services and resources to fill these needs. 6. Transportation coordination. 7. Medication management plan. 8. Language and disability service access. 9. Barriers to care and the strategies designed to reduce or eliminate them. 10. Advance Care Planning or End-of-Life Decision Making/POLST. Once the care plan is developed, the UHA case manager shares it with all identified members of their care team, consistent with member's preferences. Care plans are exchanged with the care team in a variety of ways: 1. The member receives their care plan via mail, or electronically if requested. 2. APD/AAA caseworkers and UHA Case Managers share care plans via secure email and communicate updates in care needs telephonically or via secure email between IDT meetings.			

	3. The members' PCP receives a copy of the care plan via secure email, fax or PointClickCare based on office preference. 4. Care plans are exchanged with Affiliated DSNP (ATRIO) Case Managers through PointClickCare. Members with acute care needs may have IDT meetings scheduled as soon as possible with care team representatives. Non-acute members are scheduled for the next IDT meeting (which meets twice monthly) to discuss the care plan with the member and care team. Care plans that are updated or revised as a result of the IDT meeting will be sent to all relevant care team members within 2 business days of the change. IDT meetings focus on addressing: 1. Member's preferences and goals; including barriers, progress, and achievements. 2. Developing and evaluating collaborative care plan strategies and opportunities to improve member health. 3. Assignment of roles and responsibilities between care team members.			

	4. Coordination of services and resources to address social determinants of health needs. 5. Reviewing and updating care plans at least annually. 6. High risk members, including those receiving Medicaid funded LTSS. 7. Members newly referred or identified with LTSS needs. 8. Members with a Change in Health-Related circumstances, as defined in OAR 410-141-3865 9. Members with a transition of care in the last 14 days. Once the member care plan is firmly in place and the member is stable in their current setting, the care plan will be updated at a minimum annually; as often as needed by the members condition; or when a Change in Health-Related Circumstances, as defined in OAR 410-141-3865, occurs. Updates to the care plan are shared with the care team, as described above. **Supporting Documentation:** • DOMAIN 3 - Development and Sharing of Individualized Care Plans • CE31 - Care Coordination • APD Care Plan Template • SOP-CE31-03 Long Term Services and Supports			

	• Affiliated-MA-Plan-Report-2025			
DOMAIN 4: Transitional care practices/Care Setting Transitions				
DOMAIN 4: Transitional care practices Goals	UHA's transition of care goals focus on ensuring a successful shift from one setting or level of care to another by: -Addressing member needs to support a smooth transition -Establishing community and home support before the transition -Promoting collaborative discharge planning -Ensuring timely follow-up scheduling -Coordinating necessary services, such as NEMT, in a timely manner UHA collaborates with APD/AAA through quarterly leadership meetings to review transition processes, identify gaps, and ensure clarity across agencies. Additionally, UHA debriefs with APD/AAA during these meetings and IDT discussions	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 who review and update through assessment. They will reach out as needed to UHA 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. Document on how partners are coordinating to ensure successful transitions, transition resources including but not limited to:	Readmission rate for UHA LTSS members	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition % transitions where discharge orders (DME, medications, transportation) were arranged

	for cases where transitions were unsuccessful or members lacked necessary devices, medications, services, or supports. Members already receiving LTSS through APD: Members discharged back to a LTC facility or AFC are followed by the UHA Case Manager. They call or visit the facility to ensure the staff and member understand the discharge instructions, follow up appointments with transportation are arranged, changes to health/functional status are known, DME supplies are available. The APD Caseworker is sent a secure email with a summary of the transition and changes to the members care plan. *Members already receiving LTSS through APD-* <u>Notification and Discharge Planning:</u> UHA sends a list of admissions, including ED visits, hospitalizations, and SNF stays, from PointClickCare to APD supervisors for distribution to assigned caseworkers or transition coordinators to initiate discharge planning. The UHA Case Manager and APD Caseworker collaborate to assess the discharge plan, identify needs for additional DME or home health	• Process to coordinate appropriate discharge planning and ensure LTSS services are in place prior to discharge where needed • Communication strategies and expectations (how do you address regular hour vs. evening/weekend transitions?) • Scheduling for key follow-up assessments, planning for transportation needs, medication reconciliations before transition happens • Processes to share information and support the appropriate flow of relevant information; implement a standardized approach to effectively plan, communicate, and implement transition and care planning and follow-up • Identify cross system resources and how they may be used during transitions Incorporate processes for 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)		

	services, and determine any changes in the member's ADL or IADL abilities that may require reassessment. <u>Members Discharged Home:</u> Members discharged home receive a transitional care phone visit (if agreeable) from the UHA Case Manager. The visit includes: -Review and understanding of discharge instructions -Medication reconciliation -Scheduling and coordination of follow-up appointments -Arranging transportation as needed -Education on chronic conditions, red flags, preventive home care, and when to contact their provider -Rising Risk Assessment <u>Members Discharged to a LTC Facility or Adult Foster Care (AFC):</u> The UHA case manager follows these members by calling or visiting the facility to ensure: -Staff and the member understand discharge instructions -Follow-up appointments are scheduled, and transportation is arranged -Any changes in health or functional status are known -DME supplies are available -Rising Risk Assessment	as well as transitions between these settings. APD/AAA provides detail on best way to contact staff for LTSS assessments. APD will work with UHA, OHA and medical providers on durable medical equipment and environmental modifications needed for successful transitions. APD will track discharges that have delays due to DME issues, or lack of medical orders and report back to UHA.		

