State of California—Health and Human Services Agency
Department of Health Care Services

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Behavioral Health Information Notice No: 22-056

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: The Recovery Incentives Program: California's Contingency Management Benefit

PURPOSE: To furnish policy guidance for the Recovery Incentives Program, which provides incentives as a Medi-Cal benefit to beneficiaries with stimulant use disorder (StimUD).

REFERENCE: DHCS Contingency Management website

BACKGROUND:
CalAIM is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. As part of the CalAIM demonstration, California became the first state in the nation to receive federal approval to cover contingency management (CM) services for substance use disorders as part of the Medicaid program. California's program that offers the CM benefit is called the Recovery Incentives Program.

CM is an evidence-based, cost-effective treatment for substance use disorders; California will be focusing on stimulant use disorder (StimUD). CM reinforces individual

positive behavior change consistent with meeting treatment goals. DHCS will pilot Medi-Cal coverage of CM in select Drug Medi-Cal Organized Delivery System (DMC-ODS) counties between the first quarter of 2023 and March 2024. DHCS intends to use the pilot as a basis for informing the design and implementation of a statewide CM benefit through the DMC-ODS program, pending budgetary and statutory authority.

This Behavioral Health Information Notice (BHIN) provides state standards for the Recovery Incentives Program and outlines the steps participating DMC-ODS counties must take to implement CM services.

POLICY:

a. CM Service Overview

The Recovery Incentives Program is intended to complement substance use disorder (SUD) treatment services and other evidence-based practices for StimUD already offered by DMC-ODS providers. Eligible Medi-Cal beneficiaries will participate in a structured 24-week outpatient CM service, followed by six or more months of additional treatment and recovery support services without incentives. The initial 12 weeks of CM consists of a series of incentives for meeting treatment goals, specifically abstinence from stimulants objectively verified by urine drug tests (UDTs) negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). The incentives consist of cash-equivalents (e.g., gift cards), consistent with evidence-based clinical research for treating SUD. CM should be offered alongside other therapeutic interventions, such as cognitive behavioral therapy and motivational interviewing that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and CFR 440.130(d).

b. Beneficiary Eligibility for CM Services

CM services are only available to Medi-Cal beneficiaries who meet the following conditions:

- Are enrolled in Medi-Cal and meet access criteria for a comprehensive, individualized course of SUD treatment.
- Residing in a participating DMC-ODS county that elects and is approved by DHCS to participate in the Recovery Incentives Program.
- Receiving services in non-residential level of care operated by a DMC-ODS provider participating in the Recovery Incentives Program and offering CM in accordance with DHCS policies and procedures.

CM services delivered under the Recovery Incentives Program are only covered when medically necessary and appropriate as determined by an initial substance use disorder assessment consistent with DMC-ODS Intergovernmental Agreement (IA) showing (1) moderate or severe StimUD as defined by the clinical criteria in the Diagnostic and Statistical Manual (DSM, current edition); (2) clinical determination that outpatient treatment is appropriate per the American Society of Addiction Medicine (ASAM) criteria; and (3) that the CM benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving CM services.

Beneficiaries may access CM when transitioning to or from residential care or carceral settings, including services initiated on the day of admission and discharge or release respectively. Providing CM services on the date of admission and the date of discharge from a DMC-ODS residential level of care is an acceptable circumstance justifying multiple service billing for both a residential treatment service and a CM service at a non-residential level of care.

CM should never be used in place of medications for addiction treatment (MAT). CM may be offered in addition to MAT for people with co-occurring stimulant and alcohol or opioid use disorders.

Eligible Medi-Cal beneficiaries shall be referred to, and admitted into, treatment through a participating provider's routine beneficiary admission process. Consistent with other DMC-ODS programs, there is no minimum age limit for an individual to receive CM services if they meet all eligibility criteria. In addition, pregnant and parenting people with StimUD are eligible to receive CM services. Medi-Cal beneficiaries who are receiving care in residential treatment (e.g., ASAM levels 3.1–4.0) or institutional settings are ineligible for CM services until the day of discharge, when they are transitioned into outpatient care.

Beneficiaries under the age of 21: Covered services provided under the Recovery Incentives Program shall include all medically necessary SUD services for individuals under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in California's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and

SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or a SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

c. Assessment

Assessment consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Consistent with DMC-ODS policies described in BHIN 21-075, beneficiaries must have an ASAM multidimensional assessment completed within 30 days following the first visit with a Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor for beneficiaries 21 and older that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.5) or within 60 days if under 21 years old or experiencing homelessness. The initial clinical assessment shall confirm: (1) The individual has a diagnosis of StimUD of moderate or severe from the DSM for Substance-Related and Addictive Disorders (2) outpatient treatment is appropriate per the ASAM criteria; and (3) that CM is medically necessary.

d. Documentation

The provider shall document StimUD on the problem list (or treatment plan for Narcotic Treatment Providers, NTPs) within a beneficiary's medical record. Consistent with best clinical documentation practices, providers shall describe all interventions utilized with the beneficiary as part of their progress notes for each service to include CM in addition to any other outpatient services, such as motivational interviewing, cognitive behavioral therapy, or community reinforcement therapy. CM should not be offered to a beneficiary as a standalone treatment, but rather as one component of an individualized treatment plan. However, if a beneficiary chooses to participate only in selected services (e.g., they only participate in CM and not in other aspects of treatment), they shall not be penalized, chastised, criticized or discharged from the program for declining to participate in any treatment or recovery service or for failure to participate in all recommended treatment services. Beneficiaries needing or utilizing CM must be served and cannot be denied CM or be required to participate in other aspects of a SUD treatment program as a condition of entering or remaining in a Recovery Incentives Program.

