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Medi-Cal Contingency Management Pilot Program Policy Design

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Contents

Introduction

This California Advancing and Innovating Medi-Cal (CalAIM) Contingency Management Pilot Program Policy Design is intended to serve as a guide for Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, DMC-ODS providers, web-based and mobile incentive manager vendors, and other key stakeholders on the implementation of California Medi-Cal's CM pilot. The CM pilot will run from July 2022 through March 2024. Counties and providers may begin preparations prior to benefits becoming available no earlier than July 1, 2022. The Department of Health Care Services' (DHCS) primary goal for the pilot is to determine how to scale a proven treatment for stimulant use disorder (StimUD) in Medi-Cal in a large, complex state, supporting DHCS' broader policy goals to:

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

This draft document provides information on DHCS' initial policy and operational decisions for which stakeholders are encouraged to offer feedback, especially with respect to the amount and duration of the incentives. DHCS developed this draft policy design in partnership with nationally recognized experts from the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs and key stakeholders.

Background on Need in California

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

Unlike for opioid use disorder (OUD) and alcohol use disorder, no Food and Drug Administration-approved medications exist to treat StimUD. However, evidence-based

practices (EBPs) can be deployed, including motivational interviewing, community reinforcement approach (CRA), cognitive behavioral therapy (CBT) and, most importantly, CM.[vi]

What Is Contingency Management (CM)?

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

To expand access to evidence-based treatment for StimUD, DHCS intends to pilot Medi-Cal coverage of CM in select DMC-ODS counties beginning July 1, 2022, in accordance with recent approval from the Centers for Medicare & Medicaid Services (CMS) as part of the CalAIM demonstration.[xii] As part of the pilot, eligible Medi-Cal beneficiaries may participate in a structured 24-week outpatient CM program, followed by six or more months of additional recovery support services. Individuals will be able to earn motivational incentives in the form of low-denomination gift cards, with a total retail value determined for each treatment episode. DHCS is committed to ensuring that its CM pilot has guidelines that protect against fraud and abuse. In particular, DHCS is mindful of the importance of not violating the federal Civil Monetary Penalties Law (CMPL) or the Anti-Kickback Statute (AKS), which are enforced by the U.S. Department of Health and Human Services Office of the Inspector General (OIG). The federal government has explicitly recognized that motivational incentives delivered as part of the Medicaid-covered CM benefit according to the CM protocol for the pilot do not implicate the AKS and CMPL in the state's approved CalAIM Demonstration.[xiii] DHCS is committed to implementing CM with strong guardrails in place to ensure the integrity of CM, promote fidelity to the EBP and mitigate the risk of fraud, waste or abuse associated with the distribution of motivational incentives.

The proposed pilot will run through March 2024. DHCS will first implement CM using a web-based incentive manager vendor (with printable gift cards) and anticipates phasing in a mobile incentive manager vendor with participating DMC-ODS counties and providers no later than December 31, 2022. By implementing both web-based and mobile incentive manager options, DHCS seeks to ensure program participants without smartphones or reliable broadband access are able to receive CM services.

DHCS began working with DMC-ODS counties and providers in fall 2021 to plan for a staggered implementation with the first cohort of counties and providers starting in July 2022 and the second cohort implementing CM starting between September and December 2022. In November 2021, DHCS released an expression of interest (EOI) to initially gauge county interest in participation in the pilot, followed by a request for applications (RFA) in January 2022 to formalize DMC-ODS counties' commitments to

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

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

Implementation Timeline

DHCS will launch the CM benefit in select DMC-ODS counties using county-contracted providers beginning on July 1, 2022, with additional DMC-ODS counties and providers joining in a second cohort between September and December 2022. The pilot program will run through March 31, 2024. DHCS, counties, providers and key stakeholders will collaborate to meet key milestones related to the design and implementation of the pilot program, which are detailed in a tentative schedule in Table 1 below. DHCS plans to conduct monthly stakeholder workgroup meetings throughout the design and implementation of the CM Pilot Program.

These milestones are reviewed in further detail in later sections of this paper.

Table 1: Proposed Implementation Timeline

Date	Activity
November 2021	Released EOI for DMC-ODS counties
December 2021	Received federal approval for CM Medi-Cal Pilot Program
January 2022	Released RFA for DMC-ODS counties
	Host informational webinars for DMC-ODS counties and interested providers
	Facilitate stakeholder meeting with CalAIM behavioral health workgroup
	Release request for proposal (RFP) for web-based incentive manager vendor
February 2022	Deadline for counties to respond to RFA

Table 1: Proposed Implementation Timeline	
Date	**Activity**
	Identify DMC-ODS counties participating in Phase I and Phase II
	Release RFP for mobile incentive manager vendor
	Deadline for web-based incentive manager vendors to respond to RFP
April 2022	Award web-based incentive manager vendor contract
	Deadline for mobile incentive manager vendors to respond to RFP
May 2022	Award mobile incentive manager vendor contract
	Begin training and technical assistance (T/TA) for counties, providers and vendors
June 2022	Conduct provider readiness reviews
July 2022	Phase I DMC-ODS counties launch CM using web-based incentive manager i
	Begin data collection for evaluation
September 2022	Phase II DMC-ODS counties launch CM at the earliest
October 2022	Release preliminary assessment of CM program launch
December 2022	Phase II DMC-ODS counties launch CM at the latest
	Launch CM using mobile incentive manager
	Conduct provider fidelity reviews
July 2023	Release interim evaluation report
March 2024	Conclude CM pilot
July 2024	Release final evaluation report

Roles and Responsibilities of Key Stakeholders

The design and implementation of an effective CM pilot require close and regular collaboration among a number of entities, including the state, participating DMC-ODS counties, participating SUD providers, vendors, trainers and program evaluators. Each entity has a specific role and key responsibilities it will need to execute; these roles and responsibilities are described briefly below and expanded upon in greater detail in subsequent sections.

DHCS

DHCS will lead all aspects of the design, implementation and monitoring of the overall implementation of the CM Pilot Program, which will be informed by ongoing and close engagement with participating DMC-ODS counties, SUD providers offering CM, vendors, Medi-Cal beneficiaries and other key stakeholders.

