

California Access to Recovery Effort



CARE 3

Policies and Procedures

April 2011



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funded by the federal Substance Abuse and Mental Health Services Administration*



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I. DEFINITIONS AND TERMS

For the purposes of the CARE program, the following definitions and terms apply:

A. ADP

ADP means the State Department of Alcohol and Drug Programs.

B. AOD

AOD means alcohol and other drugs.

C. ATR

ATR means the Access to Recovery program, a grant from the federal Substance Abuse and Mental Health Services Administration awarded to 25 states and five tribal organizations for a four-year period.

D. Brief Treatment

A specific type of outpatient services that are short term and directed toward helping to resolve or manage a specific substance misuse or abuse problem. It is solution-focused, goal-oriented, and concentrates on here-and-now issues. It is most often used within a behavioral, cognitive, or cognitive-behavioral treatment approach. Brief treatment is most appropriate with individuals who have mild to moderate substance abuse problems and who are not in need of detoxification or hospitalization services.

E. Call Center

The call center responds to general inquires, makes referrals to assessment providers, and assists providers and clients. The call center is staffed Mondays through Fridays from 8 a.m. to 5 p.m. (except national holidays), and accepts messages during off-hours and responds the next working day. The toll-free number is (866) 350-8773.

F. CARE

CARE means the California Access to Recovery Effort program, California's implementation of the federal ATR grant.

G. CARE Website

The CARE website has general information on the CARE program available to individuals, their families, or other interested parties. It also contains information for providers and clients. The CARE website address is www.CaliforniaCares4Youth.com

H. Case Manager

A case manager is chosen by the client (before, during, or after the assessment process), and is the single point of ongoing contact in the CARE program to ensure access to needed services, motivate the client in his/her recovery, and collect required GPRA data.

I. Continuing Care

For purposes of the CARE program, continuing care is a type of voucher that is available for clients after they have completed an initial phase of outpatient treatment. The intent of the voucher is to help transition the client to a cost-effective, lower level of care that provides ongoing support over an extended period of time.

J. GPRA

GPRA means the Government Performance and Results Act, which requires that federal agencies set performance targets and evaluate to what extent programs are meeting those targets. To meet this requirement, SAMHSA developed a data collection instrument specifically for the ATR program to track the performance of clients using vouchers for access to treatment and recovery services.

K. Independent Client Choice

Independent client choice means that a CARE client is able to select his/her service provider without coercion from all participating providers qualified to provide the necessary services. The provider options must include at least two organizations, with at least one to which the client has no personal or religious objection. The provider choices may not be limited to two locations of the same provider organization.

L. In Recovery

For purposes of the CARE program, being in recovery means that the individual had an AOD abuse or dependence disorder in the past but is no longer using alcohol or drugs, and there has been no more than six months since the individual's last AOD use or last treatment episode contact.

M. Life:WIRE

Life:WIRE is a proprietary web-based text-messaging service that allows treatment and recovery support providers to pre-program text-messages for distribution to clients on specific dates/times to serve as appointment reminders, questions to determine status/progress, and motivations to support the client's ongoing recovery.

N. MAXIMUS

MAXIMUS, an ADP contractor, is the agency that operates the call center and the electronic voucher management system.

O. Service Members

Individuals who are currently serving in United States military, including National Guard and Reserve members, up through age 25.

P. Provider Directory

A CARE provider directory is available to assist clients in making informed choices when choosing service providers. The directory contains provider information such as services offered, service settings, and program specialties.

Q. Recovery Capital

The quantity and quality of internal and external resources that an individual can bring to bear on the initiation and maintenance of recovery (i.e., family and social supports, stable environment, motivation for change, individual strengths and assets).

R. Recovery Support Services

An array of activities, relationships and services designed to assist a CARE client's participation in treatment, improve functioning, and support continued recovery.

S. SAMHSA

SAMHSA means the federal Substance Abuse and Mental Health Services Administration, the federal agency funding the ATR grant.

T. SCO

SCO means the California State Controller's Office.

U. TMAC

TMAC means Telephone Monitoring and Adaptive Counseling, a telephone-based continuing care intervention.

V. Tobacco

For purposes of CARE program eligibility, tobacco is not considered a drug of abuse or dependence. For GPRA data collection purposes, tobacco should be included as a drug if the client is a minor.

W. Veterans

Individuals who have been discharged from the United States military, regardless of discharge status, up through age 25.

X. Voucher

A CARE program voucher is an electronic record that provides evidence of ADP's agreement to pay an organization for allowable services provided to a CARE program client who requests such services. Vouchers have a maximum dollar value and a specified time limit and are issued based on availability of grant funds.

Y. VMS

VMS means the voucher management system, a web-based database system through which vouchers are requested and authorized, and billings and demographic data are submitted.

Z. Youth

Individuals who are between the ages of 12 and 20, inclusive.

II. CARE PROGRAM GOALS AND PRINCIPLES

A. The broad goals of the CARE program are to:

1. Provide vouchers for treatment and recovery support services to substance abusing youth and young service members/veterans who reside in Butte, Los Angeles, Sacramento, Shasta, and Tehama Counties.
2. Ensure that all clients have a genuine, independent choice of service provider that reflects their personal needs and preferences.
3. Empower clients to be involved in their recovery by being part of all decisions made about the services they receive.
4. Ensure that individuals receive safe and effective services.

B. The overarching principles of the CARE program are:

1. No single program, service or approach is appropriate for all individuals. Matching settings, interventions, and services to each individual's particular needs and preferences is critical to his/her ultimate success.
2. Faith-based and other nontraditional organizations can be significant partners in a client's recovery, and clients have the right to maintain their religious identity in the provision of services.

3. Recovery support can be an appropriate initial choice over admission to clinical treatment, such as when an individual has a low problem severity and high recovery capital (internal and external recovery support assets) that makes it likely he/she can initiate and sustain recovery without professional treatment.

III. PROVIDER ELIGIBILITY

A. Provider Approval Process

1. To participate in the CARE program, an organization/entity must submit an application and be approved by ADP.
2. ADP will post notices on the CARE website when it is accepting provider applications. ADP may limit provider enrollment to specific geographic areas or specific types of services based on need, or may close the enrollment process if the provider network meets the diverse needs and preferences of the clients being served.
3. ADP has exclusive rights to determine a provider's eligibility to participate in the CARE network. Such determination will be based on licensure or certification in good standing, history of licensing or certification complaints or enforcement action, appropriateness of services, staff training and qualifications, evidence of staff and organizational competency, interviews with the organization or entity staff, and other knowledge of significance unique to the individual provider, including performance with CARE requirements.
4. Falsifying or misleading information, misrepresenting qualifications or credentials, or omitting relevant material facts on an application will result in the application being rejected. It is also grounds for terminating a participating provider.
5. A provider's approval to participate in CARE will be specific to the type of services and geographic location identified in the approval notice. Approval to participate in CARE does not award or assign any sort of licensure or certification, or supersede the legal requirements of federal, state, county or municipal law.
6. ADP shall not approve applications from organizations/entities which, based on past performance, have been noncompliant with CARE policies and procedures and/or have demonstrated that they do not have adequate staffing or administrative capacity to participate in the CARE program.

B. Eligibility Requirements

The eligibility requirements for providers are as follows:

1. Assessment Provider, Individual
 - a. The individual must be licensed in California as a psychologist, Marriage and Family Therapist (MFT), or Licensed Clinical Social Worker (LCSW);
 - b. The individual must have at least two years experience conducting clinical assessments for the targeted population (youth and their families and/or service members and veterans);
 - c. The individual must have at least one year experience working with clients with AOD problems;
 - d. The individual must not have any conflict of interest that would create a bias towards or against any particular provider(s).
2. Assessment Provider, Organization
 - a. The organization must be certified by ADP as a Drug Medi-Cal provider and/or as meeting the *AOD Treatment Program Standards*;
 - b. All staff who will conduct assessments must be either licensed professionals (physician, psychologist, MFT, LCSW, registered MFT intern or associate clinical social worker under the supervision of a licensed therapist) with AOD-specific training and experience; or certified AOD counselors, certified by one of the counselor certification organizations approved by ADP, pursuant to the Counselor Certification Regulations, (California Code of Regulations (CCR), Title 9, Section 13035(a)).
 - c. If the organization also applies to provide CARE treatment and/or recovery support services, the organization must have a separate assessment unit and multi-level, multidisciplinary review of placement and referral decisions.
3. Recovery Support Only Assessment Provider
 - a. The organization must meet the requirements for a recovery support provider;
 - b. All staff who will conduct assessments must be either licensed professionals (physician, psychologist, MFT, LCSW, registered MFT intern or associate clinical social worker under the supervision of a licensed therapist) with AOD-specific training and experience; or certified AOD counselors, certified by one of the certification organizations approved by ADP, pursuant to the Counselor Certification Regulations, (CCR, Title 9, Section 13035(a)).
 - c. If the organization also applies to provide CARE recovery support services, the organization must have a separate assessment unit and multi-level, multidisciplinary review of referral decisions.

4. Outpatient Treatment Provider

- a. The organization must be certified by ADP as a Drug Medi-Cal provider and/or as meeting the *AOD Treatment Program Standards*;
- b. The organization must have been providing AOD treatment services to the targeted population (youth or service members and/or veterans) for at least 3 years; OR
- c. The organization must have been providing AOD treatment and recovery, mental health, or other behavioral health services for at least one year and employ a program director or clinical supervisor who is an AOD counselor certified by one of the certification organizations approved by ADP, pursuant to the Counselor Certification Regulations, (CCR, Title 9, Section 13035(a)) and who has at least 3 years experience providing AOD treatment services to the targeted population (youth and/or service members and veterans).
- d. The organization must utilize staff qualified by training and/or education to provide services to the targeted population (youth and/or service members and veterans).

