Drug Medi-Cal Organized Delivery System

Part of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration Waiver

INTERIM EVALUATION REPORT

Prepared for the California Department of Health Care Services
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Contents

Acronym List

Acronym	Text
AIAN	American Indian/Alaska Native
AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
Asian/PI	Asian/Pacific Islander
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHC	Behavioral Health Concepts
BHCIP	Behavioral Health Continuum Infrastructure Program
BHIN	Behavioral Health Information Notice
CA	California
CalAIM	California Advancing and Innovating Medi-Cal
CBHDA	County Behavioral Health Director's Association
CDPH	California Department of Public Health
CIN	Client Index Number
CLIA	Clinical Laboratory Improvement Amendments
CM	Contingency Management
CMBQ	Contingency Management Beliefs Questionnaire
CMS	Centers for Medicare & Medicaid Services
CONTINUUM™	ASAM CONTINUUM™ software (Note: proprietary tool for LOC recommendations)
COVID-19	Coronavirus Disease 2019
CY	Calendar Year
CalOMS-Tx	California Outcome Measurement System – Treatment
DD	Difference-in-Differences
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBPs	Evidence-Based Practices
ECM	Enhanced Care Management
ED	Emergency Department

EQRO	External Quality Review Organization
ES	Event Study
FFS	Fee-for-Service
FY	Fiscal Year
HIPAA	Health Insurance Portability and Accountability Act
HSAG	Health Services Advisory Group
IMD	Institutions for Mental Diseases
IOT	Intensive Outpatient Treatment
ISAP	Integrated Substance Use and Addiction Programs
LOC	Level of Care
LOS	Length of Stay
MAT	Medication for Addiction Treatment
MCP/FFS	Managed Care Plan / Fee-for-Service
MEDS	Medi-Cal Eligibility Data System
MH	Mental Health
MHSIP	Mental Health Statistics Improvement Program
MMEF	MEDS Monthly Extract File
MPF	Master Provider File
NCQA	National Committee for Quality Assurance
NTP/OTP	Narcotic Treatment Program / Opioid Treatment Program
OHRPP	Office of the Human Research Protection Program
OP	Outpatient
OUD	Opioid Use Disorder
PH	Physical Health
PHC	Partnership HealthPlan of California
PIPs	Performance Improvement Projects
PMPM	Per Member Per Month
PROMIS	Patient-Reported Outcomes Measurement Information System
RE-AIM	Reach, Effectiveness, Adoption, Implementation, and Maintenance
RSUDA	Rapid Stimulant Use Disorder Assessment
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT+	Substance Abuse Prevention Treatment+ Committee

SMS	Short message services
STC	Special Terms and Conditions (CMS waiver context)
SUD	Substance Use Disorder
StimUD	Stimulant Use Disorder
TEA	Treatment Effectiveness Assessment
TEDS	Treatment Episode Dataset
THCP	Traditional Health Care Practices
TPS	Treatment Perceptions Survey
UA	Urinalysis
UCLA	University of California, Los Angeles
UDT	Urine Drug Test
WM	Withdrawal Management

A. Executive Summary

This is the Interim Evaluation Report for the Evaluation of the Drug Medi-Cal Organized Delivery System (DMC-ODS). As of August 2025, DMC-ODS has been implemented in 40 counties containing 97.3 percent of California's population.

Summary of the demonstration

DMC-ODS was created to test the impact of expanding access to an evidence-based continuum of SUD services and organizing service delivery to Medicaid-eligible individuals with substance use disorders (SUDs). Under DMC-ODS, care is organized according to the American Society of Addiction Medicine (ASAM) Criteria for SUD services. The ASAM Criteria are a set of guidelines developed by ASAM to set standards for appropriate assessment, placement, and treatment planning of clients with SUD and co-occurring disorders. Services covered under DMC-ODS also create a continuum of care, including access to residential treatment in institutions with more than 16 beds. The demonstration was also intended to facilitate greater local control, accountability, and administrative oversight.

To address rapidly rising stimulant overdoses, Contingency Management (CM) was later added to DMC-ODS under a new pilot program known as the Recovery Incentives Program: California's Contingency Management Benefit. Implementation of this program commenced in March 2023.

Principal results

Access

- Difference-in-Differences analyses suggest that the introduction of DMC-ODS significantly increased the unique number of clients receiving DMC-funded services by 16 percent since inception.
- County administrators overwhelmingly reported that DMC-ODS had a positive impact on access.

- Clients provided high ratings on their access to treatment.
- The number of ASAM Criteria-based Level of Care screenings and assessments, which typically precede entry or re-entry into treatment services, has been successfully maintained at 2021 baseline levels.
- Rates of initiation to any SUD treatment after an ASAM brief screening are increasing.
- Timely admissions to the level of care indicated by an ASAM Criteria-based assessment are also increasing, though a shift in use of brief initial screenings in 2023 may have contributed to this result.

Treatment

- Treatment engagement has been successfully maintained at baseline levels.
- Client ratings of treatment have remained consistently high over time.
- County administrators have consistently reported that DMC-ODS has improved quality of care.
- Continuity of pharmacotherapy for clients with opioid use disorder has been stable over time.

Coordination

- Readmissions to withdrawal management increased unexpectedly in 2023.
- Most (84%) clients agree that their treatment program works with their physical health care providers to support their wellness.
- Most county administrators agree that DMC-ODS has had a positive impact on coordination between SUD and physical health services (59%), and mental health services (69%).

Health Equity

- Analyses suggest DMC-ODS has had a positive impact on most racial/ethnic groups but had a larger impact on the unique number of White members receiving services compared to other racial/ethnic groups. Research suggests COVID-19 may have had a disproportionately negative impact on access among Black members, which may have offset gains among this group. This, combined with the more recent addition of new DMC-ODS counties with relatively higher White populations, may have contributed to the disparity.

- On most other measures, no meaningful disparities were found between age, gender, and racial/ethnic groups.

Contingency Management

Contingency management was provided through the Recovery Incentives Program as a new service, making it ideal for a different set of evaluation methods based on the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework, which is appropriate for the implementation of a targeted new practice. UCLA is in the process of collecting data on the final part of this framework, maintenance, but the program has excelled in the remaining areas of the framework to date:

- Reach: The program reached about 8,500 clients as of June 2025. This new program is currently reaching an estimated one quarter of all California Medi-Cal members in outpatient treatment for stimulant use.
- Effectiveness: The program achieved high levels of retention, engagement, and negative urine drug test results. Clients also overwhelmingly reported that the program led to improved health, reduced stimulant use, reduced use of emergency departments or inpatient hospitalization, and made them better members of the community.
- Adoption: Over 100 sites had adopted the program as of June 2025. Clinical Laboratory Improvement Amendments (CLIA) waiver requirements[1] were initially a barrier, but have since subsided as a challenge. In rural areas, staffing and hiring difficulties, combined with small client populations, may make adoption less compelling.
- Implementation – providers rated the program very positively on an array of measures, though staffing and staff turnover remained challenges.

[1] All facilities in the U.S. that perform testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under CLIA. Urine tests used in the Recovery Incentives Program are considered "CLIA waived tests." However, DMC-ODS providers must still obtain a CLIA "waived test" certification and be registered with the California Department of Public Health (CDPH) or be accredited by an approved accreditation body. Providers can apply online for both CLIA Waiver and State Lab Registration through Laboratory Field Services, part of CDPH.

Interpretations

Overall, the data suggest that DMC-ODS is making progress toward most of the demonstration's goals. Specifically, although data in this Interim Evaluation Report are preliminary, and there are currently data gaps that need to be filled in the final Summative Report, particularly for Goals 3 and 4, the preponderance of currently available data suggest progress toward six of the eight goals:

- Goal 1: Increased rates of identification, initiation, and engagement in SUD treatment services.
- Goal 2: Increased adherence to and retention in treatment.
- Goal 3: Reductions in overdose deaths, particularly those due to opioids
- Goal 4: Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
- Goal 6: Improved access to care for physical health issues
- Goal 8: An effective contingency management program, including cost-effectiveness and effects on beneficiary outcomes.

Evidence was mixed for Goal 5, fewer readmissions to the same or higher level of care, and Goal 7, improved health equity.

Recommendations

- Explore and address the underlying causes of increasing readmissions to withdrawal management. The evaluation team will continue to explore potential data explanations and reach out to stakeholders for input as needed.
- Explore and address the underlying causes for mixed results on health equity. The evaluation team will continue to explore potential data explanations and reach out to stakeholders for input as needed.
- Continue efforts to expand treatment capacity and support workforce development, both of which are commonly cited barriers to access within DMC-ODS.

- Convene an expert advisory group to discuss possible ways to further improve and expand the Recovery Incentives Program. These may include the following suggestions:
    - Weigh the effectiveness and costs of increasing the current $599 annual limit on incentives. The program has been effective with this limit in place, but SAMHSA has also set a $750 limit on contingency management in State Opioid Response grants,[2] and the median inflation-adjusted incentive amount used in contingency management studies that achieved a medium to high effect size is $1,536.[3]
    - Revisit the escalation-reset design of the incentive schedule, particularly whether to retain the "reset" portion, and whether to start with higher amounts to strengthen early engagement. Vermont uses a higher incentive ($20) for each stimulant-negative sample to engage clients early.[4, 5] Weigh this carefully against evidence for the well-established advantages of the escalation-reset design[6]
    - Consider strategies to expand the number of participating counties and providers, potentially taking lessons learned from counties that have successfully launched a disproportionately large number of providers, as well as examining barriers faced by counties that have lower numbers of providers and clients.

[2] Substance Abuse and Mental Health Services Administration. (2025). SAMHSA Advisory: Using SAMHSA funds to implement evidence-based contingency management services. Available at: https://library.samhsa.gov/sites/default/files/contingency-management-advisory-pep24-06-001.pdf

[3] Rash C.J., Black S.I., Parent S.C., Erath T.G., McDonell M.G. Data-Driven Contingency Management Incentive Magnitudes: A Review. JAMA Psychiatry. Published online July 2, 2025. doi:10.1001/jamapsychiatry.2025.1341

[4] Rawson, R.A., & Erath, T. (2024). Vermont protocol – contingency management for stimulant use. [unpublished], Vermont Center on Behavior & Health, University of Vermont.

[5] Erath, T., & Rawson, R.A. (2024). Contingency management and stimulant use. Available at: https://www.healthvermont.gov/sites/default/files/document/dsu-contingency-management-substance-use.pdf

[6] Roll, J. M., & Shoptaw, S. (2006). Contingency management: schedule effects. *Psychiatry Research, 144*(1), 91-93.

- Consider strategies to increase enrollment of new clients entering from the community, and referrals from medical and correctional settings, in addition to those referred from residential or other outpatient treatment.
- Explore the feasibility of expanding contingency management to other settings, including primary care (e.g. Federally Qualified Health Centers), mobile units, street medicine, and telehealth.

B. General Background Information

Issues California is Addressing with the 1115 Demonstration Waiver

The Drug Medi-Cal Organized Delivery System (DMC-ODS) was created by the California Department of Health Care Services (DHCS) with the intent of addressing many previously existing limitations in the Drug Medi-Cal system. Prior to DMC-ODS, the system was comprised of limited and fragmented services, creating gaps that undermined client access and quality of care. The continuum of substance use disorder (SUD) services was uncoordinated, making it difficult for clients to navigate. SUD treatment providers indicated that many important services they provided or wished to provide for clients were not billable or were restricted in other ways that made it difficult to provide proper care to clients. Providers were not necessarily required to deliver evidence-based practices consistent with current research, and counties lacked the authority to fully ensure the quality and accountability of their local SUD providers.

DMC-ODS was also created to test the impact of organizing service delivery to Medicaid-eligible individuals with SUDs. The intent was to demonstrate that organized SUD care improves quality, access, and coordination and integration of treatment for beneficiaries while decreasing other health care system costs. Under DMC-ODS, care is organized according to the American Society of Addiction Medicine (ASAM) Criteria for SUD services. The ASAM Criteria are a set of guidelines developed by ASAM to set a standard for appropriate assessment, placement, and treatment planning of clients with SUD and co-occurring disorders as well as to set a standard for SUD providers. Services under DMC-ODS also create a continuum of care and requirements that allow for local control, accountability, and greater administrative oversight.

DMC-ODS is also addressing stimulant-related overdose death rates, which are 12.7 times higher in California today than 15 years ago, putting stimulants approximately on

par with opioid-related overdose deaths.[7] Currently, no Food and Drug Administration-approved medications exist for the treatment of stimulant use disorders (StimUD), but studies have repeatedly supported the use of Contingency Management (CM) as a highly effective evidence-based practice in the treatment of StimUD, particularly in reducing drug use.[8,9,10,11,12] Therefore, to address rapidly rising stimulant overdoses, CM was added to DMC-ODS under a new pilot program known as the Recovery Incentives Program: California's Contingency Management Benefit. This program began implementation in March 2023. County participation in the Recovery Incentives Program is optional.

The Recovery Incentive Program is a 24-week intervention with 12-weeks of twice weekly urine drug test (UDT) testing/incentives starting at $10 for each stimulant-abstinent sample, escalating by $1.50 for each week of consecutive abstinence. The following 12-weeks is defined as a stabilizing period in which UDTs are collected once per week and stimulant-free samples are rewarded with either a $10 or $15 gift card, with a final possible gift card worth $21 in week 24. Members can earn a maximum of $599 over the 24-week period in the form of gift cards, and are also limited to $599 per calendar year if they enroll more than once. Program sites and specified staff must complete the protocol training and meet all readiness criteria

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[7] Based on 12-month rolling averages from Q1 2009 and Q1 2024 psychostimulant data from: https://skylab.cdph.ca.gov/ODdash/. Total overdose deaths based on combination of psychostimulant and cocaine-related deaths.

[8] De Crescenzo, F., Ciabattini, M., D'Alò, G. L., De Giorgi, R., Del Giovane, C., Cassar, C., Janiri, L., Clark, N., Ostacher, M. J., & Cipriani, A. (2018). Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis. *PLoS medicine*, *15*(12), e1002715.

[9] Farrell, M., Martin, N. K., Stockings, E., Bórquez, A., Cepeda, J. A., Degenhardt, L., Ali, R., Tran, L. T., Rehm, J., Torrens, M., Shoptaw, S., & McKetin, R. (2019). Responding to global stimulant use: challenges and opportunities. *Lancet (London, England)*, *394*(10209), 1652–1667.

[10] AshaRani, P. V., Hombali, A., Seow, E., Ong, W. J., Tan, J. H., & Subramaniam, M. (2020). Non-pharmacological interventions for methamphetamine use disorder: a systematic review. *Drug and Alcohol Dependence, 212*, 108060.

[11] Brown, H. D., & DeFulio, A. (2020). Contingency management for the treatment of methamphetamine use disorder: a systematic review. *Drug and Alcohol Dependence, 216*, 108307.

[12] Ronsley, C., Nolan, S., Knight, R., Hayashi, K., Klimas, J., Walley, A., Wood, E., & Fairbairn, N. (2020). Treatment of stimulant use disorder: A systematic review of reviews. *PloS one*, *15*(6), e0234809.

before receiving approval from DHCS to launch and initiate enrollment. The program manual, requirements, and training materials are available at https://www.uclaisap.org/recoveryincentives/, and the Incentive Schedule can be found in Attachment D.

Given the national interest in CM and California's role as the first state to implement CM through a Medicaid 1115 demonstration project, this report places particular emphasis on CM to support and inform similar initiatives in other states.

Population Groups Impacted by the Demonstration

DMC-ODS' target population is Medicaid-eligible individuals with SUDs. To receive DMC-ODS services, beneficiaries must reside in a participating county. Currently, DMC-ODS is implemented in 40 counties that cover 97.3 percent of the state's population.[13] The participating counties are shown in Figure B1.

On October 16, 2024, CMS approved an amendment to California's 1115 waiver that added coverage for Traditional Health Care Practices (THCP) received through Indian Health Service facilities, Tribal facilities, or Urban Indian organization facilities. California will initially provide this coverage through DMC-ODS, but due to the later start date and continuing roll-out of this project, a separate evaluation plan was submitted to CMS on August 29, 2025 and is under review.

Brief Description and History of DMC-ODS Waiver Implementation, Including Approval Date.

DMC-ODS was originally approved by CMS in August 2015 and later became part of California's Section 1115 Medicaid Waiver, entitled Medi-Cal 2020, which ended December 31, 2021. It is now part of California Advancing and Innovating Medi-Cal (CalAIM), which is being implemented through a combination of 1115 and 1915b waivers. CalAIM was approved December 29, 2021, took effect January 1, 2022, and will continue through December 31, 2026.[14] This Interim Evaluation Report will accompany a

[13] Projections Prepared by Demographic Research Unit, California Department of Finance, 2025: https://dof.ca.gov/wp-content/uploads/sites/352/Forecasting/Demographics/Documents/E-4_2025_InternetVersion.xlsx

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

state application to renew the CalAIM 1115 Section Demonstration, including the DMC-ODS waiver of the institutions for mental disease (IMD) exclusion for substance use treatment. No changes were made to the demonstration during the currently approved period.

Period of Time Covered by the Evaluation

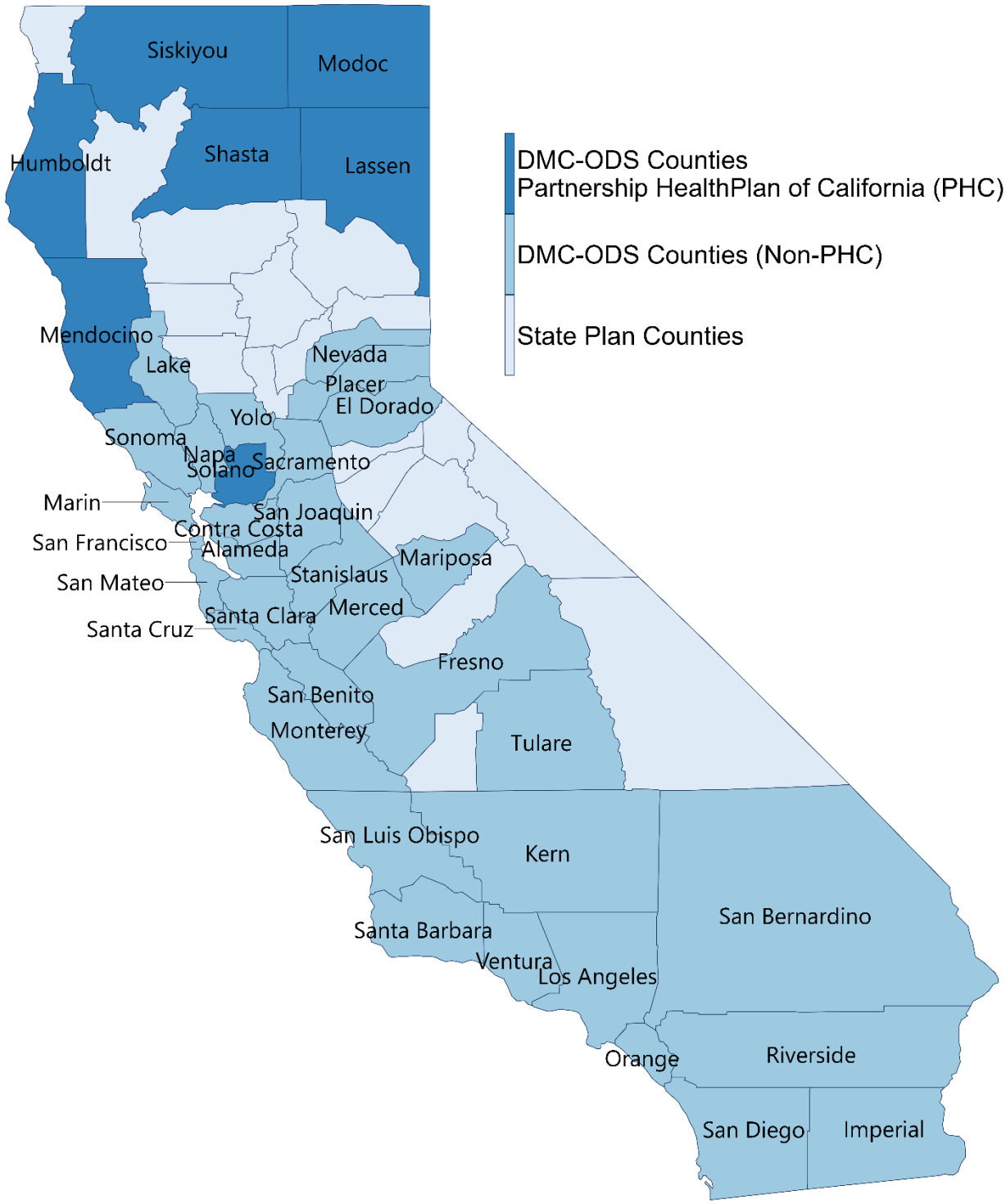
The evaluation will cover the entire demonstration waiver from 2022-2026, using a baseline year of 2021 unless otherwise noted. Data extending back to a pre-DMC-ODS baseline of 2016 are used during difference-in-differences analyses for calculations to take advantage of the staggered implementation of counties over time, which facilitates causal inference. This Interim Evaluation Report covers an evaluation of DMC-ODS with end dates varying according to the limitations of the data sources. Most administrative datasets were analyzed through 2023 due to data reporting lag on more recent data, while survey data collected directly by UCLA are reported through 2024 or 2025, depending on the dates of collection.

Additional Information

For a more detailed description of DMC-ODS and evaluations of earlier years of implementation, please refer to the previous evaluation reports submitted by UCLA in CYs 2016 through 2022,[15] as well as the Midpoint Assessment Report (currently being reviewed by CMS, anticipated publication by January 2026). For the full approved Evaluation Design, see Attachment A.

[15] http://uclaisap.org/dmc-ods-eval/html/reports-presentations.html

Figure B1. *Participating DMC-ODS counties, 2025.*



C. Evaluation Questions and Hypotheses

This evaluation will examine whether DMC-ODS continues to achieve eight goals: the six goals as required by STC 46,[16] an additional seventh goal on health disparities in the pursuit of CalAIM's goal of improving health equity, and an eighth goal based on STC 57e requirements specific to a CM evaluation. All eight goals are included in the CMS-approved Evaluation Design and are addressed to the extent currently possible in this Interim Evaluation Report, but more complete data and analyses will be available for the final Summative Report.

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate;
6. Improved access to care for physical health conditions among beneficiaries.
7. Improved health equity across DMC-ODS performance and outcome measures.
8. An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes.

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

Due to the introduction of CM in the current waiver, as well as California's role as the first state to implement such a program under an 1115 waiver, this report includes a particular emphasis on this topic.