DHCS' key responsibilities include:

- **Funding.** DHCS will provide funding for the pilot, including training resources, startup funds for capacity building and other activities to prepare counties and providers to implement the pilot, as well as funding to support the provision of CM to eligible Medi-Cal beneficiaries. DHCS will provide the nonfederal share of the Medicaid service and administrative costs for CM services. Additional information regarding the CM reimbursement approach is discussed later in this document.
- **Contracts.** DHCS will also directly manage the contracts with the DMC-ODS counties, UCLA training and evaluation teams, the web-based and mobile incentive manager vendor(s) and any other vendors it chooses to contract with to support the CM pilot.
- **Oversight.** DHCS will work closely with counties to monitor the pilot to ensure that beneficiaries are receiving CM services in accordance with program requirements and as a safeguard against fraud, waste and abuse. While a DHCS contractor will provide a readiness review and fidelity review for every provider, DHCS expects counties to oversee the benefit as part of their DMC-ODS monitoring and oversight responsibilities. DHCS will release an audit tool for counties to use to monitor providers. This tool will align with the fidelity review tools will be developed by the state's contracted trainer and program evaluator. The oversight roles of DHCS and the counties are under further development.
- **T/TA.** DHCS, with the assistance of UCLA, will sponsor initial and ongoing training for counties and providers to implement CM, as well as targeted technical assistance (TA) to individual providers.
- **Evaluation.** DHCS, with the assistance of UCLA, will conduct a rigorous evaluation of the CM pilot to determine its efficacy and help inform the design and implementation of a statewide CM benefit. Per federal demonstration

requirements, the evaluation of CM will be incorporated into the broader evaluation of the CalAIM 1115 demonstration.

- **Outreach.** DHCS will develop a communications and outreach strategy, building on current efforts, that educates and informs individuals in California about CM and its availability in the Medi-Cal program that will implemented in collaboration with participating DMC-ODS counties and providers.

DMC-ODS Counties

Participation in the CM Pilot Program will be optional for DMC-ODS counties. Counties may request approval to participate in the CM Pilot Program by responding to the RFA issued in January 2022. All counties that DHCS determines are able to meet the criteria for participation in the CM pilot program by the implementation date will be approved to participate in the CM pilot Program. To ensure that counties and CM providers are sufficiently trained and equipped to deliver CM in accordance with DHCS' developed protocols, DHCS anticipates offering a two-phase implementation, with an initial cohort of counties and select providers beginning in July 2022 and others between September and December 2022. Counties must propose a Phase I or Phase II start date for pilot participation and describe their plan to implement CM at one or more provider sites by the start date in their RFA response. Depending on the availability of resources, DHCS may need to work with counties to identify whether an individual county will participate in Phase I or Phase II. Counties approved for participation in the CM Pilot Program will be required to work with DHCS and the web-based and mobile incentive manager vendor(s) to prepare for and implement the CM pilot.

Each participating county's key responsibilities include:

- **Network Development.** Participating counties will be required to build throughout the pilot a network of CM providers that are equipped to serve Medi-Cal beneficiaries living with StimUD in accordance with DHCS requirements. DHCS, with the assistance of UCLA, will assist counties in gauging the readiness of providers to offer CM, including staggering onboarding of providers who will participate in the pilot.
- **T/TA.** Counties will participate in required trainings to enable them to manage CM services delivered through the pilot as well as help facilitate the provision of T/TA for SUD providers offering CM.
- **Funding and Reimbursement.** Counties will be responsible for adhering to the funding and reimbursement guidance that will be forthcoming from DHCS. The guidance will include a suggested reimbursement rate range for counties to consider for reimbursing CM.
- **Reporting.** Counties will be required to collect information from their providers and share it with DHCS to support oversight and monitoring of pilot services as well as inform the state's evaluation of the pilot.
- **Monitoring and Quality Improvement.** Counties will work with DHCS and UCLA in reviewing readiness and fidelity reviews and assisting providers in

delivering high-quality CM and will work with these organizations to troubleshoot programmatic and technical issues.

SUD Providers

DMC-ODS providers that offer nonresidential levels of care, including outpatient, intensive outpatient, narcotic treatment programs (NTPs) or partial hospitalization, will be eligible to provide CM services to qualifying Medi-Cal beneficiaries living with StimUD in accordance with federal, DHCS and their DMC-ODS county's requirements.

Among their responsibilities, participating SUD providers will be required to participate in the following activities:

- **T/TA.** Providers will participate in required DHCS-conducted trainings prior to and during the CM pilot, take part in an initial readiness review and participate in ongoing TA to ensure that providers are delivering services in accordance with evidence-based protocols.
- **Assessment and Treatment Documentation.** Providers shall screen and assess clients consistent with DMC-ODS requirements, including the requirement for an American Society of Addiction Medicine (ASAM) assessment within 30 days of entry to care (up to 60 days for adolescents or clients experiencing homelessness) and shall follow DHCS documentation standards, as part of CalAIM. The provider shall determine client eligibility for CM services in accordance with the eligibility standards included below and provide other treatment and recovery services as indicated, based on the client's needs (e.g., individual or group therapy, care coordination, peer services).
- **Service Delivery.** Providers shall have a dedicated CM coordinator to provide CM to all qualified participants, including those who elect to receive incentives via the web-based or mobile incentive manager vendor(s).
- **Reporting.** Providers shall provide an efficient set of data to support regular monitoring of the pilot as well as the DHCS evaluation of the pilot. This will include the submission of claims data for reporting and reimbursement purposes.

Web-Based Incentive Manager Vendor

DHCS intends to contract with a web-based incentive manager vendor to manage the tracking and distribution of incentives to Medi-Cal beneficiaries. The web-based incentive manager vendor will be selected through a competitive procurement process in early 2022 and will be active in participating counties at the launch of the pilot program in July 2022. At the start of the pilot, the web-based incentive manager vendor will be responsible for incentive distribution for all program participants through electronic or paper gift cards. Providers will distribute printed gift cards generated by the web-based incentive manager vendor to CM clients.

The web-based incentive manager vendor will be responsible for calculating incentive amounts based on urine drug screen results, disbursing incentives to program

participants and tracking incentive payment dates and amounts over time in accordance with DHCS protocols.

The web-based incentive manager vendor will also be required to demonstrate readiness prior to implementation of the pilot, participate in DHCS trainings preceding and during the pilot, and adhere to reporting, privacy and security requirements.

Mobile Incentive Manager Vendor(s)

DHCS also intends to contract with one or more mobile incentive manager vendor(s) to enable Medi-Cal beneficiaries to receive motivation incentives via their smart devices. The mobile incentive manager vendor(s) will be selected via a competitive procurement process in 2022 and will be active in select participating counties no later than December 2022. Once the mobile incentive manager vendor(s) are operational, providers will be able to offer new program participants the option to use either the web-based or mobile incentive manager. Participants will not be able to switch from the web-based to the mobile incentive manager partway through the CM program.

