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The Recovery Incentives Program: California's Contingency Management Benefit

Frequently Asked Questions (FAQs)

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This document includes DHCS' responses to frequently asked questions from DMC-ODS county representatives and provider sites that intend to participate in the Recovery Incentives Program and offer contingency management (CM) services. Find additional information about the Recovery Incentives Program on the [DHCS website](#), and submit additional questions to countysupport@dhcs.ca.gov.

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County & Provider Participation in the Recovery Incentives Program

1) What is the expected launch date of the Recovery Incentives Program?

DHCS is working closely with counties and participating provider sites to prepare for implementation of the Recovery Incentives Program. Participating counties and providers will receive start-up funding, comprehensive training and ongoing technical assistance to support their implementation of the program.

All counties approved to participate in the Recovery Incentives Program will be expected to begin offering contingency management (CM) services in late 2022 - early 2023. DHCS will share additional updates about the Recovery Incentives Program timeline on [the DHCS website](#).

2) Will DHCS be drafting a new Recovery Incentives Program contract for participating Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, or will this be part of an existing contract?

DHCS will be drafting a new amendment for counties participating in the Recovery Incentives Program that will be appended to their existing DMC-ODS Intergovernmental Agreements. DHCS anticipates that contract amendments will be processed in late 2022 or early 2023.

3) Are all provider sites required to begin offering CM services on the Recovery Incentives Program start date?

Providers will not be required to begin offering CM on the county's start date. Each county's participating provider sites will be phased in based on their readiness to offer CM services as verified by DHCS' training and technical assistance contractor.

4) Can a county drop out of the Recovery Incentives Program?

Once a county signs its contract amendment to join the Recovery Incentives Program, the county is obligated to continue the pilot with at least one provider site through November 30, 2023. However, DHCS does not have the authority to require individual providers to offer CM services.

5) What provider types are eligible to offer CM services? Can non-DMC-ODS providers participate in the Recovery Incentives Program?

DMC-ODS providers offering outpatient, intensive outpatient and/or partial hospitalization services, and NTPs are eligible to offer CM. Non-DMC-ODS providers are not eligible to participate in the Recovery Incentives Program.

6) Is there a minimum number of providers that participating counties need to contract with to offer CM?

There is no minimum number of provider sites a participating county must contract with to offer CM. DHCS recognizes that some counties, particularly smaller counties, will have a limited provider network for CM services.

7) Can counties identify additional providers to participate in the Recovery Incentives Program that are not included in the county's program application? Do new providers need to be approved by DHCS?

Yes, a county may add providers to the Recovery Incentives Program. All providers will need to participate in training and pass a readiness review before offering CM services. Counties should alert UCLA when adding a provider so UCLA can include the provider in

their outreach. Please email gucortez@mednet.ucla.edu when adding a provider. New providers do not need to be approved by DHCS.

8) Will DHCS allow counties the local authority to impose financial sanctions on contracted providers to ensure compliance with Recovery Incentives Program requirements?

Counties must administer the Recovery Incentives Program in compliance with DMC-ODS policies. Recoupment should only be performed in the case of fraud, waste or abuse, in which case the county shall notify DHCS before taking action. If a county learns that a CM provider site is deviating from state-mandated protocols, counties must require the provider to follow the protocols, and may use enforcement tools such as corrective action plans, increasing the intensity of technical assistance through the county or the DHCS-contracted technical assistance providers and notifying DHCS.

9) What training and technical assistance is available for participating counties and providers?

All participating counties and provider sites will receive training and ongoing technical assistance to support implementation of the Recovery Incentives Program that is coordinated by the UCLA Training and Implementation team. Required training includes an asynchronous CM Overview training (released in May 2022) and a comprehensive live virtual Implementation training (to be released in Summer – Fall 2022). Providers will also receive a Provider Training Manual that details the program protocols.

10) Do participating providers need to participate in ongoing fidelity reviews?

Yes, as part of the technical assistance offered by the UCLA Training and Implementation team, participating provider sites will participate in periodic fidelity reviews to determine adherence to the required protocol. Fidelity monitoring will occur twice within the first 6 months of implementation and then once every 6 months thereafter. At a future point, fidelity monitoring responsibilities will transition from the UCLA Training and Implementation team to the participating DMC-ODS County.