5. Recovery Support Provider

- a. The organization must be registered as a business with the California Secretary of State's Office and be in good standing;
- b. The organization must obtain and maintain all required occupancy and zoning permits;
- c. The organization must have documented policies/procedures that address at least:
 - 1) the organization's purpose and philosophy;
 - 2) standards of conduct for all staff and volunteers, including roles, boundaries, supervision, conflict of interest, and training; and
 - 3) client rights and grievance procedures.
- d. The organization must have a governing body (e.g., a board of directors) that meets according to their bylaws to provide fiscal planning and oversight, ensure quality improvement in service delivery, establish policies to guide operations, ensure responsiveness to the community and individuals being served, and delegate operational management to a program manager in order to effectively operate its services.
- e. The organization must utilize fiscal management policies, procedures, and practices consistent with generally accepted accounting principles and applicable state and federal laws and regulations;
- f. The organization must have a risk management strategy that includes adequate insurance to cover risks;

- g. The organization must have at least one year of experience providing the same type of services to the targeted population (youth and/or service members and veterans).
- h. The organization must utilize staff qualified by training and/or education to provide services to the targeted population (youth and/or service members and veterans).

6. Case Management Provider

- a. The applicant entity (sole proprietor, partnership, or corporation) must be registered as a business with the California Secretary of State's Office and be in good standing;
- b. The entity must not be affiliated with any treatment or recovery support provider participating in the CARE program;
- c. The entity must obtain and maintain all required occupancy and zoning permits;
- d. The entity must have documented policies/procedures that address at least:
 - 1) the entity's purpose and philosophy;
 - 2) standards of conduct for all staff and volunteers, including roles, boundaries, supervision, conflict of interest, and training; and
 - 3) client rights and grievance procedures.
- e. The entity must utilize fiscal management policies, procedures, and practices consistent with generally accepted accounting principles and applicable state and federal laws and regulations;
- g. The entity must have a risk management strategy that includes adequate insurance to cover risks;
- h. The entity must have at least one year of experience providing case management services to the targeted population (youth and/or service members and veterans);
- i. The entity must be committed to maintaining ongoing contact with clients/former clients for at least six months after intake;
- j. The entity must utilize and supervise staff who have the following education, skills, knowledge, and experience:
 - 1) At least an associate's degree (or a certificate from a training program) in human services or behavioral sciences, OR be a registered or certified AOD counselor.
 - 2) Previous on-the-job experience as a case manager or social worker.
 - 3) Ability to communicate and manage time effectively, be organized and responsible, have a strong desire to help others, and be culturally sensitive.
 - 4) Knowledge of the programs, services, and resources in the community.
 - 5) Understanding of the client/patient confidentiality laws and regulations contained in Code of Federal Regulations (CFR) Title 42 and Health Insurance Portability and Accountability Act (HIPAA).

C. Religious Organization Rights and Requirements

1. Pursuant to the Charitable Choice Provisions and Regulations (CFR Title 42, Part 54), faith-based/religious providers have the right to maintain their religious character, express their religious beliefs, and integrate religious activities into the provision of services, so long as they otherwise satisfy the CARE program requirements.
2. A faith-based/religious organization may not expend CARE funds to support any inherently religious activities, such as worship or proselytization.
3. Each CARE client will be presented with at least two appropriate provider choices, at least one of which must be a provider to whom they have no religious objection.
4. If, while receiving CARE services from a faith-based/religious organization, a CARE client objects to the religious character of the provider, the provider must refer the client back to the case manager to choose an alternate provider.

D. Provider Termination

A provider's approval shall immediately and automatically terminate whenever the following occurs:

1. The program changes ownership, including sales or transfer of ownership or the program, unless the transfer of ownership applies to the transfer of stock when the program is owned by a certified corporation and when the transfer of stock does not constitute a majority change in ownership;
2. The program surrenders their AOD and/or Drug Medi-Cal certification;
3. The program voluntarily and/or involuntarily terminates;
4. The program moves operation of the program from the location identified on the application to another location without notifying the CARE unit;
5. The program owner dies;
6. The program is actually or constructively abandoned. As used in this section, the term "constructive abandonment" shall include insolvency, eviction, or seizure of assets or equipment resulting in the failure to provide AOD services to participants; or
7. The program fails to be licensed and/or AOD certified in accordance with all applicable state licensing statutes and regulations.

IV. ORGANIZATIONAL ROLES AND RESPONSIBILITIES

A. ADP

ADP is the state agency receiving the federal grant funds being used for vouchers and is responsible for the overall success of the CARE voucher program. ADP is responsible for the following:

1. Establishing policies and procedures;
2. Approving eligible providers;
3. Monitoring and assessing provider performance;
4. Identifying provider training and technical assistance needs;
5. Conducting provider orientations and trainings;
6. Facilitating resources to meet training and TA needs;
7. Collecting and analyzing program data;
8. Auditing provider claims and authorizing payments;
9. On-site provider visits to determine compliance and provide technical assistance; and
10. General oversight and support for the program.

B. MAXIMUS

MAXIMUS, through a contract with ADP, operates the call center and the electronic voucher management system (VMS). MAXIMUS is responsible for the following:

1. Staffing and maintaining the call center for provider and client assistance;
2. Issuing (or rejecting) vouchers to clients via the VMS (per the policies and procedures established by ADP);
3. Tracking voucher clients, services and associated costs;
4. Collecting required outcome and financial data from providers via the VMS;
5. Generating a provider payment file based on VMS billings.

C. State Controller's Office (SCO)

The SCO, through an interagency agreement with ADP, is responsible for the following:

1. Processing payments authorized by ADP;
2. Making payments directly to providers;
3. Auditing tape claims; and
4. Onsite fiscal audits if fraud or abuse is suspected.

D. Ad Hoc Advisory Committee

ADP will utilize an ad hoc advisory committee to provide guidance on specific issues. ADP will contact individuals to participate based on their knowledge of, and involvement and experience with, the specific issue or topic of concern.

E. Assessment Providers

Assessment providers are the entry point for all CARE clients. Individuals are referred to an assessment provider from the call center, the CARE website, and other referral sources. Assessment providers are responsible for the following:

- a. Meeting with a potential client immediately upon referral, but no more than five working days after the referral (unless potential client is unavailable until later);
- b. Referring individuals to another assessment provider if the assessment cannot be conducted within five working days;
- c. Conducting a financial screening to determine the individual's eligibility for other programs/funds sources such as Drug Medi-Cal (DMC), private insurance, Department of Veterans Affairs benefits, etc.
- d. Determining client eligibility and prioritizing admission according to Section VI;
- e. Conducting either a comprehensive psychosocial assessment of treatment and recovery support service needs or an abbreviated assessment for recovery support only, utilizing tools approved by ADP;
- f. Identifying the level and type of treatment and/or recovery support services needed by the client and determining if those needs can be met by the CARE program;
- g. Connecting the client with a case manager and verifying that they meet to complete program admission;
- h. Protecting clients' personal information and participation in treatment or recovery services from unauthorized disclosure by complying with the federal confidentiality regulations related to the release of alcohol and drug abuse records (CFR Title 42, Part 2); and
- i. As applicable, complying with the privacy and security requirements at CFR Title 45, Parts 160 and 164 (the HIPAA regulations).
- j. Maintaining a file for each client as specified in Section XVIII; and
- k. Attending any training or performance review required by ADP.

F. Case Managers

Case managers are responsible for the following:

1. Meeting with the client as soon as possible after the client has been assessed, but at least within three days.
2. Developing a positive relationship with the client as the single point of ongoing contact within the CARE program, to foster client self-determination and meet client needs.
3. Providing to the client a *CARE Client Handbook* and going over the information with the client.

4. Utilizing the CARE provider directory to identify service providers that match the level and type of treatment and/or recovery support services the client needs as recommended by the assessment provider.
5. Providing an unbiased explanation of the service options to the client to ensure that they can make an informed, individual choice about the service provider(s) that will best meet their needs and personal preferences.
6. Involving the client's family/guardian, when appropriate, to assist and support the client during his/her decision process.
7. Referring the client to programs/services outside the CARE network if needs cannot be met by the CARE program or if needed services are covered by another fund source.
8. Scheduling an intake appointment with the client's chosen provider(s), assisting the client with transportation to the appointment, if needed, and following up to ensure access.
9. Informing the client about the requirement to provide Government Performance Results Act (GPRA) and satisfaction data; collecting the client data required by GPRA at intake, discharge, and six-month follow up, and submitting the GPRA data via the VMS; and distributing the satisfaction survey.
10. Establishing linkages between all CARE services and advocating for their client's needs.
11. Facilitating program transfers and changes in treatment level, if warranted. Includes working with treatment providers to ensure that clients appropriate for continuing care vouchers receive them in a timely manner.
12. Making accessible the means for clients to travel to and from treatment or recovery support services, job interviews, medical appointments, 12-step or other support groups, school, work, childcare providers, or other engagements that support recovery. This may include either transporting the client themselves, or providing vouchers for public transportation.
13. Maintaining contact with the client/former client throughout their CARE episode and for at least five months after intake. This includes reengaging the client if he/she drops out of the program and locating a former client to conduct the required GPRA interviews and distributing a client satisfaction survey.
14. Protecting clients' personal information and participation in treatment or recovery services from unauthorized disclosure by complying with the federal confidentiality regulations related to the release of alcohol and drug abuse records (CFR Title 42, Part 2).
15. As applicable, complying with the privacy and security requirements at CFR Title 45, Parts 160 and 164 (the HIPAA regulations).
16. Maintaining a file for each client as specified in Section XVIII; and
17. Attending any training or performance review required by ADP.

G. Treatment and Recovery Support Service Providers

Treatment and recovery support providers are responsible for the following:

1. Accepting vouchers from clients who are appropriate for their services, as long as they have available capacity.
2. Verifying that the client has a valid voucher and that it is assigned to the provider's VMS account prior to beginning service provision.
3. Informing and orienting each client upon admission about applicable program rules, participant requirements, and other expectations.
4. Providing appropriate services to clients as authorized by the voucher and specified in service plans developed by the provider and the client. Includes requesting continuing care and recovery management vouchers as appropriate.
5. Notifying the case manager when a client is discharged.
6. Reporting all specified client and service data via the VMS.
7. Maintaining a file for each client as specified in Section XVIII.
8. Attending training or performance reviews required by ADP.
9. Protecting clients' personal information and participation in treatment or recovery services from unauthorized disclosure by complying with the federal confidentiality regulations related to the release of alcohol and drug abuse records (CFR Title 42, Part 2).
10. As applicable, complying with the privacy and security requirements at CFR Title 45, Parts 160 and 164 (the HIPAA regulations).

