CCO-LTSS Partnerships MOU Template:

MOU Period: Jan. 1, 2021____ thru Dec. 31, _2024_

Submit your CCO's CCO-LTSS MOU by January 15th to CCO.MCODeliverableReports@state.or.us.

CCO Name ___AllCare Health____ OHA Contract #161755-9___________________________________

Partner AAA/APD District (s) Names/Locations **Rogue Valley Council of Governments and Aging and People with Disability District 8**

If more than one AAA/APD office in your CCO Geographic Region Please Circle or X Whichever Applies: Single Combined MOU___ Multiple MOUs_X__

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
CCO will clearly articulate: AllCare Health will clearly articulate: Medicaid-funded long-term care (LTC) services are legislatively excluded from Care Coordination Organizations (CCO) budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will coordinate care and share accountability for individuals receiving Medicaid-funded LTC services. Care Coordinators involve members, and/or their authorized representatives in the development of the individualized care plan (ICP). Care Coordinators inform members and/or their authorized representatives of the Interdisciplinary Care Team (ICT) meetings and invite/engage them as appropriate. This is a non-binding agreement between AllCare Health (Medicaid, Medicare Advantage and DSNP), Rogue Valley Council of Governments and Aging People with Disabilities District 8. The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system.	**AAA/APD will clearly articulate:** The regional Area Agency on Aging is the Senior and Disability Services Department (SDS) for District 8 (Jackson and Josephine Counties) and is located within Rogue Valley Council of Governments (RVCOG) in Central Point, Oregon. Two advisory councils assist with this advocacy. The Senior Advisory Council (SAC) is made up of up to 21 community members, appointed by the RVCOG SDS Board of Directors, and is mandated under the federal Older Americans Act to advise the Area Agency on Aging Program Director. The Council provides advice and assistance with new program development and service implementation to meet the needs of seniors and people with disabilities, are advocates and sources on information to the community, and advise on key issues and emerging trends. The Disability Services Advisory Council (DSAC) is made up of up to 11 members of the community, and meets monthly to advise local Aging and People with Disabilities (APD) offices on program policy and the effectiveness of services provided (such as Medicaid and SNAP) to both seniors and younger people (18-64) living with disabilities.

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CCO-LTSS APD/AAA MOU(s): See MOU Worksheets for additional detail on MOU expectations in each domain

MOU Service Area:				
Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success**	**Annual Report on Specific Statewide Measures of Success (provide data points*) —monthly & annual [REQUIRED data points at minimum}**
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members	AllCare Health receives the 834 eligibility file which is received on a bi -monthly basis. This information is used to coordinate targeted care based on the individualized needs specific to each member, assess potential further needs and collaborate with the member's medical care team. This file identifies for us each member who is LTSS, and has a Care Coordinator assigned. When a member does not have a Care Coordinator assigned we	APD/AAA will provide AllCare Health bi-monthly reports and the access to identify members with high health care needs; this includes relevant data on all CCO members receiving Medicaid funded long -term care services, a change in care provider and Medicare plans. APD/AAA will coordinate and communicate methods to proactively identify and intervene with members who are at	AllCare Health's IT has refined the case management EHR record which includes care plan interventions, task and reports to capture data exchange, referrals and assessments. See attachments for current examples of EHR documentation: Domain_1_834Report Domain_1a_LTSS-MOU_Staff Training Guide Domain _1b_APD_Ref Domain_1c_APD_Communication Domain_1d_Incoming_Referral_APDAAA	# of members with LTSS that prioritization data was shared during each month/year Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year] —calculated by OHA from data submitted # of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) # of APD/AAA referrals to CCO for ICC review

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	engage our Care Coordinators to conduct a Health Risk Assessment. Once a member is identified for referral to APD/AAA, we telephonically reach out to the screener of the day at APD to initiate this referral process. APD/AAA will telephonically, fax or secure email AllCare Health to initiate a referral for Care Coordination. AllCare Health communicates with APD/AAA as identified above for referrals. APD/AAA and AllCare Health engage in ICT meetings every 2 weeks. ICT meetings are held via zoom. Prior to each ICT meeting an agenda, including a list of members, is provided 24 hours in advance, via fax, for case review/staffing. During	risk of becoming high needs. APD/AAA will communicate key health related information, including risk assessments created by LTC providers and local Medicaid APD/AAA offices. There will also be collaborative efforts in developing, reporting and meeting metric requirements for the following: linking supportive resources, health promotion and prevention, plus safeguards for members.		# of completed referrals for ICC review [Monthly/Year Total]

