

CM is an evidence-based, cost-effective treatment for substance use disorders (SUDs); the Recovery Incentives Program only covers CM for StimUD. CM reinforces individual positive behavior change consistent with meeting treatment goals. DHCS 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 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.

This BHIN provides state 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 SUD treatment services and other evidence-based practices for StimUD already offered by DMC-ODS providers. Eligible Medi-Cal members 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, 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, community reinforcement, and motivational interviewing.

c. Member Eligibility for CM Services

CM services are only available to Medi-Cal members 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 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.

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.

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

Eligible Medi-Cal members shall be referred to, and admitted into, treatment through a participating provider's routine 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 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.

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 behavioral health and determine the appropriate level of care and course of treatment for that member. Consistent with DMC-ODS policies described in [BHIN 24-001](#), members shall have an ASAM multidimensional assessment completed by a Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor that indicates the member can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.5). 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; (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 medical record.

Consistent with best clinical documentation practices, providers shall describe all interventions utilized with the member 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 as a standalone treatment, but rather as one component of an individualized plan of care. However, if a member 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. 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 the Recovery Incentives Program.

SUD providers offering CM are responsible for providing or referring members to additional services for other non-StimUD SUDs indicated in their problem list. For example, if a member 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 with MAT or refer the member to another provider for MAT, as clinically appropriate. DHCS' MAT policy, applicable to all DMC-ODS providers, is also described within [BHIN 23-054](#).

Each CM visit shall be documented consistent with existing DHCS policy described in [BHIN 23-068](#).

f. Member Education/Orientation

Before beginning CM treatment, a Medi-Cal member 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 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 lapses or relapses and seeks readmission and the process for a member 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 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

Members shall receive incentives for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. Participating members 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 g.iii. of this BHIN.

ii. Harm Reduction

Harm reduction is an essential component of any treatment program. A high number of overdose deaths are due to the synthetic opioid fentanyl and other illicit substances, which have been mixed in or added 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 in the Recovery Incentives Program.

Recovery Incentives Programs shall:

- Establish and implement a protocol to prescribe FDA-approved Opioid Overdose Reversal Medications¹ (e.g., Naloxone, Nalmefene) to all members with an opioid, sedative and/or stimulant use disorder as outlined below.
- Establish and implement an opioid overdose reversal medication distribution protocol for members who do not obtain a prescription for an opioid overdose reversal medication.
- Provide education to each CM member regarding:
 - The risks associated with fentanyl and its presence in the illicit drug supply.
 - Harm reduction safety strategies, such as the use of drug test strips (e.g., fentanyl, xylazine) and harm reduction programs which distribute test strips for home use, based on information from the California Department of Public Health Overdose [Prevention Initiative webpage](#). Please note that reimbursement for covered CM services in the Recovery Incentives Program does not include drug 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 for additional information regarding harm reduction safety strategies, approved CLIA waived UDTs that test for fentanyl, and reimbursable costs.

¹ [AB 2760](#) (Wood, Chapter 324) was signed into law in 2018 and becomes effective on January 1, 2019. This bill requires prescribers to offer a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to a patient when certain conditions, which are specified in the bill, are present. This bill also requires a prescriber, consistent with the existing standard of care, to provide education to a patient and their designee, or if the patient is a minor, to the patient's parent or guardian, on overdose prevention and the use of naloxone or other similar drug approved by the FDA.

- Specific education regarding the use of opioid overdose reversal medication.

Providers shall either replace the opioid overdose reversal medication whenever a member needs an additional dose, due to the opioid overdose reversal medication expiring or due to use in the community or remind a member to obtain a new dose through a pharmacy or local organization.

DMC-ODS providers can provide pharmacy-dispensed opioid overdose reversal medication onsite to members by leveraging the Medi-Cal pharmacy benefit. As a best practice overdose prevention measure, providers can prescribe opioid overdose reversal medication to all members who are participating in the Recovery Incentives Program and arrange for staff to routinely fill these opioid overdose reversal medication prescriptions at a pharmacy on behalf of members. The community pharmacy would bill these opioid overdose reversal medication prescriptions to the Medi-Cal pharmacy benefit. Pharmacists can also directly dispense naloxone and bill to Medi-Cal. The staff could bring the dispensed opioid overdose reversal medication back to the provider site for furnishing directly to patients. This method would enable the CM provider to better facilitate onsite access to opioid overdose reversal medication 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 completes the initial 24-weeks of CM treatment. The participating member 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 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 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 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 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 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 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 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. 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 fails to achieve two consecutive stimulant- negative samples within the first 12-week period, the treatment provider and member should decide whether CM is a clinically appropriate intervention for that member, and, if necessary, modify the course of treatment and update the member’s problem list and progress notes.

