California Access to Recovery Effort

CARE Program
Policies and Procedures

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CARE is a program of the California Department of Alcohol and Drug Programs (ADP) 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. Adolescent Residential Treatment

This type of voucher is available to clients assessed to need the level of alcohol or other drug treatment equivalent to Adolescent Level III in the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders* (ASAM PPC). This level of treatment is provided to youth under the age of 18 in either a facility licensed by the Department of Social Services and certified by ADP, or in an ADP-licensed and certified adult alcoholism or drug abuse recovery or treatment facility with an ADP-approved waiver to serve adolescents.

B. ADP

ADP means the State Department of Alcohol and Drug Programs.

C. AOD

AOD means alcohol and other drugs.

D. ATR

ATR means the Access to Recovery program, a grant from the federal Substance Abuse and Mental Health Services Administration awarded to 14 states and one tribal organization for a three-year period.

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 youth, their families, or other interested individuals. It also contains information for providers and clients. The CARE website address is www.CaliforniaCares4Youth.com.

H. Case Manager

A case manager is assigned to each client by the treatment or recovery support provider organization.

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 treatment. The intent of the voucher is to transition a client from clinic-based to telephone-based treatment and recovery.

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 from all participating providers qualified to provide the necessary services without coercion from the assessor or a service provider. The provider options must include at least two organizations, with at least one to which the client has no 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. Methamphetamine Client

For the purposes of the CARE program, a methamphetamine client is defined as an individual who used methamphetamine in the last 90 days prior to intake and will be receiving services specifically related to his/her methamphetamine use; or an individual who was in a restricted setting prior to entry into treatment and he/she used methamphetamine in the 90 days prior to entry into the restricted setting and will be receiving services specifically related to his/her methamphetamine use.

N. Outpatient Treatment

This type of voucher is available for clients assessed to need the levels of AOD treatment equivalent to Adolescent Level I or Level II in the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC).

O. Provider Directory

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

P. 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.

Q. SAMHSA

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

R. SCO

SCO means the California State Controller's Office.

S. Stabilization

Stabilization is a type of voucher that is available to a client in the continuing care phase who temporarily needs more intensive services to address a relapse or impending relapse.

T. TMAC

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

U. 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.

V. 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.

W. VMS

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

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 ages 12 through 20 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 youth 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. Treatment and recovery support needs to be readily available. Because substance-abusing youth may be uncertain about recovery, taking advantage of opportunities when they are ready is crucial.

3. Treatment should stabilize clients’ acute treatment issues in the appropriate level of care needed, then step clients down to continuing care services when appropriate. Continuing care should focus on incremental behavioral changes and recovery management and allow for readmission/brief intervention if relapse occurs.

4. Effective treatment and recovery support address not only the client’s AOD use, but his/her multiple needs (associated medical, psychological, social, vocational, and legal problems).

5. Faith-based and other nontraditional organizations can be significant partners in a client's recovery, and have the right to maintain their religious identity in the provision of services.

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.

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, or clinical social worker;
   b. The individual must have at least two years experience conducting clinical assessments for youth and their families;
   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, marriage and family therapist, clinical social worker, 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 (Organization)

   a. The organization must meet the requirements for a recovery support provider (either accredited non-accredited);
   b. All staff who will conduct assessments must be either licensed professionals (physician, psychologist, marriage and family therapist, clinical social worker, 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 youth ages 12 through 20 for at least 3 years; OR
   c. The organization must have been providing AOD treatment/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 and who has at least 3 years experience providing AOD treatment services to youth ages 12 through 20.

5. Residential Treatment Provider

   a. The organization must be licensed by the Department of Social Services (DSS) as an adolescent group home and be certified by ADP as meeting the AOD program standards;
   b. The organization must have been providing AOD treatment services to youth ages 12 through 17 for at least three (3) years; OR
   c. The organization must have been providing AOD treatment/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 and has at least 3 years experience providing AOD treatment services to youth ages 12 through 17.

6. Accredited Recovery Support Provider

   The organization must be accredited, certified, or approved by a nationally recognized accrediting organization or state-approval agency for the specific recovery support service for which they applied to provide.

7. Non-Accredited Recovery Support Provider

   a. The organization must be registered, and in good standing, with the California Secretary of State's Office;
   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 recovery support services to youth in the local community.

C. Religious Organization Rights and Requirements

1. Pursuant to the Charitable Choice Provisions and Regulations (42 CFR, 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 assessment provider 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. Approving eligible providers;
2. Monitoring and assessing provider performance;
3. Identifying provider training and technical assistance needs;
4. Conducting provider orientations and trainings;
5. Facilitating resources to meet training and TA needs;
6. Collecting and analyzing program data;
7. Auditing provider claims and authorizing payments;
8. On-site providers visits to determine compliance and provide technical assistance; and
9. General oversight and support for the program.

