Recovery Incentives Pilot Handbook

Michigan Department of Health and Human Services

Effective Date: January 1, 2025

The handbook outlines Medicaid policy and billing guidance for providers participating in Michigan's Recovery Incentives Pilot.

Note: The information included in this handbook is subject to change.

Contents

Preface

The Michigan Department of Health and Human Services (MDHHS) created the Recovery Incentives (RI) Pilot Provider Handbook to document guidance for providers participating in the RI Pilot. This handbook details the roles and responsibilities of providers, the basic treatment framework and billing requirements.

MDHHS requires that all providers participating in the RI Pilot be enrolled as a Medicaid provider and familiar with all Medicaid policies and procedures prior to rendering services to beneficiaries. This includes policies and procedures currently in effect in addition to those issued in the future.

While it is the intent of MDHHS to keep this handbook as updated as possible, the information provided throughout is subject to change. All current and future policies and procedures will be maintained on the MDHHS Recovery Incentives website listed below.

The handbook will be maintained on the Recovery Incentives website here:
https://www.michigan.gov/opioids/opioidsettlements/settlement-spending/recovery-incentives-pilot

1 Introduction to Contingency Management and Recovery Incentives Pilot

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.

1.1 Overview of Contingency Management

CM is an evidence-based treatment that reinforces positive behavior change consistent with meeting treatment goals, including abstinence and continued engagement, through the provision of motivational incentives. Motivational incentives are small rewards that participating beneficiaries receive when they demonstrate adherence to their treatment goals through negative drug tests and treatment attendance. 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, such as abstaining from substances and increasing lengths of stay in treatment.

1.2 Evidence for Contingency Management

Multiple studies conducted over the past 30 years demonstrate that CM is an effective intervention for substance use disorders (SUDs), including StimUD and OUD. Recent research continues to augment the evidence base for CM. For example, a systematic review in 2020 found that CM programs for StimUD are associated with consistently positive results, demonstrating their effectiveness compared with treatment as usual as well as other interventions, including community reinforcement, pharmacotherapy, and cognitive behavioral therapy (CBT).[1] For OUD, a 2021 meta-analysis found that the use of CM for individuals receiving medication treatment for OUD was associated with increased abstinence from illicit opioid use.[2]

The most common focus of CM interventions is on supporting abstinence from substance use. A 2016 systematic review reported that 74 percent of studies focused exclusively on increasing abstinence from drug use, while the remainder focused on another therapeutic goal or a combination of the two. The review found that CM was efficacious for all of these purposes.[3]

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[1] Ronsley, C., Nolan S., Knight R., Hayashi K., Klimas J., Walley A., et al. (2020). "Treatment of stimulant use disorder: A systematic review of reviews." *PLoS ONE* 15(6). doi: 10.1371/journal.pone.0234809.

[2] Bolívar, H. A., Klemperer, E. M., Coleman, S. R. M., DeSarno, M., Skelly, J. M. & Higgins, S. T. (2021). "Contingency management for patients receiving medication for opioid use disorder: A systematic review and meta-analysis." *JAMA Psychiatry*. Published online 2021. doi: 10.1001/jamapsychiatry.2021.1969.

[3] Davis D. R., Kurti A. N., Skelly J. M., Redner R., White T. J. & Higgins S. T. (2016). "A review of the literature on contingency management in the treatment of substance use disorders, 2009–2014." *Preventive Medicine*, 92, 36–46. 10.1016/j.ypmed.2016.08.008 [PubMed: 27514250].

Finally, it is important to note that CM is effective in promoting continued abstinence even after reward incentives are discontinued. A 2021 meta-analysis[4] of CM demonstrated a long-term benefit of abstinence that exceeded other evidence-based practices up to one year following treatment.

1.3 Overview of Recovery Incentives Pilot

MDHHS intends to provide CM services to eligible Medicaid beneficiaries through a two-year pilot initiative. The pilot will begin on January 1, 2025, and end on December 31, 2026, at which point MDHHS will evaluate whether to expand the program as a statewide benefit. MDHHS will work with Michigan's pre-paid inpatient health plans (PIHPs) and their contracted providers to implement the RI Pilot. Beneficiary participation in the RI Pilot is voluntary, and 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. Specific goals include:

- Increasing engagement and retention in treatment.
- Reducing use of illicit stimulants and opioids.
- Reducing the number of emergency department (ED) visits.
- Reducing adverse health outcomes (e.g., deaths, non-fatal overdoses).

2 Contingency Management 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. Beneficiaries will participate in visits (twice weekly in weeks 1–12 and once weekly in weeks 13–24) during which they will be eligible to receive incentives for meeting certain treatment goals, specifically abstinence from stimulants or opioids, as objectively verified by negative urine drug tests (UDTs), and engagement in CM services, as objectively verified by appointment attendance.

The specific substance that will be tested for will be mutually determined by the provider and the participating beneficiary. A participating beneficiary with both StimUD and OUD must, in collaboration with their provider, select either stimulants OR opioids as the target substance for the purposes of the RI Pilot. In other words, while a beneficiary should be offered appropriate treatment to address all health needs, CM under the RI Pilot may only be used to treat either StimUD or OUDs, not both. For example, if a beneficiary with both StimUD and OUD enrolls in the RI Pilot and selects stimulants as the target substance, their UDT results for opioids will not impact the value of incentives received.

Participating beneficiaries will receive full incentives for meeting their treatment goals by achieving negative drug test results for the target substance. To support treatment retention and reduce the risk of disengagement among beneficiaries who struggle to attain non-use status early in treatment, beneficiaries will receive partial incentives for continuing to attend appointments even when they have a positive test. *(See **Section 5.5 Incentive Schedule** for additional details.)*

[4] Ginley, M. K., Pfund, R. A., Rash, C. J. & Zajac, K. (2021). "Long-term efficacy of contingency management treatment based on objective indicators of abstinence from illicit substance use up to 1 year following treatment: A meta-analysis." Journal of Consulting and Clinical Psychology, 89(1), 58–71. doi: 10.1037/ccp0000552.

The incentives will be provided as a reloadable debit card, consistent with evidence-based research, and 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 OUD, such as cognitive behavioral therapy (CBT), motivational interviewing (MI), and medications for opioid use disorder (MOUD). Under no circumstances will CM services be used to replace, diminish, limit, or otherwise restrict access to and support for MOUD.

3 Beneficiary Eligibility

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

1) Are enrolled in Medicaid; **AND**
2) 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**
3) Diagnosed with a qualifying StimUD, OUD, or both as determined by a SUD provider using a multidimensional assessment that covers the dimensions in the American Society of Addiction Medicine (ASAM) Criteria; **AND**
4) Able to be appropriately treated in an outpatient setting (i.e., ASAM Third Edition levels 1.0-2.5).[5]

There is no minimum age limit for a beneficiary to receive CM services if they meet all eligibility criteria; however, beneficiaries under the age of 18 years 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 while participating in the RI Pilot. Beneficiaries who are receiving care in residential or inpatient treatment [e.g., ASAM Third Edition 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.

Any provider may refer a beneficiary to a provider participating in the RI Pilot. A beneficiary may also self-refer to a participating provider. The participating provider must assess and confirm eligibility for each beneficiary before formally enrolling them in the pilot and beginning to deliver services.

4 Provider Roles and Responsibilities

Providers play a critical role in the RI Pilot. Providers who opt to participate in the RI Pilot will be responsible for administering CM services to eligible beneficiaries. A list of providers who have been trained and approved to participate in the RI Pilot is available on the RI Pilot website.

This document uses the term ‘provider’ to refer to both the organizations/sites and individuals who are involved with the provision of CM services. Some uses of the term provider specify whether the reference is to a provider site versus an individual provider for clarity.

[5] MDHHS is transitioning to use of the fourth edition of the ASAM Criteria in 2025-2026. Once adopted, the ASAM levels that will indicate that the beneficiary can be appropriately treated in an outpatient setting will be updated to levels 1.5-2.7.

4.1 Provider Eligibility and Requirements

SUD providers are eligible to participate in the RI Pilot if they are (1) enrolled as a Medicaid provider in good standing; (2) offering outpatient, intensive outpatient, and/or partial hospitalization services; **and** (3) are licensed and certified to provide services in participating PIHP regions. This includes Narcotic Treatment Programs (NTPs) /Opioid Treatment Programs (OTPs), Substance Use Disorder Health Home (SUDHH) providers, and Certified Community-Based Behavioral Health Clinics (CCBHCs) in participating PIHP regions.

The following individual SUD providers will be eligible to administer CM:

- SUD Treatment Professional or Certified Addiction Treatment Professional, including:
    - 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.
- Certified Peer Recovery Coach.
- Clinical Nurse Specialist.
- Registered Nurse.
- Licensed Practical Nurse.
- Physician Assistant.
- Physician.
- Certified Nurse Midwife.
- Nurse Practitioner.

