Recovery Incentives Program: California's Contingency Management Benefit Program Manual

James A. Peck, PsyD, Thomas E. Freese, PhD, and Beth A. Rutkowski, MPH
UCLA Integrated Substance Use and Addiction Programs

Michael McDonell, PhD, Sara Parent, ND, and Katherine Hirchak, PhD, MHPA
The PRISM Collaborative, Washington State University

UCLA Integrated Substance Use and Addiction Programs
10911 Weyburn Ave. Suite 200
Los Angeles, CA 90024

First Edition, January 2023

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Common Terms and Abbreviations

Member (Medi-Cal member)*

California Department of Health Care Services (DHCS)

Client*

Cognitive Behavioral Therapy (CBT)

Community Reinforcement Approach (CRA)

Contingency Management (CM)

Contingency Management Coordinator (CM Coordinator; the primary CM team member)

Contingency Management Supervisor (CM Supervisor)

Drug Medi-Cal Organized Delivery System (DMC-ODS)

Incentive Manager (IM)

Methamphetamine (Meth)

Motivational Incentives

Motivational Interviewing (MI)

Recovery Incentives

Serious Mental Illness (SMI)

Substance Use Disorder (SUD)

Stimulant Use Disorder (StimUD)

Urinalysis (UA)

Urine Drug Test (UDT)

**Throughout this Manual, the terms member and client are used somewhat interchangeably. When discussing contingency management in general, we use the term client. When discussing the specific protocol and procedures associated with the Recovery Incentives Program, we use the term member.*

Chapter 1. Overview of Contingency Management

Contingency management (CM) is one of the most powerful ways to help people stop using stimulant drugs and is associated with increased abstinence for up to one year after treatment.[1,2] CM is a behavioral intervention for SUD where tangible reinforcers (e.g., gift cards, prizes) are provided when an individual meets a goal for reduction of or abstinence from one or more target substances. CM has also been applied to other treatment-related behaviors such as attendance. In the Recovery Incentives Program, CM will be used to reinforce negative urine tests for stimulant drugs (i.e., cocaine, amphetamine, and methamphetamine). In this Program Manual, we provide information on how to implement a specific research-based CM intervention that is associated with reduced stimulant drug use.

Positive Reinforcement in Contingency Management

CM is based on the learning theory of operant conditioning. In operant conditioning, a behavior increases or decreases when something in the environment (a stimulus) is either added or taken away. Three methods of changing behavior exist in operant conditioning: (1) positive reinforcement, (2) negative reinforcement, and (3) punishment. CM relies on the use of **positive reinforcement** to reinforce drug abstinence.

Psychologists have studied positive reinforcement for nearly 70 years and understand the important ways in which it influences individual behavior. Positive reinforcement occurs when a behavior (e.g., a child completes their homework) is followed by a desirable result (e.g., the parent lets them watch TV) and because of that result that behavior increases (e.g., the child completes their homework more often in the future). While all forms of operant conditioning change behavior, we know that positive reinforcement is the best way to change behavior because it does not have the negative side effects (e.g., shame, discomfort) that come with other types of operant learning such as punishment.

Positive reinforcement occurs all the time in our daily lives, from a compliment you receive from your boss for completing a project on time, to a smile from a stranger when you hold the door for them. The key aspects of positive reinforcement are that a behavior increases because someone learns that the behavior is followed by a desirable result. Positive reinforcement may happen without us being consciously aware of it, though there are substantial changes taking place in the brain in response to these activities.

Long-term use of alcohol and drugs causes damage to several areas of the human brain. One area of the brain that is highly susceptible to the effects of psychoactive substances is the reward pathways that release dopamine whenever we experience something pleasurable. Another affected area is the prefrontal cortex, where conscious thinking, reasoning, and decision-making occur. Because of this damage, it becomes much more difficult for a person using drugs to make healthy choices. CM helps rewire the neural pathways so that the person begins to make healthier choices (like not using drugs) in the future.

In CM, positive reinforcement is used to help people choose abstinence over continued substance use. A tangible reward like a gift card is given when a person submits evidence that they have not used one or more drugs. This is particularly exciting because many people living with a substance use disorder are not used to being recognized and encouraged for choosing to reduce or stop their drug use. It is also refreshing for the clinician to emphasize the benefits of negative drug test results rather than negative consequences of positive drug test results.

Questions People Ask about CM

Here are some common questions people ask about CM when they are first introduced to the intervention.

"You pay people to stop using drugs?"

Many people ask this question when first introduced to the concept of CM. While many people stop using drugs on their own, it is far more difficult to achieve abstinence without effective treatment interventions, such as CM. It is important to recognize that stimulant drugs can take over the natural reward pathways in the brain. CM helps bring the reward pathways back into balance by offering people non-drug rewards in exchange for achieving specific goals for substance use-related behaviors. This is especially important when people are just starting treatment or are new to recovery. In the Recovery Incentives Program, small incentives will be provided to help encourage people to choose abstinence over continued stimulant use. This effect is amplified by the feelings of reward from personal changes that they begin to make in their lives. [1,3–5]

"Wait, what happens if someone slips or lapses and uses drugs, do they still get rewards?"

While CM does not use punishment, it does emphasize accountability. So, a person who submits a urine sample that is positive for stimulant drugs will not receive a reward during that visit. However, they will be eligible to receive a reward the next time they submit a stimulant-free urine sample. In CM, people are encouraged to keep trying and they are offered many opportunities to succeed.

"Can CM be added onto existing treatment?"

Definitely! CM was created to be an adjunct to traditional intensive outpatient and outpatient SUD treatment and to treat co-occurring stimulant drug use in people receiving methadone in a narcotic/opioid treatment program (NTP/OTP).[7] The Recovery Incentives Program is being offered in outpatient, non-residential treatment. Because CM visits typically occur at least twice a week, CM is ideal to add to outpatient treatment models that require multiple visits per week.

"Can CM be delivered without other treatments?"

While it is ideal that CM be added to ongoing outpatient treatment, research has found that it is associated with large reductions in substance use in people who are not involved in other SUD treatment.[8–11] In fact, many individuals report that while they are not interested in "treatment," they are interested in CM. Therefore, CM is an important tool for engaging people in care. Once engaged in CM, individuals may become interested in other available SUD treatments and

ancillary services. We can also encourage individuals who are struggling to achieve abstinence to participate in other available services.

Chapter 2. Key Elements of CM

Several key elements of CM are necessary to consider when implementing an effective CM program.

The behavior selected for reinforcement (e.g., stimulant drug abstinence) should be:

- **Objective, observable, and easily measurable** by the staff member/CM Coordinator.
    - The most commonly available objective, observable measurement for stimulant abstinence is a negative urine drug test (UDT).
    - Self-report of stimulant abstinence is ***not*** an appropriate marker for monitoring behavior because it is not objective, observable, or measurable by both the clinician and client.
- **Clear and unambiguous** for the client and CM staff.
    - It should be communicated at the beginning of the CM program that the results of the UDT will be how stimulant abstinence is demonstrated, so that there is no opportunity for disagreement or confusion.
    - The Recovery Incentives Program will utilize point-of-care UDTs to assess for recent cocaine, amphetamine, or methamphetamine use. A list of UDT products that meet minimum standards for reliability and contain built-in validity assessments have been approved for this Program (see Chapter 4). Only tests from this list may be used for the Program unless otherwise approved by DHCS.
    - While other substances, such as opioids, may be identified in the UDT, this does not impact the member's receipt of an incentive; however, it should prompt a conversation about overdose prevention and general safety when using drugs.
- **Achievable** for the client.
    - The goal should be attainable early in the program. Because stimulant use can be detected by point-of-care urine drug tests for approximately 2 to 3 days after use, most individuals can stop using long enough to earn their first CM reward (i.e., they only need to have been abstinent from stimulants for a few days to earn their first incentive).

Monitoring of the behavior should be:

- **Frequent**.
    - CM works best when rewards are delivered regularly (at least once a week). Less often than that is too infrequent to counteract the immediate reinforcing effects of drug use.
    - The Recovery Incentives Program will require UDTs twice per week for the first 12 weeks and once per week for weeks 13-24.

- **Feasible**.
    - CM must be administered consistently over time. Longer treatment periods are associated with better outcomes. The standard active intervention period for CM is 12 weeks. In the Recovery incentives Program, you will administer an escalating CM schedule (this will be explained in Chapter 4) for 12 weeks, followed by a stabilization period of an additional 12 weeks (for 24 total weeks).
    - Fitting CM into your clinic workflow will require advance preparation. CM will be administered in each site by the CM Coordinator, a Back-up CM Coordinator, and/or a CM Supervisor. Prior to launching CM services, it will be important to determine specific protocols for your agency regarding where UDTs will be collected and interpreted, where CM rewards will be discussed and delivered, when CM visits will be scheduled, and how members will be linked with other needed services. These are important factors to consider as they affect the overall flow through the clinic for both members and CM staff. You will be provided guidance on this during the 2-part Implementation Training and as part of the Readiness Assessment process. Ongoing technical assistance is also available, should you need additional support.

CM Rewards (reinforcers) should be:

- **Contingent**.
    - Rewards are only provided when the agreed-upon behavior occurs. For stimulant abstinence, this means a UDT that is negative for stimulant drugs (i.e., cocaine, amphetamine, and methamphetamine).
- **Tangible**.
    - Rewards should be tangible. In this Program, rewards will be delivered in the form of an e-mail, text link, printed voucher, or other mechanism as approved by
    - DHCS. While other approaches like community reinforcement approach (CRA) do emphasize social rewards, in CM, rewards should be given for the demonstration of a specific behavior.
- **Desirable**.
    - Rewards should be desirable and something that members want, while still promoting recovery and health. Rewards must also be large enough in magnitude that they are desirable to individuals. For instance, $0.50 might not be a large enough reward to change behavior, whereas studies have shown that people will choose an incentive of $2.00 over cocaine use.
- **Immediate**.
    - Delivered as soon as possible after the behavior has been achieved and verified.
- **Escalating**.
    - Rewards should increase over time when the behavior is consistently achieved.

- **Closely Tracked**.
    - It is critical to monitor the CM incentives your agency uses for two reasons: (1) to assure high fidelity to the CM program and positive member outcomes; and (2) to assure that your agency is compliant with federal regulations (more information on federal regulations will be presented in Chapter 6 and in Appendix F).

With CM for stimulant use, the **objective**, **observable**, and **measurable** behavior is stimulant drug abstinence as measured by a point-of-care UDT. We know that the point-of-care UDTs will be able to detect most use if administered weekly. We use UDTs because they provide a measure of abstinence that is **clear and unambiguous**. Members only need to achieve a few days of abstinence to submit a negative UDT and receive a CM reward, an **achievable goal** for most members. The detection period of these tests means that we must conduct UDTs at least twice a week to accurately assess abstinence in the first 12 weeks of treatment, which also provides **frequent opportunities** for members to receive rewards.

Point-of-care UDTs are utilized in CM because it is important that reinforcers are provided **immediately** after the behavior is demonstrated. This allows the member to receive their reward right after they submit a stimulant-negative UDT. This kind of immediate gratification is essential to supporting people who are new to stimulant abstinence, since they are used to the instant "reward" they feel when they use drugs.

The **escalating nature** of the reward system is very important for maintaining stimulant abstinence and we will discuss that more in Chapter 4. The most important thing to remember when implementing CM is to make your system as **feasible** for you and your members as possible, while still maintaining the other key characteristics of CM that make it effective (i.e., observable, tangible, desirable, immediate, and escalating). Feasibility was carefully considered in the design of the Recovery Incentives Program and regular input was gathered from key stakeholders across the Drug Medi-Cal Organized Delivery System (DMC-ODS) Treatment System.

The Recovery Incentives Program protocol will be implemented in a standard fashion across all participating sites. Your treatment **setting** will also have to consider all the Program requirements to determine how to best incorporate these into existing clinic policies and procedures and workflows. You will be using a web-based Incentive Manager (IM), and you will enter information into the IM Portal during each member's visit. The IM will calculate, track, and deliver the rewards. It is important to **closely track** the CM rewards for each member you serve to assure that you are conducting CM according to best-practice standards and consistently across members. Fidelity is an important component of implementing any behavioral intervention; however, in CM, it is also critically important to assure that you are safeguarding the Program against fraud and abuse. Applicable laws and regulations are discussed in Chapter 6 and in Appendix F.

Incentives. When implementing CM, thought should be given to what types of rewards are made available. If the rewards are not appealing enough, the CM intervention may be less effective. For this Program, the protocol stipulates the use of gift cards delivered using an IM Portal. Training and consultation will be provided on the use of the IM Portal during the training and

Readiness Assessment period. Ongoing technical assistance is also available should you need additional help.

Some clinicians worry that gift cards could be exchanged for drugs, or they could be used to buy alcohol. It is important to remember that if a member uses their gift card to purchase and use stimulants, they will test positive for that drug at their next CM visit and they will not receive a reward at that visit. Therefore, they will learn that this strategy really does not work for them if they want to continue earning incentives. In addition, individuals in the Program will be asked to sign a consent form acknowledging that they will not make prohibited purchases.
Importantly, the gift cards used in the Recovery Incentives Program will be restricted to prohibit the purchase of alcohol, tobacco, cannabis, lottery tickets, and in the case of Walmart, firearms and ammunition. While some CM projects have used other tangible prizes as rewards in CM, we will not be using "prizes" in the Recovery Incentives Program and will only be providing rewards using gift cards.

How CM Builds Success: Escalation, Reset, and Recovery

Below we describe three important aspects of CM that help people stay motivated to achieve abstinence. Understanding and correctly calculating the appropriate incentive amounts is one of the most challenging aspects of CM to explain and may be the most challenging aspect of CM to implement. While CM staff need to understand these concepts, the IM will automatically perform the calculations when a UDT result is entered.

Three concepts, ***escalation***, ***reset,*** and ***recovery***, are essential to an effective CM intervention and are what makes CM different from other types of reward-based interventions. These concepts are based on many years of research, where investigators figured out exactly how to design a positive reinforcement intervention that maximized abstinence.[8–12] Below we describe these concepts in general. However, more detailed information on escalation, reset, and recovery in the Recovery Incentives Program will be provided in Chapter 4.

Escalation. In CM, we want people to be invested in their goals and we want them to learn that the longer they stay stimulant-free, the more they can gain. To facilitate this learning, CM uses an **escalating schedule of reinforcement**.[13] In other words, the amount of reward increases the longer a person remains abstinent from stimulants.

For example, a member starts CM and receives a $10 gift card for their first stimulant-free UDT. In CM, we increase the reward (e.g., by an extra $1.50) for every week of abstinence a member achieves. That means that at their first two visits they would earn $10/visit for their negative UDT, but by their second week they would earn $11.50/visit if they submit another negative UDT. This is because the two-consecutive negative UDTs represent one week of stimulant abstinence, which earns them an even higher escalation reward amount. If they submit two more stimulant-negative UDTs, their reward will increase again, for a total of $13/visit, and so on. So, by the end of 12 weeks of abstinence, a member could receive up to $26.50/visit for their final two stimulant-free drug tests. The longer the member is abstinent, the bigger their rewards get with every week of continuous abstinence. This is further illustrated in Chapter 5.

Reset. Punishments are not used in CM, though we do emphasize accountability. In the Recovery Incentives Program, when a member has a drug test that indicates they used stimulants, the member does not receive a reward that visit. The other consequence is that the IM Portal will temporarily "**reset**" the reward level. This means that members who earned the escalated amount for one or more weeks of continuous stimulant abstinence will temporarily lose the escalation. For example, when they submit their first stimulant-negative urine test after a stimulant-positive test they will reset to the original week 1 level of rewards (e.g., $10). This can be a big consequence for someone who has worked their way up to a large escalation amount. It is important to explain the concept of the reset to members, especially as they build success, and their rewards escalate in value. When they are aware that they can lose their escalated amount, this can help members stay motivated to maintain their abstinence.

Slips, Lapses, and Resets are Common in Recovery. This can be disheartening, so when a reset occurs, the CM Coordinator should remain positive and encouraging. Remember, members are typically attempting to change longstanding behaviors. Change is challenging for everyone. Make sure to praise their efforts (e.g., attending their CM appointment) and remind them of upcoming appointments and opportunities for additional rewards. You can also remind them of the opportunity for 'recovery' of their escalated reward amounts, which we describe below.

Resets and Missed Appointments. In CM, a missed appointment is a missed opportunity to submit a UDT, which results in no reward and triggers a reset. While we encourage you to be flexible (e.g., allow the member to come in later in the day if they miss a morning appointment, or allow them to reschedule for a contiguous day), we do want to emphasize accountability and we can only reward behaviors when we can objectively measure them. It is important to explain the consequences of a missed test to members.