B. MAXIMUS

MAXIMUS, through a contract with ADP, operates the call center and the automated voucher system. MAXIMUS is responsible for the following:

1. Staffing and maintaining the call center for provider and client assistance;
2. Issuing vouchers to clients via the VMS;
3. Tracking voucher clients, services and associated costs;
4. Collecting required outcome and financial data from providers via the VMS;
5. Generating monthly provider invoices based on electronic 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. Youth are referred to an assessment provider from the call center, the CARE website, and other referral sources. Assessment providers are responsible for the following:

1. 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);
2. Referring individuals to another assessment provider if the assessment cannot be conducted within five working days;
3. Determining client eligibility and prioritizing admission according to Section VI(B);
4. Providing to the client a *CARE Client Handbook* and going over the information with the client;
5. 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;
6. Identifying the level and type of treatment and/or recovery support services needed by the client;
7. 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;
8. 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;
9. Involving the client's family/guardian, when appropriate, to assist and support the client during his/her decision process;
10. 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;

11. Scheduling an intake appointment with the client's chosen provider(s) and following up if confirmation of intake from provider is not received;
12. Collecting the client data required by the Government Performance Results Act (GPRA) at intake and submitting the GPRA data via the VMS;
13. 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 (42 CFR Part 2); and
14. As applicable, complying with the privacy and security requirements at 45 CFR Parts 160 and 164 (the Health Insurance Portability and Accountability Act regulations).
15. Maintaining a file for each client as specified in Section XVIII; and
16. Attending any training or performance review required by ADP.

F. 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, grievance procedures, and other expectations, including the need to provide GPRA data at six months post-intake and upon discharge;
4. Providing appropriate services to clients as authorized by the voucher and specified in service plans developed by the provider and the client;
5. Reporting all specified client and service data via the VMS, including the GPRA data required at discharge and at 6 months post-intake;
6. Maintaining a file for each client as specified in Section XVIII;
7. Attending training or performance reviews required by ADP;
8. 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 (42 CFR Part 2); and
9. As applicable, complying with the privacy and security requirements at 45 CFR Parts 160 and 164 (the Health Insurance Portability and Accountability Act regulations).

G. Case Managers

Case managers are assigned to a client upon admission to a treatment or recovery support program and are responsible for the following:

1. Establishing linkages with other service systems and programs serving the client (including CARE recovery support providers), acting as liaison between the client and those other systems/programs, and advocating for their client's needs;
2. Recommending program transfers and changes in treatment level, if warranted; and
3. Attempting to reengage the client if he/she drops out of the program or the program otherwise loses contact with the client.
4. Attempting to locate a former client to conduct a 6-month GPRA interview.

V. CLIENT REFERRALS

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 treatment or recovery support providers.

B. Referral sources will receive education and materials from ADP 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 on the 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 list of assessment providers.

VI. ISSUANCE AND AUTHORIZATION OF VOUCHERS

A. 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. The individual must be an age of 12 through 20. If the individual is age 20 when admitted, but will or may turn age 21 while in the program, he/she may be admitted and continue in the program until his/her voucher(s) expires, is cancelled or is 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 (does not include temporary out-of-county residence for residential treatment).

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 youth can be assessed for CARE no sooner than two weeks prior to release if the purpose is to transition the youth to CARE treatment and/or recovery support services upon release.)

d. 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) Be receiving AOD treatment through some other program or funding source but need supplemental treatment or recovery support services; or

3) 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 for the CARE program, the assessment provider must refer the youth to appropriate local agencies that can provide assistance and/or support.

B. 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 used methamphetamine in the 90 days prior to intake and will receive treatment specifically related to their methamphetamine use;
b. Have experienced withdrawal from alcohol or other drugs in the past week;
c. Are currently AOD dependent and have been for at least the past year;
d. Are using alcohol and/or other drugs weekly or more frequently.

2. Assessment providers should take into consideration the individual's acceptance or resistance to treatment. If the individual is highly resistant to treatment and is unlikely to follow through with the provider referral, he/she is not a good candidate for the CARE program. **Reminder: SAMHSA expects that every individual assessed and admitted to CARE will be followed up for a 6-month GPRA interview regardless of whether or not they received any services other than the assessment.**

C. Client Enrollment

1. If the individual meets the eligibility criteria in Section A above, the assessment provider must give the individual a *CARE Client Handbook* and go over the handbook information with him/her.

2. If the individual 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.

3. Once the individual and assessor have completed the *Release of Client Information*, the assessor must do the following to enroll the individual in the CARE program:

   a. Ask the individual for his/her consent for ADP to contact the client either by telephone or mail after he/she has completed the CARE program to survey satisfaction with services provided, and enter yes or no in the appropriate space on the VMS enrollment screen. If the individual consents, the assessor must have the client sign the *Customer Satisfaction Consent* form.

   b. 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, and race/ethnicity.

   c. 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.)

   d. Enter all other mandatory fields on the enrollment screen and submit the client enrollment by clicking the "Add" button.

4. 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.

5. 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.

6. Once the client has been enrolled, the assessor should request an assessment voucher electronically via the VMS.

D. 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.

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 and organizations authorized by ADP as assessment providers.

4. Except as provided below, all youth accepted into treatment through the CARE program must meet the diagnostic criteria for a substance-related disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

    a. A youth whose AOD use symptoms are severe, but who does not meet the diagnostic criteria, may be appropriate for admission to outpatient treatment for further evaluation.

    b. If the presenting AOD history is not adequate to substantiate a diagnosis, the assessment provider may use material submitted by family members, legal guardians, etc, that indicates a high degree of probability of such a diagnosis.