SUD providers offering CM are responsible for providing or referring beneficiaries to additional services for other non-StimUD SUDs indicated in their problem list. For example, if a beneficiary has both a StimUD and a concurrent opioid use or alcohol use

disorder, the SUD provider shall, in addition to providing CM, provide the beneficiary with MAT or refer the beneficiary to another provider for MAT.

Each CM visit shall be documented consistent with existing DHCS policy described in BHIN 22-019.

e. Beneficiary Education/Orientation

Before beginning CM treatment, a Medi-Cal beneficiary must complete a thorough orientation and consent to the conditions of the program. The orientation will address the following:

- The days/times that a beneficiary must visit the facility in order to be eligible for incentives (during weeks 1–12, two weekly visits; during weeks 13–24, one weekly visit).
- The manner in which incentives will be delivered as well as an understanding of how and where incentives can be redeemed, including the prohibition of using incentives to purchase alcohol, cannabis, tobacco, lottery tickets, or for any form of gambling.
- The availability of incentives and ongoing program participation when a beneficiary lapses or relapses and seeks readmission and the process for a beneficiary to seek readmission.
- The provider's UDT procedures and an explanation and review of medications/substances that may result in false-positive UDTs.
- The rules governing when an incentive will be provided, including:
    - An explanation that the incentives are contingent on the absence of evidence of stimulant (e.g., cocaine, amphetamine, methamphetamine) use on UDT only.
    - An explanation that opioid testing will be done for the purpose of safety, due to association with overdose deaths, but will not impact the delivery of an incentive.
    - An explanation that all positive tests will be treated the same even if they result from use of one of the medications/substances known to provide false positive UDT results.
- The amount of the initial incentive and how the value increases with consecutive stimulant-free UDTs and how the value will be re-set to a lower value in case of a positive test or unexcused absence, and that increases will be reinstated after repeated negative UDTs.The maximum incentive a beneficiary can receive per year in the Recovery Incentives Program is $599.

In addition to the orientation, each program participant will be required to sign a patient agreement (containing key components required by DHCS) that sets forth conditions of participation in the Recovery Incentives Program.

f. Treatment Framework

i. Incentives

Beneficiaries will receive incentives for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. Participating beneficiaries will be able to receive a maximum of $599 in total incentives per year for successful completion of the treatment protocol. Providers have no discretion to determine the size or distribution of incentives. The size of the incentive will be based on the protocols in Section f.iii. of this BHIN.

ii. Harm Reduction

Harm reduction is an essential component of any treatment program. According to provisional data released by the Centers for Disease Control and Prevention in May of 2022, drug overdose deaths continued to rise in the United States in 2021, surpassing 100,000 deaths. A high number of these deaths are due to the synthetic opioid fentanyl, which has been found mixed in or as a replacement for many other drugs of abuse, including benzodiazepines, opiates and other opioids, and stimulants. Given the presence of fentanyl in some stimulants, death as the result of accidental ingestion of fentanyl is a real risk for beneficiaries in the Recovery Incentives Program.

Recovery Incentives Programs shall:

- Establish and implement a protocol to prescribe naloxone to all beneficiaries with an opioid, sedative and/or stimulant use disorder as outlined below.
- Establish and implement a naloxone distribution protocol for beneficiaries who do not obtain prescription naloxone.
- Provide education to each CM beneficiary regarding:
    - The risks associated with fentanyl and its presence in the illicit drug supply.
    - Harm reduction safety strategies, such as the use of fentanyl test strips and which harm reduction agencies distribute test strips for home use, based on information from the California Department of Public Health (see link).
    - Specific education regarding the use of naloxone to reverse an opioid overdose.

Providers shall either replace the naloxone whenever a beneficiary needs an additional dose, due to the naloxone expiring or due to use in the community, or remind a beneficiary to obtain a new dose through a pharmacy or local organization.

DMC-ODS providers are able to dispense naloxone onsite to DMC-ODS beneficiaries by leveraging the Medi-Cal pharmacy benefit. As a best practice overdose prevention measure, providers can prescribe naloxone to all DMC-ODS beneficiaries who are participating in the Recovery Incentives Program, and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of DMC-ODS beneficiaries. The community pharmacy would bill these naloxone prescriptions to the Medi-Cal pharmacy benefit. Pharmacists can also directly dispense naloxone and bill to Medi-Cal. The staff could bring the dispensed naloxone back to the provider site for furnishing directly to patients. This method would enable the CM provider to better facilitate onsite access to naloxone reimbursed through the Medi-Cal pharmacy benefit.

iii. Treatment Schedule

1. Overview

The Recovery Incentives Program will consist of two phases: (1) CM treatment and (2) CM continuing care.

