DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: **XX, 2024** ~~August 18, 2023~~

Behavioral Health Information Notice No: **24-XXX** ~~23-040~~
Supersedes BHIN **23-040** ~~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: Updated Guidance for the Recovery Incentives Program: California's Contingency Management Benefit

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

REFERENCE: DHCS Contingency Management website

BACKGROUND:
California Advancing and Innovating Medi-Cal (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 of a Section 1115(a) Demonstration Waiver (No. 11-W-00193/9) 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; the Recovery Incentives Program only covers CM for StimUD. CM reinforces individual positive behavior change consistent with meeting treatment goals. DHCS ~~will~~ **piloted**

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 through the federally approved CalAIM Section 1115(a) Demonstration Waiver (No. 11-W-00193/9**)**. DHCS will extend **and expand** the ~~pilot~~ program period through at least the duration of the CalAIM 1115 demonstration period (ending December 31, 2026), **to allow any DMC-ODS county to provide CM services following completion and submission of an Implementation Plan to DHCS, and DHCS approval** ~~allowing approved DMC-ODS counties to continue services beyond the original pilot end date of March 2024. DHCS will provide forthcoming information regarding the potential expansion of CM to additional DMC-ODS counties~~.

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

POLICY:

a. Recovery Incentives Program Opt-In Process

DMC-ODS counties may elect to opt in to the Recovery Incentives Program and provide CM services at any time through the duration of the CalAIM 1115 demonstration period (ending December 31, 2026). DMC-ODS counties are required to complete and submit to DHCS an Implementation Plan. The Recovery Incentives Program Implementation Plan template shall be completed and submitted to DHCS for approval. For more information on the implementation process and to access the Implementation Plan template, please visit the Recovery Incentives Program webpage.

b. 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 **members** ~~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)**, such as cognitive behavioral therapy and motivational interviewing**.

c. ~~Beneficiary~~ Member Eligibility for CM Services

CM services are only available to Medi-Cal **members** ~~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) **requirements** showing (1) diagnosis of **any of the related *moderate or severe* cocaine or stimulant use disorder diagnoses, including diagnoses in remission**, as ~~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.

Medi-Cal members are eligible for the Recovery Incentives Program based on having any of the related *moderate or severe* cocaine or stimulant use disorder diagnoses, including diagnoses in remission. In all instances, there must be a determination of medical necessity (which includes establishment of impairment and a covered diagnosis) to qualify for admission to the Recovery Incentives Program, and the interventions offered must be determined to be consistent with the standard of care. ~~Beneficiaries~~ **Members** 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. ~~A system change~~

~~in Short Doyle is currently being developed to allow beneficiaries to receive CM services on the same date they receive Residential services, as long as it is the date of admission to, or discharge from, Residential services. This shall be effective for claims with dates of service on or after July 1, 2022.~~

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 **members** ~~beneficiaries~~ shall be referred to, and admitted into, treatment through a participating provider's routine ~~beneficiary~~ **member** 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 **members** ~~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~~ **Members** 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.

d. Assessment

Assessment consists of activities to evaluate or monitor the status of a **member's** ~~beneficiary's~~ behavioral health and determine the appropriate level of care and course of treatment for that **member** ~~beneficiary~~. Consistent with DMC-ODS policies described in **BHIN 24-001** ~~BHIN 23-001~~, ~~beneficiaries~~ **members** shall have an ASAM multidimensional assessment completed ~~within 30 days following the first visit with~~ **by** 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~~. **To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice**. The initial clinical assessment shall confirm: (1) The individual has a diagnosis of **any of the related moderate or severe cocaine or stimulant use disorder diagnoses, including diagnoses in remission, as defined in the DSM, current edition** ~~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.

e. Documentation

The provider shall document StimUD on the problem list (or treatment plan for Narcotic Treatment Providers, NTPs) within a **member's** ~~beneficiary's~~ medical record. Consistent with best clinical documentation practices, providers shall describe all interventions utilized with the **member** ~~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 **member** ~~beneficiary~~ as a standalone treatment, but rather as one component of an individualized ~~treatment plan~~ **plan of care**. However, if a **member** ~~beneficiary~~ chooses to participate only in selected services (e.g., they only participate in CM and not in other aspects of treatment), they shall **remain in outpatient treatment and 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~~ **Members** needing or utilizing CM shall 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~~ **the** Recovery Incentives Program.

