

**EXHIBIT A - SCOPE OF SERVICES (OUTPATIENT)**

<b>Contractor Information</b>	
Contractor Name	Insert Name of Contractor Agency
Contract Period	FY 2026-2027
Contractor NPI	Insert Contractor Agency NPI
Contractor Taxonomy	Insert Contractor Taxonomy
Contractor Tax ID (or EIN)	Insert Contractor Tax ID
Contractor Executive Director	Insert Name of Executive Director
Contractor Medical Director	Insert Name of Medical Director
Owner Name:	Insert Name of owner(s)
Percent of Ownership:	List Percentage of each owner by each owner
Ownership Code:	(use 274 expansion code)

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

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

**EXHIBIT A - SCOPE OF SERVICES (OUTPATIENT)**

<p><b>Services Provided</b></p>	<p><b>Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) –</b> <i>[For DMC-ODS, HCPCS H0020 (NTP – All Services). Includes NTP Buprenorphine-Mono; NTP- Buprenorphine-Naloxone Tablets; NTP-Buprenorphine-Naloxone Film; NTP- Buprenorphine Injectable; NTP- Naltrexone injectable; NTP - Disulfiram and NTP- Naloxone].</i></p> <p>Services shall be provided in accordance with OTP/NTP services and regulatory requirements in accordance with Title 9, Chapter 4. Services shall be provided in accordance with an individualized member plan determined by a licensed prescriber. OTP/NTP programs shall offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone, and disulfiram.</p> <p>Services provided as part of an OTP/NTP shall include the following service components: Assessment; care coordination; counseling (individual and group); family therapy; medical psychotherapy; medication services; MAT for OUD; MAT for AUD and non-opioid SUDs; patient education; recovery services and SUD crisis intervention services. The NTP shall offer the member a minimum of forty-five minutes of counseling services per calendar month. Counseling services provided in the NTP modality can be provided in person, by telehealth (synchronous audio-only and synchronous video interactions), or by telephone. To provide synchronous audio-only counseling services without video capability, an NTP must submit a letter of need to DHCS by emailing dhcsntp@dhcs.ca.gov and requesting an exception to CCR, Title 9, Chapter 4 10345(b)(3)(A) upon the request of the member. The medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) shall be conducted in person.</p> <p>Pursuant to W&amp;I Code section 14124.22, an NTP provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal members who are not enrolled in managed care plans as long as those services are within the scope of the provider’s practice. NTP providers shall refer all Medi-Cal members that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.</p> <p><b>Out-of-County Dosing:</b> Contractor shall ensure that members receiving NTP services and working in or travelling to another county do not experience a disruption of NTP services.</p> <p><b>Early Intervention Services (ASAM Level 0.5):</b></p> <p>Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (commonly known as Screening, Brief Intervention, and Referral to Treatment, or SBIRT) is not a DMC-ODS benefit. It is a benefit in Medi-Cal Fee-for-Service (FFS) and Medi-Cal managed care delivery system for members less than 21 years of age. Early intervention services are covered DMC-ODS services for members under the age of 21. Any member under the age of 21 who is screened and determined to</p>
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be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services.

An SUD diagnosis is not required for early intervention services. A full assessment utilizing the ASAM criteria is not required for a DMC member under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used in lieu of a full ASAM for purposes of assessing for SBIRT or Early Intervention Services. A full ASAM assessment shall be performed, and the member under the age of 21 shall receive a referral to the appropriate level of care indicated by the assessment if the member's conditions or symptoms constitute diagnostic criteria for SUD. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services. Nothing in this section limits or modifies the scope of the EPSDT mandate.

**Outpatient Services (ASAM Level 1)** *[Non-DMC Service Codes: 33 (Group), 34 (Individual); Refer to Exhibit B for HCPCS/CPT Codes].*

Outpatient treatment services (also known as Outpatient Drug Free or ODF) are provided to members when medically necessary. These services may be offered for up to nine hours a week for adults, and six hours a week for members under the age of 21. Services may exceed the maximum based on individual medical necessity.