11) Does county participation in the Recovery Incentives Program contribute to a Performance Improvement Project (PIP) as required for DMC-ODS and EQR?

Yes, county participation in the Recovery Incentives Program can contribute to a PIP.

12) If the Recovery Incentives Program is successful, will CM become an ongoing DMC-ODS benefit?

Pending budget and statutory authority, DHCS intends to use the pilot period of the Recovery Incentives Program to learn about how CM services can be scaled across the state. If successful, the pilot will serve as a basis for the Administration to consider expansion of the pilot into a statewide benefit.

13) Are participating providers required to update DMC certification to participate in the Recovery Incentives Program?

No. All providers that bill the Short-Doyle Medi-Cal system must be certified to provide DMC services. For the Recovery Incentives Program, Short-Doyle will verify that the provider location is DMC-certified for an outpatient level of care (NTP, ODF, IOT, or Partial Hospitalization). There is not specific CM certification in the provider database.

14) Where can counties and providers learn more about the Recovery Incentives Program design?

Additional information about California's contingency management program is available in the [Contingency Management Policy Paper](#), which is available to download from the DHCS website. DHCS will also issue a forthcoming Behavioral Health Information Notice (BHIN) that formalizes the program policies and protocols.

Beneficiary Eligibility for the Recovery Incentives Program

15) Are CM services restricted to adults ages 18+?

There is no age restriction for CM services. Medi-Cal beneficiaries, including adolescents, who meet eligibility criteria will be able to participate in the Recovery Incentives Program. Minors under age 12 are eligible to participate with parental consent. Minors ages 12-20 who participate in the Minor Consent program do not need parental consent to participate in the Recovery Incentives Program.

16) Can beneficiaries who reside in counties that participate in the DMC-ODS Regional Model receive CM services from any county in the region?

To be eligible to participate in the Recovery Incentives Program, beneficiaries must reside in a participating DMC-ODS county. Shasta County is the only county in the DMC-ODS Regional Model Partnership that is participating in the Recovery Incentives Program.

17) Do providers need to verify beneficiary Medi-Cal eligibility before initiating CM services?

Yes, providers must verify Medi-Cal eligibility to initiate CM services and to use the incentive manager system. There can be no assumption of eligibility for beneficiaries and there is no alternative funding source for the Recovery Incentives Program if Medi-Cal eligibility is not verified.

18) Can DMC-ODS counties who participate in the Recovery Incentives Program contract with a provider who practices in a bordering county?

Yes, a DMC-ODS county participating in the Recovery Incentives Program can contract with a DMC-certified provider in a bordering county. The beneficiary's DMC-ODS county of responsibility would be required to authorize CM services delivered by the contracted provider.¹ All provider sites must be approved by DHCS during the readiness review period prior to offering CM services.

19) Will providers receive a standardized consent form for beneficiaries who choose to enroll in the Recovery Incentives Program?

Yes, DHCS and the UCLA Training and Implementation Team will provide a consent form template to participating provider sites as part of the training and technical assistance process.

20) Can a beneficiary enroll in CM prior to their admission to an outpatient program?

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 they are transitioned to an outpatient DMC-ODS provider that has been approved to offer CM. While the Recovery Incentives Program will not be offered in residential or institutional treatment settings

¹ For more information regarding DMC-ODS county of responsibility and county of residence, please refer to [BHIN 21-032](#).

(including jails or prisons) in accordance with Centers for Medicare and Medicaid (CMS) approval, DHCS intends work closely with those providers to encourage referrals and engagement during transitions from residential levels of care and post-release from jails and prisons. Medi-Cal beneficiaries can receive CM during the day of discharge from residential, inpatient, or correctional settings. Find additional details in the forthcoming Recovery Incentives Program Behavioral Health Information Notice (BHIN).

21) Will providers need to stop enrolling beneficiaries in the Recovery Incentives Program 24 weeks prior to the pilot period end date of March 31, 2024?

At this time, DHCS advises providers to end beneficiary enrollment into the Recovery Incentives Program by December 1, 2023. DHCS will release additional guidance on deadlines for beneficiary enrollment at a later date. Pending budget and statutory authority, DHCS intends to use the pilot period as a basis for informing the design and implementation of a statewide CM benefit, which would allow uninterrupted services after March 2024.