All providers must possess (or obtain) a National Provider Identifier (NPI) to deliver and be reimbursed for services. Individual providers without an individual NPI may bill for services using the NPI of their organization. As with other SUD treatment services, providers must meet all requirements for the delivery of the service, including meeting documentation requirements and participating in oversight and audit activities as needed. MDHHS and its training and technical assistance vendor may visit RI Pilot sites to verify that program requirements are being met and implemented in practice. MDHHS staff will review documentation and records and offer feedback throughout the RI Pilot.

To receive reimbursement for CM, each facility in which CM is being administered shall hold a Clinical Laboratory Improvement Amendments (CLIA) "waived test" certification. CLIA applications must be submitted to the Michigan Department of Licensing and Regulatory Affairs (LARA) at least 60 days before CM services begin. Information on how to submit the CLIA application can be found here.

4.1.1 Staffing Expectations

All participating provider sites must designate the following staff positions to ensure the provision of CM services:

- **RI Supervisor** to oversee the administration of CM services at the provider site;
- **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 required trainings as well as participate in and pass the readiness review prior to initiation of CM services. *(See **Section 9. Training Requirements** for additional details.)*

4.1.2 Recovery Incentives 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 staffing schedules. The RI Supervisor will also be a resource to the RI Coordinator if there are questions or concerns about a beneficiary interaction.

4.1.3 Recovery Incentives 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 all CM services, including:

- Provision of UDTs;
- Inputting test results into the incentive manager;
- 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.

To be eligible to offer CM services, RI Coordinators shall complete required trainings and pass a readiness review before offering CM. The RI Coordinator shall offer CM services in strict accordance with MDHHS standards.

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

- **Eligibility Verification**: Verify Medicaid 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**: Deliver CM to participating beneficiaries, including by conducting UDTs and supporting the provision of incentives.
- **Reporting**: Provide data to MDHHS to support monitoring and evaluation of the pilot, as needed.
- **Readiness Review**: Providers shall demonstrate readiness to perform with fidelity to the pilot's policies and rules.

4.1.3.1 Beneficiary Clinical Assessment

The provider will facilitate an assessment with the beneficiary consisting of activities to evaluate the beneficiary's behavioral health status and to determine the appropriate level of care and course of treatment. Beneficiaries must have evidence of a completed ASAM multidimensional assessment dated

within 12 months prior to enrollment in the RI Pilot. Beneficiaries without evidence of recent assessment must complete a new assessment prior to enrollment. For beneficiaries with evidence of recent assessment, the participating provider must review the completed assessment with the beneficiary at time of enrollment to verify accuracy. For beneficiaries under age 18, the GAIN-I-Core (which maps to the ASAM Criteria) must be the specific multidimensional assessment used to be considered a valid assessment for the purposes of determining eligibility for the RI Pilot.

The assessment must indicate that the beneficiary can be appropriately treated in an outpatient setting (i.e., ASAM Third Edition levels 1.0–2.5). The beneficiary's clinical assessment shall confirm: 1) the beneficiary has a diagnosis of StimUD, OUD, or both; 2) outpatient treatment is appropriate per ASAM criteria; and 3) that CM services are determined medically necessary.

4.1.3.2 Documentation

The provider shall document the diagnosis of StimUD or OUD in the beneficiary's medical record. Consistent with clinical documentation best practices, the provider shall complete a progress note each time a beneficiary receives CM services and include all interventions utilized with the beneficiary, as well as any other outpatient services provided to the beneficiary during the visit. CM should not be offered to a beneficiary as a standalone treatment but rather as one component of an individualized treatment plan. However, if a beneficiary chooses to participate only in CM and not in other aspects of treatment identified in their plan, they shall not be penalized, criticized or discharged from the pilot.

4.1.3.3 Complementary Services

While CM is intended to supplement and reinforce other evidence-based practices (EBPs), it is important to note that participating beneficiaries shall not be required to enroll in a comprehensive treatment program or to receive additional psychosocial services as a condition of participation in the RI Pilot. For beneficiaries living with OUD, MOUD will continue to be strongly encouraged. SUD providers offering CM services as part of the RI Pilot are responsible for providing or referring beneficiaries to additional, complementary services for the treatment of their SUD, such as the following:

- Cognitive Behavioral Therapy (CBT).
- Motivational Interviewing (MI).
- Trauma-focused therapy.
- Matrix Model.
- Medication Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD).
- Care coordination.
- Peer services and recovery supports.
- Withdrawal management.
- Additional EBPs.

4.1.3.4 Harm Reduction

Harm reduction practices can prevent overdose and death among individuals living with SUDs. In the RI Pilot, the RI Coordinator shall:

- Establish and implement a protocol to ensure that beneficiaries have access to naloxone, either through a prescription, community distribution program or other means.
- Provide education to each beneficiary regarding:
    - The risks associated with fentanyl and its presence in the illicit drug supply.

- Harm reduction safety strategies, such as the use of fentanyl test strips and which harm reduction agencies distribute test strips for home use.
- Specific education regarding the use of naloxone to reverse an opioid overdose.
- Information on safer use practices to help prevent overdose and death.
- Information on the OpiRescue smartphone app for additional resources and assistance.

Providers shall regularly review whether a beneficiary has a non-expired dose of naloxone available to them, including by checking whether they have used the dose they previously had or the dose has expired. Providers should be aware of differences between naloxone products as shelf life varies between brands. When the dose available to a beneficiary has been used or has expired, the provider will assist the beneficiary in securing a new dose through a pharmacy, their own supply or local organization. For more information on obtaining naloxone, visit https://www.michigan.gov/opioids/find-help/naloxone-page.

4.1.4 Support Staff with Delegated Roles

Unlicensed/certified staff may complete RI Coordinator responsibilities under direct supervision of the RI Coordinator or RI Supervisor. The required training for these roles will depend on site-specific decisions on responsibilities and will be determined on a case-by-case basis.

If a provider site lacks sufficient staff to designate a licensed/certified staff member as the alternate RI Coordinator, the site may request a waiver from MDHHS allowing an unlicensed/uncertified staff member to serve in this capacity under direct supervision of the RI Supervisor.

5 Basic Treatment Framework

5.1 Intake Visit

During a beneficiary's intake visit, the RI Coordinator will complete the following steps to intake the beneficiary and initiate CM services:

1. Verify Medicaid enrollment – The RI Coordinator will confirm the beneficiary is actively enrolled in Medicaid.
2. Confirm RI Pilot eligibility – The RI Coordinator will confirm the beneficiary is eligible to participate in the RI Pilot *(as outlined in the **Section 3. Beneficiary Eligibility**)*, including confirming whether the beneficiary is already currently receiving CM services for the condition being targeted in the RI Pilot (i.e., StimUD or OUD). The RI Coordinator, or another provider, should perform an ASAM multidimensional assessment to confirm beneficiary eligibility for the RI Pilot or review an existing assessment with the beneficiary if it has been performed within the last 12 months.
3. Explain the CM Services to the beneficiary and what they can expect during treatment, including:
    a. Days and times the beneficiary must visit the facility to be eligible for incentives, including addressing any potential barriers to participation such as transportation and connecting beneficiaries with appropriate services.

b. How incentives will be delivered, as well as an explanation of how incentives can be redeemed, per the guidance and limitations outlined in this document (*See **Section 5.4 Incentives***).
c. The availability of incentives and ongoing opportunities for participation when a beneficiary lapses or relapses and seeks readmission and the process for a beneficiary to seek readmission.
d. The provider's UDT procedures and explanation and review of medications/substances that may result in false-positive UDTs.
e. The rules governing when incentives will be provided, including:
    i. An explanation that the incentives are contingent on the absence of evidence of the target substance on UDTs and attendance at CM visits.
    ii. An explanation that all positive tests will be treated the same even if they result from use of one of the medications/substances known to provide false-positive UDT results.
f. The amount of the initial incentive value and how the value will follow an "escalate, reset, and recovery" model. *(See **Section 5.5 Incentive Schedule** for additional details on the "escalate, reset, and recovery" model.)* The total value of incentives that a beneficiary can receive per calendar year in the RI Pilot is $599.

4. Obtain beneficiary consent to participate in the Pilot – The RI Coordinator will ask the beneficiary to complete the RI Pilot consent form. The RI Coordinator should review the consent form verbally with the beneficiary. *(See **Appendix II. Sample Consent Form** for a sample consent form.)*
5. Enroll the beneficiary in the IM Platform – The RI Coordinator will create a beneficiary profile in the platform that will keep track of disbursed incentives. This will ensure the beneficiary is ready and in the system for their first CM visit and UDT.
6. Intake visits will not include UDTs. Beneficiaries will return for their first CM visit and provide a UDT at that time. More information regarding CM visits is below.