Outpatient treatment services include the following service components:

- (1) Assessment
- (2) Care Coordination
- (3) Counseling (individual and group)
- (4) Family Therapy
- (5) Medication Services
- (6) MAT for Opioid Use Disorder (OUD)
- (7) MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- (8) Patient Education
- (9) Recovery Services
- (10) SUD Crisis Intervention Services

**Intensive Outpatient Treatment (IOT) (ASAM Level 2.1)** *[Non-DMC Service Code: 30; DMC-ODS Service Code: Refer to Exhibit B for HCPCS/CPT Codes].*

Intensive Outpatient Treatment Services are provided to members when medically necessary in a structured programming environment. These services may be offered for a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for members under the age of 21. Services may exceed the maximum based on individual medical necessity.

Intensive Outpatient Treatment Services include the following service components:

- (1) Assessment
- (2) Care Coordination
- (3) Counseling (individual and group)
- (4) Family Therapy
- (5) Medication Services
- (6) MAT for OUD
- (7) MAT for AUD and other non-opioid SUDs
- (8) Patient Education
- (9) Recovery Services
- (10) SUD Crisis Intervention Services

**Care Coordination:** *[Non-DMC-ODS Service Code: 68; DMC-ODS: Refer to Exhibit B for HCPCS/CPT Codes].* 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.

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. 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.

Care coordination includes one or more of the following components:

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
- 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.

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.

**Recovery Services:** *[Non-DMC-ODs: Service Code 32; DMC-ODs: Refer to Exhibit B for HCPCS/CPT Codes].* Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the 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. 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).

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 MAT services, including NTP services. Members may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.

Recovery Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the member's SUD.
- 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.

For more 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.

**Medi-Cal Peer Support Services:** *[Refer to Exhibit B for HCPCS/CPT Codes].* Peer Support Services are defined as culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate member and their families about their conditions

and the process of recovery. Medi-Cal Peer support services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting. Medi-Cal Peer Support Services can be delivered as a standalone service or provided in conjunction with other DMC-ODS services or levels of care described in this "Covered DMC-ODS Services" section of BHIN 24-001 (or subsequently issued BHIN), including inpatient and residential services.

Peer Support Services are based on a plan of care approved by a Behavioral Health Professional and provided by Peer Support Specialists. A Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and who meets all other applicable California state requirements, including ongoing education requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional. A Behavioral Health Professional must be licensed, waived, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC, DMC-ODS, or SMHS.

**Contingency Management:** *[HCPCS Code: H0050 with HF Modifier]*. Contingency Management (CM) is an evidence-based treatment that provides incentives to treat people with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual, positive behavioral change, as evidenced by drug tests negative for stimulants.

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

CM Coordinator activities include:

- Providing instruction to the client regarding the CM process and protocol
- Distribution of urine drug tests (UDTs) to client
- Providing instruction to the client for UDT procedures
- Monitoring the UDT process and reading the test results (including verification of any tampering)
- Providing the test results to the client
- Entering the test results into the web-based or mobile incentive management software program
- Verifying receipt or providing incentive (such as printing of incentive gift card)
- Making referrals as necessary to clinical staff based on testing results

SUD providers offering outpatient, intensive outpatient, NTPs and/or partial hospitalization services that are licensed and certified to provide Medi-Cal and DMC-ODS services will be eligible to offer CM. SUD providers will be

required to offer accompanying SUD treatment services and EBPs for StimUD in addition to CM. Eligible programs will need to outline the array of EBPs and services they will deliver in conjunction with CM, which may include, but are not limited to:

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

**Contingency Management Multiple Registrations:**

If Contractor becomes aware that a member is actively receiving contingency management at one or more providers simultaneously, then all of the providers shall confer to determine which provider shall assume treatment responsibility for the individual. In the medical record, an inquiring program shall document the names of each program contacted, the date contacted, the time of the contact (if made by telephone), the name of program staff contacted, and the results of the contact. The provider that agrees to accept sole responsibility shall provide CM services to the member. All other providers shall immediately cease providing CM services, discharge the member, and document in the medical record the reason for the discharge. Within 72 hours of the discharge the former providers shall give the program assuming treatment responsibility written documentation of the discharge and send written notification to the DMC-ODS county(ies) with whom the providers are contracted of the circumstances involving the discharge. Within 72 hours of agreeing to accept sole responsibility for treatment, the provider that assumes sole responsibility shall send written notification to the DMC- ODS county(ies) with whom the providers are contracted of the resolution.

**Audits/Reports:**

Submit the results of any contingency management program audits performed by DHCS, UCLA or other entities to your contract manager within five (5) business days of issuance. Marin DMC-ODS is required to share the results of the audits with DHCS.

**Clinician Consultation:** *[DMC-ODS Service Code: Refer to Exhibit B for HCPCS/CPT Codes]*. Clinician Consultation consists of DMC-ODS providers who are qualified to perform assessments, as described in California's Medicaid State Plan, consulting with providers, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to DMC-ODS members. Rather, Clinician Consultation is designed to support DMC-ODS licensed

	<p>clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS members. DMC-ODS plans may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services. These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems</p>
<p><b>Performance Standards</b></p>	<p><b>Access to Care</b>  Timely access data, including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be entered into Marin’s Electronic Health Record within seven (7) days of the intake.</p> <p>Performance Standard:</p> <ul style="list-style-type: none"> <li>• Routine Appointment: First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact.</li> <li>• Urgent Appointment: First face-to-face visit within 48 hours of the request for urgent conditions.</li> <li>• There are no inequities in timely access to care when stratified by race/ethnicity and gender identity</li> <li>• First face-to-face appointment Medication Assisted Treatment appointment for members with alcohol or opioid disorders shall occur within three (3) business days.</li> <li>• At least 75% of members completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location and time of services</li> <li>• Timely access data will be entered in Marin’s Electronic Health Record within seven (7) days of first contact for 100% of members.</li> </ul> <p><b>Treatment Initiation and Engagement</b></p> <ul style="list-style-type: none"> <li>• At least 85% of members have a second treatment visit within 14 days of assessment [initiation]</li> <li>• Of those initiating treatment, at least 75% will have two treatment visits within the next 30 days [engagement]</li> <li>• There are no inequities in treatment initiation and engagement when stratified by race/ethnicity and gender identity</li> </ul> <p><b>Transitions Between Levels of Care</b>  Appropriate Care Coordinators/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in Marin’s Electronic Health Record.</p> <p>Performance Standard:</p>

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

**Care Coordination and Linkage with Ancillary Services**

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

Performance Standard:

- There is documentation of physical health and mental health screening in 100% of 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

**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.

**Medications for Addiction Treatment**

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.

Performance Standard:

- 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.

**Culturally Responsive Services**

Contractors are responsible for providing culturally responsive services. Contractors must ensure:

- Policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations.
- Translation and oral interpreter services must be available for members, as needed and at no cost to the member.
- Each program reviews monthly performance data (automated reports sent from Marin's Electronic Health Record monthly) and identifies and implements at least one performance improvement initiative annually to address any inequities noted either in the monthly dashboard or Treatment Perceptions Survey data.

Performance Standard:

- 100% of members that speak a threshold language are provided services in their preferred language.
- At least 80% of members completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services.
- 100% of contractors will implement at least one performance improvement initiative annually related to reducing inequities by race/ethnicity or gender identity.
- 100% of contractors are in compliance with the CLAS standards.

**Delivery of Individualized and Quality Care**

Member Satisfaction: DMC-ODS Providers shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually.