Recovery Incentives Program Treatment Protocol

22) Do beneficiaries need to test negative for stimulants in advance of starting CM treatment?

No, beneficiaries do not need to test negative (or positive) for stimulants in advance of starting CM treatment; however, they will not be eligible to receive an incentive until submitting a negative urine drug test (UDT).

23) If a beneficiary is already enrolled in SUD treatment, do they need to be re-screened for medical necessity in advance of starting CM treatment?

If a beneficiary already has a diagnosis of stimulant use disorder (StimUD) of moderate or severe from the Diagnostic and Statistical Manual for Substance-Related and Addictive Disorders, they do not need to be re-screened for medical necessity. Initiation of CM services will require a revised treatment plan, and the DMC-ODS IA states that a reassessment will occur when function changes; standard practice is at least every 12 months.

24) How long is CM treatment?

California's Recovery Incentives Program is a 24-week outpatient treatment, followed by six or more months of aftercare and recovery support services. During the initial 12 weeks of the Recovery Incentives Program protocol, participants will be asked to visit the treatment setting in person for a minimum of two treatment visits per week. These sessions will be separated by at least 72 hours (e.g., Monday and Thursday/Friday, or Tuesday and Friday) to help ensure that drug metabolites from the same drug use episode will not be detected in more than one UDT. During weeks 13–24, participants will be asked to visit the treatment setting for testing once a week. Participants will be able to earn incentives during each visit throughout the treatment protocol.

25) Does a beneficiary move from twice-a-week tests to once-a-week tests after 12 weeks, regardless of the results?

Yes, all beneficiaries will visit the treatment settings twice per week during the initial 12 weeks of CM treatment, followed by one visit per week during weeks 13 – 24 of CM treatment, regardless of UDT results. 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. 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 and the incentive structure would restart at Week 1. 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.

Staffing

26) What is the Recovery Incentives staffing model?

Each participating provider must have at least one CM coordinator. The CM coordinator(s) will be the main point of contact for all participating beneficiaries and will be responsible for collecting UDT samples, inputting test results, and supporting the delivery of incentives. In addition, each provider must also designate a backup CM coordinator and a CM supervisor. Additional information about these roles and responsibilities are available in the CM provider training manual provided by the UCLA Training and Implementation team.

27) Is the CM coordinator a full or part-time position?

Providers participating in the Recovery Incentives Program will be required to have a designated CM coordinator who will lead the tracking and delivery of all CM services, including administering and interpreting UDT results and distributing incentives based on the algorithm developed by the incentive manager vendor. The CM coordinator must also participate in ongoing technical assistance and implementation sessions. DHCS recommends that providers hire a part-time or full-time staff member that exclusively supports the delivery of CM. However, DHCS recognizes that this is not always possible, and some counties and providers may need to designate existing staff to serve as the CM coordinator on a part-time basis, in addition to other job functions. CM coordinators who split responsibilities across CM and other job functions will be required to conduct the same CM activities as those who are dedicated to CM.

28) Can the CM coordinator be a county staff member billing under county outpatient SUD site, but the associated ASAM Outpatient and IOT services would be available via a provider?

CM services may be offered by a county-contracted or county-operated Recovery Incentives Program provider that offers outpatient, intensive outpatient, NTPs and/or partial hospitalization services. Beneficiaries must be offered CM services in coordination with other DMC-ODS services, including individual and/or group counseling and recovery services. Counties may offer services through multiple providers, as long as each provider has completed a readiness review and been approved by DHCS.

29) What is the expected caseload of a full-time CM coordinator?

There is no minimum caseload requirement for a CM coordinator. 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.

30) How will the CM coordinator position be funded?

The CM coordinator position will be funded through the provision of billable CM services throughout the pilot. In addition, sites may use start-up funding to cover a portion of

personnel costs (e.g., the salary of the CM coordinator before care begins). Find additional details about allowable uses of start-up funding in the [Start-Up Funding](#) section below.

31) What should I do if a CM coordinator is no longer available midway through the program?

The UCLA Training and Implementation team will provide ongoing technical assistance to participating counties and provider sites throughout the course of the Recovery Incentives Program, and will be available to assist providers on a case-by-case basis.

Reimbursement for CM Services

32) How are CM coordinator services claimed, and how are providers reimbursed?

