# Core CCO 2.0 Requirements: CCO-Specific Guidance Overview

# Annual LTSS MOU & Reporting Updated November 2022

# Integration and Care Coordination for Members with Medicaid LTSS

***"Long-term services and supports (LTSS) enable older adults and adults and youth with intellectual and developmental disabilities (I/DD), physical disabilities, and mental health conditions, among other conditions, to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. Medicaid is the single leading payer of these critical services and with the aging population's projected growth, need for LTSS services is only expected to experience increased demand."***[1]

## TABLE OF CONTENTS



[1] Strengthening Medicaid Long-Term Services and Supports: A ToolKit for States, The Scan Foundation, 2017

**Purpose/Scope of this Guidance:** This document outlines core areas of CCO 2.0 responsibility for populations receiving Medicaid-funded LTSS in Oregon. This document is intended to provide guidance and technical support for the completion of required MOU(s) with APD/AAA an emphasis on local flexibility and innovation related to coordination of shared members with LTSS. This guidance material covers MOUs between CCOs and:

- Type B Area Agencies on Aging (AAA)
- State of Oregon Aging and People with Disabilities (APD) districts
- If the parties agree, Type A Area Agencies on Aging may be included in these MOUs.

This guidance does not cover: Other LTSS services required to be coordinated by CCOs with local mental health authorities, community mental health programs, community developmental disability programs or support service brokerages are not covered by this guidance.

***The purpose of the MOU is to ensure that coordination between the Oregon LTSS system and the CCO creates alignment between the two systems to provide quality care, promote coordinated care planning and care transitions, produce the best health and functional outcomes for individuals, and reduce duplication and inefficiency through better coordination across systems.***

**Oregon LTSS Population Definition:** As set forth in OAR **410-141-3500: "Medicaid-Funded Long-Term Services and Supports (LTSS)"** means all Medicaid funded services CMS defines as long-term services and supports, including both:

(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;

(b) "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.

For additional information about the Oregon LTSS system administered through Oregon DHS, please see "Overview of the Delivery System for Medicaid and Long-Term Services & Supports to Seniors and People with Disabilities 2020" document.

**Shared Accountability Goals:** Many low-income adults who need and use long-term services and supports (LTSS) have complex healthcare issues, including multiple chronic conditions to manage, and often have unmet social needs which can lead to poor health outcomes. Populations needing LTSS are among the fastest-growing populations covered by Medicaid. Oregon created a system of shared accountability between Coordinated Care Organizations (CCOs) and Oregon's Long-Term Care (LTC) system in 2013 to draw on the strengths of Oregon's medical and LTSS systems to build collaboration as part of Oregon health care transformation. The framework's intentions strove to lead the way to greater integration and coordination between the CCO and LTSS systems while remaining consistent with and strengthening Oregon's ORS 410 values to promote health, honor, dignity, and lives of maximum independence, and Oregon's Triple Aim. Oregon also made policy decisions to exclude LTSS services from the CCO global budget and have LTSS services continue to be paid for directly by the Department of Human Services (DHS). CMS also clarified expectations for coordination with LTSS services in managed care rule updates in 2016-2018, and now rules and contracts have been further updated to build on past successes as part of CCO 2.0 work.

CMS has also increased focus to promote integrated care, especially for dual eligibles (people eligible for both Medicare and Medicaid) and members with long-term service and support needs while reducing duplication across systems. Communication between health systems and LTSS providers were two main focuses of opportunities identified by the original Oregon framework for integration of LTSS and CCOs to address through shared accountability. Oregon's collaborative system is designed to promote CCOs use of evidence-based and, whenever possible, innovative, flexible and creative strategies at the community level to build the most integrated and coordinated care in accordance with individual member needs and goals. In CCO 2.0 intentions are to continue to build on initial success and continue to build coordinated care that promotes seamlessness for members needing LTSS services and programs.

**Shared Accountability Goals for MOUs** include the following:

- Protocols for reviewing and prioritizing members with LTSS services and sharing across systems
- Coordinated and aligned care and services for all individuals getting long-term services and supports.
- Care and service coordination tailored to needs specific to service environments in long-term care and home and community-based settings.
- Processes for CCO referrals to APD/AAA for LTSS assessments and service planning; processes by which the APD/AAA office or LTSS providers refer members to CCO for Intensive Care Coordination.
- Mechanisms for shared accountability –including communication, care planning, care transitions.

- Processes for addressing care transitions or addressing changes in health status or level of service, ensuring discharges receive follow-up care, assessments and monitoring.
- Ease for members in navigating and receiving care and services needed to maintain and improve health.
- Person-centered planning to address member needs, including goals to ensure health equity, language and disability access, health literacy, and promoting wellness and better health outcomes.
- Documenting success by tracking and measuring MOU activities and outcomes.

