CCO-LTSS Partnerships MOU Template:

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

Submit to CCO.MCODeliverableReports@state.or.us.

CCO Name: *Trillium Community Health Plan* **OHA Contract #** *161766*

Partner APD Name/Location: *Aging and People with Disabilities Branch 1017*
738 W. Harvard Ste. 180
Roseburg, Oregon 97470

If more than one APD/AAA office in your CCO Geographic Region, Please X Whichever Applies: Single Combined MOU: X Multiple MOUs: N/A

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	**APD Lead(s):**
Angela Hastings, Director, Care Management	Tom Maloney – APD, District Manager APD CM, located in Reedsport, will coordinate with CCO on shared membership on agreed upon processes in domains

Trillium's governance structure captures the needs of its members receiving Medicaid funded Long-Term Services and Supports (LTSS) through members who provide representation through the Board of Directors, Community Advisory Council (CAC), Rural Advisory Council (RAC) and Prevention Workgroups. Trillium's affiliated DSNP and MA plans participate in the LTSS MOU work for FBDE. All affiliated plans are within the same electronic platform which supports seamless management of the membership with ease of monitoring and reporting.	APD has an Advocacy Council made up of Advisory Council members. The Advocacy Council will continue to advocate for Medicaid services, LTSS, and Care Coordination in collaboration with the CCOs. This will be accomplished through education and training which results in letters, meetings, and conversations with local, state, and federal legislatures regarding these topics.

Applicable Laws

The Oregon Health Authority (OHA) and Coordinated Care Organization (CCOs) are Covered Entities for purpose of the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and its implementing federal regulations at 45 CFR Parts 160 and 164. As stated in OAR 407-014-0015, the Oregon Department of Human Services (DHS) is a Business Associate of OHA. HIPAA allows the sharing of Protected Health Information (PHI) between Covered Entities and Business Associates, including between a Covered Entity (CE) and the Business Associate (BA) of another CE. 45 CFR Part 164 Subpart E describes the circumstances under which CEs and BAs may use and disclose PHI about an individual. It also describes when CEs and BAs may do so without the individual's written consent. The corresponding State laws are ORS 192.553 to ORS 192.581. Under Applicable Laws, CEs and BAs may share PHI about an individual for treatment, payment, and health care operation activities without the individual's written consent. Health care operation activities include case management or care coordination.

OHA Information Sharing Expectation

This contractually required CCO-LTSS Memorandum of Understanding (MOU) is about collaboration to improve care coordination and outcomes for CCO Members receiving Long Term Services and Supports (LTSS) through DHS Aging and People with Disabilities/Area Agency on Aging (APD/AAA) offices.

ORS 414.607(3) communicates the expectation for sharing of CCO Member information between CCOs and DHS APD/AAA offices. This statute requires a CCO, its provider network, and DHS APD/AAA office to "...use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the organization's members." ORS 414.607(5) states, "This section does not prohibit the disclosure of information between a coordinated care organization and the organization's provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the laws of Oregon."

DHS APD/AAA offices are not subcontractors of CCOs for the activities covered in the MOU. The CCO is not expected to require a DHS APD/AAA office to execute a HIPAA Business Associate Agreement in relation to the MOU. However, the CCO may make a different determination if it contracts with a DHS APD/AAA office for services beyond the scope of the MOU.

Further guidance: Confidentiality and Information Sharing between CCOs and DHS APD/AAA

CCO-LTSS APD MOU:

MOU Service Area: Reedsport				
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				
CCO and APD will establish routine communication pathways to share information on mutual members that have been identified, and prioritize as having high needs to support timely access to referral (i.e. ICC or LTSS), and resources. Improved communication will support in decreasing duplicative effort, while identifying opportunities "to go upstream"	CCO conducts Health Risk Screenings (HRS) within 30 days of identifying a member with LTSS, or part of a prioritized population*, traditionally underserved **, or have a health condition or received a referral. (*older adult, hard of hearing, blind, or have other disabilities; complex or high health care needs, multiple or chronic conditions, SPMI, or receiving LTSS. ** @ risk for inpatient psychiatric	APD will provide a list of Reedsport clients and their SPL level to help determine level of risk for CCO. APD will be able to call an IDT meeting when deemed appropriate for staffing with CCO.	Monthly - CCO and APD will review # of LTSS members/consumers that completed risk screenings and discuss any issues/barriers to completions at routine	