DMC-ODS Counties offering CM services shall submit claims to Short-Doyle Medi-Cal (SD/MC) adjudication system using HCPCS code H0050, with the modifier HF on the claim 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 UDT cups and testing strips

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

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

33) Do claims submitted using H0050 require a Level of Care (LOC) modifier?

Yes, all DMC-ODS claims submitted to SD/MC require a LOC modifier. 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 site is an 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.

34) Do claims submitted using H0050 require population modifiers (e.g., for pregnant women)?

Yes, the “HD” (Pregnant/parenting women’s program) modifier and/or the “HA” (youth) modifier is required on CM claims when applicable.

35) If a beneficiary has other health coverage in addition to Medi-Cal, do providers need to bill their other insurer for CM services before billing Medi-Cal?

Given the unique nature of the CM services covered as part of the Recovery Incentives Program, providers will be able to directly bill Medi-Cal for CM services, without first billing Medicare for CM services provided to dually eligible beneficiaries. However, due to third-party liability requirements, private insurance must be billed prior to billing Medicaid to ensure Medicaid is the payer of last resort. The Short-Doyle Medi-Cal claiming system is being adjusted to accept claims for CM services that are submitted to Medi-Cal even if the beneficiary is dually eligible for Medicare.

36) Can a beneficiary’s CM diagnosis code (R82.998 or Z71.51) be their secondary diagnosis code, or must it be a primary diagnosis code? If a CM diagnosis code must be a primary diagnosis, will DHCS add these codes to the acceptable list of billable diagnoses under DMC-ODS?

As of September 7, 2021, the Short-Doyle Medi-Cal claims system has been updated to no longer deny outpatient DMC claims that do not use an included diagnosis code. Diagnosis codes for outpatient claims are now monitored outside of the Short-Doyle system. For CM, diagnosis codes can be entered as either primary or secondary diagnosis codes.

37) How will the interim rate process work?

While DHCS has provided a recommended interim rate range for counties for this new service, as with other DMC-ODS services, counties have the authority to determine rates for CM coordinator services.

- DHCS created a recommended interim rate range for DHCS payment to counties of \$35.83 to \$39.42 per 15-minute unit of service.
- The interim rates include expected staffing costs, indirect overhead, expected productivity, and costs of the UDTs and other supplies.
- The Short-Doyle Medi-Cal claims system will be coded to cap the rate at the maximum rate of \$39.42, unless the county submits a different interim rate.
- Counties may choose to submit a higher interim rate to DHCS, using the standard process, if they choose. The higher rate will be reconciled at the end of the fiscal year, using the standard cost reconciliation reports.

38) How will county administrative costs be covered?

DHCS will allow counties to invoice for allowable DMC-ODS plan administrative costs described in the application related to the administration of the Recovery Incentives Program. The non-federal share of these administrative costs will be covered with pilot funds (rather than county funds). DHCS will audit to those allowable costs during the cost reconciliation process after the close of the fiscal year. In other words, health plan administrative costs for CM services will be reimbursed in the same manner as other plan administration costs included in DMC-ODS intergovernmental agreements. DHCS intends to add a line to allow counties to separately identify administrative costs incurred to implement the Recovery Incentives Program on the MC5312. Counties will need to implement mechanisms to separately track administrative costs incurred implementing CM services, and to report these costs on the CM line of the MC5312.

39) Will DHCS reimburse costs above the 15% administrative cap?

The percentage spent by counties on allowable administration costs is determined retroactively, after the close of the fiscal year. Therefore, DHCS cannot compare claimed administrative costs against the cap until the cost reconciliation process is complete, after the close of the fiscal year. Since this information will not become available until future budget years, DHCS cannot guarantee that administrative costs above the 15% administrative cap will be reimbursable; it will depend on available funds in the CM budget.

40) How does reimbursement work for incentives disbursed to beneficiaries?

DHCS will contract with an incentive management vendor, and will directly reimburse the vendor for disbursed incentives.

Start-Up Funding

41) How much funding is available to support provider start-up costs?

DHCS has reserved up to \$5.64M to distribute to participating counties for start-up costs for fiscal year 2021-22, comprised of \$3.64M from Behavioral Health Quality Improvement Program (BHQIP) funding for start-up activities and an additional \$2M in SAMHSA block grant funding (Substance Abuse Prevention and Treatment Block Grant (SABG) funding). DHCS has also reserved \$3M for fiscal year 2022-23 to distribute to counties for start-up costs.

