

## Summary of Care Coordination Procedures for Marin County DMC-ODS Providers

### References:

[Marin DMC-ODS Provider Exhibit A- Scope of Work](#)

[Marin DMC-ODS County Clinical Practice and Administrative Guidelines](#)

[Drug/Medi-Cal Organized Delivery System \(DMC-ODS\) Standard Terms and Conditions](#)

[State-County Intergovernmental Agreement, Exhibit A, Attachment I, II, E, 3, iii. a – f](#)

### Care Coordination Responsibility

Marin County contracts with 5.0 FTE Recovery Coach/Care Managers to serve as the primary Care Coordinators of beneficiaries in the DMC-ODS. If DMC-ODS treatment providers opt to provide Care Coordination duties while the beneficiary is engaged in their facility, those providers will have Case Management\* as a benefit in their provider contracts.

### Care Coordination Duties of DMC-ODS Providers

#### Overview of Duties

DMC-ODS providers shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall:

1. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.
2. Coordinate the services the Contractor furnishes to the beneficiary:
  - a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
  - b. With the services the beneficiary receives from any other managed care organization [e.g. Partnership Health Plan or Marin Mental Health Plan.
  - c. With the services the beneficiary receives in FFS Medicaid
  - d. With the services the beneficiary receives from community and social support providers.
3. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
4. Share with Marin BHRS, DHCS or other managed care organizations [e.g. Partnership HealthPlan and Marin Mental Health Plan] serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
5. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
6. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

#### Transitions Between Levels of Care

Appropriate Case managers/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an

intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in Marin WITS. *Recovery Coach/Care Managers can also perform these functions in instances where the DMC-ODS Provider does not contract with the County for case management.*

#### Coordination and Linkage with Ancillary Services

The Contractor shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. The Contractor shall screen for and link clients with Medication Assisted Treatment, mental health and physical health, as indicated.

#### **Care Coordination Performance Standards from DMC-ODS Contracts**

- Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.
- At least 80% of beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers
- At least 70% of beneficiary records have documentation of coordination with physical health
- At least 80% of beneficiaries engaged for at least 30 days will have an assigned Primary Care Provider
- At least 80% of beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in place to coordinate care with mental health providers
- At least 70% of beneficiary records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).
- At least 80% of beneficiaries with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services

#### **Monitoring of Case Coordination Requirements**

- Language on Care Coordination requirements are included in DMC-ODS Provider Contracts and the Clinical Practice and Guidelines document [References noted above]
- During beneficiary file reviews, Marin BHRS staff review for evidence of providing the beneficiary with information on how to contact the person/entity responsible for coordinating care and other care coordination requirements
- Marin BHRS staff reviews progress on performance standards through review of the following data: Treatment Perceptions Survey; timely transitions in levels of care; evidence of follow-up post-discharge from DMC-ODS levels of care, etc.
- In FY 2019-20, Marin BHRS added explicit language to the Provider Self-Audit tool pertaining to compliance with the Care Coordination requirements
- During the formal annual onsite Provider monitoring visit, Marin BHRS staff will review documentation pertaining to compliance with Care Coordination requirements

## **\*Case Management**

Service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management can be face-to-face or over the telephone and shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law. The components of case management include:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management;
- Transition to a higher or lower level of SUD care;
- Development and periodic revision of a client plan that includes service activities;
- Communication, coordination, referral, and related activities;
- Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
- Monitoring the beneficiary's progress; and
- Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.