Oregon will face increased pressure to meet the health and LTSS needs of a growing elderly population in the coming years. The misalignment of systems, processes across systems and settings of care contributes to increased but not necessarily cost-effective utilization of the health care system and missed opportunities to improve health and outcomes. In order for individuals to receive the most integrated, coordinated and seamless healthcare and long-term services and supports, collaboration has to be a priority across systems of care. The MOU seeks to clearly define roles, responsibilities, accountability and monitoring measures for success.

## Updated MOU Documents:

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| **This document: Core CCO 2.0 Requirements: CCO-Specific Guidance Annual LTSS MOU & Reporting Overview** | Specific guidance related to CCO 2.0 expectations in CCO contracts and OARs, information on definition and identifying LTSS populations, overview of timelines and due dates, summary of materials, measurement specifics |
| **CCO to LTSS MOU Guidance CY2020 – CY 2024: Shared Accountability for Long Term Services & Supports (LTSS)--CCO–APD/AAA Memorandum of Understanding (MOU) Guidance** | Detailed Guidance, Shared Accountability Goals, CCO – LTSS MOU Guidance and Worksheets CY2020 -CY2024, overview of new timelines, Required and Optional Domains, Required MOU domain metrics, References & Links, MOU Guidance Glossary |
| **AAA/APD Overview of Delivery System for LTSS**<br>**AAA/APD Planning and Service Districts Map** | Description of LTSS services and AAA/APD roles.<br>https://www.oregon.gov/DHS/SENIORS-DISABILITIES/LTC/Documents/AAA-APD-Field-Delivery-System-Map.pdf |
| **CCO - APD/AAA MOU Template** | Template for MOU |

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| **CCO MOU Annual Report Table** | Required annual report template-- updated 11-2022 |

**Process for creating a new MOU:** The MOU(s) will be created jointly by CCO with the APD/AAA LTSS services office(s) serving that area. However, it is the CCO who is responsible to submit the MOU to OHA and to complete the annual updates and reporting to OHA. As part of CCO 2.0 there is a goal to improve uniformity in reporting so that data can be rolled up into a statewide summary which can be shared with CMS annually.

Approaching the MOU conversation: It is up to the CCO and your local field office(s) whether you create a combined regional MOU or you have separate MOUs with each AAA/APD office in the CCO region. **Conversations to improve MOU processes should happen even if you are not planning on resubmitting an updated MOU document.** CCOs have the responsibility for submitting the MOU(s) to OHA. CCOs will be required to submit an annual summary MOU report with required domain metrics in your CCO region [see MOU Report Table]. Your discussions on your new MOU with your local partners would likely benefit from providing the APD/AAA team on an update on new things in the CCO 2.0 contract; including updated information on expectations in integrated care planning and intensive care coordination and in your plans to roll out event notifications to more providers as part of your HIE roadmaps. **Discussions on areas where your CCO submitted metrics and had less than stellar performance should be a good place to have updated conversations.** For those of you with new CCO regions, a suggested beginning point for discussion is to get an understanding of each entity's current capabilities, processes, language and terminology, and limitations in each of the required domain areas. New Shared Accountability guidance for CCOs and DHS APD/AAA Offices include MOU Worksheets: Questions and Guidance that can guide your conversations.

Building on past relationships: Many CCO-LTSS MOUs and relationships will not be new and so should reflect goals for improvements characterized by the CCO 2.0 contract. Your MOU should reflect the capabilities and resources of the local entities and may be different from MOUs created by other organizations around the state. You may choose to clarify any roles your affiliated MA plans will play in the care coordination work such as in supporting interdisciplinary care team processes.

A discussion about shared outcome expectations may assist in creating agreements that are strong and relevant.

- Creating a better experience for the individual; providing "no wrong door" or seamless services across agencies;
- Processes to ensure member engagement and preferences;
- Reducing duplication across systems and preventing/avoiding cost shifting;

- Providing better care and services; improving coordination;
- Impacting preventive care, health promotion and wellness;
- Reducing disparities based on race, ethnicity, limited language proficiency; ensuring health equity and access;
- Creating better health outcomes; lowering avoidable costs; and improving health outcomes (triple aim);
- Pursuing innovative and transformational approaches to care and supportive services.

