

## EXHIBIT A - SCOPE OF SERVICES

JULY 1, 2021 – JUNE 30, 2022

<b>Services Provided</b>	<p><b>Residential Withdrawal Management (ASAM/DHCS Level 3.2-WM) – Clinically Managed Residential Withdrawal Management (WM)</b> [<i>DMC-ODS Service Code: 109 &amp; DMC-ODS Room &amp; Board: 58</i>] – Provides 24-hour structure and support with trained and credentialed personnel providing organized services in a social setting emphasizing on peer support for individuals with moderate risk of withdrawal.</p> <p>WM services are provided when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process.</p> <p>The components of Withdrawal Management services include:</p> <ul style="list-style-type: none"><li>• <b>Intake:</b> The process of admitting a beneficiary into a substance use disorder (SUD) treatment program. Intake includes the evaluation or analysis of SUD, the diagnosis of SUD, the assessment of treatment needs, and may include a physical examination and laboratory testing necessary for SUD treatment.</li><li>• <b>Observation:</b> The process of monitoring the beneficiary’s course of withdrawal as frequently as deemed appropriate for the beneficiary. This may include, but is not limited to, observation of the beneficiary’s health status.</li><li>• <b>Medication Services:</b> The prescription or administration related to SUD treatment services, and/or the assessment of the side effects and results of that medication.</li><li>• <b>Discharge Services:</b> Preparing the beneficiary for referral into another level of care, post treatment return, re-entry into the community, and/or the linkage of the individual to community treatment, housing, and human services.</li></ul> <p><b>Residential (ASAM/DHCS Level 3.1) – Clinically Managed Low Intensity</b> [<i>DMC-ODS Service Code: 112 &amp; DMC-ODS Room &amp; Board: 58</i>] – Provides 24-hour structure with trained and credentialed personnel providing clinically directed program activities and professionally directed treatments to stabilize and maintain substance use disorder (SUD) symptoms, develop, and apply recovery skills, and preparation for outpatient treatment. A minimum of 5 hours per week of individual counseling, group, and education sessions and/or structured therapeutic activities.</p> <p><b>Residential (ASAM/DHCS Level 3.3) – Clinically Managed Population-Specific High-Intensity Residential Services</b> [<i>DMC-ODS Service Code: 113 &amp; DMC-ODS Room &amp; Board: 58</i>] – Provides 24-hour care with trained and credentialed personnel providing clinical directed, less intense program activities and professional directed treatments</p>
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to stabilize and maintain SUD symptoms and to develop and apply recovery skills specific for individuals with cognitive or other functioning impairments. A minimum of 5 hours per week of individual, group, and education sessions and/or structured therapeutic activities specific for individuals with cognitive or other functioning impairments.

**Residential (ASAM/DHCS Level 3.5) Clinically Managed High-Intensity** [DMC-ODS Service Code: 114 & DMC-ODS Room & Board: 58] – Provides 24-hour care with trained and credentialed personnel providing clinical directed program activities and professionally directed treatments to stabilize and maintain SUD symptoms, develop and apply recovery skills specific for individuals with co-occurring mental health disorders. A minimum of 5 hours per week of individual, group, and education sessions and/or structured therapeutic activities specific for individuals with co-occurring mental health disorders.

Residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the individual treatment plan. Room and Board is not reimbursable through the DMC program.

\*Note: AOD Certification Standards require a minimum of 20 hours per week of individual and/or group counseling sessions and/or structured therapeutic activities shall be provided for each client in accordance with the client’s treatment plan.

