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CCO-LTSS Partnerships MOU Template:

MOU Period: April, 2022 thru December 31, 2025

Effective Date: As signed and dated below

Submit your CCO's CCO-LTSS MOU to CCO.MCODeliverableReports@state.or.us.

CCO Name: Cascade Health Alliance **OHA Contract # 161756-9**

Partner APD District (s) Names/Locations: Aging and People with Disabilities (APD) District 11 Klamath Falls, Oregon

If more than one AAA/APD office in your CCO Geographic Region **Please Circle or X** **Whichever Applies:** Single Combined MOU_**X**__ Multiple MOUs___

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
CCO will clearly articulate: How CCO governance structure will reflect the needs of members receiving Medicaid funded Long-Term Services and Supports (LTSS), for example through representation on the governing board, community advisory council or clinical advisory panel. How Affiliated MA or DSNP plan participates in the MOU work for FBDE.	**AAA/APD will clearly articulate:** How AAA/APD governance Lead(s) for participation at the community level in the board / Advisory panel for LTSS perspective/Care Coordination AAA/APD will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of members served by the regional CCO(s).

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

MOU Service Area:				
Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success**	**Annual Report on Specific Statewide Measures of Success (provide data points*) — monthly & annual [REQUIRED data points at minimum}**
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members Aligned definition and prioritization of high needs members.	1. CCO performs health risk assessment for all new members which identifies new members receiving LTSS and screens for care coordination needs. *Prioritization is also identified through CHA CM analysis of the monthly LTC consumer list provided by APD. LTSS consumers are identified in CHA EMR through an LTSS flag in the demographics window of the individual chart.* CHA and APD agree to identify high need members by considering these identification factors: • APD SPL levels 1 – 13	1. APD makes referrals to CHA for members with potential need for care coordination or when APD staff identify concerns or changes in health status which are considered high needs. 2. APD provides CHA a monthly LTC report for members in common (including DSNP) receiving long term services and supports. 3. CHA and APD factor in relevant summary acuity and screening information to identify high needs members for potential care conference/staffing. 4. APD will update CHA regarding consumers needing increased service coordination.	Process Monitoring: 1. In monthly collaboration meetings, we review members that have been identified as needing CHA CM outreach or follow up, *or members referred to APD for screening, or that APD has been notified by CHA are open to Case Management.* 2. *CHA has a standardized process for assessment of member needs through our Health Risk Assessment. Questions on this assessment are weighted to give a quantitative score, indicating what level of Case Management Outreach is required. All members receiving LTSS*	# 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 # of completed referrals for ICC review [Monthly/Year Total]

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	• ER and Hospital Utilizations *HIE Collective Medical now flags CHA and DSNP members that are identified in the monthly LTC list provided by APD. LTSS members who have ED encounters or hospitalizations are outreached and followed by CHA Transition of Care CM. APD is notified when consumer is opened to Case Management.* • Complex Conditions • Claims Data • Mental/Behavioral Health • Chemical Dependency • Complicating Circumstances • Client self-referral *Any consumer for whom APD Service Coordinators have requested Flex Fund covered items will be screened for CHA CM needs.* 2. Based on the above health risk assessment, CCO will make referrals to its case management team *for outreach* as needed.	5. Information is shared at least monthly during regular cadence of meetings *regarding need for additional services, high medical utilization and/or resolved issues* and successes.	*are captured under the prioritized population. New members receiving LTSS are initially screened within 30 days of enrollment with CHA.* *3. Run monthly report to assure members screened or referred for CM are contacted in timely manner.* 4. *As individuals with high needs are identified, they are staffed in CHA/APD IDT meetings. Follow up/monitor referral outcomes at least monthly.* ***Measurements:*** *5. # of members receiving LTSS identified through HIE as having high ED or hospital utilization* *6. # of those members outreached by CHA for CM* *7. # of those members discussed at IDT months, report run at least quarterly.* • Number of referrals *between APD and CHA in since the prior meeting*	

