COUNTY OF MARIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MARIN BEHAVIORAL HEALTH AND RECOVERY SERVICES

SUBSTANCE USE SERVICES PROVIDER MANUAL
CLINICAL PRACTICE and ADMINISTRATIVE GUIDELINES

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COUNTY OF MARIN

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

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SECTION I. OVERVIEW AND ELIGIBILITY FOR SERVICES

Introduction and Philosophy of Care

Dear Community Partners,

The past several years has presented each of us with tremendous opportunities and, sometimes what seemed insurmountable challenges in preparation for the implementation of the Drug/Medi-Cal Organized Delivery System (DMC-ODS) 1115 Waiver. Planning for and implementing this Waiver represents one of the most significant changes in the substance use delivery system's history. This historical change reflects years of advocacy for the healthcare system to formally recognize substance use disorders as a medical disorder. Parity legislation, the Affordable Care Act, the DMC-ODS Waiver and now CalAIM places substance use disorders as a vital component to the overall health of individuals, families and our communities.

We would like to thank each of you, from staff to administration, for your creativity and perseverance in transitioning our substance use treatment delivery system and providing our clients with the hope, support and care to achieve a life of recovery.

With appreciation and thanks,

Catherine Condon, MPH
County Alcohol and Other Drug Administrator

NOTE: During the COVID-19 Public Health Emergency, refer to updated guidance from DHCS on flexibilities. Resources: https://www.dhcs.ca.gov/Pages/DHCS-COVID-19-Response.aspx

Continuum of Substance Use Disorder Treatment Services

As part of the DMC-ODS, the benefit package for specialty substance use treatment services include:

- Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)[1]
- Outpatient Services (ASAM Level 1)
- Intensive Outpatient Treatment (ASAM Level 2.1)
- Partial Hospitalization Services (ASAM Level 2.5 – Optional – *Not Provided in Marin*)
- Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)
    - ASAM Levels 3.1, 3.3 & 3.5 provided directly by Marin DMC-ODS and subject to prior authorization by the County
- Withdrawal Management (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM and 4-WM)
    - ASAM Level 1 Outpatient (Ambulatory) Withdrawal Management and ASAM Level 3.2 Residential Withdrawal Management provided directly by Marin DMC-ODS
- Narcotic Treatment Program
- Medications for Addiction Treatment
- Recovery Services
- Care Coordination (formerly referred to as Case Management)
- Peer Support Specialist Services (effective July 2022)
- Clinician Consultation (formerly referred to as Physician Consultation – not a direct service to the beneficiary)

Note that Medi-Cal Managed Care Health Plans are responsible for providing Early Intervention (ASAM Level 0.5) and services provided in general acute hospitals are the responsibility of Fee-for-Service Medi-Cal.

A description of specialty substance use treatment services covered as part of Marin's ODS is below. DMC-ODS services are provided by DMC-certified providers and are based on medical necessity. Covered services are based on recommendations by an LPHA, within their scope of practice. Services shall be provided by DMC-certified practitioners.

1. **ASAM Level 0.5 - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services**
    a. Early intervention services are covered for beneficiaries under the age of 21. Any beneficiary under age 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the

[1] Alcohol and Drug Screening, Assessment, Brief Interventions and Referral (SABIRT, also known as SBIRT) is covered by Fee-For-Service and managed care delivery systems, not DMC-ODS, for beneficiaries aged 21 years and older.

outpatient level of care as early intervention 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.

b. An SUD diagnosis is not required for early intervention services.
c. A full assessment utilizing the ASAM Criteria© is not required for a beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used.
    i. 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.
d. Services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone. Nothing in this section limits or modifies the scope of the EPSDT mandate.
e. Additional clarification:
    i. SBIRT is not a DMC-ODS benefit. Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT), commonly known as Brief Intervention, and Referral and Treatment (SBIRT) is not a DMC-ODS benefit. This is a benefit in the managed care delivery system for beneficiaries aged 12 years and older.
    ii. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria© assessment.

2. **ASAM Level 1 - Outpatient Treatment Services** (often referred to as Outpatient Drug Free)
    a. Outpatient treatment services include the following: 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.
    b. Service hours:
        i. Beneficiaries aged 21 years and older: 9 hours a week
        ii. Beneficiary under the age of 21: 6 hours a week
        iii. Services may exceed the maximum based on individual medical necessity.
    c. Services may be provided in person, by telehealth, or by telephone.
    d. Medication Assisted Treatment (MAT)
        i. County is required to either offer medications for addiction 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 insufficient).

ii. County shall monitor the referral process or provision of MAT services.

3. **ASAM Level 2.1 – Intensive Outpatient Treatment Services**
    a. Intensive Outpatient Services are provided in a structured programming environment.
    b. Intensive outpatient treatment services include the following: 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.
    c. Service hours:
        i. Beneficiaries aged 21 years and older: Minimum of 9 hours with maximum of 19 hours a week
        ii. Beneficiary under the age of 21: Minimum of 6 hours with maximum of 19 hours a week
    d. Services may exceed the maximum based on individual medical necessity.
    e. Services may be provided in person, by telehealth, or by telephone.
    f. Medication Assisted Treatment (MAT)
        i. Provider is required to either offer medications for addiction 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. Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provide on-site). Providing a beneficiary, the contact information for a treatment program, is considered insufficient.
        ii. County shall monitor the referral process or provision of MAT services.

4. **ASAM Level 2.5 - Partial Hospitalization Services** (Optional DMC-ODS level – Not Currently Provided in Marin DMC-ODS

5. **ASAM Levels 3.1, 3.3, & 3.5 - Residential Treatment** (This section supersedes MHSUDS IN 16-042)
    a. Residential Treatment Services are provided in a short-term residential program through one of the following levels:
        i. Level 3.1 - Clinically Managed Low-Intensity Residential Services

   ii. Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
   iii. Level 3.5 - Clinically Managed High Intensity Residential Services
b. 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.
c. Services shall address functional deficits documented in the ASAM Criteria©
   i. Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
d. A beneficiary shall live on the premises and be considered a "short-term resident" of the residential facility where the beneficiary receives services under this DMC-ODS level of care.
e. Services may be provided in facilities of any size.
f. Services are driven by the beneficiary's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting.
g. Residential treatment services for adults under these levels 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 or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).
h. Residential providers licensed by a state agency other than DHCS must be DMC-Certified.
i. DHCS Level of Care designation and/or ASAM Level of Care Certification:
   i. All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria.
   ii. Designation is required for facilities offering ASAM levels 3.1, 3.3, 3.5.
   iii. All counties with residential facilities offering levels 3.1., 3.3, and 3.5, licensed by a state agency other than DHCS, shall have an ASAM Level of Care Certification for each of the levels of care provided at the facility under the DMCS-ODS program by January 1, 2024
j. Services may be provided in person, by telehealth, or by telephone
   i. Most services shall be in person.
   ii. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu.
k. Medication Assisted Treatment (MAT)

i. 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 partial hospitalization services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).

l. County shall monitor the referral process or provision of MAT services.

m. Length of Stay
   i. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Beneficiaries shall be transitioned to appropriate levels of care as medically necessary.
   ii. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

6. **ASAM Levels 3.7 Medically Monitored Inpatient Services & 4.0 - Medically Managed Intensive Inpatient Services** (This section supersedes MHSUDS IN 16-042)
   a. County may voluntarily cover and receive reimbursement through DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals Freestanding Acute Psychiatric Hospitals (FAPHs) or Chemical Dependency Recovery Hospitals (CDRHs). Marin DMC-ODS does not cover this level of care, though is required to have clearly defined referral mechanism and care coordination for these levels of care. Additional information can be found on the DHCS All-Plan Letter 18-001[2] which clarifies coverages of voluntary inpatient detoxification through the Medi-Cal Fee-for-Service program.

7. **Narcotic Treatment Program** (This section supersedes MHSUDS IN 16-048)
   a. Narcotic Treatment Program (NTP), also described in the ASAM Criteria© as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

[2] DHCS All-Plan Letter 1801

b. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary including:
    a. Methadone; Buprenorphine (transmucosal and long-acting injectable); Naltrexone (oral and long-acting injectable); Disulfiram; Naloxone
    b. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication.
    c. Service components:
        i. Assessment
        ii. Care Coordination
        iii. Counseling (individual and group)
            a. The NTP shall offer the beneficiary a minimum of fifty (50) minutes of counseling services per calendar month
            b. Counseling services may be provided in-person, by telehealth, or by telephone
        iv. Family Therapy
        v. Medical Psychotherapy
        vi. Medication Services
        vii. MAT for OUD
        viii. MAT for AUD and other non-opioid SUDs
        ix. Patient Education
        x. Recovery Services
        xi. SUD Crisis Intervention Services
        xii. Medical evaluation for methadone treatment: Medical history; Laboratory tests; Physical exam; Medical evaluation must be conducted in-person

8. Withdrawal Management (WM)Services

a. WM services are provided as a part of a continuum of care to beneficiaries experiencing withdrawal in the following outpatient, residential, and inpatient settings. Beneficiary shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.
b. A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities 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 beneficiary can receive comprehensive treatment services.

1. Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision).
2. Level 3.2-WM: Clinically managed residential withdrawal management (24- hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
    i. This is considered a residential level of care and therefore requires the facility to be designated as capable of delivering care consistent with ASAM Criteria©.
    ii. A DHCS level of care designation and/or an ASAM Level of Care Certification is required.

c. Service components for outpatient, residential, and inpatient settings: Assessment; Care Coordination; Medication Services; MAT for OUD; MAT for AUD and other non-opioid SUDs; Observation; Recovery Services
d. Care transitions to facilitate additional services or transition to a comprehensive treatment program.
    a. WM services are urgent and provided on a short-term basis.
    b. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate.
    c. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode.
        i. Receiving program shall adhere to initial assessment timeliness requirements.
e. WM services may be provided in an outpatient, residential, or inpatient setting.
    a. For residential settings, each beneficiary shall reside at the facility.
f. Medication Assisted Treatment (MAT) 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 partial hospitalization services if not provided on-site (Providing a beneficiary the contact information for a treatment program is insufficient).

9. **Medications for Addiction Treatment** (also known as Medication-Assisted Treatment or MAT)
    a. Medications for addiction treatment include all medications and biological products Food and Drug Administration (FDA) approved to treat Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and any SUD.
        1. Methadone; Buprenorphine (transmucosal and long-acting injectable); Naltrexone (oral and long-acting injectable); Disulfiram; Naloxone
    b. Service components: Assessment; Care Coordination; Counseling (individual and group); Family Therapy; Medication Services; Patient Education;

Recovery Services; SUD Crisis Intervention Services; Withdrawal Management Services

c. MAT may be provided in clinical or non-clinical settings.
d. MAT may be delivered as a standalone service.
e. Additional clarification on MAT
    i. DMC -ODS counties shall ensure all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT service for the beneficiary with SUD diagnoses that are treatable with medication or biological products.
    ii. Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provide on-site
    iii. Providing a beneficiary, the contact information for a treatment program is not considered sufficient.
    iv. An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary shall be made whether or not the provider seeks reimbursement through DMC-ODS.
    v. Counties shall monitor the referral process or provision of MAT services.
f. The required MAT medications were expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat opioid use disorders (OUD) and Alcohol Use Disorders (AUD)[3].
g. DMC-ODS counties have the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit
    i. This means county pays for cost for MAT medications purchased by providers and administered or dispensed on site or in the community and billed to the county DMC-ODS plan.
    ii. If the DMC-ODS county elect the above option could reimburse providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities and non-clinical or community settings.
h. DMC-ODS counties who *do not choose* to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS counties are still required to cover the drug product costs for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a stand-alone service.
i. All medications and biological produces utilized to treat SUDs, including long-acting injectables, continue to be available through the Medi-Cal pharmacy benefit *without* prior authorization and can be delivered to provider offices by pharmacies.

[3] On December 29, 2020, DHCS obtained a one-year extension for DMC-ODS 115 waiver.

j. Beneficiaries needing or using MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program.
k. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services.
l. For beneficiaries with a lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., peer support services).
m. If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the DMC-ODS provider must assist the member in choosing another MAT provider, support continuity of care and facilitate a warm hand-off to ensure engagement.