Phase 1 of CM treatment will consist of a 24-week outpatient program, during which incentives will be available for meeting the target behavior of stimulant-non-use. Weeks 1–12 of CM treatment will serve as the escalation/reset/recovery period, and weeks 13–24 will serve as the stabilizing period.

Phase 2 begins when a beneficiary completes the initial 24-weeks of CM treatment. The participating beneficiary will receive CM continuing care of six months or more, with treatment services to support ongoing recovery (e.g., counseling and peer support services). During the period of CM continuing care, participating beneficiaries may receive treatment and recovery-oriented support from DMC-ODS providers, as well as covered DMC-ODS services, including but not limited to Recovery Services.

2. CM Treatment Weeks 1-12: Escalation/Reset/Recovery Period

During the initial 12 weeks of the CM treatment, participating beneficiaries will visit the treatment setting in person for two treatment visits per week. Visits will be separated by

at least 72 hours (e.g., Monday and Thursday, or Tuesday and Friday) to minimize the chance that drug metabolites from the same drug use episode will be detected in more than one UDT. Participating beneficiaries can earn incentives during each visit the UDT indicates they have a negative sample for stimulants.

The initial incentive value is $10 for the first sample negative for stimulants in a series. For each week the participating beneficiary demonstrates non-use of stimulants (i.e., two consecutive UDTs negative for stimulants), the value of the incentive is increased by $1.50. The maximum aggregate incentive a participating beneficiary who consistently participates and has negative UDTs can receive during this initial 12-week period is $438.

A “reset” will occur when the participating beneficiary submits a stimulant-positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their incentive amount will return to the initial value of $10.

A “recovery” of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participating beneficiary will recover their previously earned incentive level without having to restart the process, no matter when in the course of the program the stimulant use occurs. Beneficiaries will not be penalized for stimulant-positive samples, even if there are several in a row, and even if the sample contains other drugs. If the beneficiary fails to achieve two consecutive stimulant-negative samples within the first 12-week period, the treatment provider and beneficiary should decide whether CM is a clinically appropriate intervention for that beneficiary, and, if necessary, modify the course of treatment and update the beneficiary’s problem list and progress notes.

3. CM Treatment Weeks 13-24: Stabilizing Period

During weeks 13–24, participating beneficiaries will visit the treatment setting for testing once a week. During weeks 13–18, participating beneficiaries will be eligible to receive $15 per stimulant-negative UDT. During weeks 19–23, they will be eligible to earn $10 per stimulant-negative UDT, and if their sample is stimulant-negative on week 24, they will earn $21. The maximum aggregate incentive a participating beneficiary will be able to receive during weeks 13–24 is $161. The total possible earnings during weeks 1–24 for all stimulant-negative tests is $599.

4. Hypothetical Example: Incentive Delivery Schedule for Consistent Abstinence from Stimulants

Table 1 illustrates an incentive delivery schedule for a participating beneficiary in a scenario where the beneficiary has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 1: Sample Incentive Delivery Schedule	
Week	**Incentive for Stimulant-Free Test**
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15.00 per week/test
Weeks 19-23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

g. Resets During Weeks 13-24 or Post-Discharge

Recovery from any substance use disorder is a process of change, not an endpoint. As such, despite the fact that weeks 13-24 are designed to be a stabilizing period, and that a beneficiary may be ready for discharge post 24 weeks, providers need to be aware of

and expect lapse or relapse from beneficiaries who are further along in the process and address such occurrences without judgement.

h. Extended Absence and Readmission Throughout CM Protocol

A beneficiary will be considered a readmission if they leave CM services for more than 30 days. At readmission, the beneficiary must have a new ASAM multidimensional assessment that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.5) and confirm that the beneficiary meets the medical necessity criteria for CM. If the beneficiary has remained engaged in other services during their absence from CM, an update to the most recent ASAM assessment is sufficient. Based on the assessment, a provider may offer other treatments as alternatives to CM if there is strong clinical evidence that CM is unlikely to produce the intended results. However, if the determination from the new assessment is that CM is an appropriate course of treatment for that beneficiary, the beneficiary may receive CM services and the incentive structure would restart at Week 1. If the beneficiary resumes CM services, they may earn incentives starting at the Week 1 scheduled incentive amount up to a maximum of $599 per year inclusive of all incentives earned that year, including previous Recovery Incentives Program participation.

If a beneficiary leaves CM services (for any reason) and returns to the program within 30 days, they shall return to the schedule of incentives as if there was no break in service, as long as the beneficiary does not exceed the $599 annual limit inclusive of all incentives earned that year, including previous Recovery Incentives Program participation.

Reaching the limit for incentives earned through the Recovery Incentives program does not mean that a beneficiary would be automatically discharged; all other clinically appropriate treatment services and/or recovery supports should continue to be offered per the beneficiary's treatment plan.

i. Provider and Staffing Criteria

i. Eligible Provider and Treatment Settings

SUD providers offering outpatient, intensive outpatient, NTPs and/or partial hospitalization services that are licensed and certified to provide Medi-Cal and DMC-ODS services are eligible to participate in the Recovery Incentives Program. Eligible providers shall:

- Serve beneficiaries residing in DMC-ODS counties that have been approved by DHCS for participation in CM services.
- Require that staff providing or overseeing CM services participate in CM-specific training developed and offered by a qualified contractor designated by DHCS.
- Undergo a readiness review by the state's contracted trainer and technical advisor to ensure that they are capable to offer CM services in accordance with DHCS standards.
- Participate in ongoing training and technical assistance, including fidelity reviews, as requested or identified by DMC-ODS counties or DHCS through ongoing monitoring to meet DHCS standards.
- Follow all other requirements for DMC-ODS participation as described in BHIN 21-075.

ii. CM Coordinator Requirements

At least one CM coordinator will administer CM services at each participating DMC-ODS provider site. Practitioners eligible to deliver the CM benefit include:

- Licensed Practitioner of the Healing Arts (LPHAs).
- SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies.
- Certified Peer Support Specialists.
- Other trained staff under supervision of an LPHA. [1]

The optimal caseload for one full-time CM Coordinator is no more than 30 beneficiaries at any given time and approximately 60 to 100 beneficiaries over the course of a year.

iii. CM Coordinator Responsibilities

The CM coordinator(s) will be the main point of contact for all beneficiaries participating in the Recovery Incentives Program. The CM coordinator(s) will be responsible for collecting UDT samples, inputting test results, and supporting the delivery of incentives.

iv. CM Coordinator, Backup Coordinator and Supervisor Training Requirements

[1] The designation "Other trained staff under supervision of an LPHA" is specific to CM, and does not change existing requirements for providers of other DMC-ODS services.

The following training is required for the primary staff of the Recovery Incentives Program, the CM Coordinator, Backup Coordinator, and the Supervisor:

- Recovery Incentives Program Overview (two-hours self-paced).
- Recovery Incentives Program Implementation Training (two three-hour live virtual sessions).
- Site Readiness Assessment.
- Monthly coaching calls.

j. CM Visit Workflow

The CM coordinator will facilitate visits with participating beneficiaries. The anticipated workflow for the first CM visit and subsequent visits is below.

i. Intake Visit

During a beneficiary's first visit, the CM coordinator will complete several steps to initiate the service, specifically:

- Conduct eligibility check – The CM coordinator or other designated personnel at the provider agency will confirm the beneficiary's current Medi-Cal eligibility as well as their eligibility for the program before initiating the CM service. The eligibility check should be done via the Automated Eligibility Verification System (AEVS) for Medi-Cal.
- Program participation consent – The CM coordinator will ask the beneficiary to complete a consent authorizing services and the secure sharing of data with DHCS and the program evaluation team, including all DHCS-required consent elements.
- Explain the CM process and reinforce the expectations set forth in Section e above.
- Enroll the beneficiary into the Incentive Manager program – The CM coordinator will complete a beneficiary profile to enroll them into the computerized system that will keep track of incentive gift cards, hereinafter referred to as the Incentive Manager.

ii. CM Visits

- Engage the beneficiary and initiate the visit – The CM coordinator will greet the beneficiary, review their progress in the program (e.g., weeks completed out of 24), log into the Incentive Manager and locate the beneficiary's record/profile.

- Conduct eligibility check – The CM coordinator or other staff within a provider agency offering CM will check beneficiary Medi-Cal eligibility monthly or per provider policy.
- Administer UDT – The CM coordinator will administer the UDT, including processing the results of the UDT in real time.
- Log results in Incentive Manager – The CM coordinator will log the results of the UDT for stimulants (i.e., positive or negative).
- Discuss results – The CM coordinator will discuss the UDT results with the beneficiary and offer other services if/as appropriate, which could include brief encouragement, motivational interviewing, and education based on the CM Coordinator's scope and training. The CM coordinator will encourage the beneficiary to meet with their counselor or LPHA. If opioid results are positive, the CM Coordinator shall document these results in the clinical chart, reinforce the risk of overdose, ensure the beneficiary has naloxone, and offer other treatment services as appropriate, including MAT if the beneficiary has a co-occurring alcohol or opioid use disorder.
- Disburse incentives consistent with "Incentive Delivery" section below
    - If the UDT result entered is negative for stimulants, the Incentive Manager will disburse the incentive generated by the Incentive Manager consistent with the "Incentive Delivery" section below.
    - If the UDT result entered is positive for stimulants, the Incentive Manager will not disburse an incentive.
- Plan for next appointment – The CM coordinator will remind the beneficiary of their next scheduled appointment (date and time). The CM coordinator should offer to answer any questions before adjourning the visit.
- Documentation – The CM coordinator shall document the visit in the chart.
- Billing – The CM coordinator shall complete claims documentation to bill the DMC-ODS county for the service, using as many units of the 15-minute code H0050 as appropriate, given the length of the visit, and using one of two ICD-10 diagnoses as at least one of the diagnostic codes (in addition to any other relevant codes for the visit; for example, the primary diagnostic code may be for stimulant use disorder, with the appropriate code below used as a secondary diagnosis):
    - R82.998: positive urine test for stimulants
    - Z71.51: negative urine test for stimulants

k. Urine Drug Testing

During each visit, the CM coordinator will collect a urine sample from the participating beneficiary. The CM coordinator shall test the sample for stimulants, including cocaine,

amphetamine and methamphetamine, as well as for opiates and oxycodone. The purpose of testing for opiates and oxycodone is to assess relative risk of exposure to fentanyl; this is based on the concept that people who use multiple categories of substances have a greater potential to accidentally ingest fentanyl than people who use a single substance due to the likelihood of additional drug sources. The tests for opiates and oxycodone, even if positive, shall not impact the beneficiary's ability to receive an incentive; however, coaching should be done and the clinical need for induction of evidence-based treatment for opioid use disorder assessed if a beneficiary tests positive for opioids. In addition, the CM coordinator shall discuss the risks associated with fentanyl; harm reduction safety strategies, including the use of fentanyl test strips, and ensure the beneficiary has access to naloxone and knows how it is used.

To receive Medi-Cal reimbursement for CM, DMC-ODS providers shall hold a Clinical Laboratory Improvement Amendments (CLIA) "waived test" certification and be registered with the California Department of Public Health (CDPH) (or be accredited by an approved accreditation body). Laboratory Field Services, which is part of the California Department of Public Health, has an online application process through which providers can apply for both the CLIA waiver and the state registration. Providers should choose certificate type "Registration" and be prepared to upload three forms: the CMS 116, LAB 182, and LAB 183.

Each UDT must be performed in accordance with the manufacturer's instructions for the test, and the CM provider must ensure that waived testing personnel meet facility-defined minimum requirements and have records of training and competency assessment.

Providers shall use appropriate precautions to avoid tampering with UDT specimens, including the following: requiring beneficiaries to leave personal possessions (e.g., backpack, purse, items in pockets) in a secure location outside of the restroom; requiring beneficiaries to thoroughly wash hands or use hand sanitizer prior to entering the restroom, including between fingers and under nails; turning off access to hot water in the restroom (or turning off the water faucet altogether, and requiring hand-washing outside of the restroom); and adding bluing agent to the toilet. Each test must be accompanied by reliability measures, including temperature, creatinine, and pH level.

DHCS has identified four UDTs that meet program specifications, as listed in Table 2. All products listed met the following minimum requirements:

- Cut-offs for Amphetamine (500 ng/ml), Cocaine (150 ng/ml), Methamphetamine (500 ng/ml), Opiate (300 ng/ml), and Oxycodone (100 ng/ml)
- Specimen validity measures (temperature, pH, and creatinine)

- CLIA waived by the Food and Drug Administration (FDA), and therefore meet at least one of three criteria:
    - Cleared by the FDA for home use; OR
    - Employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; OR
    - Pose no reasonable risk of harm to the patient if the test is performed incorrectly.
- Cost per test is reasonable.

The FDA list of CLIA-waived tests is available here.

If a site would like to request an existing UDT product be evaluated and approved for use in the Recovery Incentives Program, please email the following information to CountySupport@dhcs.ca.gov:

- Package Insert
- Cut-offs for Amphetamine, Cocaine, Methamphetamine, Opiate, and Oxycodone
- Cross-Reactivity List for Amphetamine, Cocaine, Methamphetamine, Opiate, and Oxycodone (if applicable)
- Info on specimen validity (if the cup includes this or not)
    - Temperature strip
    - pH
    - Creatinine
- Certification: CLIA-Waived and/or FDA approved

DHCS will review each request submitted by a provider for an alternative UDT and either approve or deny the request for an alternative UDT. The CM provider cannot receive reimbursement for CM unless this test has been approved by DHCS.

Table 2: Recovery Incentives Program Approved UDTs						
Company Name	**Product Name**	**Required Tests**	**Additional Tests Included in Standard Cup**	**General Cost Estimate for Standard Cup (as of 6/15/22)**	**Company Website**	**Contact Information**
CLIAWaived, Inc.	12 Panel IDTC Cups II with Adulterants	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, MDMA, MTD, PCP, TCA, THC	$4.99 per cup; around $124.75 per box of 25.	https://cliawaived.com/cliawaived-inc-idtc-12-panel-cup-with-adulterants.html	Telephone: 858-481-5031 Email: info@cliawaived.com
CLIAWaived, Inc.	14 Panel IDTC II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, EDDP, MDMA, MTD, PCP, TCA, THC	$4.50 per cup; around $112.50 per box of 25.	https://cliawaived.com/cliawaived-inc-14-panel-idtc-ii.html	Telephone: 858-481-5031 Email: info@cliawaived.com
Lochness Medical	Multi-Drug One Step Cup II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, BUP, MDMA, EDDP, KET, THC, MTD, MDPM,	$5.40 per cup.	https://www.lochnessmedical.com/Product/Cups/16970	General Inquiries: 1-888-506-2658 info@lochnessmedical.com Orders: orders@lochnessmedical.com

Table 2: Recovery Incentives Program Approved UDTs						
Company Name	**Product Name**	**Required Tests**	**Additional Tests Included in Standard Cup**	**General Cost Estimate for Standard Cup (as of 6/15/22)**	**Company Website**	**Contact Information**
			PCP, PPX, TRA, TCA			Support: support@lochnessmedical.com
Premier Biotech	Bio-Cup 12-Drug Panel Drug Test	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, MDMA, MTD, PCP, THC	$2.50-$3.00 per cup; around $68.75 per box of 25.	https://premierbiotech.com/innovation/rapid-testing/urine-testing/premier-bio-cup/	Product Questions: 888-686-9909 Laboratory Questions: 855-718-6917

l. Incentive Delivery

i. Overview

Upon learning the results of the UDT, the CM coordinator must inform the beneficiary, and enter the results into a secure Incentive Manager program that includes strict safeguards against fraud and abuse. CM staff shall not play any role in calculating or determining the appropriate size of the incentive payment, but shall follow the algorithm in the Incentive Manager program exactly. The Incentive Manager program shall compute the appropriate incentive amount earned according to the protocol detailed above. The incentive amount shall be delivered immediately to participating beneficiaries in the format of an e-mail, hard copy, refillable gift card, or other mechanism as approved by DHCS.

1. Incentive Calculations

The Incentive Manager shall automatically calculate the appropriate incentive amount based on the UDT results with adjustments for the escalating value, re-set and recovery features as described in Section f.iii above. Upon each visit, the CM coordinator shall enter the results of the UDT into the Incentive Manager program, and the program will report the appropriate incentive amount, per the protocol. A positive test for stimulants shall result in the participating beneficiary receiving no incentive, along with encouraging coaching from the CM coordinator. A negative test for stimulants shall result in an incentive amount as indicated by the Incentive Manager program, considering escalations and resets.

After the incentive amount is determined, the Incentive Manager program shall disburse the incentive and shall track all incentives awarded to all participating beneficiaries, including the CM staff who conducted the visit, the format of the incentive provided to the beneficiary, the date the incentive was distributed and the amount of the incentive.

Participating beneficiaries shall receive incentives in a format approved by DHCS to which the Incentive Manager will make deposits upon entry of stimulant-negative UDT results. Restrictions shall be placed on the incentives so they cannot be used to purchase cannabis, tobacco, alcohol or lottery tickets.

m. Billing and Reimbursement

i. Billing for CM Activities

Providers offering CM shall bill HCPCS code H0050, with the modifier HF on the claim form for each CM visit as they would for any other DMC-ODS service. The designated code and modifier is designed to reimburse the bundled costs of a single beneficiary visit to a CM coordinator, billed in 15-minute increments, which include:

- CM coordinator time: pre-, during, and post-visit with the beneficiary
- Supervision
- Indirect overhead
- Costs of purchasing urine drug test cups and testing strips.

In addition, each claim or encounter for CM shall include a diagnosis specific to the UDT test results. The following diagnosis codes shall be used on claim forms (these diagnoses can be used in addition to other diagnoses relevant to the visit):

- R82.998: Diagnosis for positive urine test for stimulants.
- Z71.51: Diagnosis for negative urine test for stimulants.

Level of care (LOC) modifiers will still be required for all DMC-ODS claims. The LOC modifier entered on the claim should correspond to the Drug Medi-Cal Service Group for which the service facility location is certified. For example, if the provider is certified for Outpatient Drug Free (ODF) the county should include “U7” on the claim in addition to the “HF” and if applicable the HA or HD modifier.

Please refer to the DMC-ODS Billing Manual for general guidance about billing.[2]

ii. Start-Up Funding for Providers

DHCS distributed start-up funding to participating DMC-ODS counties to distribute to providers, proportionate to historical DMC-ODS spending. (See “administrative funding” below for guidance on county start-up costs). Counties may retain a maximum of 15% for administrative costs; the remainder must be distributed to providers to cover start-up funding.

Allowable start-up costs include:

- Staff recruitment and hiring costs.
- Personnel costs (e.g., the salary of the CM coordinator before beneficiary care begins, covering training and orientation time, or early patient engagement activities).
- Changes to provider information and billing systems.

[2] Please visit https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx for additional guidance, including a DMC-ODS Billing Manual effective July 1, 2023.

- Technology costs: hardware or software.
- Other supplies needed to carry out CM services, such as urine drug test (UDT) cups.
- Capital improvement costs needed to carry out CM services (BHQIP funding only; see below).
- Outreach among Medi-Cal beneficiaries.

DHCS has allocated $3.64M from Behavioral Health Quality Improvement Program (BHQIP) funding for provider start-up activities for FY 21-22. DHCS has also allocated an additional $2M in SAMHSA block grant funding, which must be expended by December 2022. SAMHSA funds used for this project will be from Substance Abuse Prevention and Treatment Block Grant (SABG) funding. BHQIP funds will be distributed to participating DMC-ODS programs in advance of expenditures, and the DMC-ODS programs have discretion on how and when to administer the funds, as long as they follow DHCS Recovery Incentives guidelines, and at least 85% of funds are distributed to providers. Counties are required to submit a narrative report to DHCS documenting the use of BHQIP start-up funds no later than March 31, 2023.

In contrast, SAMHSA funds are distributed after the expenditures are incurred, and DHCS will reimburse DMC-ODS programs for appropriate expenditures (up to 15% for county-incurred costs, and at least 85% for provider-incurred start-up costs). In addition to the requirements above related to allowable expenses, SABG funding has specific restrictions as set forth in 45 CFR 96.135. Consistent with current SABG processes, counties must submit quarterly invoices for reimbursement of all SABG-funded CM start-up costs, and continue other existing SABG reporting requirements. The invoices and SABG reporting requirements will be submitted to a DHCS contractor, and DHCS will provide additional information on the submission process at a later date. As detailed in the SABG Policy Manual, counties must submit monthly CalOMS-Tx data and report quarterly expenses on SABG invoices.

iii. Administrative Funding

Counties may invoice DHCS for allowable DMC-ODS administrative costs related to the administration of CM. The non-federal share of these administrative costs will be covered with State funds (rather than county funds). DHCS will audit to those allowable costs during the cost reconciliation process after the close of the 22-23 fiscal year. DHCS will add a line to allow counties to separately identify administrative costs incurred to implement CM on the MC5312. Counties shall implement mechanisms to separately track administrative costs incurred to implement CM and report these costs on the CM line of the MC5312.

iv. Reimbursement for Incentives

DHCS will contract with an Incentive Manager vendor, and will directly reimburse the vendor for incentives. DMC-ODS counties and providers will **not** bill DHCS for incentives disbursed.

n. Coordination Between Providers

i. Resolving Multiple Registrations

When it is determined that a beneficiary is actively receiving CM at one or more providers simultaneously, then all of the providers must confer to determine which provider will assume treatment responsibility for the individual. In the medical record, an inquiring program shall document the names of each program contacted, the date contacted, the time of the contact (if made by telephone), the name of program staff contacted, and the results of the contact. The provider that agrees to accept sole responsibility will provide CM services to the beneficiary. All other providers shall immediately cease providing CM services, discharge the beneficiary, and document in the medical record the reason for the discharge. Within 72 hours of the discharge the former providers must give the program assuming treatment responsibility written documentation of the discharge and send written notification to the DMC-ODS county(ies) with whom the providers are contracted of the circumstances involving the discharge. Within 72 hours of agreeing to accept sole responsibility for treatment, the provider that assumes sole responsibility must send written notification to the DMC-ODS county(ies) with whom the providers are contracted of the resolution. DMC-ODS counties must document and maintain records of duplicative CM service provision and make available such information to DHCS upon request.

ii. Inter-County Transfers

During the process of an inter-county transfer, in situations where the beneficiary resides in a participating DMC-ODS county but the County of Responsibility as recorded in the DHCS Medi-Cal Eligibility Determination System (MEDS) is another county, CM providers in the County of Residence will conduct the screening/assessment and admit the beneficiary for medically necessary services while the inter-county transfer process is underway to update the County of Responsibility field in MEDS. DMC-ODS counties and providers cannot delay admission or the provision of medically necessary DMC-ODS services, including CM services, to beneficiaries whose County of Residence is a DMC-ODS county participating in the Recovery Incentives Program on the basis of the

County of Responsibility being another county. As described in BHIN 21-032, the claim adjudication system for DMC-ODS and DMC services allows the county submitting the claim to be either the beneficiary's County of Residence or the beneficiary's County of Responsibility as recorded in MEDS. The County of Residence may submit claims and receive payment for DMC-ODS and DMC services so long as the inter-county transfer has been initiated by the beneficiary and all other applicable requirements set forth in BHIN 21-032 are met.

iii. Courtesy Services for Temporary Travel

In situations where a beneficiary receiving CM services from their DMC-ODS County of Responsibility temporarily travels to another DMC-ODS county that also participates in the Recovery Incentives Program, and the beneficiary is unable to attend scheduled CM service appointments during their travel, the DMC-ODS County of Responsibility must reimburse CM services that an out-of-county DMC-ODS provider participating in the Recovery Incentives Program delivers to the beneficiary. The DMC-ODS CM service provider in the County of Responsibility must provide a courtesy CM service order form to the out-of-county DMC-ODS CM service provider signed by the medical director or program physician. The order form must specify the beneficiary's last contact with the local CM coordinator, the number of weeks of participation in the protocol, interval of UDTs, and any other special instructions consistent with the guidelines for CM services issued within this BHIN.

