EXHIBIT A - SCOPE OF SERVICES

RESIDENTIAL AND RESIDENTIAL WITHDRAWAL MANAGEMENT

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** ☐ Motivational Interviewing ☐ Cognitive Behavioral Therapy ☐ Relapse Prevention ☐ Trauma-Informed Treatment ☐ Psycho-Education ☐ Contingency Management
Population Served (Check all that apply)	☐12 – 17 years ☐ 18+ years ☐ 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	☐ Yes ☐ 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) ☐ Less than 0.25 miles ☐ Between 0.25 and 0.5 miles, ☐ Between 0.5 and 1 miles ☐ More than 1 mile
Telehealth Capacity:	☐ Telehealth Only ☐ In-Person Only ☐ Hybrid (Telehealth and In-Person)
Capacity of Medi-Cal:	(Maximum number of Medi-Cal beneficiaries this location can serve)
Teaching Facility:	☐ Yes ☐ No
Facility Type:	(use 274 expansion codes)
Institutional Facility Type:	(use 274 expansion codes)

EXHIBIT A - SCOPE OF SERVICES

RESIDENTIAL AND RESIDENTIAL WITHDRAWAL MANAGEMENT

<table>
<tr>
<td>Services Provided</td>
<td>Residential Withdrawal Management Services
Withdrawal Management Services are provided to beneficiaries experiencing withdrawal in the following residential settings:

Level 3.2-WM: Clinically managed residential withdrawal management (24- hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)
[DMC-ODS Service Code: 109 & DMC-ODS Room & Board: 58 / HCPCS H0012]

Withdrawal Management Services include the following service components:

Assessment
Care Coordination
Medication Services
MAT for OUD
MAT for AUD and other non-opioid SUDs
Observation
Recovery Services

Withdrawal Management Services may be provided in an outpatient, residential or inpatient setting. If beneficiary is receiving Withdrawal Management in a residential setting, each beneficiary shall reside at the facility. All beneficiaries receiving Withdrawal Management services, regardless in which type of setting, shall be monitored during the detoxification process. Providers are required to either offer MAT directly, or have effective referral mechanisms to the most clinically appropriate MAT services in place (defined as facilitating access to MAT off-site for beneficiaries while they are receiving withdrawal management services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).

Withdrawal management services are urgent and provided on a short-term basis. When provided as part of withdrawal management services, service activities, such as the assessment, focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate. If it has not already been completed in relation to the Withdrawal Management episode, the full ASAM Criteria assessment shall be completed within 30 days of the beneficiary’s first visit with an LPHA or registered/certified counselor for non-Withdrawal Management services (or 60 days for beneficiaries under 21, or beneficiaries experiencing homelessness), as described above.</td>
</tr>
</table>

Residential Treatment Services

Residential Treatment Services are delivered to beneficiaries when medically necessary in a short-term residential program corresponding to at least one of the following levels:

- Level 3.1 - Clinically Managed Low-Intensity residential Services
  [*DMC-ODS Service Code: 112 & DMC-ODS Room & Board: 58 / HCPCS H0019.*

- Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
  [*DMC-ODS Service Code: 113 & DMC-ODS Room & Board: 58/ HCPCS H0019.*

- Level 3.5 - Clinically Managed High Intensity Residential Services
  [*DMC-ODS Service Code: 114 & DMC-ODS Room & Board: 58 / HCPCS H0019.*

All Residential services provided to a client while in a residential treatment facility may be provided in person, by telehealth, or telephone. Telehealth and telephone services, when provided, shall supplement, not replace, the in-person services and the in-person treatment milieu; most services in a residential facility shall be in-person. A client receiving Residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. Each client shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Providers are required to either offer MAT directly, or have effective referral mechanisms in place to clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving residential treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).

Residential Treatment Services:
Residential Treatment services for adults in ASAM Levels 3.1, 3.3., and 3.5 are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health (DPH), and Freestanding Acute Psychiatric Hospitals (FAPHs) licensed by DPH.