10. Peer Support Services (This section of the information notice supersedes MHSUDS IN 17-008) Implemented as a County Option *Effective July 1, 2022*

1. Services are provided by Certified Peer Support Specialists[4]
    a. A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification.
    b. A Peer Support Specialist must meet all other applicable California state requirements, including ongoing education requirements.
    c. Peer Support Specialists must provide services under the direction of a Behavioral Health Professional. “Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval and signing of client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the service provided. Services are provided under the direction of a physician; a licensed or waivered psychologist; a licensed, waivered or registered social worker; a licensed, waivered or registered marriage and family therapist; a licensed, waivered or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).
        i. Behavioral Health Professionals must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid

[4] Behavioral Health Information Notice 21-041

State Plan as a qualified provider of DMC-ODS or Specialty Mental Health Services.[5]

ii. Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements.

d. 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.

2. 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. Beneficiaries may concurrently receive Peer Support Services and services from other levels of care.
3. Peer Support Services are based on a plan of care approved by a Behavioral Health Professional (see definition of Behavioral Health Professional above; this term is specific to the administration of Peer Support Services). Services may be provided with the beneficiary or in collaboration with significant support person(s).
   a. Services may 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.
4. Service components
   a. Educational Skill Building Groups - providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiary 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.
   b. Engagement services - 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.

[5] Supplement 3 to Attachment 3.1-A of the California State Plan. DMC-ODS services are described in the "Expanded SUD Treatment Services" section

c. Therapeutic Activity - 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.

5. Peer Support Services are delivered and claimed as a standalone service.
6. Services may be provided in a clinical or non-clinical setting.

11. Recovery Services

1. Recovery services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level with emphasis on the beneficiary as the central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management.
2. 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.
3. Services may be provided based on the beneficiary's self-assessment or provider assessment of relapse risk.
4. Diagnosis of "remission" is not required to receive Recovery Services
5. Services may be provided concurrently with MAT services, including NTP services.
6. Services may be provided immediately after incarceration with a prior diagnosis of SUD.
7. Services may be provided in person, by telehealth, or by telephone
8. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described.

12. Care Coordination (This section supersedes in part MHSUDS IN 17-045 regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Case Management).

1. Care coordination was previously referred to as "case management" for the years 2015-2021.

2. Care coordination shall be provided in conjunction with *all* levels of treatment.
3. 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.
4. Service components include one of more of the following:
    a. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
    b. 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.
    c. 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.
5. Care Coordination may also be delivered and claimed as a standalone service in a DMC-ODS County.
6. Services can be provided in clinical or non-clinical settings, including the community.
7. Services may be provided in-person, by telehealth, or by telephone
8. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.[6]

13. Clinician Consultation (This section supersedes, in part, MHSUDS IN 17-045 regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Physician Consultation).

1. Clinician consultation is *not* a direct service provided to a beneficiary.
2. Clinician Consultation replaces and expands the previous "Physician Consultation" service referred to during the years 2015-2021.
3. 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. Clinician consultation:
    a. Includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific beneficiaries.

[6] DMC-ODS counties shall have an executed memoranda of understanding to support care coordination

   b. Consists of DMC-ODS LPHAs consulting with other LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.
4. County may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services.
5. Clinical consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

Eligibility for Marin County Substance Use Services

Establishing Eligibility for Services – Step 1

The benefit package available within Marin County's Organized Delivery System is for Marin residents who are considered part of the safety net population. Unless otherwise specified in the contract with Marin County, reimbursement shall only be provided to individuals that meet the following criteria:

- Must be a resident of Marin County; and
- Must be a Marin County Medi-Cal Beneficiary (or have an inter-county transfer indicating Marin as the County of Responsibility initiated – Refer to BHIN 21-032); or
- Marin County Low Income Uninsured (<138% FPL).

For **individuals eligible for Marin Medi-Cal**—but not yet enrolled—Providers shall work with the client to assist in obtaining benefits. Provider staff shall work with the client directly or engage the applicable Recovery Coach/Care Manager to ensure that the eligibility process commences **within 14 calendar days** from admission to services.

For **individuals not eligible for either Marin Medi-Cal or the Marin County Low Income Uninsured** threshold (e.g. individuals that exceed the income threshold for Medi-Cal or have commercial insurance), Providers may serve these individuals and seek sliding scale reimbursement directly from the client. The fee shall be based on the sliding fee scale approved by the County Alcohol and Drug Administrator. BHRS is not responsible for reimbursement for the services for these clients.

BHRS is also not responsible for reimbursement for services provided to **out-of-county Medi-Cal beneficiaries** (excluding courtesy dosing provided in accordance with CCR Title 9). Prospective beneficiaries requesting services should be referred to their home county. If the beneficiary has initiated and provides documentation regarding transferring their Medi-Cal to Marin County, contact your BHRS Contract Manager for how to proceed. Per DHCS Information Notice 21-032, counties and providers should use the County of Responsibility field in MEDS and MEDSLITE to determine which county is responsible to provide authorizations (whenever authorizations are needed to approve care) and to pay claims for medically necessary services for eligible beneficiaries. The only exception to this policy is when a beneficiary has initiated an Inter-County

Transfer to confirm a change of residence. In that case, the County of Residence is responsible for authorizations and claims. Additional information can be found at the following links: DHCS Information Notice 21-032 and County FAQ on Working with Out of County Beneficiaries.

Determination of Eligibility will be performed as follows: Providers shall verify the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for Drug/Medi-Cal services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS's DMC Provider Billing Manual. [State-County Intergovernmental Agreement, Exhibit A, Attachment I]. For additional information, please refer to the DHCS DMC Billing Manual and County FAQ on Verifying Medi-Cal Eligibility.

Contractors can determine if an individual meets the low-income uninsured threshold (<138% FPL) through their existing financial assessment process and verification of Marin County residency. With the exception of Residential treatment, as long as the Contractor ensures the eligibility criteria are met, there is no prior authorization permitted or required from the County. For Residential treatment, the County shall provide prior authorization within 24 hours of the prior authorization request being submitted by the provider. The Couty will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service. Please follow the TAR process.

No one shall be denied service based solely on inability to pay and with the exception of beneficiaries with a Share of Cost, Medi-Cal should be considered payment in full.

Note that American Indian and Alaska Native individuals who are eligible for Medicaid and reside in Marin County can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to BHIN 20-065 for additional information.

Initial Assessment – Step 2

Medi-Cal beneficiaries whose county of responsibility is Marin are able to receive covered and clinically appropriate DMC-ODS services consistent with the following assessment, access, and level of care determination criteria.

Initial Assessment Completion

For all levels of care, except for residential treatment services and Narcotic Treatment Programs:

- Initial assessment may be conducted Face-to-face, Telephone (synchronous audio-only), Telehealth (synchronous audio and video), or in the community or home. It shall be completed by an LPHA or registered/certified alcohol and other drug counselor. When completed by a registered/certified counselor, there shall be consultation between the counselor and LPHA (in person, via telephone or via telehealth), and documentation of the initial assessment shall reflect consultation between the LPHA and registered/certified counselor. The initial diagnosis shall be determined and documented by the LPHA.

For Residential Treatment:

- Prior authorization for residential and inpatient services (excluding WM services) is required within 24 hours of the prior authorization request being submitted by the provider. Marin DMC-ODS shall review the DSM and ASAM Criteria© to ensure that the beneficiary meets the requirements for the service. Refer to the section on Residential Authorizations for additional information.

For Narcotic Treatment Programs:

- History and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity.

Timeliness and Covered Services During Initial Assessment

Beneficiaries aged 21 years and older:

- The initial assessment using the ASAM Criteria© shall be completed within 30 calendar days following the first visit with an LPHA or registered/certified counselor.
- Covered and clinically appropriate services may be provided during the 30-day initial assessment period.

Beneficiaries under 21 years of age:

- The initial assessment using the ASAM Criteria© shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
- Covered and clinically appropriate services may be provided during the 60-day initial assessment period.

Adult beneficiaries experiencing homelessness:

- The initial assessment using the ASAM Criteria© shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
- The practitioner shall document that the beneficiary is experiencing homelessness and requires additional time to complete the initial assessment.

Timeliness when beneficiary withdrawal from treatment prior to completion of assessment: When beneficiary withdraws from treatment prior to completion of the assessment or establishing a diagnosis, and later returns to care, the 30-day or 60-day assessment period starts over

Diagnosis During Initial Assessment (except for Residential treatment services)

- Diagnostic determination shall be made by an LPHA
- Covered and clinically appropriate services may be delivered following the first visit with an LPHA or registered/certified counselor and may be delivered before a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established. A provisional diagnosis may be used prior to establishing diagnosis.

  - Provisional diagnoses are used prior to the determination of a diagnosis or in cases where suspected SUD has not yet been diagnosed.
    - An LPHA may document and categorize a suspected SUD under "Other Specified" and "Unspecified" disorder or "factors influencing health status and contact with health services" (Z-codes).
    - Diagnoses shall be updated by an LPHA when a beneficiary's condition changes to accurately reflect the beneficiary's needs
- Medically necessary services may be provided for:
  - up to 30 days for beneficiaries 21 years of age and older
  - up to 60 days for beneficiaries under the age of 21 or for beneficiaries experiencing homelessness.

Accessing Services After Initial Assessment – Step 3

Adults (Age 21+ years)

- A service is considered "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) for a Substance-Related and Addictive Disorder with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; OR
  At least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

Youth (12-17 years) and Young Adults (18-20 years)

- Services are considered "medically necessary" if the service is necessary to correct or ameliorate screened health conditions ((pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations).
- Services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

Diagnosis After Initial Assessment

- Diagnostic determination shall be made by an LPHA
- Covered and clinically appropriate services may be delivered following the first visit with an LPHA or registered/certified counselor and may be delivered before a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established. A provisional diagnosis may be used prior to establishing diagnosis.
  - Provisional diagnoses are used prior to the determination of a diagnosis or in cases where suspected SUD has not yet been diagnosed.

    - An LPHA may document and categorize a suspected SUD under "Other Specified" and "Unspecified" disorder or "factors influencing health status and contact with health services" (Z-codes).
    - Diagnoses shall be updated by an LPHA when a beneficiary's condition changes to accurately reflect the beneficiary's needs
- Medically necessary services may be provided for:
    - up to 30 days for beneficiaries 21 years of age and older
    - up to 60 days for beneficiaries under the age of 21 or for beneficiaries experiencing homelessness.

Additional Considerations

Services for covered services are reimbursable even when:

- Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above.
- The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
- The beneficiary has a co-occurring mental health disorder.
    - Clinically appropriate and covered DMC services delivered by DMC providers are covered and reimbursable whether or not the beneficiary has a co- occurring mental health disorder.
    - The county shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if the assessment determines that the beneficiary does not meet the DMC-ODS Access Criteria for Beneficiaries After Assessment.
    - The county shall not disallow reimbursement for clinically appropriate and covered SUD prevention, screening, assessment, and treatment services due to lack of inclusion in an individual treatment plan, or lack of client signature on the treatment plan.

Level of Care Determination

The American Society of Addiction Medicine (ASAM) Criteria shall be used to determine the appropriate level of SUD treatment service[7]

- Placement and level of care determination shall be in the least restrictive level of care that is clinically appropriate to treat the beneficiary's condition.
- A full ASAM assessment shall be repeated when a beneficiary's condition changes.
- Timeliness - If a beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over as noted above.
- As outlined above, clinically necessary services are permissible prior to completion of a full ASAM assessment.
- An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. *Please note that no preliminary level of care*

[7] W&I Code 14184.402(e)

recommendation or screening tool is a substitute for a comprehensive ASAM Criteria© assessment.