Summary of key evaluation questions, hypotheses, data sources, and analytic approaches

Table C1 below summarizes the questions, hypotheses, and measures to be used in this evaluation. These measures often use a combination of claims data and data specific to California's evaluation of DMC-ODS (e.g., California's ASAM Level of Care (LOC) Placement data, Incentive Manager data, UCLA-administered surveys). Measures in **bold** are reported in this Interim Evaluation Report. Measures shown **without bold** are excluded due to data limitations or availability challenges, but they will be included in the final Summative Report.

All of the research questions and hypotheses in this evaluation promote the objectives of Title XIX and XXI by assessing whether DMC-ODS has provided access to high-quality services that improve the health outcomes of low-income individuals.

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Purpose: Reduction in overdose deaths, particularly those due to opioids. (*Purpose* on Driver Diagram, also Goal 3) Question: Are rates of overdose deaths impacted by the demonstration? Hypothesis: People with opioid use disorders (OUD) who receive MAT and people with StimUD who participate in the Recovery Incentives Program will be less likely to have an overdose death compared to people with OUD and StimUD who do not receive these services, respectively.						
Primary Driver: Reduce overdose deaths	Overdose deaths overall and among opioids and stimulants separately	None	N/A	N/A	California Comprehen-sive Death File, CA Department of Public Health matched to DMC Claims	Compare individuals with StimUD who participated in the Program to those who did not. Time period: Start of Recovery Incentives Program (2023) through end of waiver (2026) Compare individuals w/OUD who received Medications for Addiction Treatment (MAT) to those who did not, determine whether access to MAT increased under DMC-ODS (2015-2026) Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc.

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Goal 1: Increased rates of identification, initiation, and engagement in SUD treatment services. Question: Does the demonstration increase access to and utilization of SUD treatment services? Hypothesis: Counts or rates will be maintained at benchmark year* levels or higher.						
Primary Driver: Increased rates of identification, initiation, and engagement in treatment	**Number of ASAM Criteria-based level of care screenings and assessments**	None	Number of ASAM LOC screenings and assessments	N/A	ASAM LOC Placement data	Descriptive statistics using parametric and/or non-parametric tests of statistical significance and/or regression analysis to confirm identification, IET rates, and timely admission to the indicated level of care are maintained or improve between comparison & waiver periods Note: Engagement measure adjusted from 30 to 34 days to align with NCQA and state monitoring metrics.
	Initiation among beneficiaries with an ASAM Criteria-based brief screening	NQF #0004 adaptation	Number of beneficiaries who initiated treatment within 14 days of the index episode start date	Number of beneficiaries with an ASAM brief screening with a level of care recommendation	DMC Claims, ASAM LOC Placement data	
	Engagement in treatment among DMC-ODS clients	NQF #0004 adaptation	Initiation of tx and two or more encounters with any SUD diagnosis within 34 days after initiation	Number of beneficiaries (above) who initiated treatment	DMC Claims, ASAM LOC Placement data	
Secondary Driver: Ensure appropriate and timely placement according to ASAM Criteria	**Timely admission to the indicated level of care within 30 days of ASAM Criteria-based brief screenings**	None	Admission within 30 days of an ASAM Criteria-based brief screening	Beneficiaries with an ASAM brief screening with a level of care recommendation	DMC Claims, ASAM LOC Placement data	Descriptive Statistics (2020-2026, contingent on data availability)

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Secondary Driver: Ensure clients are satisfied with services	**UCLA Client Treatment Perceptions Survey ratings, % of clients providing a 4 or higher rating on all questions**	UCLA	Clients providing a 4 or 5 rating	All TPS participants	UCLA Client Treatment Perceptions Survey	Descriptive statistics (2020-2025)
Secondary Driver: Quality improvement efforts	**UCLA County administrator survey questions on the impact of QI activities and the EQRO**	None	N/A	N/A	County administrator survey	Descriptive statistics (2020-2026)
Goal 2: Increased adherence to and retention in treatment. Question: Do enrollees receiving SUD services adhere to and remain in treatment? Hypothesis: Adherence and retention will be maintained at benchmark year* levels or higher.						
Primary Driver: Adherence to and retention in treatment	Days in treatment	None	N/A	N/A	DMC Claims CalOMS-Tx	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis and quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2020-2026, contingent on data availability)

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Secondary Driver: Improve care coordination and transitions between levels of care	Transition to specialty care after withdrawal management	None	Withdrawal management (WM) discharges followed by DMC-ODS treatment within 7 or 14 days	WM discharges	DMC claims, MCP/FFS data**	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2020-2026, contingent on data availability)
Goal 4: Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. Question: Do enrollees receiving SUD services experience improved health outcomes? Hypothesis: DMC-ODS implementation will be associated with reductions in utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.						
Primary driver: Reduced utilization of ED and inpatient hospital settings	Utilization (e.g., days)	None	Clients who received DMC-ODS treatment who had any ED and inpatient hospital visits during and after treatment	Clients who receive DMC-ODS treatment	DMC Claims MCP/FFS data**	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2015-2026, contingent on data availability)
	Paid claim amounts	None	N/A	N/A	DMC Claims MCP/FFS data**	

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Goal 5: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. Question: Does the demonstration reduce withdrawal management readmissions? Hypothesis: DMC-ODS implementation will be associated with fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.						
Primary driver: Readmissions to withdrawal management	**Re-admissions within 30 days of discharge**	None	Clients re-admitted to withdrawal management within 30 days of discharge from withdrawal management	Clients discharged from withdrawal management	DMC Claims CalOMS-Tx	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2015-2026, contingent on data availability)

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Goal 6: Improved access to care for physical health conditions among beneficiaries. Question: Does the demonstration improve coordination of care? Hypothesis: DMC-ODS implementation will be associated with improved access to care for physical health conditions among beneficiaries.						
Primary driver: Ensure client satisfaction with services	**Treatment Perceptions Survey item: "Staff here work with my physical health care providers to support my wellness."**	None	Clients providing a rating of 4 or 5	All clients responding to the TPS survey	Treatment Perceptions Survey	Confirm client satisfaction w/ coordination is at benchmark year* levels/higher. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2020-2025)
Secondary driver: Improve care coordination	**Percentage of clients with ambulatory or preventive care visits before and following treatment**	NCQA adaptation	Number of clients with SUD who had an ambulatory or preventive care visit during the measurement period	Number of beneficiaries with DMC-ODS treatment	MCP/FFS data** DMC claims	Compare ambulatory or preventative care visits before & after treatment. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2015-2026, contingent on data availability)

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Goal 7: Improved health equity across DMC-ODS performance and outcome measures. Question: Does the demonstration reduce health disparities? Hypothesis: Health disparities will decrease.						
Primary Driver: Improve health equity	**Timely admission to indicated level of care**	None	Clients admitted to their indicated level of care within 30 days of ASAM brief screening	Clients who received an ASAM brief screening	ASAM LOC Placement data DMC Claims	Compare rates by race, ethnicity, and age. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2017-2026) Note: Engagement measure adjusted from 30 to 34 days to align with NCQA and state monitoring metrics specifications.
	Treatment engagement	NQF #0004 adaptation	Initiation of treatment and two or more encounters with any SUD diagnosis within 34 days after initiation	Number of beneficiaries who initiated treatment	DMC Claims	
	Any other measures on which meaningful disparities emerge					

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Goal 8: An effective contingency management program, including cost effectiveness and effects on beneficiary health outcomes. Question: Has the Recovery Incentives Program been effectively implemented? Hypothesis: Effective implementation will lead to improvements in client retention, discharge status, self-reported outcomes, drug test results, deaths, and healthcare utilization among clients participating in the Recovery Incentives Program.						
Primary driver: Improvements in Recovery Incentives Program outcomes	**Days in treatment, engagement, discharge status, self-reported satisfaction and improvement in health, SUD, arrests, ED and inpatient hospital utilization, costs, deaths**	None	N/A	N/A	Client surveys, DMC claims, MCP/FFS data,** CalOMS-Tx, Death data	Compare outcomes between clients with StimUD participating in the Recovery Incentives Program and those in non-Recovery Incentives Program treatment programs (where available), controlling for background characteristics. Comparisons by demographics. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis
	Rates of positive, negative, and missed drug screens	None	Negative urinalysis outcomes	Sum of all possible tests over the planned course of treatment	Stimulant drug tests / incentive manager vendor	Compare rates of positive, negative, and missed drug screens among individuals with StimUD in the Recovery Incentives Program and compare rates to those found in the literature using a one-sample t-test or analogous procedure (2023-2026)

Table C1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Primary driver: Fidelity to the CM model	**Drug screen results, Days in treatment, Discharge status, Self-reported improvement, Overdose rates, ED and inpatient hospital utilization (SUD or all diagnoses)**	None	N/A	N/A	Data from incentive manager vendor, fidelity assessments, provider surveys, client surveys, CalOMS-Tx, DMC-ODS claims	Compare outcomes (e.g., drug screen results, days in treatment, discharge status, self-reported improvement, overdose rates, ED utilization, inpatient utilization) between higher- and lower-fidelity providers according to measures developed by UCLA Descriptive statistics using parametric and/or non-parametric tests, and/or regression. (2023-2026)
Secondary driver: Implementation of an effective and accessible CM program	**Newly developed survey questions adapted from an existing questionnaire and qualitative interviews**	None	N/A	N/A	Provider surveys and interviews	Descriptive analyses from survey to track implementation challenges and successes over time and qualitative analyses of interview transcripts
	Use of CM based on DMC claims	None	Clients receiving CM	Clients with StimUD in eligible levels of care	DMC-ODS claims CalOMS-Tx	Track percentage of people in treatment for StimUD who participate in the Recovery Incentives Program; Descriptive statistics using parametric and/or non-parametric tests, and/or regression. (2023-2026)

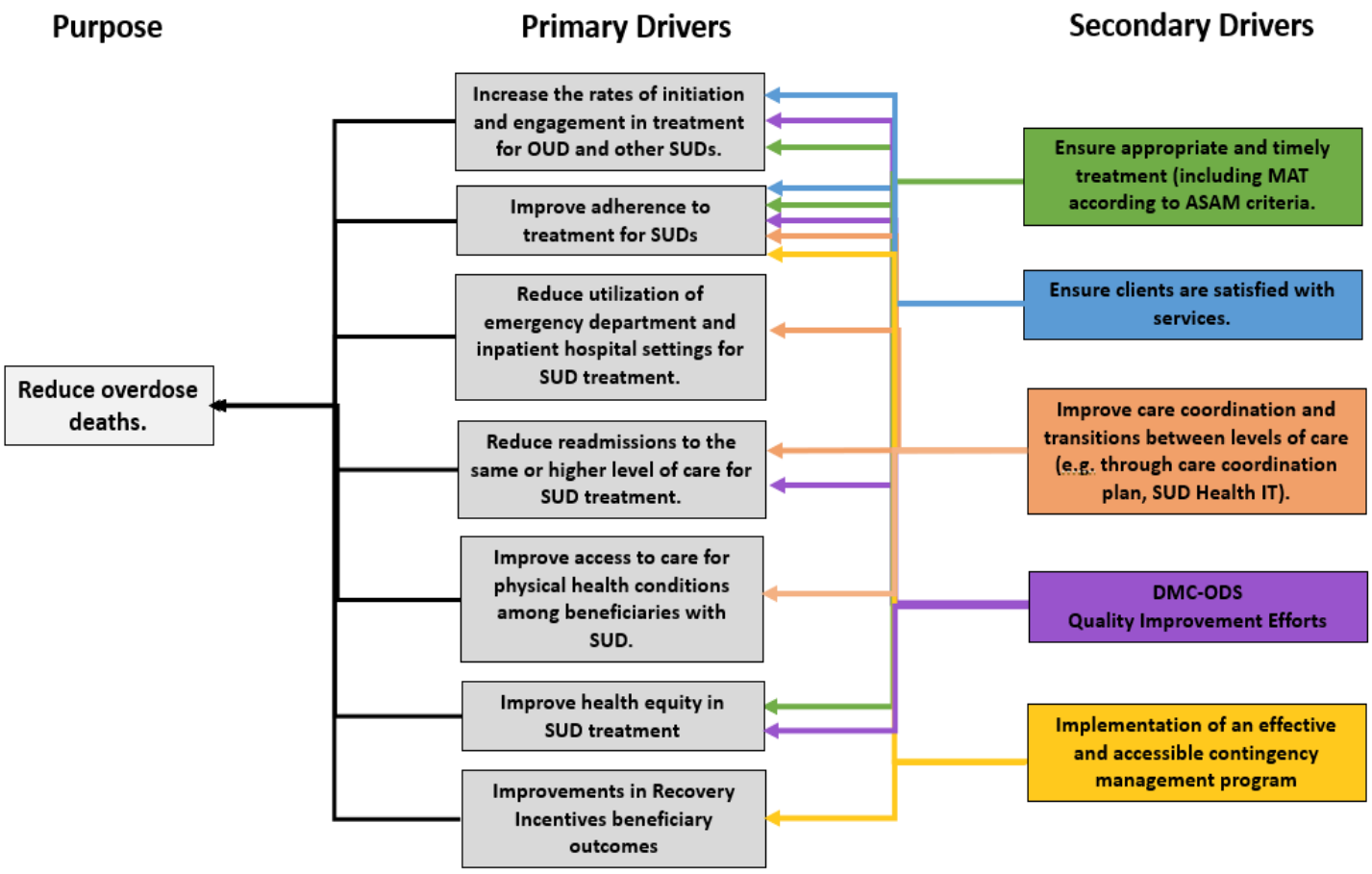
** Benchmark year is 2021, but where appropriate and data allows, a longer timeframe is used. Recovery Incentives data collection started in 2023.*

*** ED, hospital, and associated cost data come from MCP/FFS data is historically subject to reporting delays of about 3 years.*

To the extent possible, the final Summative Report will also examine total costs as well as cost drivers measured on a Per Member Per Month (PMPM) basis before and during the demonstration periods (2015-2026 contingent on data availability), e.g., total Medicaid costs and total federal Medicaid costs, SUD-Institutions for Mental Diseases (IMD) costs, other SUD costs, and non-SUD costs, and inpatient costs, non-ED outpatient costs, and ED outpatient costs. Data acquisition is ongoing for these analyses.

Figure C1 shows each of the goals as primary drivers toward the ultimate reduction in overdose deaths to aid readers in understanding the rationale behind the demonstration features and evaluation outcomes.

Figure C1. *Driver Diagram*



D. Methodology

Methodological Design

The evaluation employs a mixed-methods design that integrates both quantitative and qualitative approaches, offering a more comprehensive perspective than either method could provide on its own. These methods are tailored to leverage different types of comparisons depending on the specific measure being assessed. Where appropriate, administrative data from Drug Medi-Cal (DMC) claims are used within a difference-in-differences framework to account for varying county implementation timelines, aligning with CMS recommendations for rigorous evaluation designs.[17] This approach essentially combines pre-post comparisons and comparisons across counties to test whether changes are detected when counties "go live" but not at the same time in other counties. In other cases, data (e.g., stakeholder surveys, interviews, ASAM Criteria-based Level of Care Placement data) are only available post-implementation, in which case post-only analyses are conducted.

The CM evaluation focuses on the initial implementation of a targeted set of new practices designed for a specific population within defined services settings. This contrasts with evaluation of the broader DMC-ODS program, which was originally approved in 2015 and encompasses the full continuum of substance use disorder care. Therefore, the evaluation approach for the Recovery Incentives Program has a different, more implementation-oriented focus organized around the RE-AIM framework (Glasgow, 1999):

1. **Reach**. Reach is measured as the percentage of people in treatment for StimUD who participate in the Recovery Incentives Program. UCLA is also evaluating

[17] Reschovsky, J.D. and Bradley, K. (2019). Planning Section 1115 Demonstration Implementation to Enable Strong Evaluation Designs. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/enable-strng-eval-dsgn.pdf

whether there are disparities in its reach to different beneficiary populations (e.g., race, ethnicity, gender, age, county).

2. **Effectiveness.** Effectiveness is based on results of drug testing, treatment retention, and treatment engagement.

3. **Adoption.** Adoption is measured by describing how many provider sites deliver Recovery Incentives Program services.

4. **Implementation.** Implementation is evaluated by the degree to which CM is carried out with fidelity to the Recovery Incentives Program protocols and by tracking adaptations made. Perceptions of challenges and areas for potential improvement are also being collected from provider staff and participants through surveys and semi-structured interviews.

5. **Maintenance.** Maintenance will be assessed by examining whether counties and provider agencies continue delivering Recovery Incentives Program services, the consistency of their delivery, and any adaptations made to the program throughout the evaluation period. Additionally, information from surveys and interviews focusing on factors that could promote or impede the continued delivery of Recovery Incentives Program services after the end of the pilot period will be evaluated.

Target and Comparison Populations

The population targeted by DMC-ODS is Medicaid-eligible individuals with SUD. Where appropriate, data from State Plan (non-DMC-ODS) counties and the variation in the staggered Go-Live dates of DMC-ODS counties over time are exploited for comparison purposes as described in the analytic methods section below.

In some cases, particularly when analyzing datasets that did not exist prior to DMC-ODS implementation, the evaluation design is focused on monitoring the maintenance of previously measured improvements. In these cases, the waiver year 2021 is used as a benchmark to measure the maintenance of improvements as CalAIM extends DMC-ODS into 2022 and beyond. Where possible, the data from a longer timeframe is used to evaluate and place data from 2021 into a larger context, particularly in light of the potential impact of COVID-19 on this period. A description of these efforts is summarized in Attachment B.

In other cases, where improvements have not previously been established, data is analyzed to establish whether the initial Medi-Cal 2020 waiver was associated with or caused improvements, as well as whether those improvements have been maintained during the current CalAIM waiver.

As a result of the above considerations, time periods for different measures can differ according to the following rules: 1. Where maintenance is hypothesized, the starting year is 2020 or earlier (see Attachment B), based on data availability, to provide a comparison for 2021. After confirming 2021 as the appropriate baseline, it then serves the benchmark for the ensuing years. 2. Where administrative data are available prior to DMC-ODS, the starting year is 2016 to provide pre-DMC-ODS data to serve as a baseline.[18] 3. Analyses based on data collected specifically for the Recovery Incentives Program start in 2023 when data collection began. For this report, end dates also depend on the most recent available data without data lag at the time of analyses: 2023 for claims data, 2024 for statewide client treatment perception surveys, and 2025 for Incentive Manager data and other surveys and interviews. The primary target population for the Recovery Incentives Program evaluation is clients who receive CM for the treatment of StimUD. A comparison population will consist of clients who receive treatment for StimUD but do not receive CM. Analyses using this comparison population are in progress and will be reported in the final Summative Report.

Evaluation Period

DMC-ODS under CalAIM is considered an extension of DMC-ODS under the previous Medi-Cal 2020 waiver. Therefore, the evaluation period for the evaluation extends from the date the first two counties implemented DMC-ODS on February 1, 2017 through the end of the CalAIM waiver on December 31, 2026. However, exact dates for this Interim Evaluation Report differ by analysis depending on data availability and data reporting lag times, as described in the previous section. The evaluation period for the Recovery Incentives Program evaluation has the same end date, but implementation began in March 2023.

[18] Although initially we planned to use a baseline that extended back to 2015, California converted from ICD-9 to ICD-10 coding on October 21, 2015, which we found created challenges in the comparing claims data across that boundary. To avoid this issue, the baseline started in 2016, more than one year prior to the first DMC-ODS "Go Live" dates.

Evaluation Measures

All evaluation measures are summarized in Table C1 of the previous section.

Data Sources

Administrative Data Sources

California Outcome Measurement System, Treatment (CalOMS-Tx)

CalOMS-Tx is California's existing data collection and reporting system for all clients in publicly funded SUD treatment services. Treatment providers collect information from clients at admission and discharge and send this data to DHCS each month. CalOMS-Tx provides California's contribution to the Treatment Episode Dataset (TEDS) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). CalOMS-Tx includes client background (e.g. demographics, source of referral, number of prior treatment episodes, housing, employment, criminal justice status, number of children), treatment information (e.g. treatment discharge status, use of medications), and 30-day measures at admission and discharge (e.g. number of arrests & jail days, family conflicts, social support). This makes CalOMS-Tx data richer in many respects than other data sources (e.g. claims), though it has its own limitations (see methodological limitations section). CalOMS-Tx data was received in June 2025. More information on CalOMS-Tx can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

Death Data

The California Department of Public Health (CDPH) provides data from their California Comprehensive Death File to DHCS for all Medi-Cal beneficiaries. UCLA has submitted an application to CDPH to use this data to identify overdose deaths as a key outcome measure. All-cause deaths will also be examined if the data allows. At the time of reporting, data has not yet been received by UCLA and are not available for analysis, but it is anticipated this data will be available to report these analyses in the final Summative Report.

Drug Medi-Cal Claims (DMC Claims)

In California, Medicaid-funded SUD treatment is paid for through DMC claims. DMC is a carve-out for specialty care SUD treatment. For this evaluation, DMC claims data provides information on client demographics, access to treatment after DMC-ODS implementation, the types of services provided, and costs. New billing procedures currently under development are expected to record the delivery of CM services and potentially positive or negative drug test results. DMC claims data provides detailed data on services received and is likely to be more complete than other datasets like CalOMS-Tx, but is limited in content to billing-related data. DMC claims data used in this report was received in June 2025.

Incentive Manager Vendor Data

The incentive manager vendor for the Recovery Incentives Program, under contract with DHCS, collects data on incentive payments while administering incentives. Table D1 below lists the data elements collected. Incentive Manager data used in this report was received in April 2025.

Managed Care Plan and Fee-for-Service Data (MCP/FFS)

In California, Medicaid-funded medical care (excluding SUD and serious mental illness) is paid for either through managed care plans or fee-for-service reimbursement. For the UCLA evaluation, MCP/FFS data provides information on client demographics, types of services, and costs.

Medi-Cal Eligibility Data System (MEDS)

The MEDS database provides information on all California Medi-Cal beneficiaries. These data, particularly the MEDS Monthly Extract File (MMEF), are used to calculate penetration rates. Data used in this report was received in January 2025.

Master Provider File (MPF)

The MPF is DHCS's comprehensive list of SUD treatment programs in the state of California. The MPF includes information on all SUD treatment facilities, including mailing addresses and DMC certification and decertification dates, among other

provider-level information. In combination with lists of IMD facilities, MPF can be used to identify provider identification numbers for these facilities, therefore enabling IMD-specific analyses using CalOMS-Tx and DMC claims data.