Excused Absences. In some instances, a member may have a legitimate reason not to attend an appointment. If the member notifies the clinic or CM Coordinator ahead of time with a valid reason for missing an appointment, the CM Coordinator should attempt to reschedule the visit for an earlier or later time that same day or on a contiguous day, so that the visit is not missed. If the visit cannot be rescheduled, it is counted as an 'excused absence' instead of an 'unexcused absence'. Excused absences include a planned surgery or other medical procedure, illness, death in the family, or a court date, etc. The member must provide documentation of the reason for the absence at the next scheduled visit (e.g., note or receipt from a medical clinic, funeral announcement, or court document). Failure to provide documentation for an excused absence will result in that absence being coded as an unexcused/missed appointment and an incentive reset will occur. A member may have up to two consecutive excused absences; if the excused absence extends to three or more visits, it will trigger an incentive reset.

Recovery. 'Recovery' refers to the return to previously achieved reward levels when a member returns to sustained abstinence (as defined by two consecutive stimulant-negative UDTs). This is possibly the most challenging aspect for the CM Coordinator to track, though the IM Portal will take the guess work out of things since it automatically calculates the correct reward amount at each CM visit. The idea of the recovery is that we do not want a single episode of using (one stimulant-positive test) to turn into continued drug use. Therefore, if a member has achieved an escalated reward amount, let's say of $16 per stimulant-negative UDT and then they submit a

UDT that indicates use (or they have an unexcused absence) and the reset occurs, we want to give them motivation to return to abstinence as soon as possible. So, if the member submits a stimulant-negative UDT after a reset, they receive the $10 incentive for that UDT. If the next UDT is also negative for stimulants, they return to the place in the escalation schedule where they would have been had the positive UDT or unexcused absence not occurred. For instance, if they had the positive UDT or unexcused absence at the second visit of week 5, when they would have earned $16 for a stimulant-negative UDT, the next stimulant-negative UDT would result in a $10 incentive, and if the next UDT after that is also negative, they would earn $17.50 (recovery of the $16 escalation, plus the next escalation). They will then continue the incentive schedule from that reward amount. This will be demonstrated in more detail in Chapter 4. The 'recovery' helps people get back on track after a stimulant-using episode and gives them a reason to return to abstinence after use. We will put it all together later and show you how escalation, reset, and recovery work through an example member's CM program.

Chapter 3. Evidence that CM Works

Now that we have told you about CM in general, it's time to share with you the evidence that CM is an effective intervention for treating stimulant use disorder (StimUD).

Research Evidence. Multiple studies conducted over the past 30+ years demonstrate that CM is the most effective intervention for StimUD, including methamphetamine, amphetamine, and cocaine use disorders.[1,3–5,7] It also works well for treating nicotine use disorder and opioid use disorder.[7,17] Given the lack of medication-assisted treatment options for stimulant drugs, such as methamphetamine and cocaine (there are currently no FDA-approved medications for StimUD), CM is an important clinical tool in the treatment of StimUD.

More evidence supports the effectiveness of CM for StimUD than any other treatment.[1,3,4,9,18] Multiple meta-analyses have been published on CM. A meta-analysis is a comprehensive review of research studies where all the studies done on a topic are combined and analyzed together.

Several meta-analyses collectively support the efficacy of CM as an intervention for stimulant use and other substance use disorders.[1,7,16,19–21] One meta-analysis found that compared to all other cognitive and behavioral interventions for substance use disorders, CM was the most powerful way to assist clients to stop using drugs.[1]

Research also finds that the effect of CM is lasting. In fact, one study found that the effects on abstinence rates of a treatment episode of CM at a 12-month follow-up assessment are comparable to the effects on abstinence rates of a treatment episode of cognitive behavioral therapy at a 12-month follow-up assessment.[2,22] We also know that those individuals who stay in CM longer are more likely to continue to be abstinent after the CM intervention is completed.[22]

CM also has important secondary positive benefits and impacts on health. It has been found that when one drug is targeted in CM (e.g., a stimulant such as methamphetamine) individuals not only stop using that drug, they stop using other substances, as well (e.g., alcohol).[8–10,23] In another study, researchers found that people with co-occurring StimUD and serious mental illness (SMI) who received CM had fewer psychiatric symptoms and inpatient psychiatric hospitalizations than those who did not receive CM.[9]

In addition, multiple cost-effectiveness studies demonstrate that the cost savings of CM associated with reduced substance use and improved mental health outweigh the costs of rewards, UDTs, and staff time needed to implement the intervention.[14, 24] Therefore, CM reduces substance use and saves money too.

CM is also an effective intervention for diverse cultural groups. The CM team at Washington State University (WSU) partnered with five American Indian and Alaska Native communities to study whether CM was associated with reduced alcohol and drug use. They found that CM was associated with lower alcohol, stimulant drug, and cannabis use.[10,11] Participants and clinicians also reported that the adapted CM intervention was consistent with their community values. WSU has developed a separate CM manual and training materials for American Indian and Alaska Native communities who are interested in this culturally-adapted CM model.

Clinician and Client Evidence. After implementing CM for a while, clinicians have seen the positive impact it has on their clients, their practice, and on their overall clinic or agency. In surveys, clients appreciate the more positive environment of their CM program and providers viewed CM more positively because their clients' treatment attendance increased.[25–27] Clients affirmed that incentives enhanced their motivation to remain abstinent and the CM program provided accountability to do so.

While clients report that they like receiving prizes or gift cards, more often they emphasize that they really liked their CM providers and how CM helped them change their lives. Specifically, they report how positive their CM providers are, that CM holds them accountable in a positive way, and that CM providers are respectful. One of the WSU CM studies was called the HONOR project, in part because as CM providers we are honoring people when they choose to be abstinent.[11]

Clinicians also like CM, with 77% of clinicians saying they would use it if given the opportunity to do so.[27] Many clinicians share concerns when the idea of CM is first introduced to them. These concerns relate to "paying" people to stop using drugs and the belief that people should be intrinsically motivated to change. Another concern is that CM only rewards abstinence, so it seems inconsistent with harm reduction approaches that meet people where they are currently. CM was initially developed to help people who were receiving methadone to reduce or stop using stimulant drugs, like cocaine. So, CM was originally developed in the context of medication-assisted treatment to reduce the harms associated with substance use. Overall, when it comes to clinicians' initial concerns about CM, it is very common that as soon as clinicians start seeing the successes their clients have in CM, their opinions change.

Currently, the biggest barrier to implementation of CM is financial. More specifically, there has not been an easy way to pay for CM rewards, despite the average cost per client ($300-$500) being relatively low. Increasingly, federal, state, and local governments, as well as treatment agencies and insurers are seeing the benefits of CM, particularly for StimUD. Some are now providing funding for CM incentives. The Recovery Incentives Program is funded as a Medi-Cal benefit. California is the first state in the nation to cover CM as a Medicaid benefit under CalAIM (California Advancing and Innovating Medi-Cal).

Chapter 4. A CM Model for Stimulant Drugs

So far, we have reviewed CM, what it is, what makes it work, and how it is based on research evidence. Now it is time to talk about how to implement the Recovery Incentives Program protocol in your site. Below we describe an evidence-based CM model to reward stimulant drug abstinence. That means it is based on models used in CM studies that are associated with clinically significant reductions in drug use.

CM for Stimulants Overview

- **Identify Behavior for Reinforcement –** Stimulant abstinence as measured by point-of-care UDTs for amphetamine, methamphetamine, and cocaine.
- **Frequency of Monitoring and Reinforcement –** Twice-weekly on non-consecutive days, such as Mon/Thurs or Tues/Fri for the first 12 weeks and once weekly in weeks 13-24.
- **CM Intervention –** 12-weeks of CM starting at $10 for each stimulant-abstinent sample, escalating by $1.50 for each week of consecutive abstinence (assessed twice-weekly). This will be followed by a 12-week stabilizing period in which UDTs will be collected once per week and stimulant-free samples will be rewarded with either a $10 or $15 gift card, with a final possible gift card worth $21 in week 24.

Stimulant Urine Drug Testing in CM

UDTs as a Tool for Success. In CM, we use UDTs in a very different way than they are traditionally used in typical SUD treatment. In CM, we celebrate UDT results that demonstrate abstinence, and we value an individual's efforts to remain engaged in treatment even after recent drug use (i.e., UDT positive for stimulants). UDTs are a tool for facilitating rewards, not a tool for "catching" clients who have used drugs. In fact, you will notice that we never use the terms "clean" or "dirty" when we refer to UDT results. These terms are stigmatizing and judgmental, so we do not use them in CM. Instead, we use the terms recommended by the test manufacturers: positive (indicates use) and negative or stimulant-free (indicates no recent use).

It may take some time for members and treatment programs to get accustomed to this new way of using UDTs. In CM, UDTs are still used to keep people accountable, but the focus is on a positive accountability that facilitates trust, self-efficacy, and pride. In fact, many CM members report that they really value urine testing because it helps them remember that they are accountable to themselves and their CM provider when they have urges to use.

To facilitate this new approach to urine testing, we do not require directly observed tests, though we do use tools like integrated thermometers to reduce the chances that someone will be tempted to carry in someone else's urine or to dilute their own urine sample using water or other liquids or to contaminate the sample using bleach or other chemicals. Temperature strips ensure that the sample temperature is near normal body temperature, creatinine levels detect dilution, and pH levels detect contamination. All of these safeguards are included in the UDTs approved

for the Recovery Incentives Program. It is important to include validity measures such as requiring the member to wash their hands before handling the testing supplies (to prevent members from putting bleach under their fingernails and urinating on them, which would contaminate the urine sample), applying bluing agent in the toilet the member will use, and turning off the hot water in the restroom that will be used for the UDTs. And if you do suspect an inaccurate test, it is important to have a conversation with the member, informing them that they will only earn rewards for valid samples.

Remember, many members are trying to unlearn a history where a positive UDT resulted in negative outcomes, like judgment from the treatment provider, shame, jail time, loss of custody, or being "fired" from a treatment program. So, having a nonjudgmental conversation often solves the problem of inaccurate or invalid tests. The bottom line is that if you emphasize the positive and nonjudgmental approach to urine testing that balances accountability and trust, and remind members that the results are confidential, and that the only negative consequence for this visit is not earning an incentive, they will be less likely to tamper with their urine samples.

What if the Results Seem Wrong? CM studies have conducted tens of thousands of UDTs over the last 30+ years. And if you are an SUD treatment provider, you probably have a lot of experience with UDTs, as well. Like us, you probably have at times obtained a UDT result from a client that just doesn't seem to make sense. It might be a negative test from a person you knew was arrested for possession over the weekend or a test that indicates use from someone who has been in recovery for months.

UDTs are not perfect and understanding the detection periods of each test is important to using them appropriately. At the same time, we know that UDTs are more accurate than self-report, when they are used frequently enough to detect use. They also take self-report off the table, so clients are not tempted to provide inaccurate information about their use. In CM, rewards are based on the UDT result and it is important that clients are informed of this right from the start.

In the tens of thousands of UDTs that have been conducted, it is almost always the case that after the dust settles, it is the person's self-report that was inaccurate, not the UDT (when the test is used properly). Additionally, there are prescription and over-the-counter medications containing amphetamine, pseudoephedrine, or their metabolites that can cause a false positive test. Members will be provided with a list of medications that may cause a false positive test (see the Recovery Incentives Sample Consent Form in Appendix A) and informed that they should not use these during their participation in the Recovery Incentives Program. Rewards will be based solely on the results of the UDTs, and all positive tests will be treated the same, even if they result from the use of one of these medications.

Note: when there is a voiced dispute from a member who insists that there must be a problem with the test being performed, you may offer to retest the member to either confirm the original test or to overturn it. This should be done with a new point-of-care UDT. The member should be informed that the results of the second test will be binding. A second test should be used **very sparingly** and primarily as a way to preserve the clinical relationship with a member who is very upset. Clinical judgment must be used, so we encourage you to consult the CM Supervisor if this situation occurs. Also remember that reimbursement rates are based on a single test per visit, so additional tests would be an expense incurred by the site. We also encourage you to seek out

consultation from an expert on the UCLA Training and Implementation Team if you are confused by a test result. You can request individualized expert consultation through the Recovery Incentives Program Warm Line.

Frequency of UDTs. In the first 12 weeks of the Program, we will be monitoring stimulant drug use twice per week, on two non-consecutive days. This fits well within the standard intensive outpatient treatment setting, where clients attend group two to five times a week. Testing shall be separated by at least 48 hours, and ideally, 72 hours (e.g., Monday and Thursday OR Tuesday and Friday) to minimize the chance that drug metabolites from the same drug use episode shall be detected in more than one UDT.

The Recovery Incentives Program may only be implemented in DMC-ODS outpatient, intensive outpatient, partial hospitalization, and NTP/OTP treatment clinics/programs. CM implemented in these settings will consist of twice-weekly visits for the first 12 weeks of the program and once weekly visits for the second 12 weeks of the program (i.e., weeks 13-24).

Stimulant-Specific UDTs. Point-of-care UDTs are available for stimulants, including amphetamine, methamphetamine, and cocaine. A selection of UDT kits have been approved for use in the Recovery Incentives Program. Each cup includes tests for amphetamine, methamphetamine, cocaine, cannabis, oxycodone, and opiates; some (not all) of the approved UDT kits also test for fentanyl. They also test for benzodiazepines, MDMA, PCP, and several other substances depending on the specific test kit. The purpose of testing for oxycodone and opiates is to assess the relative risk of exposure to fentanyl or other synthetic opioids; this is based on the concept that a person who uses in a polysubstance pattern has a greater potential to accidentally ingest fentanyl than a person who uses a single substance due to the likelihood of additional drug sources. Please note that reimbursement for covered CM services in the Recovery Incentives Program does not include independent urine testing to detect the presence of fentanyl in a specimen, nor does it include reimbursement for fentanyl test strips. However, DMC-ODS providers are not prohibited by DHCS from independently testing for fentanyl as part of urine drug testing. Please refer to the Frequently Asked Questions document for additional information regarding harm reduction safety strategies, the use of drug test strips, approved CLIA waived UDTs that test for fentanyl, and reimbursable costs.

The opiate-, oxycodone, or fentanyl-related results, even if positive, shall not impact the member's ability to receive an incentive; however, counseling should be provided, and an assessment should be completed for the clinical need for induction of an evidence-based medical treatment for opioid use disorder. If the CM Coordinator is an LPHA or certified/registered SUD counselor, they can complete the assessment. If the CM Coordinator is not an LPHA or certified/registered SUD counselor (i.e., a Peer Support Specialist), the CM Coordinator shall refer the member to an LPHA or SUD counselor for the assessment. In addition, the CM Coordinator shall discuss the risks associated with fentanyl, harm reduction safety strategies including the use of fentanyl test strips, and ensure the member has access to naloxone and knows how it is used. If the member is positive for any of the substances tested in the UDT cup, this shall not impact their ability to receive incentives related to their stimulant test results. However, inquiring if the use of other substances is impacting their stimulant use and assessing for the need for referral

to other behavioral treatments to address these substances may be warranted, particularly if the member is having difficulty attaining consecutive stimulant-negative UDTs.

The cocaine UDT detects only the use of cocaine; it will not detect amphetamine or methamphetamine use. The Recovery Incentives Program requires UDTs that test for all three substances. The amphetamine test is designed to detect prescription drugs, like methylphenidate (Ritalin®, Concerta®) or other amphetamines (i.e., Adderall®). It is likely that a person who uses methamphetamine will return a positive test for amphetamines too. The methamphetamine UDT will identify methamphetamine and not other amphetamines. As mentioned above, it is possible that a member could test positive for amphetamine or methamphetamine if they take a cold medicine that contains amphetamines, pseudoephedrine, or similar compounds. All positive tests will be handled the same (i.e., no reward) even if they result from use of medications. Therefore, it is very important to discuss this with members as they enroll in the Recovery Incentives Program.

The amphetamine, methamphetamine, and cocaine tests approved for use in the Program have the following metabolite detection thresholds:

	Metabolite	Threshold	Min Detection	Max Detection
Amphetamine	d-Amphetamine	500 ng/mL	2-7 hours	2-4 days
Methamphetamine	D(+)-Methamphetamine	500 ng/mL	2-7 hours	2-4 days
Cocaine	Benzoylecgonine	150 ng/mL	1-4 hours	2-4 days

*Minimum and maximum detection periods as listed in package insert for CLIAwaived, Inc. Instant Drug Test Cup.

Remember the detection periods described above are provided for overall guidance. However, detection periods of UDTs for any given person will vary depending on the amount of drug used and individual-level factors. Also, the detection period for methamphetamine and cocaine urine tests is up to four (4) days. Therefore, if you are conducting CM visits twice a week, it may take up to two (2) UDTs before a member tests negative for these drugs after they stop using. Reminding the member of this can help maintain motivation as they are working toward their first stimulant-negative UDT. If you ever have questions about a potential "false" positive or negative test you can always request consultation.

It is also important to remember that point-of-care UDTs have an expiration date. Therefore, it is important that you do not order more tests than you can use over a given period and that you ask for the expiration date of the tests you purchase before you place your order if your volume of urine drug testing is relatively low.