- *Note: Staff performing assessments must complete the two e-learning ASAM modules: "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". For More information, contact County Contract Manager.*

Access to Substance Use Treatment Services

How to Access Substance Use Treatment Services

Beneficiaries may access services in a variety of ways including contacting a network provider, a community partner or contacting the Beneficiary Access Line. Marin County's Beneficiary Access Line is a functional 24/7 County-operated Integrated Mental Health and Substance Use toll free Access Line (1-888-818-1115), is accessible in prevalent non-English languages. Oral interpretation services and Text Telephone Relay or Telecommunications Relay Service (TTY/TRS) services are made available for beneficiaries, as needed

Beneficiaries are able to locate the Access Line telephone number from a variety of sources, including the County of Marin website and printed outreach materials. Access is staffed with LPHAs who conduct an initial screening for substance use disorders and provide direct referrals to DMC-ODS contracted or County-operated providers.

Beneficiaries referred to a Provider or who self-selects a provider without a referral from Access, are screened and if indicated, are assessed by an LPHA—or by a certified/registered alcohol and drug counselor and reviewed by an LPHA—using the ASAM Criteria. Beneficiaries are offered admission to the appropriate ASAM level of care. If after assessing the beneficiary, the provider determines them to be more appropriate for an ASAM level of care not offered by the provider, then the provider will immediately refer the beneficiary to another DMC-ODS service that provides the indicated ASAM level of care or to the Access Line, and will document to the referral.

Residential Authorizations

The Marin County Access line (Telephone: 1-888-818-1115) is a point of entry for both mental health and substance use services including screening, assessment, referral and treatment authorizations. It is the responsibility of BHRS staff to ensure that access to specialty mental health and substance use services are conducted in the least restrictive way.

The Quality Management or Access Team can authorize residential substance use treatment services for anyone potentially being billed for through a contract with the County of Marin, including: Marin County Medi-Cal beneficiaries; Marin County low income uninsured individuals; and individuals from any California County seeking Perinatal Residential services.

In compliance with DHCS BHIN 21-0075, it is BHRS policy to respond to all submitted Treatment Authorization Requests (TARs) within 24 hours of receipt. Residential providers are required to

send the TAR and documentation supporting the recommended level of service so that the County staff can review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service and authorize treatment. TARs can only be reviewed and authorized by LPHAs. Authorization requests shall be submitted via secure/encrypted email to: BHRSAuthSUS@marincounty.org.

After-hours Authorization

In order to prevent delays in admissions to treatment, BHRS on-call clinical staff will provide authorization within 24 hours of the request for eligible TARs submitted on a County holiday or weekend.

Initial Authorization

Requests for initial authorization are to be submitted to BHRS Quality Management 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. Providers are authorized to admit a beneficiary to residential treatment within 7 days of the authorized TAR, though the BHRS Residential Contract Manager may approve admissions up to 30 days from the approved TAR date on a case-by-case basis.

Continuing and Extension Authorization

Requests for continuing and extension authorizations are to be submitted to BHRS Quality Management on the TAR – *Continuing and Extension 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, beyond the first 60 days for youth and 90 days for adults, can be granted for up to 30 days for both youth and adults at a time.

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 Marin County resident or any population specified in a contract with a Residential provider 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 ASAM diagnostic and dimensional criteria and the DMC-ODS documentation standards and STCs.

If BHRS Access responds to a TAR as "pending", Contractor shall respond within 24 hours of the request for additional information.

Timely Access Standards

DMC-ODS providers, except for OTP Providers, shall aim to perform a face-to-face assessment with eligible beneficiaries no later than ten (10) business days from the first contact. OTP Providers shall perform a face-to-face assessment for eligible beneficiaries with three (3) business days from the first contact.

Providers shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments. Providers shall also have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries [State-County Contract, Exhibit A, Attachment I, Part V; State-County Intergovernmental Agreement, Exhibit A, Attachment I; BHRS-46]

In the unlikely event that admission to treatment shall be greater than 10 business days, due to non-budget related capacity issues, DMC-ODS providers shall issue a NOABD and provide interim services and seek to link the beneficiary with another provider offering the appropriate ASAM Level of Care. In addition to providing interim services within the required timeframe, the program shall also provide the beneficiary with referrals to other programs that have immediate availability.

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. The Table below outlines applicable performance standards:

Mandatory Performance Measure	Target
Routine: Number of days from initial contact to first face-to-face appointment [should track first offered and first scheduled; should also track time from ASAM Assessment to Admission]	Within 3 business days for OTP; Within 10 business days for other ODS services
Urgent*: First face-to-face visit within 48 hours of the request for urgent conditions.	Within 48 hours
Emergency*: Access to emergency medical care for medical conditions	Immediate
First Dose of NTP: Timeliness of services to the first dose of NTP	Within 3 business days
MAT Evaluation: Number of days for face-to-face Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders	Within 10 business days from identification

After Hours Care: Access to afterhours care	100% of DMC-ODS Providers
Follow-Up: Number of days to treatment services following an acute level of care (withdrawal management, residential or hospital)	Within 7 calendar days
Transitions Between Levels of Care: Transitions between levels of care for beneficiaries re-assessed as needing a different level of care	Within 10 days of the re-assessment
Residential Authorization: Time for the County Access Line to respond to TARs and time for the Residential Provider to respond to County Access Line Pending TARs	Within 24 hours
Initiation: Percent of clients in treatment who initiate a second treatment visit/day within 14 days of screening for a SUD	75%
Engagement: Percent of clients in treatment initiating treatment who then engage in at least two treatment visits/days within the next 30 days	75%
Satisfaction: Percent of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location and time of services	75%

*__Urgent__: Urgent care means care necessary for a condition that is not life threatening but which requires treatment that cannot wait for a regularly scheduled clinical appointment because of the prospect of the condition worsening without timely medical or behavioral health intervention

*__Emergency__: An emergency medical condition is present when you have symptoms that cause severe pain or a serious illness or an injury, which a prudent layperson (a careful or cautious non-medical person) believes, could reasonably expect without medical care could:

- Put your health in serious danger, or
- If you are pregnant, put your health or the health of your unborn child in serious danger,
- Cause serious harm to the way your body works, or
- Cause serious damage to any body organ or part.

Role of Provider in Beneficiary Protections

Beneficiary Informing Materials

Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain the all Beneficiary Informing Material at least once a year and thereafter upon request: DMC-ODS Beneficiary Booklet and Provider Directory. The County will produce required

beneficiary informational materials in English and Spanish. Contractor shall request materials from the County, as needed.

Grievance and Appeals

Contractor shall 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.

Contractor shall maintain, and provide to County upon request, the complaint procedure to be utilized in the event that there is a complaint regarding services provided under this Agreement. Contractor shall ensure that recipients of service under this Agreement have access to and are informed of Contractor's complaint procedure.

Notice of Adverse Beneficiary Determination (NOABD)

A formal communication of any action and consistent with 42 CFR 438.404 and 438.10. Contractor shall have written procedures to ensure compliance with the following:

- 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. [BHRS-33]

Please note that Marin has no discretion and must follow federal/state requirements for timing of notices, which are outlined in DHCS MHSUDS IN: 18-010E. Per the following exceptions to the requirement to provide 10-day advance notice (see 42 CFR 431.213 and 42 CFR 483.15(c)(4)(ii)), "Notice must be made as soon as practicable before transfer or discharge when:

A. The safety of individuals in the facility would be endangered [due to the clinical or behavioral status of the resident];
B. The health of individuals in the facility would be endangered;
C. The resident's health improves sufficiently to allow a more immediate transfer or discharge [and the resident no longer needs the services provided by the facility];
D. An immediate transfer or discharge is required by the resident's urgent medical needs [and is necessary for the resident's welfare, and the resident's needs cannot be met by the facility]; or
E. A resident has not resided in the facility for 30 days."

SECTION II. CLINICAL PRACTICE GUIDELINES FOR SERVICE DELIVERY

Service Delivery Regulations and Requirements

The Practice Guidelines represent a combination of local, State and Federal regulations, standards and guidelines, as well as best practices for effectively treating substance use disorders. Contracted and County-operated providers are expected to adhere to all applicable regulations, standards, guidelines, policies and practices.

Overview of Regulations

Site Certification(s)

Providers in Marin County's DMC-ODS are required to obtain and maintain the following, as applicable:

- Drug Medi-Cal Certification
- AOD License (NTP, Residential)
- Level of Care Designation (for Residential and Residential Withdrawal Management)
- DHCS BHIN 21-075: DMC-ODS Requirements for 2022-2026

Re-Certification Events: Contractor shall notify DHCS and the County Alcohol and Drug Administrator within the timeframes noted in the State Contract, in addition to applicable federal, state and local regulations and policies of any triggering recertification events, such as change in ownership, change in scope of services, remodeling of facility, or change in location. [State-County Contract, Exhibit A, Attachment I; MHSUS-ADP-18; BHRS-24]

Drug/Medi-Cal: CCR Title 22, CCR Title 9 and DMC-ODS STCs/DHCS BHIN 21-075

Title 22 and Title 9 contain most of the regulatory requirements for delivering services within the substance use treatment system. As Marin County opted in to the Drug/Medi-Cal Organized Delivery System (DMC-ODS) Waiver, providers are also held to the Standard Terms and Conditions (STCs). BHIN 21-075 replaces the Section 1115 Standard Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I § 14184.102(d), until county contract amendments are executed, DMC-ODS counties shall adhere to the terms in the Behavioral Health Information Notice, BHIN 21-075, where current contracts are silent or in conflict with the terms of BHIN 21-075.

Managed Care Regulations – 42 CFR Part 438

As part of opting into the DMC-ODS, Marin County became a managed care plan and subject to applicable Medi-Cal Managed Care Regulations.

State/County Contracts

DHCS/County DMC-ODS Intergovernmental Agreement

The County receives funding from DHCS pursuant to an annual contracting arrangement whereby the County contractually obligate any of its sub-contractors to also comply with applicable requirements. Refer to this link for the DMC-ODS Intergovernmental Agreement.

Substance Abuse Prevention and Treatment Block Grant (SABG)

The County receives funding from DHCS pursuant to an annual contracting arrangement whereby the County contractually obligate any of its sub-contractors to also comply with applicable requirements. The SABG contract includes the continuum of prevention, intervention, treatment and recovery support services. Refer to this link for the SABG Contract for Substance Use Services.

Required Standards and Guidelines

Alcohol and Drug Program Certification Standards

BHRS requires that all Contracted substance use treatment programs to be certified by the California Department of Health Care Services and comply with applicable Alcohol and Drug Program Certification Standards.

Drug/Medi-Cal Certification Standards

Substance use treatment program participating in the Drug/Medi-Cal program are required to comply with the applicable Drug/Medi-Cal Certification Standards.

Minimum Quality Drug Treatment Standards for SABG

All substance use treatment providers that have any SABG funding are required to comply with the Minimum Quality Treatment Standards.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The national Culturally and Linguistically Appropriate Services (CLAS) Standards which are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. It is intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final report, OMH, 2001).

To ensure access to quality care by diverse populations, each service provider receiving funds from the State-County Contract shall adopt CLAS national standards (2016 version). [State-County Contract, Exhibit A, Attachment I, Part I; BHRS-57; 42 CFR 438.206(c)(2)]

Perinatal Guidelines

Perinatal programs shall comply with the Perinatal Practice Guidelines FY 2018-19 until such time new Perinatal Services Network Guidelines are established and adopted. [State-County Contract, Exhibit A, Attachment I, Part IV; BHRS-66]

Adolescent Guidelines

Contractor shall follow the guidelines in The State of California Youth Treatment Guidelines in developing and implementing adolescent treatment programs until such a time a new Youth Treatment Guidelines are established and adopted. [State-County Contract, Exhibit A, Attachment I, Part 1V; BHRS-60]

Sober Living Standards

Sober Living Environments (SLEs) shall comply with all components under the Marin County Health and Human Services Guidelines for Sober Living Environments until such a time a new Sober Living Environment Standards are established and adopted. [PSC: Exhibit A – Scope of Services]

Residential Guidelines

Residential programs shall comply with all requirements under DMC-ODS. [PSC: Exhibit A – Scope of Services]

Purchase, Prescription or Provision of Marijuana

Federal grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Primary Prevention – Strategic Prevention Framework

The Prevention Provider will provide activities and initiatives that follow the guidelines of SABG Prevention Set-aside funds and the guidelines of the Strategic Prevention Framework.