ASAM Level of Care: The assessed and actual level of care (and justification if the levels differ) shall be recorded in Marin's Electronic Health Record with seven (7) days of the assessment.

Performance Standards:

- At least 80% of members will report an overall satisfaction score of at least 3.5 or higher on the Treatment Perceptions Survey
- Overall satisfaction scores are balanced when stratified by race/ethnicity and gender identity
- At least 80% of members completing the Treatment Perceptions Survey reported that they were involved in choosing their own treatment goals (overall score of 3.5+ out of 5.0)

	<ul style="list-style-type: none"> <li>• Contractor will implement with fidelity at least two approved EBPs</li> <li>• 100% of members participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care</li> <li>• At least 70% of members admitted to treatment do so at the ASAM level of care recommended by their ASAM assessment</li> <li>• At least 80% of members are re-assessed within 90 days of the initial assessment</li> </ul>
<b>Outcomes</b>	<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"> <li>• Engagement in the first 30 days of treatment (at least two treatment sessions within 30 days after initiating treatment)</li> <li>• Reduction in substance use</li> <li>• Reduction in criminal activity or violations of probation/parole and days in custody</li> <li>• Increase in employment or employment (and/or educational) skills</li> <li>• Increases in family reunification</li> <li>• Increase engagement in social supports</li> <li>• Maintenance of stable living environments and reduction in homelessness</li> <li>• Improvement in mental and physical health status</li> <li>• member satisfaction</li> </ul> <p>These metrics will be analyzed by program and at a minimum, stratified by race/ethnicity and gender identity</p>
<b>Training</b>	<p>Applicable staff are required to participate in the following training:</p> <ul style="list-style-type: none"> <li>• DMC-ODS Training (within 30 days of hire and at least annually)</li> <li>• Compliance, Information Privacy and Security – Including 42CFR Part 2 and HIPAA/Law &amp; Ethics (Within 30 days of hire and at least annually)</li> <li>• ASAM E-modules 1 and 2 (Prior to Conducting Assessments)</li> <li>• Cultural Humility (At least four hours annually) <ul style="list-style-type: none"> <li>○ One Cultural Humility training (annually)</li> <li>○ Once LGBTQ+ training (annually)</li> <li>○ Cultural Competency Training to include Trans Inclusive Health Care (within 45 days of hire and every two (2) years thereafter.</li> </ul> </li> <li>• Oath of Confidentiality (Review and sign at hire and annually thereafter)</li> <li>• At least five hours of continuing education in addiction medicine annually for LPHA staff, including Medical Director</li> <li>• Marin’s Electronic Health Record and CalOMS Treatment (Prior to Use of Marin Electronic Health Record and thereafter as needed)</li> <li>• CalMHSA CalAIM Trainings – Including documentation requirements, CPT code training, EHR and other applicable trainings (within 30 days of hire)</li> </ul>

	<ul style="list-style-type: none"> <li>• Naloxone Training – Ensure at least one staff member, at all times, on the premises who knows the location of naloxone or other FDA-approved opioid antagonist medication, and who has been trained in its administration.</li> <li>• CPR/First Aid training (<i>Reference: AOD Certification Standards, one staff or HCP on duty and physically present at the program at all times, who is qualified by the American Red Cross or other recognized agencies and capable of providing CPR &amp; first aid.</i>)</li> <li>• MAT Training (BHIN No. 23-054): Evidence of training personnel about the benefits and risks of MAT. Information shall be specific to each type of medication offered to clients. (Within 6 months of hire &amp; as needed thereafter)</li> <li>• For Adolescent Providers: Training for case managers related to AOD treatment, community resources, physical and sexual abuse, family dynamics and legal issues [Reference: Adolescent Best Practice Guide]</li> </ul> <p>Contractors shall maintain pertinent evidence of training completion in personnel files. Contractors shall also submit evidence of training during the Site Visit process, or at additional times upon request.</p>
<p><b>Contract Changes</b></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"> <li>• Proposing to add or remove a service modality and/or CPT/HCPCS code</li> <li>• Proposing to transfer substantive programmatic work to a subcontractor</li> <li>• Proposing to add or remove rendering provider types</li> <li>• Demand for <b>Marin Medi-Cal members</b> exceed contracted capacity</li> </ul> <p><u>Budget</u></p> <ul style="list-style-type: none"> <li>• Proposing to increase or decrease FTE</li> <li>• Proposing to increase the contract maximum</li> </ul> <p>Contractor shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures, (<a href="http://www.MarinBHRS.org">www.MarinBHRS.org</a>), Contract Exhibit I and Practice Guidelines (<a href="http://www.MarinBHRS.org">www.MarinBHRS.org</a>), 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 members or 90% capacity (facility at capacity).</p>
<p><b>Spanish Services Incentive</b></p>	<p>Payment #1 Deliverables and Performance Target (ODS and Non-ODS)</p> <ul style="list-style-type: none"> <li>• Complete Implementation Plan and Spanish Services Questionnaire</li> </ul>