Table D1. *Data Variables and Descriptions. Incentive Manager Vendor Data.*

Variable	Description
Beneficiary name	Client's full name: first and last
Client Index Number (CIN)	Client's unique identification number
Provider name	Rendering provider/CM coordinator name
Provider Business Name	Service facility organization name
National provider identifier	Rendering provider/CM coordinator number
Date of service	Date drug test was performed
Drug test results	Positive or negative for stimulants
Calculated incentive amount on date of service	Incentive amount owed to client on date of service
Disbursed incentive amount on date of service	Amount disbursed when the client requests it
Current bank balance	Balance if client opts to "bank" incentive amounts
Cumulative disbursed incentive amounts	Total incentive amounts disbursed to member
Visit Number	Visit 1 through 36 (per enrollment period, clients can continue to reenroll until they reach $599 in a calendar year.)
Absence Type	Type of absence - Excused or Unexcused
Absence Note	Reason for absence – proof needed for excused absences

UCLA Evaluation Data Collection Activities

ASAM Level of Care (LOC) Placement Data

Given that the ASAM Criteria are a defining feature of DMC-ODS, a large new data collection effort was initiated across DMC-ODS counties to collect data on the use of ASAM Criteria-based LOC brief initial screenings, initial assessments, reassessments, and services delivered. This endeavor has been a collaborative effort between UCLA, DHCS,

and counties. DHCS Information Notice 17-035 describing the requirements and procedures to collect ASAM Criteria-based LOC data was released in September 2017 and was superseded by Information Notice 18-046 on October 1, 2018. These data include the date of screening or assessment, type (brief initial screen, initial assessment, follow-up assessment), indicated LOCs (per screener or assessment result), actual placement decision(s), the reason for the difference between indicated and actual LOCs (if any), and the reason for delays in placement (if any). Data on three types of screenings or assessments are possible, defined as follows on the data collection instrument.

- Brief Initial Screen: a brief initial screening that preliminarily determines an LOC placement until a full assessment can be performed
- Initial Assessment: a longer comprehensive assessment meant to determine the LOC recommendation and establish medical necessity
- Follow-up Assessment: following an initial assessment, any re-assessment of the client occurring during the same treatment episode

Up to three indicated and actual levels of care could be recorded. Indicated and actual levels of care defined as:

- Indicated LOC. This is the initially recommended LOC according to the screening/assessment instrument prior to taking client preference into account. For example, this would be listed under "Final Level of Care Recommendations" if using CONTINUUM™ software.
- Actual LOC/Withdrawal Management (WM) placement decision. This is the actual LOC decided upon after client input and the LOC where the client is referred.

The options for LOC, as worded in the LOC reporting template, are listed in Table D2. These include broad To Be Determined (TBD) options to allow for the results of brief initial screenings to indicate a general treatment modality the client should report to for further assessment (e.g., outpatient) without specifying the exact LOC to be received there (e.g., 1-outpatient or 2.1-intensive outpatient). The list also includes Withdrawal Management levels of treatment, which can be combined with other levels of care.

Table D2: *ASAM Level of Care Categories and Descriptions*

Category	Level of Care Description
No Treatment	None
TBD Categories	Outpatient/Intensive Outpatient (OP/IOT), exact level TBD
TBD Categories	Residential, exact level TBD
TBD Categories	Withdrawal Management (WM), exact level TBD
TBD Categories	Ambulatory WM, exact level TBD
TBD Categories	Residential/Inpatient WM, exact level TBD
Medication-Assisted Treatment	Narcotic Treatment Program / Opiate Treatment Program (NTP/OTP)
Early Intervention	0.5 Early Intervention
Outpatient Services	1.0 OP (Outpatient)
Outpatient Services	2.1 Intensive Outpatient (IOT)
Outpatient Services	2.5 Partial Hospitalization
Residential Services	3.1 Clinically Managed Low-Intensity Residential
Residential Services	3.3 Clinically Managed Population-Specific High-Intensity Residential
Residential Services	3.5 Clinically Managed High-Intensity Residential Services
Residential Services	3.7 Medically Monitored Intensive Inpatient Services
Residential Services	4.0 Medically Managed Intensive Inpatient Services
Withdrawal Management (WM)	1-WM Ambulatory WM without Extended Onsite Monitoring
Withdrawal Management (WM)	2-WM Ambulatory WM with Extended Onsite Monitoring
Withdrawal Management (WM)	3.2-WM Clinically Managed Residential WM
Withdrawal Management (WM)	3.7-WM Medically Monitored Inpatient WM
Withdrawal Management (WM)	4-WM Medically Managed Intensive Inpatient WM

If at least one of the indicated and actual levels of care do not match, providers are asked to select the reason for the difference. The options are shown in Table D3:

Table D3: *Reasons for Difference Between Indicated and Actual Level of Care*

Reason for Difference
Not applicable – no difference
Clinical judgment
Lack of insurance/payment source
Legal issues
Level of care not available
Managed care refusal
Client preference
Geographic accessibility
Family responsibility
Language
Used two residential stays in a year already
Other

ASAM Level of Care data used in this report were received in August 2025.

County Administrator Surveys and Interviews

UCLA continues to develop and distribute online surveys to obtain information and insights from county SUD/behavioral health administrators participating in the delivery of services under DMC-ODS. Surveys are being conducted annually to address DMC-ODS-related perceptions, barriers, and facilitators. Past topics have included, for example, access to care, screening and placement practices, training needs, quality of care, coordination, and integration of services. Questions on additional topics, including the Recovery Incentives Program, are being added as driven by the evaluation design and other new issues as they emerge. UCLA also conducts in-depth interviews with stakeholders on an as-needed basis to further inform and understand the findings from the administrative and survey data. Surveys are administered online and are sent to either all DMC-ODS counties (currently 40) or all counties (58 counties, 57 surveys because Yuba and Sutter counties share a single administrator). Historically nearly all county administrators have responded (most recently 39 out of 40, 97.5%), eliminating the need for stratification.

Treatment Perceptions Survey (TPS)

TPS was developed by UCLA as part of the initial DMC-ODS evaluation in 2017. TPS for adults was based on San Francisco County's Treatment Satisfaction Survey; and TPS for youth was based on Los Angeles County's Treatment Perceptions Survey (Youth). Both survey questionnaires include items from the Mental Health Statistics Improvement Program (MHSIP). Input on the development of both surveys was collected from DHCS, the Substance Abuse Prevention Treatment+ Committee (SAPT+) of the County Behavioral Health Director's Association (CBHDA) of California, DMC-ODS External Quality Review Organization (EQRO) Clinical Committee, Behavioral Health Concepts (BHC), the Youth System of Care Evaluation Team at Azusa Pacific University, and other stakeholders. The tool has since been validated[19] and data collection has occurred annually during a five-day survey period among counties participating in DMC-ODS since 2018. TPS serves multiple purposes: 1) it fulfills counties' EQRO requirement to conduct a client satisfaction survey at least annually using a validated tool, 2) it addresses the data collection needs for the CMS required evaluation of DMC-ODS, and 3) supports DMC-ODS quality improvement efforts and provides key information on the impacts of DMC-ODS.

TPS is administered annually as part of a major statewide undertaking by UCLA, counties, and providers during a specified five-day survey period in the fall. Providers are directed to administer the survey to every client receiving services both in-person or via tele-health during this time.

The current survey for adults includes 16 statements addressing client perceptions of access, quality, care coordination, outcome, and general satisfaction. The survey for youth includes 19 statements in the same five domains as the adult survey plus an additional domain, therapeutic alliance. Survey respondents indicate the extent to which they disagree or agree with statements using a 5-point Likert scale (1= Strongly disagree and 5= Strongly agree). In 2021, both adult and youth surveys added one item about their utilization of services via telehealth. In 2023, one additional question was added to the Outcome domain (adult and youth), one additional question was added to

[19] Teruya C., Joshi V., Urada D., Trabin T., Iturrios-Fourzan I., & Huang Y.C. (2022). Development and Measurement of the Treatment Perceptions Survey (TPS) for Clients with Substance Use Disorders. *Journal of Behavioral Health Services Research, 49*(2),190-203.

the Care Coordination domain (adult), and one additional question was added in the telehealth section (adult and youth). The survey also collects demographic information (i.e., gender, age, race/ethnicity, and length of time receiving services at the treatment program).

Participation in the TPS survey administration is offered via both paper submissions and through an online HIPAA-compliant survey platform. TPS survey forms for both adults and youth are available in 13 languages (English, Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, Cambodian) and in one-page and two-page (larger font) versions. The relevant Behavioral Health Information Notices, survey instructions, forms in multiple threshold languages, and other materials (i.e., Frequently Asked Questions, TPS Codebook, sample county and program summary reports) are available online at https://www.uclaisap.org/client-treatment-perceptions-survey/index.html.

County administrators coordinate the survey administration and data collection within their provider network and submit the paper forms or electronic data files to UCLA for processing. The data are analyzed, and county- and provider-level summary reports are prepared and made available to participating counties. Counties are also given access to their raw data files and respondents' written comments.

Engagement has remained consistent each year. The number of surveys collected each year has grown as the number of counties going live under DMC-ODS has increased. In 2021, the total number of surveys received was 16,628 from 30 counties. By 2024, the total number of surveys received had increased to 20,146 from 39 counties.

The TPS survey items by domain can be found in Attachment C.

Recovery Incentives Program-Specific Data Collection

Recovery Incentives Site Readiness and Launch Status Tracking Log

The UCLA Evaluation team communicates regularly with the UCLA Training and Implementation Support team to maintain status updates of CM site preparation and launch updates. The UCLA Training Department maintains a CM Site Readiness and Launch Status Tracking Log and shares this data with the UCLA Evaluation team as needed. This information allows the UCLA Evaluation team to monitor barriers

and facilitators to launch, while also triggering a timeline for when Provider and Client surveys are disseminated, according to the Evaluation Plan. Recovery Incentives Program Client Surveys

To obtain client perceptions of the Recovery Incentives Program, UCLA is using two methodological approaches. The first approach employs a cross-sectional data collection method, and the second uses a longitudinal method. While the evaluation plan describes use of only the longitudinal data collection method, UCLA opted to launch an extra cross-sectional survey early in the implementation of the program to obtain timely client feedback. This also allowed the evaluation team to test and refine procedures for the longitudinal survey, while also allowing time for more programs to launch, thereby increasing the generalizability of the longitudinal survey results beyond sites that launched relatively early.

Recovery Incentive Program CM Client Cross Sectional Survey

The cross-sectional survey was implemented between February 5, and March 8, 2024, just under a year after the launch of the program. To provide flexibility to the programs, UCLA allowed each site to select one week (Monday through Friday) during this 5-week period to participate. UCLA included program sites that were approved to launch prior to Jan 1, 2024, that had at least two clients enrolled in the Recovery Incentives Program. A total of 49 program sites met these inclusion criteria, and all eligible sites participated. During their selected collection week, programs were instructed to provide all active CM clients with the opportunity to complete a short and confidential online feedback survey using UCLA's HIPAA-compliant Qualtrics platform. Programs were provided with a flyer to share with their active CM clients which included instructions and a survey link/QR code unique to that program, allowing clients to scan the code and participate using their own mobile device. UCLA also offered a tablet device to all program sites to facilitate onsite completion if needed.

The survey captured information on client perceptions of CM, client behaviors (e.g., drug use, use of emergency room and hospital services, etc.), and overall perceptions of CM implementation, including areas needing improvement.

In addition to collecting quantitative data, the survey included opportunities for clients to elaborate on their answers through open-ended responses, and UCLA used these responses as qualitative data (described below).

As compensation for their time, UCLA issued a $10 e-gift card to clients (separate from the incentives program earnings) for completing this feedback survey. Prior to issuing the compensation, UCLA verified that each respondent was an active client within the Incentive Manager database and confirmed that each respondent had completed the survey only once. As part of the survey, clients were required to provide direct contact information to receive the compensation and were also asked if they would be willing to be contacted by UCLA using these methods to engage in future surveys or interviews.

Using this cross-sectional method, UCLA collected 547 client surveys across the 49 program sites, obtaining feedback from clients in all stages of the program. Most respondents (90%) consented to be contacted for follow-up surveys and interviews. Based on the number of active clients at each site in the Incentive Manager data while the survey was being conducted and the number of surveys received from these sites, a 51.8% response rate was achieved.

Recovery Incentive Program CM Client Longitudinal Follow-up Surveys

The CM Client Longitudinal follow-up Survey collection effort launched in May 2025 with the intention of obtaining client feedback and perceptions of the Recovery Incentives Program during and after their 24-week treatment experience. Data collection points were scheduled at four points in time: Week 1 (baseline), Week 6, Week 14, and Week 28 (one month following protocol completion). Methods were informed by a small pilot based on the cross-sectional sample (n=48), which helped the team fine-tune survey questions, develop client tracking methods, and make projections of response rates and sample sizes to ensure adequate statistical power.

UCLA invited participation from program sites that were approved to launch prior to January 17, 2025 with two or more active members (n=92 program sites). All 92 program sites agreed to participate, functioning as partners to offer the survey opportunity to their clients. Program staff were instructed to only offer the opportunity to clients who were “newly starting” the Recovery Incentives Program (in week one only) during an assigned two-week period between May 5 and June 30, 2025. UCLA engaged

with sites to determine their preferred two-week collection window and provided them with a study flyer for clients to scan for voluntary and confidential participation. A QR code/link on the flyer connected clients to the online Client Survey Information Sheet and baseline survey. Survey materials were offered in English and Spanish and tablet devices were provided to sites that requested one.

Mirroring the cross-sectional survey, once baseline surveys were received through UCLA's HIPAA-compliant Qualtrics platform, UCLA confirmed eligibility by verifying the CM start date/Week one status (as shown in the Incentive Manager database) and assuring valid contact information (e.g.: email and/or mobile phone), which participants needed to provide to receive compensation and future follow-up surveys. UCLA issued a $20 e-gift card for completed and verified baseline surveys. These gift cards were separate from the Recovery Incentives Program earnings and therefore did not have any impact on participants' $599 limit in the program. The three additional follow-up survey collection points offered escalating compensation rates of $40, $60, and $80 e-gift cards provided at each stage. Increasing the compensation at each time point is designed to enhance response rates as well as encourage participation from those that discontinue early from the Recovery Incentives Program. At the close of the baseline collection period, 222 baseline surveys were collected, including at least one client from each participating program. Most respondents (96%) consented to be contacted for follow-up interviews. The response rate will be calculated upon receipt of Incentive Manager data with client data through June 30, 2025.

The survey questions were similar to the cross-sectional survey, capturing perceptions of CM, client behaviors (e.g., drug use, use of emergency room and hospital services, etc.) and repeated measures of the PROMIS, TEA and TPS items with additional elements inquiring about unexcused or missed visits, the experience of UDT testing for financial incentives, and overall feedback on the intervention protocol, highlighting areas for potential improvement. In addition to collecting quantitative data, the survey included opportunities for clients to elaborate on their answers through open-ended responses and inquired if they would be willing to be contacted for a qualitative interview. Each follow-up survey asked the participant about their current status in the program and their reasons for discontinuation if applicable, and also collected ongoing consent for the next follow-up survey.

At the time of this report, baseline data and preliminary findings are available from the week six follow-up time point. The week 14 data collection point initiated in mid-August 2025 and collection of this CM Client longitudinal effort through week 28 data point will continue through February 2026.

Recovery Incentives Program Client Interviews

The study team is conducting semi-structured interviews with approximately 40 clients purposively selected from participants in the longitudinal Recovery Incentives Program survey who provided permission for UCLA to contact them for an interview during that survey. Participants are being selected to represent a range of perspectives on the Recovery Incentives Program, individuals who are at various stages of program participation, and a mix of people who complete full 24 weeks of the Recovery Incentives Program and people who stop the program before completion. Participants are being asked about the program's strengths and ways the program can be improved.

Recovery Incentives Program Provider Surveys

UCLA is surveying program staff who are engaged in the delivery of the CM protocol, specifically CM supervisors, CM coordinators, and counselors at each site who see the most CM clients. As counties are approved to launch, county leads are asked to provide an email contact for their participating treatment programs. UCLA contacts these program leads to obtain email contact information for the specific staff members assigned to the three roles at each site.

Following approximately five months of implementation with at least one active client, the three identified providers are sent online surveys via UCLA's HIPAA-compliant Qualtrics platform. The survey highlights provider knowledge and beliefs about CM and challenges within the program's implementation. This survey includes items from the previously validated Contingency Management Beliefs Questionnaire (CMBQ).[20] As a token of thanks, providers are sent $30 e-gift cards upon completion of these surveys.

[20] Rash, C. J., Petry, N. M., Kirby, K. C., Martino, S., Roll, J., & Stitzer, M. L. (2012). Identifying provider beliefs related to contingency management adoption using the contingency management beliefs questionnaire. *Drug and alcohol dependence, 121*(3), 205-212.

Survey collection initiated in the Fall of 2023, five months following the first program launch.

The goal is to collect surveys from the first 100 programs that have active client participation in the Recovery Incentives Program across the state. At the time of this report, this goal has almost been reached: 98 active programs have been sent surveys, yielding 272 survey responses. The findings presented in this report, however, reflect responses exclusively from CM supervisors, CM coordinators and back-up coordinators (n=244) because counselors, despite providing informative commentary, were not trained in the protocol and maintained limited feedback and knowledge about the implementation of the Recovery Incentives Program.

Recovery Incentives Program Provider Interviews

The study team is conducting interviews and/or focus groups with a sample of about 15 total provider individuals from agencies that implement the Recovery Incentives Program. Providers are being selected to create a sample that serves counties of different size (large, medium, small), geographic location (Northern, Southern, Central regions of the state), and levels of satisfaction with the Recovery Incentives Program as identified in provider surveys. Interviews began shortly after provider survey data collection and will end when additional themes cease to emerge from data collection (saturation has been achieved). Interviews are focusing on identifying the strengths and weaknesses of the Recovery Incentives Program and potential ways to improve the uptake and effectiveness of the program. All interviews are being recorded and professionally transcribed for analysis.

Recovery Incentives County Administrator Interviews

The study team is also interviewing county SUD treatment administrators from ten counties participating in the Recovery Incentives Program to learn about the strengths and weaknesses of the program from counties' perspective. These interviews are focusing on identifying factors that promote or inhibit the reach of the Recovery Incentives Program and identifying ways to further disseminate and maintain program implementation in the future. Counties are being selected to be representative of counties of different size (large, medium, small), geographic location (Northern, Southern, Central regions of the state), and varying levels of program reach (calculated

as the share of county StimUD clients who receive Recovery Incentives Program services). All interviews are being recorded and professionally transcribed for analysis.

Analytic Methods

Analysis of Quantitative Data

Due to the size of California's population and the associated statistical power available for analysis of statewide databases, comparisons using inferential statistics on many of the datasets used in this report may suggest statistical significance even when these differences are small and not meaningful. Furthermore, inferential statistics are designed to make inferences about a population from a random sample taken from that population. However, many of the datasets used in this evaluation (e.g., DMC claims, CalOMS-Tx, county administrator survey data with response rates near 100%) represent data on essentially the full population of interest rather than a random sample. Therefore, in cases where *p*-values may be inappropriate or misleading, descriptive statistics are used with percentages, odds ratios, or other methods to convey the size and meaning of differences to readers. However, advanced statistics will also be used to examine multivariate relationships and difference-in-difference analyses as described below.

Event Study (ES) and Difference-in-Difference (DD) designs are used where appropriate to analyze whether the introduction of DMC-ODS causally affected certain outcomes of interest. Specifically, UCLA uses these designs when analyzing administrative data (e.g., DMC claims and CalOMS-Tx) for some outcomes. Given the staggered roll-out of DMC-ODS across counties in California over time, exploiting this variation within the ES and DD designs allows us to estimate a causal effect of DMC-ODS. These analyses cover the entirety of DMC-ODS, including the Medi-Cal 2020 years inclusive of the 2021 extension, and CalAIM. Data starting in 2016 are used for the pre-DMC-ODS period. All ES and DD models use data from DMC claims at the county-month-year-level.

The difference-in-differences model compares pre-post changes in outcomes in treated units to pre-post changes in outcomes in untreated units, for a single treatment. Given the variation in treatment timing, i.e., the variation in the introduction of DMC-ODS across counties in California over time, exploiting this variation within the ES and DD designs allows us to estimate a causal effect of DMC-ODS. This will remain true if new

counties opt-in to participate in DMC-ODS. The widely accepted empirical strategy in this context is the Two-Way Fixed Effect Difference-in-Differences model (2WFE DD) given by the following equation:

$$Y_{it} = \beta_0 + \beta_1 \cdot Treat_{it} + \alpha_t + \theta_i + \epsilon_{it}$$

where *Treat* is a binary variable equal to one when a county goes live with DMC-ODS and equal to zero otherwise; α_t is a time vector containing month-year indicators; and θ_i is a unit vector containing indicators for the 58 counties. Standard errors are clustered by county, and all regressions are weighted by the county-level population. The above equation can be modified to include a vector of county level time-varying controls, including the percentage of the population that is White, Black, or Hispanic, the percentage of the population that are youth, ages 18-25, 26-35, 36-45, and 46 plus, the poverty rate, unemployment rate, and high school graduate rate.[21] The Average Treatment effect on the Treated (ATT) is given by β_1.

Identification of β_1 comes from within-county variation in DMC-ODS implementation during the sample period. The main assumption of DD designs is the parallel trends assumption. This assumption states that in the absence of treatment, the unobserved differences between the treatment and control groups would be similar over time. Although UCLA cannot directly test this assumption, the evaluation team can assess the assumption in this setting in at least two ways:

1. Include a county-specific linear time trend in the estimating equation. This controls for unmeasured county trends unfolding linearly (e.g., sentiment towards SUD treatments).
2. Perform an event study analysis. This is done by including leads and lags of DMC-ODS indicator variable in the equation above. Ideally, the coefficients on all of the leads of DMC-ODS indicator variable will not be statistically

[21] We also tested the inclusion of a measure of social vulnerability, the social vulnerability index (SVI), which measures demographic and socioeconomic factors that adversely affect communities. The SVI index data is available from the Centers for Disease Control at the county-year level through 2022. When we modified the above specifications to include the SVI data, and limited our estimation sample to 2016-2022, the results were quantitatively similar to those presented in the Results section below using the full 2016-2023 sample without the SVI control variable. We therefore did not use SVI for the results in this report to retain our ability to include 2023 data.

significant. This indicates that trends in the main outcomes of interest in the treated and control counties were not trending differently prior to DMC-ODS adoption.