All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria. Residential treatment facilities licensed by DHCS offering ASAM levels 3.1, 3.3, 3.5, and 3.2-WM must also have a DHCS Level of Care (LOC) Designation and/or an ASAM LOC Certification that indicates

	that the program is capable of delivering care consistent with the ASAM Criteria In order to participate in the DMC-ODS program and offer ASAM Levels of Care 3.1, 3.3, or 3.5, residential providers licensed by a state agency other than DHCS must be DMC-certified. In addition, facilities licensed by a state agency other than DHCS must have an ASAM LOC Certification for each level of care provided by the facility under the DMC-ODS program by January 1, 2024. DMC-ODS counties will be responsible for ensuring and verifying that DMC-ODS providers delivering ASAM Levels of care 3.1, 3.3 or 3.5 obtain an ASAM LOC Certification for each level of care provided effective January 1, 2024. Residential Treatment services can be provided in facilities of any size. The statewide goal for the average length of stay for residential treatment services provided by participating counties is 30 days. The goal for a statewide average length of stay for residential services of 30 days is not a quantitative treatment limitation or hard "cap" on individual stays; lengths of stay in residential treatment settings shall be determined by individualized clinical need. Contractors shall ensure that beneficiaries receiving residential treatment are transitioned to another level of care when clinically appropriate based on treatment progress. DMC-ODS Counties shall adhere to the length of stay monitoring requirements set forth by DHCS and length of stay performance measures established by DHCS and reported by the external quality review organization. Residential Treatment Services include the following services: • Assessment • Care Coordination • Counseling (individual and group) • Family Therapy • Medication Services • MAT for OUD • MAT for AUD and other non-opioid SUDs • Patient Education • Recovery Services • SUD Crisis Intervention Services **Care Coordination:** *[Non-DMC: Service Code: 68 / 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. If claimed as a standalone service, it cannot be built into the daily rate and Contractor shall have procedures describing what is included in the Residential and Care Coordination rates and how tracking to ensure no duplication of services or claiming. 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: Service Code 32 / 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. **Clinician Consultation [***Refer to Exhibit B for HCPCS/CPT Codes]* Clinician Consultation consists of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction 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. **Re-Assessments** Adult beneficiaries in Residential treatment shall be re-assessed at a minimum of every 45 days. Youth beneficiaries in Residential treatment shall be re-assessed at a minimum of every 30 days, unless there are significant changes warranting more frequent reassessments. ASAM Level of Care data shall be entered into Marin's Electronic Health Record 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's Electronic Health Record within seven (7) days of the intake. Performance Standard: • Routine Appointment: First face-to-face or telehealth appointment shall occur within five (5) and no later than 10 business days of initial contact. First face-to-face or telehealth Medication Assisted Treatment appointments for beneficiaries with alcohol or opioid disorders shall occur within three (3) business days. • 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 • At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location 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.

	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 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: • 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 receive a follow-up contact within seven (7) days of discharge from Residential treatment or Residential Withdrawal Management. • 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.

<table>
<tr><td></td><td>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
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</td></tr>
<tr><td>Client Outcomes</td><td>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</td></tr>
<tr><td>Training</td><td>Applicable staff are required to participate in the following training:
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)
a. One Cultural Humility training (annually)
b. Once LGBTQ+ training (annually)</td></tr>
</table>

	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's Electronic Health Record and CalOMS Treatment (Prior to Use of Marin's 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.
	• Residential Withdrawal Management (WM) Providers: Personnel providing, monitoring or supervising the provision of WM services shall complete the following:
	    o Certified in cardiopulmonary resuscitation
	    o Certified in first aid
	    o Trained in the use of Naloxone
	    o Six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of WM services.
	    o Repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment.
	    o Eight (8) hours of training annually that covers the needs of residents who receive WM services.
	
	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.