The Prevention Provider will use primary prevention funds for individual-level, community-level and environmental prevention strategies and evaluation measures to evaluate all programs. Environmental strategies incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems, and policies. Coalitions should select strategies that lead to long-term outcomes. Increasing fines for underage drinking, moving tobacco products behind the counter, not selling cold, single-serving containers of beer in convenience stores and increasing access to treatment services by providing Spanish-speaking counselors are all examples of environmental strategies.
The Prevention Provider will follow the follow the Strategic Prevention Framework (SPF) with the following elements:

- Assessment: Collect data to define problems, resources, and readiness within a geographic area to address needs and gaps.
- Capacity: Mobilize and/or build capacity within a geogrpahic area to address needs.

- Planning: Develop a comprehensive strategic approach that includes policies, programs, and practices creating a logical, data-driven plan to address problems identified in the assessment.
- Implementation: Implement evidence-based prevention strategies, programs, policies, and practices.
- Evaluation: Measure the impact of the SPF and the implementation of strategies, programs, policies and practices.

SPF also includes two guiding principles:

- Cultural competence: The ability to interact effectively with members of diverse population.
- Sustainability: The process of achieving and maintaining long-term results.

Evidence Based and Best Practices

Evidence Based Practices (EBP)

As a requirement of the Marin County DMC-ODS, each provider must implement—and assess fidelity to—at least two of the following Evidenced Based Practices per provider, per service modality:

- **Motivational Interviewing**: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on beneficiaries' past successes.
- **Cognitive-Behavioral Therapy**: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
- **Relapse Prevention**: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
- **Trauma-Informed Treatment**: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
- **Psycho-Education**: Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Marin County DMC-ODS is also participating in Phase I of the Contingency Management Pilot and participating outpatient/OTP providers are expected to adhere to terms and conditions outlined in the State and County/Provider contracts.

Tips for Ensuring Fidelity of EBPs

Does the program have an EBP treatment fidelity plan? The plan should include:

- A method for ensuring that treatment "dose" (intensity, frequency, length of contact) is consistent among clients with similar diagnoses.
- A protocol for the delivery of EBP that outlines accurate and consistent delivery.
- A method for determining that the clinicians are adhering to the protocol.
- A method for identifying areas for course correction (drift) and provide an outline for implementation of course correction.
- A training schedule and description of the training for clinicians (through documentation). Required elements to ensure they have been satisfactorily trained to deliver the intervention are:
    - Standardization of training upon hire: ensuring all clinicians are trained in the same manner.

- Skill acquisition: should include didactic sessions, modeling, use of video materials, training manuals, role plays.
- Measurement of clinician skill: determining performance criteria that include a rating for a "demonstrated understanding of key concepts" and documentation of review.
- Maintenance of skill over time: continued training and EBP documented with performance reviews.

Are regularly and randomly performed, documented, assessments kept by the program and made available to auditors? The assessment should include:

- A list of current scripted intervention protocols.
- A list of current treatment manuals that are utilized.
- A list of current staff training for each EBP implemented.
- A Performance review rating(s) for each clinician's understanding of EBP (self-assessment tool).
- A Self-report anonymous questionnaire from client's (a way to measure a client's comprehension: understand and perform treatment related behavioral skills and cognitive strategies) also referred to as "Treatment Receipt."
- Qualitative interviews with clinician and clients alike.
- Direct observation of a clinician from a performance reviewer.

American Society of Addiction Medicine Criteria (ASAM)

To ensure that beneficiaries have access to the full continuum of care for substance use disorder treatment, the array of benefits offered through the DMC-ODS Waiver are modeled after the ASAM criteria, which is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. [Reference: DHCS ASAM Fact Sheet, 10/2015).

DMC-ODS Provider Requirements:

- **DHCS Level of Care or ASAM Designation**: DMC-ODS residential and residential withdrawal management treatment providers must receive a DHCS issued Level of Care or ASAM designation prior to providing services to beneficiaries.
- **ASAM Training**: At minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care".
- **Assessment Tool Based on ASAM**: All providers shall use the County-provided Assessment Tools for Adults and Adolescents, unless another tool has been approved by the County.
- **ASAM Level of Care Determinations**: The initial assessment using the ASAM Criteria shall be performed by an LPHA or registered/certified counselor. After the LPHA establishes a diagnosis and documents the basis for diagnosis, the ASAM Criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services. If

the facility does not provide the indicated level of care, then the DMC-ODS provider shall link the beneficiary to another agency that offers that level of care.

- **ASAM Re-Assessments**: A full ASAM assessment shall be repeated when a beneficiary's condition changes (ex: achieving treatment plan goals, lack of progress on treatment plan goals, identification or intensification of new problems that cannot be addressed at current level of care, and at the request of the beneficiary).
- **ASAM Data:** All ASAM data shall be entered into Marin WITS within seven (7) days of the assessment.
- **Performance Standards:**
    - 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

Medication-Assisted Treatment within All Levels of Care

Research has shown that a combination of FDA-approved medications and behavioral counseling is more effective for treating substance use disorders than either intervention alone. As such, Medication Assisted Treatments (MAT) need to be part of a comprehensive approach to treating substance use disorders and beneficiaries with opioid or alcohol use disorders should be provided options for access MAT, as appropriate.

As noted by SAMHSA, "a common misconception associated with MAT is that it substitutes one drug for another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication."

FDA-Approved MATs for Opioid Use Disorders include*:

- Methadone – Methadone is a clinic-based opioid agonist that does not block other narcotics while preventing withdrawal while taking it; daily liquid dispensed only in specialty regulated clinics.
- Naltrexone (oral and long-acting injectable) – Naltrexone is an office-based non-addictive opioid antagonist that blocks the effects of other narcotics; daily pill or monthly injection.
- Buprenorphine (transmucosal and long-acting injectable) – Buprenorphine is an office-based opioid agonist/ antagonist that blocks other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or 6-month implant under the skin.

FDA-Approved MATs for Alcohol Use Disorders include*:

- Disulfiram - Disulfiram is a medication that treats chronic alcoholism. It is most effective in people who have already gone through detoxification or are in the initial stage of abstinence. This drug is offered in a tablet form and is taken once a day.

- Acamprosate - Acamprosate is a medication for people in recovery who have already stopped drinking alcohol and want to avoid drinking. It works to prevent people from drinking alcohol, but it does not prevent withdrawal symptoms after people drink alcohol. It has not been shown to work in people who continue drinking alcohol, consume illicit drugs, and/or engage in prescription drug misuse and abuse. The use of Acamprosate typically begins on the fifth day of abstinence, reaching full effectiveness in five to eight days. It is offered in tablet form and taken three times a day, preferably at the same time every day.
- Naltrexone - When used as a treatment for alcohol dependency, naltrexone blocks the euphoric effects and feelings of intoxication. This allows people with alcohol addiction to reduce their drinking behaviors enough to remain motivated to stay in treatment, avoid relapses, and take medications.

*Source: SAMSHA

DMC-ODS Provider Requirements

- Providers shall either offer medications for addiction 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 insufficient).
- Provider 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.
- Providers—include Sober Living Environments—may not discriminate based on a beneficiary's use of prescribed Medication Assisted Treatment.

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 a MAT assessment and/or MAT services

Coordination of Care

A fundamental premise of the DMC-ODS is that beneficiaries receive whole person client-centered care. To achieve this vision, each beneficiary in the DMC-ODS shall have an assigned Care Coordinator, which can either be provided through a Recovery Coach/Care Manager or directly by the treating provider. Coordination of Care responsibilities focus on:

- Ensuing successful transitions between ASAM levels of care, including linking a beneficiary to services if assessed at a level of care not offered by the provider
- Ensuing beneficiaries are linked to other services, including mental health, primary care and Medication Assisted Treatment

- Ensuring effective communication between treating providers and other systems of care, such as Probation or Social Services
- Providing navigation support for clients and family members
- Facilitating and tracking referrals between systems of care

DMC-ODS Provider Requirements

- Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful. As allowable, communicate to BHRS, DHCS or other managed care organizations serving the beneficiary (e.g. Partnership Health Plan or BHRS Mental Health Plan) the results of screenings/assessments in order to prevent duplication of those activities.
- Provide all care coordination responsibilities noted above either directly, or if unable to provide directly, then engage a Recovery Coach/Care Coordinator to oversee all case management and care coordination responsibilities. Provider shall communicate to the beneficiary—including providing information on how to contact their designated person/entity—the name/entity of who is formally designated as primarily responsible for coordinating services
- Coordinate DMC-ODS services with the services the beneficiary receives from: 1) any other managed care organization, such as Partnership Health Plan (Health Plan) or Mental Health Plan (Specialty Mental Health Services); Fee for Service (FFS) Medi-Cal system; and 3) other community and social support providers.
- Link clients with mental health, primary care and MAT, as indicated
- Provide or arrange for transportation, as needed, to medically necessary services, such as treatment visits and appointments referenced in treatment plans
- Appropriate Care coordinators 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
- Follow-up with beneficiaries within seven (7) days of discharge from DMC-ODS services to ensure successful linkage with the next level of care
- Maintain and shares, as appropriate, a beneficiary health record in accordance with professional standards.
- Ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care and that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, and 42 CFR Part 2, to the extent that they are applicable

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).
- 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 have a documented follow-up encounter within seven (7) days of discharge from DMC-ODS services

Staffing Regulations and Requirements

Required Staff Trainings

Providers are required to have all applicable staff adhere to the DMC-ODS STCs, 42 CFR Section 438, Title 22, Title 9, State/County contracts and local policies by participation in following trainings as outlined below:

Training	Timeframe	Attendees
Required Training		
Cultural Humility Training LGBTQ+ Training	One Annually One Annually	All Providers All Providers
Oath of Confidentiality	Sign at Hire and Annually	All Providers
Non-Discrimination	At Hire and thereafter as needed	All Providers
DMC-ODS	Annually	DMC-ODS Providers
42 CFR Part 2, HIPAA, Law & Ethics, Information Privacy & Security	Annually	DMC-ODS Providers
ASAM E-Modules 1 and 2	Prior to Performing Assessments	DMC-ODS Providers
CPR and First Aid	As outlined in Regulation	DMC-ODS Providers
Marin WITS and CalOMS Treatment	Prior to Use of Marin WITS and thereafter as needed	DMC-ODS Providers
Five hours of CEU in Addiction Medicine	Annually	DMC-ODS LPHAs
PPSDS – Prevention Data	Prior to Use and thereafter as needed	All Prevention Providers
Recommended Training		

ASAM A, B, C Training	As needed	DMC-ODS Providers
Medication Assisted Treatment	At least one within first six months of hire and then as needed	DMC-ODS and SLE/RR Providers

DMC-ODS Provider Credentialing and Re-Credentialing

In addition to responsibilities outlined in the County/Provider Contract Exhibit I and DHCS Information Notice 18-019, which is based on 42 CFR, Part 438.214 DMC-ODS Providers are responsible for performing and documenting the following to ensure that staff are appropriately licensed, registered, waivered and/or certified as required by state and federal law.

Required Duties and Documents for Licensed and Certified Providers:

- License Verification

Contractor shall ensure that all staff and subcontractors providing services will have all necessary and valid professional certification(s) or license(s) to practice the contracted services. This includes implementing procedures of professional license checks, credentialing and re-credentialing, monitoring limitations and expiration of licenses, and ensuring that all providers have a current National Provider Identifier (NPI) through the National Plan and Provider Enumeration System (NPPES). Contractor shall provide evidence of these completed verifications when requested by County, DHCS or the US Department of Health & Human Services.

- Counselor Certification

Effective April 1, 2005, any individual providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program are required to be certified. In accordance with HSC Section 11833(b)(1), any individual who provides counseling services in a licensed or certified AOD program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization. Licensed professionals (LCSW, MFT, Psychologist or interns) are not required to be certified.
[Reference: Adoption of Chapter 8 (commencing with Section 13000), and Amendment of Sections 9846, 10125, and 10564, Division 4, Title 9, California Code of Regulations, Health and Safety Code 11833(b)(1), and MHSUDS Information Notice No. 16-058]

If a Provider's license, certification, or registration has lapsed, then they cannot provide any of the treatment services listed above until such a time as their license, certification, or registration becomes active again.