	3. *HRA screening is re-evaluated annually or following a known triggering event to ensure member risk is accurately identified. Review of scoring from LTC report also shows any change in member needs/abilities.* 4. *CCO notifies APD of consumer engagement with CHA CM through referral form sent via a secure email or fax line, (listed in the Case Management electronic file LTSS> Resources). (See attached referral form.)*			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	*CCO will identify consumers with high ED utilization/hospitalizations and refer to APD for assessment of changed needs.* 1. *CCO follows workflow for identifying and responding to prioritized members.* (See attached workflow.) 2. CCO notifies APD when members are enrolled in ICC or CM services during bi-weekly Interdisciplinary Team (IDT) meetings. 3. CCO Case Management collaborates with member, member representatives,	APD periodically sends *CHA LTSS Project Manager an updated APD service coordinator* contact list to support with case coordination. *This list is added to the LTSS > Resources Tab in CM files.* 1. APD will identify non-traditional health care providers such as Long Term Care Community Registered Nurse (LTCCRN), HCW and Caregivers if applicable. 2. APD has Diversion Transition workers who attend weekly SNF care conferences and will share information with the CCO TOC care		# of members with LTSS that are addressed/staffed via IDT meetings monthly % of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month total annual IDT meetings completed by CCO-APD/AAA teams

	providers, LTCCNs, DSNP CM, other interested parties and APD case managers through regular, scheduled bi-weekly meetings. *4.Parties will be notified of upcoming IDT meetings which may be held in person or virtually, by email invitations.* *5. Care plans are reviewed, updated and distributed following CHA CM Model of Care.* 6. CCO will share person-centered care plans and updates with agency CM or LTCCN through *secure email and/or* IDT meetings.	coordination team and inform the care team how to make referrals to APD. 3. Diversion Transition workers will narrate in APD case records and share information with case managers/supervisors via secure-mail. 4. APD will identify individuals for care conferencing and staffing referrals. 5. APD will commit to attending care conferences/staffing meetings to keep the process relevant and to review outcomes. 6. APD will visit with member or members representative in person, by phone or virtual platform to establish care transition, goals, preferences and supports needed. 7. APD will inform CCO of services being provided by APD during IDT meetings		% of times consumers participate/attend the care conference (IDT) by month/year % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	CCO develops person-centered care plans based on comprehensive assessment of member which includes health history, medication reconciliation, need for advanced care planning, identifies BH needs, SDOH,	APD will provide education and training to CCO CM staff as APD processes change and are updated.	Process Monitoring: 1. CCO will perform random member care plans audits to ensure goals and interventions reflect member needs.	% 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

	language preferences and accessibility needs with member's identified needs and preferences and agreement to any referrals made to community partners on behalf of the member. This is a standardized process for all CHA and DSNP members, including LTSS-CHA/DSNP members enrolled in a CHA CM Program. CCO CM care plans are reviewed monthly or if triggering event or change of condition is noted, and if needed, updated to reflect ongoing or new needs. Member goals are reviewed at least monthly with member and during IDT meetings. CHA shares person-centered care plans and updates with agency CM or LTCCN during regular IDT meetings and with member and providers at least monthly per CHA Case Management Model of Care.	1. APD agrees to share CAPS assessments and relative service plan information. 2. APD will participate in bi-weekly collaborative meetings to share and receive updated information of care and care needs. 3. APD will engage members in their care planning when appropriate. --Identifies how APD/AAA supports the flow of relevant information into shared care planning; implement a standardized approach to effectively plan, communicate, and implement care planning and follow-up -- Defines how APD/AAA will share key health-related information, including risk assessments generated by LTSS providers and local Medicaid AAA/APD offices into CCOs' individualized care plans development for members with intensive care coordination needs. --Explains how care plans are shared and updated among care team members, expectations for how often care plans are reviewed, triggers for updates. -- Documents how individuals are involved in care planning and ensures beneficiaries are treated fairly, are informed of their choices, and have a	2. APD will track CAPS Assessments needed for consumers care planning. Measurements: 3.APD will Track number of CAPS assessments done as a result of CHA referrals. 4.CHA will review data quarterly on number of IDT meetings initiated for members receiving LTSS. 5.CHA will review data quarterly of # of person-centered care plans for members with LTSS that are updated at least every 30 days/quarterly and shared with all relevant parties	that are updated at least every 90 days/quarterly and shared with all relevant parties

	Care plans will be updated as needed following IDT/Care Conferences.	strong and respected voice in decisions about their care and support services • 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 ICC or otherwise have identified gaps or concerns about health care needs of members with LTSS. 4. APD will track • Client Assessment Planning System (CAPS) assessment results		
DOMAIN 4: Transitional care practices				
DOMAIN 4: Transitional care practices Goals	1. CCO CM will attend scheduled collaborative discharge IDT planning meetings to evaluate member's activity and progress and conduct concurrent reviews as appropriate for changing levels of care.	1. APD Diversion Transition Coordinators follow consumers for 90 days after Diversion or Transition unless consumer declines the service. 2. APD's Case Managers and Diversion Transition Workers will work together with the consumer	*1.CHA will review data quarterly on number of discharge assessments completed for change in LOC, to determine what resources were obtained by member prior to discharge*	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME, medications, transportation) were arranged