42) What are allowable uses of the provider start-up costs?

DHCS recognizes that providers will incur significant start-up costs due to the need to hire, orient, and train the CM coordinator before that coordinator can begin seeing beneficiaries and billing for services. Allowable 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 beneficiary engagement activities)
- Changes to provider information and billing systems
- Technology costs: hardware or software
- Other supplies needed to carry out CM services, such as UDT cups
- Capital improvement costs needed to carry out the Recovery Incentives Program (BHQIP funding only; see below)
- Outreach among Medi-Cal beneficiaries

43) Will all providers seeking to offer contingency management receive start-up funding?

DHCS will distribute start-up funding to counties, proportioned based on historical DMC-ODS spending. Counties may retain a maximum of 15% of BHQIP funds for administrative costs; the remainder must be distributed to providers to cover start-up funding. For SABG funds, counties must follow State and Federal laws and policies pertaining to allowable costs, including those outlined in [BHIN 20-020](#) pertaining to indirect costs.

44) What is the timeline for DHCS' disbursement of start-up funding for providers?

DHCS distributed fiscal year 2021-22 BHQIP funding to participating counties in May 2022. Each participating county will also receive an allocation of reimbursable SAMHSA funds to cover provider start-up costs. 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. DHCS will release specific SABG invoicing and reporting guidance for start-up costs in September 2022.

Fiscal year 2022-23 BHQIP funding to participating counties before the fiscal year end. Counties will be notified prior to these distributions of both amounts and timeline.

45) Are there any restrictions on the uses of start-up funding?

Consistent with specific restrictions as set forth in 45 CFR 96.135, SABG funding cannot be used:

- To provide inpatient hospital services
- To make cash payments to intended recipients of health services
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment

- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds
- To provide financial assistance to any entity other than a public or nonprofit private entity
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year
- To purchase treatment services in penal or correctional institutions.

46) Do counties need to return any unused start-up funding to DHCS?

Yes, counties must return any unused BHQIP funding following the March 31, 2023 reporting deadline. Counties must submit quarterly invoices for reimbursement of all SABG-funded CM start-up costs, and will not receive funding for costs that are not invoiced.

47) What is the deadline for expending start-up funds?

SABG funding must be spent by December 31, 2022. BHQIP funding must be reported on by March 31, 2023.

48) Can start-up funds be used for system-wide training, outside of the Recovery Incentives Program?

No, start-up funding may only be used for expenses related to the Recovery Incentives Program. Allowable uses of start-up funds are listed in Q. 45.

49) Will allowable administrative costs be based on actual costs or start-up funding allocations?

Allowable administrative costs will be based on actual program spending for both BHQIP and SABG funding.

50) What pre-implementation requirements will providers receiving start-up funding need to meet?

In advance of offering CM services, providers participating in the Recovery Incentives Program must meet the following pre-implementation requirements. Requirements include:

- Having a signed contract or contract amendment with a DMC-ODS county to offer CM services (other than Indian Health Care Providers delivering CM to American Indian/Alaska Native beneficiaries, which are exempt from the contract requirement)
- Attending all required pre-implementation trainings
- Completing readiness review

51) What post-implementation requirements will providers receiving start-up funding need to meet?

Post-implementation requirements must be met within the first year of offering CM services. Requirements include:

- Meeting required reporting requirements
- Attending required technical assistance sessions
- Passing preliminary fidelity review

52) Should counties report on BHQIP start-up funds in the same BHQIP reporting template as other CalAIM activities?

Counties are required to submit a separate and distinct narrative report to DHCS documenting BHQIP funds used for the Recovery Incentives Program no later than March 31, 2023. Reports should be submitted to BHQIP@dhcs.ca.gov. Each report should identify the following:

Name of provider	Amount distributed	Date distributed	Date CM contract/contract amendment signed	Date provider completed readiness review*	Confirmation that the provider completed required trainings (yes/no)*

*Providers may receive funding in advance of completing the trainings and readiness review, as long as they are willing to return the funding to the county if they do not complete these deliverables and withdraw from the program. If the provider does not complete the trainings nor readiness review within four months of program launch, the start-up funds must be returned to the county.

53) When is the earliest date a county can invoice for SABG start-up costs (including both direct and indirect administrative costs)?