with prevention and implementation of care coordination activities that reduce unnecessary ER visits or hospitalizations.	hospitalization, receiving intensive mental health services, or transitioning from Oregon State Hospital) By rule, all members receiving Medicaid LTSS are offered Intensive Care Coordination (ICC) Services CCO will provide a list of members that could not be reached through all available means to APD for assistance on other contact information CCO will provide monthly reporting that combines data from authorizations and claims for physical/behavioral/dental and other key shared initiatives (Hot Spotter) to APD.	APD will review list of unable to reach to determine if any other information is available for CCO outreach.	Monthly CCO and APD will review # of members identified as high needs with LTSS. Also will capture # of members per route identified (risk screening/reporting/referral) for opportunities. Quarterly (and as indicated) CCO and APD will review # of members referred to SDS/ODDS/MH agencies for new LTSS service assessments and #	# 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 for new LTSS service assessments (for persons with unmet needs)

	CCO will monitor HotSpotter report to identify opportunities for non LTSS members and make referral to APD or ODDS for service assessment CCO will receive referrals from APD telephonically or through CMreferral@TrilliumCHP.com for Intensive Care Coordination review and will have a case manager respond within 1 business day CCO will report monthly on members identified (referrals/reporting), screened and accepted/declined Intensive Care Coordination (ICC).	APD will provide monthly report of members – (Includes assessment scores, SPL, service plan, case worker, and other prioritization data) to CCO to be included in HotSpotter report APD will report out on status of referrals received at monthly meeting APD will identify members who have a health condition or are considered a priority population to refer for ICC to the CCO. APD will review reporting of members that declined ICC and determine if outreach from APD case worker may support member in accepting or identify a barrier to being able to participate.	of members referred for service plan hour increase/change. Quarterly (and as indicated) - CCO and APD will review # of members identified as high risk. Of those # of members declined ICC and # of members APD outreached post decline and accepted. Quarterly (and as indicated)- CCO will report on 1 business day response time % compliant	# of APD referrals to CCO for ICC review # of completed referrals for ICC review [Monthly/Year Total]
DOMAIN 2: Interdisciplinary care teams				

CCO and APD will establish and maintain on-going interdisciplinary care teams, consisting of representation from CCO, APD/AAA/ODDS/MH, PCP, LTSS, Specialist and other agencies/service providers working with the member. The interdisciplinary care teams will coordinate care and develop individualized care plans for identified high needs, mutual members. Identify processes and resources to support best practices to build care plans and integrated approaches for member supports.	CCO will set up routine cadence of Interdisciplinary Care Team Meetings for at least twice per month. CCO will monitors for changes of condition, transitions of care and other opportunities for care plan updates. CCO will work with the member in identification of their preferred Interdisciplinary Care Team members. This should include member, member rep, primary care, specialists, and APD/AAA/ODDS/MH and community agencies working with the member. CCO will coordinate formal invitation and set up to the meeting. Capture of attendees/notes/CP update. CCO will encourage and support member engagement in the care planning process to ensure member preference and success of plan	APD will participate in interdisciplinary care team meetings to support their member. APD will request ICT meetings when identified as needed, especially during LTSS transitions of care. (i.e. ICF to AFH, RCF to in home)	Quarterly (and as indicated) - CCO and APD will meet to review # of members with LTSS due for IDT meeting, # of members that decline attendance and participation (and why) # of members ICT not routine by reason (transitions of care) And review for opportunities to reduce duplication of actions and services	# of members with LTSS that are addressed/staffed via IDT meetings monthly % of months where IDT care conference meetings with CCO and APD occurred at least twice per month total annual IDT meetings completed by CCO- APD 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)