	2. *CCO CM will collaborate with APD/DDS and other partners to promote successful transition from one level of care to the next. This will include completing discharge from current LOC assessment in CHA EMR. CHA TOC CM will collaborate with APD Diversion Team and member to assure that member has copy of discharge summary, prescriptions, follow up orders, transportation and any needed DME for safe discharge to next level of care.* 3. CCO CM will enroll high risk CHA and DSNP members who are LTSS recipients in the CHA TOC Program where members are engaged and contacted weekly for 30 days post discharge from inpatient facility. 4. APD and CHA have a mutual understanding to avoid NOMNC/NOAs notice delivery the day before weekend begins. *CHA will initiate a cadence of quarterly debrief meetings between TOC CM and APD Diversion Team members to discuss transitions that were not*	to determine activities of daily living eligibility, member preferences, goals and assess for risks and barriers. 3. APD will provide education and training to CHA Case Managers as APD processes change and are updated. *4. APD will provider CHA Manager of Clinical Ops updated contacted list of Diversion Coordinators.* 5. APD and CHA will have a mutual understanding to avoid notice delivery of NOMNC/NOA's the day before weekend begins for both CCO and DSNP members. 6. Weekly staffing between APD, SNF and CHA in which both will disclose essential medical and social needs to identify risk and assist in planning. 7. APD's Diversion Transition Workers receives referrals to assist consumers who need to transition from hospital or nursing facility. Diversion Transition Workers provide information on different care settings (from hospital to home, hospital to SNF, adult foster	*and what obstacles prevented a smooth transition of care.* *2.CHA will track information on number of members transitioning from one CCO to another and review qualitative data on those members to indicate appropriate APD/AAA office was notified.*	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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	smooth, to promote process improvement.	home to assisted living etc.) and the process for the transition. Diversions and transitions are Monday through Friday. Any diversions or transitions that happen on the weekend are done by hospital or nursing facility staff unless details planned prior to the weekend. 8. APD's Diversion Transition Coordinators will follow consumers for 90 days after diverting or transitioning consumer unless consumer declines the service. 9. APD's Case Managers and Diversion Transition Workers will work together with the consumer to determine activities of daily living eligibility, member preferences, goals and assess for risks and barriers. 10. APD/CCO meetings scheduled twice a month provide a clear communication venue for prescreening admissions and effective transition planning to enhance continuity of care for high risk members.		
DOMAIN 5: Collaborative Communication tools and processes				

DOMAIN 5: Collaborative Communication tools and processes Goals	• 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 (address all domains) • 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	• 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 (address all domains) • 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.		# 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 leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	*CHA offers NEMT through Translink* *CHA offers Flex Fund and Health Related Spending benefits for CHA and DSNP members to*	In scheduled collaborative meetings, phone calls and emails: --Each organization will share types of programs and resources and process for qualifying/accessing services. --Each organization will share how supportive resources assist building		

	cover items excluded by insurance. *CHA has a Benevolence Fund for review of high spend interventions excluded from insurance benefit.* *CHA will present information on supportive benefits provided to CHA and DSNP members at least annually APD staff; will present on new support programs as they are developed.*	communication or processes in other domain areas. --Educate consumers about how the CCO and AAA/APD work together to ensure that they can navigate the system and understand what is provided by the CCO and what is provide by AAA/APD.		
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals	--CCOs shares process for access to health promotion and prevention activities and services available through the CCO. Share resources for members with LTSS in local communities, including access to culturally-specific programs where available. --CCO will share process by which CCO considers Health Related Services	--APD/AAA will educate CCOs on current health promotion and prevention services that are offered, including access to culturally-specific programs where available. --APD/AAA will help LTSS Consumers, CCOs and other partners to access and engage in health promotion and		

	Requests for health and wellness activities (formerly flexible services, see glossary). --CCO shares 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	prevention programs available in the community.		
OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals	--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	--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		

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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 or DHS will require review or co-signature to the MOU.

CCO Authorized Signature: DocuSigned by: Arthur Peterson C99F4D2210E94F8...

Name: Arthur Peterson

Title: Director Clinical Operations 4/28/2022

APD Field Office Authorized Signature: DocuSigned by: Gloria Pena A98F195EC6FF476...

Name: Gloria Pena

Title: District Manager 4/28/2022

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