

EXHIBIT A - SCOPE OF SERVICES (OUTPATIENT)

Contractor Information	
Contractor Name	Insert Name of Contractor Agency
Contract Period	FY 2023-24
Contractor NPI	Insert Contractor Agency NPI
Contractor Taxonomy	Insert Contractor Taxonomy
Contractor Tax ID (or EIN)	Insert Contractor Tax ID
Contractor Legal Entity Number	Insert the Legal Entity Number of Contractor Agency
Contractor Executive Director	Insert Name of Executive Director
Contractor Medical Director	Insert Name of Medical Director
Owner Name:	Insert Name of owner(s)
Percent of Ownership:	List Percentage of each owner by each owner
Ownership Code:	(use 274 expansion code)

Program Profile: Complete a Program Profile for Each Contracted Site	
Program Name	Insert Program Name
Service Location(s)	Insert Addresses for Service Delivery sites
ASAM/DHCS Level(s) of Care	Insert Levels of Care
Evidence Based Practices (EBPs)	Select EBPs Utilized for Contracted Services <input type="checkbox"/> Motivational Interviewing <input type="checkbox"/> Cognitive Behavioral Therapy <input type="checkbox"/> Relapse Prevention <input type="checkbox"/> Trauma-Informed Treatment <input type="checkbox"/> Psycho-Education <input type="checkbox"/> Contingency Management
Population Served (Check all that apply)	<input type="checkbox"/> 12 – 17 years <input type="checkbox"/> 18+ years <input type="checkbox"/> Other
Program NPI	Insert Program NPI
Program Taxonomy	Insert Program Taxonomy
DHCS Provider ID (6-Digit)	Insert Provider ID
DMC Certification Number	Insert DMC Certification Number
Hours of Operation	Insert Hours of Operation
Count of Licensed Beds:	Insert Count of Licensed Beds (if applicable)
Language Line Available	<input type="checkbox"/> Yes <input type="checkbox"/> No

Assistive Aid:	Indicate if this location is ADA accessible and/or has TDD equipment
Assistive Transportation:	(Distance between site and the closest public transport) <input type="checkbox"/> Less than 0.25 miles <input type="checkbox"/> Between 0.25 and 0.5 miles, <input type="checkbox"/> Between 0.5 and 1 miles <input type="checkbox"/> More than 1 mile
Telehealth Capacity:	<input type="checkbox"/> Telehealth Only <input type="checkbox"/> In-Person Only <input type="checkbox"/> Hybrid (Telehealth and In-Person)
Capacity of Medi-Cal:	(Maximum number of Medi-Cal beneficiaries this location can serve)
Teaching Facility:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Facility Type:	(use 274 expansion codes)
Institutional Facility Type:	(use 274 expansion codes)

EXHIBIT A - SCOPE OF SERVICES (OUTPATIENT)

<p>Services Provided</p>	<p>Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5): Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (commonly known as Screening, Brief Intervention, and Referral to Treatment, or SBIRT) is not a DMC-ODS benefit. It is a benefit in Medi-Cal Fee-for-Service and Medi-Cal managed care delivery system for beneficiaries aged 21 years and older.</p> <p>Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. Any beneficiary under the age of 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. As noted above, this does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services”. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services.</p> <p>A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used. If the beneficiary under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed, and the beneficiary shall receive a referral to the appropriate level of care indicated by the assessment.</p> <p>Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone.</p> <p>Outpatient Services (ASAM Level 1) [<i>Non-DMC Service Codes: 33 (Group), 34 (Individual); Refer to Exhibit B for HCPCS/CPT Codes</i>]. Outpatient treatment services are provided to beneficiaries when medically necessary (offering up to nine hours a week for adults, and six hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers are required to either offer medications for addiction treatment (MAT, also known as medication-assisted treatment) directly, or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is</p>
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insufficient). Outpatient treatment services (also known as Outpatient Drug Free or ODF) include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

Intensive Outpatient Treatment (IOT) (ASAM Level 2.1) *[Non-DMC Service Code: 30; DMC-ODS Service Code: Refer to Exhibit B for HCPCS/CPT Codes]*. Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment (offering a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Intensive Outpatient Treatment Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

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. 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.

Contractor shall have procedures for: 1) obtaining releases/consents to exchange information with applicable mental health/primary care providers; 2) linking beneficiaries to and coordinating with applicable mental health and primary care providers; and 3) providing beneficiaries the contact information of their assigned Care Coordinator.

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.

Peer Support Services: *[Refer to Exhibit B for HCPCS/CPT Codes]*. Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other people supporting the beneficiary (defined as collaterals) if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. Peer Support Services are delivered and claimed as a standalone service. Beneficiaries may concurrently receive Peer Support Services and services from other levels of care. Peer support services are based on a plan of care approved by a Behavioral Health Professional (see definition of Behavioral Health Professional below; this term is specific to the administration of Peer Support Services). Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity services as defined below:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement services means activities and coaching led by Peer Support Specialists to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

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.

