

EXHIBIT A - SCOPE OF SERVICES (OUTPATIENT)

JULY 1, 2022 – JUNE 30, 2023

Services Provided	<p>Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5): 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 and Medi-Cal managed care delivery system for beneficiaries aged 21 years and older.</p> <p>Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. Any beneficiary under the age of 21 who is screened and determined to 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. As noted above, this does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health 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.</p> <p>A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used. 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.</p> <p>Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone.</p> <p>Outpatient Services (ASAM Level 1) [<i>Non-DMC Service Codes: 33 (Group), 34 (Individual); DMC-ODS Service Code: 91</i>]]. Outpatient treatment services are provided to beneficiaries when medically necessary (offering up to nine hours a week for adults, and six hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers are required to either offer medications for addiction treatment (MAT, also known as medication-assisted 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). Outpatient treatment services (also known as Outpatient Drug Free or ODF) include the following service components:</p>
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- 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

Intensive Outpatient Treatment (IOT) (ASAM Level 2.1) [*Non-DMC Service Code: 30; DMC-ODS Service Code: 105*]. Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment (offering 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 adolescents). Services may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. 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 intensive outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Intensive Outpatient Treatment Services include the following 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

Care Coordination: [*Service Code: 68*]. Care coordination shall be provided to a client in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. DMCODS Counties, 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 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. Care coordination can be provided in clinical or nonclinical settings (including the community) and can be provided face-to-face, by telehealth, or by telephone. 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.

Recovery Services: *[Service Code 32]*. Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary’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 beneficiaries. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Services may be provided in person, by telehealth, or by telephone. Recovery Services can be delivered and claimed as a standalone service, or as a service delivered as part of other levels of care.

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 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.

Peer Support Services: *[BH Prevention Education: H0025 / Self-Help/Peer Services: H0038]*. 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. 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. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can 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. Peer Support Services are delivered and claimed as a standalone service. Beneficiaries may concurrently receive Peer Support Services and services from other levels of care. Peer support services are based on a plan of care approved by a Behavioral Health Professional (see definition of Behavioral Health Professional below; this term is specific to the administration of Peer Support Services). Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity services as defined below:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries 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.
- Engagement services means 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.
- Therapeutic Activity means 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.

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 beneficiaries 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 DMCODS 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

Clinician Consultation: *[DMC-ODS Service Code: 91-4; 105-4]*. Clinician Consultation consists of DMC-ODS LPHAs consulting with LPHAs, 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 beneficiaries. Rather, 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. It includes consultations between clinicians designed to assist DMC-ODS beneficiaries. DMC-ODS Counties 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

Assessments: Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary

	<p>withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.</p> <p>The initial assessment shall be performed face-to-face, by telehealth (“telehealth” throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home. If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.</p> <p><u>Re-Assessments</u>: Assessments shall be updated as clinically appropriate when the beneficiary’s condition changes.</p> <p><u>ASAM Training</u>: Staff performing assessments shall complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.</p>
Telehealth	<p>If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the patient record the provision of this information and the patient’s verbal or written acknowledgment that the information was received.</p>
Performance Standards	<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 Marin WITS 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) 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

- First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur within three (3) business days.
- At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location and time of services
- Timely access data will be entered in Marin WITS within seven (7) days of first contact for 100% of beneficiaries.

Treatment Initiation and Engagement

- At least 85% of beneficiaries have a second treatment visit within 14 days of assessment [initiation]
- Of those initiating treatment, at least 75% will have two treatment visits within the next 30 days [engagement]
- There are no inequities in treatment initiation and engagement when stratified by race/ethnicity and gender identity

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 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.
- 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 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

Medications for Addiction Treatment

Contractors will either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for beneficiaries with SUD diagnoses that are treatable with medications or biological products. 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 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 Determination: The ASAM Criteria shall be used to determine placement into the appropriate level of care for all beneficiaries and is separate and distinct from determining medical necessity.

- a. For beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor.
- b. For beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered/certified counselor.
- c. A full ASAM Criteria Assessment is not required to deliver prevention and early intervention services for beneficiaries under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5).
- d. If a beneficiary withdraws from treatment prior to completing the ASAM Criteria assessment and later returns, the time period starts over.
- e. A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
- f. A full ASAM assessment does not need to be repeated unless the beneficiary's condition changes.

Beneficiary placement and level of care determinations shall ensure that beneficiaries are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition. 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
- Overall satisfaction scores are balanced when stratified by race/ethnicity and gender identity
- At least 80% of beneficiaries completing the Treatment Perceptions Survey reported that they were involved in choosing their own treatment goals (overall score of 3.5+ out of 5.0)
- Contractor will implement with fidelity at least two approved EBPs

	<ul style="list-style-type: none"> • 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
Outcomes	<p>In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that will be evaluated and measured include, but are not limited to:</p> <ul style="list-style-type: none"> • Engagement in the first 30 days of treatment (at least two treatment sessions within 30 days after initiating treatment) • Reduction in substance use • Reduction in criminal activity or violations of probation/parole and days in custody • Increase in employment or employment (and/or educational) skills • Increases in family reunification • Increase engagement in social supports • Maintenance of stable living environments and reduction in homelessness • Improvement in mental and physical health status • Beneficiary satisfaction <p>These metrics will be analyzed by program and at a minimum, stratified by race/ethnicity and gender identity</p>
Training	<p>Applicable staff are required to participate in the following training:</p> <ul style="list-style-type: none"> • DMC-ODS Training, including Documentation Standards (At least annually) • Information Privacy and Security – Including 42CFR Part 2 and HIPAA/Law & Ethics (At 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. Once LGBTQ+ training (annually) c. One Working with Interpreters training (Bi-annually) • Oath of Confidentiality (Review and sign at hire and annually thereafter) • At least five hours of continuing education in addiction medicine annually for LPHA staff, including Medical Director • Marin WITS and CalOMS Treatment (Prior to Use of Marin WITS and thereafter as needed)
Program Licensure, Certification and Standards	<p>Contractor shall possess valid DHCS Alcohol and Drug Certification and DHCS DMC certification for the contracted level of care.</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>
Beneficiary Protections and	<p><u>Beneficiary Informing Materials</u></p> <p>Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the</p>

<p>Beneficiary Informing Materials</p>	<p>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: BHRM 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 MarinBHRS.org; including the following:</p> <ul style="list-style-type: none"> • Contractor shall request consent from beneficiaries for the County of Marin to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. Should a beneficiary refuse to consent, then the Contractor is responsible for issuing any applicable NOABD directly to the beneficiary. • Contractor shall log the NOABD on the 'Provider NOABD Log' and submit by the 10th of each month via encrypted email to the County SUD Admin Team with copies of the issued NOABDs.
<p>Contract Changes</p>	<p>If significant changes are expected, you must submit a request in writing to the contract manager. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:</p> <p><u>Scope of Work</u></p> <ul style="list-style-type: none"> • Proposing to re-distribute units of service between existing service codes by more than 20% • Proposing to add or remove a service modality • Proposing to transfer substantive programmatic work to a subcontractor • Proposing to provide any services by telephone or field-based <p><u>Budget</u></p> <ul style="list-style-type: none"> • Proposing to re-distribute more than 20% between budget categories • Proposing to increase or decrease FTE • Proposing to increase the contract maximum <p>Contractor shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures (www.MarinHHS.org/policies-</p>

	<p>procedures) and Practice Guidelines (www.MarinBHRS.org), 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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