CCO-LTSS Partnerships MOU Template:

MOU Period: Jan. 1, 2022_____ thru Dec. 31, 2022_____

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

CCO Name __PCS Community Solutions – Central Oregon _____ OHA Contract #__161762_____

Partner AAA/APD District (s) Names/Locations ___ This is a non-binding agreement between PCS Community Solutions (Central Oregon) ("PCS" or "CCO") and the Department of Human Services Aging and People with Disabilities District 10 ("AAA/APD"); hereinafter referred to as AAA/APD. AAA/APD serves the following geographic location: Deschutes County, Jefferson County, and Crook County; northern Klamath County members residing in zip codes: 97733, 97737, and 97739. AAA/APD has agreed to serve these counties through this Memorandum of Understanding (this "MOU"). The parties agree to conduct this work in accordance with Oregon Health Authority's ("OHA") CCO to LTSS MOU Guidance CY2020-CY2024 guidance document, as that document may be amended (the "OHA Guidance"). To the extent that there is any language in this MOU that conflicts with the OHA Guidance, the OHA Guidance will supersede the language in this MOU.

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): PCS Care Management	APD/AAA Lead(s):

CCO will clearly articulate:	AAA/APD 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. • PacificSource Community Solutions ("PCS") Care Managers will identify members who might be interested in serving as representatives on the CAC or CAP (Willamette Health Council) and the Medicaid Community Health Coordinator will facilitate invitations to these workgroups. PCS Medicaid care managers are currently managing the PCS FBDE members, and these members will be identified and staffed by either AAA/APD case managers or PCS care managers for bi-monthly IDT staffing. The regional DSNP care managers will be invited to attend IDT meetings and will have the same process for referring members identified in this MOU. • PacificSource care managers and AAA/APD care managers will discuss members who might be a good fit for representation of available boards and these members will be shared with the PCS Community Health Coordinator.	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). • AAA/APD care managers will invite members that they identify through their case management work as being potentially appropriate for representation on local boards and will connect members via secure email to appropriate contacts.

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

MOU Service Area: Deschutes County, Jefferson County, and Crook County; northern Klamath County members residing in zip codes: 97733, 97737, and 97739

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 mimimum}
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members	• All members are screened annually for health risks via the Health Risk Assessment. Members who have an identified risk are offered Care Management services. • In addition, members are identified via algorithms embedded within our EHR if they meet the definition of a Prioritized Population. Prioritized Populations include members who are engaged in LTSS and/or AAA/APD services, and members identified with Medicare/DSNP primary. • Members referred to Care Management are screened for the appropriate level of Care Management including Care and Community Coordination (CCC), Intermediate Care	• AAA/APD will provide the CCO with access to information needed to identify members with LTSS and high health care needs via email on a monthly basis. This will be sent to the PCS a Team Lead or designee (please see transition map/contact sheet). • AAA/APD leadership will share, via secure email to PCS leadership, key health-related information including risk assessments, service priority levels, and individuals LTSS care plans generated by LTSS providers and local AAA/APD offices that will assist the CCO in completing a comprehensive individualized care plan for CCO members with intensive care coordination needs.	• PCS and AAA/APD's staff will work together to identify individuals with high care needs or with the potential for high care needs that may be avoidable with proactive management by having timely communications regarding members that meet or may meet the high care needs criteria. • AAA/APD agrees to share with PCS information regarding in-home service clients that AAA/APD's case managers believe to be at risk due to accepting a lower than authorized care plan, losing housing due to a notice for eviction or involuntary move out, or any other bio-psychosocial factor(s) influencing stability	# 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]

