MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Rita Subhedar

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

MDHHS is launching the Recovery Incentives (RI) Pilot to provide contingency management (CM), an evidence-based treatment for individuals living with either stimulant use disorder (StimUD), opioid use disorder (OUD), or both. CM reinforces individuals' positive behavior change by adhering to treatment goals, including abstinence and engagement in treatment, through the provision of motivational incentives. The pilot will run from October 1, 2024-September 30, 2026, and eight PIHPs will be participating. This pilot was included in the Section 1115 BH/SUD waiver renewal application and may be eligible for FMAP once approved by CMS. The RI Pilot will also be funded in part by the opioid settlement funds. The State of Michigan will receive hundreds of millions of dollars through settlements with manufacturers and distributors of opioids over the next 18 years, and these funds will be used to support programs such as the RI Pilot that address the harms of the overdose crisis.

Reason for policy (problem being addressed):

Stimulant use is increasing in Michigan at an alarming rate. In 2021, 30 percent of overdose deaths showed the presence of cocaine, and 17 percent indicated the presence of other psychostimulants, like methamphetamine. (https://www.michigan.gov/opioids/category-data) Unlike other substance use disorders, there are no medications to treat StimUD and no medications to reverse the effects of an overdose. CM is the leading evidence-based treatment for StimUD, and is often used to treat OUD as well, with several recent studies demonstrating increased abstinence from illicit opioid use at the end of treatment (https://doi.org/10.1371/journal.pone.0234809). Starting October 1, 2024, beneficiaries with these diagnoses will be able to receive CM treatment from participating providers in select PIHPs.

Budget implication:

☐ budget neutral
☒ will cost MDHHS $ 6.4 million, and is budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

Yes - because this pilot is supported by opioid settlement funds in addition to FMAP, this pilot is a joint initiative with the Office of the Chief Medical Executive, which is managing the distribution of opioid settlement funds, and BPHASA. Katie Abraham is a policy advisor who works in the Office of the Chief Medical Executive and is an advisor on the pilot.

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Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☒ Yes ☐ No If yes, Submission Date: **2/28/24**

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2427-BH	**Date:** July 16, 2024

Comments Due: August 20, 2024
Proposed Effective Date: October 1, 2024
Direct Comments To: Rita Subhedar
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Policy Subject: Recovery Incentives (RI) Pilot

Affected Programs: Medicaid, Healthy Michigan Plan, Maternity Outpatient Medical Services (MOMS), MIChild

Distribution: All Providers

Summary: This policy announces a new pilot treatment for certain types of substance use disorder.

Purpose: MDHHS will be piloting a new treatment for stimulant use disorder and opioid use disorder called contingency management, where participants receive incentives for positive behaviors, such as abstinence and engagement in treatment.

Cost Implications: This pilot will be funded through opioid settlement funding and federal matching funds. State general funds will not be used to fund the pilot. (Approximately $6.4 million in opioid settlement funds will be used.)

Potential Hearings & Appeal Issues: None

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☒ **No** ☐ **Submitted date:** February 28, 2024

Tribal Notification: Yes ☒ **No** ☐ **- Date:** February 5, 2024

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: All Providers

Issued: August 30, 2024 (Proposed)

Subject: Recovery Incentives (RI) Pilot

Effective: October 1, 2024 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan (HMP), Maternity Outpatient Medical Services (MOMS), MIChild

I. General Information

The Michigan Department of Health and Human Services (MDHHS) is launching the Recovery Incentives (RI) Pilot to provide contingency management (CM) for beneficiaries living with 1) a stimulant use disorder (StimUD), 2) an opioid use disorder (OUD), or 3) both.

CM is an evidence-based treatment that reinforces individual positive behavior change consistent with meeting treatment goals, including abstinence and engagement in treatment, through the provision of motivational incentives. These motivational incentives are small rewards that participating beneficiaries receive when they demonstrate adherence to their treatment goals through negative drug screenings and engagement in treatment. The incentives are a central element of CM, consistent with research that suggests providing people with immediate positive reinforcement for not using substances to which they are addicted may help return the reward pathways in their brain to a pre-addiction state. CM can improve outcomes by supporting beneficiaries in meeting treatment goals and making behavior changes that drive recovery.

MDHHS intends to provide CM services on a pilot basis under the authority of the §1115 Behavioral Health Demonstration. The pilot will end on September 30, 2026, at which point MDHHS will determine whether to expand the program as a statewide benefit. Participation in the Pilot is voluntary, and enrolled beneficiaries may opt-out at any time.