5. The assessment provider should include and engage the client's family or guardians in the assessment process and choice of providers, if appropriate.

6. Based on the results of the assessment, standardized placement criteria and clinical judgment, the assessment provider will determine the needed type and level of treatment and/or recovery support services.

7. If the assessment indicates a need for services that are not covered by the CARE program (i.e. mental health services), the assessment provider must refer the client to other programs to address those needs.

8. If the assessment reveals that the client does not meet the diagnostic criteria for a substance-related disorder, or does not otherwise qualify for CARE services, the assessment provider must refer the client to more appropriate services. (If the intake portion of the GRPA tool was already submitted, the assessment provider must complete the discharge portion of the GPRA tool in accordance with the procedures specified in Section XVII(A)).

9. If the assessment provider determines that an adolescent needs residential treatment and the client concurs, the assessment provider must follow the approval process in Section J below.

E. Intake GPRA Requirements

1. The assessment provider must determine whether or not the individual is a "methamphetamine client" as defined in Section I of this document, and enter yes or no in the appropriate space on Section A of the GPRA tool.

2. The assessment provider must conduct the remainder of the intake GPRA interview with the client and submit the data via the VMS.

3. The assessment provider must inform the client that his/her treatment or recovery support provider will need to collect GPRA data again upon discharge and at six months post-intake, and that the client is eligible to receive a monetary incentive for participating in the six-month GPRA interview.

F. Client Choice

1. The assessment provider 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.
2. The assessment provider 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.

3. The assessment provider 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.

4. The assessment provider'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.

5. If the assessment provider recommends the client receive both treatment and recovery support services, but the client chooses not to access recovery support services immediately, the treatment provider must let the client know that he/she can access recovery support services any time prior to the expiration date of his/her treatment voucher by contacting ADP.

G. Verifying Service Availability

1. Prior to requesting a service voucher(s) for the client, the assessor must contact the client's chosen provider(s) and ensure that the provider has available capacity.

2. If the provider(s) is able to admit the client, the assessor should schedule an intake appointment for the client.

3. If the provider does not have available capacity, the assessor must find another provider of the client's choice that has available capacity.

H. Outpatient Treatment and Recovery Support Voucher Issuance

1. The assessment provider will complete and submit to the call center via the VMS a voucher request for outpatient treatment and/or recovery support. 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).

2. The call center will reject the voucher request unless and until the intake GPRA is submitted, and the provider may not bill for an assessment unless and until the intake GPRA is submitted.

3. Upon receipt of an appropriate voucher request, the call center will authorize an outpatient treatment and/or recovery support 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.

4. The assessment provider must also request a client followup voucher to be assigned to the client's chosen treatment provider, except if the client is receiving recovery support services only, the client followup voucher must be assigned to the client's chosen recovery support provider.

5. ADP will limit the number of vouchers redeemed by any one service provider based on available funds; and a provider's staffing patterns, hours of operation, administrative capacity, and past performance.

I. Referral to Treatment and Recovery Support for Voucher Services

1. The assessor will 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 assessment provider;

c. A copy of the completed assessment. For clinical assessments, a copy of the assessment results is sufficient if it includes 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 plan;

d. Any other appropriate evaluation and intake documents.

2. If the assessor does not receive the *Referral Completion* notice, he/she should follow up with the client and/or the provider to ensure access to services.

J. Adolescent Residential Treatment Voucher Request and Client Referral

1. Prior Authorization

a. If the assessment provider determines that an adolescent (age 12-17) needs residential treatment and the client concurs, the assessment provider must contact the client's chosen provider and ensure that the provider has available capacity and that the client is appropriate for their services.

b. If the chosen residential provider has available capacity and the client is appropriate for their services, the assessment provider must submit to ADP a completed *Adolescent Residential Treatment Services Preauthorization Request* form.

c. ADP will notify the assessor if the request is approved or denied. If the request is approved, ADP will also notify the client's chosen residential treatment provider so they can arrange for the client to be admitted.

2. Voucher Request/Issuance and Continuing Authorization

a When the client presents at the residential program for admission, the residential treatment provider must complete and submit to the call center via the VMS a voucher request for adolescent residential treatment.

b. Upon receipt of an appropriate voucher request, the call center will authorize the first 15-day residential treatment voucher. The residential provider should then follow the procedures for redeeming the voucher as specified in Section K.

c. Authorization for each additional 15-day voucher (up to 60 days maximum) must be requested by the residential treatment provider via the same form faxed to ADP. To avoid a lapse in services, the treatment provider must submit the form to ADP 3-5 days prior to the current voucher expiration date. ADP will notify the provider if the request is approved or denied. If the request is approved, the provider must complete and submit to the call center via the VMS a request for another 15-day residential treatment voucher.