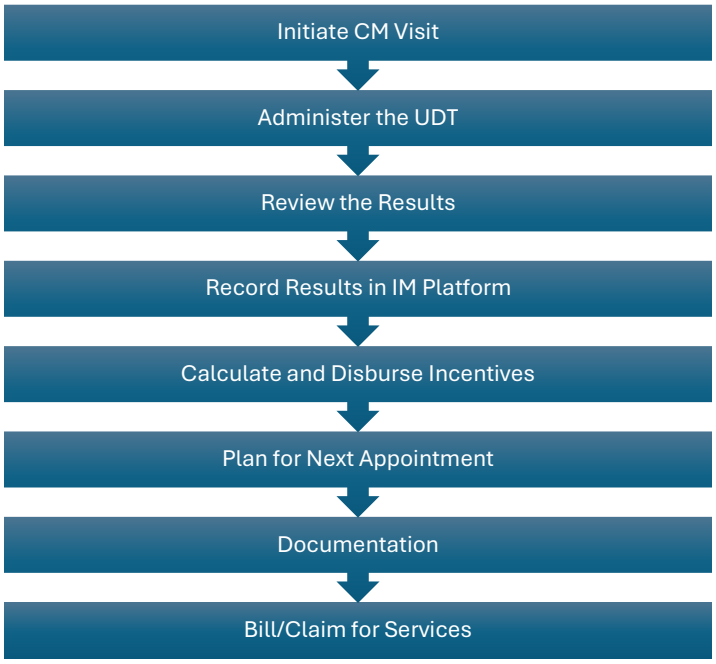
5.2 Contingency Management Visits

The RI Coordinator will greet the beneficiary at each CM visit, review their progress in the RI Pilot, and administer their UDT. The RI coordinator will complete the following tasks during each CM visit:

1. Initiate the CM visit – The RI Coordinator will engage the beneficiary and review where they are in the 24-week treatment period. At the outset of the visit, the RI Coordinator should log into the Incentive Manager and locate the beneficiary's record.
2. Administer the UDT – The RI Coordinator will administer the UDT, including processing the result of the UDT in real time. *(See **Section 5.3 Urine Drug Testing** for additional details on administering* UDTs*.)*
3. Review Results – The RI Coordinator will discuss the UDT result with the beneficiary and provide and/or refer to other services, as appropriate. Other services could include brief encouragement, motivational interviewing and education. If the UDT result is positive, the CM Coordinator shall reinforce the risk of overdose, ensure the beneficiary has naloxone, and offer referral to other treatment services as appropriate, including MAT if the beneficiary has a co-occurring alcohol or opioid use disorder.
4. Record results in IM Platform – The RI Coordinator will record the result of the UDT (i.e., positive or negative) for the target substance.

5. Calculate and disburse incentives – Through the IM platform, the RI Coordinator will view the calculated incentive amount and disburse the incentive to the beneficiary consistent with the incentive schedule. (*See **Section 5.5 Incentive Schedule.***)
6. Plan for next appointment – The RI Coordinator will remind the beneficiary of the date and time of their next scheduled appointment. The RI Coordinator should also remind the beneficiary of the maximum value of the incentive the beneficiary is eligible to earn in the next visit to support ongoing engagement. The RI Coordinator will offer to answer any questions before adjourning the visit and refer to other services, as appropriate.
7. Documentation – The RI Coordinator shall document the visit in the beneficiary's chart.
8. Bill/Claim for Services – The RI Coordinator should complete and submit a claim for services delivered. *(See **Section 6 Billing and Reimbursement** for additional details.)*

Figure 1: Summary of CM Visit Process/Flow



5.3 Urine Drug Testing

During each visit, the RI Coordinator will collect a urine sample from the participating beneficiary. The RI Coordinator shall test the sample for the target substance (i.e., stimulants or opioids). Each UDT must be performed in accordance with the manufacturer's instructions for the test. RI Coordinators shall use appropriate precautions to avoid potential beneficiary tampering with UDT specimens, including the following:

- Requiring beneficiaries to leave personal possessions (e.g., backpack, purse, items in pockets) in a secure location outside of the restroom.
- Requiring beneficiaries to thoroughly wash hands or use hand sanitizer prior to entering the restroom, including between fingers and under nails.

- Turning off access to hot water in the restroom (or turning off the water faucet altogether and requiring handwashing outside of the restroom).
- Adding bluing agent to the toilet.

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

- Cut-offs for Amphetamine (500 ng/ml), Cocaine (150 ng/ml), Methamphetamine (500 ng/ml), Opiate (300 ng/ml), and Oxycodone (100 ng/ml), as applicable to the target substance.
- Include 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 ***Appendix I. Sample Urine Drug Tests*** of this handbook for a sample list of UDTs that can test for 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, as applicable, will be considered. Only one of the current CLIA waivered tests test for fentanyl, which is flooding the illicit opioid supply. 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.

To receive reimbursement for CM, each facility in which CM is being provided shall hold a Clinical Laboratory Improvement Amendments (CLIA) "waived test" certification. *(See **Section 4.1 Provider Eligibility and Requirements** for additional details.)*

5.4 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.

The maximum amount of incentives a beneficiary can receive may not surpass $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 two months of CM visits and received $244 in incentives and then elects to re-enter the RI Pilot after 60 days post exit, they would only be eligible to receive up to $355 for the remainder of the calendar year. *(See **Section 5.6 Disenrollment From and Readmission to the RI Pilot** for additional details.)*

5.4.1 Incentive Delivery

Upon reading 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 ***Section 5.5 Incentive Schedule.*** The incentive amount shall be delivered immediately to participating beneficiaries in the

format of a reloadable debit card. RI Coordinators do not have discretion in determining the value or distribution of incentives.

5.4.2 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 date the incentive was distributed, and the amount of the incentive.

5.5 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 the target substance. 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 test positive for the target substance.

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

Table 1 below provides an overview of the incentive schedule.

Table 1: Incentive Schedule Parameters

Week	Incentive Type	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

Example incentive schedules under three hypothetical scenarios are detailed in ***Sections 5.5.4 – 5.5.6***.

5.5.1 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 should be separated by at least 72 hours whenever possible. Participating beneficiaries can earn incentives during each visit they have a negative UDT for the target substance.

The initial incentive value is $10 for the first negative UDT. An "**escalation**" occurs when the participating beneficiary demonstrates non-use of the target substance over the course of one 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 total value of incentives a participating beneficiary who meets program expectations for attendance and negative UDTs can receive during this initial 12-week period is $438.

To encourage continued engagement in treatment, beneficiaries who provide a positive UDT will be provided with a reduced incentive amount of $5.00.

A "**reset**" will occur when the participating beneficiary submits a UDT that is positive for the target substance or has an unexcused absence. The next time they submit a UDT that is negative for the target substance, their incentive amount will return to the initial value of $10.

- An unexcused absence is one in which the participating beneficiary does not notify the provider site in advance of the appointment. If the beneficiary contacts the provider or the provider can contact the beneficiary and reschedule in a timely manner, then the absence can be changed to an excused absence and rescheduled to avoid disruption in care.
- An excused absence is one in which the participating beneficiary notifies the provider site in advance of the appointment. Beneficiaries will not receive an incentive for an excused absence, but their incentive is not reset. Excused absences may be rescheduled to another time in the week and be considered a 'kept' appointment if the provider site has available appointments.

A "**recovery**" of the pre-reset value will occur after two consecutive UDTs that are negative for the target substance. 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 use of the target substance occurs. Beneficiaries will not be penalized for UDTs that return positive for other substances that are not being targeted under the RI Pilot.

5.5.2 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 a fixed $15 per UDT that is negative for the target substance. During weeks 19–23, they will be eligible to earn a fixed $10 per negative UDT, and if their sample is negative on week 24, they will earn $21. During weeks 13–24, incentives available to be earned each week will be fixed and will not vary based on the result of the UDT obtained in the previous visit. In Weeks 13-24, incentives will be provided only for negative UDTs;

no incentives will be provided for continued engagement in visits in which the submitted UDT returns positive for the target substance.

The maximum total value of incentives a participating beneficiary will be able to receive during weeks 13–24 is $161. An example incentive schedule under a hypothetical scenario in which a beneficiary submits UDTs in weeks 13–24 that are positive for the target substance is detailed in ***Section 5.5.6.***

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.