3. CM Treatment Weeks 13-24: Stabilizing Period

During weeks 13–24, participating members shall visit the treatment setting for testing once a week. During weeks 13–18, participating members 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 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 in a scenario where the member 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 SUD is a process of change, not an endpoint. As such, despite the fact that week's 13-24 are designed to be a stabilizing period, and that a member may be ready for discharge post 24 weeks, providers need to be aware of and expect lapse or relapse from members who are further along in the process and address such occurrences without judgement.

i. Extended Absence and Readmission Throughout CM Protocol

A member shall be considered a readmission if they leave CM services for more than 30 days. At readmission, the member shall have a new ASAM multidimensional assessment that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.7) and confirm the member meets the medical necessity criteria for CM. If the member 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, the member may receive CM services and the incentive structure would restart at Week 1. If the member 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 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 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 would be automatically discharged; all other clinically appropriate treatment services and/or recovery supports should continue to be offered per the member's plan of care.

In rare circumstances, following completion of the 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. The documentation must clarify that outpatient treatment continues to be appropriate for the member and include the provider's reasoning for resuming CM services. In this scenario, the member still may not exceed the \$599 annual limit for earned incentives, and once that limit is reached the member would no longer be eligible for the Recovery Incentives Program and should be transitioned to continuing care services.²

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 residing in DMC-ODS counties that meet eligibility criteria 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](#).

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:

- 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.

² 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.

- Certified Peer Support Specialists.
- Other trained staff under supervision of an LPHA.³

iii. CM Coordinator Responsibilities

The CM coordinator(s) shall be the main point of contact for all members 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. The anticipated workflow for the first CM visit and subsequent visits is below.

i. Intake Visit

During a member'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 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 for Medi-Cal.
- Program participation consent – The CM coordinator shall ask the member to complete a consent authorizing services and the secure sharing of data with

³ 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.

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 above.
- Enroll the member into the Incentive Manager program – The CM coordinator shall complete a member 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 and initiate the visit – The CM coordinator shall greet the member, review their progress in the program (e.g., weeks completed out of 24), log into the Incentive Manager and locate the member’s record/profile.
- Conduct eligibility check – The CM coordinator or other staff within a provider agency offering CM shall check member 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 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 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 has opioid overdose reversal medication, and offer other treatment services as appropriate, including MAT if the member 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 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. 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. There are CLIA-waived urine drug tests that include fentanyl-specific testing approved for use in the program. The tests for opiates, oxycodone, and/or fentanyl, even if positive, shall not impact the member'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 tests positive for opioids. In addition, the CM coordinator shall discuss the risks associated with fentanyl; harm reduction safety strategies, including the use of drug test strips, and ensure the member has access to opioid overdose reversal medication 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 CDPH, 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 to leave personal possessions (e.g., backpack, purse, items in pockets) in a secure location outside of the restroom; requiring members 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 the UDTs that meet program specifications, as listed on the DHCS Recovery Incentives Program [Approved UDTs page](#). 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 drug 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 drug test strips, approved CLIA waived UDTs that test for fentanyl, and reimbursable costs.

If a site would like to request an existing UDT product be evaluated 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.

m. Incentive Delivery

i. Overview

Upon learning the results of the UDT, the CM coordinator shall inform the member, 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 in the format of an e-mail, text link, printed voucher, 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 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 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, including the CM staff who conducted the visit, the format of the incentive provided to the member, the date the incentive was distributed, and the amount of the incentive.

Participating members 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 visit to a CM coordinator, billed in 15-minute increments, which include:

- CM coordinator time: pre-, during, and post-visit with the member
- 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 modifiers.

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.

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 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 15, 2024. DHCS will extend the 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 [MedCCC Library](#) for general guidance about billing.

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.

Counties shall implement mechanisms to separately track administrative costs incurred to implement CM and report these costs on the CM line of the MC5312.

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. 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 after August 15, 2024.

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 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. All other providers shall immediately cease providing CM services, discharge the member, 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 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 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 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 24-008](#), the claim adjudication system for DMC-ODS and DMC services allows the county submitting the claim to be either the member's County of Residence or the member'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 member and all other applicable requirements set forth in BHIN 24-008 are met.

iii. Courtesy Services for Temporary Travel

In situations where a 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 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. Prior to the 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 member's travel plans and schedule an appointment for the member 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 member's service location within the incentive manager program during the member's temporary travel. Prior to the 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 member's pending return and schedule an appointment for the 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 member service location within the incentive manager program, prior to the 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 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 to monitor utilization of CM services. 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 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.

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 an optional audit tool for counties to monitor providers that offer CM on an ongoing basis.

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 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.

3. DHCS Meetings

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

4. Final Report

Counties shall submit a brief final report regarding the Recovery Incentives Program to DHCS no later than 60 days after the end of their agreements with DHCS. DHCS will provide more guidance on the Final Report. DHCS anticipates the Final Report will be incorporated into the Final Evaluation Report conducted by DHCS' contractor. Please, contact RecoveryIncentives@dhcs.ca.gov for any questions.

Sincerely,

Original signed by,

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