The primary goals of the RI Pilot are to improve health outcomes for beneficiaries living with either StimUD OUD, or both. These goals include:

- Increasing engagement and retention in treatment
- Reducing the number of emergency department (ED) visits
- Reducing the rate of repeated ED visits

- Reducing adverse health outcomes (e.g., deaths, non-fatal overdoses)

The purpose of this bulletin is to establish the policies and operational requirements that will be used by Prepaid Inpatient Health Plans (PIHPs) and providers to implement the RI Pilot.

II. CM Service Overview

Eligible beneficiaries who opt-in to the RI Pilot will participate in a structured 24-week outpatient CM service followed by at least six months of aftercare and recovery support services. The initial 12 weeks of CM consists of a series of incentives for meeting certain treatment goals, specifically abstinence from stimulants or opioids, objectively verified by negative urine drug tests (UDTs) and engagement in CM services. The incentives will be provided in the form of a gift card or debit card, consistent with evidence-based research, and will be distributed via an Incentive Manager (IM) platform. Providers delivering CM will also use the IM platform to enter beneficiary information pertaining to each CM visit.

The RI Pilot is intended to complement SUD treatment services and other evidence-based practices for StimUD and/or OUD, such as cognitive behavioral therapy (CBT), motivational interviewing (MI), and MOUD.

III. Participating PIHPs

PIHPs will serve as the central point of contact for MDHHS and will organize networks of qualified providers to deliver CM services to eligible beneficiaries. PIHP participation in the RI Pilot is optional. PIHPs demonstrated their interest in the RI Pilot by applying to MDHHS' Request for Application (RFA) in January 2024. All PIHPs that applied to participate in the pilot and met the criteria for participation were approved. The list of PIHPs participating in the RI Pilot are as follows:

- NorthCare Network, Region 1
- Southwest Michigan Behavioral Health, Region 4
- Mid-State Health Network, Region 5
- Community Mental Health Partnership of Southeast Michigan, Region 6
- Detroit Wayne Integrated Health Network, Region 7
- Oakland Community Health Network, Region 8
- Macomb County Community Mental Health, Region 9
- Region 10 PIHP, Region 10

PIHPs will be responsible for the administrative oversight, coordination, and provision of CM services via their provider networks.

IV. Beneficiary Eligibility

CM services are only available to beneficiaries who meet the following criteria:

1. Reside in a region served by a participating PIHP, OR
   If the beneficiary is American Indian/Alaska Native (AI/AN), is served by a participating Tribal Health Center (THC) or Tribal Federally Qualified Health Center (Tribal FQHC); AND
2. Diagnosed with a qualifying StimUD and/or OUD, or both, as determined through an assessment conducted by a SUD provider.

Eligible beneficiaries will be referred to the RI Pilot by their clinical provider. There is no minimum age limit for a beneficiary to receive CM services if they meet all eligibility criteria; however, beneficiaries will be subject to existing laws governing minor consent and restrictions on certain provider types in providing behavioral health services to minors. Beneficiaries must not be enrolled in another CM program for StimUD and/or OUD while participating in the RI Pilot. Beneficiaries who are receiving care in residential treatment [e.g., American Society of Addiction Medicine (ASAM) levels 3.1–4.0] or other institutional settings are ineligible to participate in the RI Pilot until they are discharged into an outpatient level of care.

V. Provider Roles and Responsibilities

A. Provider Eligibility and Requirements

SUD providers offering outpatient, intensive outpatient, and/or partial hospitalization services who are licensed and certified to provide services in participating PIHP regions will be eligible to participate in the RI Pilot. This includes Narcotic Treatment Programs (NTPs), Opioid Health Home (OHH) providers, and Certified Community-Based Behavioral Health Clinics (CCBHCs) in participating PIHP regions. The following SUD providers will be eligible to administer CM:

- SUD Treatment Professional, including:
  - Certified Addiction Treatment Professional
  - Certified Alcohol and Drug Counselor (CADC)
  - Certified Advanced Alcohol and Drug Counselor (CAADC)
  - Certified Clinical Supervisor (CCS)
  - Any other provider who, working within their scope of practice, is licensed or certified to render behavioral and counseling services
- Peer Recovery Coach
- Clinical Nurse Specialist
- Registered Nurse
- Practical Nurse
- Physician Assistant
- Physician
- Pharmacist
- Certified Nurse Midwife
- Nurse Practitioner

