2025-2026 CCO–Aging and People with Disabilities/ Area Agencies on Aging Memorandum of Understanding Guidance

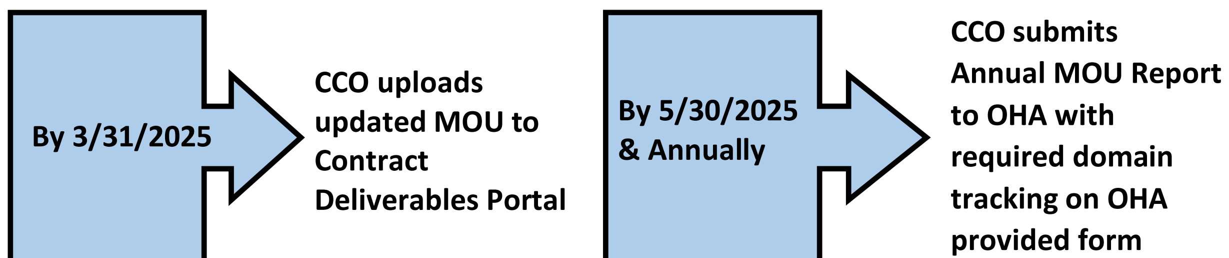
Shared Accountability for Long Term Services & Supports

Deliverable Requirement: CCO-Long Term Services and Supports (LTSS) memorandum of understanding (MOU) are required between Coordinated Care Organizations (CCOs) and the Aging and People with Disabilities (APD) district or Area Agency on Aging (AAA) organizations that authorize Medicaid-funded long-term services and supports (LTSS) within the CCO service delivery area. This document outlines the Core Domains and data fields for MOU reporting and timelines for submission to OHA. MOU(s) must be created by CCOs with the APD districts or Type B AAA organizations. The CCO may collaborate with Type A AAA organizations, if desired. CCOs must submit the MOU and annual updates to OHA. Guidance document changes align with Oregon Administrative Rule updates and implementation of Health Related Social Needs (HRSN) services.

CY2025 – CY2026 MOU Timeline: This guidance covers MOUs between CCOs and Type B Area Agency on Aging (AAA) or State of Oregon Aging and People with Disabilities (APD) Districts related to coordination of shared members with LTSS. If the parties agree, Type A Area Agencies on Aging may be included in these MOUs.

This guidance does not cover other LTSS services required to be coordinated by CCOs with local mental health authorities, community mental health programs, community developmental disability programs or support service brokerages are not covered by this guidance. To meet requirements in OARs to serve all members with LTSS, CCOs may want to pursue similar coordinated care processes with other providers such as those involved with 1915i services or ODDS services.

CCOs should be aligning MOUs with feedback from CCO-LTSS MOU reporting and updated Oregon Administrative Rules with care coordination requirements (effective 2/1/24). See page 7 for additional suggested focus areas for new MOU conversations. Technical assistance is available for any questions. Contract Due Date Reminders:



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Shared Accountability for Long Term Services & Supports (LTSS) CCO– APD/AAA Memorandum of Understanding (MOU) Guidance

MOU Purpose & Overview:

"People needing LTSS include older adults and younger people with intellectual and developmental disabilities, physical disabilities, behavioral health diagnoses (such as dementia), spinal cord or traumatic brain injuries, and/or disabling chronic conditions. A beneficiary's age, gender, socioeconomic status, living arrangement, and access to information about care options, in addition to his or her health and disability status, can influence the types and amounts of LTSS utilized and the duration of care needed. The LTSS beneficiary population is growing more racially and ethnically diverse, which has implications for ensuring cultural competency and language access in outreach, assessment, care planning, and service delivery policies and practices. LTSS encompasses the broad range of medical and personal care assistance that people may need – for several weeks, months, or years – when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability. Long-term services and supports provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping), and the care planning and care coordination services help beneficiaries and families navigate the health system and ensure that the proper providers and services are in place to meet beneficiaries' needs and preferences."

The purpose of the MOU is to ensure that coordination between the Oregon LTSS system and the CCO creates alignment between the two systems to provide quality care, promote coordinated care planning and care setting transitions, produce the best health and functional outcomes for individuals, and reduce duplication and inefficiency through better coordination across systems. Oregon seeks to ensure people with care needs or disabilities of all ages receive the supports and services they need to live independently and with dignity of risk in the setting of their choice and to receive quality care and supports to manage their health successfully. The purpose of these strategies is to ensure that coordination between the two systems is systematically occurring. A strong partnership focused on these goals supports Oregon's triple aim of better care, better health and lower costs and DHS goals in person-centered care and planning, promoting independence and choice in living situations, and ensuring dignity for all.

The MOU should ensure that coordination between the two systems by addressing the following goals:
<u>Shared Accountability Goals for MOUs:</u>

- Protocols for reviewing and prioritizing members with LTSS services and sharing across systems.
- Coordinated and aligned care and services for all individuals getting long-term services and supports.
- Care and service coordination tailored to needs specific to service environments in long-term care and home and community-based settings.
- Processes for CCO referrals to APD/AAA for LTSS assessments and service planning; processes by which the APD/AAA office or LTSS providers refer members to CCO for Care Coordination.

- Mechanisms for shared accountability –including communication, care planning, care transitions.
- Processes for addressing care transitions or addressing changes in health status or level of service, ensuring discharges receive follow-up care, assessments, and monitoring.
- Ease for members in navigating and receiving care and services needed to maintain and improve health.
- Person-centered planning to address member needs, including goals to ensure health equity, language and disability access, health literacy, and promoting wellness and better health outcomes.
- Documenting success by tracking and measuring MOU activities and outcomes.

Building on Shared Accountability Partnerships:
Oregon developed the goals for building MOUs for shared accountability for members with input from stakeholders, healthcare providers and policy leaders. The Oregon Legislature has set goals for both OHA and DHS on serving members across Oregon. Each CCO is responsible for delivering high quality, person-centered coordinated healthcare to members. The population served by CCOs include all CCO members receiving Medicaid-funded LTSS from community-based care including adult foster homes, residential care facilities, assisted living facilities, nursing facilities, as well as those receiving in-home services and supports or in other settings.

Medicaid-funded LTSS services are legislatively excluded from CCO budgets and are paid for directly by the Department of Human Services (DHS). Local APD and Type B AAAs authorize, manage, and monitor these services. In some regions of the state, these responsibilities are carried out by DHS/ Aging and People with Disabilities (APD) field offices, and in other regions, DHS has contracted with Type B Area Agencies on Aging (AAAs). In order for individuals to receive the most integrated, coordinated, and seamless healthcare and long-term services and supports, collaboration has to be a priority across systems of care. The MOU seeks to clearly define roles, responsibilities, and measures of success for tracking and reporting MOU activities.

System Coordination between CCO/LTSS:
System and care coordination are key activities of health system transformation and are critical activities for a high performing healthcare system that coordinates services and activities of the Area Agency on Aging (AAA)/State's Aged and People with Disabilities (APD) system and their contractors with the CCOs and their delivery system network. Successful coordination will improve comprehensive person-centered care plans, align care and service delivery, and provide the right amount of care at the right time for beneficiaries across the LTSS system. CCOs and the AAA/APD system will need to implement care coordination strategies tailored to the unique skills and service environments associated with home care, home and community-based care, acute care, skilled nursing facility care and long-term nursing or other residential care.

OHP members needing LTSS services often have multiple complex conditions, extremely limited personal resources, and complicated interplay of providers and care needs. A significant portion of clients receiving LTSS programs are also dual eligible beneficiaries, making it critical to also involve the member's Medicare Advantage or DSNP plan care coordinator and Medicare providers to reduce duplication and involve all parties in supporting interdisciplinary care planning. The misalignment of systems, processes across systems and settings of care contributes to increased but not necessarily cost-effective utilization of the health care system. Oregon will face increased pressure to meet the health and LTSS needs of a growing older adult and persons with disabilities population in the coming years.

Oregon's Policy Goals for Health System Transformation:
In the initial decade, Oregon's unique coordinated care model has made progress on the triple aim goals of

better health, better care and lower costs. The Oregon Health Plan (OHP) is the source of health coverage for nearly one million Oregonians, the Oregon Health Plan (OHP) and its 16 coordinated care organizations (CCOs) have improved access to primary care, reduced costly emergency room visits, and saved the state an estimated several billion dollars in avoided health care costs. Despite these successes, there is more work to do to ensure all Oregonians can be as healthy as possible and address the gaps and challenges that persist in our health care system. OHA's CCO 2.0policy recommendations build on Oregon's strong foundation of health care innovation and seek to make improvements based on best practices and evidence, as well as stakeholder and community input.