The total duration of treatment will be held to a maximum of 24 weeks for all participating beneficiaries; treatment duration will not be extended to allow beneficiaries to 'make up' missed appointments. In other words, a beneficiary will have a maximum treatment duration of 24 weeks regardless of how many visits are missed, excused or otherwise.

5.5.3 Post-Treatment: Recovery Support Services

Upon conclusion of the 24-week outpatient treatment experience, providers will be required to offer beneficiaries at least six months of additional recovery support services. Such services may include, but are not limited to, counseling and peer services. While six months is the minimum duration of ongoing support that must be offered, participating providers should continue to provide clinical and recovery support services for as long as medically necessary and mutually determined with the participating beneficiary. Beneficiaries are not obligated to accept the offer of additional support services as a condition of participating in the RI Pilot.

5.5.4 Hypothetical Example: Incentive Delivery Schedule for Consistent Abstinence from Target Substance

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 negative for the target substance during each visit over the 24-week period.

Example Scenario: Ms. A. is living with StimUD. She enrolled in the RI Pilot and submitted UDTs that were negative for stimulants for the entire duration of treatment. Ms. A earned $599 in incentives.

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	N/A
	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	

Table 2: Hypothetical Incentive Delivery Schedule for Consistent Abstinence					
Week	**Visit**	**UDT Result**	**Incentive Earned (For Visit)**	**Incentive Earned (Cumulative)**	**Notes**
	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	
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	

Table 2: Hypothetical Incentive Delivery Schedule for Consistent Abstinence					
Week	**Visit**	**UDT Result**	**Incentive Earned (For Visit)**	**Incentive Earned (Cumulative)**	**Notes**
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**

5.5.5 Hypothetical Example: Incentive Delivery Schedule with Positive Urine Drug Tests and Absences (In First 12 Weeks of Participation)

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 the target substance in the first 12 weeks of participation.

Scenario: Ms. C. is living with OUD. She enrolled in the RI Pilot and submitted two UDTs each week that were negative for opioids for the first three weeks (or first six visits). On the seventh and eighth visits, Ms. C. tested positive for opioids. From the ninth 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. Ms. C earned $428 in incentives.

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

Table 3: Hypothetical Incentive Delivery Schedule with Positive UDTs and Absences					
Week	**Visit**	**UDT Result**	**Incentive Earned (For Visit)**	**Incentive Earned (Cumulative)**	**Notes**
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
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	

Table 3: Hypothetical Incentive Delivery Schedule with Positive UDTs and Absences					
Week	**Visit**	**UDT Result**	**Incentive Earned (For Visit)**	**Incentive Earned (Cumulative)**	**Notes**
24	36	Neg	$21.00	$428.00	**Total incentive amount**

5.5.6 Hypothetical Example: Incentive Delivery Schedule with Positive Urine Drug Tests (in Second 12 Weeks of Participation)

Table 4 illustrates an incentive delivery schedule for a participating beneficiary in a scenario in which the beneficiary has some instances of UDTs that are positive for the target substance in the second 12 weeks of participation (i.e., the period in which the incentives available to be earned each week are fixed and do not vary based on the result of the UDT obtained in the previous visit).

Example Scenario: Mr. E. is living with StimUD. He enrolled in the RI Pilot and submitted UDTs that were negative for stimulants through week 15 (or visit 27). On the 28th visit, Mr. E. tested positive for stimulants before testing negative on visits 29–32. Mr. E. tested positive again on the 33rd visit. On the 34th visit, after coaching and additional support from his care team, Mr. E. tested negative and continued to test negative through the end of treatment. Mr. E. earned $584 in incentives.

Table 4: Hypothetical Incentive Delivery Schedule with Positive UDTs					
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	

Table 4: Hypothetical Incentive Delivery Schedule with Positive UDTs					
Week	**Visit**	**UDT Result**	**Incentive Earned (For Visit)**	**Incentive Earned (Cumulative)**	**Notes**
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	
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	$483.00	
16	28	Pos	**$-**	$483.00	***Positive UDT; no reset***
17	29	Neg	$15.00	$498.00	
18	30	Neg	$15.00	$513.00	
19	31	Neg	$10.00	$523.00	
20	32	Neg	$10.00	$533.00	
21	33	Pos	**$-**	$533.00	***Positive UDT; no reset***
22	34	Neg	$10.00	$543.00	
23	35	Neg	$10.00	$553.00	
24	36	Neg	$21.00	$574.00	**Total incentive amount**

5.6 Disenrollment From and Readmission to the Recovery Incentives Pilot

Providers and beneficiaries should maintain open channels of communication about the beneficiary's treatment plan and collaboratively identify ways to address any challenges encountered over the course of treatment. If the beneficiary fails to achieve two consecutive negative samples within the first 12-week period, the provider and beneficiary should decide together whether CM is a clinically appropriate intervention for that beneficiary and, if necessary, modify the course of treatment.

5.6.1 Disenrollment from the Recovery Incentives Pilot

Beneficiaries may choose to discontinue participation in the RI Pilot at any time. Beneficiaries may also discontinue participation based on mutual agreement with the provider that the RI Pilot is not meeting the needs of the beneficiary.

Additionally, providers may, at their discretion, disenroll a beneficiary from the RI Pilot to another care setting after any one of the following:

- Eight consecutive positive tests throughout the treatment period.
- Eight consecutive unexcused absences in the first 12 weeks of treatment.
- Four consecutive unexcused absences in the second 12 weeks of treatment.

If a beneficiary goes more than 30 days between any two visits, they will be disenrolled from the RI Pilot.

An unexcused absence is defined as an absence without advance notification to the provider prior to the planned visit. Providers should work to re-engage beneficiaries in treatment when possible and prioritize a supportive as opposed to punitive approach to care. In cases of a disenrollment, the provider must document the reason for disenrollment in the treatment record and in cases of disenrollment due to unexcused absences, document the number of outreach attempts made to try and re-engage the beneficiary in care.

5.6.2 Readmission to the Recovery Incentives Pilot

A beneficiary who has been disenrolled from the Pilot, whether at the discretion of the provider or of their own accord, may be considered for readmission to the RI Pilot. 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 Third Edition levels 1.0–2.5) and confirm the beneficiary meets the medical necessity criteria for CM. If the assessment determines CM is clinically appropriate, the beneficiary can re-enter the RI Pilot. If the assessment determines CM is not the appropriate clinical treatment, providers may offer other treatments as alternatives.

If the beneficiary discontinues participation and later becomes readmitted, they will restart the incentive schedule at week one, 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. The provider offering CM does not have to be the same provider who initially provided CM during the beneficiary's prior pilot participation.

6 Billing and Reimbursement

All providers reported on claims for services must be Medicaid-enrolled. All providers participating in the pilot must also be contracted network providers with the PIHP in the region in which they provide services, with the exception of THCs and Tribal FQHCs providing services to AI/AN beneficiaries. *(See following subsections for additional details and **Section 7 PIHP Roles and Responsibilities** for additional details on the role of PIHPs in the RI Pilot.)*

Refer to the Billing & Reimbursement for Professionals chapter and the Billing & Reimbursement for Institutional Providers chapter of the MDHHS Medicaid Provider Manual for additional billing information.

6.1 Beneficiaries in Pre-paid Inpatient Health Plans

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) or OUD (F11), reflecting the beneficiary's diagnosis being treated with CM. Providers may bill both for time spent in direct contact with the beneficiary and time spent performing additional tasks associated with the CM visit (e.g., documentation, administering the UDT). Time spent supervising staff may not be separately billed.

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 according to PIHP billing protocols. Until PIHPs are notified that the State's 1115 Behavioral Health Demonstration Waiver has been approved, provider agencies will submit H0047 as a $0 code. This will be used for tracking purposes, and PIHPs will submit Financial Status Reports (FSRs) that correspond to the H0047 submissions by providers for reimbursement.

6.2 American Indian 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 CM 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 atypical 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 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 ***Section 6.1***. Providers should verify during the intake process that the beneficiary's PIHP is participating in the pilot.

7 Pre-paid Inpatient Health Plan Roles and Responsibilities

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. Participating 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. PIHPs participating in the RI Pilot are listed here: https://www.michigan.gov/opioids/opioidsettlements/settlement-spending/recovery-incentives-pilot

PIHPs are responsible for the administrative oversight, coordination and provision of CM services via their provider networks, including the following tasks:

- Develop and maintain a provider network to deliver CM in the PIHP's region.
- Execute contracts or contract amendments with providers, as needed; all providers must be enrolled in the PIHP's provider panel to offer CM (with the exception of THCs and Tribal FQHCs).
- Participate in and complete required trainings, as well as conduct oversight of provider completion of required trainings, as appropriate.
- Participate in technical assistance, as well as conduct oversight of provider participation in technical assistance, as appropriate.
- Reimburse providers for the provision of CM services via the RI Pilot. PIHPs will pay provider claims on a timely basis for services associated with a CM visit.
- Report to MDHHS on RI Pilot implementation to support oversight and monitoring; participate in evaluation.