All facilities that are implementing the RI Pilot will be required to obtain at minimum a current Clinical Laboratory Improvement Amendments (CLIA) waiver prior to implementation.

i. Staffing Expectations

All participating provider sites must designate an RI Supervisor to oversee the administration of CM services at the provider site, an RI Coordinator to administer CM services, and at least one designated Alternate RI Coordinator to ensure continuity of treatment when the RI Coordinator is unavailable. All of these individuals must complete all required trainings as well as participate and pass the readiness review prior to initiation of CM services.

ii. RI Supervisor Responsibilities

The RI Supervisor will be fully trained in the principles of CM and the logistics of onsite implementation. The RI Supervisor will be able to administer all aspects of CM directly to beneficiaries if needed, and will perform fidelity checks for staff involved in providing CM. The RI Supervisor will also play an important role in setting policies and procedures at the site-level and managing office logistics such as determining hours for appointments, locations for testing, technology needs, and scheduling staffing. The RI Supervisor will also be a resource to the RI Coordinator if there are questions or concerns about a beneficiary interaction.

iii. RI Coordinator Responsibilities

The RI Coordinator(s) will be the main point of contact for all beneficiaries participating in the RI Pilot and will be responsible for conducting UDTs, inputting test results, supporting the delivery of incentives, and referring beneficiaries to additional services and supports, as needed. These tasks can be delegated to unlicensed/certified support staff only when the RI Coordinator is physically present and providing direct supervision. During the CM service visit, the RI Coordinator will discuss the results of the UDT with the beneficiary and offer other services as appropriate, including encouragement, motivational interviewing, and education.

RI Coordinators are expected to carry out the following tasks in the delivery of CM:

- **Eligibility Verification:** Verify Medicaid/HMP eligibility of beneficiaries participating in the RI Pilot at least weekly.
- **Participant Consent.** Obtain consent from beneficiaries prior to enrollment in the RI Pilot.
- **Assessment and Treatment Documentation:** Screen and assess beneficiaries consistent with program requirements; maintain treatment records and document CM visits.
- **Service Delivery:** Ensure availability of a dedicated RI Coordinator to oversee delivery of CM to participating beneficiaries.

- **Reporting:** Provide data to MDHHS to support monitoring and evaluation of the pilot, as needed.
- **Readiness and Fidelity Reviews:** Providers shall participate in and demonstrate readiness to perform with fidelity to the Pilot policies and rules.

VI. Urine Drug Testing (UDT)

During each visit, the RI Coordinator will collect a UDT from the participating beneficiary. The RI Coordinator shall test the sample for stimulants or opioids based on the condition being treated by the CM service. Each UDT must be performed in accordance with the manufacturer's instructions for the test.

RI Coordinators shall use appropriate precautions to avoid tampering with UDT specimens.

Each UDT used for the purposes of the RI Pilot must meet the following parameters:

- Cut-offs for Amphetamine, Cocaine, Methamphetamine, Opiate, and Oxycodone within established parameters.
- 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;
  - 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 beneficiary if the test is performed incorrectly.

For all participating beneficiaries who are receiving both buprenorphine and CM services for the treatment of OUD, RI Coordinators should use UDTs that have the ability to detect buprenorphine so as to avoid a false positive. See Attachment 1 of this policy for a sample list of UDTs that can test for both buprenorphine and other opiates.

Many UDTs have the ability to test for multiple substances; however, for the purposes of the RI Pilot, only the presence of stimulants or opioids will be considered. The presence of other substances may be useful to guide clinical practice and other treatment recommendations and will not have a negative impact on incentives earned by the beneficiary.

VII. Incentives

Participating beneficiaries will receive incentives for negative UDTs and engagement in CM services. They will be able to receive a maximum of $599 in total incentives per calendar year for successful participation in the treatment protocol.

If a beneficiary discontinues participation during the 24-week treatment period, that beneficiary may be eligible for readmission to the Pilot if determined to meet eligibility criteria by a provider. The provider offering CM does not have to be the same provider who initially provided CM during the beneficiary's prior Pilot participation.

The total amount of incentives a beneficiary can receive remains capped at $599 per calendar year, even if a beneficiary exits and re-enters the Pilot multiple times in a calendar year. For example, if a beneficiary exits the RI Pilot after completing approximately 2 months of CM visits and received $244 in incentives prior to exiting and then elects to re-enter the RI Pilot after 60 days post exit, they would only be eligible to receive up to $355.