o. Oversight, Monitoring, Fidelity Reviews, and Reporting

i. Oversight

DMC-ODS Counties participating in the Recovery Incentives Program are responsible for administering CM in accordance with DHCS policies and rules. DHCS expects participating DMC-ODS counties to oversee the CM benefit as part of their DMC-ODS oversight capabilities. Counties shall be responsible for overseeing each CM provider to ensure the quality and appropriateness of service delivery.

ii. Monitoring

An individual within the provider agency with responsibility for overseeing the use of organizational funds (e.g., chief financial officer or their designee) shall conduct a monthly audit of the incentive delivery functions including the software calculations and incentive distribution records of the organization. Each provider must develop and

implement a policy consistent with this requirement. Audit results must be made available to the county or DHCS upon request.

Participating counties will receive data from the Incentive Manager on a monthly basis that will include reports by provider and in aggregate regarding:

- Utilization of CM services.
- UDTs outcomes (i.e., positive and negative UDT results).
- Completion rates of CM.
- Total rewards.

Participating counties shall review these data elements on a monthly basis to monitor utilization of CM services. Counties shall meet with Recovery Incentives Program on a quarterly basis to review data. Counties will identify if CM providers would benefit from technical assistance to address issues regarding utilization or quality. Counties shall refer CM providers that may need technical assistance to the state's contracted trainer and technical advisor based on the counties' oversight efforts.

Participating counties shall report to DHCS oversight activities in quarterly progress reports. Such reporting shall include all of the following:

- Enrollment information to include the number of DMC-ODS beneficiaries served in the Recovery Incentives Program.
- Summary of operational or policy development issues, complaints, grievances, and appeals related to the Recovery Incentives Program.
- Enrollment information for new providers participating in the Recovery Incentives Program.

Participating counties shall be responsible for monitoring all CM providers to ensure compliance with state and federal law and contractual obligations. County monitoring processes shall comply with:

- State and federal law;
- Medicaid guidance including the CalAIM 1915b and 1115 Waivers and the Medicaid State Plan;
- CM protocol and other requirements as specified in this BHIN, and other relevant regulatory guidance documents including the DMC-ODS IA; and
- Provider contracts.

Monitoring activities shall include onsite visits, video meetings, and/or desk reviews. DHCS will provide an audit tool for counties to monitor providers that offer CM on an ongoing basis. DHCS will train counties in the use of the audit tools.

iii. Fidelity Reviews

Each provider will also be required to participate in fidelity reviews to determine adherence to the CM protocol. Fidelity reviews will be facilitated by the state's contracted trainer and technical advisor as part of ongoing training and technical assistance. Providers will participate in two fidelity reviews within the first 6 months of implementation of CM and then once every 6 months thereafter.

Fidelity reviews will include a cross-check of incentives delivered to beneficiaries with data in the incentive distribution database. The fidelity review shall also ensure that for each participating provider the total amounts paid for incentives provided match UDT results.

In coordination with the state's trainer and technical advisor, the county will participate in fidelity reviews to ensure the provision of CM consistent with the clinical protocols described in this guidance and ensure that client record reviews are conducted for each provider to evaluate assessment and treatment activities and confirm alignment between assessment information, ASAM criteria, level of care determinations and CM services provided. Providers will receive support from the county and the State's training and technical advisor to address any deficiencies. A corrective action plan may be implemented for issues identified during reviews and any follow up action identified in these plans will be monitored by the county.

The participation of DMC-ODS counties in the fidelity review process will support a potential future transition of fidelity reviews from the state's contracted trainer and technical advisor to the county.

iv. Reporting

1. Evaluation

Counties may be contacted by DHCS or its contractors to participate in surveys and interviews. Counties are required to submit CalOMS-Tx data from their providers according to normal reporting procedures. For more on CalOMS-Tx reporting, please see https://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx.

2. Quarterly Reporting

Counties shall also be responsible for complying with all state and federal reporting requirements related to this project.

3. DHCS Meetings

Counties shall participate in meetings with DHCS and the state's contracted trainer and technical advisor regarding CM implementation at a cadence to be determined by DHCS. These meetings will provide opportunities to discuss project progress, resolve implementation barriers and challenges, and ensure appropriate linkages and coordination with other projects supported by state funding.

4. Final Report

Counties shall submit a brief final report regarding the Recovery Incentives Program to DHCS no later than 60 days after the end of their agreements with DHCS. DHCS will provide more guidance on the Final Report. DHCS anticipates the Final Report will be incorporated into the Final Evaluation Report conducted by DHCS' contractor.

Please contact RecoveryIncentives@dhcs.ca.gov for any questions.

Sincerely,

Original signed by

Ivan Bhardwaj, Acting Chief
Medi-Cal Behavioral Health Division