CCO-LTSS Partnerships MOU:

MOU Period: Jan. 1, 2021 thru Dec. 31, 2024
CCO Name: Yamhill Community Care **OHA Contract #: 161768**

Partner AAA/APD District (s): Northwest Senior & Disability Services (AAA) Yamhill County, Polk County; Washington County (APD) Office

If more than one AAA/APD office in your CCO Geographic Region: Single Combined MOU_X__ Multiple MOUs___

Shared Accountability

Each CCO is responsible for delivering high quality, person-centered health care to members, including members receiving Medicaid-funded LTSS community-based care including adult foster homes, residential care facilities, assisted living facilities, nursing facilities, in home services and supports and other settings.

Rule Reference:

(OAR) 410-141-3500, Medicaid-Funded Long-Term Services and Supports (LTSS)
(OAR) 410-141-3160, Integration and Care Coordination
(OAR) 410-141-3865, Care Coordination Requirements
(OAR) 410-141-3870, Intensive Care Coordination
42 CFR 438.208, Coordination and Continuity of Care
CCO Contract, Exhibit J

Medicaid-funded long-term care (LTC) services are legislatively excluded from Coordinated Care Organization (CCO) budgets and are paid for directly by the Department of Human Services (DHS). Local LTSS offices authorize, manage, and monitor these LTSS 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). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services.

Purpose

To reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, YCCO and the LTSS system are responsible for coordinating care for the individuals served by both CCO and the local LTSS office. One of the strategies of shared accountability is the completion of a MOU between the CCO and local Aging and People with Disabilities office(s) and partnership with YCCO’s Affiliated Medicare plan Providence Health Assurance. MOUs are a tool for sustaining and enhancing working relationships and processes between these entities and holds both systems accountable for outcomes.

This MOU is a non-binding agreement (“Agreement”) between <u>Yamhill Community Care Organization (CCO),</u> and

NorthWest Senior & Disability Services (AAA) and Washington County (APD) office. The mutual goal of the Agreement is to improve person-centered care by aligning care to provide quality care, produce the best health and functional outcomes for individuals, avoid cost shifting between systems and prevent escalation of costs for both systems. In addition, our goals include reducing disparities based on race, ethnicity, limited language, or health literacy, and/or other disabilities, and to pursue innovative and transformational approaches to care. A strong partnership focused on these goals supports Oregon's triple aim of better care, better health, and lower costs. To achieve these goals, the parties to this Agreement desire to set forth their respective roles and responsibilities to coordinate care and share accountability for Medicaid funded long term care.

Agreement

The effective dates for this agreement are January 1, 2021 to December 31, 2024. Now therefore, CCO and AAA/APD agree to participate in the following activities:

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	**AAA/APD Lead(s):**
CCO governance structure will reflect the needs of members receiving Medicaid funded Long-Term Services and Supports (LTSS), through partner (lead) participation in the YCCO governing structure: Community Advisory Council, Quality & Clinical Advisory Panel, and content focused subcommittees. The Affiliated MA and DSNP plan partners role are to participate in: • Joint operating committees applicable to FBDE members • Content focused subcommittees to enhance the LTSS care delivery system • Bi-directional data exchange for shared FBDE members • Member care coordination and system communication	AAA/APD governance Lead(s) will participate at the community level in the YCCO Board and Quality & Clinical Advisory Panel for LTSS perspective/Care Coordination. AAA/APD is responsible for articulating how the membership of the local governing boards, advisory councils, and governing structures reflect the needs of members served by the YCCO region in quarterly MOU meetings and through annual quality assessment and performance improvement evaluations. AAA/APD will participate in CCO leadership and community advisory processes as appropriate.