Having a shared and realistic understanding of the services, philosophy, and operational capabilities of both the CCO and LTSS services and coordination from the APD district office or AAA organization should aid in the development of the MOU. [For additional information about Oregon's LTSS system, please see "Overview of the Delivery System for Medicaid and Long-Term Services & Supports to Seniors and People with Disabilities" document.] CCOs can look at targets to improve outcomes and how these MOUs can support those goals [Examples: Opportunities to look at how nursing home residents receive screenings, care or monitoring that prevents avoidable hospitalizations; or social determinants supports that could be provided to members receiving HCBS to keep them able to live independently in the community and staying healthy versus facing barriers that lead to declining health status.]

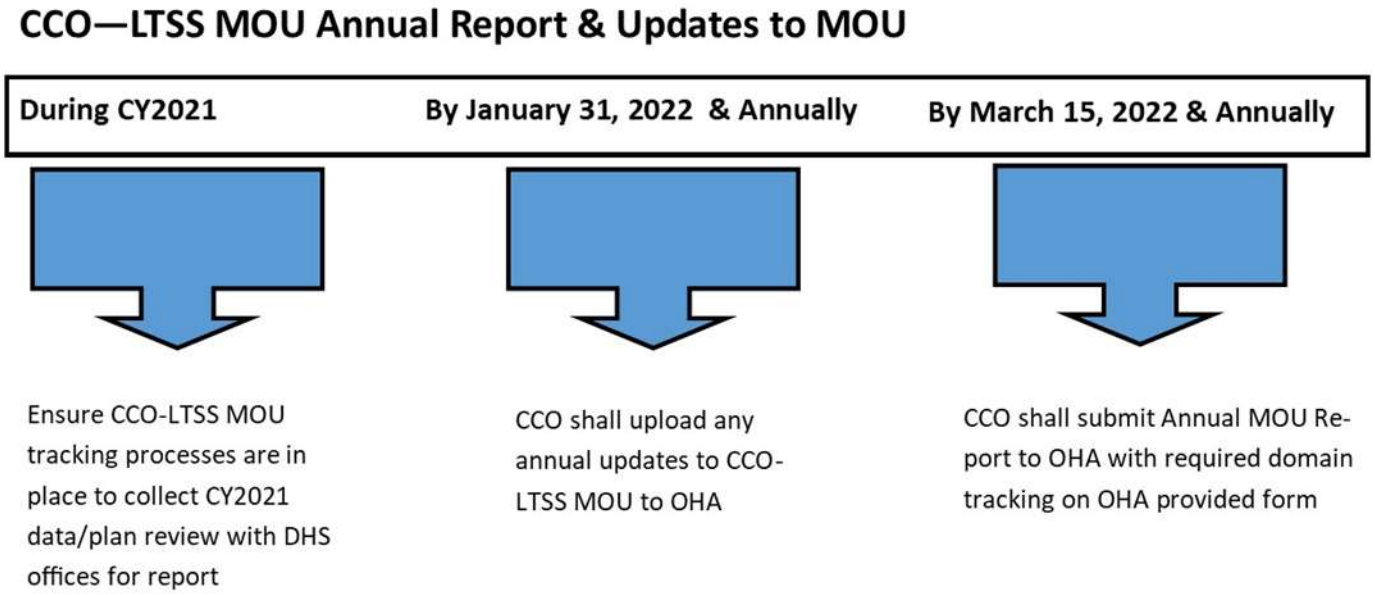
Key considerations in MOU development include:

- Who is the lead contact in each organization for day to day operation of MOU?
- What are the core activities, policies, processes outlined in the MOU that will meet goals to improve member outcomes and experience?
- What are the tracking mechanisms needed to track progress toward MOU goals?
- What are the methods for problem solving/resolution and check-ins?
- How do we align the MOU to advance metrics and outcomes for CCO members with LTSS?

## Technical Assistance Support Contacts for MOU

| ***OHA CCO Technical Assistance*** | ***DHS APD/AAA Technical Assistance*** |
|---|---|
| *Jennifer Valentine, Operations and Policy Analyst, Health Systems Division*<br>*Email: Jennifer.B.Valentine@state.or.us*<br>*Mobile: 503-519-3341* | *Naomi Sacks, Policy Analyst, Long Term Services & Supports Aging & People with Disabilities*<br>*Email: Naomi.E.Sacks@dhsoha.state.or.us*<br>*Mobile: 503-385-7168* |