V. REFERRALS TO CARE

- A. All potential CARE clients must first go to an assessment provider. They can be referred to an assessment provider by the CARE call center, the CARE website, or directly from referral sources, including case managers or treatment and recovery support providers.
- B. ADP will make available to referral sources education and materials that instruct them to refer potential clients either directly to an identified assessment provider or to the CARE call center or website.
- C. When a potential client or his/her representative calls the CARE toll-free number, the call center will provide general information about the CARE program and refer the client directly to the assessment provider of their choice to determine program eligibility. The CARE website also has information available on the referral process and a directory of assessment providers.

VI. ISSUANCE AND AUTHORIZATION OF VOUCHERS

- A. ADP may limit the number of vouchers that can be redeemed by any one service provider based on provider staffing patterns, hours of operation, administrative capacity, and past performance.

B. Client Eligibility

1. When a potential client presents to an assessment provider, the assessment provider will determine the individual's eligibility based on the following criteria:
 - a. Youth must be between the ages of 12 and 20, inclusive. Active service members (including National Guard) and veterans must not be older than age 25. If the individual is at the upper age range when admitted but will have a birthday while in the program, he/she may be admitted and continue in the program until his/her voucher(s) expires, is cancelled or depleted, whichever comes first.
 - b. The individual must reside in one of the following counties: Butte, Los Angeles, Sacramento, Shasta, or Tehama. If the client moves out of one of these areas while in the program, the voucher will be cancelled.
 - c. The individual must not be detained or incarcerated in a juvenile hall, county jail, in-custody camp, or a California Department of Corrections and Rehabilitation institution or camp (except an incarcerated individual can be assessed for CARE no sooner than two weeks prior to release if the purpose is to transition the individual to CARE treatment and/or recovery support services upon release.)
 - d. The individual must not have any other funding source available to pay for the needed services, based on a financial screening to be conducted by the assessor. If the needed services are covered by another fund source, the assessor must refer the individual to services outside the CARE network.
 - e. The individual must meet one of the following conditions:
 - 1) Demonstrate symptoms of AOD use that indicate a need for AOD treatment based on a brief screening; or
 - 2) Demonstrate symptoms of AOD use but low problem severity and high recovery capital that indicate a likelihood of initiating and sustaining recovery with recovery support services but without clinical treatment; or
 - 3) Be receiving AOD treatment through some other program or funding source but need supplemental treatment or recovery support services; or
 - 4) Be in recovery from AOD abuse or dependence and need recovery support services to sustain recovery. For purposes of the CARE program, being in recovery means that the individual had a substance abuse disorder diagnosis in the

past but is no longer using, and there has been no more than six months since the individual's last AOD use or last treatment episode contact.

2. If the individual is not eligible or appropriate for the CARE program, the assessment provider must refer him/her to the appropriate local agencies that can provide assistance and/or support.

C. Admission Preference

1. Assessment providers are responsible for giving preference for admission to the CARE program, in the following order, to individuals who:
 - a. Have low substance use problem severity and high recovery capital that indicate a likelihood of initiating and sustaining recovery with recovery support services (without clinical treatment);
 - b. Are in recovery and need a recovery support voucher to sustain their recovery.
 - c. Can benefit from brief treatment.
 - d. Are receiving DMC outpatient treatment but need supplemental services not covered by DMC (such as additional individual counseling and family therapy).
2. Assessment providers should take into consideration the individual's acceptance or resistance to services. If the individual is highly resistant and is unlikely to follow through with the provider referral, he/she is not a good candidate for the CARE program.

D. Client Enrollment

1. If the individual meets the eligibility criteria in B of this section and wishes to access CARE services, the assessor must obtain the individual's consent before proceeding any further, using the *CARE Release of Client Information* form.
2. Once the individual has consented to admission by signing the *Release of Client Information*, the assessor must do the following to enroll the individual in the CARE program:
 - a. Collect, validate and enter the following information from the individual into the VMS enrollment screen: first and last name, address, telephone number, gender, social security number (SSN), date of birth, race/ethnicity, and military status.
 - b. If the individual cannot or will not produce his/her SSN, the assessor must utilize the following formula as a substitute (in this exact order): last two digits of the year of birth, two digit day of birth, two digit month of birth (YYDDMM); first letter of first name,

and first two letters of last name. (Example: John Smith, born 07/05/1988 would be 880507JSM.)

- c. Enter all mandatory fields on the enrollment screen and submit the client enrollment by clicking the “Add” button.
3. The VMS will check for duplicate client enrollments based on the individual’s name, address, date of birth, and SSN. If there is no current or former client with duplicate information, the VMS will issue the client a unique identifier.
4. If the VMS gives an error message stating “client with same SSN already exists,” the assessor must request a new episode using the ID number that appears in the error message. The call center will determine whether the individual is eligible for a voucher.
5. Once the client has been enrolled, the assessor should request an assessment voucher electronically via the VMS.

E. Client Assessment

1. Upon receipt of confirmation of client eligibility and the electronic assessment request, the call center will authorize a voucher for either a comprehensive psychosocial assessment or an abbreviated assessment for recovery support only (as long as grant funds remain available and absent any other restrictions). At that time, the assessment voucher will become available for use by the client at the assessment provider. An assessment conducted before an assessment voucher is authorized or prior to the start date will not be reimbursed.
2. The assessment provider will conduct either a comprehensive psychosocial assessment of clinical treatment and recovery support needs, or an abbreviated assessment for recovery support only, using standardized instruments approved by ADP (see Appendix 1).
3. Assessments must be conducted individually, not in a group setting; in a manner and setting that maintains the individual’s confidentiality; and only by individuals authorized by ADP as assessment providers.
4. The assessment provider should include and engage the client’s family or guardians in the assessment process and choice of providers, if appropriate.

F. Level of Care and Placement Decisions

Based on the results of the assessment, ASAM Patient Placement Criteria, and clinical judgment, the assessment provider will determine the needed type and level of services.

1. If the assessment reveals that the client does not qualify for CARE services, the assessment provider must refer the client to other more appropriate local programs/services.
2. All individuals accepted into CARE outpatient treatment must meet the diagnostic criteria for a substance-related disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM). However, the brief length and low intensity provided by the outpatient treatment voucher may be contraindicated for some individuals, such as those with a long-term history of relapse and unsuccessful treatment episodes, severe substance dependence, a co-existing psychiatric disorder or developmental disability, or high level of past trauma.
3. Light or moderate users or at-risk users can be offered recovery support services where they can receive education, brief interventions, and support services to help them reduce use and achieve abstinence.

G. Connection between Assessor and Case Manager

1. The assessment provider must connect the client with an approved CARE case manager by contacting the case manager before, during, or immediately after the assessment appointment.
2. If the assessor selects a case manager based on availability and/or an ongoing working relationship, the assessor must notify the client that he/she can choose a different case manager at any time.
3. The assessment provider must complete and sign the Assessment Provider Certification section of the *Provider Choice Verification* form and give that, along with a copy or summary of the client's assessment results to the case manager. The assessment provider must verify that the case manager meets with the client and may not bill for an assessment unless and until the client has met with a case manager.

H. Orientation and Intake

The intake and orientation service includes all the tasks listed in this section. The case manager may not bill for the intake/orientation service unless/until all tasks are completed.

1. Prior to meeting with a new client, the case manager must request the client's case management voucher electronically via the VMS. Any case management services conducted before a case management voucher is authorized or prior to the start date will not be reimbursed.
2. The case manager must meet with the client as soon as possible after the client has been assessed, but at least within 3 days, to orient the client to the program and complete CARE client intake. The appointment can be conducted at the same place as the assessment, or at another time and/or location more convenient for the client.
3. The appointment must be conducted face-to-face with the client, in an individual (not a group) setting, in a manner and setting that maintains the individual's confidentiality; and only by individuals authorized by ADP as case management providers.
4. The case manager must give the client a *CARE Client Handbook* and go over the handbook information with him/her. The case manager must put his/her name and contact information on the back cover of the *Handbook*.
5. The case manager must do the following related to GPRA data collection/submission and the customer satisfaction survey:
 - a. Conduct the intake GPRA interview with the client and submit the data via the VMS before requesting treatment or recovery support vouchers.
 - b. Inform the client of the need to collect GPRA data again upon discharge and at six-months post-intake.
 - c. Inform the client that they will be asked to submit a satisfaction survey at discharge or at six-months post intake (whichever comes first).
 - d. Notify the client that he/she will receive a monetary incentive for participating in the GPRA interview and completing the satisfaction survey.
 - e. Have the client complete the *Health Study Locator* form to assist in finding the client for future follow-up.
 - f. Offer the client a copy of the *Health Survey Appointment* to help them remember when the GPRA interviews are due.
 - g. Ask for the client's consent to contact him/her telephonically for GPRA interviews, and have him/her complete the *Telephone Interview Consent* form if consent is given.

6. The case manager must make available to the client the CARE provider directory, either in hard copy or by viewing it online, to help match the client with a service provider(s) that best meets his/her needs and preferences based on the assessment.
7. If the assessment indicated a need for services that are not covered by the CARE program (i.e. mental health services), the case manager must refer the client to other programs to address those needs and assist the client to access those services.
8. The case manager must identify all viable provider options, and help the client narrow the choices down to at least two appropriate, eligible providers. At least one of the options must be a provider to whom the client has no religious objection, and the options may not be limited to two locations of the same provider organization.
9. The case manager must present to the client information on the provider options, including types of services the providers offer, hours of operation, setting, whether they are faith-based, participant requirements, and other information to help the client make an informed choice.
10. The case manager's certification that he/she presented provider options to the client and the client's certification that they made an independent choice must be documented on the *Provider Choice Verification* form and placed in the client's file, and a copy must be given to the client.
11. The case manager must ensure the client's chosen provider has available capacity by either accessing the Provider Voucher Limits report on the VMS or contacting the provider. If the provider does not have available capacity, the case manager must find another provider of the client's choice that has available capacity.
12. The case manager must complete and submit to the call center via the VMS a request for the client's treatment and/or recovery support voucher.
 - a. The voucher request must identify the type of voucher(s) needed (see Section VII for the various voucher types) and the client's choice of provider(s). (The call center will reject the voucher request unless and until the intake GPRA is submitted.)
 - b. Upon receipt of an appropriate voucher request, the call center will authorize the voucher(s) for the client to redeem for services at their chosen provider(s) (as long as grant funds remain available and absent any other restrictions). The voucher authorization will include client identification, voucher type and value, the provider selected, and effective (start) and expiration (end) dates.