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

MOU Service Area:				
Shared Accountability Goals with AAA/APD 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**
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members To implement care coordination activities that prevent and/or reduce unnecessary ER visits or hospitalization, YCCO and AAA/APD partners will implement and share risk screening and assessment information on priority and high-risk populations identified for LTSS or ICC need	Identification of needs through risk assessment: • Refine identification points that trigger intensive care coordination for high needs members receiving Medicaid funded LTC services. • Assess universal risk screening processes that identify individuals for critical factors quarterly. • Factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers. • Document referrals and other relevant health information, priority level, and ICP received from AAA/APD for LTSS needs assessment. • Share information from community health assessments and individual risk assessments of individuals and communities defined as high risk with designated AAA/APD staff.	Identification of needs through risk assessment: • Work with CCO to create a universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs CCO members receiving Medicaid funded LTC services. • Share with CCO the service priority level and information from standardized risk assessment in the Client Assessment and Planning System (CA/PS), of individuals with service priority levels ranging from 1-13, living in their own home or in a community-based setting, or those individuals having the potential to need LTSS and intensive care coordination to assist with selection of members designated as high risk	Evidence of progressive alignment of universal risk screening processes # of case of mutual concern submitted for review and discussion each month Quarterly meeting minutes between agencies to assess the effectiveness of cross-agency risk assessment and screening processes	Universal risk screening processes will be approved by a majority at quarterly MOU leadership meetings. # 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

	Coordination and Communication activities: • Provide AAA/APD staff contact information and streamlined process for referring members to ICC risk assessment. • Agree to submit at least one case of mutual concern for discussion every 2 weeks, using a standardized presentation format at least one week prior to the Multidisciplinary Care Team (MDT). • Agree to provide intense care coordination as defined in this document. Additionally, it is agreed that either CCO or AAA/APD may offer up individual members for consideration of intensive care coordination outside of the specific parameters listed here. • Provide follow-up on referrals within timeframe requirements based on OARs. Tracking and continuous improvement: • Monitor communication and coordination activities with AAA/APD real time when assessing members receiving Medicaid-funded LTSS services and monthly	Coordination and Communication activities: • Provide CCO with access to information needed to identify LTSS members with high care needs, such as health related information, service priority level, individualized care plans. • Make referrals to CCO for members with potential need for Intensive Care Coordination/(ICC) risk assessments as AAA/APD staff identify concerns or gaps or changes in health status • Coordinate and submit at least one case of mutual concern for discussion every 2 weeks, using a standardized presentation format at least one week prior to the Multidisciplinary Care Team (MDT). These high need members will receive intense care coordination as defined in this document. CCO or AAA/APD may offer up individual members for consideration of intensive care coordination outside of the specific parameters listed here. • Share with CCO information regarding in-home service clients the Case Manager believes to be at		# 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] MOU quarterly meeting agenda and minutes

	to evaluate best practice in care management and identify barriers in timely responses. Track monthly all information received from AAA/APD around health-related information, priority level and ICPs. These records will be monitored for gaps or changes in format and data provided. Methods of information sharing: CCO shares information on complex members requiring IDT/MDT conferencing at least every 2 weeks at a multi-disciplinary care team meeting held at a mutually agreed upon location.	risk due to accepting lower than authorized care plan, or anyone with a notice for eviction or involuntary move out, or any other bio-psychosocial factor(s) influencing their stability in their current environment. Tracking and continuous improvement: • Agrees to revisit these criteria a minimum of every two years, to determine whether these agreements have been effective in identifying high care need members. Methods of information sharing: • AAA/APD is sharing member information as above monthly. Information will be shared electronically if available, by fax or email to the designated contact person or back-up.		
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams YCCO and AAA/APD partners will establish	• CCO supports the flow of information to AAA/APD by keeping contact information up to date. • CCO facilitates a biweekly MDT meeting (also known as IDT conferences) inviting APD/AAA staff,	• AAA/APD defines roles, responsibilities, and process for assignment of and participation in the CCO care team, including coordination with CCO lead care coordinator, for members needing	# of quarterly meetings in the year with discussion that addresses a. MOU agreements b. identification of strengths of the MOU	# of members with LTSS that are addressed/staffed via IDT meetings monthly