Similar to the web-based incentive manager vendor(s), the mobile incentive manager vendor(s) will be required to calculate incentive amounts based on urine drug screen results, disburse incentives to program participants and track incentive payment dates and amounts over time through both a patient-facing mobile application and a provider-facing portal. While some existing mobile incentive manager vendors also provide drug screening, counseling and peer services in other settings, the mobile incentive manager vendor(s) will not be permitted to offer DMC-ODS billable services such as individual counseling, group counseling or case management during the CM pilot. DHCS may, however, include in the contract other functionalities, such as appointment reminders, self-assessment surveys and other features.

The mobile incentive manager vendor(s) will also be required to demonstrate readiness, participate in DHCS trainings and adhere to reporting, privacy and security requirements.

County Selection and Implementation Activities

Counties will be critical DHCS partners in the implementation of the CM pilot. Counties that participate in DMC-ODS can apply to participate in the CM pilot with benefits beginning in July 2022 (Phase I) or between September and December 2022 (Phase II). All counties that DHCS determines are able to meet the criteria for participation in the CM pilot program by the implementation date will be approved to participate in the CM Pilot Program. Participating counties will work closely with DHCS, SUD providers, trainers, vendors and program evaluators to implement CM services. DHCS released an EOI for counties in November 2021, followed by a formal RFA for counties to complete in January 2022. DHCS plans to identify the DMC-ODS counties that will participate in Phases I and II of the pilot program in February 2022.

Expression of Interest (EOI)

To help inform the design of the CM program, specifically the training needs of counties and their providers, DHCS shared a nonbinding EOI with DMC-ODS counties in November 2021. The EOI solicited information from counties regarding their interest in participating in the pilot, the number of providers they anticipated would be interested in offering and ready to offer CM in 2022, estimates on the number of beneficiaries living with StimUD the counties anticipate would participate in the program, and the types of support they and SUD providers will require to participate in the program. DHCS has incorporated the feedback received from the counties in its CM training and evaluation plans. Specific findings from the EOI include:

- Approximately two-thirds of respondents (21 counties) expressed interest in participating in the pilot program. An additional eight counties are "maybe" interested in participating in the program.
- In total, interested counties estimate 337 providers will offer CM as part of the pilot. Most interested counties (19) anticipate having between one and five participating providers, with two larger counties (Alameda, Los Angeles) estimating that 20+ providers will offer CM.
- The majority of interested counties (23 counties) anticipate that at least some provider organizations will be prepared to implement CM beginning July 1, 2022.
- Most respondents (16 counties) expect at least some participating provider organizations to be NTPs.
- In total, interested DMC-ODS counties estimate that more than 20,000 eligible Medi-Cal beneficiaries will participate in the pilot program.
- All counties (100%) report interest in offering CM using both the web-based and mobile incentive manager(s).
- The vast majority of counties report needing on-demand training for individual clinicians (88%), workflow support (81%), IT TA for providers (78%), CM TA for providers (75%) and live virtual training for individual clinicians (75%).

DHCS recognizes these are preliminary estimates and will work with approved counties and providers to ensure a thoughtful and well-planned implementation. DHCS intends to cohort the number of counties and providers that offer CM to ensure counties and providers are sufficiently supported during implementation.

Request for Applications (RFA)

In January 2022, DHCS disseminated an RFA to counties participating in the DMC-ODS program. The intent of the RFA is to formalize counties' intent to participate in the CM pilot, revise estimates regarding the potential number of providers that will offer CM, and define conditions of participation that counties will need to meet (either on application or soon after). Among counties that intend to participate, the RFA will also gauge their interest in participating in Phase I of implementation in July 2022 or Phase II beginning services in September 2022.

The RFA includes:

- County-provided information, including:
  - Current care options for individuals living with StimUD.
  - The proposed network of providers that would participate in the CM Pilot Program and dates when they will be prepared to implement CM.
  - Support or TA needed to implement the CM Pilot Program.
  - Interest in implementing in Phase I beginning in July 2022 or in Phase II between September and December 2022.
- Attestations by the county, including:
  - Willingness to participate in the pilot.
  - Collecting provider reporting information in a consistent process or format (e.g., web portal) and report information consistent with the reporting schedule developed by the evaluation team.
  - Allowing only contracted DMC-ODS providers enrolled/certified in Medi-Cal (new or existing) to participate in the pilot.
  - Designating at least one CM coordinator per program.
  - Allowing only Medi-Cal beneficiaries residing in the DMC-ODS county who are eligible for CM and currently treated by DMC-ODS providers to receive services.
  - Executing contracts with providers by a certain date so that statewide training efforts can begin on May 1, 2022.
  - Participating in training for county staff.
  - Facilitating training for participating providers.
  - Verifying that staff offering CM in contracted provider organizations are trained on all aspects of CM before they render services.
  - Participating in ongoing T/TA efforts.
  - Committing to delivering CM according to standardized protocols put forth by DHCS.
  - Making the necessary infrastructure changes (e.g., adding procedure codes) to allow providers to submit the required information.
  - Complying with DHCS auditing and monitoring guidelines.

Network Development and Service Implementation

CM will be offered during the initial pilot as a Medi-Cal benefit from July 1, 2022, through March 31, 2024. CMS has approved CM benefits beginning in July 2022 through December 2026. DHCS intends to use the results of this initial pilot period to inform the expansion of CM to a statewide benefit, pending legislative and budgetary authority from April 2024 through December 2026. DMC-ODS counties interested in offering CM will be required to respond to the RFA by mid-February 2022. DHCS will identify all counties participating in the program in February 2022. Participating counties will be responsible for identifying and selecting SUD providers who will offer CM. Counties and their providers participating in Phase I will begin required trainings in May 2022, with the second cohort of counties and sites beginning training prior to implementation at a later date

In order to participate in the pilot, each SUD provider must be DMC-certified and must be a contracted DMC-ODS provider. In addition, other network development and implementation activities that participating counties will undertake include, but are not limited to:

- Scheduling and participating in a potential readiness review process to ensure that CM coordinators in each provider organization are able to provide CM consistent with clinical and administrative requirements (e.g., able to use the designated web-based and mobile incentive manager(s)).
- Collecting information from each provider for the evaluation, including claims specifically for CM.
- Collaborating with the evaluation and T/TA teams to identify early and ongoing implementation issues.
- Ensuring that providers have the necessary safeguards in place to ensure that they comply with existing and subsequent federal guidance on CM.
- Participating in ongoing TA, fidelity monitoring and mentoring efforts.

CM Program Approach

DHCS' framework for an effective model of CM is based on rigorous research and California's unique needs. While the details of the duration and size of incentive payments may undergo further refinement, the basic design anticipates that eligible Medi-Cal beneficiaries will participate in a structured 24-week outpatient CM program, followed by six or more months of additional recovery support services.