**New website for guidance materials:** https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-LTSS.aspx




**The next report due date for CY2022 data is March 15, 2023**

**CY2023 data report will be due on March 15, 2024**

## Identifying Your LTSS Populations:

Many CCO-APD/AAA MOUs created mechanisms to share information about high needs populations with LTSS. This regional list process has varied across MOUs and may have only focused on members transitioning, those being care conferenced, or having immediate needs. However, with new managed care rules, CMS identified managed care populations receiving any LTSS as high-risk populations. As part of the updated rules, CMS required a new state notification requirement to ensure that CCOs could identify CCO members receiving LTSS programs. OHA shared information via the All Plan System Technical workgroup in 2018 and released guidance to assist plans in utilizing the new notification on the **834 enrollment report**. This indicator is "a yes indicator" when select LTSS programs are present at the time of the 834 data update. This information is contained in the 834 Loop 2750. This information is meant to directly assist with the new requirements to identify LTSS populations and provide required risk screening within 30 days, or to use the indicator to prioritize members with LTSS for

review for ICC or care coordination, or to trigger shared ICP development or sharing as required in OARs. The indicator may still miss some LTSS services or programs that were determined at the time to not have regularly updated information available through MMIS. Programs included in the LTSS Indicator:

**T_BENEFIT_PLAN_GROUP**

| LOC Plan (reference only) | Plan Description (reference only) | SAK_BENEFIT_PLAN_TYPE NUMBER(9,0) | SAK_PUB_HLTH NUMBER(9,0) | DTE_EFFECTIVE NUMBER(8,0) | DTE_END NUMBER(8,0) |
|---|---|---|---|---|---|
| DDBL | Children's Intensive In-home HCBS Behavioral | 6012 | 1041 | 20180101 | 22991231 |
| DDCL | DD Comprehensive HCBS Waiver | 6012 | 1042 | 20180101 | 22991231 |
| DDEL | DD Eligible | 6012 | 2058 | 20180101 | 22991231 |
| DDKL | DD Comm First Choice K Plan | 6012 | 2073 | 20180101 | 22991231 |
| DDSL | DD In-Home Supports HCBS Waiver | 6012 | 1044 | 20180101 | 22991231 |
| ICPL | Independent Choices | 6012 | 1048 | 20180101 | 22991231 |
| KPSL | State Plan K Services for APD | 6012 | 2076 | 20180101 | 22991231 |
| MFNL | Medically Fragile Children non-waivered | 6012 | 1051 | 20180101 | 22991231 |
| MFWL | Medically Fragile Children HCBS Model Waiver | 6012 | 1052 | 20180101 | 22991231 |
| MIWL | Medically Involed Children's Services Waiver | 6012 | 1053 | 20180101 | 22991231 |
| NFCL | Nursing Home | 6012 | 1054 | 20180101 | 22991231 |
| NFSL | Nursing Home Short-Term | 6012 | 1056 | 20180101 | 22991231 |
| SPHL | Spousal Pay In-Home Services | 6012 | 1062 | 20180101 | 22991231 |

Because the LTSS indicator does not provide direct information about the specific LTSS program or services the member has, additional conversations with your local APD/AAA districts or the member to further risk-stratify populations for care coordination, or complete health risk assessments continue to be necessary.

**MOU Required & Optional Domains:** New 2020 Guidance outlines required and optional domains **[see CCO to LTSS MOU Guidance CY2020 – CY 2024 Shared Accountability for Long Term Services & Supports (LTSS) CCO–APD/AAA Memorandum of Understanding (MOU) Guidance]** for the CY2021 Contract period, and annually thereafter. Each required and optional domain for the CCO – LTSS MOU has a domain worksheet that provides and overview of minimum requirements and highlights opportunities to build connections and sample questions that might trigger shared planning for MOU activities in that domain.

**CCOs should be striving to build activities and processes with APD/AAA districts to address the following in the MOU:**

**REQUIRED DOMAINS:**

1. **Prioritization of high needs members**
2. **Interdisciplinary care teams**
3. **Development and sharing of individualized care plans**
4. **Transitional care practices**
5. **Collaborative Communication tools and processes**

**Optional Domains:** These domain areas are optional based on local partnership goals (for more detail on each domain see domain worksheets pages) and do not have statewide metrics reporting, however CCOs are encouraged to set local goals and measures to build comprehensive processes.

- **A: Linking to Supportive Resources**
- **B. Health Promotion and Prevention**
- **C: Safeguards for Members**

**2020 – 2024 MOU & Reporting Process:** The CCO - LTSS MOU should address core elements outlined in the CCO 2.0 contract which are summarized in CCO supplemental materials and in domain information in this document. The required domains must be addressed in the CCO-LTSS MOU and required data points collected and provided to OHA in annual reports on Report Template by the CCO. A MOU template document is provided for the MOU that documents agreements and metrics/measures of progress toward goals.