UCLA can also modify the above equation to estimate lagged effects and heterogeneous effects of DMC-ODS. Specifically, the evaluation team can determine if the programs have stronger (or weaker) effects over time and if the effects differ by client demographics. UCLA conducted robustness checks to determine if both sets of fixed effects (FEs) and county-level controls are needed. Specifically, UCLA starts with a model that only includes time and county fixed effects. It then estimates another model that includes both sets of FEs plus county-level controls. If the estimates are very similar, it presents only the estimates of the full model (i.e., with controls). This is standard practice in nearly every published difference-in-difference paper (including both FEs and time-varying controls). The FEs are only picking up time-invariant county and provider effects. But, if the evaluation team knows variables like the poverty rate, unemployment rate, COVID-19 policies, etc. vary across counties and across time, those need to be included in the regression.

Analysis of Recovery Incentives Program Incentive Manager Data

In June 2025, UCLA received Incentive Manager Vendor data from DHCS containing data on members who participated in the Recovery Incentives Program. This dataset contained records for 7,351 unique participants who participated in the program between April 3, 2023, and April 30, 2025. In July, UCLA received updated aggregate counts showing that nearly 8,500 participants have enrolled in the program. However, the main analyses were necessarily limited to the 7,351 participants in the June 2025 dataset for whom full data were available.

To obtain demographic information (age, sex, and race/ethnicity) about the program enrollees through April 2025, UCLA merged the Incentive Manager dataset with MMEF and CalOMS-Tx.

First, the CM data received from the Incentive Manager was checked to ensure that it accurately aligned with the stipulations in the CM Program Manual. The program manual breaks the program into two periods: Period 1 (weeks 1-12), in which the member takes two drug tests per week for a possible total of twenty-four tests;

Period 2 (weeks 13- 24) allows the member to take one test per week for a total of twelve tests.

UCLA created an enrollment variable to ensure that the maximum number of tests a member received was 36 and that the longest they were enrolled in the program was 24 weeks. This variable was designed to denote each participant's enrollment attempt (first, second, third, etc.). The enrollment variable was based on the number of tests and the time gap between each successive observation, which was set to less than 30 days. Specifically, if the time between successive observations for a participant exceeded 30 days, UCLA assumed that the first enrollment attempt had ended and the second had begun. UCLA verified the transitions between enrollment attempts by tracking the incentive amount earned or paid for each negative test result. This approach allowed UCLA to accurately capture and analyze the participants' engagement and re-engagement with the program.

UCLA also ensured that the incentives disbursed for each negative drug test matched what is outlined in the CM manual. Last, UCLA cleaned the data to ensure that the absence type was accurate based on acceptable criteria defined in the CM manual.

After confirming that the Incentive Manager data was accurate, UCLA calculated the following metrics and matched the CM outline. Although this data included a wider range of variables for these metrics, UCLA only used variables CIN, provider business name, date of service, drug test results, disbursed incentive amount on date of service, visit number, and absence type.

UCLA determined the expected number of tests for each participant by multiplying the weeks they were in each period by the respective testing frequency. For example, if a participant was in the program for the full 24 weeks, UCLA calculated the expected number of tests as follows:

Weeks 1 to 12: 12 weeks * 2 tests per week = 24 tests

Weeks 13 to 24: 12 weeks * 1 test per week = 12 tests

Thus, the total expected number of tests for this participant would be 24 + 12 = 36 tests.

UCLA then summed these expected test counts across all participants to determine the total number of samples that should have been collected.

Rates of positive drug tests are compared to rates from the CM literature. UCLA reviewed all studies cited in a recent systematic review of CM trials for the treatment of methamphetamine use[22] supplemented by a PubMed search of 2020-2022 articles with the key terms "contingency management" and "stimulant." Among these sources, three studies[23,24,25] reported sufficient information to calculate the percentage of negative results among submitted tests. The average weighted for study size, was 85.3 percent.

In addition, UCLA evaluated the data in a more conservative way by counting each unexcused absence as a positive drug test. This was made under the assumption that if a client missed an appointment and did not get it excused, it was assumed that they were going to test positive for stimulants. While this was certainly not going to be the case every time, it provided a more conservative estimate for how the program is working when considering absences.

However, one study[26] determined that the percentage of negative urinalysis outcomes out of *all possible* tests showed the most consistent performance, compared to alternative measures e.g., weeks of continuous abstinence. This measure conservatively

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[22] Brown, H. D., & DeFulio, A. (2020). Contingency management for the treatment of methamphetamine use disorder: a systematic review. *Drug and Alcohol Dependence, 216*, 108307.

[23] Roll, J. M., & Shoptaw, S. (2006). Contingency management: schedule effects. *Psychiatry Research, 144*(1), 91-93.

[24] Stitzer, M. L., Gukasyan, N., Matheson, T., Sorensen, J. L., Feaster, D. J., Duan, R., Gooden, L., Del Rio, C. & Metsch, L. R. (2020). Enhancing patient navigation with contingent financial incentives for substance use abatement in persons with HIV and substance use. *Psychology of Addictive Behaviors, 34*(1), 23.

[25] Strona, F. V., McCright, J., Hjord, H., Ahrens, K., Tierney, S., Shoptaw, S., & Klausner, J. D. (2006). The acceptability and feasibility of the Positive Reinforcement Opportunity Project, a community-based contingency management methamphetamine treatment program for gay and bisexual men in San Francisco. *Journal of Psychoactive Drugs, 38*(sup3), 377-383.

[26] Miguel, A. Q., Smith, C. L., Burduli, E., Roll, J. M., & McPherson, S. M. (2021). Validating the clinical relevance of alternative stimulant use treatment outcome measures by examining their association with 3-month follow-up outcomes. *Experimental and Clinical Psychopharmacology, 29*(3), 288.

treats missed tests the same as positive tests. Therefore, this measure is also used for the evaluation. Three articles[27,28,29]reported sufficient information to calculate the percentage of negative urinalysis results among all possible tests, producing a weighted average of 47.7 percent.

Analysis of Quantitative Survey Data

County administrator, provider, and client surveys include Likert rating scales and binary measures (e.g., yes/no). While the administrator survey data represents responses from the full population of administrators, the provider and client survey data are analyzed in greater depth.

Descriptive statistics, including mean and standard deviation for continuous outcomes as well as frequency and percentage for binary outcomes, are estimated for all survey samples. Bivariate comparisons are made between coordinators and counselors in the case of provider surveys.

Multiple regression modeling for a continuous outcome (e.g., a 1-5 Likert rating scale) and/or logistic regression modeling for a binary outcome (i.e., yes/no) are being conducted separately. On provider surveys, the staff's role (i.e., coordinators versus counselors) are a covariate in regression modeling. This analysis will be conducted upon completion of the longitudinal survey and will be shown in the final Summative Report.

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[27] Carrico, A. W., Gómez, W., Siever, M. D., Discepola, M. V., Dilworth, S. E., & Moskowitz, J. T. (2015). Pilot randomized controlled trial of an integrative intervention with methamphetamine-using men who have sex with men. *Archives of Sexual Behavior, 44*(7), 1861-1867.

[28] Shoptaw, S., Klausner, J. D., Reback, C. J., Tierney, S., Stansell, J., Hare, C. B., Gibson, S., Siever, M., King, W. D., Kao, U., & Dang, J. (2006). A public health response to the methamphetamine epidemic: the implementation of contingency management to treat methamphetamine dependence. *BMC public health*, *6*, 214.

[29] Miguel, A. Q., Smith, C. L., Burduli, E., Roll, J. M., & McPherson, S. M. (2021). Validating the clinical relevance of alternative stimulant use treatment outcome measures by examining their association with 3-month follow-up outcomes. *Experimental and Clinical Psychopharmacology, 29*(3), 288.

All analyses will be conducted at both statewide and county levels, and by demographic groups to look for differences in access and outcomes by race, ethnicity, gender, and age.

Analysis of Qualitative Data

Analysis of Survey Data

The research team used conventional content analysis (Hsieh & Shannon, 2005) on comments clients left in response to open-ended survey questions to identify salient themes in the data. Overall, the team analyzed 1,331 client comments. The team used the same method for open-ended survey comments on the county administrator surveys conducted in 2024 and 2025.

Analysis of Interview Data

All interviews and group discussions are being recorded and transcribed, while qualitative data from surveys (e.g., free text responses to open-ended questions) are being extracted and organized into a spreadsheet. The evaluation team is analyzing these data using a systematic and iterative process according to established and accepted procedures for qualitative research. This process will begin by organizing data into key study domains (King 2004) related to the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, Maintenance). Within each domain, initial analyses used codes that emerged from the qualitative data. See Table D4 for a list of codes that are being used to guide analyses and identify overarching data trends.

Table D4. *Codes for Recovery Incentives Program Qualitative Data Analysis*

RE-AIM DOMAIN	CODES
Reach	R1: What determines which StimUD clients receive CM and which do not? R2: What are the barriers and facilitators of Recovery Incentives Program service delivery? R3: Are there disparities in the reach of Recovery Incentives Program services to different treatment populations? What can be done to mitigate these disparities?
Effectiveness	E1: How effective do stakeholders believe the Recovery Incentives Program is in helping clients remain in treatment? Helping them achieve and maintain abstinence from stimulants? E2: What can providers do to enhance the Recovery Incentives Program's effectiveness with the clients they serve? What can administrators and policymakers do to facilitate these changes?
Adoption	A1: What factors do counties consider when deciding whether to participate in the Recovery Incentives Program? What factors do program leaders and individual providers consider? A2: What are the practical barriers to/facilitators of Recovery Incentives Program adoption? A3: What policies and procedures could help promote the effective adoption of the Recovery Incentives Program?
Implement-ation	I1. What are the barriers to/facilitators of high-fidelity CM implementation? I2. What adaptations are being made to CM as it is being implemented? What impacts do these have on intervention fidelity and effectiveness? I3. What policies and procedures could help promote the effective implementation of the Recovery Incentives Program?
Maintenance	M1. What makes programs and providers decide to continue to participate in the Recovery Incentives Program? What makes them decide to discontinue it? M2. What policies and procedures could help promote the maintenance of the Recovery Incentives program in the future if it becomes a standard Medi-Cal benefit?

After organizing qualitative data with codes, UCLA is using constructivist grounded theory to guide the process of reading transcripts, coding data, and comparing/contrasting emerging patterns and themes using constant comparative methods.[30,31] Portions of coded transcripts are being randomly and independently coded by two researchers to ensure that the codes are being applied consistently and have acceptable levels of agreement indicating good reliability. The evaluation team is meeting regularly to share insights and observations from the interviews and/or focus groups throughout the evaluation and discuss emerging themes. Once qualitative data analyses are completed, qualitative data will be triangulated with survey and other quantitative data to identify areas where the results from the data sets converge, complement one another, and/or expand on one another.[32] [33].

The qualitative data collected from the different stakeholder groups (e.g., county administrators, treatment providers, clients) is being analyzed separately as well as across the different groups, and over time (e.g., early vs. later in the implementation of the project) to identify themes and patterns. Findings are being shared with members of key stakeholder groups (DHCS, county administrators, and program staff) to verify and interpret findings.

[30] Charmaz, K. (2017). The power of constructivist grounded theory for critical inquiry. Qualitative inquiry, 23(1), 34-45.

[31] Glaser, B. G. & Strauss, A. L. (1967). The Discovery of Grounded Theory. Strategies for Qualitative Research. Chicago: Aldine. King, N. (2004) Using templates in the thematic analysis of texts. In C. Cassell & G. Symon (eds) Essential Guide to Qualitative Methods in Organizational Research. London: Sage Publications. Pp. 256-270

[32] Creswell, J. W. (2003). Research design: Qualitative, quantitative, and mixed methods approaches (2nd ed.). Thousand Oaks, CA: Sage Publications.

[33] Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlian, P., Hurlburt, M., & Landsverk, J. (2011). Mixed method designs in implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 38*, 44-53.

E. Methodological Limitations

The California administrative data sets used in this evaluation have many of the same shortcomings as other administrative data sets, particularly related to inconsistent reporting and missing data.[34] Delays in data reporting also limit analyses of recent data. UCLA is analyzing CalOMS-Tx and DMC claims using the most recent available complete data, which typically requires disregarding more than one year of data. For this reason, many analyses of administrative data end in December 2023 to ensure the results are not unduly affected by data reporting lag.

COVID-19 also presents a challenge. The 2022-2023 timeframe covered in this report occurred during the National Public Health Emergency that started in March 2020 and ended in May 2023. UCLA examined the appropriateness of 2021 as a baseline year and determined that it is preferable to using a pre-COVID-19 year or the more temporally distal 2020, but it is possible that COVID-19 effects on the SUD treatment system faded from 2021 to 2023 and as use of services and assessments rebounded, this could have boosted some metrics in favor of 2022 and 2023 when compared to 2021. New counties have continued to join DMC-ODS after the COVID-19 public health emergency ended which will help to partly mitigate these issues during analyses. The final Summative Evaluation due in 2028 will provide better context by examining a longer timeframe after the end of the Public Health Emergency.

CalOMS-Tx data is partly reliant on self-reported data, particularly with respect to outcome questions (e.g., drug use in the last 30 days). Some terms are also somewhat

[34] Evans, E., Grella, C. E., Murphy, D. A., & Hser, Y. I. (2010). Using administrative data for longitudinal substance abuse research. The journal of behavioral health services & research, 37(2), 252-271

subjective, like discharge status terms (e.g., completed treatment, satisfactory progress, and unsatisfactory progress). To partly ameliorate this problem, these categories are combined into "successful" (completed, satisfactory progress) and "unsuccessful" (unsatisfactory progress) discharges.

DMC claims data tends to be more complete than CalOMS-Tx data because providers are more motivated to submit them quickly for payment, but this is not universally true. In some cases, under DMC-ODS, new billable services (e.g., recovery services) are being delivered but DMC claims are not being submitted, in part due to confusion over what is allowable. In others, billing codes change. UCLA is monitoring county administrator and provider survey and interview responses for signs of billing difficulties that may affect claims data, and monitoring billing code changes to ameliorate these issues.

While DMC claims data have an advantage over CalOMS-Tx in completeness, CalOMS-Tx has advantages in the depth of data. CalOMS-Tx includes client background (e.g. demographics, primary and secondary drug, source of treatment referral, number of prior treatment episodes, housing, employment, criminal justice status, number of children), as well as treatment discharge status and a number of outcome measures in the last 30 days, both at admission and discharge (e.g. number of arrests and jail days, family conflicts, social support). These cannot be derived from claims. These datasets are therefore complementary and can be used together to develop a better understanding of DMC-ODS implementation than either dataset alone.

Interview and survey data are limited by the honesty of respondents and the response rate. Additionally, an inherent limitation of cross-sectional treatment surveys like those used for Recovery Incentives Program and TPS is that they only reach individuals who were actively participating in the program at the time of data collection. While this presents an accurate snapshot of those in treatment at that time, it does not necessarily represent the views of all individuals who entered treatment because individuals who disengage early, who may tend to be less satisfied with their services, are less likely to be surveyed. This may limit the generalizability of the results. For this reason, UCLA is currently collecting a second Recovery Incentives Program survey using longitudinal methods. This survey begins in the client's first week of participation in the program and these same clients are being surveyed even if they discontinue treatment. When data collection is completed, this will also provide insight into the extent to which cross-sectional and longitudinal results differ.

Urine drug test results are objective but can be biased by missed tests. That is, clients may be more likely to skip tests that would have been positive. This would be a rational decision on the clients' part since an unexcused absence and a positive test have the exact same impact on the incentives, but a positive test involves time and possibly embarrassment. Such decisions may, however, result in an artificially high percentage of negative results among urine samples that were actually submitted. Different assumptions have been tested to address this, including conservatively assuming missed tests would have tested positive for stimulants.

Urine drug tests can also be undermined by tampering. However, Recovery Incentives Program protocols[35] require the use of UDT cups with temperature strips, tests for creatinine/specific gravity and pH to detect use of other people's urine, dilution, or contamination. Procedures also require members to wash their hands before handling test supplies and require the application of bluing agent in toilets and turning off hot water in restroom used for testing to further discourage dilution.

Wherever possible, different types of data are being examined in parallel to converge on underlying constructs being measured and thereby mitigate the limitations of each dataset.

[35] https://www.uclaisap.org/recoveryincentives/docs/training/Program-Manual-with-Appendices-2025-08-26.pdf

F. Results

Goal 1: Increased rates of identification, initiation, and engagement in SUD treatment services.

Hypothesis: Counts or rates will be maintained at benchmark year levels or higher.

Counts of Clients Served: Raw counts and demographics

Table F1 shows calendar year (CY) 2021 and CY 2023 demographic and service modality number of unique clients using DMC Claims for clients receiving services in the counties that implemented DMC-ODS by that year.

As shown in the table, the demographics among clients receiving SUD treatment in DMC-ODS counties remained fairly stable from 2021 to 2023. The percentage of clients receiving residential services increased, reflecting DMC-ODS' impact on the mix of services being delivered. While the total number of unique clients dipped slightly, this may in part reflect data reporting lag in the 2023 data.[36]

Counts of Clients Served: Event Study and Difference-in-Differences Estimates

To empirically assess the impact of DMC-ODS on the number of clients receiving services, we estimated event study and Difference-in-Differences (DD) models. Specifically, the DD models compare the posttreatment (e.g., post-DMC-ODS implementation) difference in the outcomes of interest between DMC-ODS and State Plan counties to the pretreatment (e.g., pre-DMC-ODS implementation) difference in the outcomes of interest between DMC-ODS and State Plan counties. The ES models are similar to the DD models, but ES models allow the effect of DMC-ODS to vary from 12 months or more prior to introduction to 12 months or more after the introduction.

[36] While 2023 data appeared to be mostly complete, new records were still being added in 2025. A number of changes associated with payment reform were implemented in 2023, which might have affected some claim submissions.

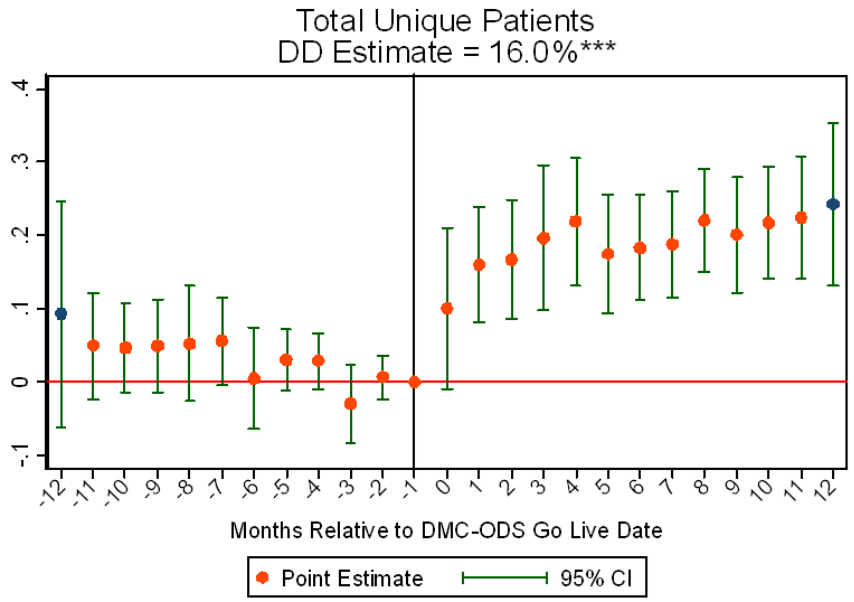
Table F1. *Number of unique clients by demographics and service modality for DMC-ODS counties. DMC Claims (CY 2021 and CY 2023).*

	DMC-ODS Counties			
	2021		2023	
Demographics	**N**	**Percent**	**N**	**Percent**
Race				
White, Non-Hispanic	38,931	35.6%	34,616	33.0%
Black, Non-Hispanic	10,777	9.9%	10,113	9.6%
Hispanic	35,893	32.8%	37,171	35.4%
Asian/Pacific Islander, Non-Hispanic	1,987	1.8%	1,750	1.7%
American Indian/Alaska Native, NH	901	0.8%	937	0.9%
Other Race, Non-Hispanic	20,895	19.1%	20,283	19.3%
Total	109,384	100.0%	104,870	100.0%
Age				
12-17	3,031	2.8%	4,872	4.6%
18-25	9,874	9.0%	7,808	7.4%
26-35	37,636	34.4%	33,963	32.4%
36-45	27,037	24.7%	28,521	27.2%
46+	31,885	29.1%	29,739	28.3%
Total	109,463	100.0%	104,903	100.0%
Sex				
Male	65,734	60.1%	64,162	61.2%
Female	43,729	39.9%	40,741	38.8%
Total	109,463	100.0%	104,903	100.0%
Service Modality				
Outpatient	33,556	30.7%	31,299	29.8%
Intensive Outpatient	10,223	9.3%	7,761	7.4%
Residential	25,536	23.3%	28,236	26.9%
NTP/OTP	40,148	36.7%	37,607	35.8%
Total	109,463	100.0%	104,903	100.0%
# Live Counties	37		38	

Figure F1 below presents the ES estimates and the overall DD estimate of the effect of DMC-ODS introduction, using DMC Claims data, on the natural log of the unique number of clients receiving services. The natural log of the unique number of clients receiving services is taken to reduce the skewness of the outcome, and for ease of

interpretation of the coefficients. The figure indicates a sharp increase in the unique number of clients receiving services after the introduction of DMC-ODS. The DD coefficient suggests that, compared to State Plan counties, the introduction of DMC-ODS significantly increased the unique number of clients receiving DMC-funded services in DMC-ODS counties by 16 percent.