Eligibility for CM Services

In order to be eligible for CM services, Medi-Cal beneficiaries must:

- Be diagnosed with a qualifying StimUD.
- Be assessed and determined to have a StimUD for which CM is medically appropriate. The presence of additional SUD and/or diagnoses does not disqualify an individual from receiving CM. Likewise, beneficiaries who are receiving other treatments for SUD, including medications for addiction treatment (MAT), are eligible. CM should not be a replacement for MAT.
- Reside in a participating DMC-ODS county that elects and is approved to pilot CM.
- Consistent with DMC-ODS policies, have an ASAM multidimensional assessment completed within 30 days following the first visit with a Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor for beneficiaries 21 and older that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.5) (or within 60 days if under 21 years old or experiencing homelessness).
- Not be enrolled in another CM program for SUD (based on the beneficiary's electronic health record).
- Receive services from a nonresidential DMC-ODS provider that offers CM. Such DMC-ODS providers offer levels of care, including outpatient treatment, intensive outpatient treatment, partial hospitalization and NTPs. Eligible individuals include those entering outpatient treatment and those transitioning from a higher level of care (e.g., post-residential care).

Appropriate beneficiaries will be referred to and admitted into treatment through a participating provider's routine beneficiary admission process. There is no minimum age limit for an individual to receive CM services if they meet all eligibility criteria. Medi-Cal beneficiaries who are receiving care in residential treatment (e.g., ASAM levels 3.1–4.0) or institutional settings are ineligible for CM services until they are released into outpatient care.

Eligible Provider and Treatment Settings

SUD providers offering outpatient, intensive outpatient, NTPs and/or partial hospitalization services that are licensed and certified to provide Medi-Cal and DMC-ODS services will be eligible to offer CM. SUD providers will be required to offer accompanying SUD treatment services and EBPs for StimUD in addition to CM. Eligible programs will need to outline the array of EBPs and services they will deliver in conjunction with CM, which may include, but are not limited to:

- Individual, group or family counseling using modalities such as the following:
  - CBT
  - CRA
  - Motivational interviewing
  - Trauma-informed therapy
  - Matrix Model[1]
  - Treatment and Recovery for Users of Stimulants (TRUST) protocol[2]
  - Additional evidence-based modalities
- MAT
- Patient education
- Care coordination
- Peer supports
- Withdrawal management
- Recovery services

Care Planning

Once a Medi-Cal beneficiary has been assessed as eligible for and expresses interest in StimUD treatment services, they will collaborate with their SUD provider to develop a plan of care that is documented (e.g., via a problem list and progress notes or, in the case of an NTP, a treatment plan). CM will be available as one component in a care plan for StimUD and should not be generally offered as a stand-alone treatment. Care plans will include other behavioral interventions designed to support beneficiaries to reduce stimulant use, as described in the subsection above.

[1] The Matrix Model offers a framework for engaging individuals living with StimUD in treatment and encouraging nonuse of stimulants. Patients enrolled in treatment learn about addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored through the administration of UDTs.
[2] TRUST (Treatment and Recovery for Users of Stimulants) is a comprehensive program that includes evidence-supported strategies. See training section for more information on TRUST.

DHCS' objective in providing CM services, for the purposes of this pilot, is to treat StimUD using a harm reduction approach that promotes low-barrier access to treatment. Participating providers will orient candidates for CM to their individualized and person-centered treatment and educate them on the importance of all aspects of their treatment. Encouragement will be given to promote beneficiary involvement in all aspects of the care plan to optimize outcomes. To the extent possible, SUD providers should offer CM during times the beneficiary is present in the treatment program and avoid scheduling an excessive number of additional clinic visits for beneficiaries. The compatible scheduling of CM activities with other services will enhance optimal participation in treatment. However, if a beneficiary chooses to participate only in selected services (e.g., they only participate in CM), they will not be penalized, chastised, criticized or discharged from the program for failure to participate in all recommended treatment. Program participants who discontinue CM prematurely will be invited to reenter treatment. Further, participants who complete a course of treatment and experience a recurrence of stimulant use will be invited to continue and/or reenter treatment.

Participants are eligible to receive motivational incentives for urine drug samples that include other drugs, as long as the test is negative for stimulants. The presence of opioids or other drugs shall not be an indication to terminate the patient from CM treatment but rather shall be an indication the patient may need additional treatment, either concurrently or subsequently. CM providers shall document attempts to refer beneficiaries to additional SUD treatment, but a beneficiary's unwillingness to participate in additional treatment shall not be grounds for dismissing the beneficiary from the CM program. The beneficiary's clinical record shall reflect the beneficiary's changing needs and include referrals for additional treatment, as appropriate.

Medi-Cal Beneficiary Education

Before beginning CM treatment, a Medi-Cal beneficiary will be required to complete a thorough orientation and consent to the conditions of the program. The purpose of the orientation is to provide information regarding the overall CM program, the proposed schedule of visits, the process for administering urine drug tests (UDTs), disbursements of incentives (either by the web-based or mobile incentive manager vendor(s)) and maximum amounts earned. The orientation will be led by the CM coordinator. Information provided at the orientation includes:

- Days/times of visits (during weeks 1–12, two weekly visits; during weeks 13–24, one weekly visit; ongoing weekly, biweekly or monthly visits, as needed, to maintain recovery beginning in week 25). Recovery services after week 25 shall be part of an individualized recovery support program, as determined by the treatment provider and client.
- Urine drug testing procedures.

- An explanation that the incentive will be contingent on the absence of evidence of stimulant (cocaine, amphetamine, methamphetamine) use on UDT only. (Saliva or other types of drug testing are not reimbursable as part of this pilot.)
- An explanation that the result of the UDT will be the determining factor in the decision to deliver an incentive.
- The amount of the initial incentive and how the value increases with consecutive stimulant-free UDTs and how the value will be re-set to a lower value in case of a positive test. (See Table 2 below.)
- An explanation of the maximum value the incentive can reach with a possible accumulated total for stimulant-free UDTs over the course of the treatment period.
- An explanation that beneficiaries can rejoin the program if they drop out of treatment.
- An explanation of how the incentive will be delivered (either through a mobile or web-based app or via a paper certificate) as well as an understanding of how and where incentives can be redeemed.