3. Linkage to Outpatient Services Upon Exit from Residential Treatment

a. When a client has completed or nearly completed residential treatment, the residential treatment provider must attempt to link the client to outpatient treatment services in the community where the client resides.

b. Once arrangements have been made for the client to be admitted to the outpatient program upon exit from the residential facility, the residential treatment provider must:

1) Request a community linkage voucher assigned to themselves (the residential provider); and
2) Request an outpatient treatment voucher and a client follow-up voucher to be assigned to the outpatient treatment provider (if being referred to another CARE provider).
3) Fax the following documentation to the clients chosen outpatient treatment provider:
   a. Client identifying information
   b. Assessment or assessment summary
   c. Treatment plan or summary of the client's progress to date that provides adequate information for the outpatient treatment provider to determine the appropriate treatment needed for the client.

c. When the client's admission into the outpatient treatment provider is confirmed, the residential treatment provider can bill for the community linkage service.

K. 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 will immediately contact the assessor to arrange a new provider referral. The provider must also fax the completed *Referral Completion* notice to the assessment provider.

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 will 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* notice to the assessor within three days of the admission. This notice will verify the client's admission to the program and the date of admission. A copy of the form must be maintained in the client's file.

4. Inform and orient the client about the program including rules, participation requirements, grievance procedures, and other expectations.

5. Inform the client of the need to collect GPRA data upon discharge and at 6 months post-intake.

   a. Have the client complete the *Health Study Locator* form to assist in finding the client for future follow-up.
   b. Give the client a copy of the *Health Survey Appointment* to help them remember when the GPRA interviews are due.
   c. Ask for the client's consent for the program to contact him/her telephonically for GPRA interviews, and have him/her complete the *Telephone Interview Consent* form if consent is given.

6. Develop an individual treatment or service plan with the client. Recovery support providers must use the *Recovery Support Service Plan* form.

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. Via the VMS, request allowable continuing care, recovery management, and stabilization vouchers needed by the client.

10. Conduct discharge and six-month post-intake GPRA interviews, as specified in Section XVII.

VII. VOUCHER TYPES AND EFFECTIVE PERIODS

A. Assessment

Assessment vouchers are in effect for 30 days from the date of issuance.

B. Adolescent Residential Treatment

Adolescent residential treatment vouchers are in effect for 15 days from the date of issuance. A client may be issued up to four continuous adolescent residential treatment vouchers with prior authorization (as specified in Section VI (J)), so the maximum length of stay is 60 days. When a client is ready to be released from residential treatment, the provider must attempt to link them with an outpatient treatment provider.

C. Outpatient Treatment

Outpatient treatment vouchers are in effect for three months from the date of issuance. 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.

D. Methamphetamine Treatment

1. A client needing outpatient treatment who is identified upon enrollment as meeting the definition of a methamphetamine (meth) client will be issued a meth treatment voucher that has a greater value than an outpatient treatment voucher to allow more intensive services to meet their unique needs.

2. Methamphetamine treatment vouchers are in effect for three months from the date of issuance. If the voucher is depleted at the end of three months or earlier and the client still needs services, the treatment provider must request a continuing care voucher. If the voucher is not depleted at the end of three months and the client still needs services, the provider must request an extension. A methamphetamine treatment voucher can be extended for an additional 30 days if all the following criteria are met:

   a. Funds remain available on the voucher;
   b. The service provider requests the extension between seven and two days prior to the expiration date;
   c. ADP has not instituted any restrictions against extensions.

3. If a client is not identified as a meth client upon enrollment, but is later identified through a drug test, client or law enforcement disclosure, or other means, the provider must submit the *Post Intake Notification of Meth Client* form to ADP.

4. If no more than 30 days have elapsed since the client's intake and no more than $500 has been billed on the outpatient treatment voucher, ADP will approve a voucher change for the client (from outpatient treatment to methamphetamine treatment). ADP will notify the call center and the provider, who will need to request the voucher change through the "Maintain Change Request" process in the VMS.

E. Continuing Care

1. A client is eligible for a continuing care voucher no sooner than two months after being issued an outpatient treatment or methamphetamine 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. (Therefore, if a treatment provider's 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.

5. A continuing care voucher can be extended for an additional 30 days if all the following criteria are met:

   a. Funds remain available on the voucher;
   b. The service provider requests the extension between seven and two days prior to the expiration date;
   c. The client's six-month GPRA interview was conducted and submitted via the VMS; and
   d. ADP has not instituted any restrictions against extensions.

F. 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's 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 session, 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 30 days from the date of issuance. Only one stabilization voucher will be available for a client during a CARE service episode.

G. Residential Recovery Support

Residential recovery support vouchers are in effect for 15 days from the date of issuance. Prior to the end of the 15 day period, the recovery support provider must request a recovery management voucher for a client still in need of services.

H. Recovery Support

Recovery support vouchers are in effect for three months from the date of issuance. At the end of three months or when the recovery support voucher is depleted—whichever comes first—the recovery support provider must 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.

I. 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.

3. A recovery management voucher can be extended for an additional 30 days if all the following criteria are met:

   a. Funds remain available on the voucher;
   b. The service provider requests the extension between seven and two days prior to the expiration date;
   c. The client's six-month GPRA interview was conducted and submitted; and
   d. ADP has not instituted any restrictions against extensions.

J. Client Followup

1. Client followup vouchers are in effect for 8 months from the date of intake to allow completion of the six month post-intake GPRA.