	<ul style="list-style-type: none"><li>• Commitment to ongoing completion of demographic data and language fields for services delivered in Spanish</li></ul> <p>Payment #2 Deliverables and Performance Targets (ODS Providers Only)</p> <ul style="list-style-type: none"><li>• Complete Plan Update Template</li><li>• Tier 1 Payment: 25-49% increase in services delivered in Spanish from baseline -or Tier 2 Payment: 50%+ increases in services delivered in Spanish from baseline</li></ul> <p>Data Notes:</p> <ul style="list-style-type: none"><li>• Baseline Calculation Period: 4/8/26 – 6/30/26</li><li>• Tier Calculation Measurement Period:<ul style="list-style-type: none"><li>○ Numerator: Eligible services between 7/1/26 – 3/31/27 in complete and error free status and with Spanish marked as the client and service language.</li><li>○ Denominator: All services between 7/1/26 – 3/31/27 in complete and error free status</li></ul></li><li>• Eligible services: DMC-ODS billable services, regardless of client payer</li></ul>
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**EXHIBIT A - SCOPE OF SERVICES: PROGRAM REPORTING**

DOCUMENT TITLE	DUE DATE	WHERE SUBMITTED	SUBMISSION FORMAT
<b>Ongoing/ As Needed</b>			
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 <sup>th</sup> 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 calendar days; Other client-specific data should occur within 7 days of event	Marin Electronic Health Record  Technical Assistance: <a href="mailto:BHRSEHRsupport@MarinCounty.gov">BHRSEHRsupport@MarinCounty.gov</a> CalMHSA Help Desk Contract Manager	Electronic Submission
Adult Drug Court Weekly Reports	By 12 noon every Thursday	ADC Coordinator (Jennifer Wasson) <a href="mailto:jen.wassonj@marincounty.gov">jen.wassonj@marincounty.gov</a> 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]	<a href="https://marincounty.jotform.com/232765872721059">https://marincounty.jotform.com/232765872721059</a>	JotForm
<b>Monthly Submission</b>			
Monthly Provider Check and attestation	By the 10 <sup>th</sup> of the month	BHRS Office – Administrative Services Associate	E-mail
All Billing Invoices and Supporting Documentation	By the 10 <sup>th</sup> of the month	EHR and BHRS Office (as applicable)	Electronic Submission
DATAR	By the 10 <sup>th</sup> of the month	State DHCS	Electronic Submission
Resubmission of Denied DMC Claims	By the 20 <sup>th</sup> of the month following notice of denial	Marin Electronic Health Record	Electronic Submission
NOABD Log and Issued NOABDs	By the 10 <sup>th</sup> of the month	SmartCare   BHRS Office – Administrative Services Associate	E-Mail   SmartCare
<b>Annual Submission</b>			
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
Cost Reports	To Be Determined	Marin HHS - Fiscal	TBD