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	ICT meetings information exchanged includes but is not limited to the member's Health Risk Assessment (HRA), Intensive Care Coordination (ICC) Assessment, individualized care plans (ICP), APD/AAA service plan, and case reviews typically via fax, and/or via zoom. The current case management Electronic Health Record (EHR) tool being used captures the incoming and outgoing APD/AAA referrals.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	AllCare Health (Medicaid, Medicare Advantage and DSNP), Interdisciplinary Care Team Meetings (ICT) occur every other week, and/or as needed to specifically coordinate planned transitions of care for members who are in the acute care setting and skilled nursing facilities, and	APD/AAA shall support and participate in AllCare Health Interdisciplinary Team Meetings (ICT) if needed to coordinate planned care for CCO members. This shall include CCO members who are in the acute care setting	IDT meetings are tracked in a number of ways to best document collaboration, participation and care plan progress. Each IDT meeting held can be found in a Member's EHR. Additionally, meetings are tracked with a sign in sheet and IDT case presentation form. See attachments for current IDT documentation: Domain_2_IDT_Case_Presentation.pdf Domain_2a_IDT_Meeting_Temp.pdf	# of members with LTSS that are addressed/staffed via IDT meetings monthly % of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month

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	are experiencing increased complexities in the transfer process. This also includes member's transitioning from a home setting to a higher level of care. These ICT meetings are scheduled by APD/AAA through the end of the year and held via zoom. Members and their Interdisciplinary Care Team (ICT), are invited to attend and participate in ICT meetings. This includes, but is not limited to, the member, the attending medical provider, and other medical professionals caring for the member, case managers from APD/AAA or other collaborative agencies and/or participants who the member identifies. Members identified for ICT meeting agenda is determined by active unmet needs, or barriers to support, care or	and skilled nursing facilities, and are experiencing increased complexities in the transfer process. The following information to be shared at each meeting as needed: provider information, care supports in place, Medicare plans, assessments, treatment and care plans, care transitions, discharge follow-up care, referrals, case worker contact information and any other necessary information to assist in the coordination of care for the CCO member such as legal guardian information.		total annual IDT meetings completed by CCO-APD/AAA teams % of times consumers participate/attend the care conference (IDT) by month/year % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)

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	goals, (Domain 1).			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	AllCare Health Care Coordination works with all providers, including community and social support providers, as well as with the member in creating a patient centered care plan. Care plan development includes the member, family and/or other individuals identified by the member, medical providers and community agencies which is documented and recorded. Care Planning is created and started upon initiation of the referral. Care Coordination telephonically or in person, engages with the member, attempts to complete the Health Risk Assessment to identify special health care needs, which guides the creation of the ICP. If a member is in need of end-of-life	The following care plan information shall be coordinated between agencies to support individualized member care and ensure there is no duplication of services initially and on an ongoing basis. Care plans to include evidence based practices with the member, family and/or other individuals involved in care plan creation and completion, medical providers and community agencies which is documented and recorded. Other information to be shared pertinent in care planning shall be: member living situation preference and cost, most cost effective option to	AllCare Health's EHR has been designed to only populate individualized care plans with system triggers notifying case owners to complete monthly reviews. Care plans are to be shared as necessary with the member, the member's medical care team, APD/AAA and other entities involved in the member's care. Supervisors conduct regular case audits verifying completion of state timelines. Reports are also generated as needed from the EHR for reporting purposes. See attached documentation: Domain_3_ChartAuditTool Domain_3a_Individualized_Care_Plans_with_Updates.docx Domain_3b_AllCare_Health_Nondiscrimination_and_Language_Access_OHA.pdf Domain_3c_achhc_faq_interpreter_services-pq.pdf	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals % of CCO person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties

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	care planning, medication reconciliation, these services are engaged through Care Coordination efforts, and our utilization management team. If a member is in need of language / disability services we utilize our language access teams to assist and provide linguistically appropriate support. Collaboration with the Care team is to support individualized member care and ensure there is no duplication of services as well as understanding APD/AAA service plan for the member in order to support member's goals with other care teams. AllCare Health's (Medicaid, Medicare Advantage and DSNP), goal for care plan creation is to ensure member centric and holistic care, coordinated between	meet the member's care need, APD case worker information, LTC contact information and any other supportive individual involved in the member's care. Additionally, risk assessments generated by the LTC providers shall be integrated into the care plans shared.		