Costs must be invoiced to DHCS when they were incurred specifically for the Recovery Incentives Program, and no sooner than May 2022.

Provider Outreach

54) Are CM providers allowed to conduct outreach to help potential beneficiaries learn about the Recovery Incentives Program?

Yes, CM providers can conduct outreach related to the Recovery Incentives Program. Outreach can increase the likelihood that eligible beneficiaries will learn about CM services, which may in turn increase the likelihood that they will initiate and adhere to a treatment program for their StimUD. Provider communications about the Recovery Incentives Program (and any other health care service) should not be inaccurate, misleading, or coercive. See Q. 58 for best practices when communicating about the Recovery Incentives Program.

55) Will providers face risk under federal law if they offer or communicate about the Recovery Incentives Program?

No; in general, federal law restricts providers' ability to offer financial incentives as part of beneficiary therapy or beneficiary recruitment. However, the federal government has explicitly stated that the federal Anti-Kickback Statute (AKS) and the Civil Monetary Penalties Law (CMP) do not apply to motivational incentives that are delivered as part of the Medicaid CM benefit so long as the incentives are provided in compliance with the CMS-approved CalAIM Section 1115 Demonstration waiver and the DHCS-approved Recovery Incentives Program protocol. Thus, providers may promote this benefit as they would any other benefit under DMC-ODS. However, DHCS strongly suggests that providers do so in accordance with the guidelines and best practices discussed in Q. 57 and 58.

56) If a provider offers CM services under DMC-ODS, does that mean the provider can also offer other types of beneficiary incentives without legal risk?

No, the AKS and CMP do not apply to the Recovery Incentives Program. However, the AKS and CMP apply to any other beneficiary incentives offered by providers that are not authorized in CalAIM Section 1115 Demonstration Waiver.

57) Are there any limits on how providers can communicate the availability of motivational incentives under the Recovery Incentives Program?

Yes; over the years, the U.S. Department of Health & Human Services Office of Inspector General (OIG) has cautioned providers about various problematic communications activities that may violate the AKS or the CMP. The OIG's guidelines apply to the promotion of all health care services. For example, depending on the circumstances, it may create legal risk if a provider were to do any of the following:

- Offer motivational incentives to beneficiaries who do not qualify for the Recovery Incentives Program.
- Communicate about the Recovery Incentives Program in a manner that is inaccurate, misleading, or coercive (see below for examples of permissible outreach language).
- Offer financial incentives to Medi-Cal beneficiaries over and above the motivational incentives available in the Recovery Incentives Program.
- Pay for outreach or beneficiary recruitment services on a commission basis, or in a manner that otherwise takes into account the volume or value of business generated.
- Offer financial incentives to other health care providers in exchange for telling beneficiaries about, or referring beneficiaries for, CM and related SUD services.

58) What are some best practices for communicating about the Recovery Incentives Program?

When communicating about the Recovery Incentives Program with current beneficiaries, potential beneficiaries, or the general public, providers should avoid any statements that are inaccurate, misleading, or coercive. See below for a list of DOs and DON'Ts, which apply to general CM outreach materials as well as conversations with current or potential beneficiaries.

DO	DON'T
Clarify that the Recovery Incentives Program is available to individuals who meet certain eligibility criteria, such as having a qualifying StimUD, enrolling in Medi-Cal, and residing in a participating county.	Use language that could mislead ineligible people into believing that they will qualify for incentives.
Explain that the Recovery Incentives Program is intended to support treatment goals over time, such as substance non-use and treatment adherence.	Suggest that a beneficiary will receive an incentive just for showing up.
Accurately describe the nature and potential value of the motivational incentives (e.g., “up to \$599,” “gift cards to use at retail and grocery stores”).	Overstate the potential value of the incentives (e.g., “almost \$1,000!”), or state that incentives will be made in cash.
Ensure beneficiaries understand that participation in the Recovery Incentives Program is optional.	Suggest that a beneficiary must enroll in the Recovery Incentives Program in order to receive other health care services.
Let potential beneficiaries know that incentives are conditioned on undergoing a medical assessment and taking regular drug tests, in accordance with DHCS’ Recovery Incentives Program protocol.	Suggest that incentives are conditioned on beneficiaries receiving services beyond those required under DHCS’ Recovery Incentives Program protocol.
Emphasize that CM is a new and exciting service under DMC-ODS to support people with StimUD.	Suggest that CM services are unique to a particular provider, or that one provider’s CM services are better than another’s.

