

EXHIBIT A – SCOPE OF SERVICES

CARE COORDINATION AND RECOVERY SERVICES

JULY 1, 2026 – JUNE 30, 2027

Services Provided	<p>Care Coordination: <i>Non-DMC-ODS Service Code: 68; DMC-ODS: Refer to Exhibit A for HCPCS/CPT Codes].</i> Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the member with linkages to services and supports designed to restore the member to their best possible functional level.</p> <p>Care coordination shall be provided to a member in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. Standalone Care Coordination refers to providing care coordination services to a member who is not actively receiving treatment at a level of care (e.g. they are attempting to engage in treatment or the providers are coordinating a referral). Standalone Care Coordination services can be provided for up to 30 days during the initial assessment period (or up to 60 days if the member is experiencing homelessness or under 21 years of age).DMC-ODS plans, through executed memoranda of understanding, shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.</p> <p>Care coordination includes one or more of the following components:</p> <ol style="list-style-type: none">1. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.2. 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.3. 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.4. For guidance on claiming for care coordination within a level of care or as a standalone service, please refer to the most current DMC-ODS Billing Manual. <p>Contractor shall have procedures for: 1) obtaining releases/consents to exchange information with applicable mental health/primary care providers; 2) linking members to and coordinating with applicable mental health and primary care providers; and 3) providing members the contact information of their assigned Care Coordinator</p> <p>Recovery Services: <i>[Non-DMC-ODS: Service Code 32; DMC-ODS: Refer to Exhibit A for HCPCS/CPT Codes]</i> Recovery Services are designed to</p>
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	<p>support recovery and prevent relapse with the objective of restoring the member to their best possible functional level. Recovery Services emphasize the member’s central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.</p> <p>Recovery Services can be delivered as a standalone service, concurrently with the other levels of care described in the “Covered DMC-ODS Services” section of BHIN 24-001 (or subsequently issued BHIN), or as a service delivered as part of these levels of care. Recovery Services may be provided in clinical or non-clinical settings (including the community).</p> <p>Members may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Members do not need to be diagnosed as being in remission to access Recovery Services. Members may receive Recovery Services while receiving other DMC-ODS services, including MAT services and including NTP services. Members may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.</p> <p>Recovery Services include the following service components:</p> <ol style="list-style-type: none"> 1. Assessment 2. Care Coordination 3. Counseling (individual and group) 4. Family Therapy 5. Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the member’s SUD. 6. Relapse Prevention, which includes interventions designed to teach members with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the member’s SUD <p>For additional guidance regarding information on DMC-ODS claims for services delivered by peers as a component of Recovery Services, please refer to BHIN 22-005.</p>
<p>Performance Standards</p>	<p>Access to Care</p> <p>Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be entered into the BHRS EHR within seven (7) days of the intake.</p> <p>Performance Standard:</p> <ul style="list-style-type: none"> • Routine Appointment: First face-to-face appointment shall occur within five (5) business days and no later than 10 business days of initial contact. Urgent Appointment: First face-to-face visit within 48 hours of the request for urgent conditions. • There are no inequities in timely access to care when stratified by race/ethnicity and gender identity

- Timely access data will be entered in the Marin’s Electronic Health Record within seven (7) days of first contact for 100% of members.

CalAIM Justice Involved Re-Entry Initiative - Behavioral Health Links

As part of Behavioral Health Links, Contractor is required, within 14 days prior to release (if known), and in coordination with the pre-release care manager, or designee, to ensure processes are in place for a BH Link between the correctional behavioral health provider, Contractor, and the member.

Transitions Between Levels of Care

Appropriate Care coordinators/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in Marin’s Electronic Health Record.

Performance Standard:

- Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.
- There are no inequities in transitions between levels of care when stratified by race/ethnicity and gender identity

Care Coordination and Linkage with Ancillary Services

The Contractor shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. The Contractor shall screen for and link clients with mental and physical health, as indicated. Contractors will implement procedures to ensure members are provided contact information for their assigned Care Coordinator(s) and document in the client record.