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	agencies and medical professionals caring for the member. See optional domain A for process to link community resources to care plans. APD/AAA and AllCare Health engage in ICT meetings every 2 weeks. These are held via zoom. Care plans are shared during ICT meetings. (Domain 1) Each care plan is reviewed at least every 90 days or more frequently and after every ICT meeting, allowing for care plan amendments to meet the needs and care of all members.			
DOMAIN 4: Transitional care practices				
DOMAIN 4: Transitional care practices Goals	AllCare Health has processes written into various policies and procedures outlining specific transitions of care for members. Within these policies, it outlines state guidelines	For CCO members in residential, inpatient, long-term care, home to a higher level of care, or other similarly licensed care facility, APD will support and participate in	AllCare Health's EHR automates system triggers for all TOC cases to contact agencies involved in the member's care. The system as triggers specific tasks to coordinate medication, DME, transportation and other TOC needs as identified by the Centers for Medicare and Medicaid Services (CMS) Transitions of Care. All completed actions are reportable and shall be submitted upon request. See reference document:	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME,

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	and specific timelines to be followed while working with members. AllCare Health has interdepartmental systematic guidelines to map the coordination and care for members transitioning between care settings. This provides decision-making processes for clinical and non-clinical staff reviewing behavioral, physical, and oral health service requests. Upon identification of a member with special healthcare needs or LTSS (long-term services and supports), various qualified staff are available to assist in the transition, this includes resources needed for Social Determinants of Health (SDOH). Such qualified staff may include, but is not limited to, Health Related Services, Non	discharge meetings as follows: • Transition meeting must be held 30 days prior to the member entering the CCO's service area; and/or • If applicable to another facility or program or as soon as possible if CCO is notified of impending discharge with less than 30 days of notice of discharge. This information may be informational only if care coordination is needed or outlined in current CCO-LTSS state guideline requirements.	Domain_4_ChartAuditTool Domain_4a_Transition_of_Care_Program_Summary.pdf Domain_4b_Transitions of Care Case File Example.docx	medications, transportation) were arranged prior to discharge/did not delay discharge? % CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)? # of Debrief meetings held quarterly to post-conference transitions where transition wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4]

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	Emergent Medical Transportation (NEMT) Liaison, Register Nurses, Behavioral Health Specialists, Respiratory Therapists, Traditional Health Workers and Pharmacists. AllCare Health also has a dedicated team that focuses on transitions of care within Care Coordination. Staff attend in person facility meetings and meet with members face to face. Dedicated transitions of care staff work to ensure key post discharge planning begins at the time of admission, to include follow up appointments are made, as well as ensuring any DME, medications, home health services, and entirety of discharge orders follow member from one care setting to another or to home. This includes additional benefits such as home meal delivery and			

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	remote patient monitoring. In person visits to care facilities has been limited based on the current COVID pandemic.			
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	When an AllCare Health member is identified for referral to APD/AAA, we telephonically reach out to the screener of the day at APD to initiate this referral process. APD/AAA will telephonically, fax or secure email AllCare Health to initiate a referral for Care Coordination. (Domain 1) AllCare Health has various reporting mechanisms in place notifying multiple internal departments of hospital events and services obtained by members. This includes claims review by our Utilization Management team.	Both entities will continue to expand, improve and utilize communication resources available. APD/AAA shall continue to receive CCO referral requests which includes request for assessment of services. AllCare Health's communication between entities shall be documented and supplied to OHA reporting requirements.	AllCare Health's EHR case management documenting system allows all completed actions within a member's case to be reportable and shall be submitted upon request. AllCare also utilizes external HIE platforms to produce HEN reports. Additionally, claim data reports are utilized for monitoring, potential referrals, collaboration of care and care coordination as needed. See reference document: Domain_5_Collective_Medical_Cohorts_Including_SNF_and_Daily_Hospital.pdf	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments # of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments MOU includes written process documents (prioritization, IDT, care planning, transitions) that clearly designate

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	Through the use of Collective Medical, our Care Coordinators are able to monitor, in real time on a daily basis, member hospitalization, emergency department utilization and SNF discharge events. These events can trigger care planning updates, referrals to APD/AAA or other supports/engagement as needed. Staff also utilize Health Information Exchange (HIE) platforms to obtain further information that results in the need to collaborate with agency partners such as APD/AAA. The HIE can also provide additional information regarding members care team. AllCare Health will review annually with the APD/AAA team our unique and varied utilization of community based tools, like the HIE and Collective Medical,			leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).

