Short Report

The Recovery Incentives Program: California's Contingency Management Benefit
Early Implementation Lessons Learned, February-June 2023

Prepared by
Howard Padwa, Ph.D., Madelyn Cooper, B.A., Carissa Loya, B.A.,
Sze Yi Celine Tsoi, B.A., Brittany Bass, Ph.D., Valerie P. Antonini, M.P.H.
& Darren Urada, Ph.D.

UCLA David Geffen School of Medicine
Integrated Substance Abuse Programs

Report prepared for California Department of Health Care Services - Agreement 20-10462
Deliverable 16 - June 30, 2023

TABLE OF CONTENTS

PURPOSE

California has faced a growing stimulant epidemic in recent years, with over half of the state's population that is receiving substance use disorder (SUD) treatment having problems related to stimulant use (California Outcome Measurement System – Treatment—CalOMS-Tx, 2023). Skyrocketing rates of stimulant-related hospitalizations (Zhao et al., 2021) and overdoses (California Department of Public Health, 2022) have transformed stimulant misuse into a public health emergency. Currently, the most effective treatment for stimulant use disorders (StimUDs) is contingency management (CM), an evidence-based, cost-effective treatment that utilizes drug testing and incentives to facilitate abstinence from stimulants (AshaRani et al., 2020; Brown & DeFulio, 2020; Farrell, et al., 2019). To address its stimulant crisis, California obtained permission from the Center for Medicare and Medicaid Services to become the first state to provide CM for Medicaid beneficiaries with StimUD as a pilot project under a Section 1115 Waiver (California Department of Health Care Services – DHCS, 2022).

California is delivering CM through its Recovery Incentives Program. In counties that have received DHCS approval to provide Recovery Incentives services, Medi-Cal beneficiaries who have StimUD diagnoses and receive treatment in non-residential levels of care are eligible to participate. Under the Recovery Incentives Program, beneficiaries receive 24 weeks of outpatient CM services, which consist of a series of incentives (in the form of cash-equivalent gift cards) for meeting goals for abstinence from stimulants as objectively verified by point-of-care urine drug tests (UDTs) (DHCS, 2022). For further details on the Recovery Incentives Program, see the resources and documents available on DHCS' Contingency Management website, https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx.

UCLA's Integrated Substance Abuse Programs (UCLA-ISAP) is evaluating the Recovery Incentives Program under contract with DHCS. The UCLA-ISAP evaluation (UCLA-ISAP, 2022) is utilizing the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework developed in the field of implementation science (Glasgow, Vogt, & Boles, 1999; RE-AIM, 2023) to evaluate the Recovery Incentives Program in the following domains:

- Reach: What percentage of people receiving treatment for StimUD participate in the Recovery Incentives Program? Are there disparities in reach to different beneficiary populations (e.g., race, ethnicity, gender, age, county)?
- Effectiveness: Based on UDT results, how effective is the Recovery Incentives Program in helping beneficiaries achieve abstinence from stimulants? What impact does Recovery Incentives Program participation have on treatment retention and treatment engagement?
- Adoption: How many provider agencies deliver Recovery Incentives Program services?
- Implementation: To what degree is CM implemented with fidelity to Recovery Incentives Program protocols? What are perceived challenges and areas for potential improvement?
- Maintenance: To what degree do programs implementing the Recovery Incentives Program continue providing the service throughout the evaluation period? What could promote or impede the continued delivery of Recovery Incentives Program services after the end of the pilot program period?

The data sources for the UCLA-ISAP evaluation include DHCS administrative databases (CalOMS-Tx, California Department of Public Health's Comprehensive Death File, Drug Medi-Cal Claims, Medi-Cal Eligibility Data System, Master Provider File Medi-Cal Managed Care Plan/Fee-for-Service Data, Recovery Incentives Program Incentive Manager, Short-Doyle Medi-Cal Mental Health Claims) and primary data that UCLA-ISAP collects directly (ASAM Level of Care data, beneficiary/provider/county administrator surveys and interviews, fidelity assessments, observation of training and technical assistance activities - implementation trainings, readiness assessments, and coaching calls) (UCLA-ISAP, 2022).

This report is the first evaluation report UCLA-ISAP will prepare throughout the course of the Recovery Incentives Program, fulfilling Deliverable 16 of UCLA-ISAP's contract with DHCS (Contract 20-10462).

FINDINGS

The Recovery Incentives Program was originally scheduled to begin in July 2022, but it did not actually launch (preparing sites to begin delivering services) until February 15, 2023. Consequently, many of the administrative datasets and primary sources described above have yet to generate sufficient data for analysis. The only data sources used in the present report are the observations of training and technical assistance activities conducted by the UCLA-ISAP Training and Implementation Support team. Thus, all findings presented in this report are initial and highly preliminary, since they are based on data from just the first four months of program implementation (February 15-June 16, 2023), which consisted mostly of ramp-up training and readiness assessment activities for the Recovery Incentives Program.

Reach

The Recovery Incentives Program enrolled its first beneficiary on April 3, 2023. According to data provided by the UCLA-ISAP Training and Implementation Support team, a total of 156 beneficiaries have enrolled statewide as of June 16, 2023. Based on counts of the StimUD population receiving treatment in California in 2021 (the last year with fully available data), this represents approximately 0.29% of the Medi-Cal beneficiaries receiving StimUD treatment statewide, and 0.32% of eligible beneficiaries in the 24 counties participating in the pilot. Due to the small sample size, small number of programs that have begun providing services, and early stage of program implementation, it is not possible to report any meaningful findings concerning beneficiary demographics or subpopulations at this time.

Effectiveness

Since no beneficiaries have completed the Recovery Incentives Program's 24 weeks of CM services, there is no data on program effectiveness at this time.

Adoption

As of June 16, 2023, it is anticipated that 166 sites across 24 counties will participate in the Recovery Incentives Program pilot. This represents approximately 27.6% of outpatient/intensive outpatient programs statewide and 33.4% of such programs in the 24 counties that are participating in the Recovery Incentives Program. Of these 166 sites, 63 (38.0%) have completed the two-part implementation trainings and are eligible to participate in the readiness assessment process, both of which are required before beginning service delivery. A total of 18 sites (10.8% of the total number of sites planning to participate) have completed the readiness assessment process and 13 (7.8%) have received DHCS approval to start delivering CM services, with the first site receiving approval in March 2023. Seven of these sites are in Los Angeles County, four are in Riverside County, one is in Kern County, and one is in San Francisco County. Twelve of these thirteen sites have enrolled at least one beneficiary in CM services.

Implementation

From February 15-June 16, 2023, the UCLA-ISAP team observed and/or took detailed notes on 25 implementation trainings, 13 readiness assessment interviews (which are required for all programs prior to Recovery Incentives Program implementation), and one monthly coaching call (which is required for all programs that have begun implementation). In the course of these activities, UCLA-ISAP identified perceived challenges and areas for potential improvement, voiced by providers and staff who will be responsible for implementing the Recovery Incentives Program. The six major themes that emerged in these discussions were related to: (1) eligibility requirements; (2) UDT testing procedures; (3) use of UDT results outside of the Recovery Incentives Program; (4) concerns about incentives; (5) incentive manager software; and (6) logistical challenges.

It should be noted that all of these perceived challenges and areas for potential improvement are ones that were mentioned by providers who will be delivering Recovery Incentives services, but are not necessarily actual barriers to program implementation, since DHCS has policies and procedures in place to address these issues and the UCLA-ISAP Training and Implementation Support team has communicated appropriate policies to providers as needed. Moreover, since program implementation just began, it is too early in the Recovery Incentives Program to say if any of these issues have impeded the program or require any shifts in policy and practice—they are only being mentioned here as perceived challenges and areas for potential improvement to potentially inform guidance that DHCS and the UCLA-ISAP Training and Implementation Support team may provide for sites later in the Recovery Incentives Program.

- *Eligibility Requirements:* In several trainings, providers expressed concern about Recovery Incentives Program eligibility requirements that prevent some individuals with StimUD from participating. For example, when told that beneficiaries using certain medications are ineligible, some providers voiced concern about telling clients that they would need to alter other parts of their treatment plan by discontinuing contraindicated medications if they wanted to receive CM services. Others asked about flexibility to serve clients who are not current Medi-Cal beneficiaries, such as those whose Medi-Cal eligibility has lapsed or individuals who are not Medi-Cal eligible but have alternative coverage (e.g., the MyHealthLA program in Los Angeles County).

- *UDT Testing Procedures*: During trainings, many providers pointed out how the UDT procedures required by the Recovery Incentives Program differed from those they already had in place for other services that utilized testing. In particular, providers reported that they already had UDT procedures that involved sending samples to outside laboratories for testing (instead of utilizing on-site point-of-care tests as required for Recovery Incentives Program), that tested for fentanyl (which currently approved Recovery Incentives UDTs do not do), and/or required observation of beneficiaries providing samples (whereas Recovery Incentives Program does not require direct observation). In some meetings, providers voiced concern about the reliability of Recovery Incentives Program protocols, bringing up that beneficiaries could “cheat” on UDTs by adulterating samples and/or utilizing other peoples’ urine/synthetic urine if allowed to provide samples without direct observation. Providers mentioned these concerns even though approved UDT procedures for the Recovery Incentives Program have validity measures to detect and prevent tampering. Other questions that providers mentioned in pre-implementation trainings and discussions concerned how they should handle cases when beneficiaries contest UDT results.

- *Use of UDT Results Outside Recovery Incentives Program:* One issue that emerged in several pre-implementation discussions regarded the potential of sharing results of UDTs conducted for the Recovery Incentives Program with other providers. Some providers asked about sharing results of UDTs with providers outside of Recovery Incentives teams who delivered other services (e.g., counseling, medication support) to Recovery Incentives beneficiaries. Others reported that if they did this, it could create problems for beneficiaries who are participating in probation, criminal justice, or child welfare-related programs since disclosure of substance use could have legal ramifications.

- *Concerns about Incentives:* Several issues related to incentives came up in implementation trainings and readiness assessment discussions. In some discussions, providers expressed concern that beneficiaries would believe that they are “being paid not to use drugs” through the Recovery Incentives Program, and that CM could attract individuals who feign StimUD symptoms just so they can enroll and receive the incentives. Some providers were concerned about jealousy from clients who are not eligible for CM services (e.g., because they do not have a StimUD diagnosis, because they are not Medi-Cal beneficiaries), or the apparent “unfairness” of having some people in their program receive incentives but not others. Other providers expressed concern about the value of the incentives used in the CM protocol, and asked about the potential to adjust the incentives for inflation (something that is currently not feasible due to concern about exceeding the Recovery Incentives Program’s $599 annual limit). Another issue that emerged in discussions focused on beneficiaries receiving incentives when they did not necessarily need them or clinically benefit from them. For example, one provider asked if there are

any safeguards to prevent beneficiaries from participating in Recovery Incentives Program twice by completing the protocol and then re-enrolling after the new year begins, so they can earn up to $599 twice. Another provider expressed concern that beneficiaries who disengage from treatment and relapse could still come back to the program and "demand" incentives they had already banked from previous successful UDT tests even after they resume stimulant use.

- *Incentive Manager Software:* Providers reported anxiety about utilizing the Recovery Incentives Program incentive manager software correctly in implementation trainings. Among the few sites that have begun service delivery, there have been cases where staff was unable to enter UDT results into the system because it only allows two entries in every seven-day period. At other sites, CM staff did not enter test results into the incentive manager system in real time even when beneficiaries did show up for UDT appointments.

- *Logistical Challenges:* Providers mentioned logistical challenges for both staff and beneficiaries as a potential concern and barrier to Recovery Incentives Program implementation. From the staffing perspective, providers in trainings and readiness assessments reported that many agencies have a small workforce and high levels of turnover, potentially making it difficult to maintain the three dedicated staff the Recovery Incentives Program requires. Other participants reported concern that it could be difficult to accomplish required activities in each CM visit (i.e., UDT service, data entry, discussion of results with beneficiaries) during just one billable 15-minute increment. Workload is also a concern for providers who already began delivering services. During the coaching call, providers from one agency reported that they have had challenges keeping up with all of the work of providing CM, and that they are going to need to train more staff than they originally anticipated to keep the program running smoothly. From the beneficiary perspective, providers reported that everyday occurrences such as transportation barriers or physical illnesses such as COVID-19 could frequently prevent them from showing up for UDT appointments.

Providers who have begun delivering Recovery Incentives Program services have also noted some strategies that seemed to have worked well in early implementation. In particular, providers have noted success in: (1) educating potential participants about the Recovery Incentives Program; (2) handling missed UDT appointments; and (3) providing positive reinforcement for beneficiaries who choose to "bank" their earned incentives (delay receiving incentives until a later date so they can save up to purchase a larger item):

- *Educating Potential Participants about the Recovery Incentives Program*: Providers reported several strategies for educating beneficiaries with StimUD about the Recovery Incentives Program and engaging them in CM services. These have included reviewing beneficiary rosters and making a point to tell individuals with StimUD about the Recovery Incentives Program, announcing the roll-out of Recovery Incentives in groups, and posting fliers about their Recovery Incentives Program services at step-down SUD treatment programs and local community events.

- *Handling Missed UDT Appointments*: Providers reported that thus far, they have not faced many challenges when beneficiaries have missed UDT appointments. In some cases, providers have called beneficiaries after their absence to remind them about appointments and schedule other times to come in—even just to talk if they were not confident they would have a successful UDT—thus keeping them positively engaged in care.

- *Providing Positive Reinforcement for Beneficiaries Who Choose to "Bank" Incentives*: In the Recovery Incentives Program, beneficiaries have the right to forego immediate receipt of incentives so they can save up to receive a large, lump-sum incentive once they complete the program. This approach, while potentially helpful in motivating beneficiaries with the potential for a large incentive, can also have the drawback of diminishing the immediacy of the reward beneficiaries receive for each successful UDT result. To provide some sort of immediate reward, one provider reported that for beneficiaries that are choosing to "bank" their rewards, he shows them a screen image that illustrates the cash value of the

incentives they earned that day and throughout their participation in the Recovery Incentives Program immediately after each UDT.

Maintenance

Since programs have only recently rolled out the Recovery Incentives Program, there is no information concerning factors that may promote or inhibit the future sustainment of the program at this time.

Next Steps

Though it is still very early in Recovery Incentives Program implementation, qualitative data have highlighted some areas where programs may struggle with CM service delivery, as well as potentially promising strategies that can support implementation. UCLA-ISAP will continue to monitor these areas as the Recovery Incentives Program continues to unfold, and advise DHCS on potential implications that evaluation findings may have for CM implementation and effectiveness in future reports.

GLOSSARY

ASAM Level of Care Data	American Society of Addiction Medicine Level of Care Data
CADPH	California Department of Public Health
CalOMS-Tx	California Outcomes Measurement System – Treatment (Administrative Database)
CM	Contingency Management
DHCS	California Department of Health Care Services
RE-AIM	Reach, Effectiveness, Adoption, Implementation, Maintenance (Implementation Science Framework)
StimUD	Stimulant Use Disorder
SUD	Substance Use Disorder
UCLA-ISAP	University of California, Los Angeles – Integrated Substance Abuse Programs
UDT	Urine Drug Test

REFERENCES

AshaRani, P.V., et al. (2020). Non-pharmacological Interventions for Methamphetamine Use Disorder: A Systematic Review. *Drug and Alcohol Dependence, 212,* 108060.

Brown, H.D., & DeFulio, A. (2020). Contingency Management for the Treatment of Methamphetamine Use Disorder: A Systematic Review. *Drug and Alcohol Dependence, 216,* 108307.

California Department of Health Care Services (DHCS) (2022). *Behavioral Health Information Notice 22-056 – The Recovery Incentives Program: California's Contingency Management Benefit.*

California Department of Public Health (2022). *California Overdose Surveillance Dashboard.* Retrieved from https://skylab.cdph.ca.gov/ODdash/

California Outcomes Measurement System – Treatment (CalOMS-Tx) (2023)

Farrell, M., et al. (2019). Responding to Global Stimulant Use: Challenges and Opportunities. *The Lancet, 394*(10209):1652-1667.

Glasgow, R.E., Vogt, T.M., & Boles, S.M. (1999). Evaluating the Public Health Impact of Health Promotion Interventions: The RE-AIM Framework. *American Journal of Public Health, 89*(9):1322-1327.

RE-AIM – Improving Public Health Relevance and Population Health Impact (2023). Retrieved from https://re-aim.org/

University of California Los Angeles, Integrated Substance Abuse Programs (UCLA-ISAP) (2022). *California Drug Medi-Cal Organized Delivery System Evaluation Design, Revised 12/15/2022.* Los Angeles, CA: The Author.

Zhao, S.X. et al. (2021). Socioeconomic burden of rising methamphetamine-associated heart failure hospitalizations in California from 2008 to 2018. *Circulation: Cardiovascular Quality and Outcomes, 14*(7): e007638.