CLIA-Waived Certification. In order to participate in the Recovery Incentives Program and receive Medi-Cal reimbursement for CM services, DMC-ODS providers must attain a Clinical Laboratory Improvement Amendments (CLIA) "waived test" certification and be registered with the California Department of Public Health

(CDPH) (or be accredited by an approved accreditation body). Laboratory Field Services, which is part of the California Department of Public Health, has an online application process through which providers can apply for both the CLIA Waiver and State Lab Registration. Sites should choose certificate type "Registration" and be prepared to upload three forms: the CMS 116, LAB 182, and LAB 183. Sites that already have a CLIA Waiver and State Lab Registration in place can use these certificates for the Recovery Incentives Program, even if their original application was for another test. It may take up to six months for CDPH to process applications once they are correctly submitted. It is therefore essential that sites submit applications as soon as possible, if needed. The user manual for submitting CLIA waiver applications can be found here.

Each UDT must be performed in accordance with the manufacturer's instructions for the test (see Appendix B), and the identified Site Lab Director must ensure that waived testing personnel meet facility-defined minimum requirements and have records of training and competency assessment.

Importance of Point-of-Care Tests. Several commercially available UDT cups make onsite, immediate testing feasible without the need for specialized laboratory equipment or training. See page 21 for a link to a list of approved cups that meet minimal standards for validity testing, cutoff values, and coverage of necessary substances (amphetamines, methamphetamine, and cocaine).

If you are currently using a different UDT device that you think meets the UDT requirements, you can request a review of the product for potential addition to the approved product list. If you would like for your existing UDT product to be evaluated for use in the Recovery Incentives Program, please email the following information to RecoveryIncentives@dhcs.ca.gov:

- Package insert
- Cut-off values for amphetamine, cocaine, methamphetamine, opiates, and oxycodone
- Cross-reactivity list for amphetamine, cocaine, methamphetamine, opiates, and oxycodone (if applicable)
- Information on specimen validity measures (whether the cup includes these):
    - Temperature strip
    - pH
    - Creatinine
- Certification: CLIA-waived and/or FDA approved

DHCS will review each request submitted by a provider for an alternative UDT and either approve or deny the request for an alternative UDT. The site cannot receive reimbursement for CM unless the test has been approved by DHCS.

UDT kits will be purchased directly by each participating site or through their County according to their usual procurement process. Check with your County Recovery Incentives Program staff to determine how to obtain the UDT kits.

Table 1. DHCS-approved UDT Kits

Table 1 has intentionally been removed from the Program Manual.

For the current list of approved UDT products, please refer to the DHCS website for the Recovery Incentives Program Approved Urine Drug Tests.

Tracking UDT Results and Rewards. Tracking and monitoring of members will be done electronically through the Incentive Manager (IM) Portal (see Chapter 5). Carefully tracking and documenting UDT results and incentives earned and disbursed is essential to making sure your site is compliant with specific rules pertaining to providing CM as a Medi-Cal benefit (see Chapter 6, Federal Law and Incentive Payments). Entering data into the IM Portal accurately will help ensure that the Recovery Incentives Program is compliant with state and federal laws, regulations, and DHCS program requirements.

Specific Program Elements of the Recovery Incentives Program: California's Contingency Management Benefit

Below is a step-by-step process for implementing the Recovery Incentives Program.

Reinforce Behavior. Stimulant abstinence as objectively measured by point-of-care urine drug testing. The point-of-care UDTs measure cocaine, methamphetamine, and amphetamine. They will also assess for opiates and oxycodone, and, if applicable, fentanyl. A test that is positive for opiates, oxycodone, or fentanyl but negative for stimulants will still earn an incentive, because stimulant use is the focus of the Program. Because of the presence of synthetic opioids in much of the stimulant drug supply in California, the following steps shall be taken for a member who tests positive for opiates, oxycodone, and/or fentanyl.

Recovery Incentives Program sites shall:

- Establish and implement a protocol to prescribe FDA-approved Opioid Overdose Reversal Medications1 (e.g., Naloxone, Nalmefene) to all members with an opioid, sedative and/or stimulant use disorder as outlined below.
- Establish and implement an opioid overdose reversal medication distribution protocol for members who do not obtain a prescription for an opioid overdose reversal medication.
- Provide education to each CM member regarding:
    - The risks associated with fentanyl and its presence in the illicit drug supply. Harm reduction safety strategies, such as the use of fentanyl test strips (e.g., fentanyl, xylazine) and harm reduction programs that distribute test strips for home use, based on information from the California Department of Public Health Overdose Prevention Initiative webpage. Specific education regarding the use of naloxone to reverse an opioid overdose.

Whenever a member needs an additional naloxone dose, due to the naloxone expiring, or due to use in the community, CM Teams shall either replace the naloxone or remind a member to obtain a new dose through a pharmacy or local organization. DMC-ODS providers are able to dispense naloxone onsite to members by leveraging the Medi-Cal pharmacy benefit. As a best practice overdose prevention measure, sites can prescribe naloxone to all DMC-ODS members who are participating in the Recovery Incentives Program and arrange for staff to routinely fill these

naloxone prescriptions at a pharmacy on behalf of the members. The community pharmacy should bill these naloxone prescriptions to the Medi-Cal pharmacy benefit. Pharmacists can also directly dispense naloxone and bill to Medi-Cal. The CM Team could then bring the dispensed naloxone back to the provider site for furnishing directly to members. This method would enable Recovery Incentive Program sites to better facilitate onsite access to naloxone reimbursed through the Medi-Cal pharmacy benefit.

Monitoring and Reward Schedule. Twice-weekly during the initial 12 weeks, either 1) Mondays and Thursdays or 2) Tuesday and Friday, if possible. If this is not possible, for instance in the event of an excused absence being rescheduled to a different day, then twice-weekly on non-consecutive days as long as there are at least 48 hours between UDTs.

Duration of Intervention. 12-weeks of CM treatment, which serves as the escalation/ reset/recovery period, plus 12 weeks of a stabilizing period. During the initial 12 weeks of CM treatment, participating members will visit the treatment program twice per week for CM services as stated above, and during the stabilizing period in weeks 13-24, participating members will visit the treatment program once per week for CM services.

Many CM interventions conducted as part of research studies have ended after 12 weeks and have not included a stabilizing period after the active intervention period. In the Recovery Incentives Program, weeks 13-24 will serve to help members stabilize and maintain the progress they made in weeks 1-12. This period is also important in terms of treatment retention. For members who have taken advantage of other clinical interventions offered by sites implementing the CM benefit, such as group or individual counseling, the continuing incentives that can be earned during the stabilizing period will be a tool to encourage members to remain fully engaged in those interventions.

Reinforcement Amount, Escalation, Reset, and Recovery. The gift card values for each qualifying urine sample will be at least $10. For each week the member achieves/maintains abstinence (i.e., two consecutive stimulant-abstinent UDTs), the gift card value increases by $1.50. Therefore, the

maximum a member could earn if they attend every CM visit and are abstinent for the entire 12 weeks is $438. During weeks 13-18, members will test once per week and will earn $15 for each negative test. Weekly testing will continue in weeks 19-23 with each negative test earning $10. In week 24, a negative test would receive $21. Thus, a member can earn a maximum of $161 for weeks 12-24, for a total of $599 across the entire 24-week period if they attend every visit and submit a stimulant-negative UDT every time.

Although the total reward per member may be as high as $599, it is unlikely that everyone will achieve this level of success in CM. Due to missed appointments and periodic stimulant use, the average cost of incentives in your implementation of the Recovery Incentives Program will be approximately half of the maximum amount possible ($599), or approximately $300 per member.

A **reset** will occur when a member submits a positive UDT or has an unexcused absence. The next time they submit a stimulant-negative UDT, their reward level will "reset" to the initial incentive value (e.g., $10).

A **recovery** will occur after two consecutive stimulant-negative urine tests. At that time, the member will "recover" their previously earned incentive level plus the next escalation of $1.50. See Table 2 below for an example of how this process works.

Gift Cards. The IM Portal will manage incentives and will dispense gift cards as the CM rewards, because they are both desirable and feasible. The current list of available gift cards appears in Chapter 5, Figure 6.

UDT and Incentive Tracking

The IM Portal will automatically calculate the appropriate incentive amount based on the UDT results with adjustments for the escalating value, reset, and recovery features described above. At each visit, the CM Coordinator will enter the results of the UDT into the IM Portal, and the IM Portal will indicate the appropriate incentive amount, per the protocol. A positive UDT for stimulants will result in the participating member receiving no incentive, along with encouraging coaching from the CM Coordinator. A negative test for stimulants will result in an incentive amount as indicated by the IM Portal, considering escalations and resets.

After the incentive amount is determined, the IM Portal will either disburse the incentive for that visit in the form of an e-mail, text link, printed voucher, or "bank" the incentive amount for future use by the member. It will also track all incentives awarded to all participating members. Additional data in the IM Portal will include the CM Team member who conducted the visit (e.g., CM Coordinator, Back-up CM Coordinator, or CM Supervisor), the format of the incentive provided to the member (i.e., text, email, or printed voucher), the date the incentive was distributed, and the amount of the incentive.

Participating members will receive incentives in the form of gift cards to which the IM will make deposits upon entry of stimulant-negative UDT results. Restrictions will be placed on the incentives so they cannot be used to purchase alcohol, tobacco, cannabis, lottery tickets or other gambling services, firearms, or ammunition.

Table 2 depicts an example of a CM gift card tracking table demonstrating reset and recovery with a stimulant-positive UDT, a missed appointment (unexcused absence), and an excused

absence. For the purposes of easy tracking and clear communication, we use the following terms: **positive** (urine test was positive for at least one stimulant drug), **negative** (urine test was negative for all stimulants), **missed** (unexcused absence), and **excused** (approved absence). An example table of incentives when all of a member's UDTs are stimulant-negative appears in Chapter 5. Remember that although you need to understand how incentives are calculated in order to explain to members, the IM Portal will calculate the incentive for you.

Table 2. Missed Sample and Positive UDT (Demonstrating Reset and Recovery)

Starting Incentive = $10, incentives escalate by $1.50 for each week of continuous abstinence

Week #	Visit #	UDT Result	Incentive Earned ($)	Week #	Visit #	UD Result	Incentive Earned ($)
1	1	Negative	10.00	7	13	**Missed**	**0**
1	2	Negative	10.00	7	14	**Positive**	**0**
2	3	Negative	11.50	8	15	Negative	**10.00**
2	4	Negative	11.50	8	16	Negative	19.00
3	5	Negative	13.00	9	17	Negative	19.00
3	6	Negative	13.00	9	18	Negative	20.50
4	7	Negative	14.50	10	19	Negative	20.50
4	8	**Positive**	0.00	10	20	Negative	22.00
5	9	Negative	**10.00**	11	21	**Excused**	**0.00**
5	10	Negative	16.00	11	22	Negative	22.00
6	11	Negative	16.00	12	23	Negative	23.50
6	12	Negative	17.50	12	24	Negative	23.50
				Total			**$323.00**

- **At visit 8**, the member submitted a stimulant-**positive** UDT. They **did not receive an incentive** that day.
- **At visit 9**, the member submitted a negative UDT, and their gift card amount was **reset** to the base amount, $10.

- **At visit 10**, the member again submitted a negative UDT, which represents another consecutive negative UDT. So, they **recovered** the previous escalation they had earned ($14.50) from visits 1-7. They also earned an additional escalation for another week of abstinence (visits 9 and 10), for a total of $16 earned that day.
- A similar cycle of reset and recovery is triggered on **visits 13-14** after the member **missed a visit** and **submitted a positive UDT**.
- At **visit 15**, their gift card amount **reset** to $10, when they returned and submitted a stimulant negative UDT.
- At **visit 16**, they demonstrated another consecutive stimulant-negative UDT, so they again **recovered** their previously earned escalations much like they did above, this time totaling $19.
- At **visit 21**, they missed their CM session due to advance notice of an excused absence. A **reset** and **recovery** is not triggered because it was an excused absence.
- At **visit 22**, their gift card amount continued at $23, again because visit 21 was an excused absence.

Program Readmission. A member will be considered a readmission if they leave the Recovery Incentives Program for more than 30 days. At readmission, the member must have a new ASAM multidimensional assessment that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.5) and confirm that the member meets the medical necessity criteria for CM. If the member has remained engaged in other services, such as residential treatment, during their absence from CM, an update to the most recent ASAM assessment is sufficient, and the member does not require a new diagnostic assessment. Based on the assessment, the site may offer other treatments *as alternatives to the CM program* if there is strong clinical evidence that CM is unlikely to produce the intended results. However, if the determination from the new assessment is that CM is an appropriate course of treatment for that member, the member may receive CM and the incentive structure would restart at Week 1. The maximum amount of incentives that can be received is $599 per member per calendar year.

A member who is readmitted to the Recovery Incentives Program will earn incentives according to the schedule described above until they earn $599 for all program participation during that calendar year. They would then be discontinued from the Recovery Incentives Program and encouraged to continue with other program services. In January of the next calendar year, the member could be reassessed and, if they meet all criteria, readmitted to the program, again with a maximum earning potential of $599 for that calendar year.

If a member leaves the CM program (for any reason) and returns to the program within 30 days, they will return to the schedule of UDTs and incentives as if there was no break in service.

In rare circumstances, following completion of the CM treatment phase of the program, a member may benefit from re-entering the CM treatment phase protocol instead of proceeding to CM continuing care services. Repeating the ASAM assessment and diagnostic assessment is not required for the member to re-enter the CM treatment phase of the program. In these instances, the clinical documentation, completed (or reviewed) by a LPHA, must demonstrate

that CM services are medically necessary and appropriate based on the standard of care. The documentation must clarify that outpatient treatment continues to be appropriate for the member and include the provider's reasoning for resuming CM services. In this scenario, the member still may not exceed the $599 annual limit for earned incentives, and once that limit is reached the member would no longer be eligible for the Recovery Incentives Program and should be transitioned to continuing care services. Re-entry to the CM treatment phase following completion of the initial CM treatment phase of the Program should prompt providers to assess whether a higher level of care than outpatient services (i.e., ASAM Level 3.1 or above) is medically necessary.

Establishing Member Eligibility for CM Services

The Recovery Incentives Program is only available to Medi-Cal members who meet the following conditions:

- Are enrolled in Medi-Cal and meet criteria for a comprehensive, individualized course of SUD treatment. Medi-Cal enrollment must be confirmed prior to initiating services through the Recovery Incentives Program.
- Reside in a participating DMC-ODS county that elects and is approved by DHCS to participate in the Recovery Incentives Program.
- Receive services in a non-residential level of care operated by a DMC-ODS provider participating in the Recovery Incentives Program and offering CM in accordance with DHCS policies and procedures.

CM services delivered under the Recovery Incentives Program are only covered when medically necessary and appropriate as determined by an initial SUD assessment consistent with DMC-ODS Intergovernmental Agreement (IA) showing (1) diagnosis of any of the related moderate or severe cocaine or stimulant use disorder diagnoses, including diagnoses in remission, as defined by the clinical criteria in the Diagnostic and Statistical Manual (DSM, current edition); (2) clinical determination that outpatient treatment is appropriate per the American Society of Addiction Medicine (ASAM) criteria; and (3) that the CM benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving CM services.

Members may access CM when transitioning from residential care or carceral settings to outpatient treatment settings, including services initiated on the day of admission to the outpatient program and discharge or release from residential care or a carceral setting. Providing CM services on the date of admission to the outpatient program and the date of discharge from a DMC-ODS residential level of care is an acceptable circumstance justifying multiple service billing for both a residential treatment service and a CM service at a non-residential level of care. Members transitioning to outpatient treatment from a controlled environment such as residential treatment or a carceral setting who have not used a stimulant in more than three months (i.e., no longer have a *current* cocaine or stimulant use disorder diagnosis) are still eligible for the Recovery Incentives Program as long as all other eligibility requirements are met.

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

Eligible Medi-Cal members shall be referred to, and admitted into, treatment through a participating site's routine client admission process. Consistent with other DMC-ODS programs, there is no minimum age limit for an individual to receive CM services if they meet all eligibility criteria. In addition, pregnant and parenting people with StimUD are eligible to receive CM services. Medi-Cal members who are receiving care in residential treatment (e.g., ASAM levels 3.1–4.0) or institutional settings are ineligible for CM services until the day of discharge, when they are transitioned into outpatient care.

Members Under the Age of 21. Covered services provided under the Recovery Incentives Program shall include all medically necessary SUD services for individuals under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in California's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or a SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

CM Visit Flow

Greet. Establish a positive relationship. Always keep the interaction pleasant and non-confrontational. The positive nature of CM allows for an opportunity to strengthen the therapeutic alliance. Your positive attention is also reinforcing to most members.