Figure F1. *Event study estimates of the effect of DMC-ODS on unique number of clients receiving services.*

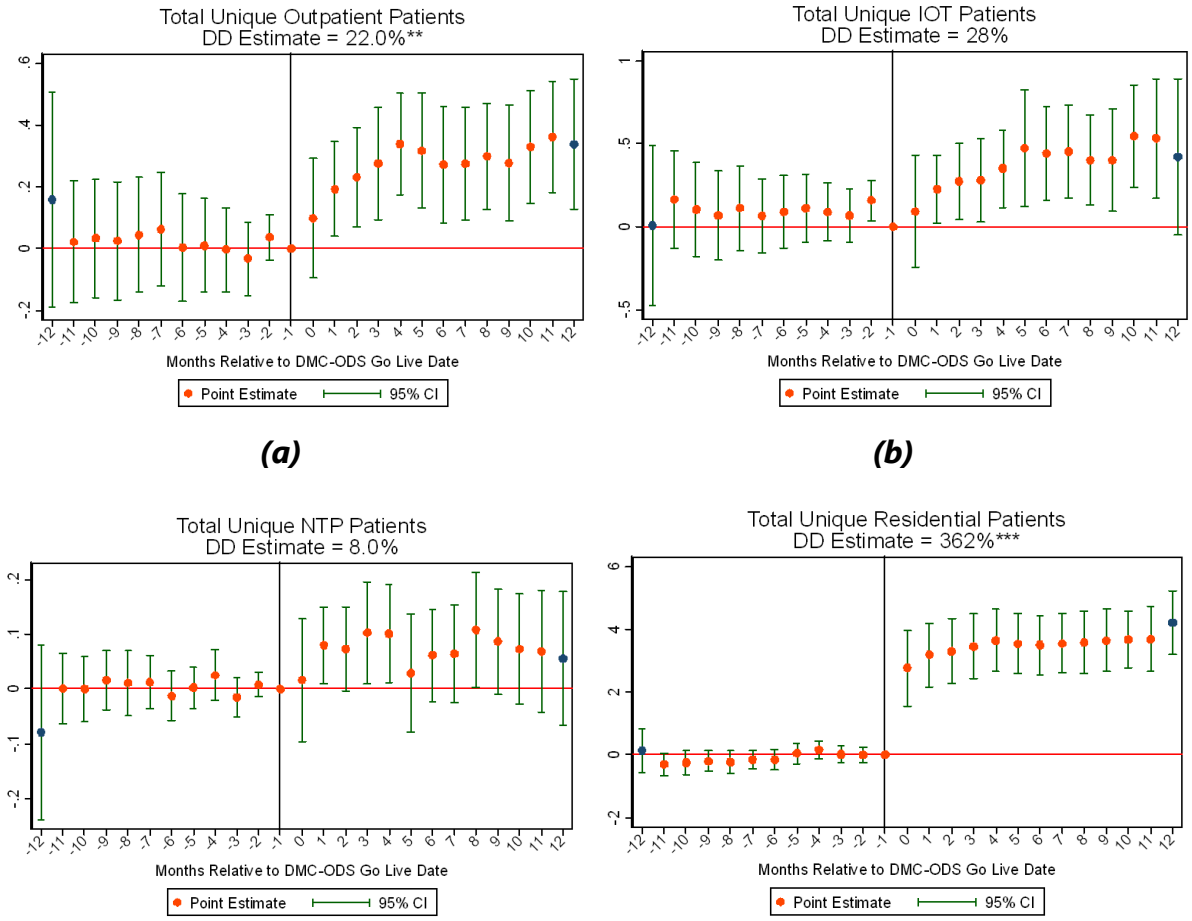


*Data source: Data are from DMC Claims for CY 2016 – CY 2023. Event study estimates (orange dots) and 95% confidence intervals (green bars) of the effect of DMC-ODS on the log of the unique number of clients receiving services are shown. All estimates are relative to the year prior to the "Go Live" date on which each county initiated DMC-ODS. The difference-in-difference estimate is also presented. *** indicates significance at the 1% level.*

To determine if the introduction of DMC-ODS affected the number of clients receiving services by modality, separate ES and DD models were estimated for outpatient services, intensive outpatient (IOT) services, NTP/OTP services, and residential services. Figure F2 panels (a)-(d) present the ES estimates and DD estimates by modality, respectively. Figure F2 suggests that the introduction of DMC-ODS had a positive impact on the unique number of clients receiving DMC-funded services across all modalities, though the estimated effects for IOT and NTP/OTP are not significant. DMC-ODS significantly increased the number of unique outpatient clients in participating counties by 22

percent, and residential clients in participating counties by 362 percent (due to the expanded coverage of residential services) in DMC-ODS counties, compared to State Plan counties.

Figure F2: *Event study estimates of the effect of DMC-ODS on unique number of clients receiving services, by modality.*



*Data source: Data are from DMC Claims for CY 2016 – CY 2023. Event study estimates (orange dots) and 95% confidence intervals (green bars) of the effect of DMC-ODS on the log of the unique number of clients receiving services are shown. Panel (a) is outpatient, panel (b) is IOT, panel (c) is NTP/OTP, and panel (d) is residential. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimate is also presented. *** indicates significance at the 1% level, and ** indicates significance at the 5% level.*

Although the overall DD results may appear to contradict those in Table F1, which show a slight decline in the unique number of clients from 2021 to 2023, the DD analysis

compares the unique number of clients receiving services in treated counties relative to State Plan counties. The DD asks, did DMC-ODS counties increase their number of clients served more than State Plan counties DD over the same time period, after accounting for common trends? Even if the number of clients declines in DMC-ODS counties post-2021, the DD can still show a positive effect if the decline was less severe than in State Plan counties. Additionally, the post-2021 decline could reflect external shocks (COVID-19 aftershocks, workforce shortages, changes in substance use/treatment seeking, etc.), not the effect of the policy.

County Administrator Feedback

Consistent with the DMC claims and CalOMS-Tx, 2025 county administrator survey respondents overwhelmingly reported that DMC-ODS had a positive impact on access to services in their county (97.0%). These results are consistent with previous responses on this annual survey.

On open-ended responses, many counties lauded increased access to a broader continuum of care since DMC-ODS implementation. Smaller counties that implemented DMC-ODS as a regional model reported benefiting from the model, as it helped them manage administrative burdens while expanding services. While citing improvements, several counties also cited challenges. Excessive paperwork requirements, staffing and capacity issues including shortages of bilingual staff, billing limitations, and delays experienced by unhoused out-of-county Medi-Cal members who wish to transfer to another county were noted as challenges faced by counties. A need for more youth residential services and withdrawal management beds was commonly cited.

Client Feedback

Most clients in DMC-ODS counties also provided favorable ratings on access to treatment. In the 2024 Treatment Perception Survey, the average rating for access domain was 4.4 out of a possible 5.0, and most adult clients agreed with the two items about access: “The location was convenient (public transportation, distance, parking, etc.)” (86.7% agreement) and “Services were available when I needed them” (90.2% agreement), which a slight increase from 2021 (85.3% and 89.1% agreement, with an average domain rating of 4.3). Youth ratings in 2024 were about the same as the 2021 ratings (84.3% and 84.8% agreement, with average domain rating of 4.2). They also

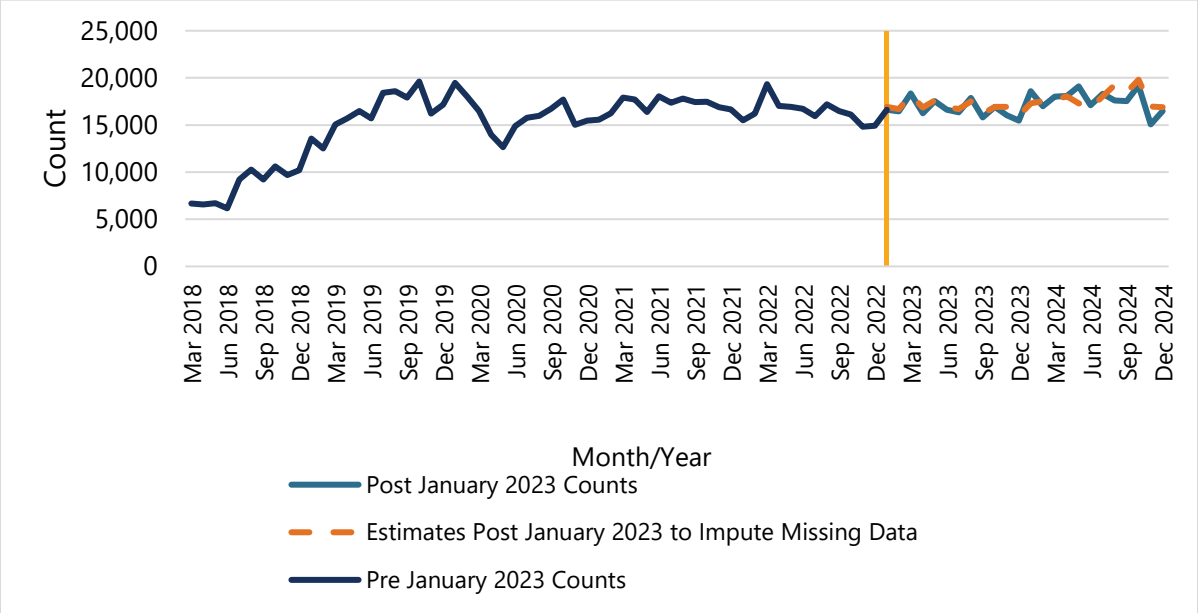
tended to agree with the youth-specific question, "I had a good experience enrolling in treatment" (84.0% agreement).

Number of ASAM Criteria-based Level of Care screenings and assessments

From January 2022 - June 2025, 672,310 screenings and assessments for 215,477 Medi-Cal clients occurred. Clients were required to receive a full ASAM Criteria-based assessment within the first 30 days of visiting a licensed practitioner of healing arts.[37]

A lag in data reporting resulted in missing data beginning at the end of 2023. UCLA generated estimates from January 2022-December 2023 with an elastic net, also known as a penalty regression, with k-fold cross-validation over 20 folds using monthly covariates from CalOMS-Tx with updated ASAM Criteria-based assessment numbers for January 2023-December 2024 to correct for this lag. As shown in Figure F3, overall assessment numbers have been relatively stable during the CalAIM period and are comparable to the baseline period of 2021.

Figure F3. *ASAM Criteria-based Assessment State Totals*



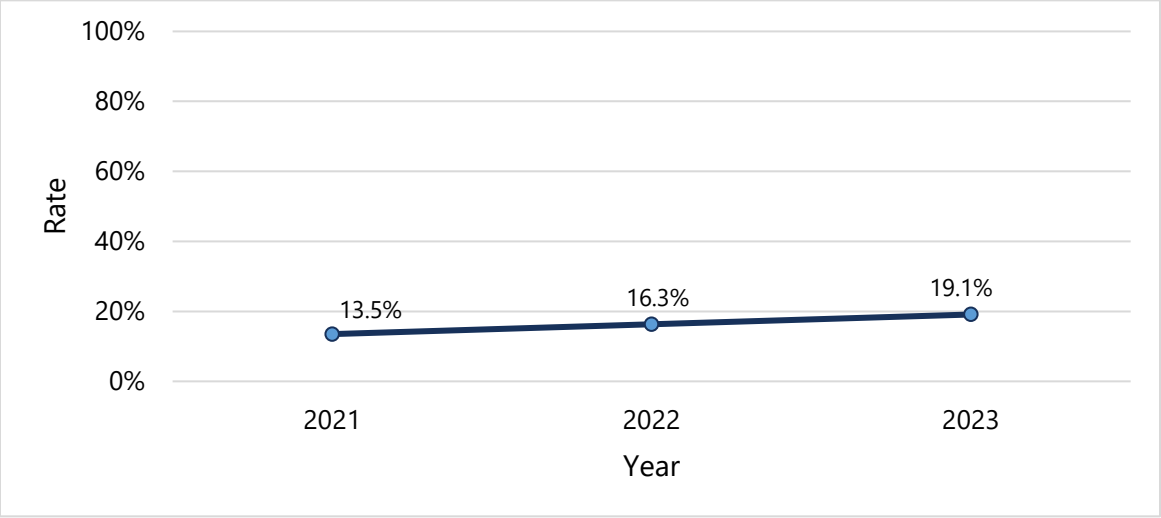
Data source: ASAM LOC Placement data

[37] Flexibilities extended the timeframe to 60 days for people experiencing homelessness in 2022 (BHIN 22-019). Requirements were further streamlined effective January 1, 2024 (BHIN 23-068)

Initiation among beneficiaries with an ASAM Criteria-based brief screening

Traditionally, initiation rates are calculated from the day of first diagnosis. However, since DMC claims are limited to SUD specialty treament, the diagnosis typically accompanies the first treatment service, resulting in initiation rates of 90% or higher. As described in the approved Evaluation Design, UCLA therefore calculates the percentage of people with a DMC treatment claim within 14 days of an ASAM Criteria-based brief screening with an indicated treatment level of care. Unlike initial ASAM Criteria-based assessments, which are commonly conducted at treatment programs after admission, brief screenings are frequently conducted outside of a treatment program such as at call centers. This demonstrates how well the system moves people from initial referral outside of a treatment setting into a treatment setting. Specifically, ASAM LOC placement data was merged with DMC claims data from CY 2021-2023 to track treatment initation, as defined by at least one treatment claim within the first 14 days after the initial ASAM Criteria-based brief assessment. As shown in Figure F4, from 2021 to 2023, the initiation of treatment within 14 days of brief screening increased from 13.5 percent to 19.1 percent. Despite the different data sources and methods, this is largely consistent with DHCS's rate reported on monitoring metric 15, initiation of AOD treatment, total AOD abuse or dependence (19.6% in 2022, 21.2% in 2023).

Figure F4. *Initiation within 14 days after ASAM Criteria-based brief screening by year*



Data source: ASAM LOC Placement data

Timely admission to the indicated Level of Care within 30 days of ASAM Criteria-based brief screenings

Figure F5 displays the rate at which treatment was received at the indicated LOC within 30 days following an ASAM Criteria-based assessment among people who intiated treatment. In 2023, 80 percent of people who had a brief screening were admitted within 30 days to the indicated LOC. Initiation rates for 14 days (68%, 65%, and 78%) were very similar to the 30 day rates, suggesting that people who received treatment within 30 days almost always received it within 14 days. These 14-day rates can also be multiplied by the 14-day initiation rates above to determine rates among all people who received brief screenings, rather than among those who received treatment. From 2021 to 2023, 9.2 percent, 10.6 percent, and 14.9 percent of all people receiving brief screenings received treatment in the indicated LOC within 14 days. There was an increase in the number of brief screenings in 2023, perhaps in response to Behavioral Health Information Notices 22-019[38] and 23-068,[39] which streamlined clinical documentation and may have increased the use of brief initial screenings, in part by clarifying that services can be covered prior to completion of a comprehensive assessment. Other changes to screening tool guidance for mental health services (BHIN 22-065,[40] BHIN 25-020[41]) or changes to billing associated with behavioral health payment reform[42] may have affected how screenings are used and could have had an indirect impact on 2023 timely admission rates. UCLA will investigate the reasons for this increase in a future county admninistrator survey.

Engagement in Treatment among DMC-ODS Clients

DMC claims data for CY 2019-2023 are also used to track treatment engagement, as measured by at least three visits (initiation and two additional visits) within the first 34

[38] https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

[39] https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf

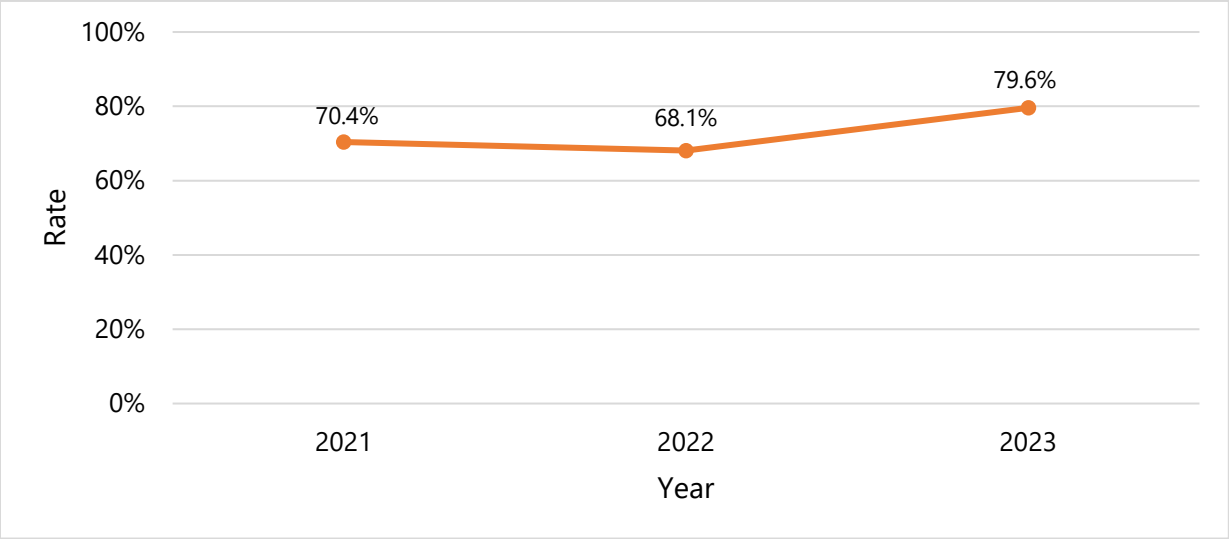
[40] https://www.dhcs.ca.gov/Documents/BHIN-22-065Adult-and-Youth-Screening-and-Transition-of-Care-Tools-for-Medi-Cal-MHS.pdf

[41] https://www.dhcs.ca.gov/Documents/BHIN-25-020-Adult-and-Youth-STTs-for-Medi-Cal-Mental-Health-Services.pdf

[42] https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx

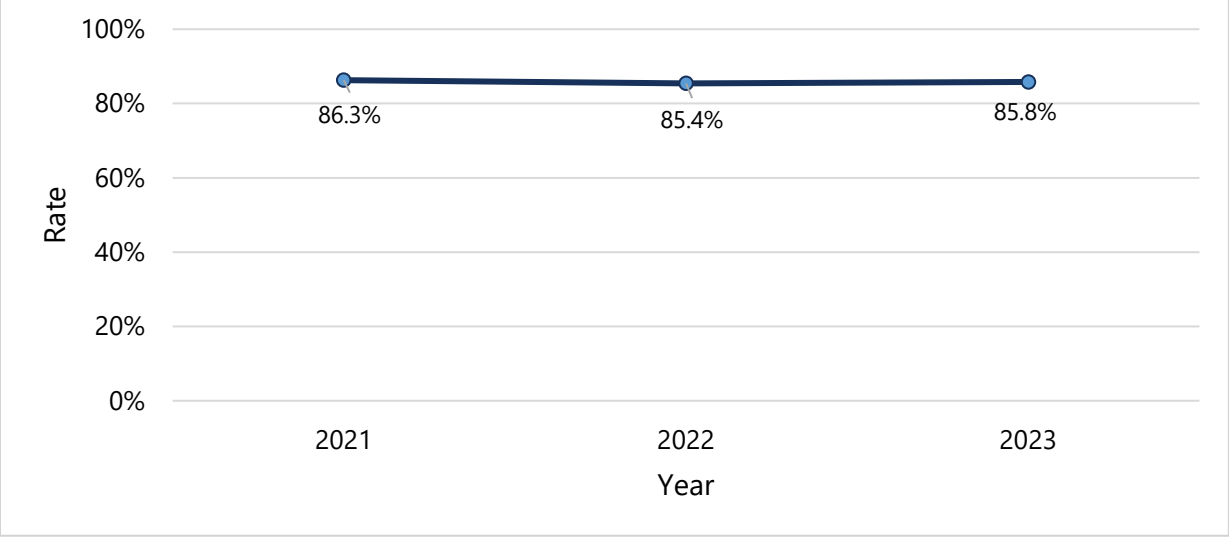
days among people aged at least 12 years old. As shown in Figure F6, from 2021 to 2023, the engagement of treatment within 34 days of diagnosis remained stable. These engagement numbers are higher than the engagement monitoring metrics DHCS reports to CMS because the results here are focused only on DMC claims, whereas the monitoring metrics include other non-specialty treatment settings.

Figure F5. *Timely admission to the indicated Level of Care within 30 days of ASAM Criteria-based brief screenings among people who initiated treatment.*



Data source: ASAM LOC Placement data

Figure F6. *Treatment Engagement by year.*



Data source: DMC Claims

Ensuring Clients are Satisfied with Services

Client Perceptions of Care/Satisfaction with SUD Treatment Services: The Treatment Perceptions Survey (TPS)

Clients' perceptions of care and satisfaction with SUD services are critical components of care quality, and are often associated with treatment outcomes.[43] [44] [45] Perception ratings across all domains and among both adults and youth since 2021 have remained high with minimal variation.

TPS Surveys Submitted

TPS participation has grown each year, reflecting the growing number of counties going live under DMC-ODS. In 2021, the total number of surveys received was 16,628 from 30 counties. For the 2024 survey period, 20,146 total TPS surveys were received; adult surveys were received from 39 counties, and adults accounted for 96.4% of forms (N = 19,429). Youth accounted for 3.6% (N = 717 from 25 counties).

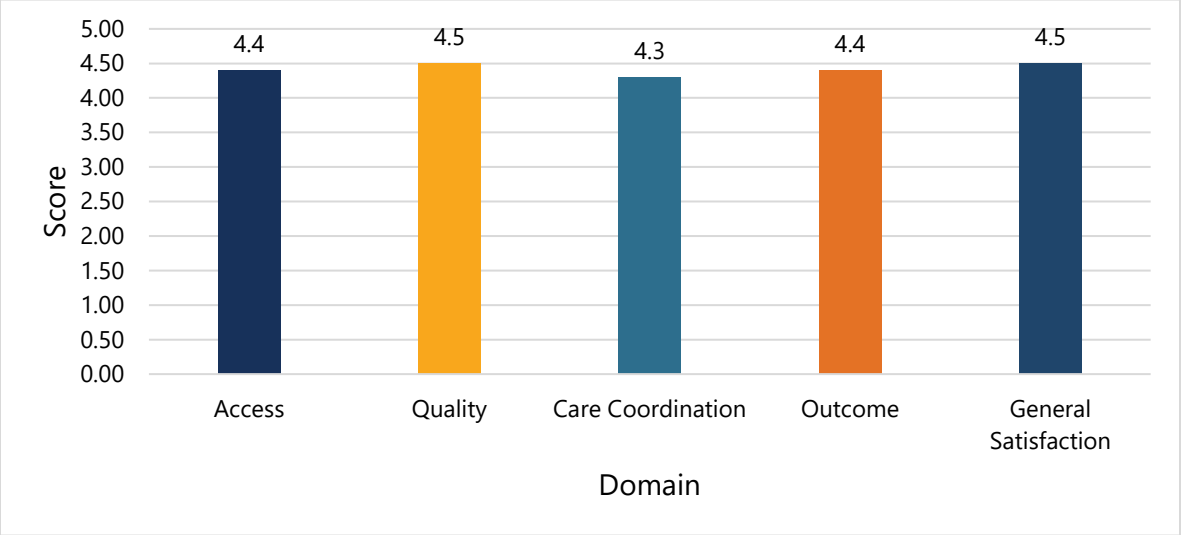
Average Perceptions of Care/Satisfaction by Domain

Adults

Average scores for each of the five domains were high (4.3-4.4 out of a possible 5.0) and continue to remain aligned with prior years: Quality and General Satisfaction domains yielded the highest scores, followed by Outcome,Access, and Care Coordination (see Figure F7).