- Complete provider readiness reviews to ensure the PIHP's providers are delivering high quality treatment (beginning October 2026).[6]
- Assist providers in addressing programmatic and technical issues, as appropriate (beginning October 2026).[7]

PIHPs will work with MDHHS and their provider networks to develop outreach and communication materials to engage beneficiaries.

PIHPs will designate one staff person to serve as the PIHP's RI Manager (distinct from the RI Supervisor and RI Coordinator required to be designated by each provider site), and at least one alternate RI Manager to facilitate implementation of the pilot and oversee related monitoring and quality improvement activities. The PIHP RI Manager and alternate shall complete all required trainings prior to initiation of CM services in their region, as well as participate and pass the PIHP readiness review.

8 Startup Funding for Provider Sites and Pre-paid Inpatient Health Plans

Recognizing that provider sites and PIHPs will incur training and administrative costs to set up CM services, MDHHS will provide one-time startup funding to provider sites and PIHPs participating in the RI Pilot. 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. 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 **Tables 5 and 6**.

Table 5. Allowable Costs for Startup Funds for Providers

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 needs 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 costs	• Flyers or events to engage Medicaid beneficiaries who may be eligible for CM services.

[6] Altarum, the state's technical assistance and training partner will be responsible for this activity through September 2026.
[7] Altarum, the state's technical assistance and training partner will be responsible for this activity through September 2026.

Table 5. Allowable Costs for Startup Funds for Providers	
Process improvement costs	• Costs associated with developing processes and protocols to support implementation of the RI Pilot.
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).

Table 6. Allowable Costs for Startup Funds for PIHPs	
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	• Training and orientation time for RI Pilot staff.
Technology costs	• Changes that may be required to PIHP information and billing systems.
Outreach and engagement costs	• Flyers or events to engage Medicaid beneficiaries who may be eligible for CM services.
Process improvement costs	• Costs associated with developing processes and protocols to support implementation of the RI Pilot.

All startup funds will be distributed to PIHPs through EGrAMS; PIHPs will be responsible for distributing startup funds to downstream providers.

Providers and PIHPs that accept startup funds will report to MDHHS how they used the funds, including the amount and description of how funds were used in alignment with the allowable costs listed above. PIHPs will complete FSRs in EGrAMS to report on use of startup funds by the PIHP as well as their contracted providers, as applicable. PIHPs shall work with their contracted providers receiving startup funding to obtain the information necessary to complete the FSR.

9 Training Requirements

RI Pilot training will equip both PIHPs and provider site staff with essential knowledge of the science and evidence behind CM, RI Pilot design, and IM platform training. The training process will differ between PIHP and provider sites. For provider sites, Altarum—the state's training and technical assistance (TTA) partner—will use a phased cohort approach to train staff in two-month long engagements, beginning in November 2024 and reoccurring regularly through September 2026.

PIHP staff will also be required to complete training prior to a provider site launching services in their region. All PIHPs will complete the required training in December 2024 on CM basics, RI Pilot design and IM vendor training.

The content of the curriculum, training topics and required TTA activities will be tailored to the unique needs of PIHPs and provider sites.

9.1 Provider Site Staff Training Process

For each cohort, groups of eight to 14 provider sites will participate with three required staff from each site, resulting in approximately 24–48 staff trained each cohort. The cohort approach and size will facilitate peer-to-peer learning. Altarum anticipates facilitating approximately six to eight training cohorts throughout the pilot period.

The RI Supervisor, the RI Coordinator and the designated Alternate RI Coordinator must complete all required trainings as well as participate and pass the readiness review prior to initiation of CM services. *(See **Section 4.1 Provider Eligibility and Requirements** for definitions of these staff roles.)*

9.1.1 Training Requirements

The required TTA for provider site staff is described below in **Table 7**.

Table 7. Training Sessions for RI Pilot Provider Sites

Session(s)	Duration	Description
Core CM Curriculum Training	Six hours	Three live, two-hour virtual sessions during the first month of cohort training. Between the second and third sessions, provider sites will complete a readiness review worksheet that outlines the standard operating procedures for their clinic. This document will serve a dual purpose of outlining key components for the readiness review and providing a manual for new staff onboarded at the site.
IM Vendor Training	One to two hours	Staff will learn how to utilize the IM platform to register beneficiaries for the pilot, record test results, dispense incentives when earned and track beneficiary progress. Upon completion of the Core CM Curriculum Training and this training, staff from each provider site will complete case examples through the IM platform in preparation for the provider site readiness review.
Provider Site Readiness Review	One hour	Live, virtual site-specific technical assistance and preparation for service launch in the second month of the cohort. These virtual sessions will review key content from the curriculum training, assess competence with use of the IM platform and strategies for communication with beneficiaries, and confirm operational logistics such as hours for services, physical space, supplies, technology and other details essential for a successful launch. Sites will continue to meet with Altarum to assess readiness throughout the second month of cohort training and beyond if

Table 7. Training Sessions for RI Pilot Provider Sites		
		the initial readiness review is not satisfactory. Sites will receive technical assistance as often as needed to prepare for launch.
Monthly Progress Report Calls	One hour monthly for seven months	Live, virtual session with all provider sites from the training cohort. Post-service launch, at least one fully trained staff member from each site will attend a mandatory one-hour progress report session monthly for at least seven months. These sessions are opportunities to troubleshoot barriers, share lessons learned with peers, and provide a brief update on progress for each site. The seven-month timeframe will provide TA through one full cycle of the 24-week pilot structure. Both PIHPs and sites will attend.

9.2 Pre-paid Inpatient Health Plan Staff Training Process

Altarum will facilitate two training sessions with PIHP staff in December 2024 and, as needed, throughout the RI Pilot. Altarum's training for PIHP staff will focus on core principles of CM, understanding the IM platform, processing payments for CM services at the provider site-level, fidelity monitoring and how to provide effective technical assistance support to provider sites following the pilot period.

9.2.1 Pre-paid Inpatient Health Plan Recovery Incentives Manager and Alternate

PIHPs will designate one staff person to serve as the PIHP's RI Manager (distinct from the RI Supervisor and RI Coordinator required at each provider site), and at least one alternate RI Manager. The PIHP RI Manager and alternate shall complete all required trainings prior to initiation of CM services in their region, as well as participate and pass the PIHP readiness review.

At least one PIHP staff member will also be required to attend and participate in the monthly progress report calls with provider sites starting in January 2025. The number of required calls will be determined in the future, with the purpose of the calls centering on transitioning TTA responsibilities to PIHPs.

Starting in October 2026 or sooner, PIHPs will take over the coordination of these calls and become the main point of contact for technical assistance for the remainder of the pilot (October–December 2026). PIHPs may customize the frequency, duration and format of calls or check-ins to meet the needs of CM implementors in their region. Altarum's TTA staff will continue to attend and assist as needed through December 2026.

9.2.2 Training Requirements

The required TTA for PIHP staff is described below in **Table 8**.

Table 8. Training Sessions for PIHPs		
Session(s)	**Duration**	**Description**

Table 8. Training Sessions for PIHPs		
PIHP CM Curriculum /IM Platform Training	Two hours	One, live virtual, two-hour session. RI Manager and alternate are required to attend this training session. The initial training will be offered twice in December 2024 and as needed throughout the pilot period to onboard new PIHP staff. PIHP staff only need to complete the training once. This session will introduce the basics of the IM platform to PIHP staff to prepare PIHP Managers to provide technical assistance to provider sites.
PIHP Readiness Review	One hour	One, live virtual, one-hour session. Prior to launching services in their region and after completing the CM Curriculum and IM platform training, each PIHP will meet with Altarum staff to review the process of billing for services and answer any questions. Two fully trained staff members are required to attend.
Monthly Progress Report Calls	One hour	The RI Manager or other trained PIHP staff member is required to attend a subset of the monthly progress report calls with provider sites in their region in order to understand the needs of their providers and begin to create a PIHP TTA plan. The required number of calls will be determined at a future date. PIHPs are encouraged to attend regularly.

10 Provider Best Practices

Incorporation of best practices in the implementation of CM at the provider level is the backbone of success for the RI Pilot.