SUD providers offering CM are responsible for providing or referring **members** ~~beneficiaries~~ to additional services for other non-StimUD SUDs indicated in their problem list. For example, if a **member** ~~beneficiary~~ has both a StimUD and a concurrent opioid use or alcohol use disorder, the SUD provider shall, in addition to providing CM, complete an assessment for MAT and provide the **member** ~~beneficiary~~ with MAT or refer the **member** ~~beneficiary~~ to another provider for MAT, as clinically appropriate.

Each CM visit shall be documented consistent with existing DHCS policy described in **BHIN 23-068** ~~BHIN 22-019~~.

f. ~~Beneficiary~~ Member Education/Orientation

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

- The days/times that a **member** ~~beneficiary~~ is required to 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 shall 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 **member** ~~beneficiary~~ lapses or relapses and seeks readmission and the process for a **member** ~~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 shall 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 shall be done for the purpose of safety, due to association with overdose deaths, but shall not impact the delivery of an incentive.
    - An explanation that all positive tests shall 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 shall be re-set to a lower value in the case of a positive test or unexcused absence, and that increases shall be reinstated after repeated negative UDTs. The maximum incentive a ~~beneficiary~~ **member** can receive per year in the Recovery Incentives Program is $599.

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

g. Treatment Framework

i. Incentives

~~Beneficiaries~~ **Members** shall receive incentives for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. Participating **members** ~~beneficiaries~~ shall 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 shall be based on the protocols in Section ~~f~~**g**.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 continue~~d~~ to rise in the United States ~~in 2021~~, surpassing 100,000 deaths **per year**. 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 **members** ~~beneficiaries~~ in the Recovery Incentives Program.

Recovery Incentives Programs shall:

- Establish and implement a protocol to prescribe naloxone to all **members** ~~beneficiaries~~ with an opioid, sedative and/or stimulant use disorder as outlined below.
- Establish and implement a naloxone distribution protocol for **members** ~~beneficiaries~~ who do not obtain prescription naloxone.
- Provide education to each CM **member** ~~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 programs distribute test strips for home use, based on information from the California Department of Public Health (see link). Please note that reimbursement for covered CM services in the Recovery Incentives Program does not include fentanyl test strips. In addition, reimbursement for covered CM services in the Recovery Incentives Program does not include **independent** urine testing to detect the presence of fentanyl in a specimen. DMC-ODS providers are not prohibited by DHCS from independently testing for fentanyl as part of urine drug testing. Please refer to the Frequently Asked Questions document **found on the Recovery Incentives Program webpage** for additional information regarding harm reduction safety strategies, **approved CLIA waived UDTs that test for fentanyl,** and reimbursable costs.
    - Specific education regarding the use of naloxone to reverse an opioid

overdose.

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

DMC-ODS providers are able to provide pharmacy-dispensed naloxone onsite to DMC-ODS **members** ~~beneficiaries~~ by leveraging the Medi-Cal pharmacy benefit. As a best practice overdose prevention measure, providers can prescribe naloxone to all DMC-ODS **members** ~~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 **members** ~~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 shall consist of two phases: (1) CM treatment and (2) CM continuing care.

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

Phase 2 begins when a **member** ~~beneficiary~~ completes the initial 24-weeks of CM treatment. The participating **member** ~~beneficiary~~ shall 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 **members** ~~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 **members** ~~beneficiaries~~ shall visit the treatment setting in person for two treatment visits per week. Visits shall be separated by at least **48 hours, and ideally** 72 hours (e.g., Monday and Thursday, or Tuesday and Friday) to minimize the chance that drug metabolites from the same drug use episode shall be detected in more than one UDT. Participating **members** ~~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 **member** ~~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 **member** ~~beneficiary~~ who consistently participates and has negative UDTs can receive during this initial 12-week period is $438.