[43] Carlson, M. J., & Gabriel, R. M. (2001). Patient satisfaction, use of services, and one-year outcomes in publicly funded substance abuse treatment. Psychiatric Services, 52(9), 1230-6;
[44] Shafer, A., & Ang, R. (2018). The mental health statistics improvement program (MHSIP) adult consumer satisfaction survey factor structure and relation to external criteria. Journal of Behavioral Health Services and Research
[45] Zhang, Z., Gerstein, D. R., & Friedmann, P.D. (2008). Patient satisfaction and sustained outcomes of drug abuse treatment. Journal of Health Psychology, 13(2), 388-400.

***Figure F7**. Average score by domain - adults*

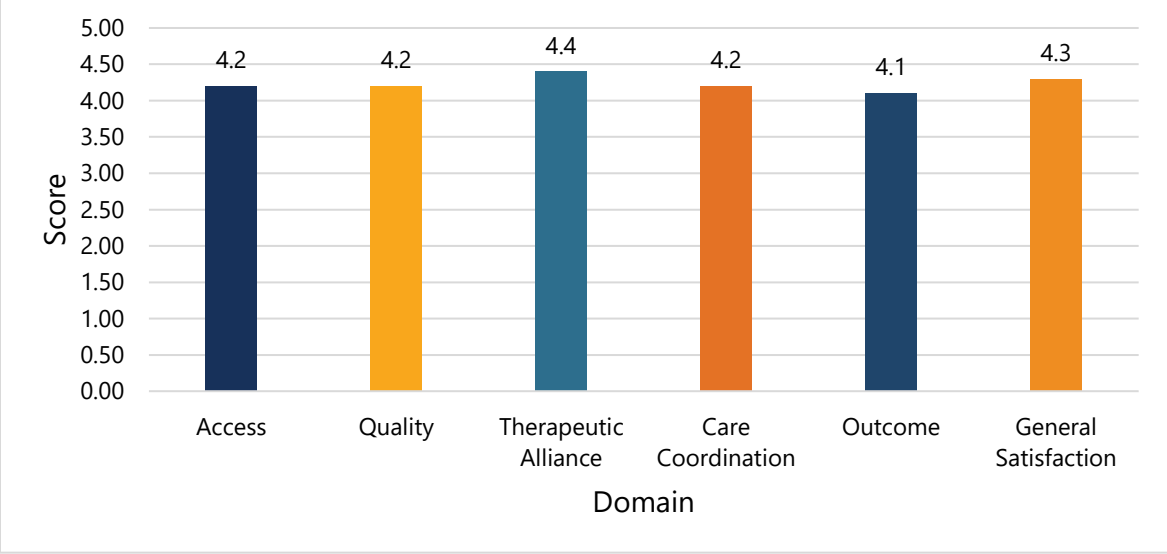


Data source: Treatment Perception Survey 2024

Youth

Among youth, average scores for all six domains were also above 4.0 in 2024, with little variability from prior years. Therapeutic Alliance once again received the highest average score followed by General Satisfaction, Care Coordination, Access, Quality, and Outcome (see Figure F8).

***Figure F8:** Average score by domain - youth*



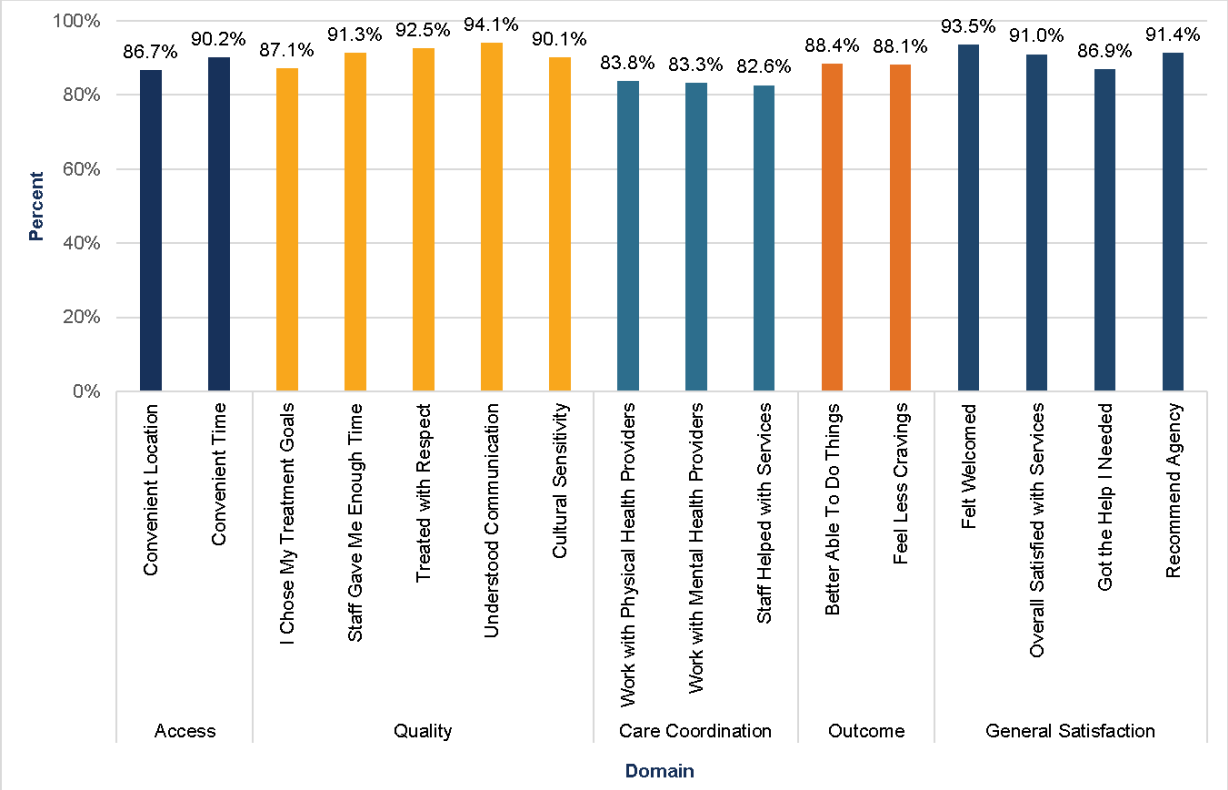
Data source: Treatment Perception Survey 2024

Percent in Agreement for Each Survey Item by Domain

Adults

As shown in Figure F9 below, the percentage of responses in agreement for each of the 16 survey items remained above 80 percent, indicating overall favorable perceptions of care among adults participating in the survey. Of the two questions with the highest percentages in agreement, one was in the Quality domain ("understood communication") scoring at 94.1 percennt; the other was in the General Satisfaction domain ("I felt welcomed") and scored at 93.5 percent. This was closely aligned with scores from previous survey administrations.

Figure F9: *Percent in agreement for each survey item by domain - adults*



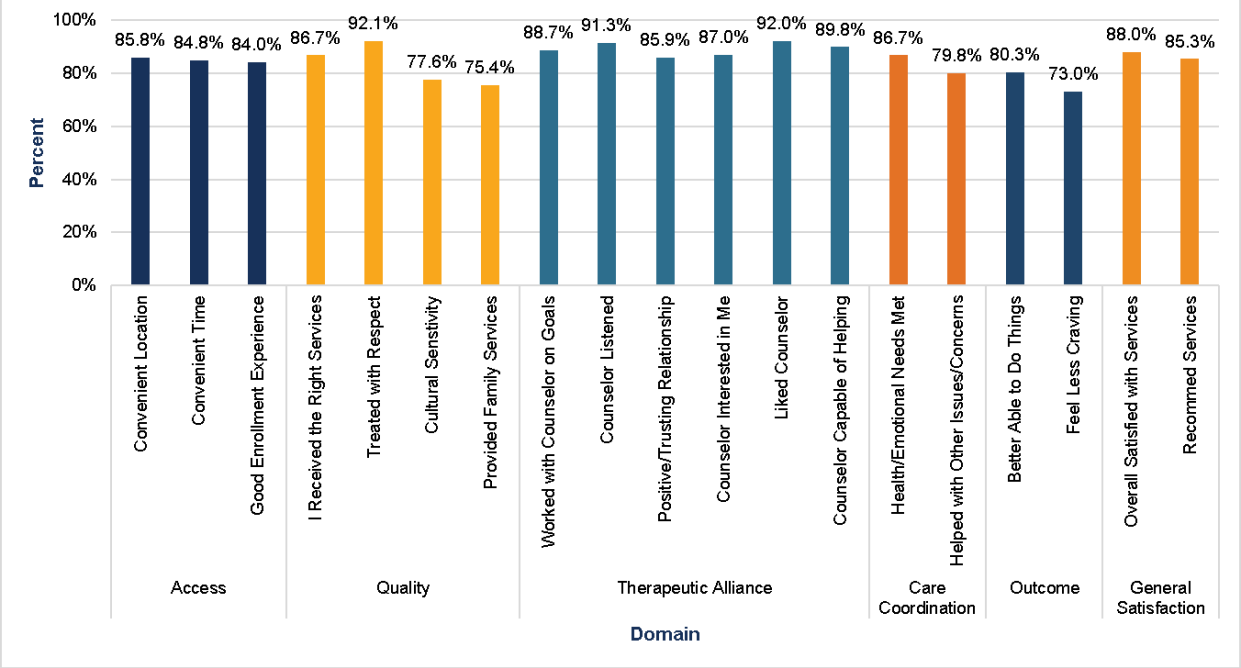
Data source: Treatment Perception Survey 2024

Youth

The percentage of youth responses in agreement for each of the 19 survey items was at least 73 percent (Figure F10). The survey items showing the highest percentages in

agreement were in the Quality domain at 92.1 percent ("treated with respect") and in the Therapeutic Alliance domain at 92 percent ("liked counselor"), followed by 91.3 percent ("counselor listened").

Figure F10: *Percent in agreement for each survey item by domain - youth*



Data source: Treatment Perception Survey 2024

Average Perceptions of Care/Satisfaction Score by Treatment Setting

Adults

The overall average score for adult survey respondents across the different treatment settings was 4.5, up from 4.4 in 2021. The overall average scores by treatment setting were 4.5 for OP/IOT, NTP/OTP and WM (standalone), and 4.3 for residential. Scores for adults in residential settings remain lower than other treatment settings, compared to previous survey administrations.

Youth

Among youth, the overall average score was 4.3, consistent with the 2021 rating. OP/IOT, with the highest number of respondents, scored at 4.3. Meanwhile, perceptions

of satisfaction in residential treatment setting increased to 4.4, compared to 2021 score of 4.2, although there were only 16 respondents.

Quality Improvement Efforts

County Administrator Feedback

County administrators have consistently reported that DMC-ODS has had a positive impact on quality of care in their counties, with 97 percent affirming this in both 2021 and 2022. This question was not asked in 2023 but will be asked again in future surveys. Most counties appreciated that DMC-ODS provided a more structured approach to services, standardized screening, placement, and treatment processes, and better monitoring requirements. Administrators also reported that the use of medical necessity criteria, ASAM LOCs, and evidence-based practices (EBPs) have elevated the standard of care and brought SUD services closer to parity with mental health programs. Respondents also noted significant improvements in maintaining consistent care across the SUD treatment continuum of care.

Through 2024, quality assurance audits and reviews from the EQRO were generally positive, reporting that the objective structured review process was seen as a valuable tool for identifying areas of strength and opportunities for growth. The process was widely appreciated for its collaborative nature, with several respondents noting that it felt more like a partnership than an audit. This data-driven approach supported the development of performance improvement projects (PIPs), informed decision-making, and encouraged counties to track key indicators such as access, timeliness, and outcomes more consistently. The process also helped counties focus attention on equity by prompting them to evaluate how services are delivered to special populations and how data is collected and interpreted through an equity lens. In this past year (2025) DHCS contracted with a new EQRO, Health Services Advisory Group (HSAG). It is still too early to fully assess the impact of this transition; however, UCLA will continue to monitor and evaluate the impact of these quality improvement efforts over time.

Goal 2: Increased adherence to and retention in Treatment

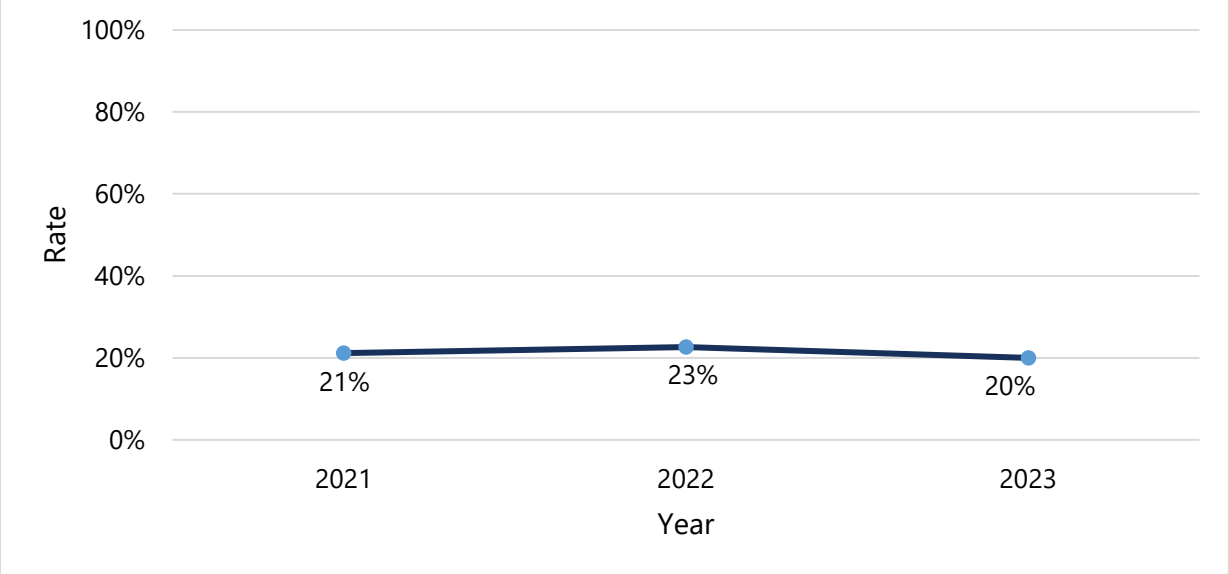
Hypothesis: Adherence and retention will be maintained at benchmark year levels or higher.

Adherence to and Retention in Treatment: Continuity of Pharmacotherapy.

To evaluate progress toward this goal, UCLA analyzed DMC claims data and measured the continuity of pharmacotherapy for 180 days. Specifically, the denominator includes the number of members 12 and older with an OUD who have at least one claim for an OUD medication. The numerator includes the number of members with an OUD who had at least 180 days of continuous pharmacotherapy. These numbers are somewhat higher than the monitoring metrics submitted by DHCS, likely because the numbers reported here are focused on Drug Medi-Cal claims, which contains data from a large number of opioid treatment programs while excluding medications for opioid use disorders prescribed in primary care and other settings outside of DMC-ODS.

From 2021 to 2023, the percentage of clients with at least 180 days of OUD medication experiences was very stable (Figure F11).

Figure F11. *Continuity of Pharmacotherapy for OUD for 180 days*



Data source: DMC claims, 2021-2023

Residential Services-Length of Stay (LOS)

In CY 2023, the average LOS for beneficiaries discharged from IMD inpatient/residential treatment for SUD was 25.2 days, a decrease from 30.7 days found at baseline (CY 2022), based on monitoring metrics reported by DHCS. While the state is showing a decrease or consistency toward the goal of a 30-day average residential LOS, county administrators were asked in 2022 how challenging it is to reach the average 30-day length of stay requirement. The majority (83%) of the 2022 county administrator survey respondents reported that it was somewhat or extremely challenging to reach this 30-day average. Three counties were undecided, and two counties noted it was somewhat or extremely easy. Administrators reported a range of strategies to manage residential treatment LOS. Common methods included medical necessity reviews, treatment authorizations, and use of ASAM Criteria to ensure appropriate levels of care. Some counties reported their averages were below 30 days when including residential withdrawal management and people leaving against medical advice, so the guidance had minimal impact for them. One county reported the guidance was helpful to ensure the least restrictive environment was being used. However, the majority of the 23 counties who provided comments cautioned that 30 days is not sufficient to stabilize many clients, with some specifically mentioning the unhoused, women with children, or those with more complex cases, and many explained that they did not have enough sober living homes to support discharging people after 30 days. They therefore expressed concern that the 30-day goal could be inconsistent with these needs. They did express appreciation for the opportunity to justify longer residential stays based on medical necessity, though some also pointed out the administrative burden this created.

Goal 3: Reduction in overdose deaths, particularly those due to opioids.

Hypothesis: People with opioid use disorders (OUD) who receive Medications for Addiction Treatment (MAT) and people with StimUD who participate in the Recovery Incentives Program will be less likely to have an overdose death compared to people with OUD and StimUD who do not receive these services, respectively.

The evaluation team is awaiting death data to test this hypothesis more directly, but opioid-related deaths in California fell from a 12-month rolling rate of 18.0 per 100,000 residents in Q4 2021 to 15.5 in the latest available preliminary data from Q3 2024. Over the same timeframe, psychostimulant (excluding cocaine)-related overdose deaths fell from 14.1 to 13.2, and cocaine-related deaths fell from 3.4 to 3.3.[46]

Goal 4: Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

Hypothesis: DMC-ODS implementation will be associated with reductions in utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

Due to managed care/fee-for-service data reporting lag, data to address this goal more fully is not yet available. However, progress on this goal was reported among participants in the Recovery Incentives Program, discussed below. This goal will be revisited in the final Summative Report.

Goal 5: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.

Hypothesis: DMC-ODS implementation will be associated with fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.

Readmissions to Withdrawal Management

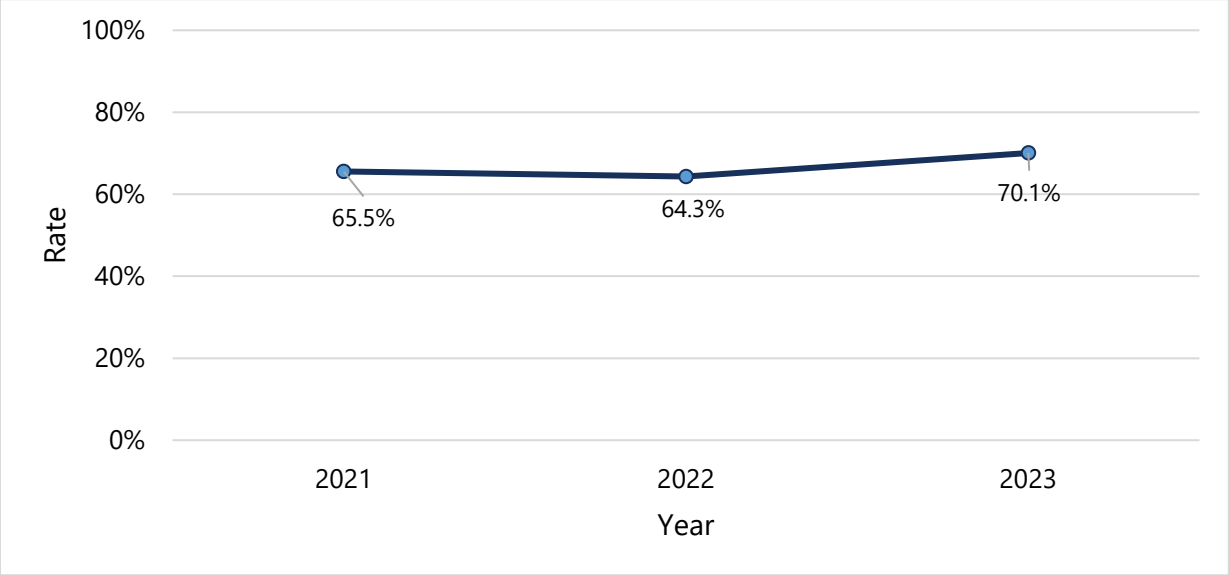
Using DMC claims data from 2019 to 2023, UCLA examined trends in readmission to withdrawal management among individuals aged 12 and older. This metric is defined as

[46] California Overdose Surveillance Dashboard, accessed September 1, 2025. Available at: https://skylab.cdph.ca.gov/ODdash/?tab=CA

the percentage of clients who receive an additional withdrawal management (WM) service within 30 days of their initial WM discharge.

As shown in Figure F12, after remaining steady from 2021 to 2022, there was an increase in this rate in 2023. It is unclear what caused this sudden increase or whether it will persist. UCLA will continue to explore this.

Figure F12. *Readmission to withdrawal management by year.*



Data source: DMC claims, 2021-2023

County Administrator Feedback

Many 2025 county administrator survey respondents reported that DMC-ODS positively impacted transitions of care within the SUD system in their county (84.0%).

On open-ended responses, most counties mentioned that DMC-ODS helped facilitate seamless transitions between appropriate levels of care and increased improvements in service retention. The majority of counties listed unstable housing, clients declining further treatment, comorbid mental health problems, and insufficient number of residential beds as the most problematic barriers that hinder clients from transitioning from withdrawal management to ongoing SUD treatment. Multiple counties reported that the factors having the greatest impact on successful transitions of care are an insufficient number of residential beds and unstable housing.

To combat re-admissions to WM services, counties suggested addressing insufficient numbers of residential beds, care coordination, increasing funding for temporary safe placements until residential beds become available, reimbursing allowances for transportation to care, and providing a highly skilled workforce to assist clients with connections to lower levels of care upon WM discharge.

Consistent with some of these suggestions, DHCS is currently seeking to address the insufficient number of residential beds through a large state investment in increasing capacity through the Behavioral Health Continuum Infrastructure Program (BHCIP).[47]

Goal 6: Improved access to care for physical health conditions among beneficiaries.

Hypothesis: DMC-ODS implementation will be associated with improved access to care for physical health conditions among beneficiaries.

Treatment Perceptions Survey (TPS)

In the 2024 Treatment Perception Survey, 83.8 percent of adult clients agreed that "staff here work with my physical health care providers to support my wellness," compared to 84.3 percent in the 2021 rating.

Perceptions from County Administrators

Coordination between Physical Health (PH) Services and SUD

On the 2021 county administrator survey, when asked if DMC-ODS positively impacted the integration of SUD and PH services in their county, 70 percent of county administrators (n=30) agreed that DMC-ODS improved SUD integration with PH services.

On the 2025 county administrator survey, 59 percent (n=39) reported a positive impact from the DMC-ODS. Part of this drop is attributable to counties that recently joined DMC-ODS and may not have experienced an impact yet. Among counties that did report a positive impact, commonly reported improvements include better coordination

[47] https://www.infrastructure.buildingcalhhs.com/

with primary care physicians, increased partnerships with Federally Qualified Health Centers, and enhanced care management[48] (ECM) practices. However, facilitators and barriers varied based on county size and infrastructure. Smaller counties reported geographic and access barriers, wait times and limited referrals. Larger counties noted improved linkages to medical care but highlighted persistent silos and expressed concerns about sustainability.