10.1 Responses to Common Myths Regarding Contingency Management

To effectively implement CM within a treatment setting, providers must be prepared to address stigmatizing attitudes and inaccurate beliefs held by staff, beneficiaries, their families and the broader community. There are common myths regarding CM including its long-term effectiveness, that it may inhibit internal motivation to change, and that it is too challenging to implement in a sustainable way. Beyond myths, there are philosophical challenges expressed by many that it is wrong to incentivize abstinence in treatment settings e.g., (pay people not to use drugs). RI Pilot providers may find even more objection to the RI Pilot, which does not require total abstinence and provides partial incentives when UDTs are positive. These myths and philosophical challenges may be addressed through consistent and clear messaging of commitment to CM by provider organizations and PIHPs, as well as continuous education on CM principles.

While RI Coordinators and Supervisors will be trained to implement CM within the treatment setting, understanding and support of CM across all provider staff and disciplines will help create a supportive environment for participating beneficiaries. Demonstration of site leadership support for the CM program as well as openness to discuss the implementation throughout the process is an important first step to increasing staff acceptance. Clinical staff may view incentives as coercive, manipulative or

fostering dependence on external rewards, despite evidence that CM does not decrease internal motivation for recovery. Still others may believe that other established treatment approaches are already sufficient, and there is no need to implement CM. Stigma and misinformation among non-clinical staff working in organizations seeking to implement CM can also be a barrier to effective adoption. Provider sites may suggest staff not implementing CM directly receive training on the model.

There are many resources for additional CM training including:

- Contingency Management for Healthcare Settings (online training) - Addiction Technology Transfer Center (ATTC) Network (attcnetwork.org).
- Motivational Incentives Suite - Addiction Technology Transfer Center (ATTC) Network (attcnetwork.org).

In addition, RI Coordinators and RI Supervisors can play a role within organizations as champions of CM. Examples of how to champion CM include:

- Hosting lunch and learn sessions facilitated by their trained CM staff.
- Providing clinical presentations of beneficiaries participating in the RI Pilot during treatment team meetings to highlight successes and answer questions.

Providers may encounter negative attitudes toward CM against a backdrop of stigma against people who use substances, more broadly. These attitudes can reinforce each other, further posing a barrier to adoption and acceptance of CM. Despite the effective use of CM approaches in the broader health care arena, the idea of using CM to support abstinence and treatment engagement for people who use drugs is not translatable. In some recovery communities, doubt about the effectiveness of CM paired with strict 12-step abstinence-based philosophies may create a conflict within the treatment setting as well as with outside support groups. Even beneficiaries themselves might have negative biases about receiving incentives for recovery or skepticism of the effectiveness of CM.

Providers may have limited ability to impact the broader community, but they should be prepared when questions are raised. Some examples on how to best respond to these questions include:

- Having written materials such as handouts, flyers or pamphlets on CM can help to increase community knowledge.
- Offering beneficiaries the opportunity to bring family or loved ones into the treatment setting for education on CM may be helpful to increase support outside of treatment walls.
- Getting buy-in from beneficiaries' support systems may help to bolster treatment engagement.
- If resources are available, proactively engaging the community—especially potential sources for referral—may help reduce misinformation about CM.
- Outreach to groups, such as recovery housing programs, inpatient treatment centers, child welfare agencies and criminal justice representatives, to discuss the availability of CM, and the evidence to support its use, may increase not only the likelihood of referral but ongoing support.

10.2 Strategies for Potential Implementation Issues

There are essential components for CM implementation supported by the RI Pilot design. These include:

- **Person-centered care:** this is evidenced by the beneficiary selection of the targeted substance.

- **Voluntary care:** beneficiaries are not required to participate in CM and can discontinue at any time.
- **Comprehensive care:** CM is intended to be an evidence-based practice available within a larger system of care.
- **Harm reduction framework:** complete abstinence from all substances is not the goal of CM (though it may be the goal of the beneficiary) and continued use of other substances does not impact the delivery of incentives. Beneficiaries are provided with harm reduction resources as part of their care.
- **Immediate reward delivery**: met through structure of automated debit card system.
- **Fidelity to the model:** rewards must be high enough to incentivize behavior—achieved by adoption of a $599 cap (as opposed to a lower limit).

Michigan's RI Pilot has been designed with fidelity to these core components of CM. At the provider level, high fidelity is essential for achieving the desired outcomes of CM, but maintaining fidelity can be difficult in real-world clinical settings. Fidelity to treatment protocols is particularly important for CM to ensure effectiveness, safeguard program integrity and prevent negative unintended consequences. There is a risk that deviation from evidence-based protocols could lead to reinforcement of negative or harmful behaviors, rather than the desired positive behaviors. In addition to the staff who receive CM training, promoting fidelity may require redesign of clinic workflows and additional investments in quality assessment and assurance processes, along with ongoing provider supervision and support. Implementation issues will arise, and providers should have a strategy on how these issues will be addressed. Holding routine meetings that foster communication with RI Pilot staff, recording challenges, establishing a culture of openness to change and accessing available TA are all action steps that providers can implement to maintain and strengthen their implementation of the RI Pilot.

10.3 Tips on How to Communicate with Beneficiaries About the Recovery Incentives Pilot

It is important that beneficiaries participating in the RI Pilot understand the structure of the program and are clear on expectations. Careful orientation of participating beneficiaries can reduce the risk of later conflict and minimize the creation of an unhealthy power dynamic. The orientation process described previously should explain incentive delivery, the use of UDTs, medications that can cause positive UDTs, how incentives are earned and distributed, and policies regarding excused and unexcused absences. While working to achieve a person-centered focus that considers individual circumstances, ambiguity about attendance expectations and how excused absences are defined may create implementation challenges. How and when UDTs can be rescheduled needs to be clear and objective, keeping in mind that 72 hours between tests is the best practice and will reduce the likelihood of two positive UDTs from the same use. A longer period between tests may not detect substance use and delay recognition of a lapse or relapse. Consistency is key.

The issue of flexibility versus strict regimen adherence is described well in the SAMHSA Guideline for Implementing CM Training and Technical Assistance:

> *"**There are many aspects to balance when considering CM implementation.** For example, balancing high risk management and high fidelity; high fidelity with high inclusion; adherence with flexibility. For example:*
>
> - *Two sides of the coin: (1) Implement an evidence-based version without moving away from the evidence to make it more clinic-friendly or more flexible; (2) Consider adaptations to meet the needs of our audiences, clinics, and communities that are disproportionately impacted by this work.*
> - *Behavioral health and substance use interventions and approaches and providers consider the whole person and therefore are responsive to cultural adaptations, destigmatizing approaches, and promoting patient-centered care. These often involve adaptations and/or flexibility.*
>
> *Looking at inequities due to race and access to care, a one-size-fits-all protocol does not solve those issues and can even drive disparities. Flexibility is needed."*

11 Incentive Manager Overview

Throughout this handbook, there have been references to the **Incentive Manager (IM) platform**, a web based- platform provider organizations and their staff (the RI Supervisor and Coordinator) will use to record the relevant activity of the beneficiaries, which will result, as appropriate, in the immediate and electronic delivery of earned incentives to the beneficiary. The IM platform will also provide vital data and analytics on the participation in the pilot, beneficiary activity and participation, earnings and provider participation.

MDHHS has selected the eRecovery solution from CHESS Health, a company focused on addressing substance use disorder through technology and peer services, to serve as the IM platform. CHESS Health has nearly a decade of experience working with behavioral health providers, public sector agencies and health plans during which the company has implemented strict technical and operational controls to protect the privacy of the sensitive data it stores, including via third-party reviews of its processes and vulnerability testing.

Provider staff will be provided with access to the CHESS Dashboard (the web front-end that will serve as the IM platform), via MI Login, which staff will use for the following purposes:

- Enrolling beneficiaries into the RI Pilot.
- Linking the beneficiary to a reloadable debit card to be handed directly to the beneficiary.
- Recording the results of the beneficiary's UDT, which, depending on the test result, may earn the beneficiary incentives, which will be paid to their reloadable debit card.
- Disenrolling beneficiaries from the RI Pilot, when applicable.

- Running reports and viewing analytics.

Additional details on use of the IM platform will be described in a forthcoming User Guide.

12 Program Oversight

PIHPs are required to complete a comprehensive review of RI Pilot provider agencies on an annual basis. This review should include review of the policies and procedures at the provider level related to the RI Pilot to ensure all requirements are included, review of training completion by staff identified for the Pilot, review of fidelity to the RI Pilot model and requirements.

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 quarterly audit of the incentive delivery functions including the incentive calculations and distribution records of the organization.

Each provider shall develop and implement a policy consistent with the RI Pilot requirements.

Participating PIHPs shall pull reports 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.

All reports should be included within the quarterly EGrAMS reports.

Participating PIHPs shall review these data elements to monitor utilization of CM services. PIHPs shall identify if CM providers would benefit from technical assistance to address issues regarding utilization or quality. PIHPs 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 PIHPs shall report to MDHHS 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 MDHHS. As part of the QPR, each county must utilize the 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.