13. The case manager must facilitate the client's admission to the provider(s) of their choice. This may include any or all of the following:
 - a. Scheduling an intake appointment for the client.
 - b. Ensuring access to the provider location(s), which may include providing or arranging for transportation, if needed, and following up with the client and/or the provider.
 - c. Assisting the client provide any information or documentation the provider requests to complete admission.
 - d. Arranging for timely and culturally-sensitive translation services if the client has limited English proficiency.

15. The case manager must provide (hand-carry or fax) a referral packet to the client's chosen treatment and/or recovery support provider(s). The referral packet must include:
 - a. A completed *Referral Letter*;
 - b. A blank *Referral Completion* notice for the provider to complete and return to the case manager. (The case manager must follow up with the client and/or the provider if he/she does not receive the *Referral Completion* notice to determine whether the client accessed services)
 - c. A copy of the assessment results including at least the final diagnosis and the needs identified in all the adolescent's major life domains—substance use, mental health, physical health, development, school/education/employment, family/peer relationships, and legal—to assist in developing a treatment or recovery plan;
 - d. Any other appropriate evaluation and intake documents.

I. Redeeming Treatment and Recovery Support Vouchers

When the client presents at the treatment or recovery support provider of his/her choice, the provider will do the following:

1. If the provider does not have available capacity or the client is not appropriate for their particular type of services, the provider must immediately contact the case manager to arrange a new provider referral. The provider must also fax the completed *Referral Completion* notice to the case manager.
2. Conduct a financial screening to determine if the appropriate and needed services for the client are available to the provider from any other fund source, as specified in Section XIX (B).

3. If the provider has available capacity and the client is appropriate for their services, the provider must accept the client's voucher by taking the following steps:
 - a. Verify that the client has a valid voucher by confirming that the client shows up on the provider's account in the VMS. Before providing any services, it is the provider's responsibility to make sure their client is enrolled in the CARE program and that a service voucher has been issued. Services provided to a client before a voucher is authorized or prior to the voucher start date will not be reimbursed.
 - b. Fax a completed copy of the *Referral Completion* form to the case manager within three days of admission. This will verify the client's admission and date of admission. A copy of the form must be retained in the client's file.
 - c. For National Guard (NG) clients seeking treatment services, the provider should obtain the client's written consent to share his/her progress with the NG Prevention Coordinator. If consent is obtained, the provider should fax the referral completion form to the NG Prevention Coordinator at 916.366.4735 (in addition to faxing the form to the case manager).
4. Inform and orient the client about their program including rules, participation requirements, grievance procedures, and other expectations.
5. Develop an individual treatment or recovery plan with the client. Recovery support providers must use the *Recovery Support Service Plan* form.
6. Assign a primary counselor who has the experience and competencies to serve the client (youth, service member or veteran).
7. Provide the appropriate and allowable CARE program services as authorized by the voucher, consistent with the client's treatment or service plan.
8. Bill for services provided in accordance with Section XXII.
9. Request allowable continuing care, recovery management, and stabilization vouchers needed by the client via the VMS.
10. Notify the case manager when the client is ready to be discharged or has not shown up for scheduled services and is unreachable.

VII. VOUCHER TYPES AND EFFECTIVE PERIODS

Only one of any type of voucher can be issued to a client during an episode, which is the time between admission to, and discharge from, the CARE program.

A. Assessment

Assessment vouchers are in effect for 14 days from the date of issuance.

B. Case Management

Case management vouchers are in effect for 8 months from the client's date of intake.

C. Outpatient Treatment

Outpatient treatment vouchers are in effect for three months from the date of issuance and cannot be extended or re-issued without ADP approval. At the end of three months or when the outpatient treatment voucher is depleted—whichever comes first—the treatment provider must request a continuing care voucher for a client still in need of services and provide TMAC services (unless the client is not a good candidate for continuing care because of ongoing consistent and heavy AOD use).

D. Continuing Care

1. A client is eligible for a continuing care voucher no sooner than two months after being issued an outpatient treatment voucher. However, if a client has continued to use consistently and heavily throughout outpatient treatment, he/she is not a good candidate for a continuing care voucher and the program should refer the client outside CARE to a program that can provide more intensive and/or longer-term treatment services.
2. The treatment provider should request the continuing care voucher approximately two to three weeks prior to the completion or depletion of the treatment voucher. This will allow an "overlap" period to help the client transition from face-to-face sessions to telephone treatment.
3. During a client's continuing care phase, TMAC (telephone) services are the primary mode of service. TMAC services must be provided in compliance with the *TMAC Clinician Manual* and counselors providing the service must be trained in the TMAC protocol. Therefore, if a treatment provider staff has not been trained to provide TMAC services, the provider may not request a continuing care voucher for any of their clients.
4. Continuing care vouchers are in effect from the date of issuance through six months from the client's intake date.

E. Stabilization

1. A client's treatment provider can request a stabilization voucher for a client in the following circumstances:
 - a. The client must be in the continuing care phase and be receiving TMAC services. (Therefore, if a treatment provider staff has not been trained to provide TMAC services, the provider may not request a stabilization voucher for any of their clients.)
 - b. Based on the TMAC protocol, the client warrants a face-to-face evaluation session, and during the face-to-face evaluation, the counselor and client determine that the client cannot follow through with ongoing phone contact because he/she has returned to the use of alcohol or drugs, or significantly increased alcohol or drug use after a period of low or moderate use.
2. Stabilization vouchers are in effect for 15 days from the date of issuance and cannot be extended or reissued.

F. Recovery Support

Recovery support vouchers are in effect for three months from the date of issuance and cannot be extended or reissued. At the end of three months or when the recovery support voucher is depleted—whichever comes first—the recovery support provider should request a recovery management voucher for a client still in need of services. However, if the client is also receiving outpatient treatment, the client may not have both a continuing care and a recovery management voucher at the same time, and the continuing care voucher takes precedence.

G. Recovery Management

1. A client is eligible for a recovery management voucher after he/she has completed or depleted his/her recovery support voucher, but no sooner than two months after being issued a recovery support voucher.
2. Recovery management vouchers are in effect from the date of issuance through six months from the client's intake date.

VIII. VOUCHER CHANGE MANAGEMENT

A. Voucher Cancellation

1. The VMS will automatically close a voucher on the 15th day after the expiration date to ensure that unused funds are disencumbered and returned to the voucher pool. No billings will be allowed after this date, as specified in Section XXII.

2. A voucher will be cancelled prior to its expiration date if a client is ineligible, the voucher funds are depleted, a discharge GPRA is submitted, or there is no activity (billing) on the voucher for 30 days after issuance.
3. ADP may implement policies for grant close-out that cancel vouchers more frequently based on no activity. ADP will give providers advance notice if this occurs.

B. Client Transfers and Changes in Level of Care

1. If a client requests a change in treatment or recovery support provider or a change is recommended by the program, the provider must refer the client to his/her case manager to ensure ongoing services.
 - a. The case manager will offer the client a new choice of service provider(s), verify that the client's chosen provider(s) has available capacity, and contact the call center to re-assign the client's voucher to the newly chosen provider(s) (or request a new voucher if there is a change in level of care).
 - b. The first provider must provide a progress summary to the new provider to help the new provider determine appropriate care.
2. If a client in continuing care needs to return to face-to-face treatment to address a relapse or impending relapse, the outpatient treatment provider should request a stabilization voucher, as specified in Section VII (E). When the client is ready to be stepped back down to TMAC (telephone) services, or when the stabilization voucher expires or is depleted, whichever comes first, the client may continue to use the remaining funds on the continuing care voucher.

C. Client Engagement and Readmission

1. If a client drops out during outpatient treatment or recovery support, the case manager must contact the client to reengage the client in services. If the client cannot be re-engaged within 30 days, the case manager must complete a discharge GPRA via the VMS.
2. Even after the client has been discharged from CARE, the case manager must maintain contact with the former client at least until the six month GPRA data can be obtained.
3. If a former client returns for treatment after being discharged from CARE, he/she is not eligible for readmission. Exceptions may be granted by ADP on a case by case basis.

IX. VOUCHER SERVICES AND RATES

A. Voucher Types and Values

Voucher Category (timeframe)	Voucher Service (allowable services/unit rates)	Maximum Value
(Psychosocial) Assessment	Assessment (\$115)	\$115
Recovery support (abbreviated) assessment	Recovery support assessment (\$45)	\$45
Service member/Veteran Outpatient Treatment (3 months)	Treatment planning (\$40); Drug testing (\$15); Individual counseling (\$17 per 15 minutes); Group counseling (\$28); Education group (\$20); Individual family therapy (\$100); TMAC orientation (\$68); TMAC telephone session (\$25); Coordination (\$5 per 10 minutes); Life:WIRE orientation (\$25); Life:WIRE monthly (\$20)	\$1,250
Outpatient Treatment (3 months)	Same as above	\$1,000
Continuing Care (through month 6)	TMAC orientation (\$68); TMAC evaluation (\$68); TMAC telephone session (\$25); Drug testing (\$15); Life:WIRE orientation (\$25); Life:WIRE monthly (\$20)	\$350
Stabilization (15 days)	Individual counseling (\$17 per 15 minutes) Group counseling (\$28)	\$200
Recovery support (3 months)	Educational service, individual (\$35); Educational service, group (\$10); Employment service, individual (\$35); Employment service, group (\$10); Spiritual coaching, individual (\$25); Spiritual coaching, group (\$10); Veterans assistance (\$35); Transportation, mileage (\$.51); Life:WIRE orientation (\$25); Life:WIRE monthly (\$20);	\$550
Recovery management (through month 6)	Educational service, group (\$10); Employment service, group (\$10); Spiritual coaching, group (\$10); Life:WIRE orientation (\$25); Life:WIRE monthly (\$20)	\$200
Case Management (8 months)	Orientation and intake (\$75); Discharge client check in, GPRA interview (\$50); 6-month client check in, GPRA interview (\$75); Client incentive (\$20); Case management (\$5 per 10 minutes); Transportation, public (\$3); Transportation, mileage (\$.51); Life:WIRE orientation (\$25); Life:WIRE monthly (\$20)	\$400

B. Service Definitions and Reimbursement Rates

The service definitions, units of service, and reimbursement rates are outlined on Appendix 2.