Coordination between MH and SUD

On the 2021 county administrator survey, when asked if DMC-ODS positively impacted the integration of SUD and MH services in their county, 67 percent of DMC-ODS county administrators agreed that DMC-ODS improved SUD integration with MH services.

On the 2025 county administrator survey, 69 percent reported a positive impact from DMC-ODS, demonstrating consistency over time. In open-ended responses, smaller counties reported the benefits of having more nimble systems and closer collaboration among providers, but faced resource limitations and training gaps, especially in psychiatric and MAT services. Larger counties reported facing complex system coordination challenges due to scale. Overall, county administrators noted improvements in access, collaboration, and awareness between mental health and SUD systems. Some reported better case management, shared screening practices, and increased parity in administrative resources.

[48] https://calaim.dhcs.ca.gov/pages/enhanced-care-managementhttps://calaim.dhcs.ca.gov/pages/enhanced-care-management

Goal 7: Improved health equity

Hypothesis: Health disparities will decrease

Access to Treatment

Table F2. *Difference-in-difference estimates of the effect of the introduction of DMC-ODS on unique number of clients, by gender and race/ethnicity.*

	Male	Female	AIAN	Asian/PI	Black	Hispanic	White
DMC-ODS Waiver	11.1%**	13.1%***	24.2%	-13.9%	5.1%	7.0%	12.1%**

	Youth	Age 18-25	Age 26-35	Age 36-45	Age 46+
DMC-ODS Waiver	38.3%**	17.9%**	15.9%**	13.5%***	6.20%

Data source: DMC Claims.

*Notes: Effect of the introduction of DMC-ODS on the unique number of clients receiving services in DMC claims, by subgroup. *** indicates statistical significance at the 1% level, ** indicates statistical significance at the 5% level.*

As shown in Table F2, DMC-ODS had a significant positive effect on the unique number of both male and female clients treated, as well as White clients. That is, post-DMC-ODS implementation, the number of male, female, and White clients significantly increased relative to state plan counties. Changes in client numbers among other racial and ethnic groups were not significantly different. Among age groups, the introduction of DMC-ODS significantly increased access among all age groups except ages 46 plus years, with effect sizes ranging from a 13.5 percent increase for ages 36-45 years to a 38.3 percent increase for youth ages 12-17 years.

In the prior Summative report, UCLA reported evidence of an increase in access for Black and Hispanic members, but these earlier results did not control for time-varying demographic and economic factors, and the period of analysis was only 2016-2019. After updating the analyses to include data through 2023, including eight new counties that implemented the waiver between 2019 and 2023, and including time-varying demographic and economic controls, the results on access by race/ethnicity changed, UCLA no longer observed positive impacts of the waiver on Black and Hispanic

members. Assessing the sensitivity of the results, UCLA first replicated its prior analyses using only 2016-2019 data but included the time-varying demographic and economic controls. For Hispanic members, once UCLA included the additional controls for changing demographic and economic factors, the statistically significant effect observed in the Summative report disappeared. For Black members, once UCLA included the demographic and economic characteristics, the effect remained statistically significant but decreases in magnitude. Next, UCLA extended its analysis through 2023 and included the time-varying demographic and economic controls, and the eight new counties that implemented the waiver between 2019 and 2023. For Hispanic members, UCLA continued to find no statistically significant impact of the waiver on access. For Black members, the faded effect appears to reflect either true COVID-19 related disparities, as research suggests COVID-19 had a larger negative effect on SUD admissions for Blacks compared to Whites[49], or diminishing efforts in waiver counties to maintain improved access over time. For White members, the estimated effect of the waiver is largely driven by the later-adopting counties, which tend to have a higher percentage of White individuals and a lower percentage of Black or Hispanic individuals in their populations compared to DMC-ODS counties that went live earlier.

Treatment Initiation among beneficiaries with an ASAM Criteria-based brief screening by demographic groups

No meaningful differences were found across age, gender, or racial/ethic groups.

Timely admission to indicated Level of Care by demographic groups

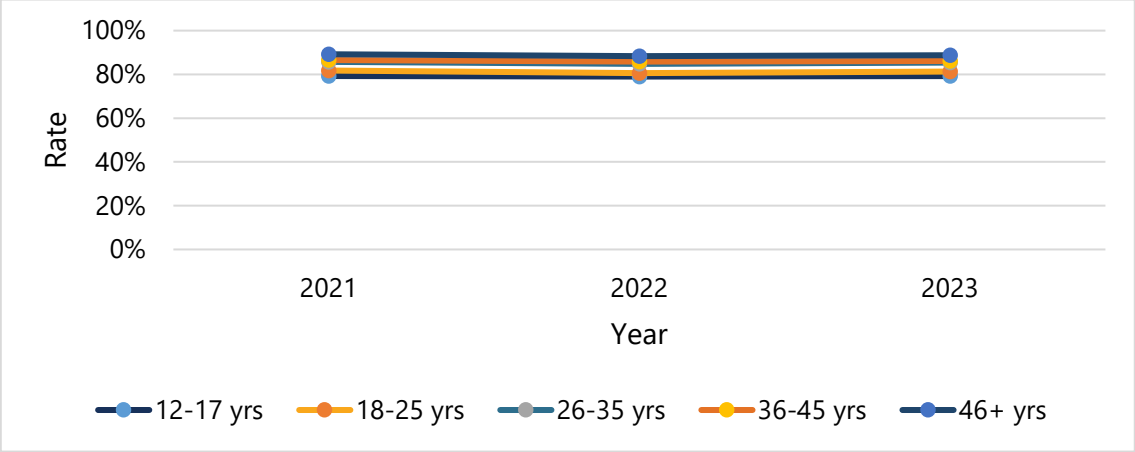
No meaningful differences were found across age, gender, or racial/ethic groups.

Treatment engagement by demographic groups

Older individuals are generally more likely to engage in subsequent SUD treatment compared to their younger counterparts. Figure F13 plots the trends for all five age groups: engagement remained relatively stable throughout most of the period.

[49] Cantor, J. H., Whaley, C. M., Stein, B. D., & Powell, D. (2022). Analysis of substance use disorder treatment admissions in the US by sex and race and ethnicity before and during the COVID-19 pandemic. *JAMA Network Open*, *5*(9), e2232795-e2232795.

Figure F13. *Treatment engagement by age.*



Data source: DMC claims, 2021-2023.

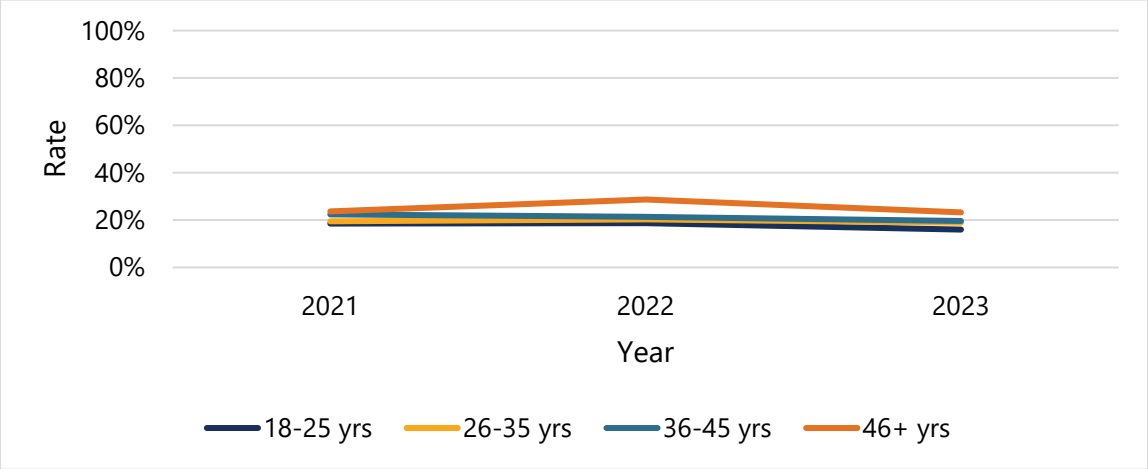
From 2021–2023, engagement rates were consistent across race, ethnicity, and gender.

Continuity of Pharmacotherapy

Between 2021 and 2023, rates of continuing pharmacotherapy for 180 days were associated with age group, with increasing rates with each successive age group, especially among the 46+ group. In 2023, clients in the oldest age group had continuity rates of 23.3 percent compared to 16.0 percent among clients aged 18-25 (Figure F14). Note: The sample size for people aged 12-17 was too small to report during the sample period.

From 2021 to 2023, the continuity of pharmacotherapy for OUD treatment was stable across all racial and ethnic groups, though AIAN rates rose sharply from 15.6 percent in 2021 to 21.6 percent in 2023. In 2023, all rates fell within a narrow band from 20.1 percent to 21.6 percent, with the exception of a modestly higher rate of 25.2 percent among Asian/Pacific Islander clients. Rates were also consistent between genders over time.

Figure F14. *Continuity of Pharmacotherapy for OUD (by age)*



Data source: DMC claims, 2021-2023.

Readmissions to Withdrawal Management

No single demographic group appeared to be driving the state's increase in readmissions in 2023.

There were no meaningful differences by age group. Nearly all groups experienced increases from 2021 to 2023 ranging from 3.9 percentage points (Hispanic clients) to 6.9 percent (Asian/Pacific Islander clients). AIAN clients experienced a decrease in readmissions (down 3 percentage points).

Among males, readmission rates increased 3.9 percentage points (66.6% to 70.6%) and among females they increased 5.5 percentage points (63.5% to 69.0%).

In summary, access increased more among White members compared to other groups, but there were no other consistent racial/ethnic differences on other measures, nor any meaningful disparities by gender. Older adults did slightly better than younger ones on measures of engagement and continuity of pharmacotherapy.

Goal 8: An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes.

Hypothesis: Effective implementation will lead to improvements in client retention, discharge status, self-reported outcomes, drug test results, deaths, and healthcare utilization among clients participating in the Recovery Incentives Program.

Program Launch and Enrollment Status

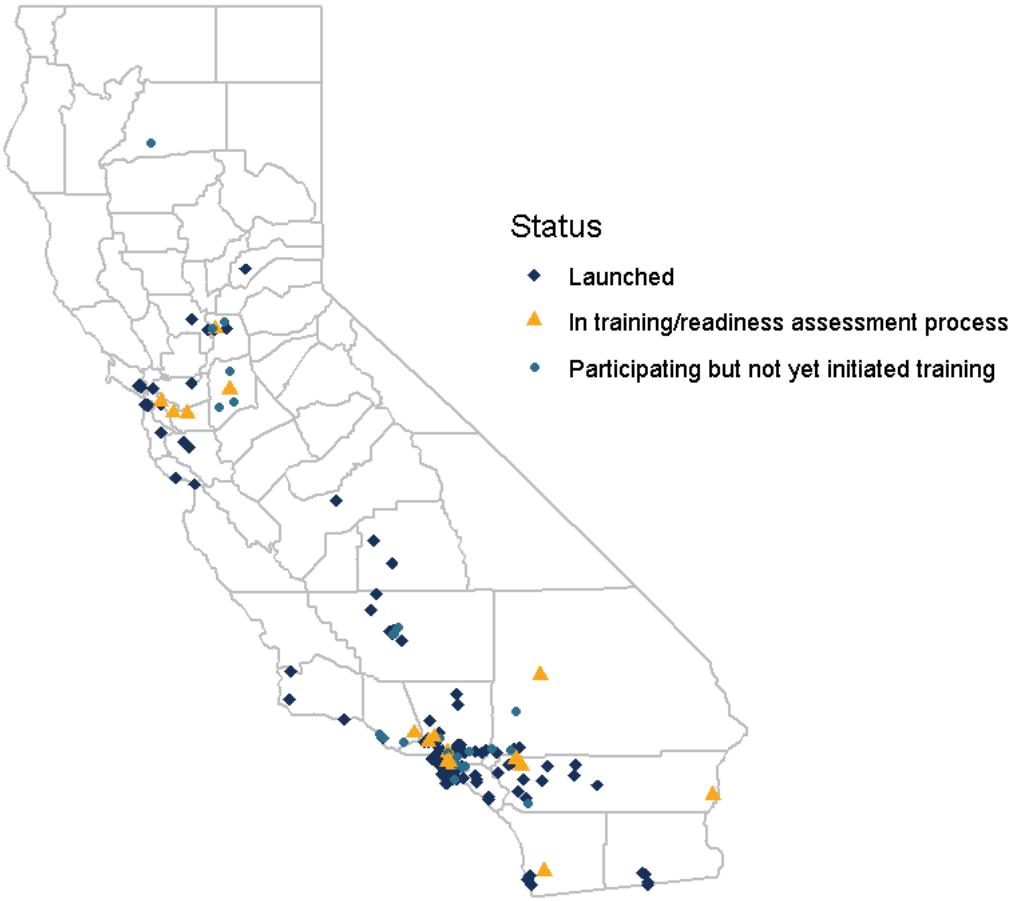
As of July 31, 2025, 24 counties have applied to participate in the CA Recovery Incentives Program, with 21 counties having at least one approved site offering CM services. One county withdrew due to staffing challenges beyond their control, which prevented them from hiring staff and finalizing the process to implement CM services. Two additional counties are actively working toward initiating CM service sites. Currently, the total number of programs that have opted in to participate in the Recovery Incentives Program is 157. This number fluctuates, as counties are continually adding, modifying, or removing sites for a variety of reasons, as described in the County Administrator Survey results.

Among these 157 programs, 111 are currently approved to launch, while 46 are either in the training and readiness process (17 programs) or have not yet engaged in the training process (29 programs). Figure F15 shows the locations of these 157 sites. Los Angeles County was an early adopter, and sites are relatively concentrated in Southern California, and to a lesser extent the Bay Area. This distribution is consistent with a map of population density in California, suggesting Recovery Incentives Program sites are launching in areas with the highest density of Medi-Cal members. While metropolitan development is expected due to population density and resources, there remains a distinct need to address access and services in rural communities.

A little over half of all Recovery Incentives Program provider sites and clients are in two counties: Los Angeles and Riverside. Although these are large counties, their proportion of the state's Recovery Incentives Program sites and clients outpaces their share of the state's population (31%) and stimulant overdose deaths (29%).

These counties may have lessons learned to share with other counties as they seek to expand participation.

Figure F15. *Geographical representation of launched and pending sites for the Recovery Incentives Program as of July 31, 2025.*



Data source: CM Site Readiness and Launch Status Tracking Log. Map created with R statistical software using longitude and latitude data processed from ArcGIS.

According to launch status data maintained by the UCLA Training and Implementation Support Team, delays in the first year of implementation were primarily due to Clinical Laboratory Improvement Amendments (CLIA)-related issues (43%), followed by staffing and hiring issues (21%). All facilities in the U.S. that perform testing on human specimens (including urine) for health assessment or the diagnosis, prevention, or treatment of disease are regulated under CLIA. These requirements are intended to

ensure safety and quality. The point-of-care urine drug tests used in the Recovery Incentives Program are required to be CLIA-waived tests, meaning they are simple to use and have a low risk for erroneous results.[50] However, DMC-ODS providers must still obtain a CLIA "waived test" certification and be registered with the California Department of Public Health (CDPH) or be accredited by an approved accreditation body. Providers can apply online for both CLIA Waiver and State Lab Registration through Laboratory Field Services, part of CDPH. It can take up to six months for CDPH to process applications once they are correctly submitted.[51] According to the UCLA Training and Implementation Support Team, DHCS has worked with CDPH staff over the course of implementation to expedite the process and as a result current application processing times are shorter than they were at the outset of the Program's launch. Improved guidance and experience have led to more streamlined administrative processes, and programs and counties are better equipped to accurately complete the necessary steps in the application process. Consistent with this, one county administrator reported that an earlier lab registration time was very long, but a more recent one was fast. The proportion of sites waiting to launch but delayed by CLIA waiver issues had fallen from 43 percent in the first year to 26 percent (12/46) as of September 2025.

Member Participation through June 2025

The number of new clients participating in the program has accelerated rapidly, growing from 13 new clients in April 2023 to over 500 new clients per month just two years later. Figure F16a presents the cumulative number of clients enrolled, while Figure 16b shows the acceleration in new clients being enrolled each month. If the June 2025 rate of 534 new clients/month is sustained, this would reach 6,408 clients per year. According to CalOMS-Tx data, there were 25,921 unique clients with Medi-Cal who were admitted to outpatient treatment for stimulant problems (primary or secondary) in 2024, which suggests the program is already reaching about 25 percent of these clients statewide.

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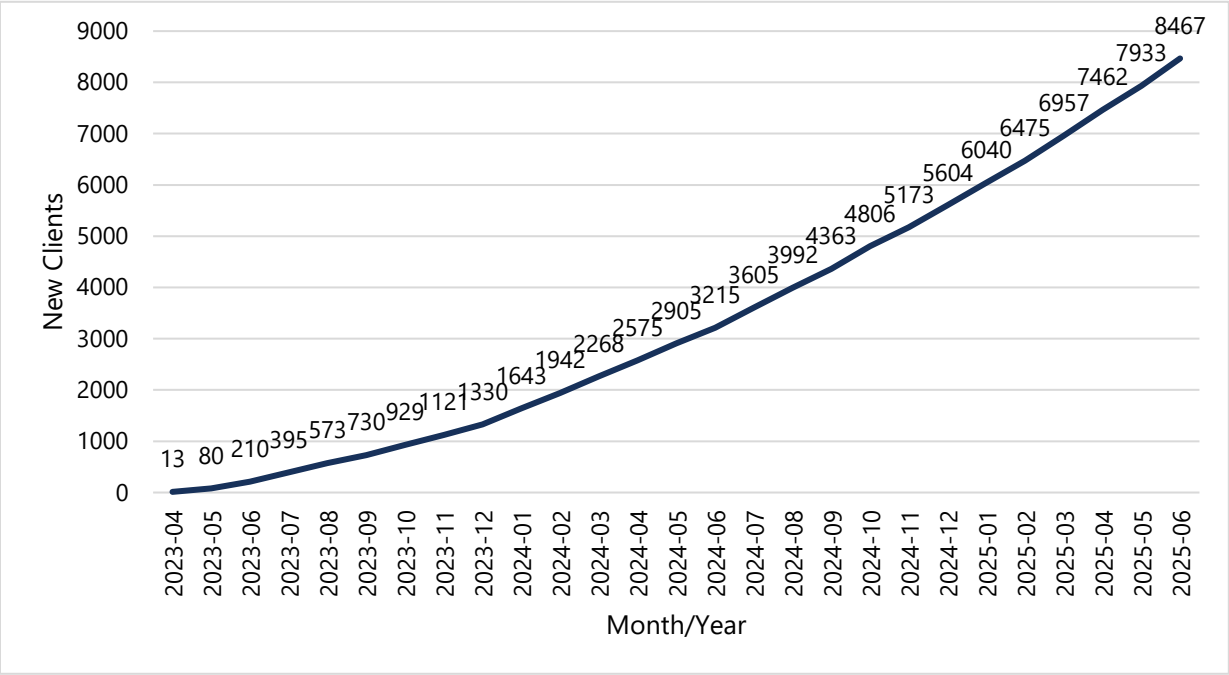
[50] https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/HowObtainCertificateofWaiver.pdf

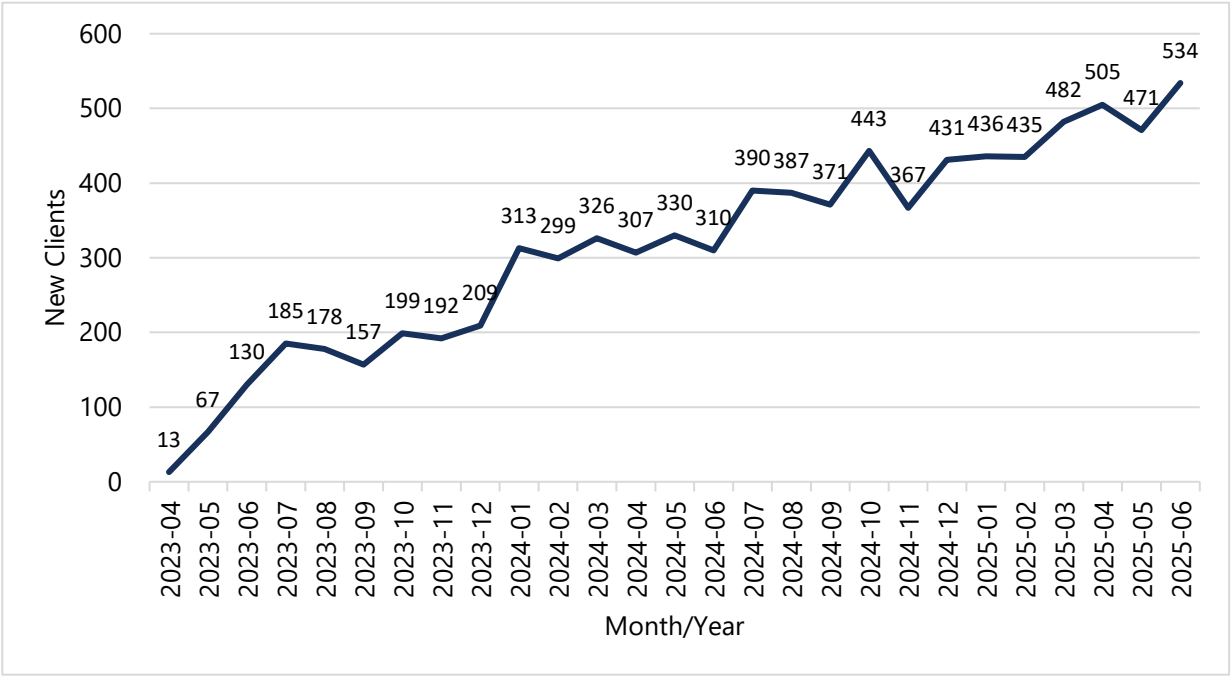
[51] Peck, J.A., Freese, T.E., & Rutkowski, B.A. (2023). Recovery Incentives Program: California's Contingency Management Benefit Program Manual. Available at: https://www.uclaisap.org/recoveryincentives/docs/training/Program-Manual-with-Appendices-2024-08-02.pdf

Figure F16a. *Recovery Incentives Program cumulative monthly enrollment (April 2023-June 2025).*



Data source: Client Incentive Manager data

Figure F16b. *Recovery Incentives Program new clients by month (April 2023-June 2025).*