In addition to the orientation, each program participant will be required to sign a client/provider agreement (developed by the provider) that sets forth conditions of participation in the CM program. This agreement will include expectations regarding their participation in the CM program. Terms shall include, but not be limited to:

- Attendance at the clinic twice weekly or weekly depending on the week of the protocol (days of the week and times specified by the clinic) to meet with the CM coordinator.
- Understanding that if the participant is absent from the clinic for six consecutive sessions, they will be considered to have dropped out of the program. If the participant continues to meet eligibility criteria for CM as outlined above, they will be invited to reenter the pilot.
- Agreeing to provide a urine specimen to be analyzed by the CM coordinator using a point-of-care testing device at each appointment.
- Understanding that the result of the UDT determines whether an incentive will be earned.
- Understanding that the use of an incentive is limited to the recipient and is not transferable.
- Understanding that incentives are not to be used to purchase cannabis, tobacco, alcohol or lottery tickets. (Rationale: these substances are linked to other substance use disorders and addictions.)
- Understanding that the result of the UA (including stimulant results and results of other drugs screened by the test) will be communicated directly to other members of the participant' s treatment team and will be a part of the participant's electronic health record.

CM Coordinator

The CM program will be administered by at least one trained CM coordinator within each provider organization (either part-time or full-time, depending on program volume). Details on DHCS training approach for CM coordinators in covered in the training and technical assistance section below. Details on DHCS' proposed reimbursement approach for CM, including the CM coordinator, is covered in the reimbursement section below. The CM coordinator(s) will be the main point of contact for all CM program participants and will be responsible for collecting UA samples, inputting test results and supporting the delivery of incentives, among other requirements. The CM coordinator will be required to complete all aspects of the CM training and pass a proficiency assessment prior to initiation of CM services as part of the readiness review process. Following initiation of services, the CM coordinator will attend weekly or less frequent CM coaching/TA sessions to report on CM implementation.

Counties must approve the CM coordinator staffing plan for each participating provider site. Subject to approval by participating counties, the following practitioners delivering care at qualified DMC-ODS providers can serve as CM coordinators:

- LPHAs;
- SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies;
- Certified peer support specialists, in those counties that choose to add the optional Medi-Cal peer support specialist provider type that will be implemented in July 2022 ; and
- Other trained staff under supervision of an LPHA[3]

The CM coordinator position should be filled by someone with the following core competencies:

- Excellent organizational skills.
- Effective skills in following laboratory and specimen handling/disposal procedures.
- Good computer skills and ability to learn new programs and computer-related tasks.
- Excellent communication skills, including the ability to effectively communicate with participants the information in the orientation session described above.

The CM coordinator will be required to have the ability to:

- Collect UA samples using the point-of-care test device, including recognition of efforts to tamper with/falsify the sample.

[3] This new staffing category is specific to the contingency management pilot. This would not change existing staffing requirements for other DMC-ODS services, which may only be provided by LPHAs, registered or certified counselors, or certified peers under the new, optional peer provider type and benefit noted above.

- Effectively communicate with the participant about the need for a new sample in situations when the sample may have been tampered with.
- Refer individuals to treatment and recovery staff for follow-up treatment, especially for individuals who test positive for stimulants and/or opioids. Participants whose urine screen suggests they are using opioids will be referred to MAT and may be offered Naloxone.
- Follow proper laboratory procedures and protocols to ensure good laboratory practice concerning cleanliness and proper handling of UDT samples.
- Accurately read the results of the UDT and explain them to the participant.
- Make an attempt to contact the participant if they miss a session, remind them of their next scheduled visit and encourage them to attend.
- Provide praise for a stimulant-free test and, if there is a stimulant-positive sample, provide encouragement for the participant to work toward a successful test on the next visit.
- Explain and collect the CM consent form.
- Enter information for reimbursement and reporting purposes.
- Enter the test results into the secure CM database, understand the incentive amount and explain it to the participant.
- Ensure the delivery of the incentive to the participant electronically via their app or print out a paper certificate for participants who do not use the app.
- Communicate with clinical staff regarding UDT results and any information of clinical relevance.
- Effectively and safely interact with participants who are intoxicated.

Drug Screening

During each visit, the CM coordinator will collect a urine sample from the program participant. The sample will be tested for stimulants, including cocaine, amphetamine and methamphetamine, as well as for fentanyl. Samples will be collected in a point-of-care test cup with temperature strips to monitor for tampered samples, and immediate results for recent stimulant use will be obtained (e.g., cocaine, amphetamine and/or methamphetamine metabolite).

The CM coordinator will receive training on motivational interviewing skills and the most productive ways to address participant claims of false-positive UDT results. In addition, one of the items in the consent-for-participation form will be an agreement that the UDTs will be collected, be processed and have results read by trained personnel, and that the result of the point-of-care test will determine the CM incentive distribution.

Incentives

The participant will be immediately informed of the results of the drug screen, and the results will be entered into the secure CM database, as detailed below. This database will compute the appropriate incentive earned according to the protocol included in the following subsection. This amount will be entered into an electronic incentive delivery

system, and the participant will receive the appropriate incentive either electronically or as a printed gift card.

Basic Treatment Framework

While the details of the duration and size of incentive payments may undergo further refinement, the basic design anticipates that the basic treatment framework (with flexibility allowed to meet each participant's needs) will be a 24-week outpatient treatment experience, followed by a recommended six-month or longer period of aftercare and recovery support services. DHCS is considering incentive limits for CM that have demonstrated effectiveness at promoting recovery and minimizing relapse that fall within DHCS' budget for the program. The CM core protocol incentive calculations use $599 as the incentive limit for illustrative purposes.

The CM core protocol is divided in half, with weeks:

- 1–12 serving as the escalation/reset/recovery period.
- 13–24 serving as the maintenance period.

A participant will be considered to have dropped out of CM when they have missed six consecutive sessions of CM services (e.g., visits with the CM coordinator). Their participation in CM has no impact on their eligibility for or right to use other DMC-ODS services. Participants will be rewarded for meeting the target behavior of being stimulant-free as measured by point-of-care UDT.

Initial 12-Week Protocol

During the initial 12 weeks of the CM protocol, participants will be asked to visit the treatment setting in person for a minimum of two treatment visits per week. These sessions will be separated by at least 72 hours (e.g., Monday and Thursday/Friday, or Tuesday and Friday) to help ensure that drug metabolites from the same drug use episode will not be detected in more than one urine drug screen. Participants will be able to earn incentives during each visit.

Reinforcement Amount, Escalation, Reset and Recovery

The initial incentive value for the first sample negative for stimulants in a series is $10. For each week the participant demonstrates nonuse of stimulants (i.e., two consecutive UDTs negative for stimulants), the value of the incentive is increased by $1.50. The maximum incentive an individual can receive during this initial 12-week period is $438.

A "reset" will occur when an individual submits a positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their incentive amount will return to the initial value (i.e., $10).

A "recovery" of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participant will recover their previously earned incentive level without having to restart the process.