C. Service Specifications

1. The allowable length specified for each service in Appendix 2 reflects the minimum and maximum time for a billable service. For example, a billable family therapy session cannot be shorter than 60 minutes, and if the session lasts longer than 90 minutes, the additional time cannot be billed to the voucher as additional service units.
2. The time to chart or document services provided is built into the service length and rate and is not a separate billable service.
3. Providers may not charge fees to clients for CARE program services or for admission to a CARE program. Providers must accept vouchers from clients as payment in full for CARE program services rendered.
4. Providers may not subcontract any portion of CARE services without prior approval from ADP.

X. PROGRAM COMPLETION AND DISCHARGE

- A. When a client is no longer receiving either treatment or recovery services under CARE (whether the client completed services, dropped out, or had no contact with any provider for 30 days or more), the case manager must complete a discharge GPRA report via the VMS in accordance with Section XVII(A)(2) to indicate results of services and to close the service episode.
- B. If a client is discharged before the six-month GPRA is due, the case manager must maintain contact with the former client at least until the six month GPRA data can be obtained.

XI. CLIENT HEALTH AND SAFETY

- A. Clients have the right to be accorded dignity in their personal relationships with staff, volunteers, and other clients, and to be free from corporal or unusual punishment, exploitation, prejudice, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, sexual harassment, mental abuse or other actions of a punitive nature.
- B. Program consequences/discipline for a client's inappropriate behavior in the program must be non-violent, age/developmentally appropriate, non-aversive, and clearly stated in the program's rules and procedures.

- C. Programs must conduct a criminal record clearance of all staff and volunteers who will have any contact with minors while they are at the program. If the review discloses that the individual has been convicted or is the subject of any criminal investigation relating to any felony or misdemeanor perpetrated against a minor, the program must prohibit that individual from any employment or volunteering resulting in any contact with clients. The program must keep the results of the criminal record review in a confidential portion of the personnel file.
- D. Programs must comply with state and federal laws and regulations regarding informed consent for children, disclosure of confidential information such as patient-identifying information (including communication with parents, guardians, courts), child abuse and neglect reporting requirements, and duty-to-warn issues (threats of violence, HIV infection risk, criminal activity).
- E. The program must provide a reasonable level of age-appropriate structure, care, and supervision to ensure the safety and security of clients and staff at all times while on the program site.
- F. All facilities must be clean, sanitary, and in good repair at all times for the safety and well being of clients, staff, and visitors.
- G. Programs must have a plan of action for continuity of services in the event the organization can no longer perform services due to facility incapacitation or loss of key personnel.

XII. MANAGEMENT OF VOUCHER FUNDS

ADP may limit the number of vouchers issued to clients based on available funds. In addition, ADP may terminate voucher issuance as needed without any advance notice to providers, clients, or potential clients pursuant to the loss of funding, expenditure of grant funds, or any other financial limitation to funds.

XIII. PRIVACY, SECURITY, AND CONFIDENTIALITY REQUIREMENTS

- A. All CARE providers, including recovery support service providers, must protect clients' personal information and participation in treatment or recovery services from unauthorized disclosure by complying with the federal confidentiality regulations related to the release of alcohol and drug abuse records (CFR Title 42, Part 2).
- B. Any CARE provider determined to be a covered entity as defined by the HIPAA regulations must adhere to the policies and procedures that the HIPAA requires for a covered entity.
- C. All providers must obtain a client's consent to release information prior to submitting any client-identifying information, including billing data, to ADP or the call center, either via phone, fax, or the VMS. Providers must use the *Consent for the Release of Confidential Information* form for this purpose.

- D. Emailing confidential client information, or attaching a document that contains confidential client information to an email, is strictly prohibited by federal and state laws and regulations.
- E. Providers may fax documents with confidential client information (client assessments, referral notices, etc.) as long as the client has consented to the release of information and the provider utilizes the *Fax Transmission of Confidential Client Information* form or its equivalent.
- F. Providers must conduct any confidential interactions with clients, such as assessments and counseling sessions, in a private space that protects their confidentiality.

XIV. DISPUTE RESOLUTION

- A. Resolving Disputes Between Clients and Providers
 - 1. Providers must have grievance procedures in place that a client can use to seek resolution of any program-related disputes with the provider. The grievance procedure must assure that the client will receive a full, fair and timely review of the disputed matter.
 - 2. Case managers must notify each client of the CARE grievance policy by providing them a copy of the *CARE Client Handbook*, which states that if an acceptable solution to any dispute with a program cannot be reached, the client may refer the dispute to ADP for resolution.
 - 3. If a dispute is referred to ADP, ADP may request that the provider submit all relevant information and evidence pertaining to the dispute within 10 working days following receipt of the ADP's request for information. This information must include:
 - a. A description of the disputed issue(s);
 - b. A summary of the client's position prepared by the client (or his/her representative) related to each disputed issue;
 - c. A summary of the provider's position related to each disputed issue;
 - d. A description of any solution proposed by the provider when the client sought resolution through the provider's grievance procedures.
 - 4. ADP will provide the disputing parties a written decision to resolve the dispute within 20 working days from receipt of all relevant information from the provider. ADP's decision is final. Either the client or the provider may terminate voucher services if unwilling to accept ADP's decision.

B. Resolving Disputes Between Providers and ADP or its Contractors

1. If a provider has a dispute or grievance with ADP or one of its contractors, the provider shall first discuss and attempt to resolve the issue informally with the CARE staff. This step shall be taken within 30 days from the time the provider knew or should have known of the dispute.
2. If the issue cannot be resolved at this level, the provider may submit a grievance report to ADP, CARE Project Director, 1700 K Street, Sacramento, CA 95811. The report must state the issues in dispute, the provider's position, and the remedy sought.
3. Within 20 working days from receipt of the written grievance report, ADP will make a determination on the grievance and provide a written decision containing the basis for the decision to the provider. ADP's decision is final.

XV. PROVIDER TRAINING

- A. Providers must participate in training provided by ADP and/or its representatives to participate in the CARE program. At a minimum, such training will include the following:
1. An overview of the CARE program
 2. Specific program requirements;
 3. The roles of ADP, its contractors, and providers;
 4. Performance objectives; and
 5. Billing and reimbursement processes.
- B. Providers will be given advance notice by ADP of all training date(s), method(s) and formats. ADP will provide training materials as necessary at no expense to the provider.
- C. If needed and/or requested, ADP may facilitate additional training available from other sources.

XVI. PROVIDER STAFF AND VOLUNTEERS

- A. The provider must orient and train all staff and volunteers who provide CARE services or administrative tasks on at least the following areas:
1. The *CARE 3 Policies and Procedures*;
 2. Protection of client confidentiality;
 3. Client rights and grievance procedures;
 4. Overview of the electronic VMS; and
 5. Code of conduct.

- B. The provider organization must utilize staff or volunteers who meet the required qualifications for CARE service provision.
- C. Individuals working in the program who come in contact with minors must pass a criminal background check.
- D. Staff and volunteer files must contain at least the following:
 - a. Job description or scope of work;
 - b. Resume or list of volunteer or life experiences;
 - c. License, certification, or related credentials;
 - d. Signature that they received orientation on the *CARE 3 Policies and Procedures*;
 - e. Evidence of applicable training; and
 - f. Results of criminal background check.
 - g. If transporting clients, copy of DMV record and proof of insurance, as applicable.

XVII. PROVIDER DATA COLLECTION AND REPORTING REQUIREMENTS

A. GPRA Data Collection and Reporting

1. Intake GPRA

Case managers must collect the required intake GPRA data from each client and submit the intake GPRA via the VMS prior to requesting a treatment and/or recovery support voucher for the client. A case management, treatment, or recovery support voucher will not be issued unless and until the intake GPRA is submitted.

2. Discharge GPRA

- a. The case manager must conduct a discharge GPRA interview with every client as soon as possible upon discharge, and submit the completed discharge GPRA via the VMS within five days of the interview to indicate results of services and to close the service episode. This includes clients who drop out of CARE services and cannot be reengaged within 30 days.
- b. If the case manager is unable to locate a client within 30 days of the last face-to-face service to do an interview, the case manager must document his/her attempts to locate the client and complete and submit the first four items in Section A, and all of Sections J and K of the GPRA tool. This is considered an “administrative GPRA.”
- c. The discharge date on the discharge GPRA must be the last date the client received treatment or recovery support services (not the date the discharge GPRA interview was conducted or the date it was submitted via the VMS).

- d. The case manager must attempt to meet face-to-face with the client/former client to collect the discharge GPRA data and document attempts in the client's file. The case manager may do a telephone interview with a client if the client is unable/unwilling to meet face-to-face with the case manager but is willing to do a telephone interview and has given his/her written consent for telephone interviews as specified in subsection 4 below.

3. Six-Month Post Intake GPRA

- a. Case managers must conduct a six-month post intake (follow up) GPRA interview with every client/former client, and submit the completed six-month GPRA via the VMS within 5 days of the interview.
- b. The six-month GPRA interview is due exactly (not a day sooner than) 5 months after the intake GPRA was conducted and is considered late if it is not completed six months after the intake GPRA was conducted. SAMHSA and ADP will allow providers to conduct the interview up to 8 months after the intake GPRA was conducted. Case managers will not be reimbursed for GPRA interviews that are conducted outside this 5 to 8 month window.
- c. The case manager must attempt to meet face-to-face with the client/former client to collect the six-month GPRA data and document attempts in the client's file. The case manager may do a telephone interview with a client if the client is unable/unwilling to meet face-to-face with the case manager for the six-month GPRA interview but is willing to do a telephone interview and has given his/her written consent for telephone interviews as specified in subsection 4 below.
- d. If the case manager is unable to locate the client/former client within eight months of the client's intake, the case manager must complete and submit the first four items in Section A and all of Section I of the GPRA tool. This is considered an "administrative six-month GPRA."

4. Method of GPRA Data Collection

- a. All GPRA data must be entered into the VMS within 5 days of the day the interview was conducted. No GPRA question can be skipped or left blank; if the response to a question is "no," the case manager must enter a "0".
- b. All intake GPRA interviews must be conducted face-to-face.

c. If a former client is unable or unwilling to meet in person with the case manager to do a discharge or six-month follow up GPRA interview, the case manager may conduct those interviews via the telephone, as described below.