59) What is an example of permissible outreach language?

Providers have the flexibility to craft their own outreach messages as long as all communications are not inaccurate, misleading, or coercive, as described above. See below for one example of messaging that follows the best practices laid out in this FAQ:

Do you struggle with meth, cocaine, or other stimulants?

You may qualify for up to \$599 in payments to help you stay off stimulants.* This treatment program is open to people who:

- Live in [participating county/counties]
- Are eligible for Medi-Cal
- Have a medical screening to make sure they’re a good fit
- Agree to regular drug testing

To learn more, contact us at [contact info].

*Recovery Incentives Program providers must provide incentives in the form of gift cards. Beneficiaries are prohibited from using CM incentives to purchase cannabis, tobacco, alcohol, or lottery tickets.

Urine Drug Tests (UDTs)

60) What type of UDTs will be used by providers participating in the Recovery Incentives Program?

DHCS has identified UDTs that meet program specifications, as listed in the forthcoming program Behavioral Health Information Notice (BHIN). All participating providers will be required to use a test that has been approved by DHCS.

61) Will positive UDTs require confirmation testing by an external lab?

DHCS has identified specific UDTs that meet program specifications and are approved for use in the Recovery Incentives Program, as listed in the forthcoming program Behavioral Health Information Notice (BHIN). All participating providers will be required to use a UDT that has been approved by DHCS and must not use a UDT that has not been approved by DHCS for use in the Recovery Incentives Program.

62) Do providers need to hold a Clinical Laboratory Improvement Amendments (CLIA) waived test certification to participate in the Recovery Incentives Program?

Yes, providers need to hold a 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 CDPH, has [an online application](#) process through which providers can apply for both the CLIA waiver and the state registration. DHCS will schedule trainings in partnership with CDPH for those sites that are not familiar with CLIA requirements.

63) Do providers need to identify a laboratory director to receive a CLIA waived test certification?

Yes, providers need to identify a waived lab director to receive a CLIA waived test certification. The requirements for a waived lab director are outlined in [Business and Professions Code section 1209\(a\)](#). If a provider site does not have access to a licensed physician or surgeon or other qualified individual to serve as a laboratory director, please reach out to your county representative for further guidance.

64) Will DHCS provide and pay for UDTs?

Provider sites must use their usual processes to purchase and administer UDTs as part of the Recovery Incentives Program. The costs of purchasing UDTs and other supplies are included in the CM reimbursement rate. Find additional details about reimbursement for CM services in the [Reimbursement](#) section above.

Incentive Payments

65) When will DHCS select an incentive manager vendor?

Inadvertent issues in the initial procurement of an incentive manager vendor have resulted in DHCS cancelling the initial procurement and initiating a new procurement. DHCS released [Request for Proposal #22-20180](#) in August 2022 and proposals are due to DHCS on September 15, 2022. DHCS will communicate new information as it is available.

66) Can a beneficiary receive an incentive if they test positive for other drugs?

If a beneficiary tests negative for stimulants, they are eligible to receive an incentive during that visit. The presence of opioids or other drugs shall not be an indication to terminate the beneficiary from CM treatment but rather shall be an indication the beneficiary may need additional treatment, either concurrently or subsequently. If a beneficiary tests positive for

another drug, the provider should provide the beneficiary with information about treatment services for that drug according to their specific needs.

67) Will each provider be able to select the type of gift cards that are distributed to beneficiaries?

No, provider sites will not select the type of gift cards that are distributed to beneficiaries. The calculation and disbursement of incentives will be conducted exclusively by the incentive manager vendor in a format approved by DHCS.

68) Will providers be required to securely store incentives on-site?

No, provider sites will not be required to store physical incentives that are distributed to beneficiaries. DHCS anticipates the incentive manager vendor will be responsible for storing incentives, which will be disbursed electronically or as a printed gift card or voucher.

69) Will incentives be adjusted for cost of living differences in across counties/regions?

In accordance with the CMS approval of the CM benefit, DHCS will pilot a standardized CM protocol, including incentive amounts, for all DMC-ODS counties and providers participating in the Recovery Incentives Program.