To verify Licensed and Associate level staff visit: https://search.dca.ca.gov/
To verify Certified and Registered level staff visit:
CCAPP:https://ccappcredentialing.org/index.php/verify-credential
CADTP:http://www.cadtp.org/counselors/search.php?term=AYALA&submit=Search
CAADE: http://caadeorg.azurewebsites.net/searchrecordscompound.php

- Proof of Continuing Education

As required by Licensing or Certifying Agency and Program

- Excluded Provider Check

Contractor shall certify, prior to the execution of the contract, that the Contractor does not employ staff or sub-contractors who are excluded from participation in federally funded health care programs. Providers shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, CA Department of Health Care Services or the US Department of Health & Human Services.

- www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
- www.sam.gov/portal/SAM - GSA Exclusions Extract
- www.Medi-Cal.ca.gov – Suspended & Ineligible Provider List

Contractor shall certify, prior to the execution of the contract that the Contractor does not employ staff or sub-contractors that are on the Social Security Administration's Death Master File. Contractor shall check the following database prior to employing staff or sub-contractors, and provide evidence of these completed searches when requested by County, CA Department of Health Care Services or the US Department of Health & Human Services.

- https://www.ssdmf.com/ - Social Security Death Master File

Contractor is required to notify County immediately if they become aware of any information that may indicate their (including employees and subcontractors) potential placement on an exclusions list.

Refer to Section III for a listing of additional documentation required to be maintained in Personnel Files. Refer to Section IV for additional information pertaining to Credentialing and Re-Credentialing.

Medical Director Requirements

Providers shall have a Medical Director who, prior to the delivery of DMC-ODS services, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

In addition to the responsibilities and requirements previously noted, the SUD Medical Director's responsibilities shall, at a minimum, include all of the following:

1) Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
2) Ensure that physicians do not delegate their duties to non-physician personnel.
3) Develop and implement written medical policies and standards for the provider.
4) Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
5) Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

6) Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
7) Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician. The SUD Medical Director may delegate his/her/their responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

Medical Policies and Standards

The Medical Director shall develop and implement written medical policies and standards for the provider. Evidence of developing and implementing medical policies and standards can include the applicable policies and standards being signed and dated by the Medical Director and a program representative. Medical Directors shall perform an annual review of medical policies and standards, with evidence being a signed and dated attestation of annual review from the Medical Director.

Eligible DMC-ODS Staff Categories and Definitions

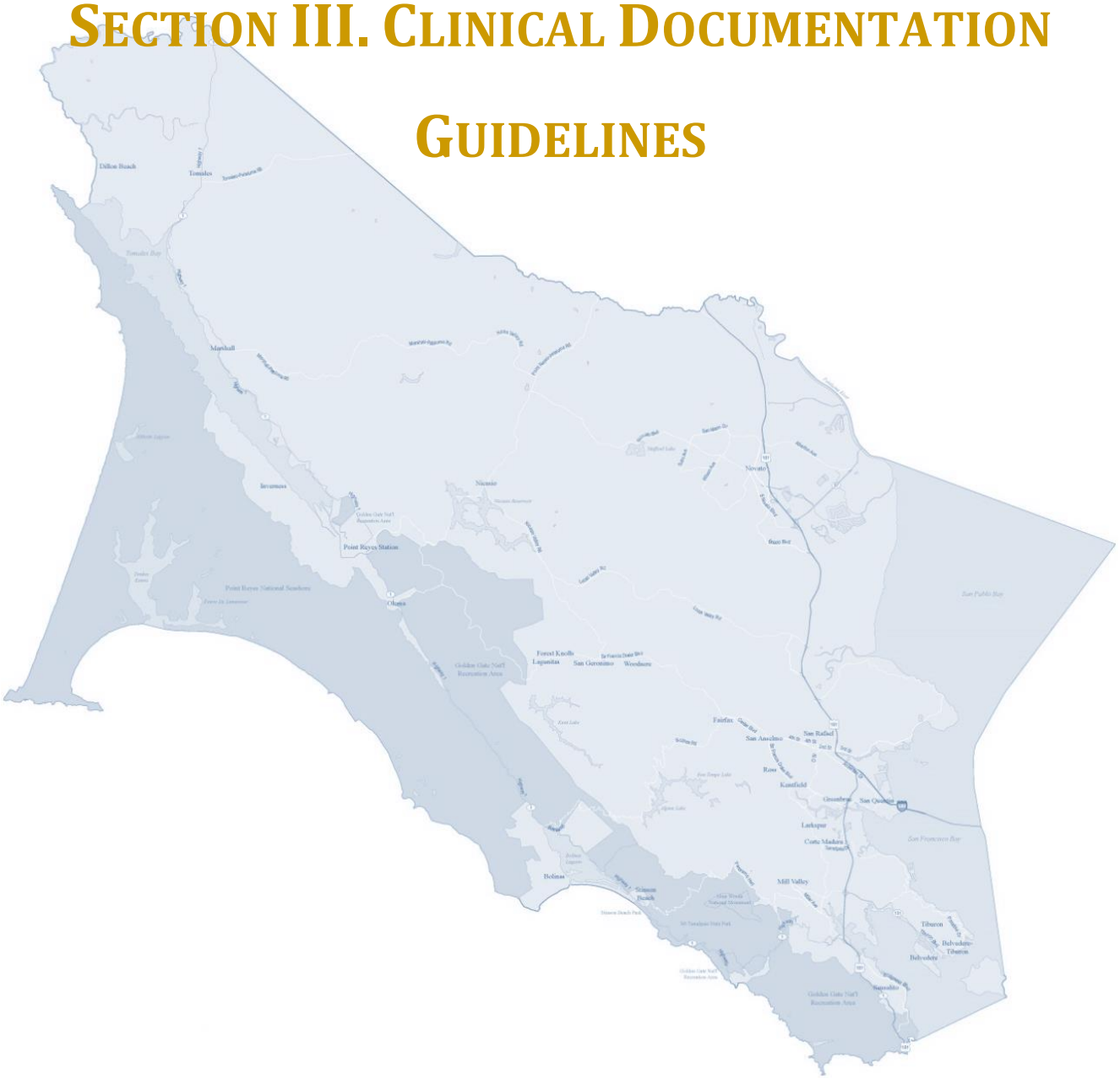
Licensed Practitioner of the Healing Arts (LPHA) Non-Physician: Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Non-Physician LPHAs include: Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

LPHA Physician: Physicians are a sub-category of the LPHA definition and must be licensed, registered, certified, or recognized under California State scope of practice statutes. Physicians shall provide services within their individual scope of practice.

Counselors: "Certified AOD Counselor" means an individual certified by a certifying organization; as defined in Section 13005(a)(2) or 13005(a)(8) of Title 9 of the California Code of Regulations.

Peer Support Specialists: Marin DMC-ODS is in the process of planning for implementation of SB 803, Peer Support Specialist Certification. A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification. A Peer Support Specialist must meet all other applicable California state requirements, including ongoing education requirements. Peer Support Specialists must provide services under the direction of a Behavioral Health Professional. " Additional information will be added upon CMS approval and DHCS review and approval of Marin's Fiscal Plan.

SECTION III. CLINICAL DOCUMENTATION GUIDELINES



COUNTY OF MARIN

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

Clinical Documentation Guidelines

Overview

Below is an overview of clinical documentation requirements for substance use treatment services. Please refer directly to applicable regulations and STCs for additional detail. Note that if there is a conflict between Title 22 and DMC-ODS STCs/BHIN 21-075, the DMC-ODS STCs/BHIN 21-075 prevail. If the DMC-ODS STCs/BHIN 21-075 are silent, then Title 22 prevails. Most documentation requirements outlined below (excluding NTP) are from the DHCS/County DMC-ODS Contract. Note that DHCS expects to release a BHIN related to documentation redesign. The Clinical Documentation Guidelines will be updated accordingly.

Beneficiary File Documentation Requirements

In addition to the requirements of 22 CCR § 51476(a), the provider shall:
Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services. Each beneficiary's individual beneficiary record shall include documentation of personal information.

Documentation of personal information shall include all of the following: Information specifying the beneficiary's identifier (i.e., name, number).; Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, beneficiary's next of kin or emergency contact.

Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including but not limited to: Intake and admission data, treatment plans, progress notes, continuing services justifications, lab orders and results, referrals, counseling notes, discharge plan, discharge summary, authorizations and other relevant treatment services rendered to the beneficiary.

Overview from Intake to Discharge

The following outlines requirements for OS, IOS, Recovery Services, Residential Treatment and Withdrawal Management. For NTP, refer to applicable Title 22 and Title 9 requirements.

Step	What to Document	Timeframe	Who Can Document
Referral and Admission	• All referrals made by the provider • If appropriate, drug screening results • Date of first contact, date of first offered assessment and date of first assessment • Beneficiary Consent to Treatment • Share of cost, if applicable, notification of DMC funding as payment in full	As needed	LPHA; Counselor

	• Review and provision of Beneficiary Informing rights and materials		
Assessment/ Intake	• Drug/Alcohol History • Medical History • Family History • Psychiatric/Psychological History • Social/recreational History • Financial Status/History • Educational History • Employment History • Criminal History, Legal Status • Previous SUD Treatment History • American Society of Addiction Medicine (ASAM) Criteria • Medical Director or LPHA review of personal, medical and SUD history if completed by a counselor	OS, IOS, Recovery Services: Initial assessment completed within 30 calendar days from the beneficiary's first visit (or within 60 calendar days if under 21 or experiencing homelessness) Residential: Within 10 calendar days from the beneficiary's admission to treatment Withdrawal Management: Within 5 days from the beneficiary's admission to treatment	LPHA; Counselor
Physical Exam	• Copy of physical examination completed within prior 12 months in beneficiary record, OR • A physical exam is performed within 30 days of admission to treatment, OR • The beneficiary's initial and updated treatment plans include a goal to obtain a physical examination, until this goal has been met.	Review within 30 calendar days from the beneficiary's admission to treatment	Physician; RNP; PA
Diagnosis	• Basis of diagnosis must be based on DSM 5 criteria • Documented separately from the treatment plan	Except Residential - Within 30 calendar days from the beneficiary's initial visit (or 60 calendar days if under 21 years of age or experiencing homelessness) – A provisional diagnosis shall be used prior to the determination of a diagnosis or in cases where suspected SUD has not yet been diagnosed	LPHA
Medical Necessity	• The medical director or LPHA evaluated the beneficiary's assessment and intake information. • If the beneficiary's assessment and intake information is completed by a counselor, the medical director or LPHA shall also document they met with the counselor through a face-to-face, telehealth or telephone	Within 30 calendar days from the beneficiary's initial visit (or 60 calendar days if under 21 years of age or experiencing homelessness) *Note: Per DHCS, if transitioning between levels of care within the same facility,*	LPHA

	review to establish a beneficiary meets medical necessity criteria. • Substance Use Disorder Diagnosis based on the DSM • Identification of level of care based on ASAM	*the same diagnosis, in conjunction with the new ASAM assessment, may be utilized to establish medical necessity.*	
Treatment Planning	• Statement of problems • Goals [If applicable, also include goal for obtaining a physical exam and goal of obtaining treatment for an identified significant medical illness] • Action steps • Target dates • Type & frequency of counseling/services • Diagnosis • Assignment of primary therapist or counselor • Client, Counselor, & LPHA signatures obtained • Physical exam: Goal if not had within 12-months prior to admission or if within 12-months and indicates a significant illness, a goal that the beneficiary obtains appropriate treatment	OS, IOS, Recovery Services: Within 30 calendar days from the beneficiary's admission to services Residential: Within 10 calendar days from the beneficiary's admission to treatment Withdrawal Management: Within 5 days from the beneficiary's admission to treatment	LPHA; Counselor *Beneficiary signs within same timeframes *If counselor completes, LPHA signs within admission timeframes [and within 15 days from counselor for OS, IOS, NTP, RSS]
Treatment Plan Reviews and Updates	• Treatment plan reviews with the beneficiary shall occur every 30 calendar days (14 calendar days for Withdrawal Management) and shall be documented in Marin WITS. • LPHA/counselor shall complete, type or legibly print name, sign and date the update treatment plan no later than 90 days after signing the initial treatment plan and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. • The beneficiary shall review, approve, type or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of signature by the LPHA or counselor. • If the beneficiary refuses to sign the initial or updated treatment, plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment. If the client refuses to participate in the treatment plan development process, be sure to document attempts made to include the client and keep a copy of the treatment plan (signed by counselor and LPHA) in the client record. • If a counselor completes the updated treatment plan, the medical director or LPHA shall review each updated treatment plan to determine whether		