- 1) The case manager must document that he/she attempted to meet in person with the client/former client.
- 2) Prior to contacting a client/former client by telephone, the client must have given his/her informed written consent via the *Telephone Interview Consent Form*.
- 3) The following guidelines for protecting clients' privacy must be strictly adhered to:
 - Never mention AOD or AOD treatment or recovery until the identity of the client has been validated.
 - Never leave a message that may identify the caller or the caller's agency as part of an AOD treatment or recovery program.
 - Never leave a voice message on a recording device at any time. Leaving messages on personal cell phones are okay.
 - When speaking to a person other than the client, do not give any more information than a first and last name, and forwarding telephone number. It is okay to state you are conducting a health survey.
 - When a client is reached, verify their date of birth and whether it is a good time for them to talk prior to conducting the interview.

B. Client Satisfaction Survey

Case managers are responsible for distributing a client satisfaction survey to each client at either the discharge or six-month post-intake GPRA interview (whichever comes first) according to the following procedures:

1. Case managers must maintain a sufficient supply of client satisfaction surveys and business reply envelopes (available from ADP) to make one available to each of their clients.
2. The case manager must write down their provider ID and the client's ID on the satisfaction survey (for tracking purposes only) and hand-deliver the satisfaction survey to each client at either the six-month post intake GPRA interview or the discharge GPRA interview (whichever comes first).
3. If the case manager conducts both the six-month post intake GPRA and the discharge GPRA interviews over the telephone, the case manager must set-up a separate face-to-face meeting to distribute the survey and

reply envelope (and incentive) to the client. If a separate meeting is necessary to distribute the survey, the case manager shall make available to the client a \$20 incentive for accepting and completing the survey.

4. The case manager should instruct the client to rate all the CARE services they have received and return the satisfaction survey directly to ADP via the postage-free business reply envelope. Alternatively, the client can seal their survey in the provided envelope and have the case manager send them in the mail.
5. The case manager must assure the client of anonymity and emphasize the importance of completing the survey.
6. The case manager must document in the client's file the date they distributed the survey (and the incentive) to the client.
7. The case manager will be notified by ADP when completed surveys are received. The case manager must follow up with all clients who have not returned completed satisfaction surveys to encourage them to return the survey, and document follow up contact in the client's file.

C. Locating Former Clients and Client Incentives

1. Locating Former Clients

- a. During the intake/orientation process, the case manager must ask the client to complete the *Health Study Locator* form to assist in finding the client for future follow-up and surveys.
- b. Case managers must adhere to state and federal laws and regulations regarding confidentiality when attempting to locate former clients for the six month post intake interview and the client satisfaction survey.

2. Client Incentives

- a. During the intake/orientation process, the case manager must notify clients that they may receive monetary incentives for participating in the six-month GPRA interview and the client satisfaction survey. Case managers can give clients a copy of the *Health Survey Appointment* coupon to help them remember when the GPRA interviews are due and when the client satisfaction survey will be distributed.
- b. Case managers must offer \$20 (or its equivalent in gift/fuel cards, bus passes/tokens or other gratuity) to a client/former client upon completion of the six-month follow-up GPRA interview as an incentive to participate.

- c. If the case manager conducts both the six-month and discharge GPRA interviews by telephone and must set up a separate face-to-face meeting to distribute the satisfaction survey, the case manager should offer the client a \$20 incentive for making the meeting and returning a completed survey.
- d. If the client is provided with an incentive, the case manager must obtain the client/former client's signature verifying that he/she received it, and keep a copy of the receipt in the client's file.

D. Program Reports

Providers must submit the following information/reports:

1. Via the VMS, assessment providers must submit required client information and an assessment request prior to conducting an assessment.
2. Via the VMS, case managers must submit the intake GPRA report and the request(s) for case management, treatment and/or recovery support vouchers after the intake GPRA is submitted.
3. Treatment and recovery support providers must submit a *Referral Completion* notice to the case manager for each referral received and/or voucher accepted within three days of receiving the *Referral Letter*.
4. All providers must invoice via the VMS for services provided within 14 days of providing a service. The first billing must be completed within 14 days of the voucher start date and all billing must be completed within 14 days of the voucher expiration date.
5. All treatment providers must complete and submit via the VMS the TMAC progress assessment summary for every TMAC session conducted with a client. A provider will not be reimbursed for a TMAC session if the summary is not submitted in the VMS.
6. All providers must complete and submit to ADP an *Organizational Change* form within three days of any changes to the information provided on the provider enrollment application. This includes any changes to the organizational status, program contact person, location, phone or fax number, email address, hours of operation, assessment staff, family therapists, and types of services provided.
7. All providers must notify ADP's CARE unit by email, fax or phone if a client dies during an episode of CARE services.

XVIII. CLIENT FILES

A. Assessment Provider Files

Assessment providers must maintain a file for each client that contains, at a minimum, the following:

1. Client identifying information, including CARE client ID number, name, address, telephone number, date of birth, and gender.
2. A copy of the *CARE Release of Client Information* form signed by the client indicating his/her consent to participate in the CARE program.
3. A copy of the completed treatment and/or recovery support assessment tool.
 - a) For treatment clients, the results of the assessment must include evidence that the client met the diagnostic criteria for a substance related disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM).
 - b) For clients who are receiving recovery support only, the assessment results must include evidence that the client met the eligibility criteria, as specified in Section VI.
4. Documentation that the assessor connected the client with an approved case manager.

B. Case Management Client Files

The case manager must maintain a file for each client that contains, at a minimum, the following:

1. Client identifying information, including CARE client ID number, name, address, telephone number, date of birth, and gender, and emergency contact (with client consent to notify contact in the case of emergency).
2. Appropriate authorizations to release confidential information.
3. The original signed *Provider Choice Verification* form verifying that the client was presented with at least two provider options for the services needed, given information about the providers, and he/she had freedom to choose the provider selected.
4. A copy of the completed intake, discharge, and six-month followup GPRA interviews, unless the GPRA interview data is entered directly into the VMS. In such a case, the file must contain a note stating when the interview was conducted and submitted via the VMS.

5. Completed *Health Study Locator* form.
6. A copy of the *Referral Letter* sent to client's chosen provider and a copy of the *Referral Completion* form from the provider(s) who admitted the client.
7. Evidence that the provider went over the *Client Handbook* with the client, including the CARE grievance procedures.
8. A copy of the completed *Telephone Interview Consent* form, as appropriate.
9. Copy of a signed receipt from the client for any incentive payment provided to the client.
10. Documentation of case management services provided. If a service billed in the VMS does not have corresponding documentation in the client's file, the provider will not be reimbursed for that service.

C. Treatment and Recovery Support Client Files

Treatment and recovery support providers must maintain a file for each client that contains, at a minimum, the following:

1. Client identifying information, including CARE client ID number, name, address, telephone number, date of birth, gender, and emergency contact (with a consent from the client to notify that contact in the case of emergency).
2. The referral packet from the case manager, including the assessment or assessment summary.
3. A copy of the completed *Referral Completion Form* and evidence that the form was faxed or otherwise submitted to the case manager.
4. Appropriate authorizations to release confidential information.
5. Documentation that the program conducted a financial screening to determine if the appropriate and needed services for the client are available to the provider from any other fund source.
6. Completed individual treatment plan or *Recovery Support Services Plan*.
7. Documentation of the services provided by the program. If a service billed in the VMS does not have corresponding documentation in the client's file, the provider will not be reimbursed for that service.

8. A completed *TMAC Progress Assessment, Counselor Version* form for every TMAC service provided (in addition to completion of the TMAC Progress Assessment summary in the VMS).
 9. A copy of the completed *Telephone Monitoring Consent* form, as appropriate.
- C. In addition to the requirements in Section (B), all treatment providers must comply with the requirements for participant files specified in Section 17015 of ADP's *Alcohol and Other Drug Program Certification Standards*.
 - D. All entries in the client's record must be legible, clear, completed, accurate, made with indelible ink or print, and recorded in a timely fashion (at least prior to billing in the VMS).
 - E. All CARE client files must be readily available for ADP review at the provider location and must be retained for at least three years.
 - F. Client files must be maintained, and information released, in a manner that ensures confidentiality and security, in accordance with CFR Title 42, Part 2.
 - G. If client records are maintained on a computer system, the provider must have a backup system to safeguard records in the event of operator or equipment failure and to ensure security from inadvertent or unauthorized access. In addition, the provider must make such electronic records available for ADP review during a site visit.

XIX. PROVIDER FISCAL RESPONSIBILITIES

A. Non-Supplantation

The ATR grant requires that CARE funds be used to expand capacity and supplement, and not supplant, current funding for substance abuse treatment and recovery support services in the State.

B. Third Party Payors and Financial Screening

Assessors, treatment and/or recovery support providers are responsible for doing a financial screening of a CARE client upon admission. If the appropriate and needed services for the client are available to the provider from any other fund source, those fund sources must be accessed and/or exhausted prior to accessing CARE voucher funds for those services. For example, if the provider is Drug Medi-Cal (DMC) certified and the client is DMC eligible, the program must bill DMC as allowable. However, if DMC does not cover all the needed services, the client is eligible to receive a voucher for those services not covered by DMC.

C. Cost Allocation

CARE providers who also receive AOD treatment funds from the county must allocate their costs equitably to all funding sources. If the provider's actual cost of a CARE service is determined to be more than the CARE reimbursement rate, the program may not charge the unreimbursed CARE cost to Net Negotiated Amount (NNA) or DMC funding.

XX. PROVIDER PERFORMANCE

A. Evaluation

ADP will evaluate the CARE program with data gathered from GPRA interviews, client satisfaction surveys, voucher utilization, and program site visits. Client characteristics, treatment processes and outcomes, service utilization, and expenditure patterns will be analyzed on an ongoing basis.

B. Regional Performance Meetings

1. Providers will be expected to participate in regional performance meetings that will be held no more than quarterly. Providers will be given advance notice of the date, time and location of the meeting.
2. The purpose of the regional performance meetings will be to:
 - a. Involve providers in problem-solving to improve performance.
 - b. Let providers share success factors and root causes of poor outcomes with each other.
 - c. Determine where improvements can be made.
 - d. Identify technical assistance and training needs and resources.