MDHHS will provide PIHPs with a reporting template. Each QPR with IM County Report shall be submitted to MDHHS at mdhhs-recoveryincentives@michigan.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 (October 1-December 31).
- Quarter 2 (January 1- March 31).
- Quarter 3 (April 1- June 30).
- Quarter 4 (July 1-September 30).

Participating PIHPs 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.
- Provider Bulletin.
- Medicaid guidance including the 1115 Waivers and the Medicaid State Plan.
- CM protocol and other requirements as specified in this handbook.
- Provider contracts.

Monitoring activities shall include onsite visits, video meetings and/or desk reviews.

12.1 Implementation Check-Ins

This section will be completed and shared.

Program Evaluation

MDHHS will contract with an independent evaluator to conduct an evaluation of the RI Pilot that meets federal and state requirements. The evaluation will measure changes in key outcomes (e.g., rates of ED visits and inpatient stays related to SUD; utilization of treatment services and medications for SUD and co-occurring mental health conditions) for beneficiaries participating in the RI Pilot. Additionally, the evaluation will assess factors related to the implementation of and fidelity to the RI Pilot model, including exploration of equity across subpopulations; measures will include rates of attendance, positive/negative/missing drug tests, disenrollment and re-engagement. Finally, the evaluation will include provider and beneficiary perceptions of the RI Pilot collected through surveys and brief structured interviews.

Providers participating in the RI Pilot must agree to share all RI Pilot clinical and cost data with MDHHS to the extent necessary to fulfill federal and state monitoring and evaluation requirements. It is the goal of MDHHS to utilize administrative data as much as possible to avoid unnecessary reporting burden on providers.

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

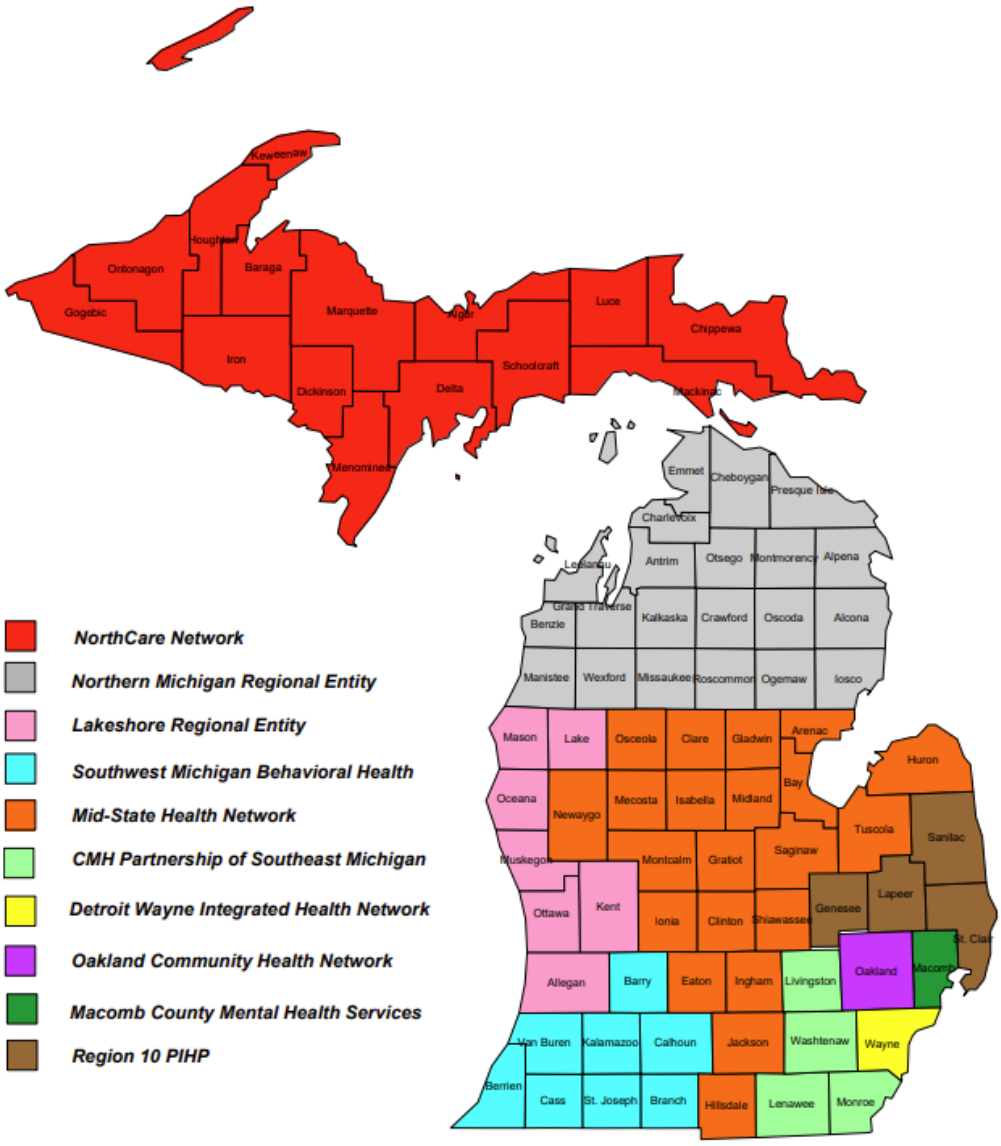
12.2 PIHP Meetings

PIHPs shall participate in meetings with MDHHS and the state's contracted trainer and technical advisor regarding CM implementation at a cadence to be determined by MDHHS. 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.

12.3 Final Report

PIHPs shall submit a brief final report regarding the Recovery Incentives Program to MDHHS no later than 60 days after the end of their agreements with MDHHS. MDHHS will provide more guidance on the

Final Report. MDHHS anticipates the Final Report will be incorporated into the Final Evaluation Report conducted by MDHHS' contractor. Please contact mdhhs-recoveryincentives@michigan.gov for any questions.


NorthCare Network
Northern Michigan Regional Entity
Lakeshore Regional Entity
Southwest Michigan Behavioral Health
Mid-State Health Network
CMH Partnership of Southeast Michigan
Detroit Wayne Integrated Health Network
Oakland Community Health Network
Macomb County Mental Health Services
Region 10 PIHP
Keweenaw
Houghton
Ontonagon
Baraga
Gogebic
Marquette
Alger
Luce
Chippewa
Iron
Dickinson
Delta
Schoolcraft
Mackinac
Menominee
Emmet
Cheboygan
Presque Isle
Charlevoix
Antrim
Otsego
Montmorency
Alpena
Leelanau
Grand Traverse
Benzie
Kalkaska
Crawford
Oscoda
Alcona
Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
Mason
Lake
Osceola
Clare
Gladwin
Arenac
Huron
Oceana
Newaygo
Mecosta
Isabella
Midland
Bay
Tuscola
Sanilac
Muskegon
Montcalm
Gratiot
Saginaw
Ottawa
Kent
Ionia
Clinton
Shiawassee
Genesee
Lapeer
St. Clair
Allegan
Barry
Eaton
Ingham
Livingston
Oakland
Macomb
Van Buren
Kalamazoo
Calhoun
Jackson
Washtenaw
Wayne
Berrien
Cass
St. Joseph
Branch
Hillsdale
Lenawee
Monroe

Appendix I. Sample Urine Drug Tests

Company Name	Product Name	Required Tests	Additional Tests Included in Standard Cup	General Cost Estimate for Standard Cup (as of 5/15/2024)	Product Link	Manufacturer Contact Information
CLIAWaived, Inc.	12 Panel IDTC Cups II with Adulterants	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, MDMA, MTD, PCP, TCA, THC	$4.99 per cup; around $124.75 per box of 25.	https://cliawaived.com/cliawaived-inc-idtc-12-panel-cup-with-adulterants.html	**Telephone:** (858) 481-5031 **Email:** info@cliawaived.com
CLIAWaived, Inc.	14 Panel IDTC II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, EDDP, MDMA, MTD, PCP, TCA, THC	$4.50 per cup; around $112.50 per box of 25.	https://cliawaived.com/cliawaived-inc-14-panel-idtc-ii.html	**Telephone:** (858) 481-5031 **Email:** info@cliawaived.com
Lochness Medical	Multi-Drug One Step Cup	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, BUP, MDMA, EDDP, KET, THC, MTD, MDPM, PCP, PPX, TRA, TCA	$5.40 per cup.	https://www.lochnessmedical.com/Product/Urine-Drug-Test-cups	**Telephone:** (888) 506-2658 **Email:** info@lochnessmedical.com Orders: orders@lochnessmedical.com