	Management (ICM) and Intensive Care Coordination (ICC). If a member is part of an identified Prioritized Population they may screen into a higher Care Management type, including ICC. • Comprehensive assessments are completed to determine member needs. If a member is identified as being involved in AAA/APD services or needing LTSS services, PCS Care Management will bring this information to regular (at least bi-monthly) Care Management meetings, or reach out to AAA/APD staff sooner as needed. Names of members who will be discussed at monthly meetings will be provided via email one week in advance (if possible). • PCS will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTSS providers.	• AAA/APD will make referrals to the CCO for members with potential need for Intensive Care Coordination ("ICC")/risk assessments as AAA/APD staff identify concerns, care gaps, or changes in health status. Referrals will be provided to PCS Care Management Team Leads through bi-monthly secure email, through bi-monthly IDT meetings, and/or via phone referrals when urgency necessitates. • AAA/APD will review the weekly LTSS Collective ED & Inpatient report and identify, via secure email, members who are appropriate to staff at bi-monthly IDT meetings. • AAA/APD will respond to the weekly email, or bring names to the IDT meeting, of any members that they would like PCS to outreach and engage in CM services. • AAA/APD case managers will review PCS care plan goal letters that they receive via secure email.	in their current environment. • PCS agrees to share information from community health assessments, relevant behavioral health information pertinent to care coordination, and individual risk assessments of those individuals and communities defined as high risk or a high utilizer with designated AAA/APD staff.	

	• High needs members are identified by PCS clinicians and MSS through ICC screening and active care management. This information is shared bi-monthly with AAA/APD via an email to AAA/APD leads from PCS leads. This email will also have the LTSS Collective ED & Inpatient report data as an attachment. • Any members referred to PCS by AAA/APD are opened in care management via ICC screen during or immediately following the IDT meeting. Following the screening, the case is assigned to a clinician. • Members identified as LTSS in PCS EMR will receive goal plan letters, and these letters are shared with member's AAA/APD case managers via email by PCS clinicians. * See attached Desktop Reference Regarding Goal Plans	• AAA/APD will share member service plans (Form 003) with PCS care managers via secure email upon request.		

DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	• IDT meetings occur bi-monthly between Team Leads from AAA/APD and Team Leads from PCS. PCS care management behavioral health clinicians and nurse care managers from Medicaid, Medicare, and DSNP team are invited to attend IDT meetings as well. Member support specialists will be invited on a case-by-case basis when they have information to contribute regarding complex members. At these meetings, behavioral health, SDOH, cultural considerations, and member goals are discussed. • PCS, when applicable, will inform the CCO member of collaboration with APD. When known, PCS will document any member goals and preferences. • High needs members are discussed at the bi-monthly AAA and PCS meetings. Notes from these meetings	• AAA/APD will identify members by using reporting provided by OHA to identify high needs shared members. • AAA/APD, when applicable, will inform the member of collaboration with PCS. When known, AAA/APD will document any member goals and preferences of care. • AAA/APD will identify any known behavioral health, SDOH, or cultural considerations, and member goals for any members discussed at bi-monthly collaborative IDT meetings. • AAA/APD case managers will attend individualized member specific IDT meetings at the request of PCS care managers when schedules allow	• AAA/APD and PCS will jointly identify high-risk members. • AAA/APD or PCS can request a plan of care meeting at any time. • AAA/APD and PCS teams will meet, at a minimum, twice monthly to address and coordinate for high needs members. AAA/APD or PCS may request additional meetings as needed In addition to member specific meetings, quarterly meetings are held with the local AAA/APD offices to debrief/discuss transitions that did not go smoothly, as well as to discuss process improvement. Both meetings are documented by meeting minutes identifying dates of meetings, agenda items, minutes and attendees. • AAA/APD and PCS will document care team members and identify a lead from each partner agency in the transition process map document.	# of members with LTSS that are addressed/staffed via IDT meetings monthly % of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month total annual IDT meetings completed by CCO-APD/AAA teams % of times consumers participate/attend the care conference (IDT) by month/year % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)