**New MOU Period:** The new MOU period at a minimum is for the calendar year in alignment with CCO contracts. An MOU can be developed with a two-year agreement period or be completed/updated on a yearly basis for the remainder of the current CCO contract period. MOUs should be signed by December 31st with an effective period of at least current year period (Jan. 1-December 31st). Any updates to the MOU should be submitted yearly by January 15th to OHA by the CCO. Neither DHS or OHA will need to sign off or review MOUs prior to submission. An OHA & DHS team will review the MOU after submission per CCO contract.

**Annual Report Submission:** CCO shall submit annually no later than March 15th an annual report to OHA that have been agreed to in a MOU or in Subcontract between the Contractor and the Type B AAA or State APD district office(s) in its Service Area on the report template provided by OHA. Annual Reports provided to OHA 2021 -2024 should include annual report on of monitoring and measurement of activities in the MOU. OHA anticipates posting annual reports, but additional details will be provided at a later date regarding specifics.

**What is due when?**

CCO Submits MOU to OHA: No additional MOU required, CCO will only submit any updates it made with partners by Jan 15th annually

CCO Submits Annual Reports to OHA: Annually on March 15th, beginning in 2022.


## CCO 2. 0 Expectations Linkages to MOU Domains:

This table highlights sections of CCO contracts and OARs that relate to core required domains for the CCO-LTSS MOU.

- CCOs shall implement procedures to share with Participating Providers, in order to avoid the duplication of services and activities, the results of its identification and Assessment of any Member identified as (i) having Special Health Care Needs, including older adults, (ii) being blind, deaf, hard or hearing, or have other disabilities, (iii) having complex medical health needs, high health care needs, multiple chronic conditions, Behavioral Health issues, including SUD, (iii) receiving Medicaid Funded Long Term Services and Supports receiving Home and Community Based Services consistent with 42 CFR §438.208
- CCOs shall have policies and mechanisms for producing, in consultation with the appropriate Providers, including Medicare Providers, an integrated treatment or care plan, or transition of care plan for Members:

**(a)** With Special Health Care Needs,

**(b)** Receiving Long Term Services and Supports,

**(c)** Who are transitioning from Hospital or Skilled Nursing Facility care,

**(d)** Who are transitioning from institutional or in-patient Behavioral Health care,

**(e)** Who are receiving Home and Community Based Services

**(f)** FBDE Members enrolled in Contractor's Affiliated Medicare Advantage or DSNP Plans in order to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes.

| **CCO Contract & OARs Responsibility** | **What is required for CCO Members with LTSS** | **Related Shared Accountability Domains** (*there may be other domains impacted in your MOU based on specific regional activities*) |
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| **Initial Health Risk Screening**<br><br>**OAR 410-141-3865** | Within 30 days for members with LTSS or those who have a known health condition or are members of priority populations; or referred, or based on health condition<br><br>Contractor shall implement mechanisms to assess Members receiving Long Term Services and Supports in order to identify any ongoing special conditions that require a course of physical health, Behavioral Health services, or care management, or all or any combination thereof.-- Exhibit B – Statement of Work – Part 4 – Providers and Delivery System, Access to Care | DOMAIN 1: Prioritization of High Needs Members |
| **Prioritized Population for ICC assessment** | Intensive Care Coordination prioritized populations include individuals who (a) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities; (b) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);<br><br>All members of prioritized populations shall be automatically assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition.<br><br>• ICC Triggering reassessment for events listed in OAR 410-141-3870. Contact the member no more than three calendar days after receiving notification of a reassessment trigger | DOMAIN 1: Prioritization of High Needs Members |

