

EXHIBIT A - SCOPE OF SERVICES

CARE COORDINATION AND RECOVERY SERVICES

JULY 1, 2022 – JUNE 30, 2023

Services Provided	<p>Care Coordination: <i>[Service Code: 68]</i>. Care coordination shall be provided to a client in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. DMCODS Counties, through executed memoranda of understanding, shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care coordination can be provided in clinical or nonclinical settings (including the community) and can be provided face-to-face, by telehealth, or by telephone. Care coordination includes one or more of the following components:</p> <ul style="list-style-type: none">• Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.• Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.• Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups. <p>Recovery Services: <i>[Service Code 32]</i>. Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary’s central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Services may be provided in person, by telehealth, or by telephone. Recovery Services can be delivered and claimed as a standalone service, or as a service delivered as part of other levels of care. Recovery Services include the following service components:</p> <ul style="list-style-type: none">• Assessment• Care Coordination• Counseling (individual and group)• Family Therapy
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- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
- Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.

Contingency Management: *[HCPCS Code: H0050 with HF Modifier]*. Contingency Management (CM) is an evidence-based treatment that provides incentives to treat people with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual, positive behavioral change, as evidenced by drug tests negative for stimulants.

CM Coordinator activities include:

- Providing instruction to the client regarding the CM process and protocol
- Distribution of urine drug tests (UDTs) to client
- Providing instruction to the client for UDT procedures
- Monitoring the UDT process and reading the test results (including verification of any tampering)
- Providing the test results to the client
- Entering the test results into the web-based or mobile incentive management software program
- Verifying receipt or providing incentive (such as printing of incentive gift card)
- Making referrals as necessary to clinical staff based on testing results

Assessments: Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.

The initial assessment shall be performed face-to-face, by telehealth ("telehealth" throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home. If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

Re-Assessments: Assessments shall be updated as clinically appropriate when the beneficiary's condition changes.

	<p>ASAM Training: Staff performing assessments shall complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.</p>
<p>Telehealth</p>	<p>If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the patient record the provision of this information and the patient’s verbal or written acknowledgment that the information was received.</p>
<p>Performance Standards</p>	<p>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.</p> <p>Performance Standard:</p> <ul style="list-style-type: none"> • Routine Appointment: First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact. • Urgent Appointment: First face-to-face visit within 48 hours of the request for urgent conditions. • 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. <p>Transitions Between Levels of Care Appropriate Care coordinators/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.</p> <p>Performance Standard:</p> <ul style="list-style-type: none"> • 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. Contractors will implement procedures to ensure clients are provided contact information for their assigned Care Coordinator(s) and document in the client record.

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

Medications for Addiction Treatment

Contractors will either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for beneficiaries with SUD diagnoses that are treatable with medications or biological products. Contractor staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent a 42 CFR, Part 2 compliant release of information for this purpose.

Performance Standard:

- At least 80% of beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders will have 42 CFR compliant releases in place to coordinate care
- At least 80% of beneficiaries with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services

Culturally Responsive Services

Contractors are responsible to provide culturally responsive services. Contractors must ensure that their 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.

Performance Standard:

	<ul style="list-style-type: none"> • 100% of beneficiaries that speak a threshold language are provided services in their preferred language. <p>Delivery of Individualized and Quality Care</p> <p><u>Evidence-Based Practices (EBPs)</u>: Contractors will implement with fidelity at least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education.</p> <p><u>ASAM Level of Care Determination</u>: The ASAM Criteria shall be used to determine placement into the appropriate level of care for all beneficiaries and is separate and distinct from determining medical necessity.</p> <ul style="list-style-type: none"> a. For beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary’s first visit with an LPHA or registered/certified counselor. b. For beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary’s first visit with an LPHA or registered/certified counselor. c. A full ASAM Criteria Assessment is not required to deliver prevention and early intervention services for beneficiaries under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5). d. If a beneficiary withdraws from treatment prior to completing the ASAM Criteria assessment and later returns, the time period starts over. e. A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services. f. A full ASAM assessment does not need to be repeated unless the beneficiary’s condition changes. <p>Beneficiary placement and level of care determinations shall ensure that beneficiaries are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition. 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.</p> <p>Performance Standards:</p> <ul style="list-style-type: none"> • 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 • 100% of beneficiaries are re-assessed within 90 days of the initial assessment
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,

	<p>the following indicators that will be evaluated and measured include, but are not limited to:</p> <ul style="list-style-type: none"> • Engagement in the first 30 days of treatment, as applicable • 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
Training	<p>Applicable staff are required to participate in the following training:</p> <ul style="list-style-type: none"> • DMC-ODS Training, including Documentation Standards (At least annually) • Information Privacy and Security – Including 42CFR Part 2 and HIPAA/Law & Ethics (At least annually) • ASAM E-modules 1 and 2 (Prior to Conducting Assessments) • Cultural Humility (At least four hours annually) <ul style="list-style-type: none"> a. One Cultural Humility training (annually) b. Once LGBTQ+ training (annually) c. One Working with Interpreters training (Bi-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, including Medical Director • Marin WITS and CalOMS Treatment (Prior to Use of Marin WITS and thereafter as needed) • Recovery Coaches may bill for an additional 16 hours of work-related professional development trainings per fiscal year. This does not include trainings referenced and required within this contract.
Program Licensure, Certification and Standards	<p>Contractor shall be linked to a valid DHCS DMC certified facility.</p> <p>Contractor shall be a certified Alcohol and Drug Counselor (certified from a DHCS approved body) in good standing and must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.</p> <p><u>Practice Guidelines:</u> Contractor shall comply with the BHRS Clinical and Administrative Practice Guidelines, which are located at www.MarinBHRS.org</p>
Beneficiary Protections and Beneficiary Informing Materials	<p><u>Beneficiary Informing Materials</u></p> <p>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.</p> <p><u>Grievance and Appeals</u></p>

	<p>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: BHRM Quality Management Unit, 20 N. San Pedro Rd., San Rafael, CA 94903</p> <p>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.</p> <p><u>Notice of Adverse Benefit Determination (NOABD)</u> Contractor shall have written procedures to ensure compliance with the County’s NOABD Procedure as outlined in ‘NOABD Process’ located on the County website MarinBHRM.org; including the following:</p> <ul style="list-style-type: none"> • 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.
<p>Contract Changes</p>	<p>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:</p> <p><u>Scope of Work</u></p> <ul style="list-style-type: none"> • 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 <p><u>Budget</u></p> <ul style="list-style-type: none"> • Proposing to re-distribute more than 20% between budget categories • Proposing to increase or decrease FTE • Proposing to increase the contract maximum <p>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.MarinBHRM.org), 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).</p>