For example, an individual submitted samples negative for stimulants during weeks 1, 2 and 3 and earned $10 per test initially; by week 3, the individual was earning $13 per test. If the individual submits a sample that is positive for stimulants on the first test of week 4, they do not earn an incentive during that visit. During the second visit of week 4, if they submit a stimulant-negative sample, they will earn a $10 incentive due to a "reset." In week 5, if the individual submits a stimulant-negative sample during the first visit, they will receive another $10 incentive. During the next visit in week 5, if the individual again submits a stimulant-negative sample, they will "recover" their previously earned incentive level and receive an incentive of $13 for that test.

Weeks 13–24: Maintenance Period

During weeks 13–24, participants will be asked to visit the treatment setting for testing once a week. During weeks 13–18, participants will be eligible to receive $15 per stimulant-negative UDT. During weeks 19–23, they will be eligible to earn $10 per stimulant-negative test, and if their sample is stimulant-negative on week 24, they will earn $21. The maximum aggregate incentive an individual will be able to receive during weeks 13–24 is $161.

The total possible earnings during weeks 1–24 for all stimulant-negative tests is $599.

Sample Incentive Delivery Schedule for Perfect Performance

Table 2 provides an example of an incentive delivery schedule for an individual who has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 2: Sample Incentive Delivery Schedule

Week	Reward for Stimulant-Free Test
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41

Table 2: Sample Incentive Delivery Schedule	
Week	**Reward for Stimulant-Free Test**
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13–18	$15.00 per week/test
Weeks 19–23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

Incentive Delivery (via Web-Based Incentive Manager)

As detailed above, CM coordinators will follow largely the same protocol whether participants receive the incentive through a web-based or mobile incentive manager. The difference in the protocols is limited to the incentive distribution method.

Incentive Calculations

The CM coordinator will use a secure CM database that will automatically calculate the appropriate incentive amount based on the UDT results with adjustments for the escalating value, reset and recovery features. This program will be designed to prevent tampering with, modifying or overriding the protocol amounts. The program will be based on a CM software package configured by the web-based incentive manager vendor for use by the State of California. Upon each visit, the results of the urine test will be entered into this database, such that each participant will have their visits/test results entered at the time of their visit. The database will operate using an algorithm based on the incentive delivery schedule described above. Using this algorithm, when a result is entered, the software will report the amount of any incentive the participant should receive per the protocol. A positive test (for stimulants) will result in the participant receiving no incentive. A negative test for stimulants will result in an incentive amount as prescribed by the software, considering escalations, resets, etc.

This task is only to be conducted by the CM coordinator or by a trained backup person (preferably a supervisor) when the CM coordinator is not available. The provider must

conduct and document that a regular audit of the incentive delivery functions has been completed, including the software calculations and incentive distribution records. This provider audit must be conducted by an individual with responsibility for overseeing the use of organizational funds. The providers will be required to submit the results of the audit with their county. DHCS will issue guidance regarding the process and template for an audit tool for counties to review these submissions. DHCS and the counties are still developing the county's role for reviewing and taking action on these audits.

Incentive Delivery Method and Parameters

After the incentive amount is determined, the CM database will automatically enter the amount into the web-based incentive manager vendor. The web-based incentive manager vendor will disburse the incentive and will track all incentives awarded to all participants with dates and amounts. The incentive amount can be immediately delivered electronically to participants via e-gift cards sent to participants' emails, or a printed gift card can be provided.

Incentive Types

Participants will be able to choose gift cards from a variety of retail stores, grocery stores and gas station outlets. Individuals will not be able to use the gift cards to purchase cannabis, tobacco, alcohol or lottery tickets.

Incentive Delivery (via Mobile Incentive Manager)

Beginning no later than December 2022, DHCS intends to work with participating counties to implement one or more mobile incentive manager vendors for the tracking and distribution of incentives. Gradually phasing in the support of the mobile incentive manager vendor will allow DHCS, counties and CM providers to gain more experience providing CM. At its core, the mobile incentive manager will serve to track and disburse incentives to participants based on urine drug screen results. During the pilot phase, DHCS will not use the mobile incentive manager to administer drug screening or provide counseling or other DMC-ODS billable services. All pilot participants, including those who will receive CM via the mobile incentive manager, will be required to receive in-person urine screening, as detailed above.

The mobile incentive manager will have the capability to perform the incentive calculations and deliver the incentives within the parameters described above while providing participants with complementary features (e.g., appointment reminders). Although these mobile CM apps provide features that will allow patients to receive information and services via the application, patients will be required to attend the treatment clinic twice per week during weeks 1–12 and weekly during weeks 13–24 to provide in-person urine samples. Counties and providers will be trained on both incentive delivery methods and expected to utilize the web-based incentive manager protocol detailed above for participants without smartphones, reliable broadband access or adequate digital literacy levels.

The CM coordinator will input the results of a participant's drug test into the mobile incentive manager vendor's provider portal. The mobile incentive manager, in turn, will calculate the appropriate incentive amount and deliver the incentive as an e-gift card to the participant's smartphone. The mobile incentive manager vendor will track all incentives awarded to participants, with dates and amounts. Participants will also be able to use the mobile application to track their own progress in the program.

Reimbursement for CM Activities

DHCS has received approval from CMS to expend an estimated $58.5 million in Home and Community-Based Services (HCBS) funding for the CM pilot. DHCS anticipates that these funds will be adequate to fully cover pilot participation by all DMC-ODS counties that are approved to participate. The state will supply the nonfederal share of the Medi-Cal payment for startup and administrative costs associated with CM, as well as CM claims. DHCS will work cooperatively with counties and providers to develop a strategy for covering startup and ongoing administrative costs.

To operationalize these services in the DMC-ODS program, DHCS will need to undertake the following activities:

- Set forth the activities that will make up CM.
- Develop procedure codes for the delivery and reimbursement of CM. (H0050 will be the billing code for CM coordinator services.)
- Provide T/TA resources to counties and providers to implement the CM benefit in their jurisdiction.
- Develop a strategy for covering any new costs that providers will incur for delivering CM, including the administration of UDTs.
- Suggest a reimbursement rate range to counties to consider for reimbursing CM.

Additional details regarding CM reimbursement will be included in the forthcoming DHCS guidance.

Contingency Management Staffing Activities

As indicated in earlier sections of this paper, various activities will be performed by staff delivering CM that DHCS will include when developing approaches for coding and reimbursement for CM. These CM-specific activities are supportive services that are delivered in tandem with other clinical services and recovery supports. During the CM pilot, DHCS will require that CM activities be provided on a face-to-face, in-person basis with no telehealth options allowed due to the need to administer a UDT. See CM Coordinator subsection above for a description of their functions.

