EXHIBIT A – SCOPE OF SERVICES

CARE COORDINATION AND RECOVERY SERVICES

JULY 1, 2023 – JUNE 30, 2024

Services Provided	**Care Coordination:** *Non-DMC-ODS Service Code: 68; DMC-ODS: Refer to Exhibit B for HCPCS/CPT Codes].* 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. Standalone Care Coordination refers to providing care coordination services to a beneficiary who is not actively receiving treatment at a level of care (e.g. they are attempting to engage in treatment or the providers are coordinating a referral). Standalone Care Coordination services can be provided for up to 30 days during the initial assessment period (or up to 60 days if the beneficiary is experiencing homelessness or under 21 years of age). DMC-ODS 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: • 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. **Recovery Services: [***Non-DMC-ODS: Service Code 32; DMC-ODS: Refer to Exhibit B for HCPCS/CPT Codes]* 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: • Assessment • Care Coordination • Counseling (individual and group) • Family Therapy • 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
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 the BHRS EHR within seven (7) days of the intake. Performance Standard: • 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 the BHRS EHR within seven (7) days of first contact for 100% of beneficiaries.
	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 the BHRS EHR. 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. 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. An effective referral mechanism/process is defined as facilitating access to MAT off-site for beneficiaries while they are receiving services if not provided on-site. Providing a beneficiary the contact information for a

	treatment program is insufficient. 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: • 100% of beneficiaries that speak a threshold language are provided services in their preferred language.
	Delivery of Individualized and Quality Care The assessed and actual level of care (and justification if the levels differ) shall be recorded in the BHRS EHR within seven (7) days of the assessment. Performance Standards: • 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, the following indicators that will be evaluated and measured include, but are not limited to: • 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	Applicable staff are required to participate in the following training: • DMC-ODS Training (Within 30 days of the initial contract start date and at least annually) • Compliance, Information Privacy and Security – Including 42CFR Part 2 and HIPAA/Law & Ethics (Within 30 days of the initial contract start date and t least annually) • ASAM E-modules 1 and 2 (Prior to Conducting Assessments) • Cultural Humility (At least four hours annually) a. One Cultural Humility training (annually) b. Once LGBTQ+ training (annually) c. One Working with Interpreters training (Bi-annually) d. One Unconscious Bias training (annually) • Oath of Confidentiality (Review and sign at contract start and annually thereafter) • At least five hours of continuing education in addiction medicine annually for LPHAs, including Medical Director • Preventing Discrimination, Harassment and Retaliation Training (within 30 days of contract start and every two years) • BHRS EHR and CalOMS Treatment (Prior to Use of EHR and thereafter as needed) • CalMHSA CalAIM Trainings – Including documentation requirements, CPT code training, EHR and other applicable trainings (within 30 days of contract start date) • Naloxone Training (Within 30 days of contract start date and thereafter as needed) Contractors shall maintain training logs, including maintaining pertinent evidence of training completion. Contractors shall also submit evidence of training during the November and May Training and Staff Certification Log submission periods, or at additional times upon request. 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	Contractor shall be linked to a valid DHCS DMC certified facility and meet all Credentialing requirements outlined in Policy BHRS-28. 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. Practice Guidelines: Contractor shall comply with the BHRS Clinical and Administrative Practice Guidelines, which are located at www.MarinBHRS.org
Digital Accessibility	Vendor shall ensure that all digital content and deliverables comply with World Wide Web Consortium's (W3C) Web Content Accessibility Guidelines (WCAG), 2.1, level AA or most recent version. Vendor is responsible for addressing accessibility problems in any implementation, configuration, or documentation delivered or performed by Vendor, and in

	any software, documents, videos, and/or trainings given and published by Vendor and delivered under this contract. Applicable laws include but are not limited to Americans with Disabilities Act, 21st Century Communications and Video Accessibility Act (CVAA) and California Government Code Sections 7405 and 11135.
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 add or remove a service modality and/or CPT/HCPCS code • Proposing to transfer substantive programmatic work to a subcontractor <u>Budget</u> • Proposing to increase or decrease hours • 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.MarinBHRS.org), Exhibit I and Practice Guidelines (www.MarinBHRS.org), including, but not limited to: 1) Contractor Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents or change in status that could affect contracted duties; 4) Reduction in DMC services; and 5) Not accepting beneficiaries or 90% capacity (facility at capacity).
Documentation	In addition to the documentation requirements outlined in Exhibit I: • All clinical documentation shall be entered into the BHRS Electronic Health Record • Other requested documentation, such as the client census and status, shall be submitted in the required timeframe using the template provided by the County

EXHIBIT A - SCOPE OF SERVICES: PROGRAM REPORTING

DOCUMENT TITLE	DUE DATE	WHERE SUBMITTED	SUBMISSION FORMAT
Ongoing/ As Needed			
Not Accepting New Beneficiaries	By 9am each day that the program is not accepting new beneficiaries	BHRS Access and Contract Manager	E-mail
Reached 90% of treatment capacity	Within seven days (and via DATAR by the 10th of the month)	County AOD Administrator and DHCSPerinatal@dhcs.gov	E-mail
EHR (CalOMS) - Client-specific data - DMC Billing - ASAM, Timely Access Data, etc.	Progress notes for routine services within 3 business days; Other client-specific data should occur within 7 days of event	Marin Electronic Health Record Technical Assistance: BHRSEHRSupport@MarinCounty.org CalMHSA Help Desk Contract Manager	Electronic Submission
Adult Drug Court Weekly Progress Reports	By 12 noon every Thursday	ADC Coordinator (Jaclynn Davis) jadavis@marincounty.org and ADC Recovery Coach	Encrypted E-mail
Staff Update Form/ Provider Update	Prior to or within 24 hours of the staff change [e.g. new or separating staff, role change]	Existing Users: BHRSEHRSupport@marincounty.org New Users: TBD	E-mail
Monthly Submission			
Monthly Provider Check and attestation	By the 10th of the month	BHRS Office – Administrative Services Associate	E-mail
All Billing Invoices and Supporting Documentation	By the 10th of the month	EHR and BHRS Office (as applicable)	Electronic Submission
Drug and Alcohol Treatment Access Report (DATAR)	By the 10th of the month	State DHCS	Electronic Submission
Resubmission of Denied DMC Claims	By the 20th of the month following notice of denial	Marin Electronic Health Record	Electronic Submission
NOABD Log and Issued NOABDs	By the 10th of the month	BHRS Office – Administrative Services Associate	E-Mail
Annual Submission			
Provider Self Audit	Projected January 2024	BHRS Office – Contract Manager	Electronic Submission
Annual Report	Projected June 30, 2024	BHRS Office – Quality Management. Copy to Contract Manager	E-mail or Hard Copy
Provider Cost Reports	To Be Determined	Marin HHS - Fiscal	TBD