inter-disciplinary 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 multidisciplinary care teams (MDT) will coordinate care and develop individualized care plans for high needs, mutual members. All individuals on the MDT will maintain confidentiality.	provider partners, CM staff, Medicare plan representative, and community resource offices to discuss complex member needs and barriers to coordination. • Regarding members identified as having "high care needs", CCO works with AAA/APD to develop efficient processes for Multi-disciplinary Care Team (MDT) meetings, identify contacts for MDT meetings, and convene MDT meetings on a regular basis (at least two times per month). • CCO ensures the twice monthly MDT members include as a minimum representative from CCO, AAA/APD, local Behavioral Health Service Providers, and local Health Care Providers such as local hospital discharge planner, community liaison from local primary care clinics, or long-term care providers. • The CCO-appointed lead provider or care team confers with all providers responsible for a member's care, including Medicare, LTC providers and AAA/APD. • CCO shares with MDT participates who is the lead person(s) from each entity (CCO, AAA/APD, and other	routine and intensive care coordination. • Regarding members identified as having "high care needs", AAA/APD works with CCO to develop efficient processes for Multi-disciplinary Care Team (MDT) meetings, identify contacts for MDT meetings, and convene MDT meetings on a regular basis (at least two times per month). • Ensure that CCO providers/care teams are notified of which CCO members are receiving LTC, the relevant local AAA/APD office contact, and contact for relevant LTC provider through a monthly shared report. • Share with MDT participates who is the lead person(s) from each entity (CCO, AAA/APD, and other MDT members) and who will be the main contact person for communication and attending the MDT. Participate in CCO team-based care processes when appropriate AAA/APD leadership agrees to:	c. challenges or barriers to meeting MOU agreements d. unexpected opportunities e. informal/anecdotal outcomes # of care plans where individual member engagement resulted in positive case outcomes	% 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)

	MDT members) and who will be the main contact person for communication and attending the MDT. To support care teams, CCO: • Schedules additional IDT meetings or conferences for prioritized members that include the member when possible • Include LTC providers and APD/AAA case managers as part of the team-based care approach • 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. CCO leadership agree to: 1. Conduct quarterly meetings to discuss: a. MOU agreements b. identification of strengths of the MOU c. challenges or barriers to meeting MOU agreements d. unexpected opportunities e. informal/anecdotal outcomes	4. Attend quarterly meetings to discuss: f. MOU agreements g. identification of strengths of the MOU h. challenges or barriers to meeting MOU agreements i. unexpected opportunities j. informal/anecdotal outcomes 5. MOUs revision to adjust agreement to reflect substantive changes Note: MOU revisions must go through the same review and approval process as new MOUs. • Identify domain activity measures or other evaluation tools related to optional MOU domains or other specific CCO/LTSS office joint efforts or goals		

	2. Document meetings and a work plan or other methodology to track next steps and follow up 3. MOUs revision to adjust agreement to reflect substantive changes Note: MOU revisions must go through the same review and approval process as new MOUs. Identify domain activity measures or other evaluation tools related to optional MOU domains or other specific CCO/LTSS office joint efforts or goals			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans YCCO and AAA/APD partners collaborate to ensure a person-center care plan is in place to address member's needs.	CCO and AAA/APD are each committed to establishing and maintaining effective communication through regularly scheduled meetings, meeting at least every two weeks in MDT meetings and in quarterly MOU meetings. When appropriate, members will be encouraged to be part of the care planning process. For example, attending MDT to discuss their preferences and what actions they would like to take in their care plan. Individualized care plans are created and shared in these bi-weekly meeting, and include:	CCO and AAA/APD are each committed to establishing and maintaining effective communication through regularly scheduled meetings, meeting at least every two weeks in MDT meetings and in quarterly MOU meetings. When appropriate, members will be encouraged to be part of the care planning process. For example, attending MDT to discuss their preferences and what actions they would like to take in their care plan. Individualized care plans are created and shared in these bi-weekly meeting, and include:	100% of cases reviewed at MDT has a documented person-centered care plan Sample of Individualized care plans reviewed for contents of the following items: a. Member/client access to needed services b. Promotion of self-management of chronic conditions and participation in health promotion /prevention activities c. How member input for care conferences was captured within four weeks prior to the	% 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