Procedure Code

There is currently no specific code for CM in the existing DMC-ODS program, so DHCS will designate the code H0050 specifically for CM. Having a specific code will be essential for ongoing DMC-ODS payment to differentiate this service from other

services and allow counties and DHCS to track utilization of CM across counties and within specific providers.

The intention is that clients could receive other clinically appropriate and covered DMC-ODS services on the same day as CM if needed. Those services would be claimed as they have always been, following DMC-ODS reimbursement methodology.

Methodology for Covering CM Costs

There are several strategies that DHCS will need to deploy in cooperation with counties and providers to seek reimbursement for CM and for DHCS to claim federal financial participation (FFP). These strategies include:

- Reimbursement for CM activities, including reimbursement of UDT supplies and testing
- Reimbursement for startup costs
- Reimbursement for incentives

There will be expenditures related to startup costs, including training as well as costs associated with the web-based and mobile application vendors. DHCS is investigating how FFP will be sought for these administrative functions and will release further guidance.

Reimbursement for CM Activities

DHCS is designating the code H0050 to cover all CM services provided by the CM coordinator. DHCS is considering developing a suggested rate (or rate range) for counties to consider when reimbursing activities performed and supplies needed by staff administering the CM program.

This will include the following costs:

- Staffing costs (salaries and benefits), inclusive of supervisors' time.
- Productivity assumptions—personal time off (PTO), initial and ongoing training, documentation, available hours per week to perform CM activities, no-shows, etc.
- Direct costs (equipment, supplies, UDTs).
- Caseload size (number of individuals who can be on a CM coordinator's caseload).

CM activities will be claimed separately from other DMC-ODS services as described above. Under the approved CalAIM demonstration, DHCS has secured a federal match for CM as a service consistent with the match for other DMC-ODS services.

Administrative Funding

Counties may bill their administrative startup costs to DHCS through invoices, which may include the allowable costs listed below. DHCS will provide additional instruction to counties on how to identify CM activities on administrative claims. The state will supply the nonfederal share of these administrative claims using HCBS funds and will seek

federal match funds for these startup activities as county administrative costs. For the duration of the CM Pilot Program, DHCS intends to reimburse expenses associated with allowable activities, including:

- Staff recruitment and hiring costs.
- Personnel costs (e.g., the salary of the CM coordinator before patient care begins, participation in CM and other agency training, administrative costs of supervision/mentoring).
- Changes to county information and billing systems.
- Technology costs: hardware or software.
- Project management and planning costs, including use of consultants and coordination with local organizations.
- Purchase of supplies or equipment.
- Provider engagement.
- Public education and marketing related to SUD treatment (materials must be reviewed by DHCS).
- Trainings for staff providing CM to offer SUD treatment services and evidence-based therapeutic practices for StimUD.
- Other costs related to pilot startup and administration.

DHCS will provide more information about reimbursement for administrative start-up costs and funding sources in future guidance.

UDT Supplies

UDT supplies and rendering UDTs will be included in the CM reimbursement methodology. Providers will be responsible for purchasing UDT kits using the payments they receive for CM services.

Reimbursement for Incentives

Incentives will be disbursed through web-based and mobile incentive managers. DHCS will hold the contracts with these vendors (individual counties will not hold incentive manager vendor contracts) and will cover their full cost. On a monthly basis (or other cadence), the web-based and mobile incentive manager vendors will submit expenditure information to DHCS for the purpose of obtaining federal matching funds.

Training and Technical Assistance (T/TA) Plan

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

All training will be provided virtually and will be live and synchronous to accommodate diverse program schedules across California. Trainings can be recorded for staff to review at their leisure following participation in the synchronous session. Training will be designed to ensure that providers acquire the skills necessary to implement either the in-person or app-based CM protocols. Prior to initiation, sites will participate in a readiness review, and additional T/TA will be provided to address any areas of concern. Ongoing TA after implementation will also be offered both virtually and on-site, as needed. Training is scheduled to start in May 2022 and will be offered throughout the remainder of the pilot period. TA will be offered from May 2022 through June 2023.

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

Required Training

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

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

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

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

- An overview of California’s CM protocol
    - App-based incentive CM protocol
    - Web-based incentive CM protocol
- CM implementation tasks.
    - Identifying eligible participants
    - Program and staff roles
    - Documentation and fidelity requirements
    - Participant management issues, including:
        - Handling missed appointments

  - Managing disagreement with and/or emotional/angry responses to UDT results and/or participants who are displaying symptoms of serious mental illness or drug intoxication, including how to effectively and safely interact with participants who are psychotic, intoxicated, paranoid or suicidal.
  - Collecting and monitoring sample collection following appropriate procedures.
  - Reading test results.
  - Recognizing and managing efforts to tamper with/falsify the sample.
  - Engaging in participant interactions (praise and/or encouragement) within the limits of the CM protocol.
  - Tracking, understanding and communicating incentive amounts in person or through the app.
  - Conducting regular audits of incentives delivered to participants and cross-checking with data in the incentive distribution database.
  - Communicating with clinical staff regarding UDT results and any information of clinical relevance.

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

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

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

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

Technical Assistance (TA)

TA for participating providers will be delivered in regularly scheduled virtual meetings that provide direct consultation on CM protocol implementation and provide an open space to facilitate peer-to-peer learning and problem-solving. Attendance at the sessions will be required for CM coordinators and backup personnel. The goal of these

meetings will be to provide coaching/mentoring through discussion of implementation issues to address immediate questions, problems and concerns in implementing the CM protocol. More targeted TA will be provided to provider agency staff and supervisors, both virtually and in person, to address specific technical issues with protocol implementation or management.

TA will also include fidelity reviews where participating agencies will receive a periodic review to determine adherence to the required protocol. TA and coaching will be provided to address any areas of concern that arise as a result of these reviews.

Optional Training

Optional training will be provided in a behavioral treatment protocol that can be utilized to augment existing program services using a structured and manualized set of interventions. Although providers are not required to offer TRUST, it has been designed as a 12-week psychosocial protocol to be used with an incentive program. This optional training will provide instruction in the delivery of a brief, structured, manualized and evidence-based behavioral intervention. The intervention contains the elements described below. TRUST can be implemented in its entirety, or individual elements can be utilized to augment existing treatment services.

The TRUST manual includes the following combined evidence-supported strategies:

- Motivational interviewing
- Elements of CBT
- Elements of CRA
- Physical exercise
- Self-help (e.g., 12-step, moderation management, Self-Management and Recovery Training (SMART) Recovery, LifeRing Secular Recovery, Secular Organizations for Sobriety)

Evaluation Plan

The impact of the CM Pilot Program will be measured through a robust evaluation process. The evaluation will be conducted between July 1, 2022, and March 31, 2024.[4] DHCS has contracted with UCLA to develop and implement the evaluation plan. The study team will work with participating counties and SUD providers to ensure that all entities are informed regarding the purpose of the evaluation, protocols and reporting requirements to be used for the pilot, and any follow-up needed that is specific to the evaluation during the pilot.