C. Onsite Visits

1. ADP will conduct unannounced on-site visits of providers for the following purposes:
 - a. To determine the level of compliance with program requirements;
 - b. To identify areas where additional technical assistance or training is needed;
 - c. To review complaint allegations; and
 - d. To inform decisions regarding noncompliant providers' continued participation in the program.
2. To participate in the CARE program, providers must agree to allow ADP employees or agents to inspect the premises, review personnel and client records, observe program operations, and interview employees and clients associated with the CARE program.

3. ADP will notify a provider in writing of the results of an onsite review, and the provider must submit a corrective action plan within the time frame specified. Failure to remedy deficiencies noted during an onsite review will result in the provider being suspended from admitting any CARE clients until the deficiencies are corrected.
4. Providers are encouraged to use the *CARE Site Visit Review Tool* for self-monitoring to ensure compliance with the requirements agreed upon as part of the application process.

D. Consequences of Noncompliance

When a provider accepts a CARE voucher, it must comply with all the requirements in the *CARE Policies and Procedures*. Failure to do so may result in sanctions, including, but not limited to, withholding payment until compliance is attained, disallowance of unauthorized billings, repayment of fraudulent billings, fiscal audits, forfeiture of CARE participation, and criminal prosecution.

XXI. FRAUD AND ABUSE

- A. ADP will take all necessary measures to prevent, detect, investigate, and prosecute acts of fraud and abuse committed against the CARE program.
1. For purposes of the CARE program, fraudulent practices include, but are not limited to, the following:
 - a. Falsifying information on the provider application or omitting relevant material facts;
 - b. Misrepresenting staff credentials or qualifications or billing for services provided by unqualified staff;
 - c. Falsifying client files, records, or other documentation;
 - d. Billing for services not rendered or billing multiple times for the same service;
 - e. Accepting payment for services not rendered or charging a client for services rendered.
 2. For purposes of the CARE program, abusive practices include, but are not limited to, the following:
 - a. Making improper diagnoses;
 - b. Misrepresenting client outcomes;
 - c. Providing client services that are not necessary or services that are inappropriate for the client's condition;
 - d. Knowingly not billing a primary payor (Drug Medi-Cal or private insurance) for an eligible client;
 - e. Offering or accepting payment to refer clients to a particular provider, or coercing a client to choose a particular provider.

3. ADP strongly encourages all providers, business associates, and clients to immediately report suspected acts of fraud or abuse by calling (916) 323-4445, or by mail to ADP CARE Unit, 1700 K Street, Sacramento, CA 95811, or by fax to (916) 445-0846.
 4. ADP will accept and investigate all reports of suspected fraud and abuse, including those filed anonymously.
 5. If a provider or any of its employees, volunteers, or board members commit client abuse, neglect or exploitation; malpractice; or fraud, embezzlement, or other serious misuse of funds, ADP may terminate the provider's participation in the CARE program immediately upon written notice to the provider.
- B. Providers must help prevent fraud and abuse by having internal controls in place that address at least the following:
1. The control of the user ID and password to the VMS so that only appropriate and authorized persons are allowed access;
 2. Control and oversight of billings, including who is authorized to enter, review, and approve billings, and segregation of these responsibilities as appropriate;
 3. Safeguards to prevent employees, volunteers or members of the governing body from using their positions for purposes that are motivated by private financial gain for themselves or others with whom they have ties;
 4. Conflict of interest, addressing financial interests, gifts, gratuities and favors, nepotism, and bribery.

XXII. PROVIDER PAYMENTS

A. Payment Overview

1. The issuance of a CARE voucher is not a guarantee of payment for services up to the full voucher value. It is a commitment on the part of ADP to pay for services actually provided, up to that maximum value while funding is available and the provider and the client remain eligible.
2. Providers will be reimbursed on a fee-for-service basis, after a service has been provided.
3. CARE does not automatically generate payment for services provided. Invoicing/billing is the responsibility of the provider.

B. Invoicing Process

1. Providers are expected to use the web-based VMS to invoice/bill for services.
 - a. Once a provider has been approved to participate in CARE, the provider will receive a welcome package by mail that will include the provider ID number, user ID number, and password necessary to access the VMS.
 - b. Provider staff who will be using the VMS must receive training on its use. Training is provided to all new providers and is available on an ongoing basis for new staff from the call center. Detailed information is also available in the *Voucher Management System Training Guide* available on the CARE website or the VMS bulletin board.
2. Providers must invoice for services within 14 days of providing the service. Vouchers are automatically closed on the 15th day after their expiration date. If services are not entered by then, the provider will not be reimbursed.
 - a. Providers bill for services by entering into the VMS the number of service units provided to a client and the date the service was provided. The VMS will automatically place each billing in a “hold” account.
 - b. The designated individual in the organization authorized to approve/sign invoices must access the VMS to release the approved billings from the “hold” account.
 - c. Prior to the upload every Monday (described in the following section), the provider who entered the services can go back into the VMS and edit any services that have been entered. After the upload, no changes can be made by the provider to services/billings entered, approved and released. If the provider is aware of an error after an upload, the provider must notify ADP to make an adjustment.
3. Providers are expected to exercise their own internal controls for VMS passwords to ensure that only the authorized person(s) are able to enter billings and approve and release billings for payment.

C. Payment Schedule

1. Providers are paid approximately every two weeks in arrears based on the billings they submit via the VMS as described above.

2. Services entered into the VMS by the provider will be uploaded to the federal data system every Monday at 12:01 am. The upload will include services approved and released into the VMS up to the preceding Friday at 12 midnight.
3. Within 15 days after the end of a two-week billing cycle, ADP will review, adjudicate and process billings included in the upload, and will submit authorized claims to the State Controller's Office (SCO). The SCO will issue and mail warrants (checks) directly to providers within 15 business days of receipt of authorized claims from ADP.

D. Recouping Unauthorized Payments

If, after payment has been made to a provider, it is determined that the payment was erroneous or inappropriate, ADP will notify the provider in writing of the amount that needs to be repaid, the reason, and the due date for repayment. The provider will have 60 days to repay the funds. If the funds are not repaid, ADP will assign the case to a collection agency to recover the funds.

XXIII. FEDERAL FUND REQUIREMENTS

Funds for the CARE program are authorized by Sections 501(d)(5) and 509 of the Public Health Service Act, 42 U.S.C. Section 290aa(d)(5) and 290bb-2, Public Law 106-310, Catalogue of Federal Domestic Assistance (CFDA) No. 93.275. CARE providers are subject to the cost principles and financial management requirements for federal grants contained in CFR Title 45, Part 74 and Part 92. Pursuant to these regulations, CARE funds may be used only for the services authorized by the voucher, and further, may not be used to:

- A. Pay for any lease beyond the project period.
- B. Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about the community).
- B. Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to \$75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)
- C. Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)
- D. Pay for housing other than residential mental health and/or substance abuse treatment.
- E. Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

- F. Pay for incentives to induce individuals to enter treatment. However, a grantee or treatment provider may provide up to \$20 or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as incentives to participate in required data collection follow-up. This amount may be paid for participation in each required interview.
- G. Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.
- H. Pay for pharmacologies for HIV antiretroviral therapy, sexually transmitted diseases (STD)/ sexually transmitted illnesses (STI), TB, and hepatitis B and C, or for psychotropic drugs.
- I. Pay the salary of an individual at a rate in excess of \$199,700 annually.

California Access to Recovery Effort (CARE) Program

Approved Assessment Instruments

AOD Assessment Instruments	Target Population
Addiction Severity Index (ASI)	Adult
Adolescent Diagnostic Interview (ADI)	Adolescent
Personal Experience Inventory (PEI)	12-18 years of age
Personal Experience Inventory (PEI) – Adult	19 years of age and older
Teen Addiction Severity Index (T-ASI)	Adolescent
Global Appraisal of Individual Needs (GAIN), Initial, core only	Adolescent and adult
Recovery Support Assessment	
ASAM Recovery Support Services (RSS) Assessment Tool	Adult and adolescent

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CALIFORNIA ACCESS TO RECOVERY EFFORT (CARE)

SERVICES RATES AND DEFINITIONS

Services Billable by Approved Assessment Providers			
Service	Description	Additional Qualifications	Service Unit/Rate
(Psychosocial) Assessment	Includes the following: screening potential client to determine eligibility; a financial screening to determine eligibility for, and availability of, other funding/resources; enrolling client in VMS, conducting and documenting a psychosocial assessment using one of the instruments mandated by ADP; identifying the level and type of treatment and recovery support services needed, connecting the client with an approved case manager.	Must be a licensed professional (physician, psychologist, MFT, LCSW, registered MFT intern or associate clinical social worker under the supervision of a licensed therapist) or a certified AOD counselor, certified by one of the certification organizations approved by ADP, pursuant to the Counselor Certification Regulations, (CCR, Title 9, Section 13035(a)).	\$115 flat rate. One assessment per episode (either psychosocial or abbreviated).
Recovery Support Assessment (Abbreviated, for recovery support-only)	Includes the following: screening potential client to determine eligibility; enrolling client in VMS, conducting and documenting an abbreviated assessment for clients needing recovery support services only using the instrument mandated by ADP; identifying the type of recovery support services needed, and connecting the client with an approved case manager.	Same as above.	\$45 flat rate. One assessment per episode (either psychosocial or abbreviated).

Services Billable by Approved Case Management Providers			
Service	Description	Additional Qualifications	Service Unit/Rate
Intake and Orientation	Meeting face-to-face with the client at least 3 days after he/she has been assessed to orient client to program and complete intake. Includes conducting intake GPRA interview and submitting data via the VMS, reviewing the <i>Client Handbook</i> , obtaining consents to release information, identifying eligible service providers that match the client's assessed needs, providing unbiased explanation of the service options to the client to ensure that they can make an informed, independent choice of provider, requesting a treatment and/or recovery support voucher, making an intake appointment at the client's chosen provider, and ensuring the client's access to his/her chosen provider.	Must have an associate's degree (or certificate from a training program) in human services or behavioral sciences, or be a registered or certified AOD counselor with on-the-job experience as a case manager or social worker.	\$75 flat rate. One per episode.
Case Management	Includes planning client's services, linking client with other needed services (including recovery support), and monitoring service delivery. Also includes time spent either on the telephone or face-to-face attempting to re-engage a client in services or to locate them to collect required GPRA data. <i>Time spent billing for services is NOT a case management function, nor are other administrative activities.</i>	Same as above.	\$5 for a 10 minute unit. Maximum 6 units (1 hour) per month.