2. Client followup vouchers must be requested by the assessment provider and assigned to the client's outpatient treatment provider, unless:

   a. The client is receiving recovery support services only, in which case the voucher must be assigned to the recovery support provider.
   b. The client is receiving adolescent residential treatment, in which case the residential treatment provider must request the client followup voucher when the client is ready to be transferred to an outpatient provider.

VIII. VOUCHER CHANGE MANAGEMENT

A. Voucher Cancellation

1. A voucher will be cancelled prior to its expiration date if a client is ineligible, the voucher funds are depleted, or a discharge GPRA is submitted.

2. 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.

B. Client Transfers

If a client requests a change in treatment or recovery support provider for any reason, the provider must refer the client to ADP or the call center. ADP will offer the client a new choice of service provider(s) and the client's voucher will be assigned to the newly chosen provider.

C. Changes in Level of Services

1. Residential treatment providers must attempt to link a discharging client to an outpatient treatment program in the client's community upon discharge. Residential treatment providers will be reimbursed for a successful linkage as evidenced by the client accessing outpatient treatment services within 14 days of discharge from residential treatment.

2. If a client in outpatient treatment needs residential treatment, the outpatient treatment provider must submit an *Adolescent Residential Treatment Preauthorization Request* form to ADP for approval. If the request is approved, ADP will notify both the provider who submitted the form and the proposed residential treatment provider, who will submit the voucher request in the VMS, in accordance with Section VI(J). The outpatient treatment provider will remain responsible for the client's discharge and 6-month GPRAs unless the client chooses a different outpatient provider to receive services from after discharge from residential treatment.

3. 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 (F). 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.

4. 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.

D. Client Engagement and Readmission

1. If a client drops out during outpatient treatment, the treatment provider must attempt to locate and/or reengage the client. If the client cannot be re-engaged with treatment services within 60 days, the treatment provider must complete a discharge GPRA via the VMS.

2. If a client is receiving recovery support services only and drops out, the recovery support provider must attempt to locate and/or reengage the client. If the client cannot be re-engaged within 60 days, the recovery support provider must complete a discharge GPRA via the VMS.

3. Even after the client has been discharged from CARE, the outpatient treatment or recovery support provider (whoever is responsible for the six month GPRA) must attempt to maintain contact with the former client (and can bill for their time under the client follow up voucher) at least until the six month GPRA data can be obtained.

4. If a former client returns for treatment after being discharged from CARE, he/she is eligible for readmission. The individual must first go to an assessment provider for another assessment.

IX. VOUCHER SERVICES AND RATES

A. Voucher Types and Values

Voucher Category (timeframe)	**Voucher Service** (allowable services/unit rates)	**Maximum Value**
(Psychosocial) Assessment	Assessment (includes intake GPRA): $150	$150
Recovery support (abbreviated) assessment	Recovery support assessment (includes intake GPRA) ($75)	$75
Adolescent residential treatment (15 days)	Residential bed day ($175)	$2,625
Residential to Community Linkage (60 days)	Community linkage ($100)	$100
Outpatient Treatment (up to 3 months)	Treatment planning ($55) Drug testing ($20); Individual counseling ($90); Group counseling ($40); Education group ($25); Individual family therapy ($125); TMAC telephone session ($20); Case management ($10)	$2,000
Methamphetamine Treatment (up to 3 months)	Treatment planning ($55) Drug testing ($20); Individual counseling ($90); Group counseling ($40); Education group ($25); Individual family therapy ($125); TMAC telephone session ($20); Case management ($10)	$3,500
Continuing Care (through month 6)	Ind. counseling ($90) (face-to-face orientation/ evaluations only, per the TMAC protocol) TMAC telephone session ($20) Group counseling ($40) Drug testing ($20) Case management ($10)	$750
Stabilization (30 days)	Individual counseling ($90) Group counseling ($40) Transportation ($2) Case management ($10)	$500
Recovery support (up to 3 months)	Educational service, individual ($40); Educational service, group ($10); Employment service, individual ($40); Employment service, group ($10); Spiritual coaching, individual ($25); Spiritual coaching, group ($10); Mentoring ($25); Recovery management checkup ($15) Transportation, mileage ($.58); Transportation, public ($2)	$500
Residential recovery support (15 days)	Residential recovery support bed day ($40)	$600

Voucher Category (timeframe)	**Voucher Service** (allowable services/unit rates)	**Maximum Value**
Recovery management (through month 6)	Educational service, group ($10) Employment service, group ($10) Spiritual coaching, group ($10) Mentoring ($25) Recovery management checkup ($15)	$250
Client Follow-up (through month 8)	Discharge plan (includes discharge GPRA) ($25) 6-month GPRA, admin ($5) 6-month GPRA, client interview ($100) Client incentive ($20) Case management ($10) Locating/re-engagement ($5)	$350

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 reflects the minimum and maximum time for a billable service. For example, the billing for an individual counseling session cannot be less than 60 minutes nor more than 90 minutes. If a billable service lasts longer than the maximum length of time, 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 the treatment or recovery support provider for 60 days or more), the treatment provider (or recovery support provider if the client is receiving only recovery support services) 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 6-month GPRA is due, the provider responsible for the GPRA must attempt to maintain contact with the former client (and can bill for their time under the client follow up voucher) at least until the six month GPRA data can be obtained.