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	in order to increase collaboration and share workflows that improve quality of care.			
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	AllCare Health continues to collaborate with medical care teams and community partners in implementing a CIE (Unite Us) platform to be utilized for resources. This closed loop referral system will be made available to multiple entities without cost or fees.	AAA agrees to review the CIE resource as a possible tool for utilization. This will allow for a more comprehensive referral system needed for assessment requests, social service supports and other needs. This system offers a more robust tracking system for outcomes, results of member needs being addressed and the coordinated efforts between all involved in the member's care. Linking to Support Services: AAA programs may include: • PEARLS: Program to Encourage Active and Rewarding Lives for Seniors	All entities will have independent reporting access for various data elements to meet individual metric outcomes, state requirements or other information needed for reporting.	

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		• OPAL: Options for People to Address Loneliness • DPP: Diabetes Prevention Program • Options Counseling • STAR-C: Dementia Support Program for Caregivers • Powerful Tools for Caregivers classes • Aging and Disability Resource Connection (ADRC) is available to assist any consumer, family member, or friend of senior or person with disability. ADRC will refer to other health promotion and prevention programs such as (but not limited to) those named above. These services are available through individual referral or through specific contract with AllCare Health to support its membership.		

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OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals	AllCare Health will abide by OHA guidelines in facilitating Interdisciplinary team meetings (IDT). Such meetings shall include invitations to the following: the member, family/support, medical care team, AllCare Health Care Coordination team, LTSS, APD/AAA and/or any other individual involved in the member's care. Crisis protocols will continue to be followed with continuous collaboration with AllCare Health's BH team, Medical Directors, Quality and Compliance plus any other internal policy and department necessary to meet the safety and wellbeing of the member within AllCare Health's reasonable duty. AllCare Health also collaborates with state entities such	APD/AAA agree to actively participate in IDT meetings and if needed will assist in inviting the necessary LTSS partners and/or other individuals involved in the member's care. Consideration for reassessment, care plan updates and communication shall be shared with AllCare Health as needed.	AllCare Health will have an identified liaison communicating with APD/AAA's liaison to evaluate processes, safeguards while evaluating necessary changes needed to meet a member's goal. Communication will be a combination of electronic and face-to-face collaboration at least quarterly.	

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	as the OHA Ombuds Program.			
OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals	AllCare Health will provide periodic CCO education and presentations to APD/AAA outlining the following: • CCO Capabilities • Processes • Language and terminology • Limitations within each required domain • Prioritization of high needs members • Interdisciplinary care teams • Development and sharing of individualized care plans • Transitional care practices • Collaborative communication tools and processes	APD/AAA will, when requested or as feasible, provide periodic agency education and presentations to AllCare Health outlining the following: • APD/AAA Capabilities • Program availability • APD/AAA Processes • Language and terminology • Limitations within each required domain • Prioritization of high needs members • Interdisciplinary care teams • Development and sharing of individualized care plans • Transitional care practices	Both entities agree to maintain education documentation and attendance for all education and training. Training shall be conducted at least annually to assist in employee turnover, program changes and or other potential barriers disrupting the member in meeting their care plan goals.	

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

Signatures of All MOU parties (APD/AAA and CCO) should be included and signed prior to December 31st. OHA/DHS review will occur after CCO submits the MOU. Neither OHA nor DHS will require review or co-signature to the MOU.

E-Signed : 04/29/2022 02:53 PM CST
Douglas Flow
doug.flow@allcarehealth.com
IP: 72.2.183.254
Sertifi Electronic Signature

Douglas Flow Douglas Flow 04/29/2022

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...itle, CCO Name, Date

E-Signed : 04/20/2022 10:49 AM CST
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Deputy District Manager APD District 8 04/20/2022

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...ame, Job Title, APD Field Office Name, Date

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

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