	continuing services are a medically necessary and appropriate for the beneficiary. • If the medical director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within 15 calendar days of signature by the counselor. Note: During the COVID-19 Public Health Emergency, DHCS granted some temporary flexibilities, including provisions related to signatures on treatment plans. These are temporary and only in effect per DHCS communications. Refer to BH Information Notice 21-046 and below: ***Signatures on Treatment Plans*** When a signature is required on a client plan and a beneficiary is unavailable to sign the plan, such as when the service is done by telehealth or telephone, the reason for the missing signature shall be documented in the client plan. It is not necessary to obtain the signature when the client returns to in-person care. The following approaches are appropriate: • Documenting in the chart that oral consent was obtained in the course of telehealth services, • Use of electronic signatures, such as via DocuSign or similar services, if the e-signature service has a business associate agreement with the applicable covered entity, • Obtaining wet signatures when an in-person visit is made, and • Documenting the reasons for any signatures that are late or missing. ***Signatures consenting to telehealth or telephone visits.*** • California law requires a patient's consent to receive services via telehealth or via telephone to be documented in the client chart. Documentation of verbal consent is sufficient. California law does not specify the frequency a provider is required to obtain consent from a patient. For facilities that participate in Medi-Cal, the DHCS licensing and certification division will accept a one-time consent in the client file. ***Signature Requirements Release of Information:*** DHCS does not have oversight authority over federal requirements. HIPAA requires all authorizations for release of information to have a signature in order to be valid per 45 CFR 164.508. There is no indication from the federal Office of Civil Rights, Health and Human Services that they have waived this requirement due to COVID.		
Continuing Services	Review of the following: • Beneficiary's personal, medical, substance use history • Most recent physical exam	OS, IOS, Recovery Services, Case Management: No sooner than five (5) months and no later than six (6) months	Medical Director; LHPA

	• Progress notes & treatment plan goals • LPHA's/counselor's recommendation • Beneficiary's prognosis		
Discharge Plan *[Unless Provider Loses Contact]*	• List of relapse triggers • Plan for avoiding relapse when faced with triggers • Support plan, with People, Organizations • A copy must be provided to beneficiary • Must be documented	Within 30 days of last face-to-face service During last face-to-face, LPHA/counselor and beneficiary sign and date plan *Note: This does not need to be completed if the beneficiary transitions to another level of care within the same facility within 30 days. The discharge in WITS is still required.*	LPHA; Counselor
Discharge Summary	• Duration of the treatment episode • Reason for discharge Narrative summary of the treatment episode • Prognosis	Within 30 days of last face-to-face	LPHA; Counselor

Sign-In Sheets

Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:

- The typed or legibly printed name and signature of the LPHA(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
- The date of the counseling session.
- The topic of the counseling session.
- The start and end time of the counseling session.
- A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session

Progress Notes

Modality	What to Document
Outpatient Services, Naltrexone, Recovery Services	The LPHA or counselor who provided the service shall record a progress note for each beneficiary who participated in the service. The LPHA or counselor shall type or legibly print their name, and sign and date the note within seven days of the session. Individual narrative summaries documented by the LPHA or counselor shall include all of the following: • The topic of the session or purpose of the service.

	• A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals. • Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service. • Identify if services were provided in-person, by telephone, or by telehealth. • If services were provided in the community, identify the location and how the provider ensured confidentiality.
Intensive Outpatient and Residential Treatment	The LPHA or counselor shall record at a minimum one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. Progress notes are individual narrative summaries and shall include all of the following: • A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals. • A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session. • Identify if services were provided in-person, by telephone, or by telehealth. • If services were provided in the community, identify the location and how the provider ensured confidentiality.
Care Coordination	The LPHA or counselor who provided the treatment service shall record a progress note. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service. Progress notes shall include all of the following: • Beneficiary's name. • The purpose of the service. • A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals. • Date, start and end times of each service. • Identify if services were provided in-person, by telephone, or by telehealth. • If services were provided in the community, identify the location and how the provider ensured confidentiality.
Clinician Consultation, Additional MAT and Withdrawal Management	The medical director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file. The medical director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service.

	Progress notes shall include all of the following: • Beneficiary's name. • The purpose of the service. • Date, start and end times of each service. • Identify if services were provided face-to-face, by telephone or by telehealth.

Reimbursement for Documentation Time

If DMC-ODS providers plan to claim for documentation time, they must submit in writing to the Contract Manager the agency's documentation standards and a plan for how they will internally monitor compliance with documentation time standards, and participate in at least one in-person training with the WITS administrator during office hours.

Following written approval by BHRS, DMC-ODS providers may submit claims for documentation time for claiming General Outpatient, Intensive Outpatient, Recovery Services and Case Management services as follows:

- The Medical Director, LPHA or counselor shall record their completion of progress notes, treatment plans, continuing services justification and discharge documentation that includes at a minimum the following:
    - Name of beneficiary
    - Date original treatment service was provided
    - Date documentation of progress note, treatment plan, continuing services justification or discharge documentation was completed, which includes start and end time.
- The Medical Director, LPHA or counselor shall type or legibly print their name, and sign and date the record within seven (7) calendar days of the service requiring documentation.

For example, if a group counseling service took place from 2:00pm – 3:00pm on January 1, 2019 and the counselor completed the progress notes from 1:00pm – 1:20pm on January 2, 2019, then the start/end time of the Encounter in WITS shall be from 2:00pm – 3:20pm on January 1, 2019—and the progress note for the Encounter should include all of the required progress note elements noted in the previous section above—plus—a note indicating the start and end date and time of the documentation for each beneficiary.

Note that initially, BHRS is limiting the time that can be claimed as follows:

- Group counseling progress notes – Up to 10 minutes per client
- Individual counseling and case management progress notes – Up to 15 minutes per session, though not to exceed the time of the service *[For example, if the case management session was 10 minutes, the time to document the progress note shall not exceed 10 minutes]*
- Documentation preparation of treatment plans, discharge documentations and continuing services justifications *[Note: this is for any documentation time outside of the face-to-face service with the client]* – BHRS-approved agency-specific standards

*Reminder: Documentation time claimed must reflect the actual time—up to the approved maximums. Documentation time shall not be rounded.

Additional Documentation Reminders:

- 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 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.
- Perform monthly verification of Marin Medi-Cal eligibility prior to rendering services
- Reference all types of services that are being prescribed, including case management and collateral, if appropriate
- LPHA shall document the face-to-face review with the counselor validating/verifying medical necessity
- Document evidence of reviewing and offering beneficiary informing materials
- Enter ASAM data for all assessments and re-assessments into the ASAM section in Marin WITS within seven (7) days of the assessment or re-assessment
- Enter into Marin WITS: Timely Access data, including requests for urgent appointments; Preferred language and language in which services are provided to the beneficiary; Evidence-based practice(s) used; No show data; documentation of follow-up post discharge from treatment; and documentation of transitions between levels of care.

Personnel File Documentation Requirements

Required Staff Documents

Contractor agrees to maintain the below requirements for each staff member whose salaries, wages, and benefits are reimbursable in whole or in part under this Agreement. All supporting documents shall be kept in personnel files. A formal evaluation shall be completed annually, or as requested by the County, through a Provider Self-Audit and on-site visit. [Reference: California Department of Health Care Services, Alcohol and/or Other Drug Program Certification Standards (Section 13000 Personnel Practices), Drug/Medi-Cal Certification Standards, and State/County Intergovernmental Agreement, Exhibit A, Attachment I.]

Provider Staff

- Job Description: Contractor shall document staff job descriptions, including but not limited to the minimum qualifications for employment (e.g. education, training, work experience), duties and responsibilities performed, salary schedule and salary adjustments, title and classification, and lines of supervision.
- Application for Employment and/or Resume
- Signed Employment Confirmation Statement/Duty Statement
- Employee Performance Evaluations

- Other Personnel Actions: Including but not limited to; commendations, discipline, status change, employment incidents and/or injuries
- Health Records: As required by the Provider, AOD Certification or Title 9
- Current registration, certification, inter status, or licensure
- Proof of Continuing Education required by licensing or certifying agency and program
- Code of Conduct: provider's Code of Conduct and for registered, certified and licensed staff, a copy of the certifying/licensing body's code of conduct. The written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
    - a. Use of drugs and/or alcohol;
    - b. Prohibition of social/business relationship with beneficiary's or their family members for personal gain;
    - c. Prohibition of sexual contact with beneficiary's;
    - d. Conflict of interest;
    - e. Providing services beyond scope;
    - f. Discrimination against beneficiary's or staff;
    - g. Verbally, physically, or sexually harassing, threatening, or abusing beneficiary's, family members or other staff;
    - h. Protection beneficiary confidentiality;
    - i. The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under; and
    - j. Cooperate with complaint investigations.
- New Staff/Provider Orientation: Contractor shall document staff member's participation in applicable New Staff/Provider Orientation.
- Staff/Role Changes: Contractor shall document in the personnel file of any staff role changes
- Training Documentation
  Contractors are required to have all applicable staff adhere to DHCS STCs by participation in following trainings as outlined below:

LPHA – Additional Requirements

Medical Director: Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a provider representative and the physician.

LPHA CEU Requirements: All LPHAs shall have at least 5 CEUs annually in Addiction Medicine.

Provider Volunteers

If a provider utilizes the services of volunteers and or interns, procedures shall be implemented which address: a. Recruitment; b. Screening; Selection; c. Training and orientation; d. Duties and assignments; e. Scope of practice; f. Supervision; g. Evaluation; and h. Protection of beneficiary confidentiality.

Additional Resources and References:

Title 22, Section 51341.1
Title 9, Chapter 4
DHCS/County DMC-ODS Intergovernmental Agreement
SABG Performance Contract
DHCS SABG Policy Manual
WITS Intake Checklist
Entering ASAM Data into Marin WITS
Entering Timely Access Data into Marin WITS
Entering Sexual Orientation and Gender Identity (SOGI) Data into Marin WITS

SECTION IV. ADMINISTRATIVE GUIDELINES

Contracts

Contract Selection

As outlined in Policy BHRS-83 Selecting Provider Contracting Requirements, Marin County BHRS establishes standards for contract selection and retention, outlines processes for contract denial and appeals, and identifies applicable provider performance requirements for primary prevention, intervention and treatment services. All standards and procedures apply equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high risk or specialized services.

In general, BHRS selects providers for programs and services through a competitive solicitation process that allows for the selection to be made on an objective and fair basis. Although the term of the award may vary depending on funding source requirements and other factors, the typical contract award term is three years, with the potential to extend to up to five years, depending on contract performance and availability of funding. Despite the term of the award, annual renewals are contingent on successful contract performance, continued need for the service(s), availability of funding and other factors that the County may deem appropriate. In general, the competitive solicitation process for existing contracted services should take place at least every five years.

Refer to Policy BHRS-83 Selecting Provider Contracting Requirements for additional detail on: 1) Selection and Retention of Providers; 2) Contract Denial and Appeal Process; 3) Provider Performance and Service Requirements; and 4) Monitoring and Auditing.