Medi-Cal beneficiaries will participate in a structured 24-week outpatient CM program, followed by six or more months of additional recovery support services. DHCS' CM program is intended to complement SUD treatment services and other EBPs for StimUD already offered by DMC-ODS providers. Consistent with other DMC-ODS programs, DHCS intends CM to be implemented in a culturally responsive and accessible way for program participants.

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

SUD providers offering outpatient, intensive outpatient, NTPs and/or partial hospitalization services that are licensed and certified to provide Medi-Cal and DMCODS services will be eligible to offer CM. SUD providers will be required to offer accompanying SUD treatment services and EBPs for StimUD in addition to CM. Eligible programs will need to outline the array of EBPs and services they will deliver in conjunction with CM, which may include, but are not limited to:

- Individual, group or family counseling using modalities such as the following: CBT; CRA; Motivational interviewing; Trauma-informed therapy; Matrix Model; Treatment and Recovery for Users of Stimulants (TRUST) protocol; Additional evidence-based modalities
- MAT
- Patient education
- Care coordination
- Peer supports
- Withdrawal management
- Recovery services

Clinician Consultation: *[DMC-ODS Service Code: Refer to Exhibit B for HCPCS/CPT Codes].* Clinician Consultation consists of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction

	<p>psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to DMC-ODS beneficiaries. Rather, Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries. DMC-ODS Counties may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services. These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.</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’s Electronic Health Record 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 • First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur within three (3) business days. • At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location and time of services • Timely access data will be entered in Marin’s Electronic Health Record within seven (7) days of first contact for 100% of beneficiaries. <p>Treatment Initiation and Engagement</p> <ul style="list-style-type: none"> • 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 <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’s Electronic Health Record.</p>

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:

- 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’s Electronic Health Record 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 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.

ASAM Level of Care: The assessed and actual level of care (and justification if the levels differ) shall be recorded in Marin’s Electronic Health Record 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

	<ul style="list-style-type: none"> • 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
Outcomes	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>These metrics will be analyzed by program and at a minimum, stratified by race/ethnicity and gender identity</p>
Training	<p>Applicable staff are required to participate in the following training:</p> <ul style="list-style-type: none"> • DMC-ODS Training (within 30 days of hire and at least annually) • Compliance, Information Privacy and Security – Including 42CFR Part 2 and HIPAA/Law & Ethics (Within 30 days of hire and 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"> ○ One Cultural Humility training (annually) ○ Once LGBTQ+ training (annually) ○ 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’s Electronic Health Record and CalOMS Treatment (Prior to Use of Marin Electronic Health Record and thereafter as needed) • CalMHSA CalAIM Trainings – Including documentation requirements, CPT code training, EHR and other applicable trainings (within 30 days of hire) • Naloxone Training – Ensure at least one staff member, at all times, on the premises who knows the location of naloxone or other FDA-approved opioid antagonist medication, and who has been trained in its administration.

	<p>Contractors shall maintain training logs for all staff, including maintaining pertinent evidence of training completion in personnel files. 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.</p>
Digital Accessibility	<p>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.</p>
Contract Changes	<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 add or remove a service modality and/or CPT/HCPCS code • Proposing to transfer substantive programmatic work to a subcontractor • Proposing to add or remove rendering provider types • Demand for Marin Medi-Cal beneficiaries exceed contracted capacity <p><u>Budget</u></p> <ul style="list-style-type: none"> • 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.MarinBHRS.org), Contract Exhibit I and Practice Guidelines (www.MarinBHRS.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>
One-Time Electronic Health Record (EHR) Documentation Adoption Incentive Payments	<p>One-Time Electronic Health Record (EHR) Documentation Adoption Incentive Payments are a one-time incentive provided to Contractor for utilizing the Marin County instance of <i>SmartCare</i> as their EHR for Marin County Beneficiaries and having their rendering providers/clinicians document into <i>SmartCare</i> in accordance with the Documentation Standards outlined in Exhibit I and the Clinical Documentation Guide. This will enable better care coordination between the county and the provider. Contracted agencies that have their staff only enter the service level billing and state reporting data will not qualify for this incentive.</p>

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 10 th 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 calendar 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 10 th of the month	BHRS Office – Administrative Services Associate	E-mail
All Billing Invoices and Supporting Documentation	By the 10 th of the month	EHR and BHRS Office (as applicable)	Electronic Submission
Drug and Alcohol Treatment Access Report (DATAR)	By the 10 th of the month	State DHCS	Electronic Submission
Resubmission of Denied DMC Claims	By the 20 th of the month following notice of denial	Marin Electronic Health Record	Electronic Submission
NOABD Log and Issued NOABDs	By the 10 th 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