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| **OAR 410-141-3870** | • Reassessment for ICC services and care plans, or if applicable, ICC plans, revised if necessary, must be performed upon member request or at minimum annually.<br><br>Results of ICC assessment shared with APD/AAA for populations with LTSS | |
| **Referral for LTSS Screening/Assessment** to partners/agencies when CCO identifies member need<br><br>**OAR 410-141-3865** | CCO must have a referral process to the appropriate partners agency (AAA/APD or ODDS) for members thought to benefit from Medicaid LTSS services to receive intake or transition assessment. | DOMAIN 1: Prioritization of High Needs Members<br><br>DOMAIN 5: Collaborative Communication tools and processes |
| **Process to receive and respond to Referral to Care Navigation or Intensive Care Coordination (ICC)** from AAA/APD or ODDS partners<br><br>**OAR 410-141-3870** | CCO must have a process to ensure LTSS program case managers can connect in a timely way to request support for a member with care navigation or a referral to ICC. Required 1 business day response time for notification of receipt of referral. | DOMAIN 1: Prioritization of High Needs Members<br><br>DOMAIN 5: Collaborative Communication tools and processes |
| **Collaborative Care Planning;** Required collaborative care/treatment planning. Known as ICP or ICCP. Revisions to ICCPs must be done at least every 3 months for Members receiving ICC Services and every twelve (12) months for other Members, or when condition or need requires. Engage member | For those Members with Special Health Care needs and Members receiving Long Term Services and Supports who are determined to need a course of treatment or regular care Monitoring, Contractor shall:<br><br>Develop and implement a written ICCP. Each Member's ICCP must be: (i) developed by such Member's Intensive Care Coordinator ***with Member participation and in consultation with any specialists caring for the Member***; (ii) approved by Contractor in a timely manner, (iii) revised upon Assessment of function need or at the request of the Member.<br><br>ICCP should reflect goals to produce, in consultation with the appropriate Providers, including Medicare Providers, an integrated treatment or care plan, or transition of care plan. CMS requires plans | DOMAIN 2: Interdisciplinary care teams<br><br>DOMAIN 3: Development and sharing of individualized care plans<br><br>DOMAIN 5. Collaborative Communication tools and processes |

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| in care plan Copy to member required.<br><br>**OAR 410-141-3860, OAR 410-141-3865, OAR 410-141-3870** | to work toward reducing duplication through collaborative care planning, following person-centered care processes. Use of screening tools, treatment standards and guidelines that support integration.<br>--ICCP developed within 10 days of enrollment in the ICC program, updated every 90 days or sooner if health needs change.<br><br>--reference Exhibit B, Part 4, Care Coordination | |
| **Engagement of Member in Care Planning**<br><br>**OAR 410-141-3870** | Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTSS providers and the member's participation<br><br>-- notify members of their ICC status and details about the ICC program and the name and contact information of their assigned ICC care coordinator be provided to members within 5 days of completion of ICC assessment<br><br>And as noted above, --reference Exhibit B, Part 4, Care Coordination | DOMAIN 2: Interdisciplinary care teams<br><br>DOMAIN 3: Development and sharing of individualized care plans |
| **Comprehensive Transition Care & Planning:** -- transitioning from Hospital or Skilled Nursing Facility care, transitioning from institutional or residential care, transitioning to Home and Community Based Services<br>**OAR 410-141-3860, OAR 410-141-3865, OAR 410-141-3870** | Transition of care should reflect goals to address needs of members to ensure a successful transition from one setting or level of care to another; including where necessary to ensure the community and home supports are in place prior to transition; methods to share discharge planning; ensure follow-up scheduling; NEMT, etc. Members should receive comprehensive Transitional Care, including appropriate follow-up, when such Member entered and left and Acute care facility or a long-term care setting.<br><br>--reference Exhibit B, Part 4, Care Integration<br><br>ICC Triggering reassessment for events listed in OAR 410-141-3870.<br><br>Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings or episodes of care.<br><br>CCO is responsible for holding Hospitals and specialty service Providers accountable for achieving successful transitions of care. CCO's primary care teams are responsible for transitioning Members | DOMAIN 4: Transitional Care Practices<br><br>DOMAIN 2: Interdisciplinary care teams<br><br>DOMAIN 5. Collaborative Communication tools and processes |

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| | out of Hospital settings into the most appropriate, independent, and integrated care settings, including home and Community-Based as well as Hospice and other palliative care settings. | |
| **HIT and Collective (Use of Event Notifications)** for Hospital Event Notifications (HEN) or Skilled Nursing Facility (SNF) Notifications: This includes addressing increasing provider use of event notifications (HIE roadmap) via Collective tools<br>**CCO Contract: Exhibit J** | CCOs should outline how they will use Event Notifications to foster collaborative care processes [AAA/APD partners are also subscribed to Collective via State Medicaid funds]. Event notifications are a tool for collaboration.<br><br>How will entities begin using new SNF notifications in care coordination processes? | DOMAIN 5. Collaborative Communication tools and processes |
| **Communication to Build Integrated Care:** CCO responsible to facilitate enhanced communication that supports a continuum of care that integrates health services among providers and agencies<br>**OAR 410-141-3860, OAR 410-141-3865** | Ensure documented processes and policies; build collaboration and communication with all providers serving members; applies to achieving ICCP, care coordination and care transition goals; reduce duplication<br><br>Goals of both systems seek to reduce avoidable hospitalizations for members in nursing facilities or receiving HCBS | DOMAIN 2: Interdisciplinary care teams<br><br>DOMAIN 5. Collaborative Communication tools and processes |
| **Wellness/Prevention:** The CCO responsible to enhance Implementation integrated Prevention, Early Intervention, and wellness activities such as chronic disease management or medication management; including outreach to increase preventive screenings/behavioral | Monitor/ensure members are receiving preventive screenings, early intervention and wellness (i.e. Depression screening, flu/shingles/pneumonia shots, medication reconciliation, falls prevention programs) | DOMAIN 2: Interdisciplinary member care teams<br><br>DOMAIN 3: Development and sharing of individualized care plans<br><br>DOMAIN 4: Transitional Care Practices |