New Provider Orientation and Training

Marin BHRS will provide orientation to new Providers on contract requirements via individual trainings, distribution of written documents, monthly Provider meetings and weekly Marin WITS office hours. Providers are responsible for providing onsite orientation and training to non-professional staff prior to performing assigned duties and ensuring professional staff possess the appropriate experience and training. While it is ultimately up to Providers to ensure staff are trained, BHRS also offers many of the required trainings, which providers are invited to attend.

Contract Execution and Renewal

A Contractor Renewal Manual has been developed to serve as a guide to orient providers to the Division's various contract renewal requirements. This manual includes the instructions and forms for the renewal process. Please visit the Contractor Resources section of our website for fillable templates, links to relevant regulations, standards and policies, and a variety of additional resources related to billing, documentation and reporting.

Credentialing, Exclusion and Debarment

Prior to the effective date of Contract, Contractor must certify that it is not excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social

Security Act. Failure to so certify will render all provisions of this Contract null and void and may result in the immediate termination of the Contract.

- www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
- www.sam.gov/portal/SAM - GSA Exclusions Extract
- www.Medi-Cal.ca.gov – Suspended & Ineligible Provider List

In addition, Contractor shall certify, prior to the execution of the contract, that the Contractor does not employ staff or sub-contractors who are excluded from participation in federally funded health care programs. Contractor shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, CA Department of Health Care Services or the US Department of Health & Human Services.

- www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
- www.sam.gov/portal/SAM - GSA Exclusions Extract
- www.Medi-Cal.ca.gov – Suspended & Ineligible Provider List

Contractor shall certify, prior to the execution of the contract that the Contractor does not employ staff or sub-contractors that are on the Social Security Administration's Death Master File. Contractor shall check the following database prior to employing staff or sub-contractors, and provide evidence of these completed searches when requested by County, CA Department of Health Care Services or the US Department of Health & Human Services.

- https://www.ssdmf.com/ - Social Security Death Master File

Contractor is required to notify County immediately if they become aware of any information that may indicate their (including employees and subcontractors) potential placement on an exclusions list.

The County and the Contractor shall comply with the provisions of Title 42 § 438.610 and Executive Orders 12549 and 12689, "Debarment and Suspension," which excludes parties listed on the General Services Administration (GSA) list of parties excluded from federal procurement or non-procurement programs from having a relationship with the County or Contractor.

Additional Required Documents for Licensed and Certified Providers Only:

<u>License Verification</u>

Contractor shall ensure that all staff and subcontractors providing services will have all necessary and valid professional certification(s) or license(s) to practice the contracted services. This includes implementing procedures of professional license checks, credentialing and re-credentialing, monitoring limitations and expiration of licenses, and ensuring that all providers have a current National Provider Identifier (NPI) through the National Plan and Provider Enumeration System (NPPES). Contractor shall provide evidence of these completed verifications when requested by County, DHCS or the US Department of Health & Human Services.

<u>Counselor Certification</u>

Effective April 1, 2005, any individual providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program are required to be certified. In accordance with HSC Section 11833(b)(1), any individual who provides counseling services in a licensed or certified AOD program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization. Licensed professionals (LCSW, MFT, Psychologist or interns) are not required to be certified.
[Reference: Adoption of Chapter 8 (commencing with Section 13000), and Amendment of Sections 9846, 10125, and 10564, Division 4, Title 9, California Code of Regulations, Health and Safety Code 11833(b)(1), and MHSUDS Information Notice No. 16-058]

If a Provider's license, certification, or registration has lapsed, then they cannot provide any of the treatment services listed above until such a time as their license, certification, or registration becomes active again.

To verify Licensed and Associate level staff visit: https://search.dca.ca.gov/
To verify Certified and Registered level staff visit:
CCAPP: https://ccappcredentialing.org/index.php/verify-credential
CADTP:http://www.cadtp.org/counselors/search.php?term=AYALA&submit=Search
CAADE: http://caadeorg.azurewebsites.net/searchrecordscompound.php

Proof of Continuing Education
As required by Licensing or Certifying Agency and Program

Attestation
Contractors must ensure that all of their network providers, delivering covered services, sign and date an attestation statement provided by BHRS in which each provider attests to the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
- A history of loss of license or felony convictions;
- A history of loss or limitation of privileges or disciplinary activity;
- A lack of present illegal drug use; and
- The application's accuracy and completeness

Contractor must file and keep track of attestation statements for all of their providers and must make those available to BHRS upon request at any time.

Additional Credentialing and Re-Credentialing Information
Refer to Contract Exhibit I, Section 13 for additional information about Credentialing and Re-Credentialing.

Contract Updates and 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 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, telehealth or field-based

Budget

- Proposing to re-distribute more than 20% between budget categories
- Proposing to increase or decrease FTE
- Proposing to increase the contract maximum

Provider Reporting and Monitoring Requirements

Overview of Program Submissions

Program Reporting

To document program activities and progress toward achieving the expect outcomes, Providers are required to collect and submit the following:

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 Contract Manager	E-mail
Marin WITS (CalOMS) - Client-specific data - Drug/Medi-Cal Billing - Addressing Errors and Open Admissions - ASAM, Timely Access	Client-specific data should occur within 7 days of event	Marin WITS: www.MarinWITS.org	Electronic Submission
Any issue that would require a Notice of Adverse Benefit Determination (NOABD)	Within 24 hours of the event requiring a NOABD	BHRS Contract Manager	E-mail (encrypted)
Adult Drug Court Weekly Progress Reports	By 12noon every Thursday	Cynthia Nisbet	Encrypted E-mail or Secure Fax
Staff Update Form	Prior to or within 24 hours of the staff change [e.g. new staff, separating staff, change of roles]	Leigh Steffy	E-mail

Monthly Submission			
Monthly Provider Check and Attestation	By the 10th of the month	BHRS Office	E-mail
All Billing Invoices and Supporting Documentation	By the 10th of the month	Marin WITS and BHRS Office	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 notification of denial	Marin WITS	Electronic Submission
Non-Fatal Overdose Outreach Log	By the 10th of the month	Susanne Mitchell	E-mail (encrypted)
Prevention Providers Only: PPSDS Data Template	By the 10th of the month	BHRS Office	E-mail
Annual Submission			
Provider Self Audit *Including Prevention Providers*	January (Annually)	BHRS Office	Hard Copy (signatures) and Electronic Copy
Annual Report *Including Prevention Providers*	July 31 (Annually)	BHRS Office	E-mail or Hard Copy
Provider Cost Reports *Including Prevention Providers*	Late August/ Early September (Annually)	BHRS Office	TBD

Not Accepting New Beneficiaries/Waitlist

In the event a Provider is unable to accept new beneficiaries, the Provider will need to report the following:

- Report to BHRS Office via e-mail by 9:00AM each day that the program is not accepting new beneficiaries
- Submit the waitlist and capacity information to DHCS via the DATAR system; for more information see: DHCS DATAR User Manual [Reference: Interim Services: BHRS-59]
- Interim services are required by all treatment services providers for any individual who is unable to be provided an intake appointment within Timely Access Standards [Reference: Interim Services BHRS-59]
- Add Client to Waitlist in Marin WITS; for more information on entering data into Marin WITS, see: How to Add a Client to Waitlist
- If the time from the initial request to the first offered face-to-face appointment exceeds 10 business days, then immediately contact the BHRS Office to ensure a Notice of Adverse Benefit Determination is issued.

Claims Submission and Re-Submission

Invoices and applicable supporting documentation are due by the 10th of the month for services delivered the preceding month.

Following claims submissions to the County by the 10th of the month for services delivered the preceding month and a subsequent utilization review of Drug/Medi-Cal files, the County will submit eligible Drug/Medi-Cal claims received by the Contractor to DHCS.

Any Drug/Medi-Cal denials shall be resubmitted, as appropriate, by the Contractor to the County, by the 20th of the month following notification of the denial.

Monthly Reporting - Provider Check and Attestation

A reminder and request for attestation of compliance with submission of required information is sent to each provider monthly. An evaluation of the signed attestation and supporting documents will be completed monthly by the provider's Contract Manager. The requirements include, but are not limited to:

	Description	Timeframe
DATAR	Submit waitlist and capacity information to DHCS via the DATAR system. [Reference: BHRS-59 and BHRS-68]	By the 10th of the month for services rendered in the previous month
Billing	Submit all claims for services rendered in the preceding month. For Drug/Medi-Cal providers, the Drug/Medi-Cal Claim Submission Certification form (DHCS 100185) shall also be completed and submitted via e-	By the 10th of the month for services rendered in the previous month

	mail to your contract manager. [Reference: MHSUS-ADP-18]	
CalOMS	Input data within seven days of the event for all clients receiving reportable services, regardless of the client's funding source. [Reference: BHRS-68]	Within seven days of the event
Open Admissions	Monitor Open Admissions on a regular basis and be sure to enter discharge and Annual Update (if applicable) data in a timely manner. Note that if a client does not receive services for 30 days, they must be discharged.	Discharges: Close in WITS within seven days of discharge. Annual Updates: Complete between 11-12 months from the last admission or Annual Update.
Staff/Role Changes	E-mail a completed Staff Update Request Form (previously titled Marin WITS User Request/Change Form) and Marin WITS Electronic Signature Agreement to Leigh Steffy (lsteffy@marincounty.org), with a copy to your contract manager. [Reference: BHRS-SUS-08]	Prior to or within 24 hours of staff changes taking effect
Priority Population/ Interim Services	Notify your contract manager when a priority population is awaiting admission to treatment. The information shall also be entered on the Interim Services List in Marin WITS. [Reference: BHRS-69]	Within 48 hours
Unusual Occurrence or Incident	Notify the County Alcohol and Drug Administrator of an Unusual Occurrence (All Providers) or Incident (Licensed Residential Providers) [Reference: Exhibit I; Title 9]	Unusual Occurrence: Within five days or ASAP Incident – Telephonic within one day
Corrective Action Plan/ Notice of Deficiency	Notify County Alcohol and Drug Administrator of receipt of any DHCS report identifying non-compliance or processing requesting a CAP and submit copy of CAP to County Alcohol and Drug Administrator. [Reference: Exhibit I]	Within two business days
For Drug/Medi-Cal (DMC) Providers [Reference: BHRS-73]		
Timely Access	Notify your contract manager of any challenges providing timely access to services	Within two business days
Reduction in Services/ Changes	Notify your contract manager in writing of any proposed reductions in covered services, changes in location, changes in ownership,	60 days prior to the proposed effective date

	remodeling or any other triggering recertification event	
Facility/Program Closure	Notify AOD Administrator in writing of plans to surrender DMC certification or close the facility	Within two business days

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).

Timely Access

Contractors are required to enter Timely Access data into Marin WITS within seven (7) days of the intake. Refer to Section I for Timely Access Standards. For more information on entering data into Marin WITS, see: Timely Access Data Entry Instructions

Serious Incident Reporting

Per Policy BHRS-06, Contractor shall report Serious Incidents (formerly referred to as unusual occurrences) to the County of Marin BHRS Quality Management and Substance Use Services. A Serious Incident is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including but not limited to physical injury and death.

Level 1

- Any event that has been reported in the media (including social media), current or recent past regardless of the type of incident.
- The event has resulted in a death or serious physical injury on the program's premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

Level 2

- All other serious incidents are reported as Level 2.

Whenever there is a determination of a serious incident, the staff member most familiar with the situation is to consult with their supervisor and/or Program Manager and complete a Serious Incident Report.

Serious Incidents need to be reported to BHRS quality management as soon as possible. A Level 1 incident is to be securely emailed to BHRSQM@marincounty.org or faxed to 415-329-3312 immediately upon knowledge of the incident. A Level 2 incident is to be securely emailed or faxed within 3 calendar days of knowledge of the incident. Copies of Serious Incident Reports must not be retained by staff, supervisors or management.

The County and DHCS retain the right to independently investigate unusual occurrences and Contractor will cooperate in the conduct of such independent investigations.

Residential substance use treatment facilities licensed by DHCS shall also comply with reporting unusual incidents as outlined in Title 9 CCR, Chapter 5, Subchapter 3, Article 1. Contractor shall notify the County Alcohol and Drug Administrator concurrently, which is a telephonic report within one (1) working day of the event, followed by a copy of the written report submitted to DHCS within seven (7) days of the event.