Authorization Process – ASAM/DHCS Levels 3.1, 3.3 and 3.5	**Initial Authorization** Requests for initial authorization are to be submitted to BHRS on the Treatment Authorization Request (TAR) – '*Initial Authorization'* form at least 24 hours before the scheduled admission date. A copy of the ASAM Continuum or County-provided ASAM assessment tool shall be attached to the TAR. Initial authorizations can be granted for up to 30 days for youth and up to 45 days for adults. An approved authorization allows for a client to be admitted to treatment within seven (7) calendar days of the approval date. Admissions later than seven (7) calendar days from the authorization date will be considered on a case-by-case basis and will require written approval by the County. **Continuing and Extension Authorizations** Requests for continuing and extension authorizations are to be submitted to BHRS Access on the 'TAR – *Continuing Authorization'* form seven (7) calendar days before to the expiration date of the current authorization. A copy of the re-assessment (ASAM Continuum or County-provided ASAM

	assessment tool) shall be attached to the TAR. Continuation authorizations can be granted for up to 30 days for youth and up to 45 days for adults. Extension authorizations can be granted for up to 30 days for both youth and adults. Clients' residential length of stay will be based on medical necessity. **Additional Information - TARs** For a TAR to be considered eligible for authorization, the individual must be a Marin County Medi-Cal beneficiary or Marin County low-income (<138% FPL) uninsured resident, meet medical necessity and the ASAM criteria for the proposed level of care. Payment and submission of claims to Medi-Cal are subject to a beneficiary's eligibility and services being rendered and documented in accordance with ODS Documentation Standards, ASAM diagnostic and dimensional criteria and the DMC-ODS STCs. If BHRS responds to a TAR as "pending", Contractor shall respond within 24 hours of the request for additional information.
Program Licensure, Certification and Standards	Practice Guidelines: Contractor shall comply with the BHRS Clinical and Administrative Practice Guidelines, which are located at www.MarinBHRS.org Licensure, Certification and ASAM/DHCS Designation ASAM/DHCS 3.2-WM: Contractor shall possess valid DHCS licensure with detoxification certification and DMC Residential certification. ASAM/DHCS Levels 3.1, 3.3 and 3.5: Contractor shall possess valid DHCS licensure and DMC Residential certification and have been designated by DHCS as capable of delivering care consistent with the ASAM criteria. All licensed AOD facilities must obtain at least one DHCS Level of Care Designation and/or at least one residential ASAM Level of Care Certification consistent with all of its program services. For more information regarding DHCS Level of Care Designation Requirements: https://www.dhcs.ca.gov/provgovpart/Documents/SB-823-Exhibit-A-1.14.21.pdf Contractors that provide Women and Children's Residential Treatment Services (WCRTS) shall comply with the program requirements and goals pursuant to California Health and Safety Code 11757.65. Program outcomes include: 1) Preserving family unity; 2) Promoting healthy pregnancies; 3) Enabling children to thrive; and 4) freeing women and their families from substance abuse. Contractor shall also comply with the Perinatal Practice Guidelines. Incidental Medical Services (IMS): IMS may only be provided following approval from DHCS. IMS shall be an additional service to all residents at an approved licensed residential facility. IMS cannot be limited to specific residents and/or beds. A licensed residential facility's HCP must ensure that IMS is appropriate for all residents. If IMS is not appropriate for a resident (as determined by a HCP), then the licensed residential facility must immediately refer the resident for placement in an appropriate level of care.

	A licensed residential facility approved to provide IMS cannot order or stock bulk prescription medications.
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: Scope of Work • 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 Budget • 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.MarinBHRS.org), Contract Exhibit I and Practice Guidelines (MarinBHRS.org), including, but not limited to: 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or Serious incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries or 90% capacity (facility at capacity).
One-Time Electronic Health Record (EHR) Documentation Adoption Incentive Payments	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 *SmartCare* as their EHR for Marin County Beneficiaries and having their rendering providers/clinicians document into *SmartCare* 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.

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