	A secure email summarizing the transition and care plan updates is sent to the APD Caseworker. <u>Members Discharged from Acute Care to a Skilled Nursing Facility (SNF):</u> The UHA case manager coordinates care for members discharged to a SNF by: -Monitoring the member's stay and risk level using the PAC Management platform in PointClickCare -Working closely with SNF staff -Communicating with the member's APD Caseworker regarding anticipated changes to the service plan -Once discharged from SNF, the above transition processes are followed to ensure continuity of care. *Hospitalized members with new LTSS needs:* The hospital care manager contacts APD to request eligibility screening. UHA case managers work closely with the hospital care manager and APD staff to coordinate the transition back home with services in place, to SNF for rehabilitation or to a facility appropriate for the members' level of care. The hospital holds weekly			

	planning meetings while members are hospitalized to plan the transition. UHA case managers, hospital care management staff, APD staff, and ATRIO Case Manager (when appropriate) attend these weekly meetings. These members will also be added to the agenda for the bimonthly IDT meeting. Once discharged to the next level of care, the transitional care processes above are followed. *Other Transitions:* When UHA Care Coordination staff identify or are notified about other transitions that occur due to a member's need or their wish to change settings of care, services levels, or have an event that changes their health status or results in an unexpected hospitalization or ER visit, UHA case managers and Care Coordination navigators address the members' needs and coordinate care with external partners, including but not limited to, the member's care team, APD/AAA, other CCOs, and other health systems, as needed. This coordination occurs through IDT meetings, or through telephonic outreach by UHA case managers and Care Coordination navigators.			

	UHA provides support through HRS funds to ensure members make a successful transition from one setting to the next. A few examples of this support are: 1) pay guardianship fees when no other funding is available, 2) pay for in-home caregiver(s) to bridge the gap between transition and when Medicaid funding is available. When UHA becomes aware that an LTSS member receiving LTSS though APD/AAA will be moving outside of Douglas County, the UHA case manager will notify the member's APD/AAA case worker via secure email. Member's UHA case manager will assist the member during the transition by coordinating continued access to services as defined in OAR 410-141-3850. **Supporting Documentation:** • DOMAIN 4 - Transitional Care Practices • CE31- Care Coordination • CE28 - Transition of Care • SOP-CE31-03 Long Term Services and Supports • Affiliated-MA-Plan-Report-2025			

				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	UHA uses PointClickCare (PCC) to: • Provide the members' assigned Case Manager's name and contact information when enrolled in care coordination services. • Upload the integrated care plan to share with provider offices utilizing the PCC platform and ATRIO Case Managers that provide medical case management for DSNP members. • Track ED visits, inpatient and SNF admissions, and discharges. This facilitates appropriate	APD Transition and Diversion team monitor hospital events and skilled nursing facility notifications through Collective and will notify UHA of members noted as having a change of condition or change to their service plan.		# 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.

	discharge planning and referral to APD/AAA services when indicated. • Utilize the PAC Management platform to monitor a member's SNF admission, reviewing SNF EMR notes, risk for readmission, lab results, and factors contributing to rising risk. Assess the discharge plan and coordinate with SNF nursing or social work staff via phone or secure email. When a UHA member is identified for referral to APD/AAA, UHA case manager or CHW telephonically reaches out to the screener of the day at APD to initiate the referral process. The referral to APD is documented in a referral assessment in Arcadia and added as an intervention to the member's care plan. Once a member is approved for services, the assigned APD caseworker and the UHA case manager will primarily communicate via telephone and secure email. APD Caseworkers send requests for UHA care coordination services by submitting a referral via secure email (see UHA Case Management			

	Referral form). The referral from APD is documented in a referral assessment in Arcadia by the UHA staff member that receives the referral. An email response is sent within one business day to the APD Caseworker that sent the referral acknowledging it was received. The referral assessment data is used to track and report on the number of referrals that are sent to APD and received from APD. UHA provides APD/AAA with contact information for designated leads, case managers, and process documents. Updates will be made as roles or processes change. **Supporting Documentation:** • DOMAIN 5 - Collaborative Communication Tools and Processes • UHA Case Management Referral Form • Affiliated-MA-Plan-Report-2025			

				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.

Brent Eichman 3/28/2025 | 8:52 AM PDT

CCO Authorized Signature, Name, Job Title, CCO Name, Date Brent Eichman, Umpqua Health Alliance, Chief Executive Officer

Thomas Maloney 3/28/2025 | 8:32 AM PDT

APD Field Office Authorized Signature, Name, Job Title, APD Field Office Name, Date Thomas Maloney, APD District Manager District 6

Jeanne Wright 3/31/2025 | 2:42 PM PDT

AAA Office Authorized Signature, Name, Job Title, AAA Office Name, Date Jeanne Wright, Douglas County Senior & Disability Services Director