- Transform Oregon's Medicaid delivery system so that it focuses on prevention, integration, and coordination of health care across the continuum of care to improve outcomes and to bend the cost curve.
- Promote the triple aim of better health, better health care, and lower costs.
- Establish supportive partnerships and implement innovative strategies that will result in higher quality, more cost-effective health care, improved outcomes, and improved access to behavioral health care.
- Promote access to care, wellness, and preventive services, address social determinants of health, and ensure culturally and linguistically appropriate services to reduce health inequities.

CCO Coordinated Care Organization Service Areas Map:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8116.pdf

Oregon's Department of Human Services Policy Goals for Long Term Services & Supports Placement Considerations:

LTSS placement decisions should balance:

- The preferences and goals of the person.
- The right of the person to live as independently as possible, in the least restrictive setting.
- The cost of the living arrangement.

Division of Roles/Responsibility:

Clear delineation of roles and responsibilities are needed to reduce duplication, improve efficiency, and meet the goals of Health System Transformation (HST). The key roles and Medicaid benefits provided by CCOs and LTSS are listed below.

Core Roles and Responsibilities:
CCO Role: Health care delivery including preventive, early intervention and acute health services, behavioral health services, substance use treatment, dental care, care coordination and information sharing, care team coordination, use of traditional health workers, Person-Centered Primary Care Homes, after hours medical consultation. Care coordination includes access to CCO Care Coordination for identified populations (including members with LTSS), and Transitional Care Coordination. Access to traditional and community health workers and peer supports. CCOs also fund some programs and services to address social determinants of health. These programs vary by CCO.
CCO Benefits: Medical/primary care; hospital services; mental health/behavioral health including substance use disorder treatment; medical transportation; Non-emergency Medical Transportation, Medicare Skilled Nursing (including Medicaid cost sharing for Medicare Skilled Nursing benefit); home health services; durable medical equipment; emergency transport (ambulance); home enteral/parenteral nutrition and IV services; rehabilitation

services such as, physical, occupational, and behavioral/mental health therapies; medical-surgical services; pharmaceutical services; speech-language pathology; audiology; and hearing aid services; transplant services; hospice services and other palliative care, oral health care. 1915i LTSS programs are carved out from DHS.
Shared Responsibility: Coordination for post-hospital extended care (PHEC) and Transitions to Medicaid-funded Long-Term Services & Supports.
Type B AAA & APD Role: Coordination and information sharing with CCO, LTSS financial and service eligibility, Person-Centered Planning, LTSS selection assistance (home and community based/Nursing Facility except when Medicare skilled), LTSS payment authorization, LTSS case management, LTSS service plan and risk monitoring and troubleshooting, Adult Protective Services, contracting for Medicaid LTSS providers, Licensing and Quality Assurance. Eligibility and enrollment for Medicaid, enrollment in Medicaid low-income programs such as Medicare Savings Programs, SNAP enrollment & benefits. Coordination and information sharing with CCOs. Types of services include: In-home supports/services, Adult Foster Care, Residential Care Facilities, Residential Care Facilities with specialty care (dementia, traumatic brain injury, etc.), Assisted Living Facilities, LTC nursing facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, Medicaid-paid Home Delivered Meals, administrative examinations and reports, non-medical transportation (except in some regions where contracted to transportation brokerages), PACE state plan (including Medicare benefits), Home and Community Based Services (K-Plan, etc.) Type B AAAs are part of statewide Aging and Disability Resource Connection (ADRC).
Type A and Type B AAA Supports and Services: The following programs and services are provided by the AAAs: information and assistance, options counseling; care transitions coaching; nursing facility transition/diversion; connection to evidence based chronic disease self-management programs, Aging and health promotion, and Older American's Act Services (information/Assistance/Outreach, In-home assistance, Family Caregiver Supports, Oregon Project Independence, respite, transportation, home and congregate meals, legal assistance, caregiver counseling/support, training). Information and assistance through the statewide ADRC.

<u>Additional community partnerships that can support individuals with LTSS:</u> CCOs may have access to lists of additional local community resources and community programs to that may assist in supporting OHP benefit recipients to maintain independence, address social determinants of health or health equity. We encourage the CCO-LTSS MOU to include sharing information across agencies about how local resources might support gaps in care needs or impact care planning or care transitions coordination. Some areas where community partners might be more directly engaged: Low-income housing, community homeless shelters and services, Low Income Energy Assistance Program, Department of Veteran's services, Parish Nursing, Oregon Food Bank sites, Oregon Housing and Community Services Department services, community specific charities and non-profit organizations, volunteers, and Community Based Organizations (CBOs) serving minority or cultural/language specific populations among others.

MOU Required & Optional Domains:

Each required domain for the CCO – LTSS MOU has a domain worksheet that provides an overview of minimum requirements and highlights opportunities to build connections and sample questions that might trigger shared planning for MOU activities in that domain. This guidance has sections for each required domain and expectations for the CCO and LTSS office(s) that must at minimum be addressed in the MOU.

REQUIRED DOMAINS:

1. **Prioritization of high needs members**
2. **Interdisciplinary care teams**
3. **Development and sharing of individualized care plans**
4. **Transitional care practices**
5. **Collaborative Communication tools and processes**

Optional Domains: These domain areas are optional based on local partnership goals (for more detail on each domain see domain worksheets pages) and do not have statewide metrics reporting, however CCOs and APD/AAA partners are encouraged to set local goals and measures to build comprehensive processes. You may also find you have already incorporated core aspects of these optional domains in the required domain activities.

A: Linking to Supportive Resources
B. Health Promotion and Prevention
C: Safeguards for Members

2025-2026 MOU Process: The CCO - LTSS MOU should address core elements outlined in the CCO contract which are summarized in CCO supplemental materials and in domain information in this document. The required domains must be addressed in the CCO-LTSS MOU and required data points collected and provided to OHA in annual reports on Report Template by the CCO. A MOU template document is provided for the MOU that documents agreements and metrics/measures of progress toward goals.

MOUs will be reviewed as in the past by a review of the completeness of each MOU's addressing each required domains' minimum expectations and the listed CCO and APD expectations. Each section should ensure to address each area clearly. Governance sections must also be complete and documents must have obtained required signatures.

New MOU Period Focus Areas: The updated MOU period aligns with the CCO 2.0 contract extension through 2026 set by the Oregon legislature. CCOs should use issues identified in annual MOU reports to improve their MOUs and prepare for continued tracking for annual reporting to OHA. Updated MOUs for this two-year period should address weaknesses as noted in feedback such as:

- Ability to track communication with APD/AAA offices and staff,
- Hospital Event Notifications (HEN) and Skilled Nursing Facility (SNF) PointClick notifications to trigger communication especially concerning care setting transitions,
- Ensuring development of care plans for a greater proportion of CCO members with LTSS or needing LTSS.
- Addressing needs at care-setting transitions for discharge to prevent readmissions or unnecessary hospitalizations.

- Sharing how referrals and supports for members may be enhanced with new 1115 HRSN waiver services.

What is due when? CCO Submits New MOU to OHA: March 31, 2025
CCO Submits Annual Reports to OHA: Annually on May 30, beginning in 2025.
Any updates to MOUs should be submitted annually by January 15th.

Technical Assistance Support Contacts for MOU

OHA CCO Technical Assistance

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MOU Worksheets: Questions and Guidance for MOU discussion

This section of guidance has worksheets for each required and optional domain. Each domain worksheet provides minimum expectations for the MOU and discussion questions that follow to assist in working out the agreed upon goals and activities that meet the expectations of the domain. The questions are not required to be asked or formally submitted as part of the MOU process. The questions are meant to stimulate discussion among partners and highlight areas that may be new from previous guidance based on current CCO or DHS activities. MOU partners are encouraged to also include optional MOU domains that are relevant to alignment and coordination, but the requirement for MOUs is to, at a minimum address the 5 required domains. CCOs are required to track required domain data fields for submission on annual reporting to OHA, local MOUs may include additional measures for tracking local MOU agreements in domains.