Performance Standard:

- There is documentation of physical health and mental health screening in 100% of member records
- At least 80% of members have 42 CFR compliant releases in place to coordinate care with physical health providers
- At least 70% of member records have documentation of coordination with physical health
- At least 80% of members engaged for at least 30 days will have an assigned Primary Care Provider
- At least 80% of members 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 member records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).
- At least 85% of members will contact information for a designated contact responsible for coordinating the member’s care

	<p>Medications for Addiction Treatment</p> <p>Contractors will either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for members with SUD diagnoses that are treatable with medications or biological products. An effective referral mechanism/process is defined as facilitating access to MAT off-site for members while they are receiving services if not provided on-site. Providing a member the contact information for a treatment program is insufficient. Contractor staff will regularly communicate with physicians of members who are prescribed these medications unless the member refuses to consent a 42 CFR, Part 2 compliant release of information for this purpose.</p> <p>Performance Standard:</p> <ul style="list-style-type: none"> • At least 80% of member 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 members with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services <p>Culturally Responsive Services</p> <p>Contractors are responsible to provide culturally responsive services. Contractors must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation and oral interpreter services must be available for members, as needed and at no cost to the member.</p> <p>Performance Standard:</p> <ul style="list-style-type: none"> • 100% of members that speak a threshold language are provided services in their preferred language. <p>Delivery of Individualized and Quality Care</p> <p><u>ASAM Level of Care:</u> All members participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in Marin's Electronic Health Record with seven (7) days of the assessment.</p> <p>Performance Standards:</p> <ul style="list-style-type: none"> • Contractor will implement with fidelity at least two approved EBPs • 100% of members participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care • 100% of members are re-assessed within 90 days of the initial assessment
<p>Client Outcomes</p>	<p>In order to assess whether members: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that will be evaluated and measured include, but are not limited to:</p> <ul style="list-style-type: none"> • Engagement in the first 30 days of treatment, as applicable • Reduction in substance use

	<ul style="list-style-type: none"> • Reduction in criminal activity or violations of probation/parole and days in custody • Increase in employment or employment (and/or educational) skills • Increases in family reunification • Increase engagement in social supports • Maintenance of stable living environments and reduction in homelessness • Improvement in mental and physical health status • Member satisfaction
Training	<p>Applicable staff are required to participate in the following training:</p> <ul style="list-style-type: none"> • DMC-ODS Training (Within 30 days of the initial contract start date and at least annually) • Compliance, Information Privacy and Security – Including 42CFR Part 2 and HIPAA/Law & Ethics (Within 30 days of the initial contract start date and t least annually) • ASAM E-modules 1 and 2 (Prior to Conducting Assessments) • Cultural Humility (At least four hours annually) <ul style="list-style-type: none"> a. One Cultural Humility training (annually) b. One LGBTQ+ training (annually) c. One Unconscious Bias training (annually) d. Cultural Competency Training to include Trans Inclusive Health Care (within 45 days of hire and every two years thereafter) • Oath of Confidentiality (Review and sign at contract start and annually thereafter) • At least five hours of continuing education in addiction medicine annually for LPHAs, including Medical Director • Preventing Discrimination, Harassment and Retaliation Training (within 30 days of contract start and every two years) • Marin’s Electronic Health Record and CalOMS Treatment (Prior to Use of Marin Electronic Health Record and thereafter as needed) • CalMHSA CalAIM Trainings – Including documentation requirements, CPT code training, EHR and other applicable trainings (within 30 days of contract start date) • CPR/First Aid Training • Naloxone Training (Within 30 days of contract start date and thereafter as needed) • Mandated Reported Training (bi-annually) adolescent providers only. <p>Contractors shall maintain pertinent evidence of training completion. Contractors shall also submit evidence of training during the Site Visit process, or at additional times upon request.</p> <p>Recovery Coaches may bill for an additional 16 hours of work-related professional development trainings per fiscal year. This does not include trainings referenced and required within this contract.</p>
Program Licensure,	<p>Contractor shall be linked to a valid DHCS DMC certified facility and meet all Credentialing requirements outlined in Policy BHRS-28.</p>