Assessment. Assessment consists of activities to evaluate or monitor the status of a member's behavioral health and determine the appropriate level of care and course of treatment for that member. Consistent with DMC-ODS policies described in BHIN 24-001, members must have an ASAM multidimensional assessment completed by a Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor that indicates the member can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.5). To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. The initial clinical assessment shall confirm: (1) the individual has a diagnosis of any of the related moderate or severe cocaine or stimulant use disorder diagnoses, including diagnoses in remission, as defined in the DSM, current edition; (; (2) outpatient treatment is appropriate per the ASAM criteria; and (3) CM is medically necessary treatment.

Intake Visit. During a member's first visit, the CM Coordinator will complete several steps to initiate the service, specifically:

- Conduct eligibility check as described above – The CM Coordinator or other designated CM Team member (e.g., Back-up CM Coordinator, CM Supervisor) at the site will confirm

the member's current Medi-Cal eligibility, as well as their eligibility for the program before initiating the CM service. The eligibility check should be done via the Automated Eligibility Verification System (AEVS) for Medi-Cal.

- The member should also be asked whether they are currently enrolled in a residential SUD treatment program. Members may not be enrolled in the Recovery Incentives Program if they are attending residential treatment.
- Before beginning CM treatment, a member must complete a thorough orientation and consent to the conditions of the Recovery Incentives Program. The orientation will address the following:
    - The days/times that a member must visit the facility in order to be eligible for incentives (during weeks 1-12, twice-weekly visits; during weeks 13-24, once-weekly visits).
    - The method of incentive delivery, as well as how and where incentives can be redeemed, including the prohibition of using incentives to purchase alcohol, cannabis, tobacco, firearms/ammunition, lottery tickets, or for any form of gambling.
    - The availability of incentives and ongoing program participation when a member lapses or relapses and seeks readmission and the process for a member to seek readmission.
    - The site's UDT procedures and an explanation and review of medications/substances that may result in false-positive UDTs.
    - The rules governing when an incentive will be provided, including:
        - An explanation that the incentives are contingent on the absence of evidence of stimulant (e.g., cocaine, amphetamine, methamphetamine) use on a UDT.
        - An explanation that opioid testing will be done for the purpose of safety, due to association with overdose deaths, but will not impact the delivery of an incentive.
        - 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.
    - The amount of the initial incentive and how the value increases with consecutive stimulant-free UDTs and how the value will be reset to the initial $10 value in the case of a positive test or unexcused absence, and that increases will be recovered upon the submission of two consecutive stimulant-negative UDTs.
    - Program participation consent – The CM Coordinator will review with the member, and obtain their signature on, a consent form authorizing services and the secure sharing of data with DHCS and the program evaluation team, including all DHCS-required consent elements. See sample consent form available in Appendix A.

- Explain the CM process and reinforce the expectations set forth above.
- Enroll the member into the Incentive Manager (IM) Portal – The CM Coordinator will complete a member profile to enroll them into the web-based IM Portal that will keep track of UDT results and incentive gift cards distributed.

Ongoing CM Visits. Engage the member and initiate the visit – The CM Coordinator will greet the member, review their progress in the program (e.g., weeks completed out of 24), log into the IM Portal and locate the member's record/profile.

- Conduct eligibility check – The CM Coordinator or other staff within a provider agency offering CM will check member Medi-Cal eligibility at least monthly or more frequently if required by agency policy.
- At the same time as the monthly Medi-Cal eligibility check, the member should be asked whether they have enrolled in a residential SUD treatment program in the past month. If the member has been enrolled in a residential level of care, they must be immediately disenrolled from the Recovery Incentives Program. They may be readmitted to the Recovery Incentives Program when they are discharged from the residential treatment program, as detailed above.
- Administer UDT – The CM Coordinator will administer the UDT, including processing the results of the UDT in real time.
- Log results in IM Portal – The CM Coordinator will log the results of the UDT for stimulants (i.e., positive or negative).
- Discuss results – The CM Coordinator will discuss the UDT results with the member and offer other services if/as appropriate, which could include brief encouragement, motivational interviewing, and/or education based on the CM Coordinator's scope of practice and training. The CM Coordinator will encourage the member to meet with their counselor or LPHA. If opiate, oxycodone, and/or fentanyl UDT results are positive, the CM Coordinator will document these results in the clinical chart, reinforce the risk of overdose, ensure the member has naloxone, and offer other treatment services as appropriate, including referral for MAT if the member has a co-occurring alcohol or opioid use disorder.
- Disburse incentives consistent with the "Incentive Delivery" section in Chapter 5.
    - If the UDT result entered is negative for stimulants, the IM will disburse the incentive generated by the IM consistent with the "Incentive Delivery" section in Chapter 5.
    - If the UDT result entered is positive for stimulants, the IM Portal will not disburse an incentive.
- Plan for next appointment – The CM Coordinator will remind the member of their next scheduled appointment (date and time). The CM Coordinator should offer to answer any questions before adjourning the visit.
- Documentation – The CM Coordinator shall document the visit in the member's medical record (or chart). The CM Coordinator shall also document StimUD on the problem list (or

treatment plan for Narcotic Treatment Providers, NTPs) within a member's medical record. Consistent with best clinical documentation practices, the CM Coordinator shall describe all interventions utilized with the member as part of their progress notes for each service to include CM in addition to any other outpatient services, such as motivational interviewing, cognitive behavioral therapy, or Community Reinforcement Approach. CM should not be offered to a member as a stand-alone treatment, but rather as one component of an individualized plan of care. However, if a member chooses to participate only in selected services (e.g., they only participate in CM and not in other aspects of treatment), they shall remain in outpatient treatment and shall not be penalized, chastised, criticized, or discharged from the program for declining to participate in any treatment or recovery service or for failure to participate in all recommended treatment services. Members needing or utilizing CM must be served and cannot be denied CM or be required to participate in other aspects of a SUD treatment program as a condition of entering or remaining in the Recovery Incentives Program.

    - If the member does not attend a scheduled visit, the CM Coordinator should document the absence and any extenuating circumstances in the member's medical record and in the IM Portal.

- Billing – The CM Coordinator shall complete claims documentation to bill the DMC-ODS county for the service, using as many units of the 15-minute code H0050 as appropriate, given the length of the visit, and using one of two required ICD-10 diagnoses (in addition to any other relevant codes for the visit; for example, the primary diagnostic code may be for stimulant use disorder, with the appropriate code below used as a secondary diagnosis):
    - R82.998: Positive urine test for stimulants
    - Z71.51: Negative urine test for stimulants
- Thank the member for coming to the clinic/program that day. Validate success as well as frustration, but always model a positive and hopeful attitude.

Chapter 5. Incentive Manager

Overview of Incentive Manager Portal

- CM Coordinator enters UDT results.
- System automatically assesses member-specific circumstances.
- System automatically applies correct incentive amount.
- Incentive amount is “dispatched”, meaning CM Coordinator can select delivery method and incentive vendor in consultation with the member.
- Incentive transaction is logged.

Adding a New Member (see Figure 1)

- Open “dashboard pane”.
- Click “+” button to the left of “member” on the top of the data table.
- Input required patient information, including client identification number (CIN) and DOB.
- Input optional information for email and/or cell number (these fields support incentive delivery).
- The CM Coordinator’s name should appear on the pane automatically.
- Confirm that your agency verified the member’s Medi-Cal eligibility in the AEVS and eligibility for CM.
- After clicking “Submit,” the CM Coordinator may see an error stating that the member already exists in the system. This is a safeguard against members trying to enroll in multiple programs simultaneously. It may also occur because the member is seeking to transfer to your site from another program.
- Instances may occur when a member needs to transfer to another site and/or county temporarily or permanently. In the case of temporary travel, the CM Coordinator at the member’s current site should engage in the following procedures.

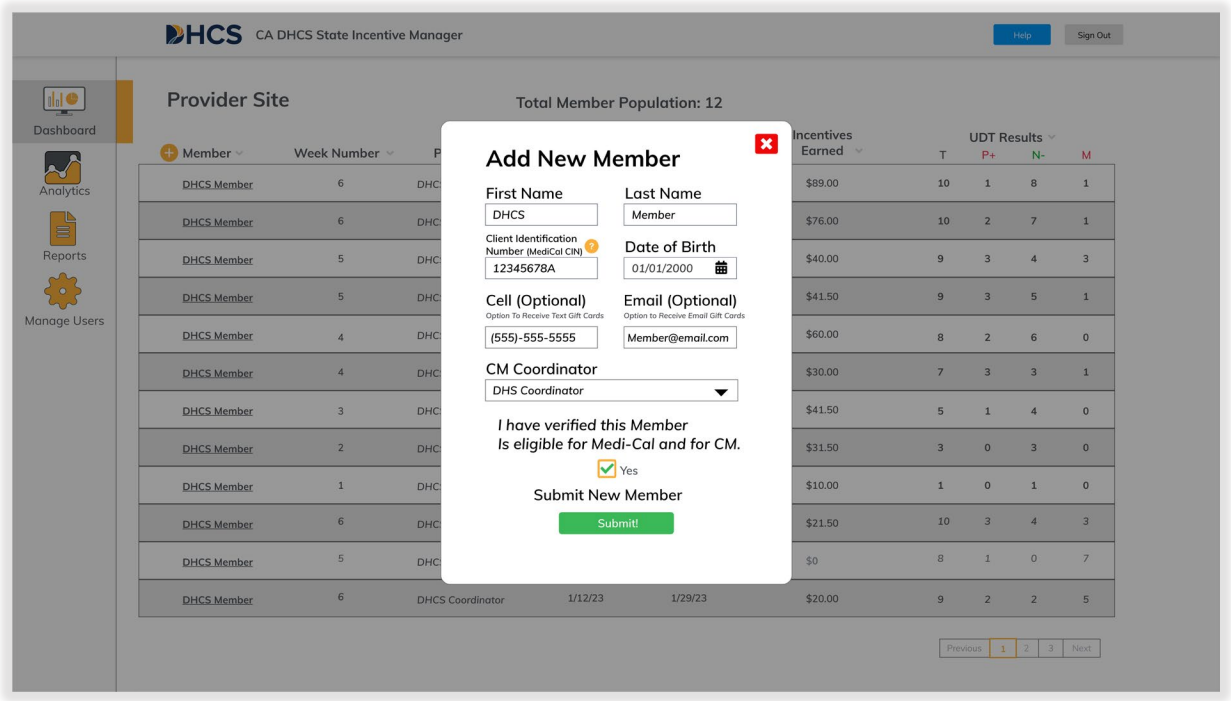
Courtesy Services for Temporary Travel

In situations where a member receiving CM services from their DMC-ODS County of Responsibility temporarily travels to another DMC-ODS county that also participates in the Recovery Incentives Program, and the member is unable to attend scheduled CM service appointments during their travel, the DMC-ODS County of Responsibility shall reimburse CM services that an out-of-county DMC-ODS provider participating in the Recovery Incentives Program delivers to the member.

Prior to the member traveling out of county, the CM Coordinator from their DMC-ODS County of Responsibility (Home CM Coordinator) shall identify and contact a participating Recovery Incentives Program provider located within the travel location’s DMC-ODS County (Travel Recovery Incentives Program provider) to notify them of the member’s travel plans and schedule

an appointment for the member based on their current UDT schedule. The Home CM coordinator shall also contact the incentive manager call center and provide them with the same information, so the call center can change the member service location within the incentive manager program during the member's temporary travel. Prior to the member returning to their County of Responsibility, the CM Coordinator from the travel location's DMC-ODS County (Travel CM Coordinator) shall contact the County of Responsibility Recovery Incentives Program provider to notify them of the member's pending return and schedule an appointment for the member based on their current UDT schedule. The Travel CM coordinator shall also contact the incentive manager call center and provide the information so the call center can change the member service location within the incentive manager program, prior to the member returning to their County of Responsibility.

Figure 1. Adding a New Member

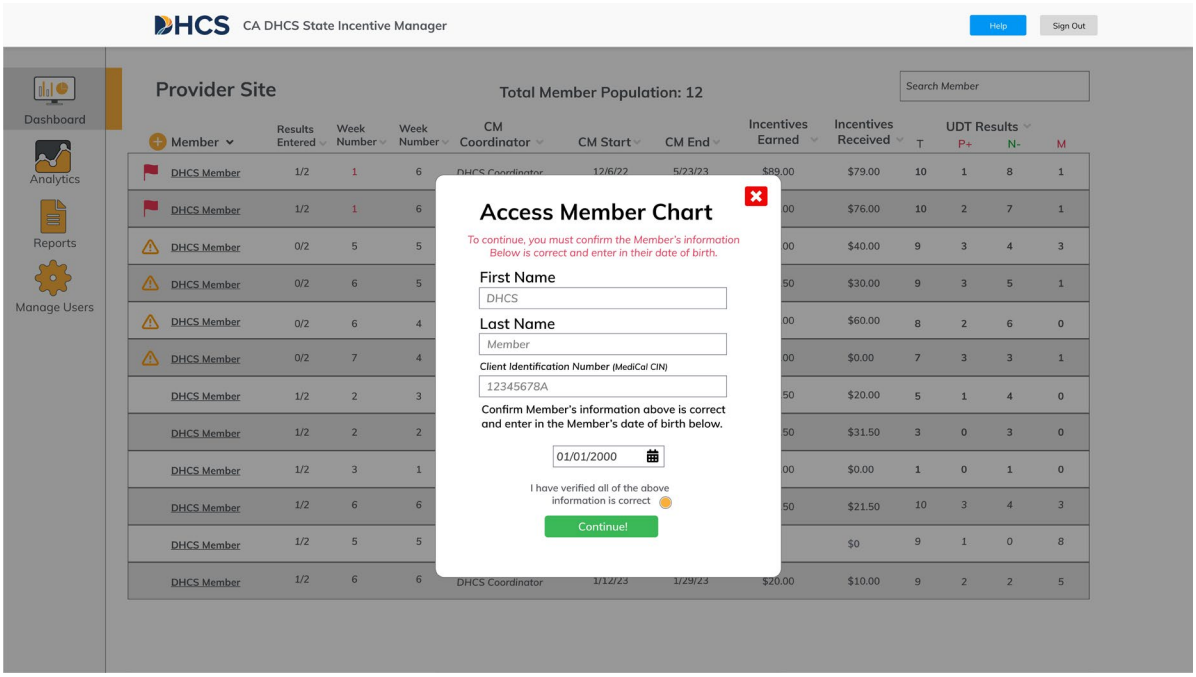


Accessing Member Chart (see Figure 2)

DHCS or County Users may access member charts.

- Click “Manage Users” on left pane
- Find the relevant member
- Enter the member’s date of birth
- Click “Continue”

Figure 2. Accessing Member Chart

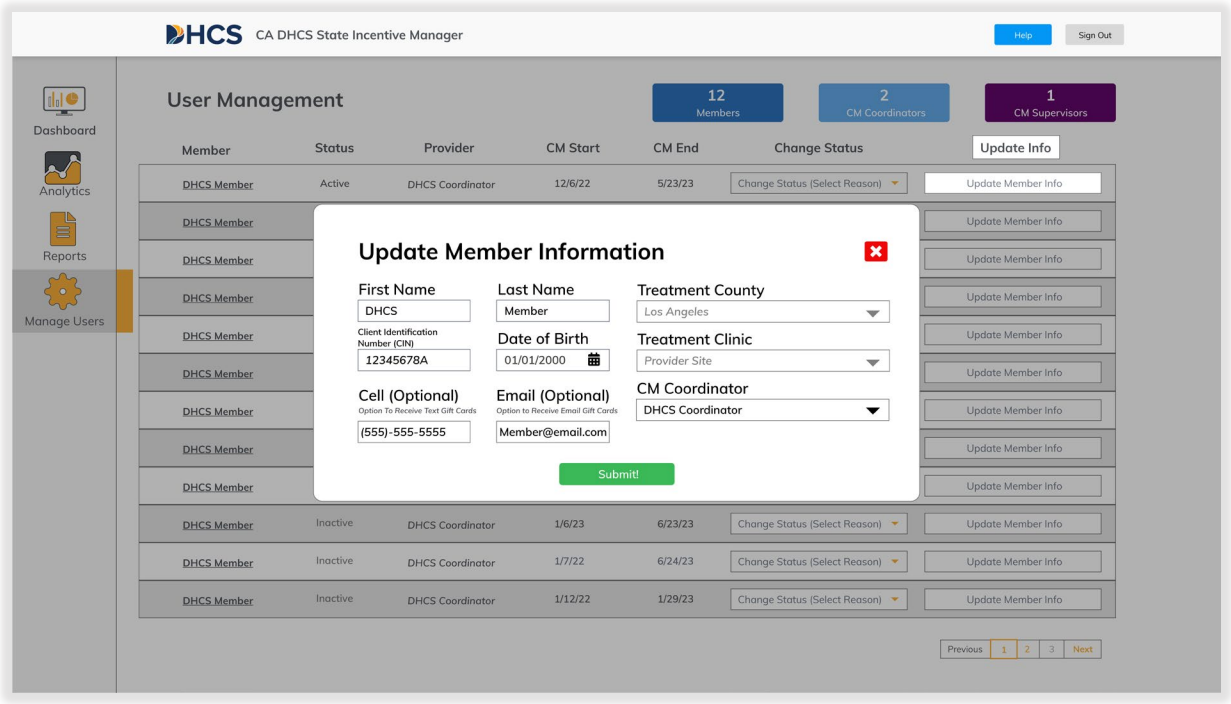


Entering Member Changes (see Figure 3)

DHCS or County Users may update member information.

- Click “Manage Users” on left pane.
- Find the relevant member.
- In the data table, click “Update Member Info.”
- At any point, a DHCS or County User can utilize the call center to assist with these changes.

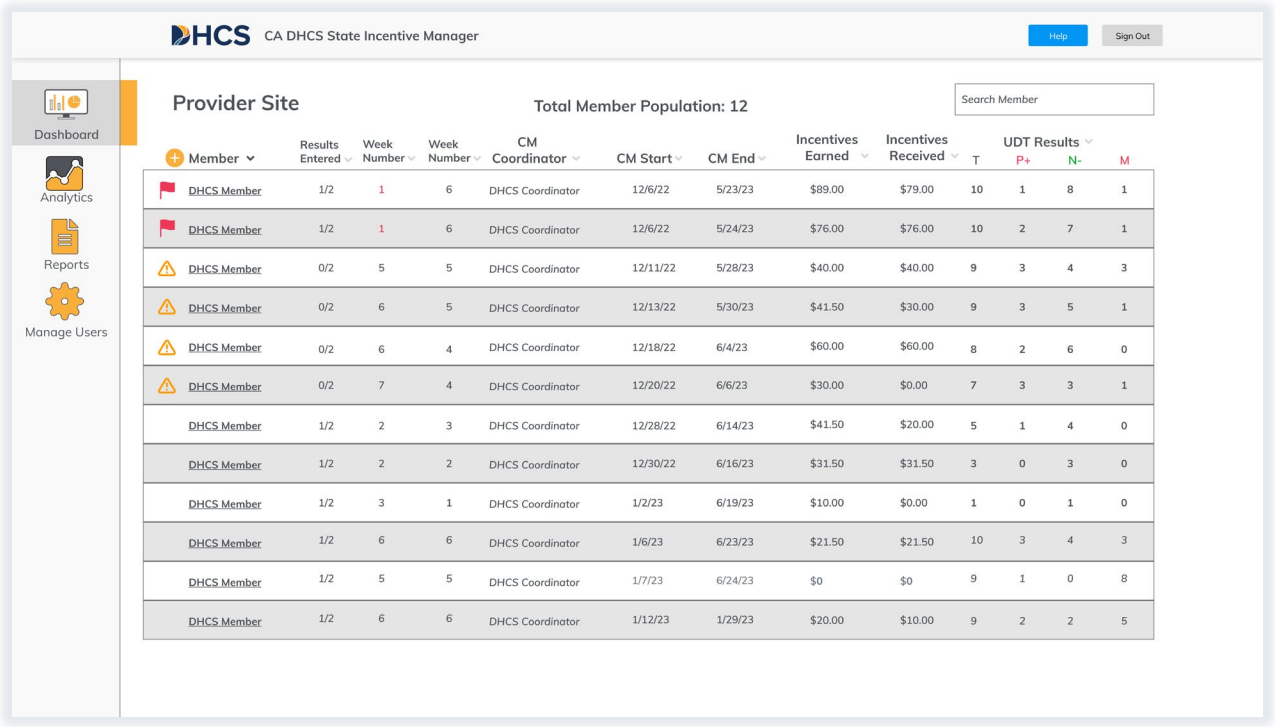
Figure 3. Member Changes



Selecting a Member to Enter UDT Results (see Figure 4)

- Open the “dashboard pane.”
- Find the member either by sorting or searching.
- Click on the member’s name (it will be underlined).
- This action will open that specific member’s chart.

Figure 4. Selecting a Member to Enter UDT Results

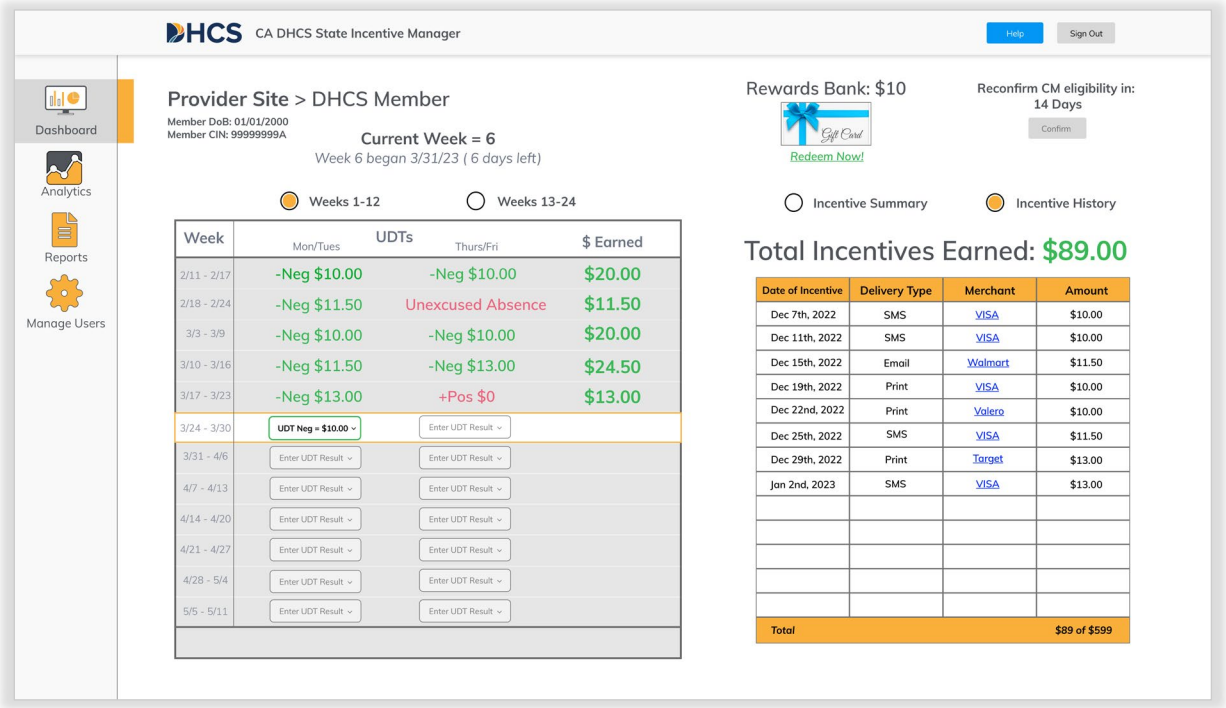


Member	Results Entered	Week Number	Week Number	CM Coordinator	CM Start	CM End	Incentives Earned	Incentives Received	UDT Results T	P+	N-	M
DHCS Member	1/2	1	6	DHCS Coordinator	12/6/22	5/23/23	$89.00	$79.00	10	1	8	1
DHCS Member	1/2	1	6	DHCS Coordinator	12/6/22	5/24/23	$76.00	$76.00	10	2	7	1
DHCS Member	0/2	5	5	DHCS Coordinator	12/11/22	5/28/23	$40.00	$40.00	9	3	4	3
DHCS Member	0/2	6	5	DHCS Coordinator	12/13/22	5/30/23	$41.50	$30.00	9	3	5	1
DHCS Member	0/2	6	4	DHCS Coordinator	12/18/22	6/4/23	$60.00	$60.00	8	2	6	0
DHCS Member	0/2	7	4	DHCS Coordinator	12/20/22	6/6/23	$30.00	$0.00	7	3	3	1
DHCS Member	1/2	2	3	DHCS Coordinator	12/28/22	6/14/23	$41.50	$20.00	5	1	4	0
DHCS Member	1/2	2	2	DHCS Coordinator	12/30/22	6/16/23	$31.50	$31.50	3	0	3	0
DHCS Member	1/2	3	1	DHCS Coordinator	1/2/23	6/19/23	$10.00	$0.00	1	0	1	0
DHCS Member	1/2	6	6	DHCS Coordinator	1/6/23	6/23/23	$21.50	$21.50	10	3	4	3
DHCS Member	1/2	5	5	DHCS Coordinator	1/7/23	6/24/23	$0	$0	9	1	0	8
DHCS Member	1/2	6	6	DHCS Coordinator	1/12/23	1/29/23	$20.00	$10.00	9	2	2	5

Member Pane (see Figure 5)

- This page contains member-specific information (from left to right).
- UDT results by visit.
- Incentives earned by week and visit.
- Next incentive amount available if UDT is negative for stimulants.
- Rewards bank.
- Reconfirmation of program eligibility (to be completed monthly; see arrow).
- Summary of incentives earned.
- Incentive history (date, delivery type, merchant, and amount).

Figure 5. Member Pane



Entering UDT Results or Absence (see Figure 6)

Once you are on the member pane:

- Identify the next available session.
    - This will be the “Enter UDT result” button that is not grayed out.
    - Other session buttons will not work when clicked on as they are locked.
- Click the “Enter UDT result” button.
- From the dropdown list, select the relevant option:
    - If the UDT was negative for stimulants, select “Stimulant-Neg ($).” This will bring up a pane on which you must enter the member’s date of birth (see Figure 7).
    - If the UDT was positive for stimulants, select “Stimulant +Pos”.
    - If the member has an excused absence, select “excused absence” and add a note.
    - If the member’s absence is unexcused, select “unexcused absence.”
- When you select the appropriate option, the “submit” button will turn green.
- To submit the result, you must click the “submit” button.
- The system will automatically calculate the correct incentive amount.
- *Note: If all options are greyed out, look in the upper right and indicate that Medi-Cal eligibility has been confirmed in last 30 days.*
- *Note: UDT results can only be entered at least 48 hours after the previous input.*

Figure 6. Entering UDT Results or Absence

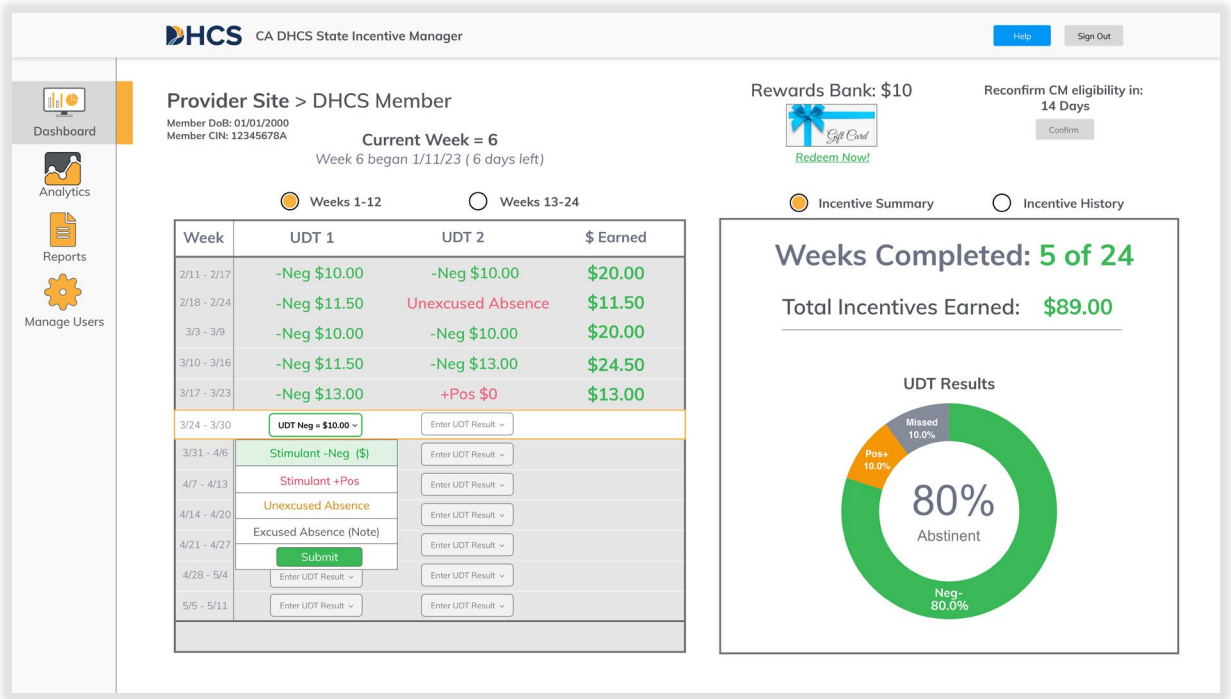
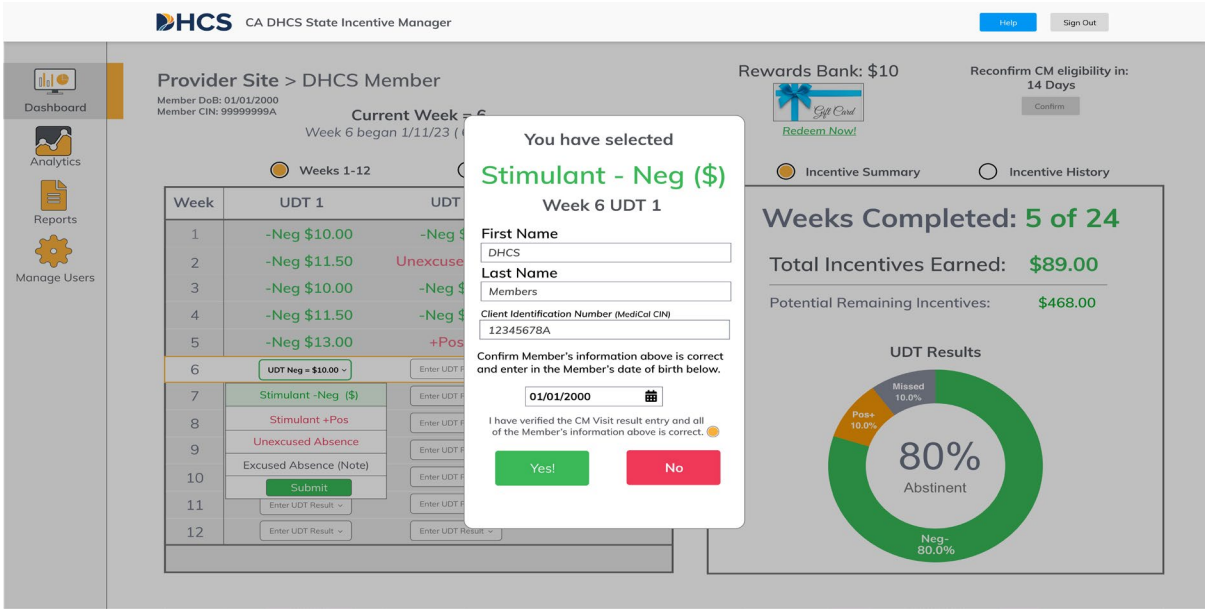


Figure 7. Entering a Stimulant-Negative UDT Result with Date of Birth Confirmation



Managing Incentive Rewards

How are rewards calculated?

- Rewards will be earned after a stimulant-negative UDT is entered into the system.
- Rewards are calculated by the system using a well-defined schedule, which is:
    - **For weeks 1-12 (2 visits per week)**, the reward amount starts at $10 and increases by $1.50 for each two consecutive stimulant-negative UDTs. Rewards "reset" (as described above) to $10 upon the next stimulant-negative UDT following a positive UDT or unexcused absence. Upon the next consecutive stimulant-negative UDT, the reward amount "recovers" to the place in the schedule where the member would have been if there had been no stimulant-positive UDT or unexcused absence.
    - **For weeks 13-24 (1 visit per week)**, the reward amounts do not change. Each stimulant-negative UDT in weeks 13-18 receives a $15 reward and each stimulant-negative UDT in weeks 19-23 receives a $10 reward. A stimulant-negative UDT in week 24 receives $21.

How are rewards delivered?

- Rewards are offered as vendor-specific gift cards delivered in the form of an e-mail, text link, printed voucher, or other mechanism as approved by DHCS.
- Rewards can be redeemed immediately or "banked" to aggregate earnings to larger amounts
- The CM Coordinator should inform members when enrolling them into the incentive manager that they are asking for the member's mobile number and email address to deliver rewards in the manner they choose.
- If shared via text or email, the reward can be added to an Apple or Google wallet.
- Gift cards are only available for vendors who prohibit purchases of alcohol, tobacco, firearms, lottery tickets, and cannabis.

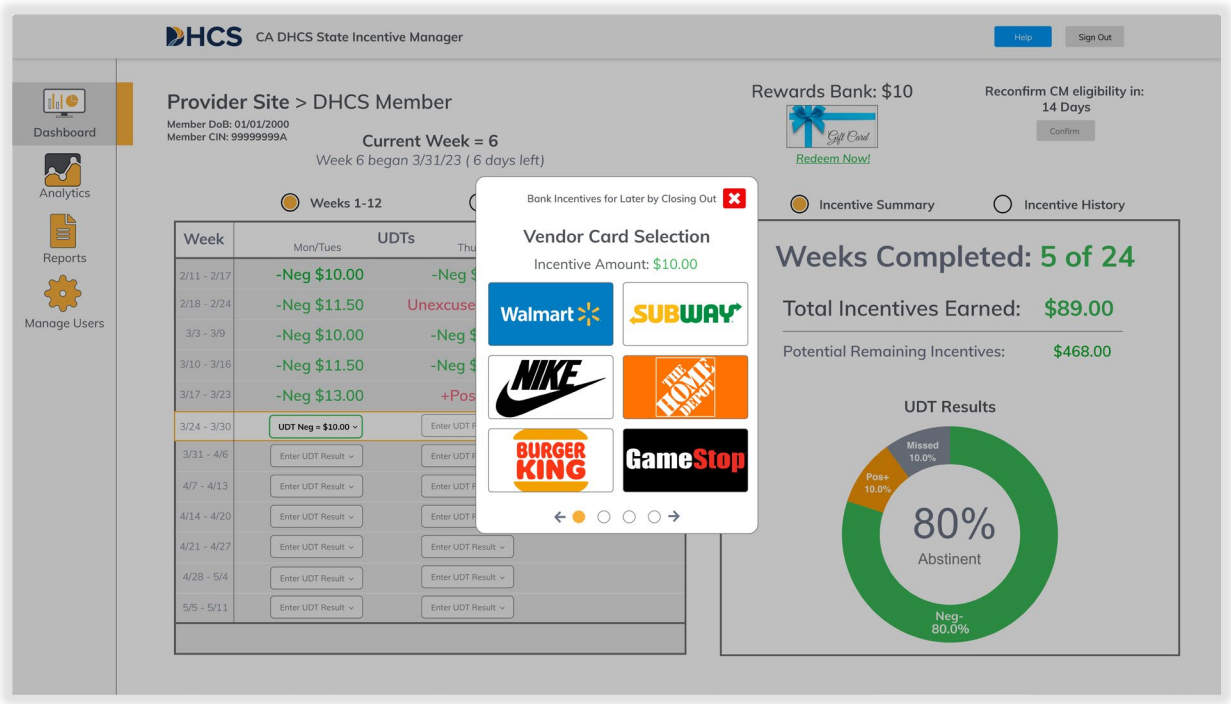
Sample Reward Schedule with all Stimulant-Negative UDTs

Week	Reward for Stimulant-Free Test
Week 1	$10 + $10 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13 + $13 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16 + $16 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19 + $19 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22 + $22 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25 + $25 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15 per week/test
Weeks 19-23	$10 per week/test
Week 24	$21 per week/test
Total	**$599**

Reward Type Selection (see Figure 8)

- Once a negative UDT is input, the system will offer the reward type selection.
- The CM Coordinator will work with the member to select the preferred vendor.
- There are two options:
    - Gift card for a specific vendor.
    - Adding funds to a virtual "bank."
- Click the preferred option and proceed to "delivery type" selection.

Figure 8. Reward Type Selection

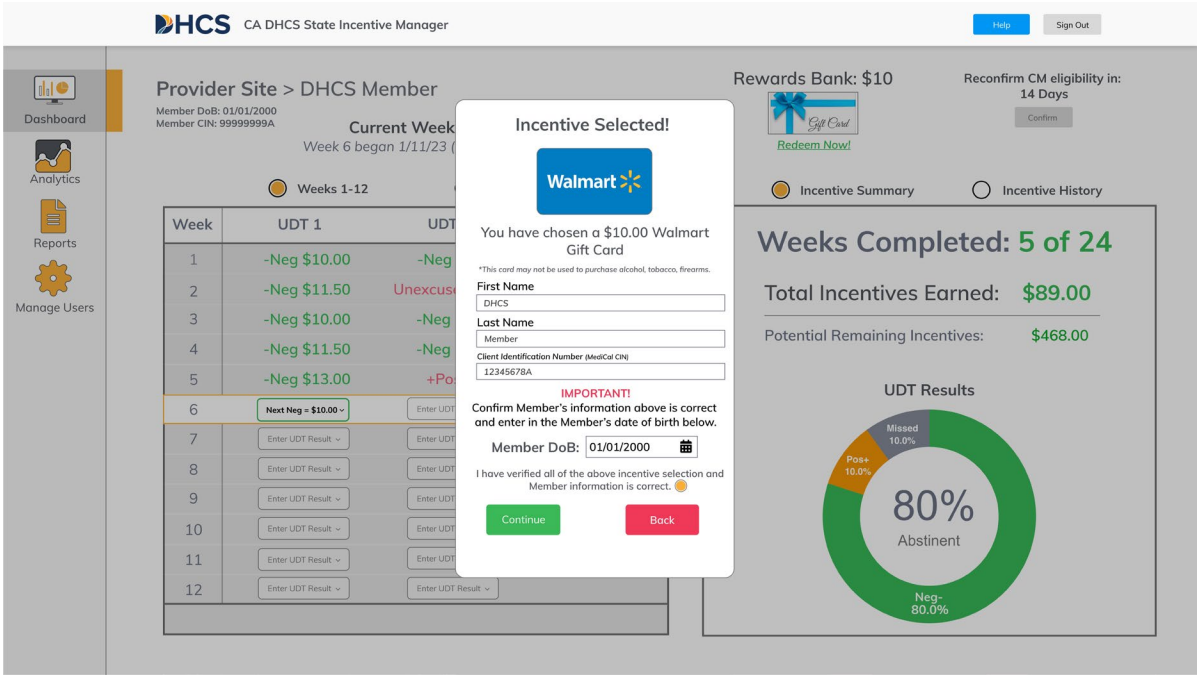


A full list of gift card vendors is available in the IM Portal.

Generating a Gift Card (see Figure 9)

- To generate a gift card the CM Coordinator must confirm the member's date of birth.

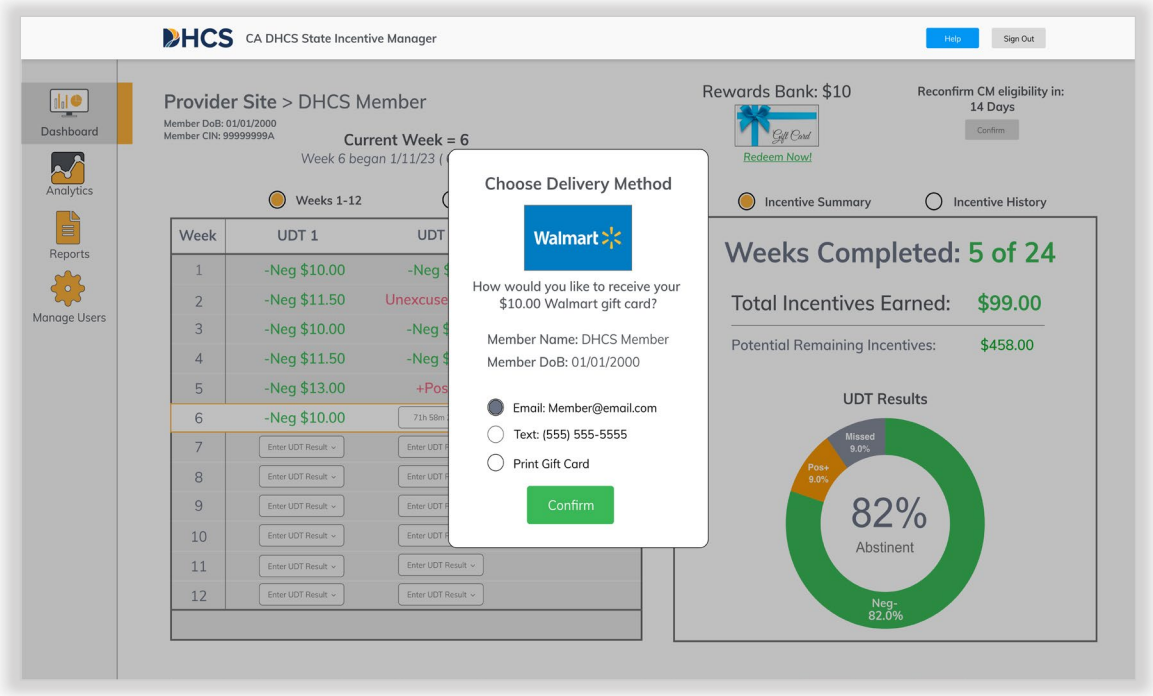
Figure 9. Generating Gift Card with Date of Birth Confirmation



Reward Delivery Type Selection (see Figure 10)

- Once a reward type is selected, the system will offer the delivery type option.
- For vendor-specific gift cards, the member can select text, email, or a printed voucher.
- *Note: For "banking" of rewards, this screen will not appear.*
- For texts, members will be required to input their phone number.
- For emails, members will be required to input their email address.
- For printed gift cards, once they are generated and printed, they *cannot* be reprinted, so the member must keep track of them.
- Text and email gift cards can be added to Apple or Google wallets.

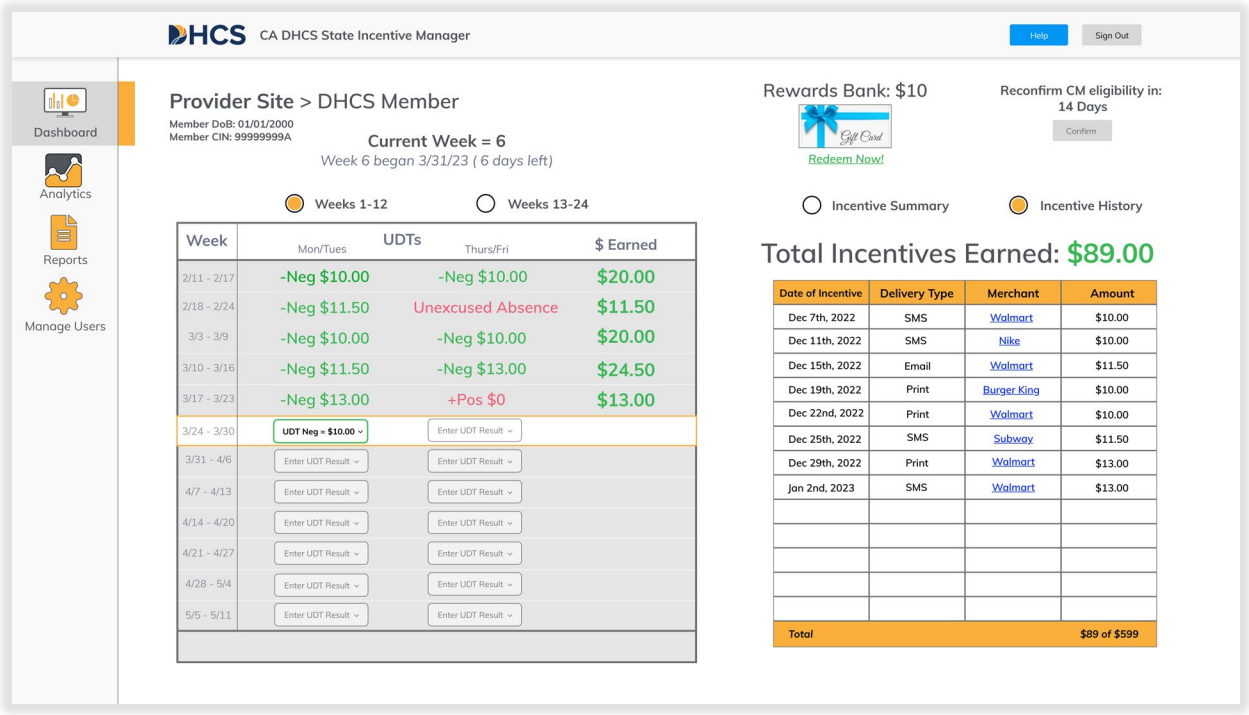
Figure 10. Reward Delivery Type Selection



Rewards Bank (see Figure 11)

- Once a reward amount has been generated, if the member chooses not to redeem it for an eGift card, unused dollars will be stored in the Rewards Bank.
- The Rewards Bank will allow the member to "save up" for higher denominations of eGift cards to redeem in the future.
- *Note: since the member will not be receiving an immediate reward, the CM Coordinator should demonstrate interest and enthusiasm; for instance, by asking the member what they are saving up for and praising them for it.*

Figure 11. Rewards Bank

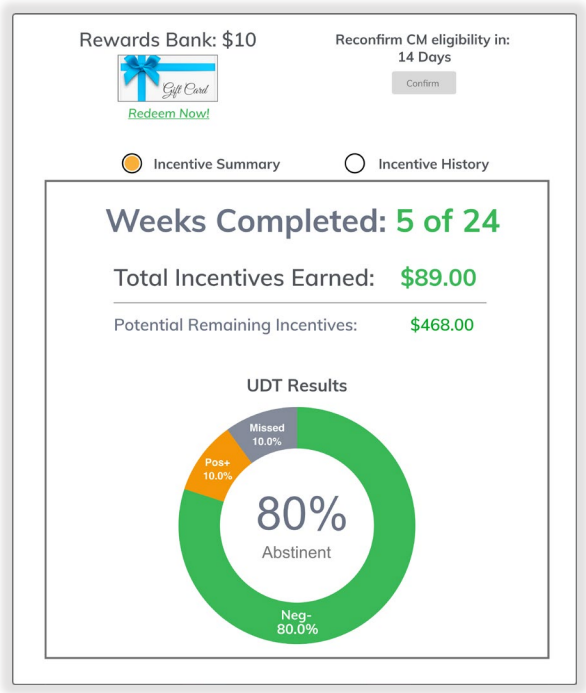


Rewards History (see Figure 12)

Rewards history for a specific member can be seen in two ways:

- As a comprehensive list of every reward earned:
  - Date
  - Delivery type
  - Vendor
  - Amount
- As a summary of results earned in total:
  - Total earnings
  - Potential remaining rewards
  - Percentage of sessions with a negative UDT

Figure 12. Rewards History



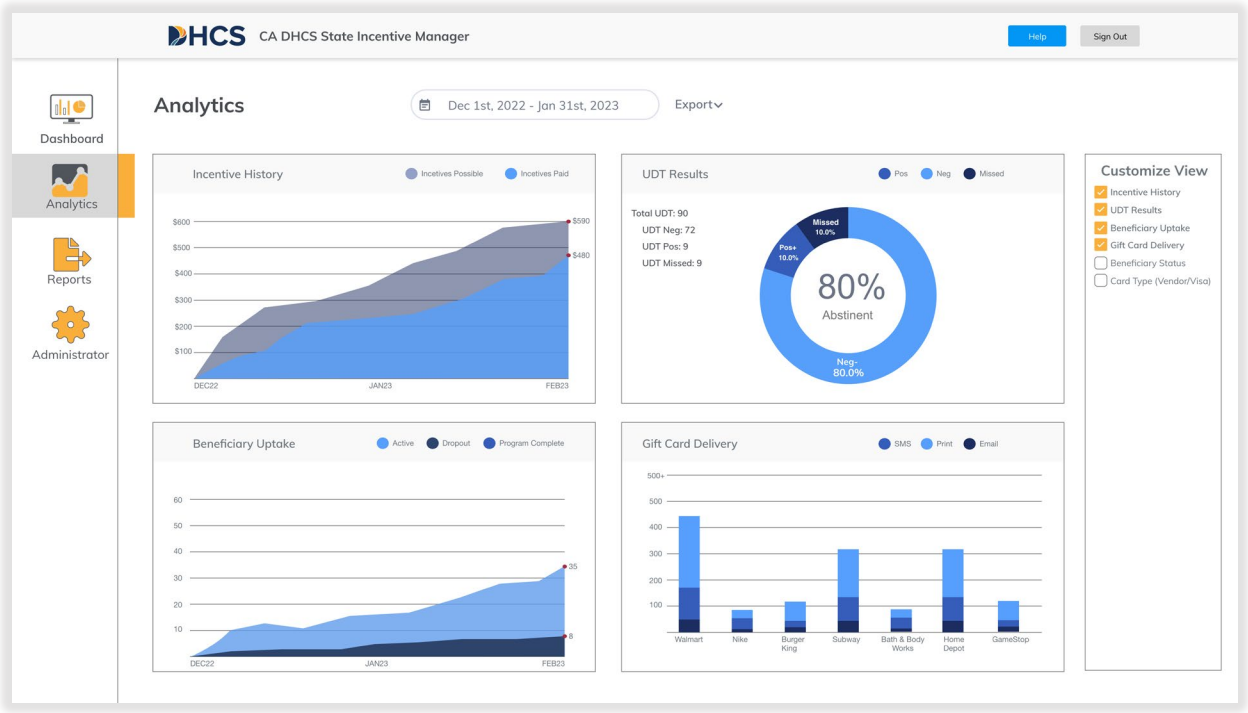
- The CM Coordinator should remind members that rewards cannot be used for purchasing alcohol, tobacco, gambling, cannabis, or firearms.
- Vendor-specific gift cards are either for vendors who do not offer these items or have inherent restrictions on purchasing prohibited items.
- The CM Coordinator should also remind members that rewards cannot be given out again once they have been delivered, so they should make sure to keep track of them.

CM Coordinator Analytics (see Figure 13)

CM staff can run analyses and reports. Available reports will vary depending on their level of permissions. To run a report, click on the “analytics” button on the left side of the portal pane.

- The analytics pane is highly customizable by the user using the “customize view” pane on the right side.
- Data can be downloaded as charts (i.e., a pdf) or raw data (i.e., csv or json).
- Data can be selected based on a specific date range.

Figure 13. Analytics Pane

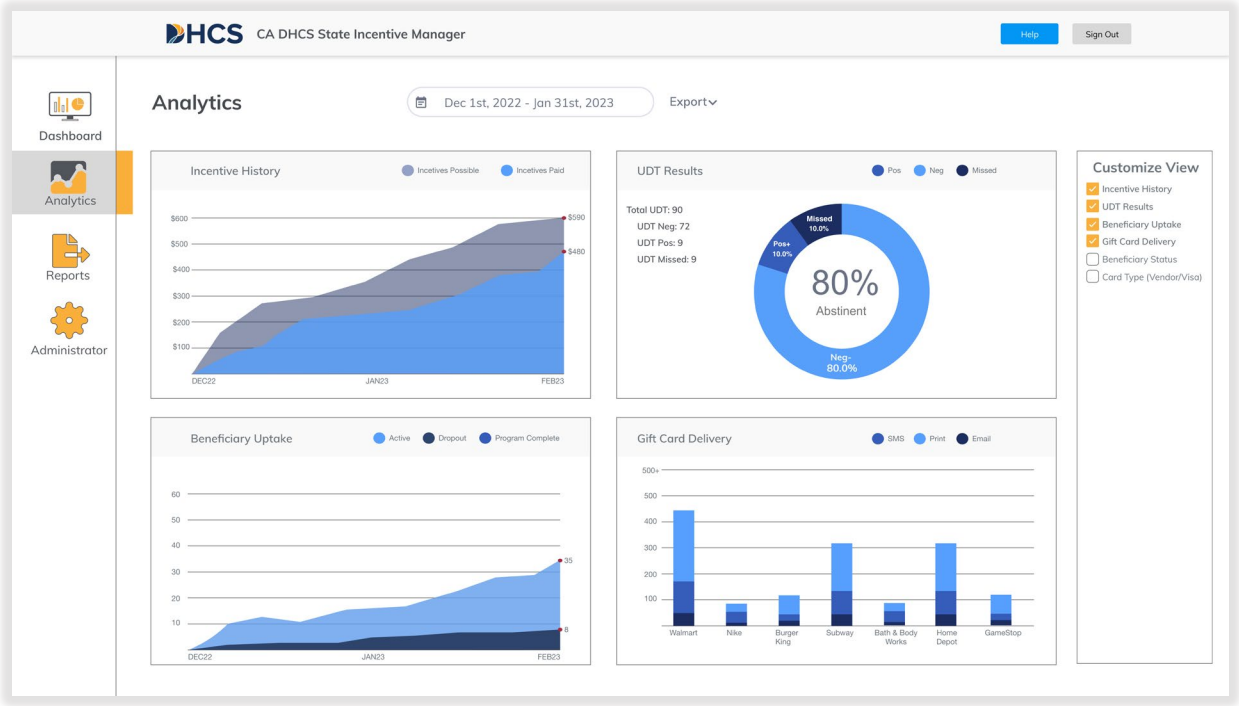


Analytics Customization (see Figure 14)

Analytics panes can be customized based on several factors.

- Selections by county will filter the data available in the charts on the left.
- Other selections will add new charts to the left side (shown in Figure 12 as reward history, UDT results, member uptake, and reward delivery type).

Figure 14. Analytics Customization

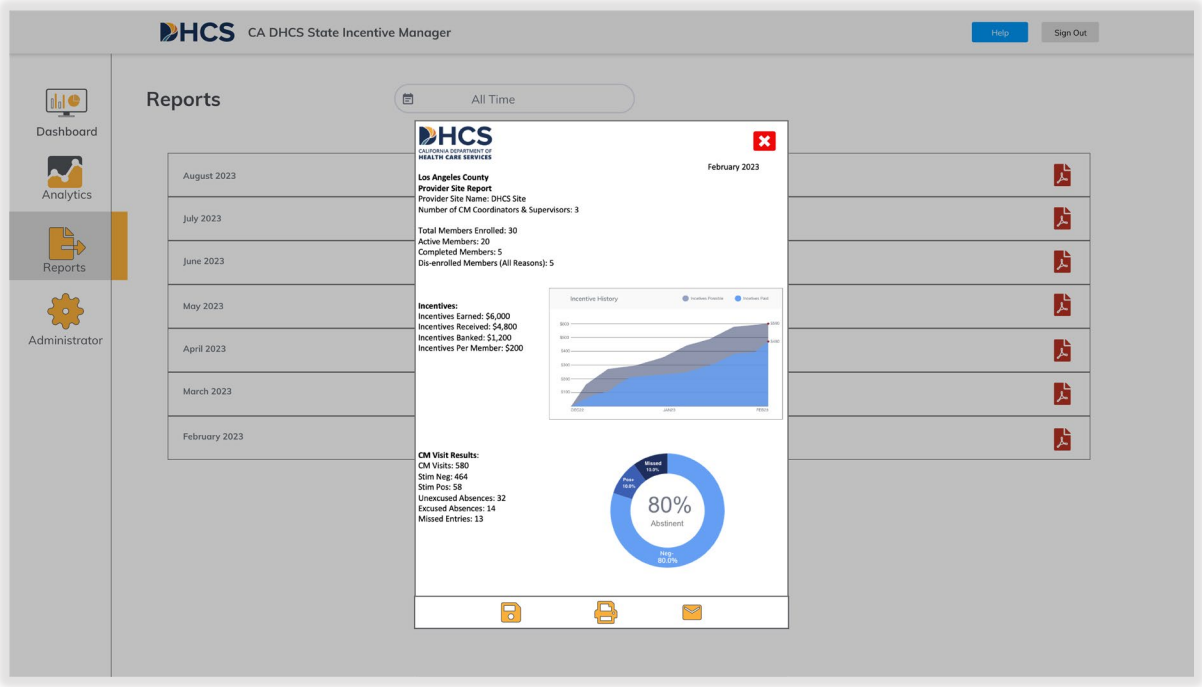


Analytics Report Pane (see Figure 15)

Reports will be compiled automatically by the system.

- Reports are available monthly.
- Reports are available at all levels for your role, i.e., CM Coordinator, CM Supervisor, County administrator, etc. and can be selected via a dropdown menu.
- Reports can be selected for specific sites or counties.
- To select a report, click the icon.
- The reports do not contain any member-level information (i.e., PHI).
- Reports may be downloaded, printed, or emailed.
- Once a specific report is selected, the report preview will pop-up.

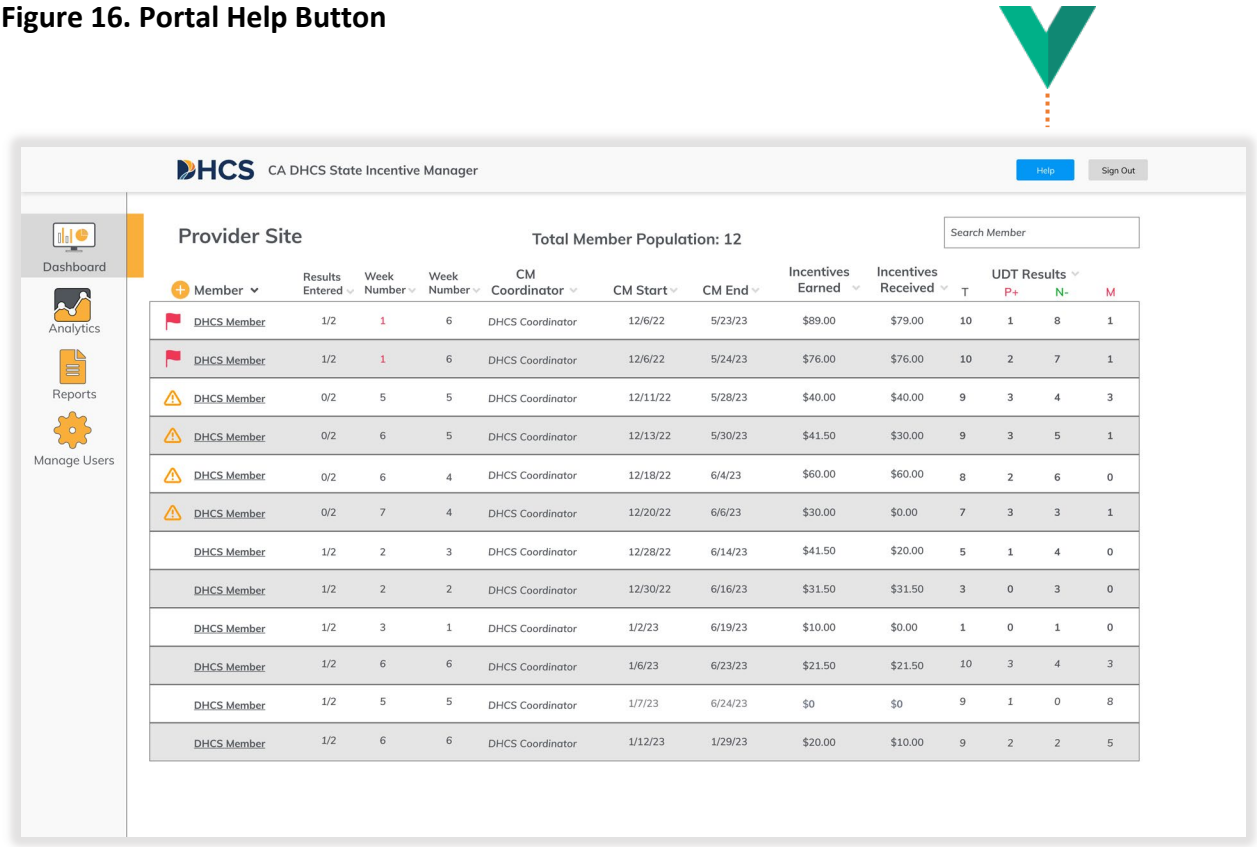
Figure 15. Analytics Report Pane



Portal Help Center (see Figure 16)

The help button is on every pane of the portal, on the upper right-hand side.

Figure 16. Portal Help Button

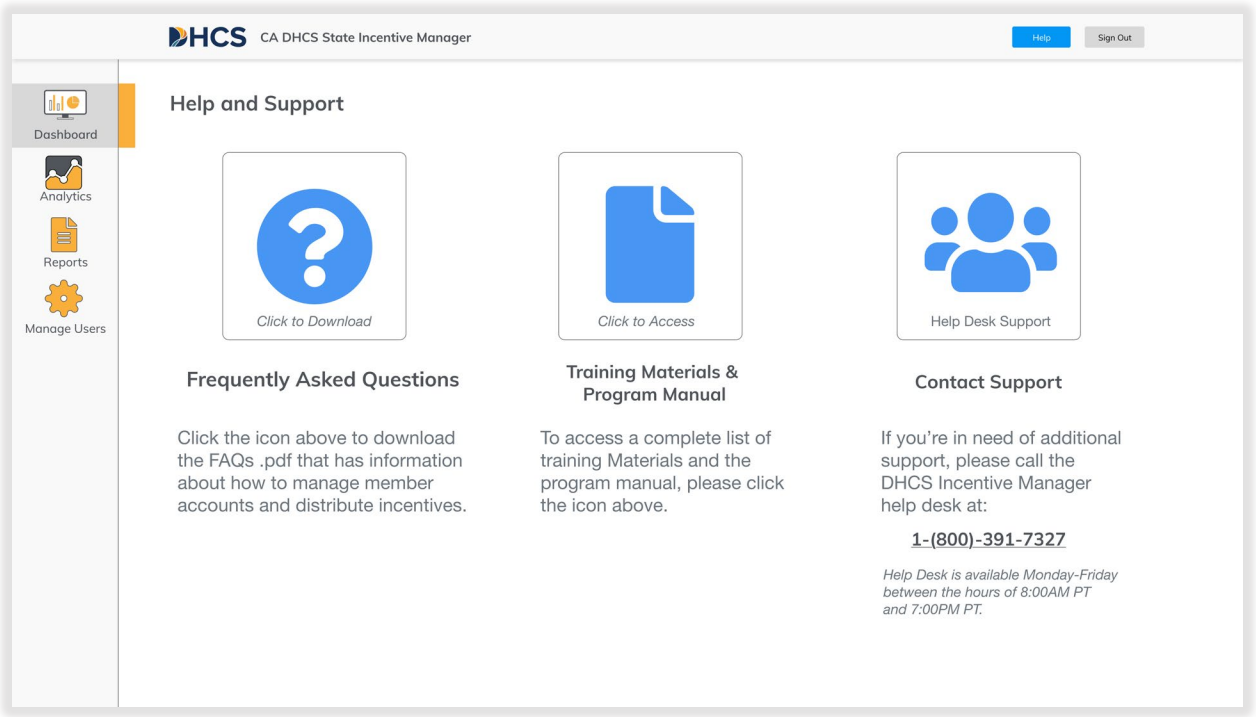


Member	Results Entered	Week Number	Week Number	CM Coordinator	CM Start	CM End	Incentives Earned	Incentives Received	UDT Results T	P+	N-	M
DHCS Member	1/2	1	6	DHCS Coordinator	12/6/22	5/23/23	$89.00	$79.00	10	1	8	1
DHCS Member	1/2	1	6	DHCS Coordinator	12/6/22	5/24/23	$76.00	$76.00	10	2	7	1
DHCS Member	0/2	5	5	DHCS Coordinator	12/11/22	5/28/23	$40.00	$40.00	9	3	4	3
DHCS Member	0/2	6	5	DHCS Coordinator	12/13/22	5/30/23	$41.50	$30.00	9	3	5	1
DHCS Member	0/2	6	4	DHCS Coordinator	12/18/22	6/4/23	$60.00	$60.00	8	2	6	0
DHCS Member	0/2	7	4	DHCS Coordinator	12/20/22	6/6/23	$30.00	$0.00	7	3	3	1
DHCS Member	1/2	2	3	DHCS Coordinator	12/28/22	6/14/23	$41.50	$20.00	5	1	4	0
DHCS Member	1/2	2	2	DHCS Coordinator	12/30/22	6/16/23	$31.50	$31.50	3	0	3	0
DHCS Member	1/2	3	1	DHCS Coordinator	1/2/23	6/19/23	$10.00	$0.00	1	0	1	0
DHCS Member	1/2	6	6	DHCS Coordinator	1/6/23	6/23/23	$21.50	$21.50	10	3	4	3
DHCS Member	1/2	5	5	DHCS Coordinator	1/7/23	6/24/23	$0	$0	9	1	0	8
DHCS Member	1/2	6	6	DHCS Coordinator	1/12/23	1/29/23	$20.00	$10.00	9	2	2	5

Three types of support are available in the IM Portal (see Figure 17):

1. Frequently asked questions documents.
2. Training videos.
3. Call center available by phone.

Figure 17. Portal Help Center



Chapter 6. Other Implementation Issues

Identifying Eligible Members

When beginning a new CM program, it is best to focus on addressing one target behavior, and therefore not everyone at your treatment site will be eligible. When implementing the Recovery Incentives Program, it is important to follow established criteria to identify eligible members. These criteria can be found in the BHIN 24-031 (see Appendix D) and should be shared with your site's intake staff and/or any treatment providers who may be able to make referrals.

The Recovery Incentives Program developed a series of outreach and communication resources, building on current efforts, for treatment providers to educate and inform Medi-Cal members about CM and its availability for individuals living with StimUD. The Recovery Incentives Program Provider Outreach and Communications Toolkit (see Appendix C) includes sample messaging for providers to use to conduct outreach with members who may be eligible for CM. The guidelines are reflective of the diverse racial/ethnic backgrounds of members who may be eligible for the CM program. A flyer and business cards (of various sizes) are available, as well, in Appendix C.

Program Roles, Supervision, Fidelity, and Evaluation

Once you have set up your CM program using the instructions provided in this Manual, DHCS policy documents (BHIN 24-031, Appendix D), and other materials generated by UCLA, you can take the following steps to select and train staff, implement the Program, and set up systems for ongoing supervision and monitoring.

Two reasons exist for closely monitoring your CM program. The first one is, just like all other evidence-based treatments, fidelity to the treatment model is essential to making sure your efforts result in good outcomes. CM is not likely to work if you do not implement the model in a way that is consistent with how it was tested in research studies. Second, you must make sure your Program consistently meets requirements for delivery and documentation of CM services. Unlike other evidence-based interventions, if you don't implement CM correctly, you could be accused of Medicaid fraud.