REQUIRED DOMAIN 1: Prioritization of high needs members

Description: In order to create better coordination for high-needs LTSS populations in the CCO-APD/AAA MOU and to impact regular information sharing on prioritized populations, identified needs for LTSS services, or need for referral to care coordination, this domain highlights core aspects of routine information sharing activities to prioritize high needs members. CCOs are required to implement risk stratification and screening for all new members or review based on changes in health status or referrals, and to implement mechanisms to assess each Member with Special Health Care Needs and Members receiving Long Term Services and Supports in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. AAA/APD staff complete assessments to determine long term services and supports eligibility, members' need for support with IADLS or ADLS, level of service and specific services members need and, in coordination with the member, develop a service plan to meet the needs and to make changes over time as needed. CCOs are also tasked with identifying opportunities "to go upstream" with prevention and to implement care coordination activities that reduce unnecessary ER visits or hospitalizations.

Minimum Expectations MOU shall:

- Identify information sharing for prioritizing LTSS populations to impact coordination of care across systems.
- Address how CCOs and APD/AAA share information to identify and select high needs members.
- Ensure a process to communicate regarding high-risk members.
- Develop and document a process to refer and receive referrals from partner agency for assessments or referrals.
- Develop and document information sharing methods.
- Gain an updated understanding of current processes for prioritization by partner agency or agencies.

CCO Expectations:	**APD/AAA Expectations:**

• CMS requires universal risk screening process by CCOs that assesses individuals for critical risk factors that trigger care coordination which by rule incorporates all members receiving Medicaid funded LTSS.
  ○ CCO will factor in relevant referral, risk assessment and screening information from local APD/AAA offices and LTSS providers.
  ○ CCOs will define how it will communicate and coordinate with APD/AAA when assessing members receiving Medicaid- funded LTSS services.
  ○ CCO will ensure APD/AAA staff have contact information for referring members to risk assessment and CCO will have process to track and follow-up on these referrals.
	• APD/AAA will provide CCOs with access to information needed to identify members with LTSS with high health care needs.
	• APD/AAA will define how it will share key health-related information, including risk assessments, service priority levels, and individualized LTSS care plans generated by LTSS providers and local Medicaid APD/AAA offices into a comprehensive individualized care plans for CCO 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.
	• Make referrals to CCOs or community partners for any Health-Related Social Needs (HRSN).

- CCO will have a process to track referrals to APD/AAA for LTSS Needs Assessments. - CCO will share information on members receipt of HRSN services with APD/AAA.	
MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. CCO shall track required metrics and include any additional locally identified monitoring metrics/measures for success in annual reporting.	

Domain Questions for Discussion:

1. How does each entity define and screen for risk/high needs? What information would be helpful to shared accountability work (i.e. each agency should share assessment data they collect during MOU discussion and how they use that data to create high-risk prioritization)?
2. Are there common definition elements (safety, preservation of living situation, avoidable declines in health status, cultural and linguistic barriers, level of service, number of chronic conditions, etc.?) that create natural focus areas and a shared definition?
3. What should be the process for prioritizing shared high-risk members? [any updates needed where processes have previously been in place?] What processes allow for efficient and effective information sharing (methods, frequency), initially and down the road?
4. How will the process assure that individuals who are traditionally underserved be included amongst the highest risk group for care coordination? (Examples include those at risk of inpatient psychiatric hospitalization, those receiving intensive mental health services or those that have transitioned from the Oregon State Hospital, minority seniors?)
5. How do CCO 2.0 priorities to address health equity, social determinants of health and engage care coordination and care plans for targeted populations impact opportunities for this domain? What opportunities exist "to go upstream" and prevent at-risk members from hospitalizations and avoidable ER visits?
6. What potential safety or high-risk concerns are there? (high-risk medications, safety in the home, etc.)
7. Who is tracking the follow up and outcomes from inter disciplinary care conferences?

Guidance:

CCO and APD/AAAs offices build processes and information sharing agreements creating a joint approach for members receiving LTSS services, and for CCOs connecting members potentially in need of LTSS services. Processes should work to take the next step toward preventing unnecessary hospitalizations and avoidable ER usage by identifying high needs members at risk of setbacks.

CCO data sharing possibilities: CCOs can share the core processes for referrals, and how CCOs review for acceptance/qualify for care coordination, risk screening or risk scoring tools and processes, triggers such as ER or hospitalizations for special monitoring, etc. When and how do CCOs "deploy" traditional health workers to support members?

APD/AAA data sharing possibilities:

Provide CCO with information on risk related information collected by APD such as, risk assessments, risk elements in the CAPS, exceptions requests, Service Priority Levels and other assessment information.

REQUIRED DOMAIN 2: Interdisciplinary care teams (IDT)

Description: CCO and AAA/APD partners will establish and maintain on-going interdisciplinary care teams, consisting of providers such as CCO, PCP, LTSS and APD/AAA representatives, as well as other agencies/services providers working with the members. The interdisciplinary care teams will coordinate care and develop individualized care plans for high needs, mutual members. Identify processes and resources to support best practices to build care plans and integrated approaches for member supports.

Minimum Expectations MOU shall:

- Include how often interdisciplinary care teams conference/meet (minimum expectation is twice per month) and scheduling process.
- Address policies and mechanisms for building & ensuring appropriate providers (including Medicare and LTSS providers as indicated) are part of IDT Team.
- Address process for engaging in consultation & review of high-risk members/clients to build integrated treatment or care plans, or other care plan updates by the inter-disciplinary team.
- Address policies and mechanisms for members and/or family or authorized representatives to be directly included in the care coordination process and/or IDT meetings and tracking for IDT meeting participation by the member/client.
- Explain how members' goals and preferences inform and are documented in the care plan.
- Processes for coordination with social and support services and resources to address social determinants of health.
- Support the appropriate flow of relevant information, implement a standardized approach to effectively plan, communicate, and implement care planning and follow-up.

CCO Expectations:	**APD/AAA Expectations:**
• Adapt team-based care approaches and ensure barriers to participation of the member receiving LTSS services are not a barrier to member/client participation in the IDT meeting. • Tracking Care Plans for members with LTSS (see measures for success).	• APD/AAA will define roles, responsibilities, and process for assignment of and participation in the CCO IDT team, including coordination with CCO lead care coordinator, for members needing routine and care coordination. • APD/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. • APD/AAA will have knowledge of and actively participate in CCO team-based care processes when appropriate.

- MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. CCO shall track required metrics and include any additional locally identified monitoring metrics/measures for success in annual reporting.

Domain Questions for Discussion:

1. How do we want to design our care teams and incorporate each agency's person-centered care planning process into a single plan to reduce duplication and ensure wholistic treatment plans where possible? [i.e. Are there established bridges between LTSS and CCO staff and providers and is there a way to leverage those bridges in the design of a care team?]
2. How do we ensure that the member and/or member's representative are able to participate in IDT meetings?
3. How do we ensure member's core providers (primary care, specialists) are engaged?
4. What social service agency representatives might be involved on the team?
5. What can we do now? Later?
6. What can we accomplish through technology, cyber/video conferencing, phone conferences vs. face-to-face?
7. What are the roles and responsibilities for members of the care team? How often will meetings occur (expectation minimum of twice monthly).
8. Do we need to create protocols/ground rules for participation, etc.? Are there limitations we need to be aware of?
9. How do we ensure we are not just collaborating on transitions from acute care, but also collaborating around cases where we could proactively help avoid hospitalizations by rallying resources and services to support members with unmet needs?
10. What potential safety or high-risk concerns are there for discussion? (high-risk medications, safety in the home, etc.)
11. Are there other individualized care plans for member? For example, at primary care clinics, behavioral health, or with Medicare providers for dual eligibles? Are there strategies for consolidating plans?

Guidance: CCO and APD/AAAs build agreements regarding their team approach for high-risk members. Teams can be utilized more broadly if mutually desired. Items to consider include, membership of care team, inclusion of individual, how team meets/shares information and frequency of meeting/sharing information, role of community information exchanges, if any.

CCO data sharing possibilities: Processes including timelines for building comprehensive care plans, use of Health Information Exchanges (HIE) or Community Information Exchanges (CIE) for referrals or sharing care plans, targets to build comprehensive care plans, leads and contacts for communication, preferred communication methods.

APD/AAA data sharing possibilities: Leads and contacts for communication; processes for member engagement in person-centered care plan development and review & care plan documentation.

REQUIRED DOMAIN 3: Development and sharing of individualized care plans

Description: CCOs and AAA/APD have requirements to ensure person-centered care planning processes are in place to address member's needs. CMS has increased expectations for reducing duplication of services, assessments and improving member experience and outcomes through more integrated approaches to care planning.