C. If a client drops out of residential treatment before the provider can link the client to outpatient treatment in the client's community (as specified in Section VIII (C)(1)), the residential provider must notify ADP of this situation. The notification (via phone or email) must include the client's ID number, the last day of service, discharge status, and the reason the program was unable to link the client to outpatient services.

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 nation.

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 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 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 (42 CFR Part 2).

B. Any CARE provider determined to be a covered entity as defined by the Health Insurance Portability and Accountability Act (HIPAA) 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. Providers must inform each client of the grievance procedures when the client is admitted to the program, which shall include ADP's address and contact telephone number for resolution if a grievance cannot be resolved at the program.

2. During the assessment process, assessment providers 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. 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;

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 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 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 Policies and Procedures*;
e. Evidence of applicable training; and
f. Results of criminal background check.

XVII. PROVIDER DATA COLLECTION AND REPORTING REQUIREMENTS

A. GPRA Data Collection and Reporting

1. Intake GPRA

Assessment providers must collect the required initial/intake GPRA data from each client when conducting the assessment and submit the intake GPRA via the VMS prior to billing for the assessment. A treatment and/or recovery support voucher will not be issued unless and until the intake GPRA is submitted.

2. Discharge GPRA

Outpatient treatment providers must collect discharge GPRA data from their clients, except if a client is receiving recovery support services only, the recovery support provider is required to collect the GPRA data.

a. A discharge GPRA must be completed for every client to indicate results of services and to close the service episode.
b. The provider must conduct the discharge GPRA interview with the client as soon as possible upon discharge, and submit the completed discharge GPRA via the VMS.
c. If a client drops out of all CARE services and cannot be reengaged into services within 60 days, the provider must complete the discharge GPRA.
d. The provider 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.
e. The provider may do a telephone interview with a client if the client is unable/unwilling to meet face-to-face with the provider but is willing to do a telephone interview and has given his/her written consent for telephone interviews as specified in Section 6 below.
f. If the provider is unable to locate the individual within 60 days of the last face-to-face service, the provider must document his/her attempts to locate the individual 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."
g. 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.

3. Six Month Post Intake GPRA

Outpatient treatment providers must collect GPRA data from their clients at six-months post intake, except if a client is receiving recovery support services only, the recovery support provider is required to collect the six month post-intake GPRA data.

a. Providers must collect and submit via the VMS a six month post intake GPRA for each client/former client to whom they provided services, even if it was only one unit of service.
b. The six-month GPRA window is 30 days before, and 60 days after, the six month post intake date; therefore, the six month GPRA interview must be conducted between 5 to 8 months after the intake GPRA was conducted.
NOTE: Reimbursable GPRA interviews are interviews conducted within the 5 to 8 month window.

c. The provider must attempt to meet face-to-face with the client/former client to collect the six-month GPRA data.

d. If the client is unable/unwilling to meet face-to-face with the provider for the six-month GPRA interview but is willing to do a telephone interview, the provider must document in the client's file his/her attempt to meet face-to-face.

e. If the provider is unable to locate the individual within eight months of the client's intake, the provider must document his/her attempts to locate the individual and 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. Locating Former Clients

   a. During the intake/orientation process, the provider responsible for collecting the discharge and six-month GPRAs must ask the client to complete the *Health Study Locator* form to assist in finding the client for future follow-up.

   b. Providers must adhere to state and federal laws and regulations regarding confidentiality when attempting to locate former clients for the six month post intake interview.

5. Client Incentives

   a. Upon intake, the provider responsible for collecting the discharge and six-month GPRA data must notify clients that they will receive a monetary incentive for participating in the six month GPRA interview. Providers can give clients a copy of the *Health Survey Appointment* coupon to help them remember when the GPRA interviews are due.

   b. Providers must offer $20 (or its equivalent in gift 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 client is provided with the monetary incentive, providers must obtain the client/former client's signature verifying that they received it, and keep a copy of the receipt in the client's file.

6. 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.

   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 provider to do the GPRA interview, the provider may conduct the discharge and six month post intake GPRAs via the telephone, as described below.

1) The provider must document that he/she attempted to meet in person with the individual.

2) Prior to contacting a client/former client by telephone, the provider must get a client's informed consent by using 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. Program Reports

Providers must submit the following information/reports:

1. Via the VMS, assessment providers must submit client demographic information, an assessment request prior to conducting an assessment, and the intake GPRA report and the treatment and/or recovery support voucher request after the assessment is conducted.

2. Treatment and recovery support providers must submit a *Referral Completion* notice to the assessor for each referral received and/or voucher accepted within three days of receiving the *Referral Letter*.

3. All providers must invoice via the VMS for services provided. 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.

4. 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.

5. 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, gender, and emergency contact (with a consent from the client to notify contact in the case of emergency).

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 *Customer Satisfaction Consent* form, if the client consented tor followup for customer satisfaction purposes.

4. 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) or that he/she did not meet the criteria but based on severe AOD symptoms, he/she is appropriate for admission to outpatient treatment for further evaluation, as specified in Section VI (C)(5).
    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(A)(1)(d)(3).