Evaluation reports will include:

- Preliminary assessment of CM program launch, to be released in October 2022.
- Interim evaluation report, to be released in July 2023.

[4] DHCS and UCLA will incorporate the CM pilot evaluation in the broader CalAIM demonstration, which covers the full demonstration period from January 1, 2022, through December 31, 2026.

- Final evaluation report, to be released by July 30, 2024.
- Up to three other evaluation reports

Further documents regarding the evaluation details are forthcoming.

Evaluation Approach

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

1. **Reach.** This will be measured as the percentage of people in treatment for StimUD who participate in CM during the pilot period. UCLA will also evaluate whether there are disparities in reach to different beneficiary populations. Data for this measure will be collected from the mobile incentive manager, DMC-ODS claims and the California Outcomes Measurement System (CalOMS).[5]

2. **Effectiveness.** Effectiveness will be based on the results of UDTs. Data will be collected from the app or by tracking incentive payments based on test results or data entered by providers into a reporting portal. UCLA will track CM's impact on treatment retention (using data from CalOMS Tx and DMC-ODS claims) and treatment attendance (using DMC-ODS claims data).

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

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

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

Methods

The evaluation will make use of existing administrative data wherever possible, but will also require cooperation from providers and participants.

Provider-Entered Data. Providers will enter data into an online portal, including:

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

- Incentive manager vendor-generated ID number (ideally non-PHI (protected health information) to enable matching with incentive payment records).
- The number of tests passed by the participant.
- The number of tests failed by the participant.
- The number of tests missed by the participant.

Reporting frequency (e.g., monthly, quarterly) will be determined in collaboration with DHCS, participating counties and providers. Note: This method may be temporary if the web-based or mobile incentive manager vendor(s) data produces consistent and accurate data that can be interpreted consistently as drug test results. Due to the central role of this measure, this method is included for now as a method of validation and a backup due to uncertainties about the availability and quality of incentive payment data. Options to implement this reporting system include an online Qualtrics-based system created by UCLA.

Incentive Payments. The web-based or mobile incentive manager vendor(s) will provide a unique participant number and dates and amounts of payments. Assuming incentives are provided for drug screen results only and incentives are provided per test, this data may be interpretable as drug test results. If either of these assumptions is not true, the provider-entered data described above will become essential on an ongoing basis.

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

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

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

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

Participant Surveys. Providers will be asked to distribute a link to an online survey for beneficiaries receiving CM. An alternative version for people without internet access

(e.g., automated phone survey) will be provided. Surveys will be conducted in two waves:

- During-treatment survey: During CM, participants will be asked for consent for the UCLA study team to contact them later for the post-treatment survey and participant interviews.
- Post-treatment survey: This will capture success stories and enable us to contact *people who left treatment*. These people will be critical to helping us see what aspects of the pilot program did not work well, how they can be addressed and how to monitor for fraud ("I wasn't using drugs but was recruited by the agency to participate for money.").

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

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

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

Outreach Plan

DHCS is committed to connecting as many Medi-Cal beneficiaries living with StimUD who reside in a pilot county to CM as possible. DHCS expects that many Medi-Cal beneficiaries living with StimUD, their families and loved ones, medical providers, behavioral health providers, and other stakeholders who refer individuals to care may generally be unfamiliar with CM, including how Medi-Cal beneficiaries can access CM.

To publicize the availability of CM to Medi-Cal beneficiaries living with StimUD, DHCS will develop a communications and outreach strategy that builds on its Choose Change California media campaign.

DHCS' community and outreach strategy will be tailored to different audiences, including counties, Medi-Cal beneficiaries, medical and behavioral providers, and other stakeholders, and will include an overview of the pilot program, program eligibility, how beneficiaries can be screened for eligibility for the program, providers who offer CM and how to obtain additional information. The community and outreach strategy will be reflective of the diverse racial and ethnic backgrounds of beneficiaries who may be eligible because of StimUD.

Monitoring and Oversight

DHCS is committed to ensuring that strong requirements are in place to protect against fraud, waste and abuse in the CM pilot. Along with securing confirmation from the federal government that CM delivered as a Medi-Cal benefit in accordance with the CM protocol does not implicate the AKS and CMPL, DHCS has built in a number of programmatic safeguards to protect against fraud, waste and abuse. DHCS will release audit tools for counties to use to monitor providers. These tools will be consistent with the fidelity review tools will be developed by the state's contracted trainer and program evaluator. Training in the use of the audit tools will be provided as a component of technical assistance provided to counties for the implementation of CM.

Each treatment program that delivers CM will have a policies and procedures (P&P) manual in accordance with DHCS guidance that clearly documents the operation of the CM intervention in detail, based on protocols and templates developed by the training vendor, UCLA. The P&P manual will include:

- A list of personnel who have been approved to deliver or perform any aspect of the CM procedure, including UDTs and method of incentive distribution (e.g., using the web-based or mobile incentive manager).
    - For participants receiving in-person incentive distribution, entry of data into the CM incentive calculator and entry of data into incentive distribution software.
- The CM protocol, including incentive schedule. This will include documentation of the maximum amount of incentives that can be earned per month and in total by each participant. Within each participant's chart, each beneficiary must have a documented clinical diagnosis of StimUD by a DMC-ODS-authorized provider. Providers will also be required to cross-match the delivery of incentives to beneficiaries with documented CM visits and billing.

In addition, there will be clear protections to avoid using incentives for recruitment (e.g., no advertisements or suggestions of rebates, refunds or kickback offers). DHCS will disseminate marketing guidelines, including scripts, for providers offering CM to use for beneficiaries seeking treatment for SUD, including StimUD. DHCS will work with counties to determine and ensure appropriate monitoring and oversight of CM providers as part of their regular on-site reviews of DMC-ODS providers, including by developing auditing protocols.

DHCS will establish appropriate oversight/work to incorporate CM into the triennial on-site review of DMC-ODS providers conducted by the department to ensure that counties are meeting their responsibilities.

Next Steps

DHCS welcomes feedback from stakeholders as it continues to refine its CM pilot design and begin operational planning. Comments may be submitted to DHCS via email

at countysupport@dhcs.ca.gov. DHCS requests that comments be submitted by January 14, 2022, to ensure they are incorporated into the design of the pilot, though DHCS will accept comments shared at a later date.

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