DHS has a long history of person-centered planning for persons needing LTSS programs and services.
The goal of person-centered planning is to create a plan that would optimize the person's self-defined quality of life, choice, and control, and self-determination through meaningful exploration and discovery of unique preferences and needs and wants in areas including, but not limited to, caregiving, choice of providers, health and well-being, relationships, safety, communication, residence, technology, community, resources, and assistance. DHS has administrative rules in Division 4, Chapter 411 HOME AND COMMUNITY-BASED SERVICES AND SETTINGS AND PERSON-CENTERED SERVICE PLANNING.

Minimum Expectations MOU shall:

- Share best practices, processes, and expectations on how to actively engage Members, Member Representatives, and their families as partners in the design and implementation of Member's individual treatment and person-centered care plans.
- Support a shared culture of integration across CCOs and LTSS service delivery systems.
- Address policies and mechanisms for producing, in consultation with the appropriate Providers, including Medicare Providers, an integrated treatment or care plan for Members.
- Developing and implementing processes for sharing information, coordinating care, and monitoring results, and creating the most comprehensive CCO care plan to address member needs.
- Explain how care plans are shared and updated among care team members, expectations for how often care plans are reviewed, triggers for updates.
- Encourage strategies to reduce all-cause readmissions and avoidable ED utilization and improve depression screening and follow-up plans for members with LTSS [CCOs should identify tracking tools for monitoring CCO metrics targets in populations with LTSS].
- Support the appropriate flow of relevant information; implement a standardized approach to effectively plan, communicate, and implement care planning and follow-up.
- Processes for coordination with social and support services and resources to address social determinants of health that support care plans and ensure access to language and disability services to ensure access.
- Incorporation of Advance Care Planning, or End-of-Life Decision Making/POLST into comprehensive care planning where appropriate.
- Include process for medication reconciliation for patients with complex or high-risk medication concerns.
- Beneficiaries are treated fairly, are informed of their choices, and have a strong and respected voice in decisions about their care and support services.

CCO Expectations:	**APD/AAA Expectations:**
• CCOs' individualized person-centered care plans will include information about the supportive and therapeutic needs	• APD/AAA will define how it will integrate key health-related information, including risk assessments generated by LTSS providers and local Medicaid AAA/APD offices into CCOs'

of each member, including LTSS services and supports needs. • Plans will reflect member or family/caregiver preferences and goals captured in APD/AAA service plans as appropriate. • Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from APD/AAA and with LTSS providers and case managers as appropriate. • CCO will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with APD/AAA where relevant to LTSS service planning. • CCOs will identify opportunities to focus on preventive approaches, screenings and strategies to reduce unnecessary hospitalizations, ER visits and maintain or improve health of members with LTSS. • CCOs will track completed care plans for members with LTSS.	individualized care plans for members with care coordination needs. • 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 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.
• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. CCO shall track required metrics and include any additional locally identified monitoring metrics/measures for success in annual reporting.	

Domain Questions for Discussion:

1. How does each entity currently develop individualized care plans? How are new CCO 2.0 contract expectations for care planning, treatment plans for members with Special Health Care Needs, and care profiles different?
2. What shared information would be most helpful to each entity in creating individualized care plans?
3. How do CMS expectations for plans to reduce duplication impact the CCO to LTSS MOU agreements?
4. Can the desired information be easily shared? How would it be shared to ensure security/privacy? How are we ensuring that we don't put unreasonable requirements on information that is allowed to be shared under HIPPA for care coordination?
5. What is a reasonable starting point and where do we want to get to and by when?
6. How can the CCOs help educate as needed, AAA/APD staff and LTSS providers about the role and availability of Traditional Health Workers? This should include types of THWs (including peer support and community health workers) in new CCO 2.0 plans and services members can access, and how these care coordination resources might support identified needs or play support roles when identifying member needs, preferences and goals in development and monitoring of care plans? How can both parties work to increase coordination and avoid duplication of work by LTSS providers and THWs?
7. How do care plans identify and incorporate goals to move toward wellness and to ensure members receive preventive assessments and services? Is wellness, chronic care management or preventive services part of member individualized care plans?

8. How does member preference become part of integrated care planning? For example, LTSS typically captures information regarding the individual's choice of living situation while CCOs will likely have information related to an individual's health goals.
9. How can the CCO and AAA/APD share information on individual preferences? What is a process for ensuring member's approve information sharing for integrated care planning?
10. How can both parties encourage member participation and facilitate participation by members?
11. What processes are used to share care plans with health care providers, member, or authorized family members, and LTSS providers where appropriate?
12. What is each agencies' process for ensuring access to interpreters or other disability access tools?

Guidance: MOUs should reflect the member information that is reasonable to collect and ensure collaborative processes can be successful in the development of individualized care plans. This area should improve over time as systems for sharing information are refined and knowledge is gained through experience. MOU should establish how client preference information known to each entity will be shared and incorporated into care planning. How do we get to the most comprehensive care plan including information from both systems for shared members?

CCO data sharing possibilities: CCOs can share any use of HIE or CIE tools for sharing care plans with providers and discuss information sharing process with DHS since at present DHS doesn't have access to these systems. Share specific targets for utilization of services (increased preventive services & screenings, etc.), or preventive approaches to reducing unnecessary hospitalizations or avoidable ER visits. Share any roles that THWs may have for members.

APD/AAA data sharing possibilities: Person-centered care planning processes and tools. State Plan personal care, Waiver personal care, Community Nursing, Other HCBS (other waiver services) utilization. (Chapter 411 Person-Centered Planning requirements (https://oregon.public.law/rules/oar_411-004-0030#:~:text=The%20person%2Dcentered%20service%20plan%20must%20be%20developed%20by%20the,the%20legal%20or%20designated%20representative) . Also APD/AAA can share National Core Indicators Aging and Disability Annual Survey data.

REQUIRED DOMAIN 4: Transitional care practices/Care Setting Transitions

Description: CCO and AAA/APD partners will develop coordinated care setting transition practices that incorporate timely-information-sharing when transitions occur, minimal cross-system 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 can occur when members 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.

Minimum Expectations MOU shall:

- Document how partners are coordinating transitions, transition resources including but not limited to:
    - Process to coordinate appropriate discharge planning and ensure services are in place prior to discharge [OAR 410-141-3860].
    - Communication strategies and expectations (how do you address regular hour vs. evening/weekend transitions?)
    - Scheduling for key follow-up appointments, planning for transportation needs, medication reconciliations and durable medical equipment needs before transition happens.
- Describe how to access information and how information sharing will happen.
- Identify cross system resources and how they may be used during transitions.
- Document/map transition processes. The written document/map should detail roles and responsibilities, minimum frequency of meetings or communications and method of communication.
- Document core activities to support various types of care transitions members may experience.
- Support the appropriate flow of relevant information; implement a standardized approach to effectively plan, communicate, and implement transition and care planning and follow-up.
- If the is participating in a Health Information Exchange (HIE) or Community Information Exchange (CIE) that shares information related to transitions, share how they are used to support transitions. [at present DHS does not typically have access to these systems].
- What flexible services or health-related services does the CCO offer that might support transitions? Support appropriate 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) as well as transitions between these settings.

CCO Expectations:	**APD/AAA Expectations:**
• CCO will demonstrate how it will coordinate and communicate with APD/AAA to incentivize and monitor improved transitions in care for members receiving LTSS services and supports, so that these members receive comprehensive transitional care. • CCO responsible to ensure transition processes include evidence-based discharge planning, setting up and monitoring of follow-up appointments, ensuring transportation,	• APD/AAA will demonstrate how it will coordinate and communicate with CCO to incentivize and monitor improved transitions in care for members receiving LTSS services and supports, so that these members receive comprehensive transitional care, as required by ORS. • APD/AAA will provide detail on best way to contact staff for LTSS assessments. • APD will work with CCO, OHA and medical providers on durable medical equipment

medication reconciliation, durable medical equipment needs/orders, etc. *Are HRSN services assessments offering any additional supports to members facing care setting transitions?	and environmental modifications needed for successful transitions.
• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. CCO shall track required metrics and include any additional locally identified monitoring metrics/measures for success in annual reporting.	