5. 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.

6. A copy of the completed intake GPRA interview, 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.

7. 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.

8. A copy of the completed *Adolescent Residential Treatment Services Preauthorization Request* form, as appropriate.

B. 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 contact in the case of emergency).

2. The referral packet from the assessment provider, including the assessment or an assessment summary.

3. A copy of the completed *Referral Completion Form* and evidence that the form was faxed or otherwise submitted to the assessment provider.

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. Evidence that the provider informed the client of CARE grievance procedures.

8. Documentation of the services provided by the program, utilizing the *Client Services Summary* form. This form may be maintained in a group program record or in the individual client's file. If a service billed in the VMS does not have corresponding documentation on the *Client Services Summary* form, the provider will not be reimbursed for that service, except as shown below:

    a. TMAC telephone sessions must be documented via a completed *TMAC Progress Assessment, Counselor Version* form in the client's file.
    b. Recovery management checkups must be documented via a completed *Recovery Management Check up Questionnaire* in the client's file.

9. Documentation of the date a continuing care or stabilization voucher was requested and justification/need for the request.

10. Completed *Health Study Locator* form.

11. When required, a copy of the completed discharge and 6-month follow-up 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.

12. A copy of the completed *Telephone Interview Consent* form, as appropriate.

13. Copy of a signed receipt from the client for an incentive payment provided for the 6-month follow-up GPRA interview, as appropriate.

14. A copy of the completed *Telephone Monitoring Consent* form, as appropriate.

C. In addition to the requirements in Section (B) above, 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 Title 42, Code of Federal Regulations, 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

Treatment and/or recovery support providers are responsible for doing a financial screening of a CARE client upon admission. If the appropriate and needed treatment 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:

   e. to determine the level of compliance with program requirements;
   f. to identify areas where additional technical assistance or training is needed;
   g. to review complaint allegations; and
   h. 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, <u>fraudulent</u> 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, unless prior approval is received from ADP to submit invoices via paper or in the case of emergency. If approved for paper submission or in an emergency, providers may invoice using a fax machine and the *Voucher Transaction* form.

2. 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.

3. 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.

4. Provider staff who will be using the web-based 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 by contacting the call center.

C. Payment Schedule

Providers are paid monthly in arrears based on the billings they submit via the VMS as described below.

1. 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. Services entered into the VMS by the provider will be uploaded to the federal data system each Monday at 12:01 am. The upload will include services entered into the VMS up to the preceding Friday at 12 midnight.

2. Prior to the weekly upload on Monday, 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 to the services entered.

3. Within a week after the last Monday of the month, an invoice reflecting the uploaded billings for that month will be generated and mailed by certified mail to the provider.

4. Providers must validate the billings on the invoice by signing (in blue ink) both the invoice and the *Invoice Cover Sheet* and returning the signed originals to ADP. If there are adjustments needed to the invoice, the provider must contact ADP.

5. Within 30 days, ADP will review and authorize invoices and 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. Therefore, providers should receive payment within 45 days of submitting their signed invoice to 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 Title 45, Part 74 and Part 92 of the Code of Federal Regulations. 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 $186,000 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	Target Population
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 all of the following: screening potential client to determine eligibility; reviewing *Client Handbook*; obtaining consents to release information; opening a client file; 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 and the eligible service providers that match those needs; providing an unbiased explanation of the service options to the client to ensure that they can make an informed, independent choice of service provider; conducting the intake GPRA interview and submitting the data via the voucher management system (VMS); and making an intake appointment at the client's chosen provider.	Must be either 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 (California Code of Regulations, Title 9, Section 13035(a)).	$150 flat rate for completed assessment, including intake GPRA. One assessment per episode (either a psychosocial assessment or abbreviated assessment).
Recovery Support Assessment (Abbreviated, for recovery support-only)	Includes all of the following: screening potential client to determine eligibility; reviewing *Client Handbook*; obtaining consents to release information; opening a client file; 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 the eligible service providers that match those needs; providing an unbiased explanation of the service options to the client to ensure that they can make an informed, independent choice of service provider; conducting the intake GPRA interview and submitting the data via the VMS; and making an intake appointment at the client's chosen provider.	Same as above.	$75 flat rate for completed assessment, including intake GPRA. One assessment per episode (either a psychosocial assessment or abbreviated assessment).

Services Billable by Approved Adolescent Residential Treatment Providers			
Service	**Description**	**Additional Qualifications**	**Service Unit/Rate**
Adolescent Residential bed day	Clinically managed residential treatment for a minor provided in a facility licensed by the Department of Social Services as an adolescent group home and certified by ADP as an alcohol or drug program that provides at least 30 hours of treatment services per week for each client.	NA	$175 per 24-hour bed day. Maximum 15 days per voucher, 60 days per client
Community linkage	A successful linkage to an outpatient treatment provider in the client's community. Includes offering the client a choice of provider, requesting the voucher(s) via the VMS, and assisting/ensuring the client access services at the outpatient facility within 14 days of discharge from residential treatment.	NA	$100 per successful client linkage

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; or 3) registered to obtain counselor certification by one of the organizations approved by ADP.	$55 flat rate for completed treatment plan. One per episode.
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, crisis intervention, discharge planning, and TMAC face-to-face orientations/evaluation. (Individual counseling provided as home visit or hospital visit is allowable.)	Same as above.	$90 per 60-90 minute session. Maximum one per day.
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, except that in addition, the staff must have been trained in the TMAC protocol either by ADP or its authorized representatives, or by another qualified individual who was trained by ADP or its authorized representative.	$20 per telephone contact.
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. *Groups where participants watch a video or listen to a didactic presentation must be billed at the education group rate, not as group counseling.*	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 AOD-using adolescents.	$40 per 60-90 minute session. Maximum one per day.
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).	$125 per 60-90 minute session. Maximum one per week.