A. Incentive Delivery

Upon learning the results of the UDT, the RI Coordinator must inform the beneficiary of the results and enter the results into the secure IM platform. The IM platform follows an algorithm for determining the size of the incentive payment, as determined by MDHHS, and as outlined in the Incentive Schedule section of this policy. The incentive amount shall be delivered immediately to participating beneficiaries in the format of a gift card or debit card. RI Coordinators do not have discretion in determining the value or distribution of incentives.

B. Incentive Calculations

The IM platform will automatically calculate the appropriate incentive amount based on the UDT results with adjustments for the escalating value, reset, and recovery features as described below. Upon each visit, the RI Coordinator enters the results of the UDT into the IM platform, and the IM platform will then report the appropriate incentive amount, per the protocol. The IM platform will then track all information relative to incentives awarded to participating beneficiaries, including the RI Pilot staff who conducted the visit, the format of the incentive provided to the beneficiary, the date the incentive was distributed, and the amount of the incentive.

C. Incentive Schedule

The RI Pilot will consist of a 24-week treatment period that is divided into two phases:

- Weeks 1–12 are the escalation/reset/recovery period with two CM visits per week.
- Weeks 13–24 are the maintenance period with one CM visit per week.

Participating beneficiaries will receive full incentives for meeting their treatment goals by providing negative UDTs for stimulants or opioids, as applicable. To address treatment retention with beneficiaries who struggle with non-use early in treatment, beneficiaries will receive partial incentives for continuing to engage in treatment even when they have a positive test.

Incentives will increase each week a beneficiary does not use stimulants or opioids, as applicable. When a beneficiary's test shows that they used a stimulant or opioid or when the beneficiary has an unexcused absence, incentives will reset to a lower amount. Once the beneficiary's UDT shows a negative result, incentives will increase.

The total value of the incentives that a beneficiary can receive through their participation in the Pilot is $599 per calendar year. Participating beneficiaries shall receive incentives in the form of a gift card or debit card. Restrictions will be placed on the incentives so they cannot be used to purchase cannabis, tobacco, or alcohol. Table 1 below provides an example incentive schedule.

Table 1: Hypothetical Assumptions for Incentive Schedule

Week	Assumptions	Value ($)
1-12	Base Incentive for Negative UDT	$10.00
	Base Incentive for Positive UDT w/ Continued Engagement	$5.00
	Weekly Increase to Incentive for Continuously Negative UDTs	$1.50
13-18	Incentive for Weekly Negative UDT	$15.00
19-23	Incentive for Weekly Negative UDT	$10.00
24	Incentive for Final Negative UDT	$21.00

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

During the initial 12 weeks of CM services, participating beneficiaries will visit the treatment setting in person for two visits per week. Visits will be separated by at least 72 hours to minimize the chance that drug metabolites from the same drug use episode will be detected through at least one of the UDTs. Participating beneficiaries can earn incentives during each visit that the UDT indicates they have a negative sample for stimulants or opioids.

The initial incentive value is $10 for the first sample negative UDT in a series. An **"escalation"** occurs when the participating beneficiary demonstrates non-use of stimulants or opioids over the course of two or more weeks (i.e., two or more consecutive negative UDTs). When this occurs, the value of the incentive is increased by $1.50 each week the UDT is negative. The maximum aggregate incentive a participating beneficiary who consistently participates and has negative UDTs can receive during this initial 12-week period is $438. To recognize continued engagement in treatment, beneficiaries who provide a positive UDT will be provided with a reduced incentive amount of $5.00. Incentives received for positive UDTs with continued engagement will be set at a maximum of 4 times per beneficiary.

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

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

2. Treatment Weeks 13-24: Stabilizing Period

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

Recovery from any SUD is a process of change that requires individuals to work towards improving their overall health and wellness. As such, weeks 13-24 of the RI Pilot are intended to be a stabilizing period in which RI Pilot providers continue to support beneficiaries as they work towards their recovery and prepare for discharge post 24 weeks.

Upon conclusion of the 24-week outpatient treatment experience, providers will be required to offer beneficiaries six months of additional recovery support services. Beneficiaries are not obligated to accept the offer of additional recovery support services.

a. Hypothetical Example: Incentive Delivery Schedule for Consistent Abstinence from Stimulants or Opioids

Table 2 illustrates an incentive delivery schedule for a participating beneficiary in a scenario in which the beneficiary has a consistent attendance record and submits UDTs that are stimulant- or opioid-negative (as applicable, based on their treatment plan) during each visit over the 24-week period.

