

EXHIBIT A - SCOPE OF SERVICES

JULY 1, 2018 – JUNE 30, 2019

Services Provided	<p>Residential (ASAM Level 3.1) – Clinically Managed Low Intensity – Provides 24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment.</p> <p>Residential (ASAM Level 3.3) – Clinically Managed Population-Specific High-Intensity Residential Services – Provides 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for outpatient treatment.</p> <p>Residential (ASAM Level 3.5) Clinically Managed High-Intensity – Provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.</p> <p>Residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the individual treatment plan. Room and Board is not reimbursable through the DMC program.</p> <p>The components of Residential Treatment Services include:</p> <ul style="list-style-type: none">• Intake: The process of determining that a beneficiary meets the medical necessity criteria and admitting the beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.• Individual and Group Counseling: Contacts between a beneficiary and a therapist or counselor. Services are provided in-person or by telephone qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction. Group counseling is described in the DMC-ODS STCs as a face-to-face contact in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the therapeutic SUD treatment needs of the individuals served.• Patient Education: Provide research-based education on addiction, treatment, recovery, and associated health risks• Family Therapy: The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient,
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help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

- Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
- Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
- Crisis Intervention Services: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.
- Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed within regulatory timeframes, reviewed every 30 days, and then updated every 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.
- Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
- Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

Group counseling is considered a clinical intervention. The other structured activities that are available in residential treatment, including patient education, are not considered clinical interventions, and are not subject to a limitation in regard to the number of participants. Any structured activity not listed in the STCs will not satisfy the requirement for reimbursement for residential treatment.

Physician Consultation: Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

Assessments

Face-to-Face: Assessments shall be face-to-face and performed by qualified staffing. If the face-to-face assessment is provided by a certified counselor, the "face-to-face" interaction must take place, at minimum, between the certified counselor

	<p>who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary.</p> <p><u>ASAM Training</u>: Staff performing assessments are required to complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.</p> <p><u>Re-Assessments</u>: 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 WITS for each assessment and re-assessment and within seven (7) days of the assessment/re-assessment.</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"> • First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact. • First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur within five (5) and no later than 10 business days. • 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 WITS within seven (7) days of first contact for 100% of beneficiaries. <p>Transitions Between Levels of Care Appropriate Case managers/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in Marin WITS.</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. • At least 80% of beneficiaries receive a follow-up contact within seven (7) days of discharge from Residential treatment or Residential Withdrawal Management.

Care Coordination and Linkage with Ancillary Services

The Contractor shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. The Contractor shall screen for and link clients with mental and physical health, as indicated.

Performance Standard:

- There is documentation of physical health and mental health screening in 100% of beneficiary records
- At least 80% of beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers
- At least 70% of beneficiary records have documentation of coordination with physical health
- At least 80% of beneficiaries engaged for at least 30 days will have an assigned Primary Care Provider
- At least 80% of beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in place to coordinate care with mental health providers
- At least 70% of beneficiary records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).

Medication Assisted Treatment

Contractors will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment for substance use disorders. 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 Competent Services

Contractors are responsible to provide culturally competent 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.
- At least 80% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services

	<p>Delivery of Individualized and Quality Care</p> <p><u>Beneficiary Satisfaction</u>: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually.</p> <p><u>Evidence-Based Practices (EBPs)</u>: Contractors will implement—and assess fidelity to—at the least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education.</p> <p><u>ASAM Level of Care</u>: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in Marin WITS with seven (7) days of the assessment.</p> <p>Performance Standards:</p> <ul style="list-style-type: none"> • At least 80% of beneficiaries will report an overall satisfaction score of at least 3.5 or higher on the Treatment Perceptions Survey • 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
<p>Client Outcomes</p>	<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>Training</p>	<p>Applicable staff are required to participate in the following training:</p> <ul style="list-style-type: none"> • Title 22, Drug/Medi-Cal (At least annually)

	<ul style="list-style-type: none"> • Information Privacy and Security (At least annually) • ASAM E-modules 1 and 2 (Prior to Conducting Assessments) • Cultural Competency (At least annually) • Oath of Confidentiality (Review and sign at hire and annually thereafter)
<p>Authorization Process – ASAM Levels 3.1 and 3.5</p>	<p>Initial Authorization Requests for initial authorization are to be submitted to BHRS Access on the Treatment Authorization Request (TAR) - <i>Initial Authorization</i> 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.</p> <p>Continuing Authorization Requests for continuing authorizations are to be submitted to BHRS Access on the TAR – <i>Continuing Authorization</i> 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. For youth, a one-time extension for up to 30 days on an annual basis can be granted. For adults, continuing authorizations can be granted for up to an additional 45 days, for a total length of stay not to exceed 90 days. A one-time extension for up to 30 days on an annual basis can be granted, for a total length of stay not to exceed 120 days. Only two, non-continuous, 90 day regimens will be authorized in a one year period. Perinatal, EPSDT and criminal justice clients may receive a longer length of stay based on medical necessity.</p> <p>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 and 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 Title 22, ASAM diagnostic and dimensional criteria and the DMC-ODS STCs.</p> <p>If BHRS Access responds to a TAR as “pending”, Contractor shall respond within 24 hours of the request for additional information.</p>
<p>Program Licensure, Certification and Standards</p>	<p>ASAM 3.2-WM: Contractor shall possess valid DHCS licensure with detoxification service authorization and DMC Residential certification</p> <p>ASAM Levels 3.1 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.</p> <p>Contractors that provide Women and Children’s Residential Treatment Services shall comply with the program requirements (Section 2.5, Required</p>

	<p>Supplemental/Recovery Support Services) of the Substance Abuse and Mental Health Services Administration’s Grant Program for Residential Treatment for Pregnant and Postpartum Women, RFA found at http://www.samhsa.gov/grants/grant-announcements/ti-14-005.</p>
<p>Beneficiary Protections and Beneficiary Informing Materials</p>	<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.</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 self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. 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></p> <p>Contractor shall have written procedures to ensure compliance with 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 immediately notify the County in writing of any actions that may require a NOABD be issued, including, but not limited to: 1) not meeting timely access standards; 2) not meeting medical necessity for any substance use disorder treatment services; and 3) terminating or reducing authorized covered services.
<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), 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 (facility at capacity).</p>
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