Services Billable by Approved Outpatient Treatment Providers			
Service	**Description**	**Additional Qualifications**	**Service Unit/Rate**
Case management	Includes planning client's services, linking the client with other needed services (including recovery support services), coordinating linkages with other systems, monitoring service delivery, and evaluating the effect of the services received. *Time spent billing for services is NOT a case management function, nor are other administrative activities.*	Staff must, at a minimum, possess a high school diploma and have been trained on working with AOD-using adolescents.	$10 for a 15 minute unit. Maximum 10 units (2.5 hours) 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.	Staff must, at a minimum, possess a high school diploma and have been trained on working with AOD-using adolescents. Staff must also have documented knowledge/skills/training in any topic area on which they are presenting.	$25 per 60-90 minute session. Maximum 1 session per day.
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	$20 per laboratory test. Maximum 4 tests per month.
Discharge plan (includes discharge GPRA)	A session with the client upon discharge to develop a recovery plan and conduct the structured interview to gather required GPRA data. Includes submitting the GPRA data via the VMS.	Staff must, at a minimum, possess a high school diploma and have been trained on working with AOD-using adolescents and conducting client interviews, including specific training on the GPRA tool and interview.	$25 flat rate for discharge plan and completed GPRA
6-Month Post Intake GPRA - client interview	A structured interview with a client/former client to gather required six-month GPRA data and submitting the data via the VMS.	Same as above.	$100 flat rate for completed GPRA
6-Month Post Intake GPRA - administrative	Completion of the administrative portion of the 6-month post-intake GPRA without meeting with the former client because he/she could not be located, and submitting the data via the VMS.	Same as above.	$5 flat rate for completed GPRA.
Client locating/ Re-engaging	Time spent either on the telephone or face-to-face attempting to re-engage a client in services (including TMAC services) or to locate them to collect required GRPA data.	Staff must, at a minimum, possess a high school diploma and have been trained on working with AOD-using adolescents.	$5 for a 5-15 minute unit (travel time is excluded). Maximum 20 units.
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 as an incentive.	NA	$20 per client upon completion of 6-month GPRA interview.

Services Billable by Approved Recovery Support Providers			
Service	**Service Description**	**Provider Qualifications**	**Service Unit/Rate**
Educational Services	Academic tutoring, homework assistance, life skills development, parenting responsibilities, family reunification, financial literacy, health promotion, anger management and violence prevention. Also may include educational enrichment activities such as sports, leadership development, recreational activities, or skill building in visual or performing arts, and music.	Must follow the curriculum or other service description provided with the application and approved by ADP.	60-90 minute session. $40 per individual session; or $10 per client in a group session. Maximum two per day.
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.	Must follow the curriculum or other service description provided with the application and approved by ADP.	$40 per individual session; or $10 per client in a group session. 60-90 minute session. Maximum two per day.
Mentoring	A face-to-face, one-on-one contact between the client and an adult who is matched with the client by a sponsoring organization that is an eligible CARE provider.	Must be consistent with the service description provided with the application and approved by ADP.	$25 per 60-90 minute contact. Maximum two per day.
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 provided by a duly ordained minister or equivalent, such as a rabbi or imam; or an individual who has an active relationship with a local religious body and has that religious body's endorsement to minister to CARE youth. 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 day.
Recovery management check up	A brief (15-20 minutes), scheduled call to a client utilizing the *Recovery Management Check-up Questionnaire* and protocol established by ADP.	Staff must, at a minimum, possess a high school diploma, been trained on working with AOD-using adolescents, and have been trained by ADP on the recovery management check-up protocol.	$15 per telephone contact.
Transportation - mileage	Actual mileage for transportation to and from treatment and recovery support services in an agency-owned vehicle utilized for transporting clients.	Organization/entity must maintain adequate auto and liability insurance coverage and utilize a driver(s) with a valid driver's license(s).	$.58 per mile. Maximum of 500 miles per client.
Transportation - public	Public transportation passes and/or tokens for base fare distributed to the client for the express purpose of accessing CARE treatment and/or recovery support services.	NA	$2 per bus pass/token. Maximum 50 per month distributed as needed, but not more than one week's supply at a time.

Services Billable by Approved Residential Recovery Support Providers			
Service	**Service Description**	**Provider Qualifications**	**Service Unit/Rate**
Residential recovery support	A combination of the recovery support services listed above provided daily to 18-20 year olds only, in a residential facility approved by local zoning to house adults.	NA	$40 per 24-hour bed day. Maximum 15 days.