Example Scenario: Ms. A. enrolled in the RI Pilot and submitted UDTs that were negative for opioids/stimulants for the entire duration of treatment.

Table 2: Hypothetical Incentive Delivery Schedule for Consistent Abstinence					
Week	**Visit**	**UDT Result**	**Incentive Earned (For Visit)**	**Incentive Earned (Cumulative)**	**Notes**
1	1	Neg	$10.00	$10.00	
	2	Neg	$10.00	$20.00	
2	3	Neg	$11.50	$31.50	
	4	Neg	$11.50	$43.00	
3	5	Neg	$13.00	$56.00	
	6	Neg	$13.00	$69.00	
4	7	Neg	$14.50	$83.50	
	8	Neg	$14.50	$98.00	
5	9	Neg	$16.00	$114.00	
	10	Neg	$16.00	$130.00	
6	11	Neg	$17.50	$147.50	
	12	Neg	$17.50	$165.00	
7	13	Neg	$19.00	$184.00	
	14	Neg	$19.00	$203.00	
8	15	Neg	$20.50	$223.50	
	16	Neg	$20.50	$244.00	
9	17	Neg	$22.00	$266.00	
	18	Neg	$22.00	$288.00	N/A
10	19	Neg	$23.50	$311.50	
	20	Neg	$23.50	$335.00	
11	21	Neg	$25.00	$360.00	
	22	Neg	$25.00	$385.00	
12	23	Neg	$26.50	$411.50	
	24	Neg	$26.50	$438.00	
13	25	Neg	$15.00	$453.00	
14	26	Neg	$15.00	$468.00	
15	27	Neg	$15.00	$483.00	
16	28	Neg	$15.00	$498.00	
17	29	Neg	$15.00	$513.00	
18	30	Neg	$15.00	$528.00	
19	31	Neg	$10.00	$538.00	
20	32	Neg	$10.00	$548.00	
21	33	Neg	$10.00	$558.00	
22	34	Neg	$10.00	$568.00	
23	35	Neg	$10.00	$578.00	
24	36	Neg	$21.00	$599.00	**Total possible incentive amount**

b. Hypothetical Example: Incentive Delivery Schedule with Positive UDTs and Absences

Table 3 illustrates an incentive delivery schedule for a participating beneficiary in a scenario in which the beneficiary has some instances of unexcused absences and some instances of UDTs that are positive for stimulants or opioids (as applicable, based on their treatment plan).

Scenario: Ms. C. enrolled in the RI Pilot and submitted two UDTs each week that were negative for opioids for the first three weeks (or first 6 visits). On the 7th and 8th visits, Ms. C. tested positive for opioids/stimulants. From the 9th through the 12th visits, Ms. C. tested negative again but missed the 13th and 14th visit without notice; these visits were counted as unexcused absences. On the 15th visit, after coaching and additional support from her care team, Ms. C. tested negative and continued to test negative through the end of treatment.

Table 3: Hypothetical Incentive Delivery Schedule with Positive UDTs and Absences

Week	Visit	UDT Result	Incentive Earned (For Visit)	Incentive Earned (Cumulative)	Notes
1	1	Neg	$10.00	$10.00	
	2	Neg	$10.00	$20.00	
2	3	Neg	$11.50	$31.50	
	4	Neg	$11.50	$43.00	
3	5	Neg	$13.00	$56.00	
	6	Neg	$13.00	$69.00	
4	7	Pos	**$5.00**	$74.00	Reset
	8	Pos	**$5.00**	$79.00	
5	9	Neg	$10.00	$89.00	Post-Reset Negative UDT #1
	10	Neg	$10.00	$99.00	Post-Reset Negative UDT #2
6	11	Neg	$13.00	$112.00	Earned amount (pre-reset) fully recovered
	12	Neg	$13.00	$125.00	
7	13	Miss	**$-**	$125.00	Reset
	14	Miss	**$-**	$125.00	
8	15	Neg	$10.00	$135.00	Post-Unexcused Absence Negative UDT #1
	16	Neg	$10.00	$145.00	Post-Unexcused Absence Negative UDT #2