Domain Questions for Discussion:

1. What does an ideal care transition involve from a consumer perspective? Is there a need for additional family or member discharge education?
2. How do you ensure cultural and individual transition needs? Do our partners provide discharge plan documents in member's language? How does each agency provide access to language services?
3. Are there staff who specialize in transitions? Are the specialized staff known to both organizations including how the staff are assigned to individual consumers or transitions? Does the staff use evidence-based practices? Are those practices shared?
4. If either party has an adopted an evidence-based transition of care model (i.e. Coleman model), how is the model ensuring processes increase percentage of members with complete discharge protocols and follow-up plans?
    a. Do discharge plans address all needs such as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DME) needs, nutrition or physical therapy needs, medications review/medication reconciliation, follow-up appointment scheduling, any assessment for LTSS services, transportation, etc.?
    b. Do discharge materials provide information on red flags/warning signs for health deterioration and given specific contacts in case of questions or what action to take regarding decline as part of transition care?
    c. Are discharge materials in the member's shared care plan so that they are available to all parties where appropriate? How do we share these plans with all providers, case managers and care coordinators at CCOs and/or Medicare Advantage plans where appropriate?
    d. Do we need to conduct an in-home safety review prior to discharge to home? Have we assessed members at home living and support situation prior to discharge? Who is responsible?
    e. Did follow-up actually occur? Do partners monitor follow-up?
    f. How are partners assessing and measuring if a transition successful? What is the process if a transition is not successful? (IDT or debrief?)
5. What tools, checks or safeguards does each system use to ensure comprehensive transition care planning? Can these tools be shared?
6. What is a reasonable time frame for communication when care transitions are occurring, or care transition planning is needed?
7. What critical information should be shared to facilitate successful care transitions?
8. What practices and approaches can we adopt that best use our talents and resources?
9. How can partners meet identify at risk members and address a member's needs to avoid hospitalization or unnecessary emergency visit before an acute care episode occurs? How can close monitoring or

follow-up post-transition prevent unnecessary readmissions?

10. Share how CCO currently uses Collective Medical data such as event notifications to trigger care coordinator's role in transitions, including new notifications process for members who are discharged to post hospital extended care by being admitted to skilled nursing facility (SNF) or hospital event notifications (HEN) or any care plan data shared via Collective to providers?
11. How does CCO currently use Health Information Exchange (HIE) to share information with providers on transition plans or follow-up activities related to transitions?

<u>Guidance:</u> Communications and coordination between CCOs and AAA/APD are particularly critical during any transition since limited resources require a close examination of areas where there is a potential for duplication of effort. Resources can act complimentary to ensure successful transition planning and transitions occur. Discussion should include understanding the roles and responsibilities during the critical period after an acute care episode, as well as transitions to Medicaid funded LTC/HCBS or other specific settings or levels of care. Processes should link efforts to reduce preventable readmissions and ER visits.

<u>CCO data sharing possibilities</u>: What information is CCO incorporating into the Collective Medical platform (care coordination contacts) or how is the CCO using the information received via Collective for its transition processes? Share CCO metrics data that CCO is monitoring for LTSS populations. What evidence-based models and tools are used by CCOs and providers? What flexible services are available to support transitions? What is the process for accessing transition related flexible services? What roles do Traditional Health Workers play in supporting member transitions?

<u>APD/AAA data sharing possibilities:</u> Share data available: Acuity on admission to nursing facilities, patterns of transition barriers if available, other data that may be available from APD Transition program manager, standard for assignment of a transition coordinator, transition coordinator role, contacts for transitions.

REQUIRED DOMAIN 5: Collaborative Communication tools and processes

Description: The CCO-AAA/APD MOU should provide details on collaborative communication at times of key events, changes in health status, service priority levels, or changes in location of LTSS service delivery, or other transitions in member's need or level of care. Having standardized communication and information sharing processes is critical to ensuring that routine processes can create opportunities to meet shared OHA and DHS goals for members with LTSS. MOUs may also want to include ways to track that regular communication processes are happening to support other key work within the CCO-LTSS systems, and MOU reporting requires tracking of IDT meetings, referrals, and follow-up.

CCOs are increasingly using electronic methods to build stronger care coordination tools to support members and providers. This includes use of Collective Medical platform event notifications tools for hospital events (HEN) including ER visits and hospitalizations and new Skilled Nursing Events (SNF) event notifications. They are just starting to receive information on new Skilled Nursing Events (SNF) as more SNFs are onboarded by Collective. [OHA has received funding from CMS to support onboarding remaining SNFs to Collective platform in 2020. Onboarding SNFs began in 2019.] They are also using Health Information Exchange (HIE) systems and may be using Community Information Exchanges (CIE) to meet information sharing for referrals, care plans and other key information such as medical records, out to health care providers, including Medicare providers where appropriate, to improve comprehensive care coordination. Each CCO had to create a Health Information Technology roadmap for CCO 2.0.

APD and Type B AAAs do not participate in Health Information Exchanges or Community Information Exchanges currently. APD and Type B AAA staff may have access to the Collective platform but are not required to use it at this time. They do not receive event notifications.

Minimum Expectations MOU shall:

- Each organization will share processes for communication, especially for ensuring referrals, IDT team meetings, care planning, or care transitions and identify key contacts for receiving communications.
- Each organization will share how they currently use Collective platform information and any specific ways they might use it, i.e. reports or other care planning or coordination processes.
- Each organization will look to relationship of this information to assist building communication or processes in other domain areas.
- CCOs will share HIE roadmap goals to expand provider access to Event Notifications and Care planning information directly to member's providers.

CCO Expectations:	**APD/AAA Expectations:**
• Ensure communication processes are clear and reflect capabilities and expectations to build cross-system collaboration to improve outcomes and reduce duplication. • Ensure communication methods are detailed and specific to enable regular communication	• Ensure communication processes are clear and reflect capabilities and expectations to build cross-system collaboration to improve outcomes and reduce duplication. • Ensure communication methods are detailed and specific to enable regular

and information sharing across all required domains. • Share how CCO is using Collective Medical hospital event notifications (HEN) within Contractor's organization, for example, to support Care Coordination and/or population health efforts. • Share how CCO is integrating new Collective Skilled Nursing Facility (SNF) notifications into care coordination and/or population health efforts and participate in opportunities for joint discussions with Collective and APD/AAA teams on SNF event notifications. • Share CCO work to link expansion of provider direct access to event notifications to care planning and care transition processes. •	communication and information sharing across all required domains. • Share how APD/AAA office is using any Collective information. • Participate in discussions as appropriate on any APD/AAA use or monitoring new SNF information (Post-Acute Care) in Collective.
• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. CCO shall track required metrics and include any additional locally identified monitoring metrics/measures for success in annual reporting.	

Questions for Discussion:

1. What are the best methods for communication to ensure collaborative coordination across systems for each core domain area? Are our communication activities clear, have clear contact methods and persons identified, and do we monitor how well we are doing at ensuring communication channels are being used consistently to achieve MOU goals?
2. How does each agency use the Collective platform reports, or other tools to inform services & planning: Address any or all that may be used by either CCO or APD/AAA within current workflows to gain better understanding:
   - Discharge planning & diversion/transition.
   - Collaborative care coordination (weekly huddles, etc.); IDT meetings.
   - Service planning & adjustments after medical events.
   - Accountability & stewardship.
   - Prevention activities: individual and population trend identification & interventions.
   - Risk monitoring & federal reporting for critical incidents.
3. How are communications and contacts triggered by event notifications/collective information? What are standard protocols for CCOs when they receive HEN or SNF event notifications? Are these notifications triggering CCOs to contact APD/AAA to ensure LTSS assessments are being scheduled?

4. What are ways we will review how communication processes are monitored and how successful they are at alerting our teams as triggers to initiate sharing prioritization information, ensuring regular IDT team meetings, care planning and transitions processes?
5. What opportunities exist for shared discussion around how customizable data or cohort reports may impact joint care coordination processes?

Guidance: CCO and APD/AAAs share their use of Collective Medical information and discuss opportunities for collaborative information sharing. Ensure communication methods are detailed and specific to enable regular communication and information sharing across all required domains in the MOU and monitoring to ensure communication occurs regularly throughout the MOU duration. MOU should ensure that contact information for sharing information also includes a regular process for updating contacts as they change throughout the duration of the MOU.

CCO data sharing possibilities: CCO can share how they are working to increase provider access to event notifications and using it for triggers for collaborative communication to address member's needs, especially for care transitions work. Share the Hospital Event and Skilled Nursing Facility event notifications that will trigger care coordination team communication from CCO care coordinator to APD/AAA. Ensure there is understanding of process and ability to request LTSS assessments for care setting transitions (such as hospital to home or home to skilled nursing).

APD/AAA data sharing possibilities: How is APD/AAA using the Collective Platform information in work? Who are the best contacts for CCOs at each APD/AAA office to discuss new events, refer members for LTSS assessments, discuss transitions, etc. Ensure there is a clear process to refer any members APD/AAA teams identify as potentially needing care coordination services to the CCO.