Services Billable by Approved Case Management Providers (continued)			
Service	Description	Additional Qualifications	Service Unit/Rate
Discharge client check-in	A session with the client upon discharge to develop a recovery plan, distribute the customer satisfaction survey, and conduct the structured GPRA interview, gather the required client data, and submit the data via the VMS within 5 days of the interview.	Same as above.	\$50 flat rate
6-Month post intake client check-in	A session with the client/former client at six-months post-intake to distribute the customer satisfaction survey and conduct the structured GPRA interview, gather the required data and submit the data via the VMS within 5 days of the interview.	Same as above.	\$75 flat rate
Client incentive	\$20 or its equivalent in gift cards, bus passes/tokens or other gratuity to a client/former client upon completion of the six month post-intake GPRA interview, and, if a separate face-to-face meeting is required to distribute the client satisfaction survey, upon accepting and completing the survey.	NA	\$20 each incentive. Maximum 2 per client.
Transportation – mileage	Actual mileage for transportation by the case manager to and from an activity related to the client's recovery. Includes transporting the client to/from those activities, or the case manager traveling to and from meeting with the client. CARE will not reimburse providers for transporting clients to inherently religious activities, such as worship activities, church, or bible study. The provider cannot bill multiple clients' vouchers for the same mileage to one location where he/she meets with multiple clients.	Provider must submit to ADP, and comply with, the <i>Provider Acceptance of Transportation Requirements and Conditions</i> , and the driver must submit a current copy of DMV record to the provider.	\$.51 per mile. Maximum 200 miles per voucher.
Transportation - public	Public transportation passes and/or tokens for base fare distributed to the client for the express purpose of accessing services directly related to the client's recovery.	NA	\$3 per bus pass/token. Maximum 50 passes/tokens per voucher.
Life:WIRE orientation	A one-time service to set up the client's access to Life:WIRE and orient him/her to the service.	Must be enrolled directly with Life:WIRE in order to bill for this service.	\$25 flat rate. Maximum one per client, per provider.
Life:WIRE, monthly	A text-messaging service that allows approved providers to send text messages to individuals for motivation, appointment reminders, and questions, to determine client's status.	Same as above.	\$20 per client per month. Maximum one per month.

Services Billable by Approved Outpatient Treatment Providers			
Service	Description	Additional Qualifications	Service Unit/Rate
Treatment Planning	A specific session that is used to develop an individualized, written plan of action that directs all treatment services and is based upon information from the assessment and input from the client. The plan establishes client goals and corresponding measurable objectives, time frames for completing objectives, and the type and frequency of services to be provided. Treatment plan updates should occur in individual counseling sessions, be documented as such, and billed under individual counseling.	Staff must be either 1) a licensed professional (physician, psychologist, MFT, LCSW, registered MFT intern or associate clinical social worker under the supervision of a licensed therapist); 2) a certified AOD counselor, certified by one of the organizations approved by ADP, pursuant to the Counselor Certification Regulations, (CCR, Title 9,	\$40 flat rate. One per episode.

		Section 13035(a)); or 3) registered to obtain counselor certification by one of the organizations approved by ADP.	
Individual counseling	A face-to-face contact between a single client and the counselor or therapist to address the emotional, psychiatric, and social concerns related to the client's AOD use and/or abuse. In addition to regularly scheduled sessions, individual counseling should be billed for sessions related to orientation to treatment, updating treatment plans, brief interventions, and crisis intervention. (Individual counseling provided as home visit or hospital visit is allowable.)	Same as above.	\$17 per 15 minute increments. Maximum 4 units (one hour) per week.
Group counseling	A face-to-face contact in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the clients. Alternative activities provided in a group setting (art therapy, supervised activities such as sports, games, outings, etc.) should also be billed at the group counseling rate. <i>Groups where participants watch a video or listen to a didactic presentation must be billed at the education group rate, not as group counseling.</i>	Same as above, except that alternative activities may be conducted/supervised by a staff person who has, at a minimum, a high school diploma and has received (and the program has documented) training on working with the target population (youth and/or military personnel).	\$28 per 60-90 minute session. Maximum two per week.
Individual family therapy	A therapeutic session that engages the client and member(s) of his/her family system as a unit. A variety of evidence-based approaches may be used such as structural/strategic family therapy, multi-dimensional family therapy, multi-systemic family therapy, and behavioral family therapy.	Staff must be a licensed professional (physician, psychologist, MFT, LCSW, registered MFT intern or associate clinical social worker under the supervision of a licensed therapist).	\$100 per 60-90 minute session. Maximum two per month.
Coordination	Includes planning client's services, communication with other systems serving the client (such as probation, child welfare), monitoring service delivery, and evaluating the effect of the services received. <i>Time spent billing for services is NOT a coordination function, nor are other administrative activities.</i>	Staff must, at a minimum, possess a high school diploma and have been trained on working with the target population (youth and/or military personnel).	\$5 for a 10 minute unit. Maximum four units (40 minutes) per month.
Education group	A planned, structured, didactic presentation at the treatment program of health and wellness information on a broad range of topics related to the client's AOD use and its effects on the client and his/her family. Possible topics include skill building, violence prevention, health issues (sexually transmitted diseases, tuberculosis, hepatitis, nutrition, smoking cessation, family planning). Parental education session topics might include stages of adolescent development, family dynamics, communication, and child discipline.	Same as above, except that staff must also have documented knowledge, skills, and training in any topic area on which they are presenting.	\$20 per 60-90 minute session. Maximum one per week.
TMAC orientation	A face-to-face orientation between the client and the counselor or therapist prior to beginning TMAC telephone sessions, in accordance with the <i>TMAC Clinician's Manual</i> .	Staff must be either 1) a licensed professional (physician, psychologist, MFT, LCSW, registered MFT intern or associate clinical social worker under the supervision of a licensed therapist); 2) a certified AOD counselor, certified by one of the ADP approved organizations. In addition, staff must have been trained in the TMAC protocol	\$68 per 50-60 minute session. Maximum one per voucher.

		either by ADP or its authorized representatives, or by another qualified individual who was trained by ADP or its authorized representative.	
TMAC telephone session	A brief (15-20 minutes), scheduled telephone call to a client utilizing the TMAC (telephone monitoring and adaptive counseling) protocol established by ADP. (May be conducted face-to-face if the client does not have access to a phone or prefers face-to-face sessions. The session structure, content, and timeframe should remain the same as if it were conducted over the telephone.)	Same as above.	\$25 per telephone contact.
TMAC evaluation	A face-to-face evaluation session with a client participating in TMAC telephone sessions who reports substance use that is extensive and/or intense or if the client has not been able to return to stable abstinence. . Per the <i>TMAC Clinician's Manual</i> , a single session should be scheduled within a week after the phone call in which the client reports the use or relapse risk.	Same as above.	\$68 per 50-60 minute session. Maximum one per voucher.
Drug testing	A laboratory test, conducted by collecting and sending samples to a laboratory, to determine whether a client is using, or has used, drugs. Testing methods may include, but are not limited to, urine, blood, and saliva. The rate includes administrative time for collection and review of results.	NA	\$15 per laboratory test. Maximum one test per month.
Life:WIRE orientation	A one-time service to set up the client's access to Life:WIRE and orient him/her to the service.	Provider must be enrolled directly with Life:WIRE in order to bill for this service.	\$25 flat rate per client. Maximum one per client, per provider.
Life:WIRE, monthly	A text-messaging service that allows approved providers to send text messages to individuals for motivation, appointment reminders, and questions, to determine client's status.	Same as above.	\$20 per client per month. Maximum one per month.

Services Billable by Approved Recovery Support Providers			
Service	Service Description	Provider Qualifications	Service Unit/Rate
Educational Services	Includes academic tutoring, homework assistance, life skills development, family reunification and parenting, financial literacy, health promotion, anger management, violence prevention, and educational enrichment activities such as sports, leadership development, recreational activities, visual or performing arts, and music.	Must follow the curriculum or other service description provided with the application and approved by ADP. Staff must have knowledge/skills/training in the topic area.	\$35 per individual session; or \$10 per client in a group session. 60-90 minute session. Maximum two per week.
Employment Services	Skills assessment and development, job coaching, career exploration, resume writing, interview skills, marketing skills, labor market information, job search assistance, job application assistance, and job retention tips.	Same as above.	\$35 per individual session; or \$10 per client in a group session. 60-90 minute session. Maximum two per week.

Veterans Assistance	Providing information, support and advocacy for returning veterans to assist in their transition to civilian life, including assistance with applying for veterans benefits.	Same as above.	\$35 per individual session. Maximum two per week.
Spiritual Coaching	Helping an individual or group of individuals to develop spiritually to initiate or sustain recovery. Services include establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one's life, achieving serenity and peace of mind, responsible decision making, and social engagement and family responsibility.	Must be a duly ordained minister or equivalent, such as rabbi or imam; or an individual with an active relationship with a local religious body and has that religious body's endorsement to minister. Must be consistent with standard protocols, practices and tenets of respective denomination.	\$25 per individual session or \$10 per client in a group session. 60-90 minute session. Maximum two per week.
Transportation - mileage	Actual mileage for transportation to and from treatment and recovery support services. CARE will not reimburse providers for transporting clients to inherently religious activities, such as worship activities, church, or bible study.	Provider must submit to ADP, and comply with, the <i>Provider Acceptance of Transportation Requirements and Conditions</i> , and the driver must submit a current copy of their DMV record to the provider.	\$.51 per mile. Maximum of 200 miles per client.
Life:WIRE orientation	A one-time service to set up the client's access to Life:WIRE and orient him/her to the service.	Provider must be enrolled directly with Life:WIRE in order to bill for this service.	\$25 flat rate per client. Maximum one per client, per provider.
Life:WIRE, monthly	A text-messaging service that allows approved providers to send text messages to individuals for motivation, appointment reminders, and questions, to determine client's status.	Same as above.	\$20 per client per month. Maximum one per month.