Table 3: Hypothetical Incentive Delivery Schedule with Positive UDTs and Absences					
Week	**Visit**	**UDT Result**	**Incentive Earned (For Visit)**	**Incentive Earned (Cumulative)**	**Notes**
9	17	Neg	$13.00	$158.00	Earned amount (pre-reset) fully recovered
	18	Neg	$13.00	$171.00	
10	19	Neg	$14.50	$185.50	
	20	Neg	$14.50	$200.00	
11	21	Neg	$16.00	$216.00	
	22	Neg	$16.00	$232.00	
12	23	Neg	$17.50	$249.50	
	24	Neg	$17.50	$267.00	
13	25	Neg	$15.00	$282.00	
14	26	Neg	$15.00	$297.00	
15	27	Neg	$15.00	$312.00	
16	28	Neg	$15.00	$327.00	
17	29	Neg	$15.00	$342.00	
18	30	Neg	$15.00	$357.00	
19	31	Neg	$10.00	$ 367.00	
20	32	Neg	$10.00	$377.00	
21	33	Neg	$10.00	$387.00	
22	34	Neg	$10.00	$397.00	
23	35	Neg	$10.00	$407.00	
24	36	Neg	$21.00	$428.00	**Total incentive amount**

D. Extended Absence and Readmission Throughout RI Pilot

A beneficiary will be considered a readmission if they leave the RI Pilot for more than 30 days. To be readmitted to the RI Pilot, the beneficiary must have a new ASAM multidimensional assessment that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.5) and confirm that the beneficiary meets the medical necessity criteria for CM. If the assessment determines that CM is clinically appropriate, the beneficiary can reenter the RI Pilot. If the assessment determines that CM is not the appropriate clinical treatment, providers may offer other treatments as alternatives.

If the beneficiary resumes CM services, they would restart the incentive schedule at Week 1, and the total amount of incentives received remains up to a maximum of $599 per calendar year inclusive of all incentives earned in previous RI Pilot participation.

VIII. Billing and Reimbursement

A. Beneficiaries in PIHPs

The RI Coordinator shall complete claims documentation to bill the PIHP for the CM visit. The RI Coordinator will bill in 15-minute units for Healthcare Common Procedure Coding System (HCPCS) code H0047. The designated HCPCS code and corresponding reimbursement rate are designed to bundle costs associated with the CM visit, including:

- RI Coordinator time
- Supervision
- Cost of UDT

Each claim shall include a diagnosis code of either StimUD (F14-15) and/or OUD (F11), reflecting the beneficiary's diagnosis being treated with CM.

In addition, each claim for CM services shall include a diagnosis specific to the UDT test result using one of the two ICD-10 diagnosis codes to indicate if the UDT is positive or negative:

- R82.998: Diagnosis for positive UDT
- Z71.51: Diagnosis for negative UDT

Claims may be denied if the two required diagnosis codes (i.e., beneficiary diagnosis and UDT result) are not included. Providers will bill and be reimbursed by PIHPs. PIHPs will subsequently be reimbursed by MDHHS for these claims on a quarterly basis.

B. American Indians and Alaska Native Beneficiaries

THCs and Tribal FQHCs that offer CM to AI/AN beneficiaries who are not in a PIHP will be reimbursed for CM services outside of the All-Inclusive Rate methodology. These providers can submit claims for CM through the Community Health Automated Medicaid Processing System (CHAMPS) and will be reimbursed on a fee-for-service (FFS) basis.

To submit FFS claims for RI through CHAMPS, the RI Coordinator must enroll in CHAMPS as an Atypical Individual Provider with the specialty "Tribal Health Center – Recovery Incentives Coordinator." Providers who are already enrolled in CHAMPS will need to complete an additional typical enrollment with this new specialty. For instructions on enrollment, visit www.michigan.gov/MedicaidProviders >> Provider Enrollment.

THCs and Tribal FQHCs must use the ASC X12N 837 5010 institutional format when submitting electronic claims for CM services. The appropriate National Provider Identifier (NPI) information is required on all institutional claims. CM services provided to

these beneficiaries should be billed on the institutional claim form using the Type 2 (Organization) clinic specialty enrolled NPI. On the institutional claim form, the Attending Provider field line should include an eligible Type 1 (Individual) enrolled NPI. Refer to the MDHHS Medicaid Provider Manual, Tribal Health Centers chapter, Billing section for additional information. Finally, the RI Coordinator enrolled Provider ID should be listed in the Other/Rendering field line (referring/rendering/ordering). **Failure to report the RI Coordinator Provider ID in this field will result in a denied claim.**

The FFS reimbursement rate is $35 per 15-minute unit. The claim should be submitted in accordance with the HCPCS code and diagnosis code requirements described in the section above.