Privacy and Security Breach Reporting

Contractor shall, immediately upon discovery of a breach of privacy and/or security of PII and/or PHI by Contractor, notify County of such breach by telephone and email or facsimile to the following contact: BHRS Privacy Officer – Ph: (415) 473-6948, e-mail: HHSCompliance@marincounty.org or Fax: (415) 473-2627. Contractor further agrees that it shall notify County of any such breaches prior to the time the County is required to notify the State pursuant to the State Contract.

In the event the State Contract requires the County to pay any costs associated with a breach of privacy and/or security of PII and/or PHI, including but not limited to the costs of notification, Contractor shall pay on County's behalf any and all such costs arising out of a breach of privacy and/or security of PII and/or PHI by Contractor.

Reporting of Potential Fraud, Waste or Abuse

If any provider suspects an overpayment or potential fraud, waste or abuse, promptly report it. You can contact the following:

- Marin County HHS Compliance Hotline (Anonymous): 415-473-6984 or HHSCompliance@marincounty.org

- DHCS Medi-Cal Fraud Hotline: 1-800-822-6222 or
  E-mail: fraud@dhcs.ca.us or
  Mail: Medi-Cal Fraud Complaint – Intake Unit, Audits and Investigations
  PO Box 997413, MS 2500
  Sacramento, CA 95899-7413

In addition, notify the County Alcohol & Drug Administrator to ensure that the DMC-ODS promptly reports and documents any overpayments. Providers shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud, **immediately upon discovery and no later than 5 calendar days** when it has identified payments in excess. All overpayments shall be returned to the County within 60 calendar days after the date on which the overpayment was identified, or the date any corresponding cost report is due, if applicable.

DHCS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Contract Monitoring

Below is an overview of the scope of Contract Monitoring. Refer to Marin County Policy BHRS-24 Monitoring for a detailed description of monthly, annual and ongoing monitoring of County-operated and contracted provider substance use services.

Monthly Monitoring – Beneficiary File Reviews

To ensure the provision of high quality care, compliance with applicable regulations, and submission of accurate claims to DHCS, BHRS Quality Management performs a monthly documentation review at all contracted and County-operated treatment facilities. The Utilization Review Specialist reviews files for new beneficiaries accessing services, beneficiaries due for a treatment plan update, and beneficiaries discharged from services. The list also includes at least one additional randomly selected beneficiary in order to review progress notes.

Based on the review, BHRS Quality Management staff will: 1) Issue a report to the provider summarizing the findings, including whether a Plan of Correction is required; 2) Issue a report to the BHRS Contract Manager identifying whether any claims shall be excluded from submission to DHCS; and 3) Offer technical assistance to providers to improve documentation, as applicable.

Ongoing Monitoring – Utilization, Quality and Compliance

In order to monitor over or underutilization of services, timely access to care, timely identification of quality of care issues, network adequacy and other pertinent information, BHRS also staff performs the following:

- On a monthly basis, reviews of units of service for each modality in order to track utilization and move funding/capacity between programs as needed
- On a monthly basis, reviews UR Report to adjust claims, as applicable, and identify trends and needs for training and technical assistance
- On a quarterly basis, reviews data included in the BHRS DMC-ODS Quality Improvement Plan in order to identify utilization, capacity, timely access, beneficiary outcomes and areas needing improvement
- On a monthly basis, reviews of the Provider Report/Attestation and follows-up, as indicated and applicable

Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the

safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

Fiscal Monitoring – Annual Cost Report

Contractor shall provide County with an annual Cost Report no later than sixty (60) days after the termination of this agreement. In addition to the annual Cost Report, Contractor shall furnish County, within one hundred and eighty (180) days of close of contractor fiscal year, a certified copy of an Audit Report from an independent CPA firm. [Reference PSC, Exhibit I] This Audit Report shall cover Contractor's fiscal year which most nearly coincides with County's fiscal year. Contractors receiving federal funds shall comply with Office of Management and Budget (OMB) Circular Number A-133, Uniform administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and other Nonprofit Organizations. Cost Report settlements shall be made when a proper Cost Report has been submitted to the County. The findings of the annual Cost Report shall be subject to an audit by County and State. The State of California may make such audits as it deems necessary for the purpose of determining reimbursement due to the County.

Contractor is responsible for the repayment of all exceptions and disallowances taken by local, State and Federal agencies, related to activities conducted by Contractor under the Agreement. Where unallowable costs have been claimed and reimbursed, they will be refunded to County. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with Contractor, and if the Contractor disagrees with audit disallowances related to its programs, claims or services, County shall, at the Contractor's request, request an appeal to the State via the County. [State-County Intergovernmental Agreement, Exhibit B]

Where contracts exceed $10,000 of state funding – the Contractor shall be subject to examination and audit of the Department of Auditor General for a period of three (3) years after final payment under contract (Government Code § 8546.7).

Annual Program and Fiscal Monitoring

Formal fiscal and program monitoring shall take place annually, or more often as requested by the County. The County will issue a written report, which will be forwarded to DHCS within two weeks of issuance. Should any Corrective Actions be required, then Contractor shall submit a written response within the timeframe outlined in the report, and such response shall be part of the official written report provided for in this section.

Annual onsite Program monitoring reviews will include, but are not limited to, the following:
Prevention Providers

- Certification of Completion of Staff Required Trainings
- Compliance with all required Policies and Procedures
- Adherence to Strategic Prevention Framework
- Objective Obtainment

- Expenditure of SAPT Block Grant Prevention Set-Aside Funding
- PPSDS Quality and Compliance
- Implementation of and Compliance with CLAS Standards

DMC-ODS and SABG Providers

- Certification of Completion of Staff Required Trainings
- Compliance with all required Policies and Procedures
- Adherence to applicable DMC-ODS STCs/IA, Title 22, Title 9, 42 CFR Part 438 and other regulations
- Objective Obtainment
- Expenditure of SABG, DMC-ODS and other Funding
- CalOMS Quality and Compliance
- Implementation of and Compliance with CLAS Standards
- Review of Personnel and Beneficiary Files
- Follow-up from County and DHCS-issued Corrective Action Plans and Grievances and Appeals
- Site Tour for review of cleanliness, Basic or Limited accessibility, and posting of required materials.
- Review of data related to quality, timeliness, access and outcomes, including Treatment Perception Survey data

Corrective Action Plan (CAP)

Corrective Action Plan means the written plan of action document which the Contractor or its subcontracted service provider develops and submits to the County to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

Where a monitoring report contains findings of non-compliance, a deadline for the agency to submit their correction action plan is provided on the report, typically 30 days from the date of the report. If there are no findings, the monitoring report represents closure of the monitoring cycle.

Additionally, Contractor shall notify the County Alcohol and Drug Administrator within two business days of receipt of any DHCS report identifying non-compliance services or processes requiring a Corrective Action Plan (CAP). Contractor shall submit the CAP to DHCS with the designated timeframe specified by DHCS and shall concurrently send a copy to the County Alcohol and Drug Administrator.

Deficiencies vs. Disallowances

Deficiencies are cited when an agency is non-compliant to federal, State, and County regulations, standards, provisions, and practices.

Disallowances are a type of deficiency that may result in taking back funds for a particular service/activity. This occurs when there is insufficient evidence or documentation that a service/activity took place or met the requirement.

Participation in External Reviews

Treatment Perception Survey

DMC-ODS Providers are required to participate in the annual administration of the Treatment Perception Survey. The target population is every adult (18+) who physically presents and receives face-to-face services at outpatient, residential, NTP, WM/detox providers within the survey period. Surveys are anonymous and direct service staff must not be present when the client completes the survey. Based on the results, all facilities must select and implement at least one Performance Improvement Project annually.

External Quality Review

As required by Title 42, Code of Federal Regulations, Part 438 the Department of Health Care Services contracts with an External Quality Review Organization (EQRO). The EQRO conducts reviews of Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans to analyze and evaluate information related to quality, timeliness, and access to DMC-ODS Services provided by California's opt-in counties and/or their subcontractors to Medi-Cal beneficiaries.

EQRO reviews consist of site visits, consumer (beneficiary) and family member focus groups, DMC-ODS and provider staff focus groups, data analysis and reporting, information system reviews, and the evaluation of DMC-ODS Performance Improvement Projects (PIPs).

Providers are expected to provide requested data and participate in various sessions, as applicable.

Finance Management

Financial Records

Contractor shall maintain books, records, files, documents and evidence directly pertinent to work under this Agreement in sufficient detail to make possible an evaluation of services provided and compliance with DHCS regulations, as applicable, and in accordance with accepted professional practice and accounting procedures for a minimum of ten (10) years after the termination of the Agreement. Contractor agrees to extend to DHCS and to the County and their designees the right to review and investigate records, programs, and procedures, as well as overall operation of Contractor's program with reasonable notice.

Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and

schedules for allocating costs. Fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with the procedures and accounting principles set forth in the State Department of Health Care Services' Cost Reporting/Data Collection Systems.

Rates

Interim rates are based on weighted averages and are for cash flow purposes– they will not be the rates reflected in provider contracts. BHRS will negotiate provider-specific fee-for-service rates.

Similar to current requirements, cost reports will need to reflect actual costs for DMC, Non-DMC and Other/Private for each modality of service. HHS Fiscal can provide technical assistance to ensure DMC-ODS providers have sufficient systems and clear methodologies to track expenditures and revenues prior to commencing services.

Client Fees

Contractor shall charge participant fees. No one shall be denied services based solely on ability or inability to pay. [Reference PSC, Exhibit I]

Contractor shall perform eligibility and financial determinations in accordance with a fee schedule approved by the Chief of Alcohol and Drug Programs for this purpose. Individual income, expenses, and number of dependents shall be considered in formulating the fee schedule and in its utilization.
[Reference PSC, Exhibit I]

Contractor agrees to have on file with the County a schedule of Contractor's published charges, if applicable.

Contractor shall conduct community-centered fundraising activities, as appropriate. [Reference PSC, Exhibit I]

Reimbursement

Contractor will be paid on a monthly basis, following the submission of an invoice (submitted through Marin WITS, as applicable, and/or on a template provided and/or agreed to by the County) for services delivered to the County's satisfaction. Contractor will be reimbursed the negotiated unit of service rate for all approved claims. For Fee for Service Providers, final settlement will be the total of approved claims times the negotiated Fee for Service rate, up to the contract maximum.

Unless otherwise noted in the contract, contractor will be reimbursed on a Net 30 basis, meaning generally, payments will be processed within 30 days from the invoice date.

Unless otherwise noted in the contract, services provided and reimbursed under this contract are only for Marin County Medi-Cal beneficiaries and low-income (< 138% FPL) uninsured Marin residents.

Additional SAPT Block Grant (SABG) Funding Requirements

Prior to expending SABG funding, every reasonable effort should be made to, including the establishment of systems for eligibility determination, billing, and collection: (1) Collect reimbursement of the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program; and (2) Secure from patient or clients payments for services in accordance with their ability to pay.

In accordance with Title 45 Code of Federal Regulations, Part 96, Section 96.137, SAPT Block Grant funding is the "payment of last resort" for services for Pregnant and Parenting Women, Tuberculosis, and HIV. [Reference 45CFR, 96.137]

SABG may not be used to pay for a service that is reimbursable by Medi-Cal.

SABG may not be used on the following activities:

- Provide inpatient services.
- Make cash payments to intended recipients of health services.
- Purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment
- Satisfy any requirement for the expenditure of SABG funds as a condition for the receipt of federal funds.
- Provide financial assistance to any entity other than a public or nonprofit private entity.
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level II of the Executive Salary Schedule for the award year: see http://grants.nih.gov/grants/policy/salcap_summary.htm.
- Purchase treatment services in penal or correctional institutions of the State of California.
- Supplant state funding of programs to prevent and treat substance abuse and related activities.
- Carry out any program prohibited by 42 USC 300x–21 and 42 USC 300ee–5 such that none of the funds provided under this Act or an amendment made by this Act shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome.