R95 Frequently Asked Questions

This FAQ documents common questions about R95 Payment Reform Capacity Building and Incentives activities. Boxes in light grey have been transferred over from the Year 1 R95 Workgroup FAQ document and updated accordingly.

Topics: Capacity Building and Reimbursement | Admissions Policy, Discharge Policy, and Staff Training | Admission Agreement and Toxicology Policy/Agreement | Service Design | Bidirectional Referrals | General R95

	QUESTIONS	ANSWERS
	General R95 Capacity Building and Reimbursement Questions	
1.	Our agency would like to participate in the Year 2 of the Capacity Building and Incentive (CB&I) Program for this fiscal year. Where can I find information regarding invoices and other deliverable requirements?	Refer to the Payment Reform-Capacity Building and Incentive Funds website for more detailed information on all the Capacity Building and Incentive activities, including invoices, reports, deliverables, and associated deadline for the current fiscal year.
2.	Is there a single CB&I attestation document that needs to be submitted? Which file on the payment reform is the attestation document?	Providers intending to participate in the Capacity Building Category: Access to Care – Reaching the 95% (R95) should submit the Invoice-Reaching the 95% (R95) for their agency. Your indication on the invoice serves as an attestation of participation. Indicate if your agency intends to participate in the capacity-building efforts listed that are deliverable-based by indicating 'yes,' 'no,' or 'maybe.' This is non-binding, and agencies can participate at any time before the due date.
3.	If we missed the submission deadline for Start-up Funding, are we still able to participate in CBI?	Yes, if you did not opt for start-up funds, you may still participate in any qualifying, non-start-up activity as a deliverable-based effort. You will receive payment when the deliverable is submitted and approved. This includes Service Design activities however you will still need to adhere to any associated deadlines and/or additional requirements specific to each respective activity.
4.	Why are the templates being created after the implementation?	All templates are created before the due dates associated with each respective capacity deliverable. Templates will serve as a point of reference for SAPC when evaluating agency's implementation in alignment with agency attestations and template submissions. Allowing time for provider input on templates that will be utilized in an agencies' implementation is an important part of this process.

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5.	Is the R95 Champion incentive available to providers who submitted updated R95 Admission and Discharge Policies in Year 1? If yes, do these documents need to be resubmitted for verification purposes?	Agencies who submitted an approved R95 Admission and Discharge Policy in Year 1 are eligible for the R95 Champion incentive in Year 2 and do not need to resubmit these documents for verification as we already have them on file. They do however need to complete one other full component for any new activities for which they are considered eligible or newly eligible, e.g., *Staff Training Presentation 2-C, Admission Agreement 2-D, Toxicology Policy 2-E, Staff Training Verification 2-F.* For more information visit the SAPC Payment Reform website and click on the section that reads Earn Incentives. Become an R95 Champion. Expectations are outlined regarding those who participated last fiscal year (Year 1) and those starting out this fiscal year (Year 2).
6.	How does payment and recoupment work? How do I request R95 funds/submit for augmentation?	Capacity Building payments will be distributed through your DMC-ODS contract and are subject to all federal, state, and county audits and verification reviews. Providers must account for funds in accordance with County accounting procedures, including separate cost centers. For additional questions, please email SAPC's Finance Services Branch at sapc-cbi@ph.lacounty.gov. By signing up and responding 'Yes' to receiving start-up funds, you attest to the completion and submission of required documentation in accordance with the Capacity Building Package specifications by the due date to avoid recoupment. Responses of 'No' will result in no advance payment of start-up funds. However, if you do not opt for start-up funds, you may still participate in qualifying, non-start-up activity as a deliverable based effort. You will receive payment when the deliverable is submitted and approved. If you receive start-up funds or submit an approved deliverable, your agency will receive a payment. If your agency fails to complete a start-up activity, the start-up funds will be recouped. To request additional funds as earned through successful R95 participation, apply for an augmentation: Finance monitors monthly billing and Contracts/Programs are alerted of any providers that are identified as needing an augmentation. Providers are encouraged to monitor their funding utilization and request any increases or decreases as needed. Funding augmentations are approved based on utilization, (providers must have utilized at least 50% of their contracted allocation), performance, and community needs. Please refer to the Provider Manual 9.0 (p. 216), the SAPCIN22-14ContractAmendments and SAPCIN22-14ContractAmendmentForm for more information on this process.

	QUESTIONS	ANSWERS
7.	If we are using a language line during a screening is the screening activity with interpretation services reimbursable by DMC? Is TA available for solving language assistance in group settings?	The focus here should be on language assistance for screening and rapidly assessing and engaging the patient. The ASAM CO-Triage is a good screening tool to use here. The interpretation is an add-on. T1013 is the add-on code for use of interpretation services during the delivery of care. This code should be used in addition to the primary service codes (e.g., individual counseling, care coordination, etc.) to indicate that service was delivered with the assistance of language interpretation services. This is an add on code with no lock outs, meaning it can be used with all primary service codes. As an add on code, it also cannot be billed individually without a primary service code. For example, if you are an SUD Counselor and used a language line to provide Spanish interpretation while administering the ASAM CO-Triage for 30 mins, you would bill 2 units of H0001 (Assessment) and add-on 2 units of T1013 (Interpretation services) onto the same claim. There is an additional $30.92 per unit for T1013 (Interpretation Services). Please note: For the language add-on to be eligible, interpretation services must be provided by another person and NOT services delivered in a 2nd language by bilingual staff and ONLY be used by an in person professional interpreter, or in-person interpretation provided by a separate bilingual staff member. Add-on rates DO NOT apply for automated/digital translation or relay services. Group counseling is a beneficial and significant intervention in SUD treatment and the purpose of language assistance is to ensure that those with limited English proficiency have equitable access to all treatment interventions, as such, it is ideal to have groups separated by language, but there are times this may not be feasible (primarily when there is only one person who speaks a different language). In this case, it is best to offer simultaneous translation with the use of headsets, which are typically made available by the interpretation vendor. SAPC recognizes the unique challenges posed in offering interpretation in group counseling sessions. As a component of the Payment Reform Capacity Building and Incentive Initiative, SAPC is supporting providers in the development of language assistance plans. These materials will be made available on the SAPC provider manual, bulletins and forms webpage under the CRLA (Culturally responsiveness and language assistance) tab. SAPC is currently exploring the use of other newer technologies to assist with updates forthcoming. For more information, please contact EAPU@ph.lacounty.gov.

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8.	Does setting up transportation through the Medi-Cal benefit fall under care coordination.	Yes. SAPC patients are eligible for the managed care transportation option. NEMT – Non-Emergency Medical Transport is covered by Medi-Cal.
	R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE *Admissions & Discharge (A&D) Policies and/or Staff Training, – 2-A, 2-B, and 2-C	
9.	Are there new Admission and Discharge Policy templates and Staff Training Presentation for FY 24-25?	Yes, there were minor updates to the instructions (orange text) in the templates for the Admission Policy (2A) due 10/30/24), Discharge Policy (2-B) (due 10/30/24) and the Staff Training Presentation (2-C) (due 11/30/24). The final templates for use can be found on the Payment Reform- Capacity Building and Incentive Funds website and are linked below. Please note while these are PDF versions you can also access word versions on the website for ease of editing and tailoring for your agency. • R95 Admission Policy Required Language (2-A) • R95 Discharge Policy Required Language (2-B) • R95 Admission/Discharge Policy Training Presentation (2-C)
10.	Does the R95 Staff Training Verification (2-F) include cooks as well as drivers?	For the purpose of this activity, "staff with direct patient contact" includes all personnel who interact with patients during the admission, treatment, and discharge processes including clerical staff, drivers, Peer Support Services Specialists, registered or certified counselors, Licensed Practitioners of the Healing Arts (LPHA) and license-eligible LPHAs, etc. You may also include cooks in this definition. The Staff Training Verification forms are available on the Payment Reform- Capacity Building and Incentive Funds website and are linked below. • R95 Staff Training Attestation Deliverable A • R95 Staff Training Attestation Deliverable B
11.	Is the R95 Staff Training Verification (2-F) available to agencies participating in the R95 Training Presentation (2-C) this year?	Yes, agencies who meet the submission deadline and are approved for Staff Training Presentation (2-C) (due 11/30/24) are considered newly eligible to participate in the R95 Training Verification (2-F) (due 3/31/25). For more information on each of these deliverables visit the Payment Reform- Capacity Building and Incentive Funds website.

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12.	Do we need to update our Admission Agreement to align with the new Admission policy if we want to participate in the R95 Initiative?	Yes, the agency Admission Agreement needs to be updated as applicable and attached to the R95 Admission Policy (2-A) upon submission (due 10/30/24). This has been added as an Attachment at the end of the Admission Policy. The template for the R95 Admission Policy (2-A) is required to be used for agencies interested in accessing Capacity Building funds. SAPC engaged its provider network in the development of the Admission Policy template to ensure its feasibility while still staying consistent with R95 aims. Agencies are welcome to participate in the Capacity Building Deliverable for Admission Agreement (2-D) (due 12/31/24) by using the required language developed in consultation with providers. The final version of the Admission Agreement (2-D) is available for use on the Payment Reform- Capacity Building and Incentive Funds website. While participation in R95 and Capacity Building activities is not currently required by SAPC, it is highly encouraged as SAPC believes it will benefit participants.
13.	How do we need to update our drug testing policy to align with R95?	Contracted providers can continue to have toxicology (known also as "drug" or "urinalysis") testing policies and participate in R95 efforts however, they need to be flexible enough to address individualized patient needs. Toxicology testing is one available (but not required) tool that can be offered alongside other clinical interventions, and toxicology testing is not a required prerequisite to patient's achieving their treatment goals and/or to demonstrate treatment progress. For example, every patient may not need to submit to toxicology testing as a part of treatment participation, while others may request or be required (if authorized via consent to release information) as part of an agreement with Probation or DCFS. The toxicology testing policy just needs to outline what is done under these circumstances. Upon approval of their R95 Discharge Policy (2-B) (due 10/30/24) agencies are welcome to participate in the Capacity Building Deliverable for Toxicology Policy and Patient Agreement (2-E) (due 12/31/24) by using the required language developed in consultation with providers. The final template can be accessed here: http://publichealth.lacounty.gov/sapc/docs/providers/payment-reform/Toxicology-Policy-Required-Language-Final.pdf. While participation in R95 and Capacity Building activities is not currently required, it is highly encouraged as SAPC believes it will benefit participants.

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14.	If we did a training presentation last fiscal year in March 2024 does that training qualify as one of the trainings?	Only trainings conducted in FY 2024-25 (after July 1, 2024) count toward the deliverable R95 Staff Training Verification (2-F). For more information, please visit the Payment Reform- Capacity Building and Incentive Funds website.
15.	CalOMS currently says we must discharge a patient after 14 days of no contact, but many patients who are in outpatient treatment are homeless or have no phone and they might just engage once every 2 weeks or once a month. The 14-day policy is too strict if we are trying to reach the 95%. Can SAPC and CalOMS agree with changing the discharge policy to be better aligned with harm reduction?	Please note that the 14-day AWOL policy for CalOMS is triggered from the scheduled appointment date. For example, if a patient received a service on 9/1/24 and scheduled their next appointment for 9/7 but failed to attend, the 14-day AWOL policy takes effect, requiring re-engagement by 9/21. If the re-engagement is successful and an appointment is scheduled for 9/15, the provider will have another 14 days from 9/15 to re-engage if the patient fails to show up. This policy aligns with R95 efforts, as providers must make every effort to re-engage patients. As long as re-engagement occurs and a new appointment is scheduled, the 14-day period resets with each re-engagement attempt. From a data perspective, when patients cannot be reengaged within 14 days, it is highly unlikely they are reengaged, and they often show up to another agency. In these instances, the CalOMS admission from the new agency gets delayed because CalOMS is still open from the original agency.