The components of Residential Treatment Services include:

- **Intake:** The process of determining that a beneficiary meets the medical necessity criteria and admitting the beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- **Individual and Group Counseling:** Contacts between a beneficiary and a therapist or counselor. Services are provided in-person or by telephone qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction. Group counseling is described in the DMC-ODS STCs as a face-to-face contact in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the therapeutic SUD treatment needs of the individuals served.
- **Patient Education:** Provide research-based education on addiction, treatment, recovery, and associated health risks
- **Family Therapy:** The effects of addiction are far-reaching and patient’s family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient’s recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help

motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

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

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

**Case Management:** *[DMC-ODS Service Code: 68]*. Service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community. They shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law. The components of case management include:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management;
- Transition to a higher or lower level of SUD care;
- Development and periodic revision of a client plan that includes service activities;

- Communication, coordination, referral, and related activities;
- Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
- Monitoring the beneficiary's progress; and
- Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

**Recovery Services:** *[DMC-ODS Service Code: 32, 109-5, 112-5, 112-5, 114-5].*

Medically necessary recovery services may be accessed after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse. Recovery services may be provided face-to-face, by telephone or via telehealth with the beneficiary and may be provided anywhere in the community.

The components of Recovery Services are:

- Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
- Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
- Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
- Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
- Support Groups: Linkages to self-help and support, spiritual and faith-based support; and
- Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

**Physician Consultation:** *[DMC-ODS Service Code: 109-4, 112-4, 112-4, 114-4]* Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

**Assessments**

Assessments shall be face-to-face or via telehealth and performed by qualified staffing. If the 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 by the LPHA in the medical record to establish the determination of medical necessity for the beneficiary. Medical necessity for DMC-ODS services shall be determined as part of the assessment process and shall be performed through a face-to-face interview or via telehealth.

	<p><u>ASAM Training:</u> Staff performing assessments are required to complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.</p> <p><u>Re-Assessments:</u> Adult beneficiaries in Residential treatment shall be re-assessed at a minimum of every 45 days. Youth beneficiaries in Residential treatment shall be re-assessed at a minimum of every 30 days, unless there are significant changes warranting more frequent reassessments. ASAM Level of Care data shall be entered into Marin WITS for each assessment and re-assessment and within seven (7) days of the assessment/re-assessment.</p>
<b>Telehealth</b>	<p>Telehealth Between Provider and Beneficiary means office or outpatient visits via interactive audio and video telecommunication systems. To utilize telehealth, contractor shall use a secure platform and have policies in place to ensure confidentiality. Unless otherwise noted by the Department of Health Care Services (e.g. exceptions due to a Public Health emergency), telehealth for group counseling is not claimable to Medi-Cal.</p>
<b>Performance Standards</b>	<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 WITS 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. First face-to-face Medication Assisted Treatment appointments for beneficiaries with alcohol or opioid disorders shall occur within three (3) business days.</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>• At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location of services</li> <li>• Timely access data will be entered in Marin WITS within seven (7) days of first contact for 100% of beneficiaries.</li> </ul> <p><b>Treatment Initiation and Engagement</b></p> <ul style="list-style-type: none"> <li>• At least 85% of beneficiaries 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>

**Transitions Between Levels of Care**

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

Performance Standard:

- Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.
- At least 80% of beneficiaries receive a follow-up contact within seven (7) days of discharge from Residential treatment or Residential Withdrawal Management.
- There are no inequities in transitions between levels of care when stratified by race/ethnicity and gender identity

**Care Coordination and Linkage with Ancillary Services**

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

Performance Standard:

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

**Medication Assisted Treatment**

Contractors will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment for substance use disorders. Contractor staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent a 42 CFR, Part 2 compliant release of information for this purpose.

Performance Standard:

- At least 80% of beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders will have 42 CFR compliant releases in place to coordinate care
- At least 80% of beneficiaries with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services

**Culturally Responsive Services**

Contractors are responsible to provide culturally responsive services. Contractors must ensure:

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

Performance Standard:

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

**Delivery of Individualized and Quality Care**

Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually.

Evidence-Based Practices (EBPs): Contractors will implement—and assess fidelity to—at the least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education.

ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in Marin WITS with seven (7) days of the assessment.