	• CCOs' individualized person-centered care plans include information about the supportive and therapeutic needs of each member, including LTC services and supports needs. • Plans that reflect member or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate. • Individualized person-centered care plans that are jointly shared and coordinated with relevant staff from AAA/APD, LTC providers and MA Affiliated and DSNP partners. • Active engagement of 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. • Identification of opportunities to focus on preventive approaches, screenings, and strategies to reduce unnecessary hospitalizations, ER visits and maintain or improve health of members with LTSS. • Be discussed with and approved by the member involved. Whenever possible, members may be present in MDT meetings and care planning.	• Key information needed such as health related information, risk assessment, service priority level into individualized care plans. • Active engagement of members in the design and, where applicable, implementation of their treatment and care plans, in coordination with CCO where relevant to treatment and LTSS service planning. • Referrals to CCO for members with potential need for Intensive Care Coordination/(ICC) risk assessments as APD/AAA staff identify concerns or gaps or changes in health status. • Share pertinent details of individual member barriers to achieving health goals that staff are aware of. This includes homelessness, misuse of medications, no phone, lack of accessible transportation, minimal or insufficient social supports. CCO and AAA/APD will share community resources and special programs. Examples of special programs include YCCO Community Health Workers (CHW) Hub, Living Well Programs, TaiChi for Better	care conference and included in the care conference d. How the care plan was reviewed with the member within four weeks after the care conference	

	• Shared barriers to achieving health goals such as member routinely does not follow up with scheduled appointments or does not have primary care provider, and there are known gaps in provider capacity in the community. CCO and AAA/APD will share community resources and special programs. Examples of special programs include YCCO Community Health Workers (CHW) Hub, Living Well Programs, TaiChi for Better Balance, Chronic Disease Self- Management program (CDSMP), Diabetes Self-Management Program (DSMP), Chronic Pain Self- Management Program (CPSMP), and other self-management programs, and the Chronic Pain Clinic.	Balance, Chronic Disease Self-Management program (CDSMP), Diabetes Self-Management Program (DSMP), Chronic Pain Self-Management Program (CPSMP), and other self-management programs, and the Chronic Pain Clinic.		
DOMAIN 4: Transitional care practices				
DOMAIN 4: Transitional care practices Goals YCCO and AAA/APD partners will develop coordinated transitional care practices that incorporate cross system education, timely-information-sharing when	• CCO is responsible for ensuring transition processes include evidence-based discharge planning, setting up, monitoring, and ensuring transportation for follow up appointments, medication reconciliation, durable medical equipment needs/orders, etc. are coordinated.	• AAA/APD will document coordination and communication efforts with CCO in its core system to ensure members receive comprehensive transitional care services and supports, as required to incent, and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive	# of identified settings where discussions to share information about transitions and transition resources occur and document in transitional care practices Review and specifically address the degree to which entities are collaborating on care transitions to ensure positive outcomes for	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders

transitions occur, minimal cross-system duplication of effort, and effective deployment of cross-system nursing and psycho-social resources at any time members experience a transition in their care setting. When appropriate, AAA/APD and CCO will work collaboratively to develop agreements around post hospital/skilled placement and roles that are most efficient yet prevent cost shifting or increases to LTC nursing home case load.	• CCO will document coordination and communication efforts with AAA/APD in its core systems to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650. • Through standard care coordination practices, CCO will notify AAA/APD within 7 days of receipt of information regarding active MDT members who have significant changes in their medical condition, requiring a different level of medical care, e.g., dialysis or hospice care.	comprehensive transitional care, as required by HB 3650. • Through standard case management practices, AAA/APD will notify CCO as soon as reasonable but not to exceed 7 days of receipt of information regarding members who have open cases at MDT move or change in setting. Including date of move, new address, type of LTC setting, member contact number, provider contact number. CCO to reciprocate if they are aware of move first, including acute hospitalizations. • AAA/APD will continue to monitor ICF Nursing Home Count and communicate barriers with CCO and Affiliated MA and DSNP plan partners as appropriate • • APD/AAA will maintain details on the best way to contact staff for LTSS assessments. • APD/AAA will work with CCO, OHA, and medical providers on durable medical equipment needs/orders, medication reconciliation, etc.	members in Quarterly partner meetings i.e. training needs, access to information sharing Annual review of existing transitional care practices and workflows	(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]
DOMAIN 5: Collaborative Communication tools and processes				

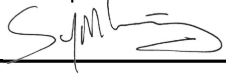
DOMAIN 5: Collaborative Communication tools and processes Goals YCCO and AAA/APD partners committed to mutual responsibility to foster cross system collaborations, training, and shared learning to reach the Triple Aim. Local, regional, and statewide cross system learning training and action to focus on best practices.	CCO facilitates a quarterly MOU meeting for partners to collaborate and define measurement and monitoring of the activities being coordinated between both entities. These meetings include review of MOU agreement, overview of progress, barriers and processes and discuss the following are met: • 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. • 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	Participate in a quarterly MOU meeting for partners to collaborate and define measurement and monitoring of the activities being coordinated between both entities. These meetings include review of MOU agreement, overview of progress, barriers and processes and discuss the following are met: • 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. • Share how AAA/APD 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	CCO and AAA/APD partners will develop an annual plan to provide cross-system learning that identifies pertinent topics such as facilitating best practices in care coordination, health promotion, transitions care, and long-term services and supports. CCO and AAA/APD partners will implement the plan as defined using available resources.	# 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

	with Collective and AAA/APD 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. • The YCCO HIT roadmap, will identify a strategy to partner with the LTSS system to improve upon any existing efforts to share relevant information electronically.			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	• Share resources and tools that exist to address social determinants of health and/or population health efforts and how individuals receiving LTSS and/or their family or authorized representative can access. • Share information on eligibility for and process by which CCO considers Health Related Services Requests. • Share how CCO deploy THWs and addresses social determinants of health or health equity goals of CCO 2.0 that may impact additional supports for members with LTSS need.	• 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)	% of MDT meetings where cross system or shared learning took place % of MDT meeting time spent on cross system or shared learning # of cross learning events # of referrals for social determinants of health and/or population health programs tracked	
OPTIONAL DOMAIN B: Health Promotion and Prevention				

OPTIONAL DOMAIN B: Cross-System Learning Goals CCO and AAA/APD partners will provide and/or support member access to evidence-based health promotion, self-management and prevention classes, group and individual.	• CCO measurements OAR 410-141-3160 shall ensure access to effective wellness. • CCO 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. • 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 AAA/APD.	• AAA/APD will provide health promotion and prevention services or work in collaboration with CCO and other partners to support access and engagement in such services. • AAA/APD will educate CCO on current health promotion and prevention services that are offered. AAA/APD will help LTSS Consumers, CCO and other partners to access and engage in health promotion and prevention programs available in the community.	CCO and AAA/APD offices will work together to develop an effective public awareness plan and referral process such that all clients in need of preventative or health promotion services will have access to such services. % of MDT cases where health prevention/promotion activities are part of the shared care plan % of joint clients who were given information about or who were referred to health prevention/promotion activities/services % of joint clients who accessed or received health prevention/promotion services # and variety of classes being offered	

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.



Seamus J. McCarthy, President/CEO, Yamhill Community Care, 04/30/2022

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

Washington County APD, 04/30/2022

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

Tanya DeHart, Executive Director, Northwest Senior & Disability Services, 04/30/2022

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