State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

Medi-Cal Contingency Management Pilot Program: Background, Training, and Evaluation of California's Recovery Incentives Program

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Introduction

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative of the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. As part of the CalAIM demonstration, California became the first state in the nation to receive federal approval to cover contingency management (CM) services for substance use disorders (SUD) as part of the Medicaid program. California's program that offers the CM benefit is called the Recovery Incentives Program. DHCS will pilot Medi-Cal coverage of CM in Drug Medi-Cal Organized Delivery System (DMC-ODS) counties that opt in to cover the service starting in 2023. DHCS' primary goal for the pilot is to determine how to scale a proven treatment for stimulant use disorder (StimUD) in Medi-Cal in a large, complex state, supporting DHCS' broader policy goals to:

- Address the ongoing and shifting SUD crisis in California through the implementation of evidence-based treatments and practices; and
- Improve the health and well-being of Medi-Cal beneficiaries living with StimUD, as measured by a reduction or cessation of drug use and longer retention in treatment.

In January 2022, DHCS released a draft policy design in partnership with nationally recognized experts from the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs and key stakeholders. In October 2022, DHCS released Behavioral Health Information Notice 22-056 providing state standards for the Recovery Incentives Program and outlining steps participating DMC-ODS counties must take to implement CM services. DHCS anticipates providing additional guidance to counties and providers in the coming months, and continuing stakeholder engagement to prepare for the implementation of the Recovery Incentives Program.

Background on Need in California

Similar to other states, California is grappling with a persistent and shifting SUD crisis. While opioids still account for the largest share of drug-related deaths in the state, deaths from methamphetamine and other stimulants have almost quadrupled since 2010.[i] Among chronic users, stimulants can cause cognitive impairments, psychosis, violent behavior, and cardiac and pulmonary disease.[ii] The number of people in California and around the country using multiple substances at the same time ("polysubstance use") is also increasing; in 2017, about half of stimulant-involved deaths nationwide also involved opioids.[iii] The widely covered overdose crisis focused on White and American Indian/Alaska Native populations, but in the past decade, the most dramatic increases in overdose rates have been among Black populations, due in part to stimulant and polysubstance use.[iv] From 2015 to 2019, the rate of increase in stimulant-related overdose deaths was 40 percent for Black populations, nearly twice the increase experienced by the population as a whole.[v] These trends make it imperative to offer effective treatment to people living with StimUD, both as a matter of

saving lives and as a matter of addressing historical disparities in the SUD treatment system.

Unlike for opioid use disorder (OUD) and alcohol use disorder, no Food and Drug Administration-approved medications exist to treat StimUD. However, evidence-based practices (EBPs) can be deployed, including motivational interviewing, community reinforcement approach (CRA), cognitive behavioral therapy (CBT) and, most importantly, CM.[vi]

What Is Contingency Management (CM)?

CM is an EBP that recognizes and reinforces individual positive behavior change consistent with meeting treatment goals, including medication adherence, as well as substance and stimulant nonuse. Under California's initial design, CM provides motivational incentives for nonuse of stimulants as evidenced by negative drug tests. The motivational incentives are an inherent and central element of CM treatment. The immediate delivery of the incentive helps tip decision-making toward avoiding stimulant use to manage difficult periods. CM repeatedly has demonstrated robust outcomes, including reduction or cessation of drug use and longer retention in treatment.[vii, viii, ix, x, xi]

To expand access to evidence-based treatment for StimUD, DHCS intends to pilot Medi-Cal coverage of CM in select DMC-ODS counties beginning in 2023, in accordance with recent approval from the Centers for Medicare & Medicaid Services (CMS) as part of the CalAIM demonstration.[xii] As part of the pilot, eligible Medi-Cal beneficiaries may participate in a structured 24-week outpatient CM program, followed by six or more months of additional recovery support services. Individuals will be able to earn motivational incentives in the form of low-denomination gift cards, with a total retail value determined for each treatment episode. DHCS is committed to ensuring that the Recovery Incentives Program has guidelines that protect against fraud and abuse. In particular, DHCS is mindful of the importance of not violating the federal Civil Monetary Penalties Law (CMPL) or the Anti-Kickback Statute (AKS), which are enforced by the U.S. Department of Health and Human Services Office of the Inspector General (OIG). The federal government has explicitly recognized that motivational incentives delivered as part of the Medicaid-covered CM benefit according to the CM protocol for the pilot do not implicate the AKS and CMPL in the state's approved CalAIM Demonstration.[xiii] DHCS is committed to implementing CM with strong guardrails in place to ensure the integrity of CM, promote fidelity to the EBP, and mitigate the risk of fraud, waste, or abuse associated with the distribution of motivational incentives.

The proposed pilot will run through March 2024. DHCS will implement CM using an incentive manager vendor with multiple gift card options, including print, e-mail or SMS (text message). By implementing both paper and mobile incentive options, DHCS seeks to ensure program participants without smartphones or reliable broadband access can receive CM services.

DHCS began working with DMC-ODS counties and providers in Fall 2021 to plan for a staggered implementation with the first cohort of counties and providers starting in the

first quarter of 2023. In November 2021, DHCS released an expression of interest (EOI) to initially gauge county interest in participation in the pilot, followed by a request for applications (RFA) in January 2022 to formalize DMC-ODS counties' commitments to participate in the pilot. Twenty-four DMC-ODS counties will be participating in the Recovery Incentives Program.

Beginning in April 2022, DHCS provided participating counties with startup funding to assist in hiring a designated CM coordinator and establishing CM program infrastructure. In addition, DHCS will provide participating counties and SUD providers comprehensive trainings with ongoing technical assistance throughout the pilot. Finally, DHCS will conduct a robust evaluation to determine the program's impact on participants' changing behaviors around stimulant use. During the pilot period, DHCS will cover the nonfederal share of CM, training costs, drug testing, and other administrative costs incurred by providers and counties to deliver CM in accordance with the program design.

DHCS intends to use the pilot as a basis for informing the design and implementation of a statewide CM benefit through the DMC-ODS program, pending budgetary and statutory authority.

Training and Technical Assistance (T/TA) Plan

As part of the Recovery Incentives Program, DHCS will provide a comprehensive, multilevel implementation T/TA program. DHCS has contracted with UCLA to develop and implement the T/TA plan. The rollout will include broad CM information dissemination designed to introduce participating county and provider staff to the concepts of CM, answer questions, and generate interest in the Recovery Incentives Program. This will be followed by specific protocol implementation training targeted to providers with county participation expected.

All training will be provided virtually and will be live and synchronous to accommodate diverse program schedules across California. Trainings can be recorded for staff to review at their leisure following participation in the synchronous session. These recorded training can be used by providers to review content, but viewing the recordings alone will not qualify as completing the required training as all participants must attend one of the live, synchronous trainings. Training will be designed to ensure that providers acquire the skills necessary to implement the in-person CM protocols. Prior to initiation, sites will participate in a readiness review, and additional T/TA will be provided to address any areas of concern. Ongoing TA after implementation will also be offered both virtually and on-site, as needed. The self-paced overview training has been available since May 2022. Implementation training is scheduled to start in January 2023 and will be offered throughout the remainder of the pilot period. TA will be offered from May 2022 through March 2024.

Additional details regarding the T/TA Plan will be forthcoming from DHCS.

Required Training

The following training components are being considered for initial and ongoing training. These include:

CM Overview Training. Statewide broad overview training will help set the context for CM, research findings, and overview of the protocol/agency requirements for implementation. The primary goal of this self-paced asynchronous training is to secure interest in and enthusiasm for participation. This training will be required for select county staff and all provider CM staff and their supervisors who are involved in the treatment of individuals living with StimUD who may be candidates for CM. Key topics include:

- Key elements of CM
- Types of reinforcers
- Common misconceptions about CM
- Research support for CM
- Open discussion regarding concerns about implementing a CM program

Specific CM Protocol Implementation Training. This intensive training will be for CM coordinators and one or two backup personnel, including a supervisor, with county participation expected. This will be followed by mandatory CM Zoom "coaching" session for the first six months after CM initiation, followed by monthly Zoom sessions for the duration of the project. This training will include:

- An overview of California's CM protocol
    - Incentive manager vendor CM protocol
- CM implementation tasks
    - Identifying eligible participants
    - Program and staff roles
    - Documentation and fidelity requirements
    - Participant management issues, including:
        - Handling missed appointments.
        - Managing disagreement with and/or emotional/angry responses to UDT results and/or participants who are displaying symptoms of serious mental illness or drug intoxication, including how to effectively and safely interact with participants who are psychotic, intoxicated, paranoid or suicidal.
        - Collecting and monitoring sample collection following appropriate procedures.
        - Reading test results.
        - Recognizing and managing efforts to tamper with/falsify the sample.
        - Engaging in participant interactions (praise and/or encouragement) within the limits of the CM protocol.
        - Tracking, understanding, and communicating incentive amounts.

    - Conducting regular audits of incentives delivered to participants and cross-checking with data in the incentive distribution database.
    - Communicating with clinical staff regarding UDT results and any information of clinical relevance, including need to coordinate referrals to other providers (e.g., MAT).

Understanding the OIG's Final Rule and Operational Guidelines. This training will include:

- Information on the OIG's Guidance, including the Final Rule and how it applies to providers offering CM.
- Specific documentation requirements to demonstrate compliance with the OIG's Final Rule for those using local documentation, including the pros and cons of the method.
- Frequently asked questions and open discussion.

Readiness Review. After completing CM training, provider organizations will be required to undertake a readiness review before being permitted to administer CM. The CM coordinator will pass a CM proficiency assessment. The readiness review will include:

- Interactive demonstration of readiness review procedures and site-specific implementation goals.
- Entering pilot cases into the incentive manager to demonstrate proficiency with these tools.
- Responding to preset scenarios, including how to handle disputes over test results, tampered samples, and positive results for drugs other than stimulants.