Performance Standards:

- At least 80% of beneficiaries will report an overall satisfaction score of at least 3.5 or higher on the Treatment Perceptions Survey

	<ul style="list-style-type: none"> <li>• Overall satisfaction scores are balanced when stratified by race/ethnicity and gender identity</li> <li>• At least 80% of beneficiaries completing the Treatment Perceptions Survey reported that they were involved in choosing their own treatment goals (overall score of 3.5+ out of 5.0)</li> <li>• Contractor will implement with fidelity at least two approved EBPs</li> <li>• 100% of beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care</li> <li>• At least 70% of beneficiaries admitted to treatment do so at the ASAM level of care recommended by their ASAM assessment</li> <li>• At least 80% of beneficiaries are re-assessed within 90 days of the initial assessment</li> </ul>
<p><b>Client Outcomes</b></p>	<p>In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that will be evaluated and measured include, but are not limited to:</p> <ul style="list-style-type: none"> <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>• Beneficiary satisfaction</li> </ul> <p>These metrics will be analyzed by program and at a minimum, stratified by race/ethnicity and gender identity</p>
<p><b>Training</b></p>	<p>Applicable staff are required to participate in the following training:</p> <ul style="list-style-type: none"> <li>• Cultural Competency (At least four hours annually)</li> <li>• Oath of Confidentiality (Review and sign at hire and annually thereafter)</li> <li>• DMC-ODS Training, including Documentation Standards (At least annually)</li> <li>• Information Privacy &amp; Security - Including 42 CFR Part 2 and HIPAA/Law and Ethics (At least annually)</li> <li>• ASAM E-modules 1 and 2 (Prior to Conducting Assessments)</li> <li>• CPR and First Aid (WM Staff - As outlined in Standards)</li> <li>• Marin WITS and CalOMS Treatment (Prior to Use of Marin WITS and thereafter as needed)</li> <li>• At least five hours of continuing education in addiction medicine annually for LPHA staff; including the Medical Director (At least annually)</li> </ul>
<p><b>Authorization Process</b> –</p>	<p><b>Initial Authorization</b>  Requests for initial authorization are to be submitted to BHRS Access on the Treatment Authorization Request (TAR) - <i>Initial Authorization</i>’ form at least 24 hours</p>



<p><b>ASAM/DHCS Levels 3.1, 3.3 and 3.5</b></p>	<p>before the scheduled admission date. A copy of the ASAM Continuum or County-provided ASAM assessment tool shall be attached to the TAR. Initial authorizations can be granted for up to 30 days for youth and up to 45 days for adults. An approved authorization allows for a client to be admitted to treatment within seven (7) calendar days of the approval date. Admissions later than seven (7) calendar days from the authorization date will be considered on a case-by-case basis and will require written approval by the County.</p> <p><b>Continuing and Extension Authorizations</b></p> <p>Requests for continuing and extension authorizations are to be submitted to BHRS Access on the 'TAR – <i>Continuing Authorization</i>' form seven (7) calendar days before to the expiration date of the current authorization. A copy of the re-assessment (ASAM Continuum or County-provided ASAM assessment tool) shall be attached to the TAR. Continuation authorizations can be granted for up to 30 days for youth and up to 45 days for adults. Extension authorizations can be granted for up to 30 days for both youth and adults. Clients' residential length of stay will be based on medical necessity.</p> <p><b>Additional Information - TARs</b></p> <p>For a TAR to be considered eligible for authorization, the individual must be a Marin County Medi-Cal beneficiary or Marin County low-income (&lt;138% FPL) uninsured resident, meet medical necessity and the ASAM criteria for the proposed level of care. Payment and submission of claims to Medi-Cal are subject to a beneficiary's eligibility and services being rendered and documented in accordance with ODS Documentation Standards, ASAM diagnostic and dimensional criteria and the DMC-ODS STCs.</p> <p>If BHRS Access responds to a TAR as "pending", Contractor shall respond within 24 hours of the request for additional information.</p>
<p><b>Program Licensure, Certification and Standards</b></p>	<p><u>Practice Guidelines</u>: Contractor shall comply with the BHRS Clinical and Administrative Practice Guidelines, which are located at <a href="http://www.MarinHHS.org/BHRS">www.MarinHHS.org/BHRS</a>.</p> <p><u>Licensure, Certification and ASAM/DHCS Designation</u></p> <p>ASAM/DHCS 3.2-WM: Contractor shall possess valid DHCS licensure with detoxification certification and DMC Residential certification.</p> <p>ASAM/DHCS Levels 3.1, 3.3 and 3.5: Contractor shall possess valid DHCS licensure and DMC Residential certification and have been designated by DHCS as capable of delivering care consistent with the ASAM criteria. All licensed AOD facilities must obtain at least one DHCS Level of Care Designation and/or at least one residential ASAM Level of Care Certification consistent with all of its program services.</p> <p>For more information regarding DHCS Level of Care Designation Requirements: <a href="https://www.dhcs.ca.gov/provgovpart/Documents/SB-823-Exhibit-A-1.14.21.pdf">https://www.dhcs.ca.gov/provgovpart/Documents/SB-823-Exhibit-A-1.14.21.pdf</a></p> <p>Contractors that provide Women and Children's Residential Treatment Services (WCRTS) shall comply with the program requirements and goals pursuant to</p>