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

A "recovery" of the pre-reset value shall occur after two consecutive stimulant-negative urine samples. At that time, the participating **member** ~~beneficiary~~ shall 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~~ **Members** shall 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 **member** ~~beneficiary~~ fails to achieve two consecutive stimulant- negative samples within the first 12-week period, the treatment provider and **member** ~~beneficiary~~ should decide whether CM is a clinically appropriate intervention for that **member** ~~beneficiary~~, and, if necessary, modify the course of treatment and update the **member's** ~~beneficiary's~~ problem list and progress notes.

3. CM Treatment Weeks 13-24: Stabilizing Period

During weeks 13–24, participating **members** ~~beneficiaries~~ shall visit the treatment setting for testing once a week. During weeks 13–18, participating **members** ~~beneficiaries~~ shall be eligible to receive $15 per stimulant-negative UDT. During weeks 19–23, they shall be eligible to earn $10 per stimulant-negative UDT, and if their sample is stimulant-negative on week 24, they shall earn $21. The maximum aggregate incentive a participating **member** ~~beneficiary~~ shall 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 **member** ~~beneficiary~~ in a scenario where the **member** ~~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**

h. 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 **member** ~~beneficiary~~ may be ready for discharge post 24 weeks, providers need to be aware of and expect lapse or relapse from **members** ~~beneficiaries~~ who are further along in the process and address such occurrences without judgement.

i. Extended Absence and Readmission Throughout CM Protocol

A **member** ~~beneficiary~~ shall be considered a readmission if they leave CM services for more than 30 days. At readmission, the **member** ~~beneficiary~~ shall 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~~**7**) and confirm ~~that~~ the **member** ~~beneficiary~~ meets the medical necessity criteria for CM. If the **member** ~~beneficiary~~ has remained engaged in other services, **such as residential treatment**, during their absence from CM, an update to the most recent ASAM assessment is sufficient, **and the member does not require a new diagnostic assessment**. 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 **member** ~~beneficiary~~, the **member** ~~beneficiary~~ may receive CM services and the incentive structure would restart at Week 1. If the **member** ~~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 **member** ~~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 **member** ~~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 **member** ~~beneficiary~~ would be automatically discharged; all other clinically appropriate treatment services and/or recovery supports should continue to be offered per the **member's** ~~beneficiary's~~ ~~treatment plan~~ **plan of care**.

In rare circumstances, following completion of the initial CM treatment phase of the program, a member may benefit from re-entering the CM treatment phase protocol instead of proceeding to CM continuing care services. Repeating the ASAM assessment and diagnostic assessment is not required for the member to

re-enter the CM treatment phase of the program. In these instances, the clinical documentation, completed (or reviewed) by a LPHA, must demonstrate that CM services are medically necessary and appropriate based on the standard of care.[1]

j. 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 **members** ~~beneficiaries~~ residing in DMC-ODS counties that **meet eligibility criteria** ~~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 24-001** ~~BHIN 23-001~~.

ii. CM Coordinator Requirements

At least one CM coordinator shall 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.[2]

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[1] **Re-entry to the CM treatment phase following completion of the initial CM treatment phase of the program should prompt providers to assess whether a higher level of care than outpatient services (i.e., ASAM Level 3.1 or above) is medically necessary.**

[2] 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. **DHCS is working to develop additional guidance to support use of this provider type.**

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

iv. CM Coordinator, Backup Coordinator, and Supervisor Training Requirements

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.

k. CM Visit Workflow

The CM coordinator shall facilitate visits with participating **members** ~~beneficiaries~~. The anticipated workflow for the first CM visit and subsequent visits is below.

i. Intake Visit

During a **member's** ~~beneficiary's~~ first visit, the CM coordinator shall complete several steps to initiate the service, specifically:

- Conduct eligibility check – The CM coordinator or other designated personnel at the provider agency shall confirm the **member's** ~~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 shall ask the **member** ~~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 **f** ~~e~~

above.