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16.	How does the State think about Residential Licensed facilities letting patients in while still using drugs? (Updated 2/03/25)	SAPC can't speak on behalf of the State. However, in discussions with State leadership, our understanding is that there is general recognition that lapses and relapses are part of the recovery process and residential licensees/facilities will encounter these episodes. SB-992 Alcoholism or Drug Abuse Recovery or Treatment Facilities (passed in 2018) updates the State Health and Safety Code (11834.26(d)) to require licensees to develop a resident relapse plan and explicitly does not require a licensee to discharge a resident due to relapse episode, or lapse. *"A licensee shall **develop a plan to address when a resident relapses**, including when a resident is on the licensed premises after consuming alcohol or using illicit drugs. The plan shall include details of how the treatment stay and treatment plan of the resident will be adjusted to address the relapse episode and how the resident will be **treated and supervised while under the influence of alcohol or illicit drugs**, as well as discharge and continuing care planning, including when a licensee determines that a resident requires services beyond the scope of the licensee. This **subdivision does not require a licensee to discharge a resident**."* Participation in the updated admission policy does not mean that residential providers are encouraging substance use or should permit patients to continue using substances on or off the property, so R95 policies are in alignment with State requirements. SAPC will continue to engage in dialogue with agency leadership and staff to address these nuances and support enrollment of patients in the most appropriate level of care based on treatment goals.
17.	What is the definition of Same Day Admission?	Same Day Admission is defined as admitting someone the same day they seek services. For example, they call on Thursday and receive their first service on same Thursday.
18.	We have those elements in other P&Ps (some in admissions, some in other documents) will that be okay for submission?	It is the intention that each required element in SAPC's Admission and Discharge (A&D) policy is explicitly included in participating agencies updated A&D P&P to be compensated for Capacity Building deliverables 2-A and 2-B. This is because it is important that direct service staff understand each of these elements and how these key components fit together to more comprehensively engage the R95 population and other patients. If there are further agency specific questions, please direct to sapc-cbi@ph.lacounty.gov with subject "A&D Policy".

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19.	How can this [R95 Admission/Discharge Policy] be implemented with a criminal justice patient with timeline deadlines from the court and probation officers' requirements of abstinence?	Similar to implementation of DMC-ODS, SAPC's position is that while treatment may be mandated by courts, the specifics of that treatment (what setting, how long, what type of treatment, etc.) are based on clinical determinations made by substance use disorder (SUD) providers and not courts/judges. This is the approach taken with mental health (MH) services and there should be an equal approach taken with SUD services. If SUD agencies are asked to abide by court mandates on specifics of treatment, SAPC suggests highlighting this position with them and contacting SAPC so we can assist with these communications. While we expect some courts to question this approach, we have made progress after DMC-ODS implementation and also anticipate being able to achieve this more appropriate approach to SUD care delivery.
20.	Are we allowed to admit someone who has used substances in the past 24 hours?	Yes, SAPC has no restrictions on our providers admitting patients who are functionally able to participate in treatment regardless of recent substance use and are advocating to bring state policy into alignment. Should provider agencies run into any regulatory or auditor barriers with providing treatment services for people who have recently used intoxicant, please alert us.
21.	How does one distinguish what a non-abstinence focused withdrawal management system might look like?	Patients who are currently using drugs will also have instances where they practice periods of abstinence and reduction in use, which can result in withdrawal. Withdrawal management is indicated for opioid, sedative, and/or alcohol withdrawal syndrome, and patients who reduce the use of these substances may experience withdrawal even if they do not completely stop. Additionally, patients may experience withdrawal when they stop one category of substances (for example, opioid withdrawal syndrome when they stop using opioids), even if they do not stop using alcohol and/or sedatives. Patient-centered withdrawal management accepts that patients may experience withdrawal variably and prioritizes access to monitoring and clinically appropriate medications and related treatments for withdrawal even if the patient is not abstinent from all intoxicants, and even if the patient is not currently committed to long-term abstinence from substances. Provider agencies are encouraged to view readiness for abstinence as continually evolving for their patients. Policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment is what SAPC is looking to evolve/change with our R95 efforts.

22.	How do we balance serving those who are not committed to abstinence while ensuring a drug-free environment for others in a residential setting?	Provider agencies are encouraged to view readiness for abstinence as continually evolving for their patients. Even patients in long-term recovery experience moments where they question their desire to maintain their abstinence, and patients who are currently using drugs will also have instances where they practice periods of abstinence and reduction in use. When SAPC encourages broadening our acceptance of individuals who are not ready for long-term abstinence, the focus is around not wanting to create barriers to accessing SUD care. This does not mean that using substances during SUD treatment is ideal or appropriate, or that discouraging use of substances is prohibited. However, having policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment is what SAPC is looking to evolve/change with its R95 efforts focused on Admissions and Discharge policies. While there are unique considerations in residential settings that need to be individualized according to the circumstances of individual patients, the reality is that providers often mix these populations every day, so providers are already admitting people who are not currently practicing full sustained abstinence into their programs today. The aim in these situations is to provide pathways for patients to feel open, comfortable, and trusting with providers to share with providers where they are in their readiness for abstinence so that providers can try to move them along the readiness continuum. As is the case with all levels of care, the "R95" approach to this situation would be to: 1. Ensure that there are policies in place that not only avoid creating barriers to care, but widen the entry door into SUD treatment settings (e.g., do not require abstinence as a pre-requisite to receive services) 2. Addressing instances of problematic use of substances during treatment on a case-by-case basis that considers both the treatment of the patient using substances as well as the treatment environment of others in treatment. This balance should not always result in the discharge of the individual who used substances, as there are instances when people lapse and use substances but are still committed to their recovery. In these instances, it can be therapeutic both for the individual patient as well as their peers to demonstrate that patients can make mistakes but still be accepted by others and treated for their SUD. 3. In some instances, the discharge of people who use/relapse while in treatment is unavoidable and, in these instances, it is important for provider agencies to consider connecting them with another level of care and/or care coordination or other services, as appropriate, so as not to disconnect the patient from treatment all together. For example, even if a patient who

	QUESTIONS	ANSWERS
		used/relapsed needs to be discharged from a residential setting, an agency needs to attempt to discharge them to an outpatient setting where they can continue to receive treatment services but not in the residential environment that was too problematic and necessitated the patient's discharge. While going into a higher level of care after relapses is ideal, if the options are connecting a patient who recently relapsed to a lower level of care or having the patient be completely disconnected from the treatment system because they either are unwilling or unable to be cared for in a higher level of care, it is preferable to connect those patients to some treatment in the lower level of care as opposed to no treatment. Recovery Services are also an option and better than disconnecting from treatment all together. These are complex considerations that are challenging to fully address in an FAQ and will be further discussed in R95 workgroup meetings
23.	How do A&D policy changes impact Class A deficiencies (the fine for those deficiencies is about $500.00 per day)?	SAPC has reviewed this State-level issue and believes there are various options to address this. While it will take time, we anticipate working with the State to make progress on this issue. Please inform SAPC Contracts and Compliance Chief, Setareh Yavari (syavari@ph.lacounty.gov), if the State issues a citation for this reason. In the meanwhile, Class A deficiencies do not conflict with the operationalization of R95 and there are ways to operationalize R95 in nuanced ways without triggering Class A concerns. For example, having policies that accept patients who are not ready for abstinence as a pre-requisite of admission or policies that do not result in automatic discharges for lapses.
24.	If someone comes in psychotic, due to substance use or mental health disorder, how should an agency determine the safest place for them? The challenge is over ever-increasing acuity levels, and the question are we SUD or Mental Health or are we both?	Participation in R95 does not mean SUD providers will need to provide services to patients with high mental health acuity – those will continue to need to be managed by the specialty DMH system – but if the patient is capable of participating in treatment, regardless of their mental health diagnosis, SAPC provider should admit the patient and provide treatment. The key determination if whether a patient with a psychotic and/or MH condition can be safely treated in your SUD care setting is based upon an assessment of their behaviors (aggression, ability to reasonably benefit from SUD treatment, etc.). If, based upon the assessment, the patient is functionally capable of participating in treatment (regardless of their diagnosis), that individual should be provided SUD setting in your care setting. It is important to recognize that a patient's MH diagnosis does not directly speak to their acuity level, as diagnoses are both sometimes incorrect (especially for people with co-occurring SUD and MH conditions) and also are time dependent. Someone with a severe MH diagnosis such as schizophrenia or schizoaffective disorder can be sufficiently stable to be safely and treated in an SUD treatment setting with good clinical outcomes.