	<p>California Health and Safety Code 11757.65. Program outcomes include: 1) Preserving family unity; 2) Promoting healthy pregnancies; 3) Enabling children to thrive; and 4) freeing women and their families from substance abuse. Contractor shall also comply with the Perinatal Practice Guidelines.</p> <p><u>Incidental Medical Services (IMS):</u> IMS may only be provided following approval from DHCS. IMS shall be an additional service to all residents at an approved licensed residential facility. IMS cannot be limited to specific residents and/or beds. A licensed residential facility’s HCP must ensure that IMS is appropriate for all residents. If IMS is not appropriate for a resident (as determined by a HCP), then the licensed residential facility must immediately refer the resident for placement in an appropriate level of care. A licensed residential facility approved to provide IMS cannot order or stock bulk prescription medications.</p>
<p><b>Beneficiary Protections and Beneficiary Informing Materials</b></p>	<p><u>Beneficiary Informing Materials</u> Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the following materials: DMC-ODS Beneficiary Booklet and Provider Directory. The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed.</p> <p><u>Grievance and Appeals</u> Contractor shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and stamped self-addressed (addressed to the County) envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. Completed Grievance/Appeal Form should be returned or mailed to:  BHRs Quality Management Unit  20 N. San Pedro Rd., San Rafael, CA 94903</p> <p>The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed. Refer to 42 CFR 438.10(g)(2)(xi) for additional information about the grievance and appeal system.</p> <p><u>Notice of Adverse Benefit Determination (NOABD)</u> Contractor shall have written procedures to ensure compliance with the County’s NOABD Procedure as outlined in ‘NOABD Process’ located on the County website <a href="http://marinhhs.org/substance-use-services-contractor-resources">marinhhs.org/substance-use-services-contractor-resources</a>; including the following:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Contractor shall log the NOABD on the ‘Provider NOABD Log’ and submit by the 10<sup>th</sup> of each month via encrypted email to the County SUD Admin Team with copies of the issued NOABDs.</li> </ul>

<b>Contract Changes</b>	<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 re-distribute units of service between existing service codes by more than 20%</li><li>• Proposing to add or remove a service modality</li><li>• Proposing to transfer substantive programmatic work to a subcontractor</li><li>• Proposing to provide any services by telephone or field-based</li></ul> <p><u>Budget</u></p> <ul style="list-style-type: none"><li>• Proposing to re-distribute more than 20% between budget categories</li><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.MarinHHS.org/policies-procedures">www.MarinHHS.org/policies-procedures</a>) and Practice Guidelines (<a href="http://www.MarinHHS.org/Substance-Use-Services-Contractor-Resources">www.MarinHHS.org/Substance-Use-Services-Contractor-Resources</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 beneficiaries or 90% capacity (facility at capacity).</p>
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