Optional Domain A: Linking to Supportive Resources

Description: Each community and agency has a variety of processes and access to supportive resources that play a critical role in supporting member success in achieving health and quality of life goals. Community resources such as housing, food, transportation, social activities, and support networks, etc. play an important role in maintaining or enhancing health. It is critical for both agencies to understand the array of services accessible to members, and how one qualifies or connects to those services. The MOU seeks to promote a no-wrong door approach to meeting the member's needs.

Minimum Expectations MOU shall:

- Each organization will share types of programs and resources and process for qualifying/accessing services.
- Each organization will share how supportive resources assist building communication or processes in other domain areas.
- Explain how the CCO and AAA/APD work together to ensure that members have information about how to navigate systems?
- Organizations will share their involvement, participation, roles, and expectations around Community Information Exchange (CIE), if being used in the community, or roles for work with ADRC or 211 systems around social determinants of health screening and navigation to local resources.

CCO Expectations:	**APD/AAA Expectations:**
• Share what new resources and tools exist to make resources, such as those addressing social determinants of health and/or population health efforts will be accessible to individuals receiving LTSS and/or their family or authorized representative. • Share information on eligibility for and process by which CCO considers Health Related Services Requests (formerly flexible services, see glossary). • Share how CCO deploy THWs or address new social determinants of health or health equity CCO goals that may impact additional supports for members with LTSS need. *Share how members get referred for HRSN services/assessments for qualification for these new benefits.	• AAA/APD will share what types of resources may be available to support members through DHS (ADRC, SNAP, Counseling on Long-term Care options, Older American's Act services, etc.). • AAA/APD will share process by which additional LTSS supports can be authorized (transportation, safety devices, funds for specific items, special needs, K Plan ancillary services). • What is the process for APD/AAA to refer members in need of new HRSN services?
• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. MOU and CCO reporting to include any additional locally identified monitoring metrics/measures for success in annual reporting.	

Questions for Discussion:

1. What are the barriers to access supportive resources in each system? Are partners well informed about each other's services?
2. What new supports are CCOs providing to support members in areas of social determinants of health (housing, food, safety). CCOs engaged in SDOH project with Oregon 211 and screening and navigating members to supports or with CIEs should share that work and how it might be of value to members with LTSS needs.
3. CCOs partnering with post-hospitalization respite care for homeless should share these unique partnerships.
4. Are there social supports that might be covered under LTSS services? What other services or supports are available through DHS?
5. What community supports exist that can complement and address other needs for members?
6. What targeted communication to members might assist in making information accessible to individuals receiving long term services and supports? Are there new ways to meet consumer expectations that information and guidance will be available about public programs, health benefits and services? (accessible materials).
7. Are there provider systems in place to track referrals and follow-up to community resources or to other providers? Is feedback given to any referral source?
8. How do we know members are able to successfully access resources? Do we monitor and conduct follow-up to ensure member's received services or supports needed?
9. What key community partners and relationships does each organization already have? Can those be leveraged to support cross agency and consumer goals?
10. Is CCO participating or using a Community Information exchange (CIE) system to share referrals, or navigation to community resources? How will duplication be avoided? Who currently has access to information and at what level of detail?

Guidance: Sharing each other's current standards and practices may assist with identifying strategies for greater consistency and efficiency in member access to information. Agreements developed should take a "no wrong door" approach to addressing individual's questions/issues and seek to find solutions at the lowest level appropriate. Work may focus on developing health literacy, culturally-specific outreach materials for targeted populations.

CCO data sharing possibilities: When and how do CCOs "deploy" traditional health workers to support members? Explain to APD/AAA process for members to access what is known in CCO terms as "Health Related Services" and how that incorporates special requests for what had been previously known as flexible services. What community partners does the CCO work with to connect members with additional supportive resources? How are the new HRSN services being deployed and how are members referred to these services?

APD/AAA data sharing possibilities: Provide CCO with any AAA programs, ADRC information and if requested, training or other information on resources APD is aware of as relevant.

Optional Domain B: Health Promotion and Prevention

Description: This optional domain allows for MOUs to implement local strategies to build cross-system activities to promote wellness, and specific health promotion and prevention activities members can access in local communities. Provides opportunities to link caregivers to resources and supports for members dealing with chronic conditions such as Alzheimer's.

Minimum Expectations MOU shall:

- Encourage partnerships to increase availability of and access to health promotion, prevention and wellness programs and resources for members with LTSS in local communities, including access to culturally-specific programs where available.
- Each organization will share current health promotion and prevention focus (example: CCOs can share focus on preventive screenings or ensuring members have a primary care home; where APD/AAA provide health promotion programs such as Stanford Chronic Disease Self-Management programs, Caregiver support programs, etc.)
- Share the use of evidence-based care transition models that include medication reconciliation, follow-up care and programs to support family caregivers.
- Share the opportunity to promote evidence-based models of health promotion and chronic disease self-management for members with LTSS.
- Identify potential unique needs for subpopulations of beneficiaries with LTSS and how cross-system MOUs can create additional opportunity to ensure health and wellness for members.

CCO Expectations:	**APD/AAA Expectations:**
• CCOs will share health promotion and prevention activities and services available through the CCO. • CCO will share process by which CCO considers Health Related Services Requests for health and wellness activities (formerly flexible services, see glossary). • CCO will share new tracking systems for navigation and referrals to community resources for social determinants of health or how members can access services from THWs. • CCO will discuss opportunities to connect members to health promotion and wellness activities and services offered through APD/AAA.	• APD/AAA will educate CCOs on current health promotion and prevention services that are offered. • APD/AAA will help LTSS Consumers, CCOs and other partners to access and engage in health promotion and prevention programs available in the community.
• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. MOU and CCO reporting to include any additional locally identified monitoring metrics/measures for success in annual reporting.	

Questions for Discussion:

1. What health promotion and prevention programs does each organization support or what programs your MOU supported in the past? MOU discussion may include plans or exploration of CCO reimbursement for approved programs such as the National Diabetes Prevention Program, Chronic Disease Self-Management programs, or Tai Chi.
2. What barriers might impede CCO members from accessing prevention programs?
3. What needs have been identified in your community (through community health assessment or other data sources) that health and prevention programs might address? Are services available in the community to address unique health issues of CCO members with LTSS needs?
4. CCO should share how traditional health workers are engaged in supporting member health and wellness and how members access these services. Are there opportunities to align THW work with programs or services offered by APD/AAA [example: CHW contacts AAA office to arrange for participation in Arthritis exercise program].
5. CCOs should share how Health Related Services (includes what was previously known as flexible funds) are available to support member needs around wellness or health prevention/promotion activities.
6. What resources exist to support family caregiver wellness (e.g. respite programs, day programs for clients)?
7. What specific programs are available in culturally specific languages or curriculums? Are there targeted approaches or communication to enhance equitable access to health promotion and prevention? What processes does each agency use to ensure language and disability access to programs or services?

Guidance: The use of evidence-based programs is preferred. Presents opportunity to explore partnerships ore continue previous relationships in MOUs to increase consumer access and engagement in evidence-based health promotion programs. Agreements developed should take a "no wrong door" approach to addressing individual's questions/issues and seek to find solutions at the lowest level appropriate.

CCO data sharing possibilities: When and how do CCOs "deploy" traditional health workers to support members? Share information on eligibility for and process by which CCO considers Health Related Services Requests (see glossary) for health and wellness activities.

APD/AAA data sharing possibilities: Provide local ADRC contact for a list of local health promotion and caregiver support programs. Provide CCO with any other locally available health promotion resources or program as relevant.

Optional Domain C: Safeguards for Members

Description: Safeguards for high-risk members are critical to both DHS and OHA. This optional domain allows for MOUs to implement local strategies to build cross-system activities and information sharing across partners to ensure safeguards for members. Since 2020 both agencies have implemented protocols to ensure added protections around the COVID 19 virus spread. Each agency has processes for ensuring member access to grievances, appeals and hearing processes, provides member rights and responsibilities, and is committed to ensuring health equity and removing language barriers. Ensuring cross-system health literacy for members provides members with key information to inform safety and how to get what is needed should improve safeguards for members.

Minimum Expectations MOU shall:

- Each organization will share process for identifying needed safeguards.
- Each organization will look to relationship of this information to assist building communication or processes in other domain areas.
- Incorporation of safeguards and methods of sharing resources with members into MOUs
- Identify potential unique needs for subpopulations of beneficiaries with LTSS and how cross-system MOUs can create additional opportunity to ensure safeguards for members.
- Ensure respect for member self-determination and "dignity of risk".