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| health assessments<br>**OAR 410-141-3860** | | |
| **Authorization of services:** Recognize unique needs of members with chronic conditions/LTSS services in the way authorization for services occurs<br><br>**OAR 410-141-3835, OAR 410-141-3870** | Contractor shall ensure the services supporting Members with ongoing or chronic conditions, or who require Long-Term care and Long-Term Services and Supports, are authorized in a manner that reflects the Member's ongoing need for such services and supports and do not create a burden to Members needing medications or services to appropriately care for chronic conditions. CCOs shall protect Members against underutilization of services.<br><br>For Members with Special Health Care Needs or receiving Long Term Services and Supports determined through an assessment to need a course of treatment or regular care Monitoring, Contractor shall have a mechanism in place to allow Members to directly access a specialist (for example, through a standing Referral or an approved number of visits), in accordance with and subject to 42 CFR §438.208(c) and as may otherwise be required under this Contract, as appropriate for the Member's condition and identified needs. | DOMAIN 3: Development and sharing of individualized care plans |
| **Building Community Resource Linkages** CCO builds support links/addresses social determinants of health, health equity, or navigating to social service agency supports<br>**OAR 410-141-3860** | Provide assistance in navigating the social systems and in accessing community and social support services such as Oregon Food bank, housing vouchers, etc. | DOMAIN 3: Development and sharing of individualized care plans<br><br>DOMAIN 4: Transitional Care Practices<br><br>Optional Domain A: Linking to Supportive Resources |
| **No Wrong Door: Beneficiary Support Mechanisms** Provide assistance with and links to grievance, appeals and hearings for any Medicaid covered service; navigation assistance | Develop assistance to provide member support with understanding and navigating system, including appropriate parties for services outside CCO scope<br><br>Ensure safety issues are addressed for high-risk members | ANY DOMAIN WHERE APPLICABLE GOALS OUTLINED |

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| **CCO Metrics: H**ow is your CCO-LTSS partnership contributing to targets for key metrics?<br><br>**(See web links to metrics in resources)** | **1.Statewide Quality Metric for CCO: All-cause readmissions**<br><br>**2. Statewide Quality Metric for CCO: Ambulatory care: Avoidable emergency department utilization**<br><br>**3. CCO Incentive Metric: Screening for Depression and Follow-Up Plan**:<br><br>**4. Other Metrics**<br><br>--Disparity Measure: Emergency Department Utilization among Members with Mental Illness<br><br>--CCO Incentive Metric: Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)<br><br>--Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control<br><br>--PQI 01: Diabetes short-term complication admission rate<br><br>--PQI 05: COPD or asthma in older adults admission rate<br><br>--PQI 08: Congestive heart failure admission rate<br><br>--PQI 15: Asthma in younger adults admission rate | Metrics reporting for Annual Report required<br><br>Examples of additional metrics that can be impacted for populations with LTSS through your MOU work. |
| **Alignment with TQS** | Opportunity exists to align targets for improvements with a TQS project. New projects must be submitted in March annually. | https://www.oregon.gov/oha/hpa/dsi-tc/pages/transformation-quality-strategy-tech-assist.aspx<br><br>Review example strategies document |

Additional guidance in CFR § 438.208 Coordination and continuity of care, CCO Contract Exhibit B – Statement of Work – Part 4 – Providers and Delivery System --2. Access to Care, 7. Care Coordination, 8. Care Integration, 9 a. Intensive Care Coordination for Prioritized Populations and Members with Special Health Care Needs

## Required MOU Data Points for Annual Reporting & Measurement Specifics:

Each CCO should develop systems to ensure data is being tracked to be reported annually for calendar year periods. Data will need to be submitted annually on the CCO-APD/AAA MOU Summary Annual Report Table due beginning in March 2022 for the CY2021 contract period. Additional information on measurement specifics are provided in the next section. The only new information required for CY2022 from previous version is in Domain 3: tracking # of members with LTSS that received care plans each month.