	are stored and accessible to PCS staff. If high needs members are identified during the bi-monthly meeting as needing additional IDT intervention, the PCS clinician will call or email the identified AAA/APD worker to invite them to a separate individualized IDT meeting. Members will be invited to individualized IDT meetings. PCS will document IDT meetings in their Electronic Health Record twice per month per LTSS Process Desktop Reference		APD/AAA caseworkers and the PCS Care Management team will collaborate to determine who would be the most appropriate to have present at care team reviews to develop the plan of care. This may include the CCO member, LTSS facility staff, PCP, AAA/APD, PCS Care Managers, Behavioral Health, and others identified in the member's care. When appropriate Medicare/Duals Special Needs Program (DSNP) provider and/or Medicare/DSNP Case Manager will be included in IDT.	
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	• PCS's individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTSS services and supports needs, end-of-life planning, and medication reconciliation post-discharge. • Language preferences (written and verbal) and disability services will be assessed, with goals and	• AAA/APD will share key health-related information including risk assessments, service priority levels, and individuals LTSS care plans generated by LTSS providers and local AAA/APD offices that will assist the CCO in completing a comprehensive individualized care plan for CCO members with intensive care coordination needs. • AAA/APD will actively engage members in the	• AAA/APD and other community partners (as needed) will develop with PCS, individual care plans for designated members that reflect their preference and goals. Clients and/or representatives will be directly involved with this process as appropriate. • All parties will share who the lead person and main point of contact is from each entity, the main point for	% 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

	plans included in the care plan. • Plans will reflect member and/or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate. • Individualized person-centered care plan goal letters will be jointly shared via secure email, and coordinated with relevant staff from AAA/APD and with LTSS providers and case managers as appropriate. • PCS will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with AAA/APD where relevant to LTSS service planning. • PCS will identify opportunities to focus on preventive approaches, screenings and strategies to reduce unnecessary hospitalizations, Emergency Room ("ER") visits, and maintain or improve the	design, and where applicable, implementation of their LTSS service plan, in coordination with CCO where relevant to health care treatment and care planning. • AAA/APD will contact the CCO via secure email to PCS leadership when they have referrals for ICC or have identified gaps or concerns about the health care needs of members with LTSS. • AAA/APD will review care plan goal letters at least quarterly. • AAA/APD will assess SDOH needs of members and share this information at bi-monthly IDT meetings.	communication, and who will attend the IDT. • All parties will share changes in assessments or member conditions that require modification of the care plan.	

	health of members with LTSS. • PCS will track completed care plans for members with LTSS flags. • PCS care managers will provide care plan goal letters for LTSS members open in care management within 30 days of ICC screening to AAA/APD via secure email. • PCS care managers will review AAA/APD service plans at least quarterly, or sooner based on member's health status changes. • All members engaged in PCS care management will have SDOH needs reviewed formally through the SDOH assessment and informally through telephonic discussions with members, providers, and community partners.			
DOMAIN 4: Transitional care practices				
DOMAIN 4: Transitional care practices Goals	• PCS will seek opportunities to improve transitions, such as sharing authorization status and other	• AAA/APD will seek opportunities to improve transitions and discuss resource options when	• AAA/APD and PCS will reference the transitional care practices map, which contains current contact	% transitions where CCO communicated about discharge

	information, to assigned caseworker when applicable. PCS will communicate by secure email, telephone and/or via bi-monthly IDT meetings. • PCS will offer training to AAA/APD staff at least once a year, and as additionally requested by AAA/APD, to improve their understanding of referral and authorization processes. • PCS Care Management staff will maintain a log of these events for purposes of tracking activity under this MOU. • AAA/APD, acute care providers (ie regional hospital), and PCS will have discharge barrier meetings at least once per week to identify members that have potential discharge barriers. Barriers will be identified prior to weekend and evening discharges whenever possible. • LTSS Collective ED & Inpatient report will be	available. AAA/APD will communicate by secure email, telephone and/or via bi-monthly IDT meetings. • PCS staff will attend AAA/APD's annual community partner training. AAA/APD will provide additional training to PCS staff, if requested, to improve their understanding of LTC processes. • AAA/APD will attend and invite PCS CM and/or UM care managers to attend discharge barrier meetings with local hospital at least once per week. • AAA/APD will review Collective ED & IP report and respond via secure email if any members identified could benefit from additional care management support. • AAA/APD will email names of members identified as needing additional support for discharge to PCS Care Management Team Leads at least bi-monthly.	information, roles, and responsibilities. AAA/APD and PCS will update the map as needed. Methods of communication will be secure email or telephone as often as needed. • AAA/APD and PCS will identify any cross system resources such as Health Related Services requests that may aid in the member's care.	planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME, 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]

