EXHIBIT A - SCOPE OF SERVICES

JULY 1, 2021 – JUNE 30, 2022

Services Provided	**Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) –** *[For DMC-ODS, Service Codes 120 (NTP – All Services), 120-9 (NTP MAT Buprenorphine), 120-10 (NTP MAT Disulfiram) and 120-11 (ODS NTP MAT Naloxone)], 120-3 (Case Management, 120-5 (Recovery Services)* Services shall be provided in accordance with OTP/NTP services and regulatory requirements in accordance with Title 9, Chapter 4. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber. OTP/NTP programs shall offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone, and disulfiram. Services provided as part of an OTP/NTP shall include: assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy, and discharge services. Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional counseling services may be provided. **Out-of-County Dosing**: Contractor shall provide any medically necessary NTP services covered by the California Medi-Cal State Plan to beneficiaries that reside in a county that does not participate in DMC-ODS. Contractor shall submit the claims for those services to the county in which the beneficiary resides (according to MEDS). **Physician Consultation:** *[DMC-ODS Service Code: 120-4].* Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. **Assessments** Face-to-Face: Assessments shall be face-to-face and performed by qualified staffing. If the face-to-face assessment is provided by a certified counselor, the "face-to-face" interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary.

	ASAM Training: Staff performing assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". Re-Assessments: Adult beneficiaries in OTP/NTP programs shall be re-assessed at a minimum of annually, unless there are significant changes warranting more frequent reassessments. ASAM Level of Care data shall be entered into Marin WITS for each assessment and re-assessment and within seven (7) days of the assessment/re-assessment.
Performance Standards	**Access to Care** Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be entered into Marin WITS within seven (7) days of the intake. Performance Standard: • Routine Appointment: First face-to-face appointment shall occur within three (3) business days of initial contact. • Urgent Appointment: First face-to-face visit within 48 hours of the request for urgent conditions. • At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location of services • There are no inequities in timely access to care when stratified by race/ethnicity and gender identity • Timely access data will be entered in Marin WITS within seven (7) days of first contact for 100% of beneficiaries.
	Treatment Initiation and Engagement • At least 85% of beneficiaries have a second treatment visit within 14 days of assessment [initiation] • Of those initiating treatment, at least 75% will have two treatment visits within the next 30 days [engagement] • There are no inequities in treatment initiation and engagement when stratified by race/ethnicity and gender identity
	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. Performance Standard: • 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. • There are no inequities in transitions between levels of care when stratified by race/ethnicity and gender identity

	Care 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 mental and physical health, as indicated. Performance Standard: • There is documentation of physical health and mental health screening in 100% of beneficiary records • 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 85% of beneficiaries will contact information for a designated contact responsible for coordinating the beneficiary's care
	Culturally Responsive Services Contractors are responsible to provide culturally responsive services. Contractors must ensure: • Policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to- day operations. • Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary. • Each program reviews monthly performance data (automated reports sent from Marin WITS monthly) and identifies and implements at least one performance improvement initiative annually to address to any inequities noted either in the monthly dashboard or Treatment Perceptions Survey data. Performance Standard: • 100% of beneficiaries that speak a threshold language are provided services in their preferred language. • At least 80% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services. • 100% of contractors will implement at least one performance improvement initiative annually related to reducing inequities by race/ethnicity or gender identity. • 100% of contractors are in compliance with the CLAS standards.

	Delivery of Individualized and Quality Care Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually. Evidence-Based Practices (EBPs): Contractors will implement—and assess fidelity to—at the least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education. ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in Marin WITS with seven (7) days of the assessment. Performance Standards: • At least 80% of beneficiaries will report an overall satisfaction score of at least 3.5 or higher on the Treatment Perceptions Survey • Overall satisfaction scores are balanced when stratified by race/ethnicity and gender identity • At least 80% of beneficiaries completing the Treatment Perceptions Survey reported that they were involved in choosing their own treatment goals (overall score of 3.5+ out of 5.0) • Contractor will implement with fidelity at least two approved EBPs • 100% of beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care • At least 70% of beneficiaries admitted to treatment do so at the ASAM level of care recommended by their ASAM assessment • At least 80% of beneficiaries are re-assessed within 90 days of the initial assessment
Client Outcomes	In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that will be evaluated and measured include, but are not limited to: • Engagement in the first 30 days of treatment (at least two treatment sessions within 30 days after initiating treatment) • Reduction in substance use • Reduction in criminal activity or violations of probation/parole and days in custody • Increase in employment or employment (and/or educational) skills • Increases in family reunification • Increase engagement in social supports • Maintenance of stable living environments and reduction in homelessness • Improvement in mental and physical health status • Beneficiary satisfaction