Company Name	Product Name	Required Tests	Additional Tests Included in Standard Cup	General Cost Estimate for Standard Cup (as of 5/15/2024)	Product Link	Manufacturer Contact Information
Premier Biotech	Premier Bio-Cup	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, MDMA, MTD, PCP, THC	$2.50-$3.00 per cup; around $68.75 per box of 25.	https://innovation.premierbiotech.com/rapid-testing/urine-testing/premier-bio-cup/	**Telephone:** Product Questions: (888) 686-9909 Laboratory Questions: (855) 718-6917
CLIAWaived, Inc.	13 Panel Cup CLIAWaived Cup with Fentanyl and Adulterants - CLIAWaived for Fentanyl Testing!	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP 10, BZO, FEN 5, MDMA 500, MTD, PCP, THC 50 + CRE, pH	$5.50 per test; $137.50 per box of 25.	https://cliawaived.com/chemtron-13-panel-cup-w-adulterants-cliawaived-for-fentanyl-testing.html	**Telephone:** (858) 481-5031 **Email:** info@cliawaived.com
Premier Biotech	14 Panel CLIA Waived Urine Test Cup	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, MDMA, MTD, PCP, THC, FYL, TCA, TML	$4.95 per test; $123.75 per box of 25 tests.	https://innovation.premierbiotech.com/rapid-testing/clia-waived/	**Telephone:** Product Questions: (888) 686-9909 Laboratory Questions: (855) 718-6917

Appendix II. Sample Consent Form

[Drawing]

Michigan's Recovery Incentives Pilot Program

Beneficiary Consent Form

The Recovery Incentives Pilot (RI Pilot) program uses the evidence-based practice of contingency management (CM) to provide motivational incentives to aid in one's recovery journey. These motivational incentives are monetary 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.

The following consent must be explained to the beneficiary and signed, in order to start participating in the RI Pilot program.

Eligibility

1. I understand I must reside in a region served by a participating Prepaid Inpatient Health Plan or be an American Indian/Alaska Native beneficiary, served by a participating Tribal Health Center or Tribal Federally Qualified Health Center.
2. I understand I must be diagnosed with a qualifying Stimulant Use Disorder (StimUD) or Opioid Use Disorder (OUD), or both, as determined through an assessment by a substance use disorder (SUD) provider using multidimensional assessment that covers the dimensions in the American Society of Addiction (ASAM) Criteria. With my provider, I will select either StimUD or OUD as the targeted substance to earn incentive payments for the duration of the program.
3. I understand I must comply with existing laws governing minor consent and restrictions on certain provider types for behavioral health services to minors. There is no minimum age limit for receiving CM services if I meet all other eligibility criteria.
4. I understand I must not be enrolled in another CM program for StimUD and/or OUD while participating in the program.
5. I understand I must not be receiving care in residential treatment (e.g., American Society of Addiction Medicine (ASAM) levels 3.1–4.0) or other institutional settings while participating in this program. I will wait until I am discharged to an outpatient level of care. During my enrollment in the RI Pilot program, I will notify the program site if I am admitted into a residential treatment program.
6. Participation in the RI Pilot program is voluntary, and I can discontinue at any time. Leaving the RI Pilot program will not impact my eligibility to participate in any other medically necessary clinical services.
7. I understand that my incentive is calculated based on attending required office visits and providing urine for urine drug tests, following the schedule below:
    - Week 0 – Intake visit, no UDT required, no incentive earned
    - Week 1-12 – 2 clinic visits, 2 UDTs
    - Week 13 – 24 – 1 clinic visit, 1 UDT

DRAFT

This form is created through a partnership with Michigan Department of Health and Human Services and Altarum, using opioid settlement funding to train and provide technical assistance to Michigan providers in the evidence-based practice of Contingency Management.

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MICHIGAN Recovery Incentives PILOT

Michigan's Recovery Incentives Pilot Program

Beneficiary Consent Form

8. I may come to the clinic more often to participate in services, and these visits will not involve submitting a urine sample for a UDT as part of the RI Pilot program.
9. I can start the RI Pilot program at any time. The RI Pilot program will not extend beyond 24 weeks.

Incentive Amount

10. I will receive an incentive payment each time I submit a RI Pilot program scheduled UDT. The incentive payment will take the form of a reloadable debit card.
11. The results of the urine drug test are final, and I agree to accept the outcome and decision of RI Pilot program staff even if I disagree with it.
12. I will receive the incentive payment immediately when I give a stimulant or opioid-negative UDT.
13. I understand that the incentive amount is auto calculated through the Incentive Manager platform and is predetermined by an equation based on UDT results and appointment number. Onsite staff cannot alter the amount delivered.
14. If all tests are stimulant or opioid-negative over 24 weeks, I will earn $599. If for any reason I need to restart the program, the maximum that I can earn is $599 per calendar year including current and any previous participation in the Recovery Incentives Program.
15. I will receive a $5 continued engagement incentive if I submit a UDT that is stimulant or opioid-positive or I am unable to provide a sample.

	Incentive Schedule		
Week	**Number of Weekly Visits/UDTs**	**Incentive Type**	**Value ($)**
1-12	2	Base Incentive for Negative UDT	$10.00
		Base Incentive for Positive UDT/No UDT w/ Continued Engagement (Appointment Attendance)	$5.00
		Weekly Increase to Incentive for Continuously Negative UDTs	$1.50
13-18	1	Incentive for Weekly Negative UDT	$15.00
19-23	1	Incentive for Weekly Negative UDT	$10.00

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MICHIGAN Recovery Incentives PILOT

Michigan's Recovery Incentives Pilot Program

Beneficiary Consent Form

	Incentive Schedule		
Week	Number of Weekly Visits/UDTs	Incentive Type	Value ($)
24	1	Incentive for Final Negative UDT	$21.00

16. During the first 12 weeks, if I submit a stimulant or opioid-positive UDT, the incentive payment will return to $10 the next time I provide a stimulant or opioid-negative UDT. Once I give a second stimulant or opioid-negative UDT, I will get back all the increases I earned previously and will continue to earn increases each time I test negative for stimulants or opioids two (2) times in a row.
17. During the second half of the Program (weeks 13-24), if I submit a stimulant or opioid-positive UDT, I will receive a $5 continued engagement incentive. On my next stimulant or opioid-negative UDT I will receive an incentive in the amount that is scheduled for that week ($15 in weeks 13-18, $10 in weeks 19-23, and $21 in week 24).

Other Considerations

18. While participating in the RI Pilot program, I will not use over-the-counter medications, prescription medications, or health supplements known to cause a stimulant or opioid-positive UDT. I have reviewed the list of items that could interfere with test results. I understand that use of these items may affect my UDT results. I agree I will discuss making any changes to my prescribed medications with my medical provider prior to making changes in my medications. I will not receive an incentive payment when my urine sample tests positive for stimulants or opioids even if the stimulant or opioid-positive UDT is from one of the medications from the list of items known to cause a stimulant or opioid-positive UDT result.
19. For unavoidable absences (e.g., a doctor appointment, illness, funeral, etc.), I will reschedule my UDT visit on a contiguous day if at all possible. If I cannot reschedule, I can request an excused absence by notifying the clinic before the missed session. I will provide documentation of the reason for the absence at the next scheduled visit (e.g., receipt from the doctor, funeral announcement, travel ticket, employer work schedule, document from judicial authority). I understand that if the clinic approves the absence, it will be recorded as excused, I will not receive an incentive for that visit, and at my next visit the incentive payment will continue at the same level as if the absence had not occurred, for up to two consecutive excused absences. If the excused absence extends to three or more visits, my incentive amount will reset to the original $10.
20. I understand that excused absences must be requested and approved prior to the scheduled visit. Visits cannot be approved as excused after the date of a scheduled visit and would be recorded as missed.

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MICHIGAN Recovery Incentives PILOT

Michigan's Recovery Incentives Pilot Program

Beneficiary Consent Form

21. I agree that I will give my own urine for all urine drug tests; I will not tamper with the urine sample; and I commit to following the rules and procedures of the Recovery Incentives Program.
22. The clinic will collect information about me throughout my participation in the Recovery Incentives Program for evaluation and incentive tracking purposes.
23. The Recovery Incentives Program staff will record my attendance, UDT results, and any incentive payments distributed in an electronic database. I understand that incentive amounts are auto-calculated by the database based on UDT results and appointment number.
24. I will be able to submit any feedback about the Recovery Incentives Program by emailing MDHHS-RecoveryIncentives@michigan.gov
25. I agree to complete evaluation surveys and forms related to my participation in the Recovery Incentives Program to help program staff understand how this program helped me and others.

Selected Substance (check one): ☐ Stimulants ☐ Opioids

_____

Printed Name **Signature** **Date**

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