- Enroll the **member** ~~beneficiary~~ into the Incentive Manager program – The CM coordinator shall complete a **member** ~~beneficiary~~ profile to enroll them into the computerized system that shall keep track of incentive gift cards, hereinafter referred to as the Incentive Manager.

ii. CM Visits

- Engage the **member** ~~beneficiary~~ and initiate the visit – The CM coordinator shall greet the **member** ~~beneficiary~~, review their progress in the program (e.g., weeks completed out of 24), log into the Incentive Manager and locate the **member's** ~~beneficiary's~~ record/profile.
- Conduct eligibility check – The CM coordinator or other staff within a provider agency offering CM shall check **member** ~~beneficiary~~ Medi-Cal eligibility **at least** monthly or per provider policy **if more frequent**.
- Administer UDT – The CM coordinator shall administer the UDT, including processing the results of the UDT in real time.
- Log results in Incentive Manager – The CM coordinator shall log the results of the UDT for stimulants (i.e., positive or negative).
- Discuss results – The CM coordinator shall discuss the UDT results with the **member** ~~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 shall encourage the **member** ~~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 **member** ~~beneficiary~~ has naloxone, and offer other treatment services as appropriate, including MAT if the **member** ~~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 shall 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 shall not disburse an incentive.
- Plan for next appointment – The CM coordinator shall remind the **member** ~~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

I. Urine Drug Testing

During each visit, the CM coordinator shall collect a urine sample from the participating **member** ~~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 **member's** ~~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 **member** ~~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 **member** ~~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 shall be performed in accordance with the manufacturer's instructions for the test, and the CM provider shall 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 **members** ~~beneficiaries~~ to leave personal possessions (e.g., backpack, purse, items in pockets) in a secure location outside of the restroom; requiring **members** ~~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 shall be accompanied by reliability measures, including temperature, creatinine, and pH level.

DHCS has identified ~~four~~ **the** UDTs that meet program specifications, as listed **on the DHCS Recovery Incentives Program Approved UDTs page** ~~in Table 2.~~ All products listed meet 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.
- Please note that reimbursement for covered CM services in the Recovery Incentives Program does not include fentanyl test strips. In addition, reimbursement for covered CM services in the Recovery Incentives Program does not include **independent** urine testing to detect the presence of fentanyl in a specimen. DMC-ODS providers are not prohibited by DHCS from independently testing for fentanyl as part of urine drug testing. Please refer to the Frequently Asked Questions document for additional information regarding use of fentanyl test strips, **approved CLIA waived UDTs that test for fentanyl**, and reimbursable costs.

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 RecoveryIncentives@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)
- Information 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**https://www.lochnessmedical.com/Product/Urin**	General Inquiries: 1-888-506-2658 info@lochnessmedical.com Orders: orders@lochnessmedical.com

					e-Drug-Test-cups	

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**Premier Bio-Cup**	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/ Premier Bio-Cup - Rapid Urine Drug Testing Product - Premier Biotech	Product Questions: 888-686-9909 Laboratory Questions: 855-718-6917

m. Incentive Delivery

i. Overview

Upon learning the results of the UDT, the CM coordinator shall inform the **member** ~~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 **members** ~~beneficiaries~~ in the format of an e-mail, **text link**, **printed voucher** ~~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~~**g**.iii above. Upon each visit, the CM coordinator shall enter the results of the UDT into the Incentive Manager program, and the program shall report the appropriate incentive amount, per the protocol. A positive test for stimulants shall result in the participating **member** ~~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 **members** ~~beneficiaries~~, including the CM staff who conducted the visit, the format of the incentive provided to the **member** ~~beneficiary~~, the date the incentive was distributed, and the amount of the incentive.

Participating **members** ~~beneficiaries~~ shall receive incentives in a format approved by DHCS to which the Incentive Manager shall 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.

n. 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 are designed to reimburse the bundled costs of a single **member** ~~beneficiary~~ visit to a CM coordinator, billed in 15-minute increments, which include:

- CM coordinator time: pre-, during, and post-visit with the **member** ~~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 shall 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 the county should include "U7" on the claim **and any other** ~~in addition to the "HF" and if~~ applicable ~~the HA or HD~~ modifier**s**.

DHCS will initially finance the non-federal share of CM services with state funds that are available for a limited period of time as a result of the DHCS Home and Community-Based Spending Plan, which includes CM services. ~~DHCS must spend these funds by March 31, 2024.~~

If counties elect to continue participation in this optional benefit after the end of the DHCS Home and Community-Based Spending Plan, they shall be responsible for the non-federal share of CM services. Because of payment lag, counties shall submit claims and applicable certifications for CM services by **August** ~~February~~ 15, 2024, in order for DHCS to cover the non-federal share of these services. In effect this means that counties shall be responsible for the non-federal share of CM services for any claims submitted after **August** ~~February~~ 15, 2024. DHCS will extend the ~~pilot~~ **program** period through at least the duration of the CalAIM 1115 demonstration period (ending December 31, 2026), allowing approved DMC-ODS counties to continue services beyond the original pilot end date of March 2024.
Please refer to the DMC-ODS Billing Manual for general guidance about billing.[3]

[3] ~~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.~~

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 shall 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.~~
- ~~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 September 30, 2023. SAMHSA funds used for this project will be from Substance Abuse Prevention and Treatment Block Grant (SABG) funding. DHCS will distribute BHQIP funds 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 June 30, 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 shall submit quarterly invoices for reimbursement of all SABG-funded CM start-up costs and continue other existing SABG reporting requirements. Participating counties shall submit invoices and SABG reporting requirements to~~

~~BHRRP@dhcs.ca.gov as standalone Recovery Incentives Program invoices, separate from other SABG invoices and costs. As detailed in the SABG Policy Manual, counties shall submit monthly CalOMS-Tx data and report quarterly expenses on SABG invoices.~~

iii. ii. 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 initially be covered with state funds that were available for a limited period of time as a result of the DHCS Home and Community Based Spending Plan. If counties elect to continue participation in this optional benefit, they shall be responsible for covering the non-federal share of administrative costs after the close of the DHCS Home and Community-Based Spending Plan. Because of payment lag, and administrative claiming occurring on a quarterly basis, in effect, this means that counties shall be responsible for the non-federal share of CM administrative costs after June 30, 2024. The MC5312 for the period ending June 30, 2024, must be submitted to DHCS no later than August 15, 2024, for processing to receive state funds.** ~~For invoices submitted before February 15, 2024, the non-federal share of these administrative costs will be covered with State funds (rather than county funds). If counties elect to continue participation in this optional benefit, they shall be responsible for covering the non-federal share of administrative costs after the close of the DHCS Home and Community-Based Spending Plan, March 31, 2024. Because of payment lag, in effect this means that counties shall be responsible for the non-federal share of CM administrative costs included in any claims submitted after February 15, 2024.~~

~~DHCS is formulating a methodology to determine the county non-federal share of administrative costs, and additional guidance will be forthcoming. 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. iii. Reimbursement for Incentives

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

If counties elect to continue participation in this optional benefit, they shall be responsible for covering the non-federal share of incentives after the close of the DHCS Home and Community-Based Spending Plan **on August 15, 2024,** ~~March 31, 2024~~. In effect, this means that counties shall be responsible for the non-federal share of incentive payments included in any invoices submitted by the CM Incentive Manager ~~that DHCS is not able to pay by~~ **after August 15** ~~March 31~~, 2024.

~~DHCS is formulating a methodology to determine the county non-federal share of disbursed incentives, and additional guidance will be forthcoming~~. **Incentive Payment funding splits will be determined using Short-Doyle Medi-Cal payment rules to determine the correct funding. The county share of the Incentive Payment received by the member will be billed back to the county using a manual process.**

o. Coordination Between Providers

i. Resolving Multiple Registrations

When it is determined that a **member** ~~beneficiary~~ is actively receiving CM at one or more providers simultaneously, then all of the providers shall confer to determine which provider shall 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 shall provide CM services to the **member** ~~beneficiary~~. All other providers shall immediately cease providing CM services, discharge the **member** ~~beneficiary~~, and document in the medical record the reason for the discharge. Within 72 hours of the discharge the former providers shall 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 shall send written notification to the DMC-ODS county(ies) with whom the providers are contracted of the resolution. DMC-ODS counties shall 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 **member** ~~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 shall conduct the

screening/assessment and admit the **member** ~~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 **members** ~~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 **member's** ~~beneficiary~~'s County of Residence or the **member's** ~~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~~ **member** and all other applicable requirements set forth in BHIN 21-032 are met.

iii. Courtesy Services for Temporary Travel
iv.

In situations where a ~~beneficiary~~ **member** 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~~ **member** is unable to attend scheduled CM service appointments during their travel, the DMC-ODS County of Responsibility shall reimburse CM services that an out-of-county DMC-ODS provider participating in the Recovery Incentives Program delivers to the **member** ~~beneficiary~~. Prior to the ~~beneficiary~~ **member** traveling out of county, the CM Coordinator from their DMC-ODS County of Responsibility (Home CM Coordinator) shall identify and contact a participating Recovery Incentives Program provider located within the travel location's DMC-ODS County (Travel Recovery Incentives Program provider) to notify them of the ~~beneficiary's~~ **member's** travel plans and schedule an appointment for the **member** ~~beneficiary~~ based on their current UDT schedule. The Home CM coordinator shall also contact the incentive manager call center and provide them with the same information, so the call center can change the ~~beneficiary~~ **member's** service location within the incentive manager program during the **member's** ~~beneficiary's~~ temporary travel. Prior to the ~~beneficiary~~ **member** returning to their County of Responsibility, the CM Coordinator from the travel location's DMC-ODS County (Travel CM Coordinator) shall contact the County of Responsibility Recovery Incentives Program provider to notify them of the ~~beneficiary's~~ **member's** pending return and schedule an appointment for the ~~beneficiary~~ **member** based on their current UDT schedule. The Travel CM coordinator shall also contact the incentive manager call center and provide the information so the call center can change the ~~beneficiary~~ **member** service location within the incentive manager program, prior to the ~~beneficiary~~ **member** returning to their

County of Responsibility**.**

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

Participating counties shall receive data from the Incentive Manager on a **quarterly** ~~monthly~~ basis that shall 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 the Recovery Incentives Program on a quarterly basis to review data.~~ Counties shall 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'~~ **county's** oversight efforts.

Participating counties shall report to DHCS oversight **and monitoring** activities in quarterly progress reports. **Following the successful launch of CM services, each participating county shall complete a Quarterly Progress Report (QPR) for a total of four consecutive quarters and submit each report to DHCS. As part of the QPR, each county must utilize the Incentive Manager (IM) to obtain their county's IM County Report. The IM County Report provides program information unique to**

each county needed to complete the QPR. A copy of the county's IM County Report shall be attached with the QPR submission. ~~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.~~ **DHCS will provide counties with a reporting template. Each QPR with IM County Report shall be submitted to DHCS at RecoveryIncentives@dhcs.ca.gov no later than 30 days following the end of each quarter, as defined below. Should any of the above dates fall on a weekend day or holiday, reports shall be submitted at the conclusion of the following business day.**

Quarters:

- **Quarter 1 (July 1 through September 30)**
- **Quarter 2 (October 1 through December 31)**
- **Quarter 3 (January 1 through March 31)**
- **Quarter 4 (April 1 through June 30)**

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

Fidelity reviews shall include a cross-check of incentives delivered to **members** ~~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 shall 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 shall 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 shall be monitored by the county.

The participation of DMC-ODS counties in the fidelity review process shall 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 **program** ~~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,

Ivan Bhardwaj, Chief
Medi-Cal Behavioral Health - Policy Division