	CCO will ensure review of preventive screenings, early intervention, management of chronic conditions and wellness are addressed as indicated at each care plan meeting.			
DOMAIN 3: Development and sharing of individualized care plans				
CCO and APD are both required to ensure person-centered care planning processes are in place to address member's needs. The expectation is to reduce duplication of services, assessments and improving member experience and outcomes through more integrated approaches to care planning while maintaining member's self-defined quality of life, choice, control, and self-determination.	CCO's Intensive Care Coordinator will develop in a person-centered process written Interdisciplinary care plan (ICP) with member participation and in consultation with any agencies and specialists caring for the member. Care plan should include member's preference on chronic disease management, preventative screenings, medication management, behavioral health assessments and wellness activities to support a successful plan. For members identified as ICC, notification of their status in ICC and the name and contact information of their assigned ICC care coordinator is provided within five days of completing the ICC assessment and care	APD will provide consumer preference from CA/PS to ensure alignment with care plan	Quarterly (and as indicated) - CCO and APD will meet to review # of care plans that document member preferences and goals. # of care plans updated every 90 days for relevant parties.	% 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

	plan must be developed within 10 days of entering into the ICC program CCO will provide support in determination of underutilization of routine medications or services through reporting. (i.e. no fills on chronic condition meds or lag fills on diabetes supplies) When underutilization is noted, TCHP CM will outreach practitioner to coordinate discussion. CCO will review and update the ICP at least every three months for members on ICC and at least annually for other members, or when condition/need requires CCO will support member's access to specialist through coordination assistance, if needed.			

DOMAIN 4: Transitional care practices				
CCO and APD will develop coordinated transitional care 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 include when member's 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.	CCO monitors for transitions of care through Collective reporting for inpatient and emergency room. Members are outreached and assessed with each transition to ensure current and new needs are quickly addressed. CCO will collaborate on APD transitions of care to support timely coordination of DME, medications and transportation before discharge date. CCO will monitor members that are relocating to another CCO region and collaborate with local APD on a warm hand off to the receiving APD agency.	APD will communicate and collaborate on transitions of care identified within LTSS/Home and Community Based Care supporting least restrictive consumer choice. This is managed through a Transition and Diversion team who review and update through assessment. They will reach out as needed to CCO staff to communicate consumers preparing for transition to ensure that discharge orders are in place. APD will assist in warm hand off to a receiving APD agency	Quarterly (and as indicated) CCO and APD will meet to review % of discharges communicated from CCO to APD prior to discharge/transition % of discharges communicated from APD prior to CCO discharge/transition. % of transitions where discharge orders were arranged before discharge and did not delay discharge. % CCO region to CCO region transfers that were communicated to the appropriate receiving APD agency. CCO and APD will hold debrief meetings when transitions were not smooth to discuss	% transitions where CCO communicated about discharge planning with APD 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 office(s) # of Debrief meetings held quarterly to post-conference transitions where transition wasn't smooth (improvement

	CCO will support member in navigating the social systems with referral to community health workers within the CCO to assist with housing, food insecurity, and other social determinant of health needs.		opportunities and lesson learned for quality improvement. (i.e. medications, equipment, Home Health, caregiver)	process approach) [Q1, Q2, Q3, Q4]
DOMAIN 5: Collaborative Communication tools and processes				
The CCO and APD MOU will support two-way collaborative communication through agreed upon modalities 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.	CCO monitors hospital event and skilled nursing facility notification through Collective. CCO will ensure communication of transition to primary care provider and APD agencies to collaborate in the reducing hospitalizations, support transitions and to trigger reassessment of needs, if a change of condition.	APD Transition and Diversion team monitor hospital event and skilled nursing facility notifications through Collective and will notify CCO on members noted as having a change of condition or change to their service plan	Monthly CCO and APD will review # of hospital and skilled nursing event notifications from Collective or other means that involved APD for consultation or were recognized as a referral potential for a new LTSS assessment. # of members who return to hospital within 30 days (IP or ED) # LTSS members who trigger for • All Cause Readmission	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD 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 teams for members with LTSS or new in-need of LTSS assessments MOU includes written process documents (prioritization, IDT, care planning, transitions) that

			• Avoidable emergency department utilization • Emergency department utilization among members with mental illness • Screening for depression and follow up. • Alcohol and Drug Misuse: SBIRT • Poor control A1c • Diabetes short term complication admission rates • COPD or asthma in older adults admission rate • Congestive health failure admission rate • Asthma in younger adults admission rate	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).

SIGNATURES:

Justin Lyman, CFO Trillium CHP April 29, 2022

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

Tom Maloney, District Manager, District 6 4/28/22

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