	These metrics will be analyzed by program and at a minimum, stratified by race/ethnicity and gender identity
Training	Applicable staff are required to participate in the following training: • DMC-ODS Training, including Documentation Standards (At least annually) • Information Privacy & Security - Including 42 CFR Part 2 and HIPAA/Law and Ethics (At least annually) • ASAM E-modules 1 and 2 (Prior to Conducting Assessments) • Cultural Competency (At least four hours annually) • Oath of Confidentiality (Review and sign at hire and annually thereafter) • At least five hours of continuing education in addiction medicine annually for LPHA staff • Marin WITS and CalOMS Treatment (Prior to Use of Marin WITS and thereafter as needed)
Program Licensure, Certification and Standards	Practice Guidelines: Contractor shall comply with the BHRS Clinical and Administrative Practice Guidelines, which are located at www.MarinHHS.org/BHRS. Contractor shall possess valid DHCS Alcohol and Drug Licensure and Certification, and DHCS DMC certification for the contracted level of care.
Beneficiary Protections and Beneficiary Informing Materials	Beneficiary Informing Materials Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the following materials: DMC-ODS Beneficiary Booklet and Provider Directory. The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed. Grievance and Appeals Contractor shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and stamped self-addressed (addressed to the County) envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. Completed Grievance/Appeal Form should be returned or mailed to: BHRS Quality Management Unit 20 N. San Pedro Rd., San Rafael, CA 94903 The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed. Refer to 42 CFR 438.10(g)(2)(xi) for additional information about the grievance and appeal system. Notice of Adverse Benefit Determination (NOABD) Contractor shall have written procedures to ensure compliance with the County's NOABD Procedure as outlined in 'NOABD Process' located on the County website marinhhs.org/substance-use-services-contractor-resources; including the following: • Contractor shall request consent from beneficiaries for the County of Marin to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. Should a beneficiary

	refuse to consent, then the Contractor is responsible for issuing any applicable NOABD directly to the beneficiary. • Contractor shall log the NOABD on the 'Provider NOABD Log' and submit by the 10th of each month via encrypted email to the County SUD Admin Team with copies of the issued NOABDs.
Contract Changes	If significant changes are expected, you must submit a request in writing to the contract manager. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to: <u>Scope of Work</u> • Proposing to re-distribute units of service between existing service codes by more than 20% • Proposing to add or remove a service modality • Proposing to transfer substantive programmatic work to a subcontractor • Proposing to provide any services by telephone or field-based <u>Budget</u> • Proposing to re-distribute more than 20% between budget categories • Proposing to increase or decrease FTE • Proposing to increase the contract maximum Contractor shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures (www.MarinHHS.org/policies-procedures) and Practice Guidelines (www.MarinHHS.org/Substance-Use-Services-Contractor-Resources), including, but not limited to: 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries or 90% capacity (facility at capacity).
Medi-Cal Administrative Activities	• Funds in the OTP/NTP contract that are eligible for CPE under the MAA program shall be used toward MAA claimable activities. MAA claimable activities are outlined in the MOU between the County and Marin Treatment Center. Examples of funding streams that may be eligible include County General Fund and Mental Health Services Act. • If there is any portion not used to support MAA claimable activities, the contractor is responsible to notify the County Contract Manager within 30 days of the end of the Fiscal Year. • Failure to fully utilize claimed eligible funds for MAA claimable activities will result in a corresponding reduction in CPE available as match to MAA for the contractor. • Funds/contributions will be expended as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51 for allowable administrative activities and these claimed expenditures have not been nor will not subsequently be used for federal match in the MAA or any other program.