While we are not lawyers, we have worked closely with leading CM experts, the federal government, and DHCS to develop a CM model that is consistent with current requirements. We strongly encourage you to monitor your CM program, so it is consistent with the requirements. Additionally, the County, DHCS, and UCLA will be assisting with monitoring of service documentation and delivery and will notify any site where problems are noted so that that they can be quickly addressed and resolved.

Choosing Staff. Contingency management protocols must be delivered consistently to be successful, so it is helpful to identify specific staff members to deliver CM. The great thing about CM is that you do not need to be a clinical treatment provider to deliver CM. CM can be delivered by therapists, counselors, physicians, nurses, peer support specialists, case managers, or medical assistants, as long as the staff have been trained in CM and certified to serve as a CM Coordinator, Back-Up CM Coordinator, or CM Supervisor. For the Recovery Incentives Program, each

participating site will be required to select from existing staff or hire a part-time or full-time staff member to serve in the role of the CM Coordinator.

The person(s) implementing CM must be recovery-oriented and believe in the positive, non-judgmental approach to treatment. If the CM Coordinator does not have training in motivational interviewing, further training will be made available by UCLA.

It is important that you make sure that the entire treatment team knows how an individual is doing in CM. If they are doing great, then the whole team should know so they can all celebrate the member's success. If, however, the member is not doing well, it is important that the clinical team knows so that they can offer additional support to them. The member should be made aware that their progress in the CM program will be shared with other providers within the site, so CM is integrated into a "team" approach to their overall clinical care. Your site should include language to that effect in your consent documents.

The CM Coordinator will be the point person for the CM program when questions arise. There is a list of Frequently Asked Question on the DHCS CM Website. UCLA has also set up a website for consultation and questions. Other staff involved with CM protocols should have their roles clearly defined as well.

- The only staff members who can administer CM are the CM Coordinator, the Back-up CM Coordinator, and the CM Supervisor. The CM Coordinator may be a Licensed Practitioner of the Healing Arts (LPHA), a certified or registered SUD counselor, certified peer support specialist, or other trained staff under the supervision of an LPHA. NOTE: The designation "Other trained staff under supervision of an LPHA" is specific to CM and does not change existing requirements for providers of other DMC-ODS services. DHCS is working to develop additional guidance to support use of this provider type.

Ongoing Supervision. It is required that the designated CM Supervisor perform fidelity checks for any staff involved in providing CM. This involves scheduling regular check-ins to assure that your CM program is being delivered consistently and rigorously over time. This routine can help to detect when a procedural shift or misunderstanding has occurred. A fidelity monitoring tool will be administered by the UCLA Training and Implementation Team.

Research has shown that fidelity to CM procedures is directly tied to CM implementation success and provider satisfaction.[12] Supervision can take the form of recorded or observed CM visits or scheduled paper or in-person assessments where the staff can demonstrate some aspects of CM delivery to their supervisor. CM Supervisors can also use the analytics features of the IM Portal to generate reports to ensure procedures are being implemented correctly and consistently. Clinic meetings should occur regularly with the CM Team to address any administrative and clinical issues that arise.

Steps for Training New Staff

1. All CM staff must complete the self-paced CM Overview Training (2 hours) and the 2-part live virtual CM Implementation Training (6 hours total delivered in two 3-hour sessions) and successfully complete a 2-part Readiness Assessment process prior to initiating CM services. Live virtual trainings will be scheduled regularly to ensure that we can

accommodate new staff quickly. Training dates and times are available here. See Appendix E for a visual flow chart of the CM Team Requirements for completing all required trainings.

2. Use this Program Manual and other training materials to orient the CM Team to administer CM for stimulant use disorders.
3. Develop and disseminate site-specific policies and procedures on how this CM protocol will be implemented at your site. This could include preparing or accessing CM protocol checklists, forms, and electronic tools, policies regarding restroom setup and UDT procedures, how space will be utilized, EHR-specific documentation/billing requirements, etc. Site-specific policies and procedures must conform to the requirements set forth in BHIN 24-031 and this Manual.
4. Next, the CM Team can practice CM with role-playing exercises and reviewing their site protocol for various scenarios to ensure they understand the CM principles and protocols. Examples of role-playing activities include practicing how to describe the CM protocol to new members or practicing the delivery of CM.
5. Have trained personnel (i.e., CM Supervisor) sit in on initial CM visits conducted by new CM Coordinators.
6. Regularly review CM documentation conducted by new CM Coordinators.

Tips for Handling Contested Stimulant-Positive UDT Results

- Remain non-confrontational (do not be accusatory or defensive) about the results, though stay firm that awarding the reinforcer is contingent on the result of the objective marker *("The gift cards can only be given out when a stimulant-negative urine test is submitted."*) Remind the member that this was agreed upon at the start of their participation in the Recovery Incentives Program so there would not be any confusion.
- If the member is insistent that they have remained abstinent since the last test, a second point-of-care UDT can be administered to determine if the first test result was a false positive. The member should be informed that the result of the second test will be the determining factor in whether they receive an incentive that day. This course of action should be used very sparingly and preferably in consultation with the CM Supervisor. If a member is VERY upset and there is concern about them leaving the program over this result, the second test can be offered. It is also important to remember that billable rates include only one UDT per visit, so the second test would not be reimbursed to your agency.
- Remind the member that some over-the-counter cold and flu medications may contain ingredients that will result in a stimulant-positive drug screen. Some amphetamine-based hallucinogens (e.g., MDMA) may also result in an amphetamine-positive drug screen. Review the list of medications to avoid (see last page of Sample Consent Form in Appendix A) with them to see if they have begun using one recently.
- Remind the member that it may take a few days for the drug metabolite to clear their system. It may take two regularly scheduled UDTs after use before a stimulant-negative test occurs.

- As a reminder, members who are taking a prescribed amphetamine (such as Adderall® – amphetamine-dextroamphetamine salts) will not be eligible for participation in the Recovery Incentives Program as there is no way to distinguish between these medications and non-prescribed use of amphetamines. Members who are taking these medications should be offered other treatment services.

Handling Excused Absences

Members will be informed in the Recovery Incentives Program consent form that if they cannot attend a scheduled appointment, they will need to tell the CM Coordinator ahead of time to reschedule or receive an excused absence. An excused absence must be requested and approved by the CM Coordinator prior to the scheduled visit. Absences cannot be approved as excused after the scheduled visit. Reasons for excused absences include having a doctor's appointment that cannot be rescheduled, illness, a court date, or a death in the family. The member must provide documentation of the reason for the absence at the next scheduled visit (i.e., receipt from healthcare clinic, funeral announcement, or court document).

- **Retention is the Goal.** Clearly establish attendance expectations at the beginning and find ways to work with each member on a case-by-case basis. Be flexible if possible and reschedule the appointment. Where possible, members should be rescheduled for the same day. Alternatively, a member can be scheduled on a contiguous day. If they reschedule in this way, they will still receive rewards according to the schedule.
    - For example: If a member tends to get called into work last minute, see if they can commit to providing a urine sample on their way into work or during a lunch break. They can always receive their incentive on a different day when they have more time.
- If the member has an excused absence as defined above, their incentive schedule will continue at their next appointment with no reset. They will not receive an incentive for the missed appointment(s), nor would their timeline be extended to 'make up' the missed appointment, but their gift card value will not be reset.
- Likewise, a staff or member holiday is a valid excused absence. The member should be rescheduled for the day before or after the holiday if possible, or they may be able to provide only one sample during a holiday week, without penalty.
- All absences will be entered into the IM Portal as either excused or missed (unexcused) so that incentives can be calculated accurately and there is no confusion later. Absences must be entered into the IM Portal on the day of the appointment since it will not be possible to enter two results on the same day later in the week (or on the following week, in the case of an absence on a Thursday or Friday). The IM Portal will automatically account for the excused or unexcused absence.
- In the event of one or more missed visits (unexcused absences), the CM Coordinator should attempt to contact the member to facilitate their return to the clinic on their next scheduled visit.

Readiness Assessment

After completion of Part 2 of the Recovery Incentives Program: California's Contingency Management Benefit Implementation Training, sites will first complete an online Readiness Assessment Self-Study Survey via Qualtrics and then participate in an interactive 1-hour Readiness Assessment Interview with UCLA staff via Zoom. To be eligible to initiate the Readiness Assessment process, at least one CM Coordinator and one CM Supervisor per site must first complete all required trainings (2-hour CM Overview on-demand course and 2-part Implementation Training).

The purpose of the Readiness Assessment is to ensure that sites are fully prepared to offer CM services in accordance with DHCS standards and the rules and regulations of the Recovery Incentives Program. Both components of the Readiness Assessment (Qualtrics Survey and Zoom Interview) are required to be completed in full prior to being permitted to administer CM services. The Readiness Assessment process includes:

- Interactive demonstration of procedures and site-specific implementation goals.
- Entering practice cases into the Incentive Manager Portal to demonstrate proficiency with these tools.
- Responding to pre-set clinical scenarios, including, though not limited to, how to handle unexcused absences, disputes over test results and positive results for drugs other than stimulants.

See Appendix E for a visual flow chart of the CM Team Requirements for completing the Readiness Assessment process.

Evaluation

The evaluation approach is organized around the RE-AIM framework, as follows.

1. **Reach:** This will be measured as the percentage of members in treatment for stimulant use disorder who participate in the Recovery Incentives Program. UCLA will also evaluate whether there are disparities in reaching different member populations.
2. **Effectiveness:** Effectiveness will be based on the results of UDTs. Data will be collected from the IM Portal. UCLA will track the impact of CM on treatment retention and treatment attendance.
3. **Adoption:** Adoption will be measured by evaluating how many treatment sites implement the Recovery Incentives Program. This will be evaluated using DMC-ODS claims data.
4. **Implementation**: Implementation will be evaluated by the degree to which the Recovery Incentives Program is implemented with fidelity to the treatment protocol. Perceptions of challenges and areas for potential improvement will also be collected from treatment program staff and Recovery Incentives Program participants.
5. **Maintenance**: Maintenance will be measured by evaluating the degree to which sites implementing the Recovery Incentives Program continue providing the benefit

throughout the evaluation period, based on data collected from the web-based IM Portal and Medi-Cal claims data. In addition, surveys and qualitative interviews with CM Coordinators and Supervisors will be conducted and focus on factors that could promote or impede the continued delivery of the contingency management benefit.

Additional evaluation expectations for sites:

- Recovery Incentives Program sites will be asked to give an online survey link or QR code to members to participate in a short (5-minute) survey or provide them with a way to participate onsite (e.g., tablet or computer). Ideally this will occur at intake or early in treatment, and members will be encouraged (but not coerced) to participate. Members will be compensated by gift card (disbursed by UCLA, not the IM Portal) and become eligible for additional follow-up surveys (also compensated). Some members participating in a survey may also be invited by UCLA to participate in interviews. Although plans may be revised, we currently anticipate that each site will be required to meet a specified number of members, at which time the site will be contacted and distribution of the survey link can be paused.
- Sites may be contacted by e-mail to participate in surveys and interviews themselves. This will be an opportunity to provide ideas on how to improve the Recovery Incentives Program and describe barriers, successes, and lessons learned that may help others in the field. The CM Coordinator may be asked to distribute an additional survey to counselors at the site.

Planning for both the member and site surveys is currently underway, and additional details and instructions will be forthcoming, but both will be essential to the evaluation of the Recovery Incentives Program, and your participation is greatly appreciated.

Federal Law and Incentive Payments

In general, federal law restricts providers' abilities to offer financial incentives as part of patient therapy or patient recruitment. The Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients).[1] The Civil Monetary Penalties Law (CMPL) authorizes the Secretary of Health and Human Services to impose civil money penalties, an assessment, and program exclusion for various forms of fraud and abuse involving the Medicare and Medicaid programs.[2]

Over the years, the U.S. Department of Health & Human Services Office of Inspector General (OIG) has cautioned providers about various problematic activities that may create legal risk

[1] https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/
[2] Ibid.

under the AKS or the CMPL, including paying people to receive care that was not medically necessary.

However, the federal government has explicitly stated that the AKS and the CMPL do not apply to motivational incentives that are delivered as part of the Medicaid-covered CM benefit, and in compliance with the DHCS-approved CM protocol. For the purpose of the Medi-Cal contingency management benefit authorized under the CalAIM 1115 demonstration:

> *These motivational incentives are considered a Medicaid-covered item or service and are used to reinforce objectively verified recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to members (42 U.S.C. 1320a-7a(a)(5), "Member Inducements CMP") would be implicated.*[3]

For more information on OIG rules for Non-Medicaid-funded Contingency Management Programs, see Appendix F.

Non-Federal Share of CM Costs

Counties may invoice DHCS for allowable DMC-ODS administrative costs related to the administration of CM. The non-federal share of these administrative costs will initially be covered with state funds that were available for a limited period of time as a result of the DHCS Home and Community Based Spending Plan. DHCS must spend these funds by August 15, 2024.

If counties elect to continue participation in this optional benefit, they shall be responsible for covering the non-federal share of administrative costs after the close of the DHCS Home and Community-Based Spending Plan. Because of payment lag, and administrative claiming occurring on a quarterly basis, in effect, this means that counties shall be responsible for the non-federal share of CM administrative costs after June 30, 2024. The MC5312 for the period ending June 30, 2024, must be submitted to DHCS no later than August 15, 2024, for processing to receive state funds. DHCS will extend the pilot period through at least the duration of the CalAIM 1115 demonstration period (ending December 31, 2026), allowing approved DMC-ODS counties to continue services beyond the original pilot end date of March 2024.

Please refer to the DMC-ODS Billing Manual for general guidance about billing.

[3] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

Chapter 7. Communicating with Members about the Recovery Incentives Program

Member Outreach

DHCS recognizes that effective outreach and marketing strategies will increase the likelihood that eligible members will learn about the Recovery Incentives program. DHCS' goal in offering CM is to ensure that eligible Medi-Cal members have access to evidence-based treatment for StimUD. Appropriate outreach may increase the likelihood that members will initiate and adhere to a treatment program for StimUD. One of the primary goals of the Recovery Incentives Program is to retain members with StimUD in treatment.

Treatment program communications about CM (and any other health care service) should be accurate, non-misleading, and non-coercive. When communicating about the CM benefit with current members, potential members, or the general public, treatment programs should avoid any statements that are inaccurate, misleading, or coercive.

See below for a list of DOs and DON'Ts, which apply to general CM outreach materials as well as conversations with current or potential CM members.

DO	DON'T
✓ Clarify that the CM benefit is available to individuals who meet certain eligibility criteria, such as having a qualifying StimUD, enrolling in Medi-Cal, and residing in a participating county	✘ Use language that could mislead ineligible people into believing that they will qualify for CM incentives
✓ Explain that CM is intended to support treatment goals over time, such as substance non-use and treatment adherence	✘ Suggest that a member will receive an incentive just for showing up
✓ Accurately describe the nature and potential value of the motivational incentives (e.g., "up to $599," "gift cards to retail and grocery stores").	✘ Overstate the potential value of the incentives (e.g., "almost $1,000!"), or state that incentives will be made in cash
✓ Ensure members understand that the CM benefit is optional	✘ Suggest that a member *must* enroll in CM to receive other health care services
✓ Let potential members know that CM incentives are conditioned on undergoing a medical assessment and taking regular drug tests, in accordance with DHCS' CM protocol	✘ Suggest that CM incentives are conditioned on members receiving services beyond those required under DHCS' CM protocol

DO	DON'T
✓ Emphasize that CM is a new and exciting option under DMC-ODS to support people with StimUD	✘ Suggest that the CM benefit is unique to a particular provider, or that one provider's CM benefit is better than another's
✓ Emphasize that use of motivational incentives is based on research	✘ Suggest that it is the only proven approach to StimUD treatment

Participating sites have the flexibility to craft their own outreach messages as long as all communications are accurate and are not misleading or coercive. As part of the 2-part Implementation Training, CM Teams will receive a Provider Outreach Toolkit (see Appendix C) that includes sample messages to communicate about the Recovery Incentives Program with eligible members.

Additional Resources and Recovery Incentives Program Articles

DHCS Recovery Incentives Program Website:
https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx

UCLA Recovery Incentives Program Website and Warmline:
https://uclaisap.org/recoveryincentives/

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Acknowledgements

Prepared in 2023 by: UCLA Integrated Substance Use and Addiction Programs
10911 Weyburn Avenue, Suite 200
Los Angeles, California 90024-2886
T: (310) 388-7647
F: (310) 312-0538
https://uclaisap.org/recoveryincentives/

At the time of writing, Thomas E. Freese, Ph.D., and Beth A. Rutkowski, MPH, served as Co-Principal Investigators of the DHCS Contingency Management and CalAIM Training Contract (#21-10456), funded by the California Department of Health Care Services to the Regents of the University of California, UCLA Integrated Substance Use and Addiction Programs. The opinions expressed herein are the views of the authors and no official support or endorsement for the opinions described in this document is intended or should be inferred.

Date Last Updated: October 9, 2024.