<table>
<tr><th>REQUIRED DOMAINS</th><th>Annual Report on Specific Statewide MOU Data Points– [REQUIRED}</th><th>Measurement Specifics:</th></tr>
<tr><td>DOMAIN 1: Prioritization of high needs members</td><td>
# of members with LTSS that prioritization data was shared during each month [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]—calculated by OHA from data submitted above.<br><br>
# of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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</table>
# of APD/AAA referrals to CCO for ICC review [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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</table>
# of completed referrals for ICC review [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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</table>
</td><td>Track any member by month for whom prioritization data shared with APD/AAA office [includes new or updates to data that requires re-prioritization]<br><br>Track referrals to APD/AAA for new LTSS service assessments per month<br><br>Track all referrals received per month from APD/AAA for ICC review (completed referrals include required CCO communication back in specified timeframes)</td></tr>
</table>

<table>
<tr>
<td>DOMAIN 2: Interdisciplinary care teams</td>
<td>
# of members with LTSS that are addressed/staffed via IDT meetings monthly [month/year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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</table>
% of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month<br><br>
total annual IDT meetings completed by CCO-APD/AAA teams<br><br>
% of times consumers participate/attend the care conference (IDT) by month/year
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg.</th></tr>
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</table>
% of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients addressed by CCO by month)
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg.</th></tr>
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</table>
</td>
<td>
Track # members with LTSS that are addressed/staffed via IDT meetings per month<br><br>
IDT Meetings: Track whether your CCO held IDT meetings at least twice per month. [Total months where at least two meetings held/12 = %]<br><br>
Provide total number of IDT meetings held in the year for members with LTSS APD/AAA Teams<br><br>
Care conferences where consumer attends/total care conferences held =% participation<br><br>
LTSS Member Care conferences /total CCO Members with LTSS = % addressed by month
</td>
</tr>
</table>

<table>
<tr>
<td>DOMAIN 3: Development and sharing of individualized care plans</td>
<td>
# of members with LTSS that received individualized care plans during each month [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
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</table>
<br>
% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals
<table>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr>
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</table>
<br>
% 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
<table>
<tr><td colspan="3">Quarter 1</td><td colspan="3">Quarter 2</td><td colspan="3">Quarter 3</td><td colspan="3">Quarter 4</td><td>Annual</td></tr>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr>
<tr><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td></td></tr>
</table>
</td>
<td>
# of members with LTSS that received individualized care plans during each month [Monthly/Year Total]<br><br>
Care plans that have member preferences and goals incorporated from direct communication with member in care planning process/Overall # of care plans completed for members with LTSS by month<br><br>
Active care plans for members with LTSS updated in Quarter & Shared/ Total Active care plans for Members Due For updates in Quarter
</td>
</tr>
<tr>
<td>DOMAIN 4: Transitiona</td>
<td>% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition?</td>
<td>Transitions for members with LTSS where discharge planning & communication with APD/AAA</td>
</tr>
</table>

<table>
<tr>
<td>l care practices</td>
<td>
<table>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr>
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</table>
<br>% transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge?
<table>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr>
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</table>
<br>% CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)?
<table>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr>
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</table>
<br># of Debrief meetings held quarterly to post-conference transitions where transition wasn’t smooth (improvement process approach)? [Q1, Q2, Q3, Q4]
<table>
<tr><td colspan="3">Quarter 1</td><td colspan="3">Quarter 2</td><td colspan="3">Quarter 3</td><td colspan="3">Quarter 4</td><td>Annual</td></tr>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr>
<tr><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td></td></tr>
</table>
</td>
<td>happens prior to discharge/transition divided by total # transitions for members with LTSS per month<br><br>Transitions for members with LTSS where discharge orders were arranged prior to discharge/transition divided by total # transitions for members with LTSS per month<br><br>CCO region to CCO region transfers with documented communication to appropriate APD/AAA offices prior to transfer divided by total # CCO-CCO transitions for members with LTSS per month<br><br>Track Debrief meetings held quarterly to post-conference transitions where transition wasn’t smooth</td>
</tr>
<tr>
<td>DOMAIN 5: Collaborative Communication tools</td>
<td># of CCO Collective Platform HEN notifications monthly result in CCO follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments</td>
<td>Hospital Event Notifications (HEN) which are triggers per month resulting in Follow-up with APD/AAA</td>
</tr>
</table>

| | | |
|---|---|---|
| and processes | <table><tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table><br># of CCO Collective Platform SNF notifications monthly that result in CCO follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments<br><table><tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg.</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table><br>____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). | Skilled Nursing Facility (SNF) Notifications which are triggers per month resulting in Follow-up with APD/AAA<br><br>Documentation: Attach 4 written process documents for each of first four domain communication processes/activities |