CCO Expectations:	**APD/AAA Expectations:**
• Share what new resources and tools exist to make resources accessible to those in need, such as those addressing social determinants of health and/or population health efforts will be accessible to individuals receiving LTSS and/or their family or authorized representative. • Ensure APD/AAA have contact information for care coordination referral for medical safety concerns that are brought to their attention.	• AAA/APD will share with CCOs, and where feasible PCPCHs, and other medical partners client's right to self-determination, respecting client choices and person-centered planning approaches • AAA/APD will share information about safety protocols. • Share Adult Protective Services definitions, mandatory reporting expectations and reporting process
• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations. MOU and CCO reporting to include any additional locally identify monitoring metrics/measures for success in annual reporting.	

Questions for Discussion:

1. What resources and supports does each agency have in place to ensure beneficiary safety?
2. Is information about types of home safety devices which might include emergency response call devices or those that provide environmental modifications at home to assist individuals in remaining independent available to providers? [e.g. are CCOs aware of specific devices and tools that can be available to assist clients with dementia safely stay in their homes? Or how to ensure that deaf or hard-of-hearing members access supportive technologies?]

3. How are the systems working together to ensure the client's right to self-determination is respected including situations in which there are safety risks?
4. How will each entity work together to coordinate a no wrong door policy for member complaints and grievances? What contacts will be provided to member to call in case of concerns?
5. What process is being used by CCOs to receive any member concerns about access to care that may be reported to the APD/AAA case manager –how should APD/AAA forward complaints and grievances?
6. What resources exist to support family caregivers with emergency challenges.
7. What other agencies in Oregon are available to address elder abuse or financial abuse situations and how does one refer to them?

Guidance: Agreements developed should take a "no wrong door" approach to addressing individual's questions/issues and seek to find solutions at the lowest level appropriate. Agencies should share protocols for addressing safeguards at each agency and identify opportunities for collaboration or how MOU will address safeguards (example: Work may center around creating comprehensive resource lists to be shared with staff at each agency).

CCO data sharing possibilities: Share protocols for addressing safeguards and approaches to ensuring members are aware of rights and key processes impacting safeguards.

APD/AAA data sharing possibilities: Share Adult Protective services data and share protocols for addressing safeguards and approaches to ensuring members are aware of rights and key processes impacting safeguards.

GLOSSARY: MOU GUIDANCE TERMINOLOGY

This Glossary is a communication tool which attempts to provide informal explanations of terms which may be used in discussions regarding the MOU. These terms should *not* be considered as alternatives to the legal or statutory definitions which are used in contract or regulatory processes**.**

Addictions Services – Refers to alcohol and other drug treatment and recovery services.

Aging and People with Disabilities (APD) – A division in the Department of Human Services (DHS) that runs programs for seniors and people with disabilities. APD does not provide long term services and supports to individuals with developmental disabilities or mental health issues. APD currently determines eligibility for Medicaid health benefits and SNAP for these individuals.

Area Agency on Aging (AAA) (Type B) – Locally governed and managed offices responsible for both Medicaid-funded long-term Care (LTC) and Older American Act services in the following counties: Clatsop, Tillamook, Polk, Yamhill, Marion, Multnomah, Linn, Benton, Lincoln, and Lane. These offices will be required partners in the development of Memo of Understanding (MOU). Area Agencies on Aging (Type A) exist in other areas of the state but do not provide Medicaid services and therefore will not be required partners in development of MOUs.

Behavioral Health – means the spectrum of behaviors and conditions comprising mental health, substance use disorders, and problem gambling.

Care Coordination: means the act and responsibility of CCOs to deliberately organize a member's service, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the member. Care Coordination requirements are described in OAR 410-141-3860, 410-141-3865, 410-141-3870, and in accordance with CFR 438.208.

Care Coordinator means a Person at the CCO providing "Care Coordination" services as defined in OAR 410-141-3860, OAR 141-410-3865 and 410-141-3870. Member's will be notified of the name and contact information of their assigned care coordinator when assigned.

Care Coordination Plan or Care Plan: means a care plan that is developed for and in collaboration with the member, their family, representatives or guardian; and in consultation with the member's providers, community supports and services, where applicable, to ensure continuity and coordination of a member's care according to their needs. Care Plan requirements are described in OAR 410-141-3865 and 410-141-3870.

Care Profile: means the electronic record a CCO develops and maintains for all members. The Care Profile is the platform that receives feeds from different data sources used to identify, track, and manage a member's needs and risk level to direct the frequency of the CCOs outreach and Care Coordination activities/opportunities that shall be offered to the member. Care Profile requirements are further

described in OAR 410-141-3865 and OAR 410-141-3870.

Care Setting Transitions: means a transition between different locations, settings, or levels of care.

Centers for Medicare and Medicaid Services (CMS) – Federal agency responsible for Medicaid and Medicare.

Chronic Conditions – A medical disease or condition, such as diabetes, arthritis, congestive heart failure or asthma that persists over time, is marked by frequent recurrence and which requires proactive outpatient treatment to prevent or minimize deterioration. This term is not used for behavioral health diagnoses.

Coordinated Care Organizations (CCO) – Business responsible for integrated, comprehensive medical care envisioned by Health Systems Transformation and which will have a contract with Oregon Health Authority to provide Medicaid funded medical, oral health (dental) and behavioral health services using a capitated (global budget) model of financing.

Community Health Assessment and "**CHA**" means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are Community engagement and collaborative participation.

Community Health Improvement Plan and **Community Improvement Plan** and **"CHP"** means a long-term, systematic effort to address public health problems on the basis of the results of Community Health Assessment activities and the Community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with Community partners, to set priorities and coordinate and target resources. A Community health improvement plan is critical for developing policies and defining actions to target efforts that promote health and defines the vision for the health of the Community through a collaborative process that addresses the gamut of strengths, weaknesses, challenges, and opportunities that exist in the Community to improve the health status of that Community.

Community Health Worker or "CHW" has the meaning as provided in OAR 410-120-0000.

Department of Human Services (ODHS) – A state agency within the State of Oregon which provides many programs designed to assist Oregonians to be independent, healthy, and safe. Aging and People with Disabilities is one of five program areas within this Department.

Developmental Disability – A medically diagnosed condition that starts before age 18 (or 22 in the case of Traumatic Brain Injury) and which prevents normal adaptive and/or intellectual functioning.

Dignity of Risk is the idea that self-determination and the right to take reasonable risks are essential for dignity and self-esteem applicable to adults who are under care such as elderly people, people living with disability, and people with mental health problems or other chronic conditions. It has also been applied to children living with disabilities. The term is used to promote respect in care provision to these populations, and to support community and independent living choices and to promote engagement of the individual in person-centered planning processes for care and treatment plans. In a care situation, dignity may be

promoted or lessened by physical environment, organization cultures, attitudes and behavior of the nursing team or others. Dignity in DHS state policy is further defined in be ORS 410.020[1] and ORS 410.710[1].
The term is also incorporated in the Olmstead decision.

Dually Eligible Individuals, or Individuals who are Dually Eligible – are individuals who receive both Medicare and Medicaid behavioral health and medical benefits. Persons who also have Medicaid long term services and supports benefits might be referred to as individuals who are 'triple eligible.' "Duals" is a short cut term for 'dually eligible individuals' and should not be used as it can be considered objectionable. OHA also uses the term **Full Benefit Dual Eligible (FBDE)** to specifically refer to duals who may be enrolled in CCOs. These are duals enrolled in BMM or BMD OHP benefit packages.

Evidence Based or Best Practices Approaches – Approaches identified through empirical research or practice which can achieve desired, verifiable health or service outcomes.

Fee for Service – A method of paying an established fee for a unit of service after it has been delivered.

Flexible Services - Flexible services are a type of Health-Related Services (HRS) as defined in OAR 410-141-3845 offered to an individual member as an adjunct to covered benefits. Flexible services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the HRS needed to supplement the member's care.

Health Equity or "HE" means a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all sectors across Oregon, including Tribal governments, to address the equitable distribution or redistributing of resources and power and recognizing, reconciling, and rectifying historical and contemporary injustices.

Health Information Exchange and **"HIE"** mean the electronic movement of health information among disparate organizations and Health Information Systems.

Health-Related Services" and "HRS" each have the meaning as provided in OAR 410-141-3500 and as described in OAR 410-141-3845. HRS means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141- 3845. Health-related services include flexible services and community benefit initiatives.