	shared with APD via secure email by Care Management Team Leads bi-weekly. * Please see attached LTSS Desktop Reference			
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	• Ensure communication processes are clear and reflect capabilities and expectations to build cross-system collaboration to improve outcomes and reduce duplication by designating a specific contact lead, typically a Team Lead. • Ensure communication methods are detailed and specific to enable regular communication and information sharing across all required domains by scheduling reoccurring IDT meeting and utilizing IDT Template to document meetings. • PCS will share how they are using Collective Medical	• 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 and information sharing across all required domains. • AAA/APD will share how they may be using any Collective HEN information. • AAA/APD will respond to PCS after receiving the Collective Medicaid LTSS Admits reports if they indent to submit a member from	• PCS and AAA/APD will work utilize the LTSS Collective ED & Inpatient report to ensure the member information is accurate and up to date PCS and AAA/APD will use secure systems when sharing information electronically. • PCS and AAA/APD will conduct regular meetings (at least quarterly) to discuss collaborative communication tools and processes to identify challenges or barriers to communication and opportunities for improvement of the process.	# 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

	hospital event notifications ("HEN") within their organization, for example, to support Care Coordination and/or population health efforts. • Care Management staff will pull the LTSS Collective ED & Inpatient report one week prior to APD meeting, and then forward to the PCS Care Management team and AAA/APD partners. Anyone from PCS Care Management or AAA/APD wanting to submit a member from the LTSS Collective ED & Inpatient report for discussion will send all submissions no later than the day prior to the scheduled meeting • PCS will share how they are 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	the Collective report for discussion will send all submissions no later than the day prior to the scheduled meeting • Participate in discussions, as appropriate, on any AAA use or monitoring new SNF information (Post-Acute Care) in Collective HEN. • AAA/APD team leads will attend quarterly leadership meetings with PCS team leads. • AAA/APD care managers will be invited to bi-monthly team meetings by leads as is appropriate to the specific case to be staffed.		needed (such as when lead contacts change).

	and AAA/APD teams on SNF event notifications. • PCS will work to link expansion of provider direct access to event notifications to care planning and care transition processes. As part of the Health Information Technology ("HIT") roadmap (improvement plan), the CCO will identify a strategy to partner with the LTSS system to improve upon any existing efforts to share relevant information electronically. • Information will primarily be shared by secure email bi-monthly from PCS Team Lead to leads at AAA/APD. Care managers at PCS may also reach out directly to AAA/APD case managers via secure email or telephone. • Meetings will take place between PCS care managers and leads, and with AAA/APD leads and care managers via secure Zoom bi-monthly.			

	• PCS Team Leads and AAA/APD Team Leads will meet to discuss processes and communication quarterly via secure Zoom. Meetings will be scheduled by PCS Care Management leads.			
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	• PCS will share information about how to access Health Related Services requests (formerly Flexible Services). PCS will share information about the social determinants of health platform "Unite Us" to offer closed-loop referrals for community resources.	• 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 (e.g. transportation, safety devices, funds for specific items, special needs, K Plan ancillary services).		
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals				

OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals				

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

Signatures of All MOU parties (APD/AAA and CCO) should be included and signed prior to 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.

Peter F Davidson CFO 4/12/22

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

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

, Michael McCormick, Interim APD Director 4/6/22

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