Services provided to non-AI/AN beneficiaries must be submitted to the beneficiary's assigned PIHP as described in the Billing via PIHPs subsection above. Providers should verify that the beneficiary's PIHP is participating in the pilot, as listed in the Participating PIHPs section of this policy.

IX. Startup Funding for Provider Sites and PIHPs

Recognizing that provider sites and PIHPs will incur training and administrative costs to set up CM services, MDHHS will provide startup funding. MDHHS will provide $15,000 to each PIHP that is selected to participate and $10,000 to each provider site that elects to participate in the RI Pilot. The first cohort of provider sites to participate in training will receive an additional $3,000 in start-up funds for a total of $13,000 because their feedback and experience on the training curriculum will be used to make improvements for subsequent cohorts. Startup funds must be used for costs associated with the planning and implementation of the RI Pilot and associated CM services. The allowable costs for startup funds are outlined below in Table 4.

Table 4. Allowable Costs for Startup Funds

Categories	Examples
Recruitment and hiring costs	• Costs associated with posting positions, as well as other recruiting and human resource expenses for hiring RI Pilot staff
Personnel costs	• The salary of the RI Coordinator before beneficiary care begins and while the provider builds up to a full caseload • Training and orientation time for RI Pilot staff
Technology costs	• Hardware and/or software need to use the IM platform • Changes that may be required to provider information and billing systems
Capital improvement costs	• Modifications to site where CM services will be delivered (e.g., to allow for reliable UDTs)
Outreach and engagement	• Flyers or events to engage Medicaid beneficiaries who may be eligible for CM services
Other supplies needed to carry out CM services	• UDT cups (Note: while the cost of UDT cups is included in the reimbursement rate, providers will need to purchase cups before initiating CM services; startup funds can help cover those initial costs)

Startup funds will be distributed to PIHPs and providers once they have completed the readiness assessment and prior to beginning training.

Providers and PIHPs that accept startup funds will report to MDHHS on how they used the funds, including the amount and purpose of how funds were used in alignment with the allowable costs listed above. The instructions and forms for reporting the use of startup funds will be provided to providers and PIHPs during training.

Attachment 1: Sample list of UDTs

The table below is a sample of UDTs RI Pilot providers can consider for use with beneficiaries. These UDTs meet the criteria described in the Basic Treatment Framework section of the Bulletin.

RI Pilot Approved UDTs					
Company Name	**Product Name**	**Required Tests**	**Additional Tests Included in Standard Cup**	**Company Website**	**Contact Information**
CLIAWaiver, Inc.	12 Panel IDTC Cups II with Adulterants	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, MDMA, MTD, PCP, TCA, THC	https://cliawaived.com/cliawaivedinc-idtc-12-panelcup-withadulterants.html https://cliawaived.com/cliawaivedinc-idtc-12-panelcup-withadulterants.html	Telephone: 858-481-5031 Email: info@cliawaived.com
CLIAWaiver, Inc.*	14 Panel IDTC II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, EDDP, MDMA, MTD, PCP, TCA, THC	https://cliawaived.com/cliawaivedinc-14-panel-idtcii.html https://cliawaived.com/cliawaivedinc-14-panel-idtcii.html	Telephone: 858-481-5031 Email: info@cliawaived.com
Lochness Medical*	MultiDrug One Step Cup II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, BUP, MDMA, EDDP, KET, THC, MTD, MDPM, PCP, PPX, TRA, TCA	https://www.lochnessmedical.com/Product/Cups/16970 https://www.lochnessmedical.com/Product/Cups/16970	General Inquiries: 1-888-506-2658 Email: info@lochnessmedical.com Email: info@lochnessmedical.com Orders: orders@lochnessmedical.com Orders: orders@lochnessmedical.com Support: support@lochnessmedical.com
Premier Biotech*	Bio-Cup 12-Drug Panel Drug Test	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, MDMA, MTD, PCP, THC	https://premierbiotech.com/innovation/rapidtesting/urinetesting/premierbio-cup/ https://premierbiotech.com/innovation/rapidtesting/urinetesting/premierbio-cup/	Product Questions: 888-686-9909 Laboratory Questions: 855-718-6917

** Can test for buprenorphine*