Technical Assistance (TA)

TA for participating providers will be delivered in regularly scheduled virtual meetings post implementation that provide direct consultation on CM protocol implementation and provide an open space to facilitate peer-to-peer learning and problem-solving. Attendance at the sessions will be required for CM coordinators and backup personnel. The goal of these meetings will be to provide coaching/mentoring through discussion of implementation issues and address questions, problems, and concerns in implementing the CM protocol in a way that is culturally responsive. More targeted TA will be provided to provider agency staff and supervisors, both virtually and in person, to address specific technical issues with protocol implementation or management.

TA will also include fidelity reviews where participating agencies will receive a periodic review to determine adherence to the required protocol. Fidelity monitoring will occur twice within the first six months of implementation and then once every six months thereafter. TA and coaching will be provided to address any areas of concern that arise as a result of these reviews.

Evaluation Plan

The impact of the Recovery Incentives Program will be measured through a robust evaluation process. DHCS has contracted with UCLA to develop and implement the evaluation plan. The study team will work with participating counties and SUD providers to ensure that all entities are informed regarding the purpose of the evaluation, protocols, and reporting requirements to be used for the pilot, and any follow-up needed that is specific to the evaluation during the pilot.

Further documents regarding the evaluation details are forthcoming.

Evaluation Approach

The evaluation approach is organized around the RE-AIM framework:

1. **Reach.** This will be measured as the percentage of people in treatment for StimUD who participate in CM during the pilot period. UCLA will also evaluate whether there are disparities in reach to different beneficiary populations. Data for this measure will be collected from the incentive manager vendor, DMC-ODS claims, and the California Outcomes Measurement System, Treatment (CalOMS-Tx).[1]

2. **Effectiveness.** Effectiveness will be based on the results of UDTs. Data will be extracted from the incentive manager vendor. UCLA will track CM's impact on treatment retention (using data from CalOMS-Tx and DMC-ODS claims) and treatment attendance (using DMC-ODS claims data).

3. **Adoption.** Adoption will be measured by evaluating how many provider agencies deliver CM services. This will be evaluated using DMC-ODS claims data.

4. **Implementation.** Implementation will be evaluated by the degree to which CM is implemented with fidelity to the protocols and by tracking adaptations made. Perceptions of challenges and areas for potential improvement will also be collected from provider staff and participants. Data for this measure will be collected from the incentive manager vendor, surveys with staff and participants, and interviews with staff and participants.

5. **Maintenance.** Maintenance will be measured by evaluating the degree to which programs implementing CM continue providing the service throughout the evaluation period, based on data collected from the incentive manager vendor and claims data. In addition, surveys and qualitative interviews with staff will focus on factors that could promote or impede the continued delivery of CM services.

[1] CalOMS Treatment (CalOMS-Tx) is California's data collection and reporting system for SUD treatment services.

Methods

The evaluation will make use of existing administrative data wherever possible, but will also require cooperation from providers and participants. Current reporting requirements for other DMC-ODS services will remain in place during the CM pilot program. Administrative data will include DMC-ODS claims, CalOMS-Tx, and where possible vital statistics and managed care/fee for service data.

Incentive Manager Data. The incentive manager vendor will include a unique participant number, UDT results, dates, and amounts of payments.

Drug Medi-Cal Claims. Short-Doyle Drug Medi-Cal claims data from participating providers will be analyzed. The UCLA evaluation team already receives this data as part of the DMC-ODS evaluation.

CalOMS-Tx. CalOMS-Tx admission and discharge records from participating providers will be analyzed. UCLA already receives this data as part of the DMC-ODS evaluation.

Provider Surveys. Provider staff will be surveyed about CM implementation, challenges, beliefs, and perceptions, and to check for signs of fraud. Participating providers will be asked to provide email addresses for their participating staff, and evaluators will send online invitations to those addresses. The surveys will be conducted online, via Qualtrics.

Provider Interviews. In addition, the study team will conduct interviews and/or focus groups with a sample of providers from agencies that implement CM as part of the pilot. These will continue until additional themes cease to emerge from data collection (saturation has been achieved). Interviews and focus groups will focus on identifying the strengths and weaknesses of the CM program and potential ways to improve the uptake and effectiveness of CM. Interviews and focus groups will be recorded, transcribed, and coded using a constructivist grounded theory approach.

Participant Surveys. Providers will be asked to provide a link to an online survey to beneficiaries receiving CM. Additional instructions on the web address and timing are forthcoming. UCLA will obtain consent from the participants to contact them and conduct surveys during and after treatment, with the goal of identifying strengths and challenges in the program.

Participant Interviews. The study team will conduct semi-structured interviews with a sample of participants who participate in the CM program to identify the program's strengths and ways the program can be improved. Interviews will be recorded, transcribed, and coded. In addition, survey respondents who report potentially fraudulent activities and provide UCLA with permission to contact them will be invited by a member of our staff for a follow-up interview.

Evaluators will work with stakeholders to identify appropriate procedures that balance the need for confidential data collection with the benefits of reporting actionable allegations to the appropriate parties.

All analyses will be conducted at both the state and county levels.

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