Health Services – Services obtained through a person's medical provider or health insurance.

Health Systems Transformation (HST) – A range of programs and initiatives activated by state and federal legislation developed to improve access to healthcare, improve health outcomes and lower healthcare costs. Development of CCO's is a critical part of this effort.

Home and Community Based Services Waiver (HCBS) – Within broad Federal guidelines, states can develop

home and community-based services programs to meet the needs of people who prefer to get long-term care services and supports in their home or community rather than in an institutional setting. These waivers are one funding mechanism for long term services and supports. Most waivers in Oregon are administered through Aging and People with Disabilities or the Office of Developmental Disabilities Services.

Individualized Care Plan – See also **Person-Centered Care and Care Plan**. A plan developed by the individual and the individual's inter-disciplinary care team to provide services and supports to meet the individual's medical, behavioral, and social needs.

Interdisciplinary Care Team (IDT) – A team that develops the individualized, person-centered care plan and/or coordinates services across medical, behavioral and long-term care systems. Ideally an IDT includes the individual, the individual's primary care physician, long term care provider, case manager, non-traditional health care worker, other health professionals as well as family members.

Learning Collaboratives – A jointly developed event or process for sharing knowledge between health care providers and community organizations serving mutual clients.

Long Term Services and Supports – For seniors and people with disabilities, these services and supports assist persons who are aged, blind or have disabilities for long periods of time. In Oregon, these services and supports can be provided in licensed care settings or in the individual's home. Licensed providers include nursing facilities, assisted living facilities, residential care facilities, specialized living facilities, and adult foster homes. In-home services and supports are provided by Home Care Workers or in-home care agencies. For eligible individuals, these services are funded through state and federal Medicaid programs. Similar services, administered by different offices, exist for medically fragile children, individuals with intellectual and developmental disabilities and individuals with chronic mental illness. **Medicaid-Funded Long-Term Services and Supports**" and "**LTSS**" has the meaning provided in each have the meaning as provided in OAR 410-141-3500.

Medicaid – A federal and state funded portion of the medical assistance programs also referred to as Title XIX or the Oregon Health Plan (OHP). Medicaid has a range of programs with differing eligibility standards.

Medicaid State Plan – The State Plan is the official statement describing the nature and scope of Oregon State's Medicaid program except for any waivers. The State Plan includes mandatory and optional services.

Medicare - A federally administered program offering health insurance benefits for persons aged 65 or older and persons who have been determined by Social Security to have long term disabilities.

Medicare Advantage Plans - Known as Medicare Part C, Advantage plans provide Medicare-covered benefits to members and may in addition to Part A and B benefits and Part D pharmaceutical benefits, offer extra benefits that Medicare does not cover, such as vision or dental services. CCOs may have one or more affiliated Medicare Advantage plans which may include Dual Special Needs Plans (DSNPs).

Memorandum of Understanding (MOU) – A written agreement between a CCO and a Type B AAA or DHS/APD District office defining the roles and services that will be provided to ensure that CCO and Medicaid long term

care services for shared clients are coordinated. Type A AAAs may also be party to these agreements but are not mandatory participants.

Mental Health Services – Refers to outpatient and in-patient mental health services ranging from prevention, crisis intervention and planning for children and adults. Services delivered will not include state hospitalization. Residential services funded under behavioral health Medicaid have been phased into the CCO responsibilities. See also **Behavioral Health Services**.

Metrics –Data or performance measures which describe health care experiences which can be quantified or compared. Information can be collected from structures, process, or outcomes. While outcomes are the ultimate measurement goal, in the early phases of system transformation most of the metrics gathered will be focused on structure and process measures to create baselines and identify reasonable benchmarks.

Oregon Health Authority (OHA) – The authority that administers the funds for Medicaid and which will execute contracts with Coordinated Care Organizations.

Oregon Health Policy Board – The nine-member Oregon Health Policy Board (OHPB) which serves as the policy-making and oversight body for the Oregon Health Authority.

Older Americans Act- A federal program, separate from Medicaid, which provides funding for a range of community services for elderly persons. These services are administered **through** Aging and People with Disabilities and delivered locally by Area Agencies on Aging (AAAs). These social support services include prevention and wellness programs, information/assistance/outreach, in-home assistance, family caregiver supports, respite, transportation, home and congregate meals, legal assistance and caregiver counseling/support. The AAAs which provide these services are important community partners for CCO's.

Person-Centered Care – A practice of identifying what is important to and for an individual and the social, health, behavior and financial supports they will need. Person-centered care is always provided in a manner that balances issues of risk and safety with the person's goals and preferences.

Patient-Centered Primary Care Home (PCPCH) – The Patient-Centered Primary Care Home is a new model of primary care that focus on wellness and prevention, coordination of care, active management, and support of individuals with special health care needs. PCPCHs are expected to provide person centered care with attention to the person's social, physical and behavioral health care needs.

Peer has the meaning as provided in OAR 309-019-0105.

Peer Support Specialist has the meaning as provided in OAR 309-019-0105.

Peer Wellness Specialist has the meaning as provided in OAR 309-019-0105.

Peer-Delivered Services and **"PDS"** each have the meaning as provided in OAR 309-019-0105.

Physical Health Services – Refers to medically necessary services including the care and treatment provided by

a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem. Oregon prefers to use the more inclusive "health services" term noted above when referring to the comprehensive services are envisioned to provide.

Personal Health Navigator has the meaning as provided in ORS 414.025.

Program for All Inclusive Care for the Elderly (PACE) – The Program for all Inclusive Care for the Elderly (PACE) is provided by a managed care entity that provides medical, dental, mental health, social services, transportation and long-term services and supports to persons age 55 and older on a pre-paid capitated basis in accordance with a signed agreement with the state and CMS. PACE programs may be provided as an alternative to CCOs.

Shared Accountability – Medicaid funded long-term services and supports are legislatively excluded in HB 3650 from CCO global budgets and will continue to be paid for directly by the state through the Department of Human Services. This exclusion is called a 'carve out' and creates the possibility of misaligned incentives between the CCO's and the long-term services and supports (LTSS) system. In order to reduce costs and assure shared responsibility for delivering high quality, person-centered care, CCO's and the LTSS system will need to share accountability for the services provided to mutual clients. Accountability will be measured in through reporting methodologies which will inform the development of performance measures. A memorandum of understanding between the local CCO and APD/AAA is a mandatory method of shared accountability.

Special Needs Plans – The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) coordinated care plan (CCP) that was specifically designed to provide targeted care to individuals with special needs. Some special needs plans target dually eligible persons and provide coordinated Medicaid and Medicare services. Other types of special needs plan are for institutional care or chronic disease care. Oregon has several Dual Special Needs Plans (DSNPs) affiliated with CCOs to build integrated care for duals.

Social Determinants of Health and Equity and **"SDOH-E"** each means the social, economic, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Social Determinants of Health fall into the following domains: neighborhood and built environment, economic stability, education, and social and Community health. SDOH-E is further defined in OAR 410-141-3735.

Special Health Care Needs means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either 1) have functional disabilities, 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or Family problems that lead to the need for placement in foster care), or 3) are a Member of the Prioritized Populations listed in the CCO Contract.

State 1115 Waiver or **Demonstration Waiver** means the 1115 Waiver issued to Oregon by CMS on or about January 12, 2017, for the period ending June 30, 2022. 1115 waivers are issued by CMS in accordance with Section 1115 of the Social Security Act pursuant to which CMS waives federal guidelines relating to Medicaid in order to permit states, including Oregon to pilot and evaluate innovative approaches to serving Members.

Traditional Health Workers and "THW" – Refers to personal health navigators, peer support or wellness specialists and community health workers who meet competency standards established by the OHA. Each have the meaning defined in OAR 410-180-0305.

Transitions—now defined as Care Setting Transitions – General term to identify the activities and coordination that must occur as individuals with health and long-term services and supports needs move between locations and/or different service programs The goal for transitions is to have the communication and continuity of service needed to support the individuals health, preferences and goals. Care Setting Transitions are usually required when persons move between hospitals, sub-acute and post-acute nursing facilities, the individual's identified home, primary and specialty care, or institutional care.

Treatment Plan has the meaning as provided in OAR 410-141-3500.

Triple Aim means the three goals of a Transformation and Quality Program as follows: (i) providing better care to Members, (ii) improving Member health, and (iii) doing so at a lower cost.

References & Links: See OHA Shared Accountability site at https://www.oregon.gov/oha/hsd/ohp/pages/cco-ltss.aspx

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