<p>Certification and Standards</p>	<p>Contractor shall be a certified Alcohol and Drug Counselor (certified from a DHCS approved body) in good standing and must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.</p> <p><u>Practice Guidelines</u>: Contractor shall comply with the BHRS Clinical and Administrative Practice Guidelines, which are located at www.MarinBHRS.org</p> <p>All DHCS-certified SUD treatment providers are required to comply with the applicable requirements in the DHCS Certification for Alcohol and Other Drug Programs (revised February 2025).</p>
<p>Contract Changes</p>	<p>If significant changes are expected, you must submit a request in writing to the contract manager. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:</p> <p><u>Scope of Work</u></p> <ul style="list-style-type: none"> • Proposing to add or remove a service modality and/or CPT/HCPCS code • Proposing to transfer substantive programmatic work to a subcontractor <p><u>Budget</u></p> <ul style="list-style-type: none"> • Proposing to increase or decrease hours • Proposing to increase the contract maximum <p>Contractor shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures (www.MarinBHRS.org), Exhibit I and Practice Guidelines (www.MarinBHRS.org), including, but not limited to: 1) Contractor Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents or change in status that could affect contracted duties; 4) Reduction in DMC services; and 5) Not accepting members or 90% capacity (facility at capacity).</p>
<p>Documentation</p>	<p>In addition to the documentation requirements outlined in Exhibit I:</p> <ul style="list-style-type: none"> • All clinical documentation shall be entered into the Marin Electronic Health Record within three (3) business days for routine services and within 24 hours for crisis services. Other requested documentation, such as the client census and status, shall be submitted in the required timeframe using the template provided by the County
<p>Spanish Services Incentive</p>	<p>Payment #1 Deliverables and Performance Target</p> <ul style="list-style-type: none"> • Complete Implementation Plan and Spanish Services Questionnaire • Commitment to ongoing completion of demographic data and language fields for services delivered in Spanish

EXHIBIT A - SCOPE OF SERVICES: PROGRAM REPORTING

EXHIBIT A

DOCUMENT TITLE	DUE DATE	WHERE SUBMITTED	SUBMISSION FORMAT
Ongoing/ As Needed			
Not Accepting New Members	By 9am each day that the program is not accepting new members	BHRS Access and Contract Manager	E-mail
Reached 90% of treatment capacity	Within seven days (and via DATAR by the 10 th of the month)	County AOD Administrator	E-mail
EHR (CalOMS) - Client data - DMC Billing - ASAM Timely Access, etc.	Progress notes for routine services within 3 business days; Other client-specific data should occur within 7 days of event	Marin Electronic Health Record Technical Assistance: BHRSEHRsupport@MarinCounty.gov CalMHSA Help Desk Contract Manager	Electronic Submission
Adult Drug Court Weekly Reports	By 12 noon every Thursday	ADC Coordinator (Jennifer Wasson) jen.wasson@marincounty.gov and ADC Recovery Coach	Encrypted E-mail
Staff Update Form/ Provider Update	Prior to or within 24 hours of the staff change [e.g. new or separating staff, role change, license update]	Staff User Access Form	JotForm
Monthly Submission			
Monthly Provider Check and attestation	By the 10 th of the month	BHRS Office – Administrative Services Associate	E-mail
All Billing Invoices and Supporting Documentation	By the 10 th of the month	EHR and BHRS Office (as applicable)	Electronic Submission
Resubmission of Denied DMC Claims	By the 20 th of the month following notice of denial	Marin Electronic Health Record	Electronic Submission
NOABD Log and Issued NOABDs	By the 10 th of the month	BHRS Office – Administrative Services Associate	E-Mail
Annual Submission			
Provider Self Audit	Projected January 2027	BHRS Office – Contract Manager	Electronic Submission
Annual Report	Projected June 30, 2027	BHRS Office – Quality Management. Copy to Contract Manager	E-mail or Hard Copy

**EXHIBIT A – PROVIDER RATE AND SERVICE TABLE AND
EXHIBIT B - RATES**

PROVIDER:		Rate:
Code	Code Description	Type of Services
T1017	Targeted Case Management, Each 15 Minutes	Care Coordination Codes
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	Care Coordination Codes
H2015	Comprehensive community support services, per 15 minutes	Recovery Services Codes
H2017	Psychosocial Rehabilitation, per 15 Minutes	Recovery Services Codes
H0001	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	Assessment
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	Assessment
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	Assessment
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	Assessment
H0049	Alcohol and/or drug screening	Assessment

H0005	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	Group Counseling Codes
H0004	Behavioral health counseling and therapy, 15 minutes.	Individual Counseling Codes
T1006	Alcohol and/or substance abuse services, family/couple counseling	Individual Counseling Codes
H2014	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	Treatment Planning Codes
H2027	Psychoeducational Service, per 15 minutes	Treatment Planning Codes
T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification.	Discharge Services Codes
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Services Code
Meeting	Meeting related to Recovery Coach services, required training, other	Custom Code
Documentation Time	Time spent documenting in SmartCare, not client specific	Custom Code
ISL305	Court Hearing Time	Projected ISL Code
ISL306	Probation Non-Billable Meeting	Projected ISL Code
ISL301	Client Non-Billable Service Must Document	Projected ISL Code