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25.	Will we keep the "Drug Free Environment" Policy? Drug Free Environment is a State requirement.	As far as California's Drug Free Workplace Policy, it is not clear that this is a key barrier; drug-free workplaces are able to serve people who may have drugs on them given that most places don't pad people down. It's important to distinguish between the fact that our R95 policies will not promote drug use or possession; our R95 policies will promote serving people at different levels of readiness for abstinence. The State does not require providers to discharge a patient for using substances on or off site.
26.	What about the liability and the potential for civil lawsuits stemming from: residential with patients who use, triggering others, possibly putting child residents at risk, and the risk of overdose? Some patients have prison sentences hanging over their heads and DCFS cases.	These will need to be individualized responses – perhaps connecting that person with other services even if your door isn't the door for help. If we discharge people who are at risk for having overdose it doesn't reduce their risk but rather reduces the risk for them to overdose on your site. We need to interpret risk carefully whereas it has been used to justify things that don't help people. We understand the purpose of having rules in place and residential requirements. We would also like to encourage providers to have a more nuanced approach that is focused on lowering barriers. We are trying to make a shift and are actively working at state level to make modifications. SAPC has provided support to agencies in past in addressing concerns from the state and will continue to do so as needed.
27.	As counselors we cannot ethically conduct some services if person is under the influence as the patient may not be able to consent to services. How do we protect ourselves as a counselor, an organization and the patient?	There is not an ethical issue in treating people who are intoxicated. Our ability to determine whether a patient is intoxicated is based upon our observations of their behavior, and we do not have the ability to definitively confirm whether an intoxicant is present in the patient's body without toxicology testing. Patients are able to be treated based on their capacity to consent to and participate in treatment; being intoxicated does not universally impair a patient from consenting to treatment. Patient treatment should be aligned with the patient's functionality, not intoxication status. SAPC supports providers who incorporate ethical practice into their work and who understand the welfare and trust of their patients are dependent on a high level of professional conduct. It is our hope that providers will use a low barrier approach while navigating the process of obtaining informed consent while prioritizing what is best for the patient's wellbeing.

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28.	Can the R95 Policy be specifically for the R95 population and we have another Admission Policy for the criminal justice and DCFS population?	No. Your agency's admission and discharge policies should be applicable to all patients in your care. To receive reimbursement for an updated admission and discharge policy, agencies must apply it to all individuals served funded by the SAPC contract, including those involved with Probation and DCFS. These policies are not inconsistent with serving individuals who consent to release information to DCFS and/or Probation and who indicate a commitment to be abstinent and participate in toxicology testing, and who also may be ambivalent about abstinence or lapse during the treatment episode. SAPC supports continued dialogue on this topic to increase provider understanding and adoption of lowering barriers to care and addressing associated implementation challenges.
29.	Is SAPC going to submit admission and discharge policies for DHCS review and/or approval?	No. SAPC has communicated with DHCS on the local R95 initiative and DHCS is supportive of establishing lower barrier access to care. SAPC should be contacted if State representatives indicate concern or cite agencies as a result of implemented changes.
30.	Has there been any further consideration about extending the initial engagement auth flexibilities to residential LOC's?	No, State policy does not currently permit initial engagement authorizations for residential LOCs, so that is not a flexibility that SAPC can offer our provider network.

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31.	How should we verify medical necessity for 30–60-day authorizations- do referring agencies need credentials to authorize medical necessity for service or does a valid referral work?	Initial engagement authorizations are approved for non-residential levels of care without documentation of medical necessity, so referral agencies do not need specific credentials or specific referral sources to obtain a 30-60 day initial engagement authorization for non-residential services. This initial engagement authorization process is explained in several UM meetings, most recently at the Nov 15th meeting posted here: http://publichealth.lacounty.gov/sapc/providers/treatment-provider-meetings.htm Initial engagement authorization specific slides 21-27 cover how initial engagement authorizations work: http://publichealth.lacounty.gov/sapc/NetworkProviders/qiumpm/111523/Provider-UM-Meeting.pdf With PCNX, providers indicate which of their non-residential treatment authorizations are initial engagement authorizations on page 4 of Sage-PCNX Service Authorization Request Guide. SAPC will run a count using this PCNX radio button to manage our count on initial engagement authorizations. Initial engagement authorizations are submitted within 30 days of the initial date of service and are submitted irrespective of the source of referral. For additional guidance please refer to the recently posted Substance Use Disorder Treatment Services Provider Manual Version 9.0 under Initial Engagement Authorizations here.
R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE *Admission Agreement and/or Toxicology Policy and Patient Agreement – 2-D, 2-E, and 2-F		
32.	Are the Admission Agreement levels of care and the services typed in blue necessary for a provider that does not render those levels of care or services?	While the blue text on templates signifies required text, please include only the levels of care and services offered by your agency.

	QUESTIONS	ANSWERS
33.	Can I still participate in submitting the Admission Agreement (2-D), Toxicology Policy (2-E) and Staff Training Verification (2-F) if also participating in the Admission Policy (2-A), Discharge Policy (2-B) and Staff Training Presentation (2-C)?	Yes, agencies who meet the submission deadline for the Admission Policy (2-A), Discharge Policy (2-B) (due 10/30/4) and Staff Training Presentation (2-C) (due 11/30/24) and are approved are considered newly eligible to participate in the Admission Agreement (2-D), Toxicology Policy and Patient Agreement (2-E) (due 12/31/24), and R95 Training Verification (2-F) (due 3/31/25). For more information on each of these deliverables visit the Payment Reform- Capacity Building and Incentive Funds website.
34.	We can provide Spanish interpretation for individual sessions but not for groups as it has proven to be disruptive. To what extend are we promising free interpreter services? Is there new technology available to provide interpretation in a group setting?	SAPC's provider network must comply with federal, State and local laws and regulations regarding non-discrimination, language assistance, and ensure that culturally, developmentally, and linguistically appropriate services are provided to patients in the SUD specialty system. For more information, please visit the SAPC IN 24-02 Requirements for Ensuring Culturally and Linguistically Appropriate Service SAPC recognizes the unique challenges posed in offering interpretation in group counseling sessions and is currently exploring the use of other newer technologies to assist with updates forthcoming. Please refer to question 7, above.
	R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Service Design – 2-G, 2-H, 2-I	
35.	Can I participate in the Customer Walk-Through (2-H) and Plan (2-I) for newly designated sites even if I participated in this deliverable in Year 1?	Yes, you can participate in the Service Design deliverables Customer Walk-Through (2-H) for a site that was not approved during Year 1. However, Plan (2-I) is agencywide (not site specific). If you **did not** participate in this effort in Year 1, you are eligible. For more information, please visit the Payment Reform- Capacity Building and Incentive Funds website.

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36.	Can I participate in the Service Design Follow-Up Implementation Process Improvement (2-G) if I am also participating in the Customer Walk-Through (2-H) and Plan (2-I) this year?	Only provider agency site(s) who participated in and submitted an approved Service Design Implementation/Investment Plan *(formerly 2E-3)* in Year 1 (FY 23-24) may participate in Service Design Follow-Up Implementation Process Improvement (2-G) in Year 2. For more information, please visit the Payment Reform- Capacity Building and Incentive Funds website.
37.	Are treatment providers who are also harm reduction sites still eligible for this incentive?	Yes, when the site(s) used as part of the Service Design component of the R95 Initiative is also a treatment site.
	R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Bidirectional Referrals – 2-J, 2-K	
38.	What is the due date for Treatment Agency Staff Participation in Harm Reduction Trainings (2-J)? Is there an accompanying attestation form for (2-J)?	The Treatment Agency Staff Participation in Harm Reduction Trainings (2-J) due date is 3/31/24. The Treatment Agency Staff Participation in Harm Reduction Trainings Attestation and Verification form can be accessed here and on the SAPC Payment Reform Capacity Building and Incentive Funds website.
	R95 General Questions	
39.	Where can I find the meeting presentation slides and documents reviewed during R95 Workgroup Meetings?	R95 Workgroup Meeting presentation slides and documents will be posted on the SAPC website meeting under Provider Meetings, under R95 Workgroup Meetings, under the most recent meeting date.

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40.	Where can I find the R95 calendar?	The most recent version will be posted on the SAPC website meeting under Provider Meetings, under R95 Workgroup Meetings under the most recent meeting date. It is also available via a link on the Payment Reform- Capacity Building and Incentive Funds website banner message under Year 2 Provider R95 Meeting and Deliverables Calendar or under the Capacity-Building & Incentives Trainings webpage. Updates to the calendar will be shared following R95 Workgroup meetings and posted to the website.