Data source: Client Incentive Manager data

Table F3. *Provider and Client Characteristics from Surveys, and Client Incentive Manager/MMEF/CalOMS-Tx*

	Provider Survey (N = 244)	Client Cross-Sectional Survey (N = 547)	Client Incentive Manager Data (N = 7,351)	Client Longitud-inal Survey (N = 222)
Race/Ethnicity	N = 229	N = 520	N = 6,254	N = 222
American Indian/Alaska Native	1.8%[a]	-	0.9%[a]	-
Asian/Pacific Islander	6.6%[a]	-	2.1%[b]	-
Black	6.1%[a]	11.7%[ab]	12.8%[b]	8.6%[ab]
Hispanic/Latino	37.6%[a]	46.5%[ab]	53.3%[b]	48.2%[ab]
White	39.7%[a]	28.1%[b]	27.3%[b]	21.6%[b]
Another	1.8%[ab]	0.0%[a]	1.7%[b]	-
Multiple races	6.6%[a]	10.2%[a]	1.7%[b]	13.5%[a]
Gender Identity	N = 235	N = 530	N = 6,254	N = 222
Male	34.9%[a]	54.5%[b]	60.2%[b]	59.5%[b]
Female	64.3%[a]	-	39.6%[b]	-
Another gender identity	0.9%[ab]	-	0.2%[b]	-
Sexual Orientation	N = 228	N = 505		N = 222
Straight/Heterosexual	87.3%[a]	81.8%[a]	N/A	84.7%[a]
Gay or Lesbian	7.5%[a]	8.1%[a]	N/A	9.0%[a]
Bisexual	4.4%[ab]	7.9%[b]	N/A	-
Another	0.9%[ab]	-	N/A	-
Multiple sexual orientations	0.0%[a]	-	N/A	0.0%[a]
Age	N = 239	N = 414	N = 6,254	N = 222
18-25	2.1%[a]	7.0%[ab]	7.2%[b]	5.4%[ab]
26-34	15.5%[a]	33.8%[b]	35.7%[b]	30.6%[b]
35-44	30.5%[a]	31.6%[a]	33.4%[a]	36.4%[a]
45-54	25.9%[a]	17.9%[ab]	15.4%[b]	15.8%[ab]
55-64	23.6%[a]	-	7.1%[b]	-
65+	2.1%[a]	-	0.7%[a]	-

	Provider Survey	Client Cross-Sectional Survey	Client Incentive Manager	Client Longitud-inal Survey
Language Client Selected for Survey		N = 547		N = 222
English	N/A	97.0%[a]	N/A	-
Spanish	N/A	3.0%[a]	N/A	-
Client Week in Program		N =547		N =222
Weeks 1-2	N/A	10.9%	N/A	100.0%
Weeks 3-4	N/A	16.5%	N/A	0.0%†
Weeks 5-12	N/A	35.8%	N/A	0.0%†
Weeks 13-24	N/A	26.0%	N/A	0.0%†
Weeks 24+	N/A	10.8%	N/A	0.0%†

N/A = Not Applicable; a,b Percentages with different letters on the same row differ significantly (p<.05). - = Suppressed for privacy due to small cell size, or if inclusion would enable calculation of a small cell size; Provider survey data as of July 31, 2025; Client Cross-sectional data collected Feb/Mar 2024; Incentive Manager Data as of April 30, 2025; Client Longitudinal data collected May/June 2025. † = Clients were in weeks 1-2 when they started the longitudinal survey.

Provider and Client Characteristics

Table F3 contains information on the participants in the provider and client surveys, as well as clients in the Incentive Manager data merged with MMEF and DMC Claims.

Client survey participant demographics were similar to the demographics of all clients in the Incentive Manager data, suggesting the client survey was representative of all Recovery Incentives Program clients. Providers were significantly more likely than clients to be White, female, heterosexual, and older than the participating clients.

In addition to the information provided below, treatment providers reported on their roles and experience. Only 5 percent of providers reported having less than 1 year of experience, 62 percent had 1-10 years of experience, and 33 percent had more than 10 years. 40% reported that their primary role was CM supervisor, 41 percent were CM coordinators, and 19 percent were backup CM coordinators.

Recovery Incentives Program Outcomes

In June 2025, UCLA received Incentive Manager Vendor data from DHCS containing data on members who participated in the Recovery Incentives Program. This dataset contained

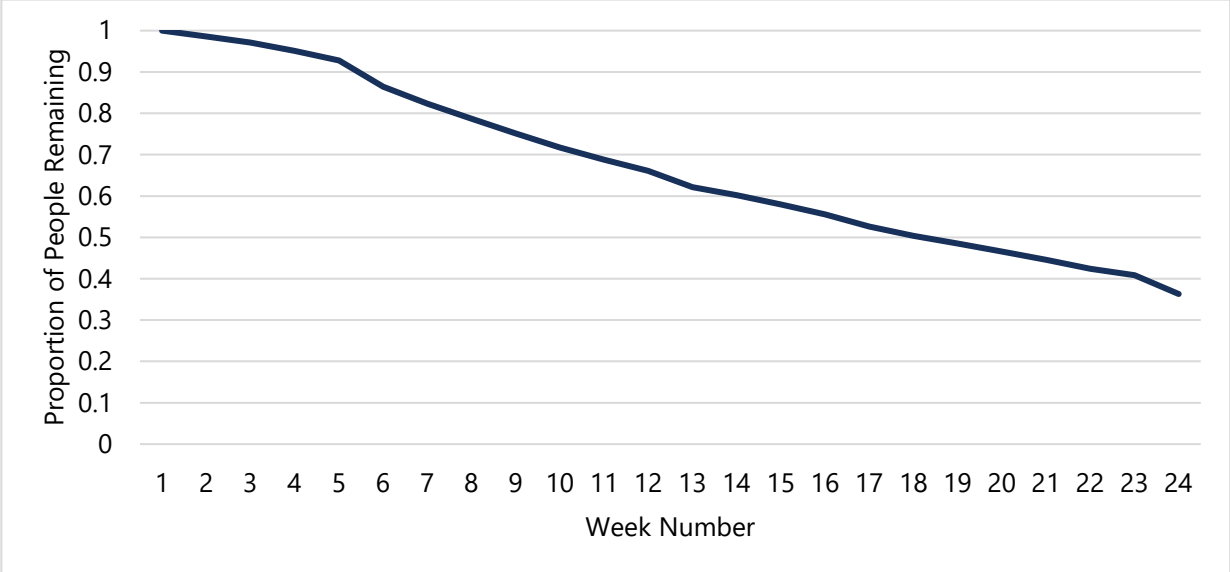
records for 7,351 unique participants who participated in the program between April 3, 2023, and April 30, 2025.

Participants in the program can re-enroll if they have not earned $599 within any calendar year. If participants enrolled, UCLA included only their first participation in the program in the analyses that follow. UCLA also limited its calculations to just the clients that had the ability to complete the program, meaning they needed to be in the program for at least 24 weeks. This resulted in a sample size of 5,010.

Recovery Incentives Program Retention

Figure F17 below shows the retention curves for the 5,010 clients in the analysis sample. As shown in the figure, there are no clear drop off points in the program even when the incentive schedule changes at week 12. Rather, people exit the program at a relatively steady rate over the course of the 24-week program. Clients spent an average of 15.6 weeks in the program, and the median was 17.1 weeks.

Figure F17: *Cumulative Frequency Distribution of participation duration of the 5,010 clients who had the opportunity to complete the full CM program*



Data source: Client Incentive Manager data. Participation duration of the 5,010 clients who had the opportunity to complete the full CM program. This figure is limited to participants' first time in the CM program; it does not reflect those who re-entered the program.

Rates of Positive, Negative, and Missed Drug Screens

As of April 30, 2025, there were 7,351 unique clients (unique clients refers to distinct individuals who have undertaken a urine drug test or UDT. Each unique client is counted once, regardless of the number of tests they have undergone), resulting in 132,244 negative and 5,791 positive drug results. There were also 8,501 excused absences and 38,183 unexcused absences.

For clients who met the inclusion criterion of being able to complete the CM protocol (defined as those who started the program at least 24 weeks before the data cutoff date of April 30, 2025), there were 5,010 unique clients with 103,704 negative drug results and 4,884 positive drug results, alongside 6,607 excused absences and 30,485 unexcused absences.

Table F4 summarizes the UDT results of the 5,010 clients who were eligible to complete the program. These results are further broken down by 4 retention groups based on their time in treatment.

Table F4. *Retention and drug test results among all clients who had time to complete the program*

RETENTION			% NEGATIVE UDT RESULTS		
Definition	N	%	Submit-ted	Unexcused absences = positive	Among all possible tests
Completed 24 weeks	1,819	36.3%	96.0%	86.0%	86.4%
Completed 12 weeks, not 24	1,493	29.8%	96.3%	72.0%	55.9%
30 days but not 12 weeks	1,164	23.2%	90.9%	45.3%	17.7%
one session but less than 30 days	534	10.7%	81.0%	30.2%	4.8%
TOTAL	5,010	100%	95.5%[1]	74.8%[**]	52.6%[2]

**Eligible to complete the program - each client enrolled at least 24 weeks before 4/30/2025*

[**] Not a value currently found in literature

[1] Significantly better when compared to literature values at the $p < 0.001$ level

[2] Significantly better when compared to literature values at the $p < 0.05$ level

As shown in the table, 36.3 percent of clients completed the full 24 weeks, while another 29.8 percent completed at least 12 weeks, meaning more than 66 percent of the clients who were eligible to complete the program finished at least Phase 1 (or 12 weeks). In contrast, only 10

percent of the clients failed to complete 30 days. Additionally, the clients that stay in the program longer tend to have better UDT results.

The UDT results are split into two different categories. The '% negative' column gives the percentage of negative UDTs for all tests taken. The '% negative counting unexcused absences as positive' provides a more conservative view of the UDT results in assuming that every time a client had an unexcused absence for an appointment, they would have tested positive for stimulants. In reality, this is likely an overly conservative assumption because preliminary surveys in progress suggest that when a client misses an appointment, it is usually because of a scheduling conflict, rather than using stimulants. Therefore the true percentage of negative UDTs likely lies somewhere between these rates reported for these two categories.

As a whole, the program has resulted in 95.5 percent negative drug test rate and, with a conservative approach, 74.8 percent negative drug test rate when assuming all unexcused absences would be positive.

Comparisons to the CM Literature

For context, in the CM program implemented in the Department of Veterans Affairs, 92 percent of samples were negative, compared to 95.5 percent in the Recovery Incentives Program.

As described in the methodology section, UCLA also reviewed clinical studies in the CM literature to calculate the percentage of negative results among submitted tests. The average, weighted for study size, was 85.3 percent. The 95.5 percent rate in the Recovery Incentives Program is therefore higher than the results in CM trials. Preliminary analyses suggest this difference may be attributable to clients in the Recovery Incentives Program who transitioned from previous treatment outpatient or residential treatment and were relatively stable at the time they started in the program. Among clients who had used stimulants recently when they started the Recovery Incentives Program (comparable to participants in CM trials), 87 percent of submitted tests were negative, similar to the 85.3 percent in the literature.

An alternative measure is the percentage of negative urinalysis outcomes out of *all possible* tests. This measure conservatively treats missed tests the same as positive tests, even if some of these tests would have occurred after the client discontinued treatment. As discussed in the methodology section, a search of the literature produced a weighted average of 47.7 percent, which is exceeded by the 52.6 percent found in the Recovery Incentives Program.

The number from the literature is based on studies that included a mix of both recent and non-recent stimulant users.

Stimulant Use Results by Subgroup

To further examine UDT and retention outcomes in the Recovery Incentives Program, UCLA merged the Incentive Manager data with CalOMS-Tx. In doing so, UCLA was able to identify specific subcategories of clients to show how the program works for people at different stages in their recovery.

Looking at just the clients who were eligible to complete the program, meaning they started 24 weeks before the data cutoff point of 4/30/2024, UCLA was able to identify 2,384 clients that had had a CalOMS-Tx admission within 30 days of their start date in the Recovery Incentives Program. UCLA expects to identify more clients in the future, but are currently limited by data reporting lag.

Table F5 below shows the groups UCLA was able to extract from the 2,384 clients from the merged Incentive Manager and CalOMS-TX data. These groups consisted of:

- Recent Users (N = 695) - Clients that reported more than 0 days of stimulant use in the previous 30 days around the time of their start date in the program
- Started following residential treatment (N = 727) - Clients that were recently discharged from residential treatment before their Recovery Incentives start date
- Started following outpatient treatment without Residential (N =573) - Clients that were admitted to outpatient treatment within 6 months before their Recovery Incentives start date and had not been discharged prior to starting the program. This group is mutually exclusive from groups 1 and 2.

Other (N = 389) - Clients that did not fall into any of the above categories. The ‘other’ group could include people who are living in sober living facilities, previously were incarcerated, or had been in other controlled environments like hospitals.

Table F5. *UDT and Retention results by baseline categories.*

	RETENTION			% NEGATIVE UDT RESULTS		
Recent Users	Definition	N	%	Submit-ted	Unexcused absences = positive	Among all possible tests
	Completed 24 weeks	169	24.3%	90.4%	77.6%	79.4%
	Completed 12 weeks, not 24	167	24.0%	87.0%	58.1%	44.2%
	30 days but not 12 weeks	210	30.2%	76.8%	31.7%	12.0%
	One session but less than 30 days	149	21.4%	66.0%	21.6%	3.5%
	TOTAL	695	100%	87.0%	59.1%**	34.3%
Starting following Residential Treatment	Definition	N	%	Submit-ted	Unexcused absences = positive	Among all possible tests
	Completed 24 weeks	299	41.1%	99.7%	91.2%	90.1%
	Completed 12 weeks, not 24	253	34.8%	99.5%	79.3%	62.0%
	30 days but not 12 weeks	132	18.2%	98.4%	60.1%	24.6%
	One session but less than 30 days	43	5.9%	98.3%	44.1%	7.2%
	TOTAL	727	100%	99.5%	83.3%**	63.5%
Started following Outpatient Treatment	Definition	N	%	Submit-ted	Unexcused absences = positive	Among all possible tests
	Completed 24 weeks	242	42.2%	99.0%	86.0%	89.1%
	Completed 12 weeks, not 24	169	29.5%	97.2%	75.0%	57.2%
	30 days but not 12 weeks	122	21.3%	96.7%	50.5%	20.8%
	One session but less than 30 days	40	7.0%	89.7%	29.4%	5.7%
	TOTAL	573	100%	98.2%	77.8%**	54.4%
Other	Definition	N	%	Submit-ted	Unexcused absences = positive	Among all possible tests
	Completed 24 weeks	181	46.5%	98.8%	90.0%	90.8%
	Completed 12 weeks, not 24	109	28.0%	98.4%	71.8%	57.2%
	30 days but not 12 weeks	70	18.0%	96.1%	47.1%	17.7%
	One session but less than 30 days	29	7.5%	92.9%	48.2%	7.5%
	TOTAL	389	100%	98.5%	80.3%**	62.0%

**Eligible to complete the program means started at least 24 weeks before 4/30/2025*

*** Not a value currently found in literature.*

As shown the table above, all groups had mostly positive retention and UDT results. The clients who stepped down from residential treatment did exceptionally well with more than 75 percent of these clients completing at least Phase 1 of the Program and overall having a 99.5 percent negative UDT rate (83.3% when counting unexcused absences as positive UDTs). The outpatient and other groups also performed very well with both groups having over 70 percent completing at least Phase 1 and over 98 percent negative UDTs. The 'Recent Users' group performed noticeably worse than the other groups, but still almost 50 percent of these clients completed Phase 1 and overall 87.0 percent of the UDTs taken were negative.

These results suggest the Recovery Incentives Program is effective for people at all stages of Stimulant Use Disorder treatment. Both recent users and clients who transitioned into the program from residential treatment are responding positively to the program.

Demographic Results

UCLA compared the UDT and retention results across age, race, and sex demographics and found no statistically significant differences between any groups. UCLA will continue to monitor outcomes by demographics as the program continues to grow.

Recovery Incentives Program Engagement

Treatment Engagement is defined by the National Committee for Quality Assurance as the percentage of clients who engaged in ongoing treatment, including two additional interventions or medication treatment events for SUD, or one long-acting medication event for the treatment of SUD, within 34 days of the initiation.[52] Using the Incentive Manager data, UCLA defines engagement as the percentage of clients who took two or more UDTs in the 34 days following their Enrollment Date, a variable created in the Incentive Manager dataset, in the Recovery Incentives Program.

Of the 7,351 clients enrolled in the program as of April 30, 2025, 6,794 had been enrolled for at least 34 days and were eligible to meet the engagement criteria defined above. Of these, 6,290 clients took two or more UDTs within their first 34 days, resulting in an engagement rate of 92.6 percent

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[52] https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/

Recovery Incentives Program Discharge status

Of the 5,010 clients in the Incentive Manager data that were eligible to complete the program, 2,385 had an admission record in CalOMS-Tx within 30 days of their Recovery Incentives Program start date. Of these, 1,705 had discharge records, and among these, 1,089 (63.9%) had a successful discharge status.[53] For comparison, in 2022, prior to 'Incentives Program implementation, 39.7 percent of outpatient Medi-Cal clients with stimulants as their primary or secondary drug problem had a successful discharge, suggesting clients in the Recovery Incentives Program are far more likely to succeed.

Client Cross Sectional Survey Results

Client survey results from the cross-sectional study were analyzed by demographic variables (race/ethnicity, gender identity, sexual orientation, and age). No statistically significant, meaningful differences were detected between groups. The results below are therefore described in aggregate across all demographic groups.

A summary table of survey and interview results can be found in Attachment E. More detailed results could not be included to remain in compliance with DHCS deidentification guidance.

Self-reported substance use, perceptions, and related behaviors (last 30 days)

As shown in Table F6, 89 percent of clients who had participated in the Recovery Incentives Program for more than four weeks reported not using any substance in the last month.

Notably, among clients who were participating in week 1 or week 2, 69 percent also reported no use of stimulants in the past 30 days. This suggests many participants had reached some level of abstinence before entering the Recovery Incentives Program, consistent with analyses showing many entered after having participated in residential or outpatient treatment, and provider interview feedback that it was easier to recruit existing clients to the program than to bring in new ones directly from the community.

Most respondents in the program did not feel their drug use was out of control, but the majority reported having a drug problem, spending time using or craving drugs, and that their drug use had caused problems with people close to them. The answers regarding the time they spent using drugs appears inconsistent with their reported days of use, suggesting

[53] Successful discharges are defined by the CalOMS discharge status categories indicating the person completed treatment plan & goals or left before completion with satisfactory progress.

clients may have misunderstood one question or the other. UCLA will attempt to gain further clarification using the currently ongoing client longitudinal survey.

Table F6. *Client self-reported drug use perceptions, and related behaviors*

Question (past 30 days, clients in the program for 4+ weeks)	Result	N
How many days have you used stimulants?	89% zero days	452
How many days have you used drugs and alcohol, other than stimulants?	88% zero days	471
I felt that my drug use was out of control	72% not at all	480
I had a drug problem	31% not at all	475
I spent a lot of time using drugs	51% not at all	481
I craved drugs	31% not at all	474
My drug use caused problems with people close to me	55% not at all	476

Data Source: CM Cross-sectional survey. Responses from members who had participated in the Recovery Incentives Program for more than four weeks.

Client perceptions of the impact of the Recovery Incentives Program on their treatment and outcomes

Nearly all participants (90%+) reported that the Recovery Incentives Program had a positive impact on their treatment, helped them stop using stimulants, and helped them across an array of outcomes ranging from better health to being a better member of the community.

Participants were also asked about their use of emergency rooms and hospital stays. Fewer participants responded to this question compared to others, perhaps suggesting some participants had not used emergency rooms or hospitals previously and felt the question was not applicable to them. However, among the 333 clients who did respond (61% of participants), 80 percent reported the Recovery Incentives Program had a positive impact on their use of emergency rooms or hospital stays.

Table F7. *Client perception of the program on their treatment and outcomes*

Question (all clients)	Result	N
How much of a positive impact did the intervention have on your treatment response? *(1= no impact, 10 = definite impact)*	91% positive (6+ rating)	508
Did the Program help you stop using stimulants? *(Yes, it helped me a lot, Yes it helped me a little, No it made no difference, No, it had a negative impact)*	91% Yes (a little / a lot)	539
Did the Program significantly help you economically? *(Yes, it helped me a lot, Yes it helped me a little, No it made no difference, No, it had a negative impact)*	93% Yes (a little / a lot)	534
Has your health improved? In what way and how much? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc.? *(1 = none or not much better, 10=much better)*	90% better (6+rating)	510
How much better are you with stimulant use? Consider the frequency and amount of use, money spent on stimulants, amount of drug craving, time spent being high/drunk, being sick, in trouble, and in other drug-using activities, etc. *(1 = none or not much better, 10=much better)*	82% better (6+rating)	476
Are you a better member of the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people? *(1 = none or not much better, 10=much better)*	92% better (6+ rating)	516
How much better are you in taking care of personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments? *(1 = none or not much better, 10=much better)*	95% better (6+ rating)	519
How much of a positive impact did the Program have on how often you visited an emergency room or stayed overnight in a hospital for a physical health problem? *(1 = had no impact, 10= had a definite impact)*	80% positive (6+ rating)	333

Data Source: CM Cross-sectional survey. Responses from members who had participated in the Recovery Incentives Program for more than four weeks.

Understanding the Recovery Incentives Program Procedures

Clients reported overwhelmingly that the procedures were easy to understand, with 82 percent reporting it was very easy to understand, and another 16 percent reporting it was relatively easy. Only 2 percent of clients found the procedures difficult to understand. Ratings of the Recovery Incentives Program Elements

Table F8. *Client ratings of program elements.*

How beneficial is each of the following aspects of your treatment for stimulant use (1 = Not Beneficial at all 10 = Extremely Beneficial)	Result (6+ rating)	N
Urine drug testing	94%	506
Gift cards	93%	504
Discussions with CM staff	92%	469
Individual counseling	92%	494
Case management	91%	458
Group counseling	90%	482

Data Source: CM Cross-sectional survey. Responses from members who had participated in the Recovery Incentives Program for more than four weeks.

Clients were asked how beneficial various aspects of the program were to their treatment. Overall, each aspect was reported to have more benefit than not, with the gift cards and urine testing receiving the highest ratings.

Incentive Options

Most participants (90%) also reported overwhelmingly being "quite a bit" or "very much" satisfied with the gift card incentive options offered as part of the Recovery Incentives Program.

Client Longitudinal Survey Results

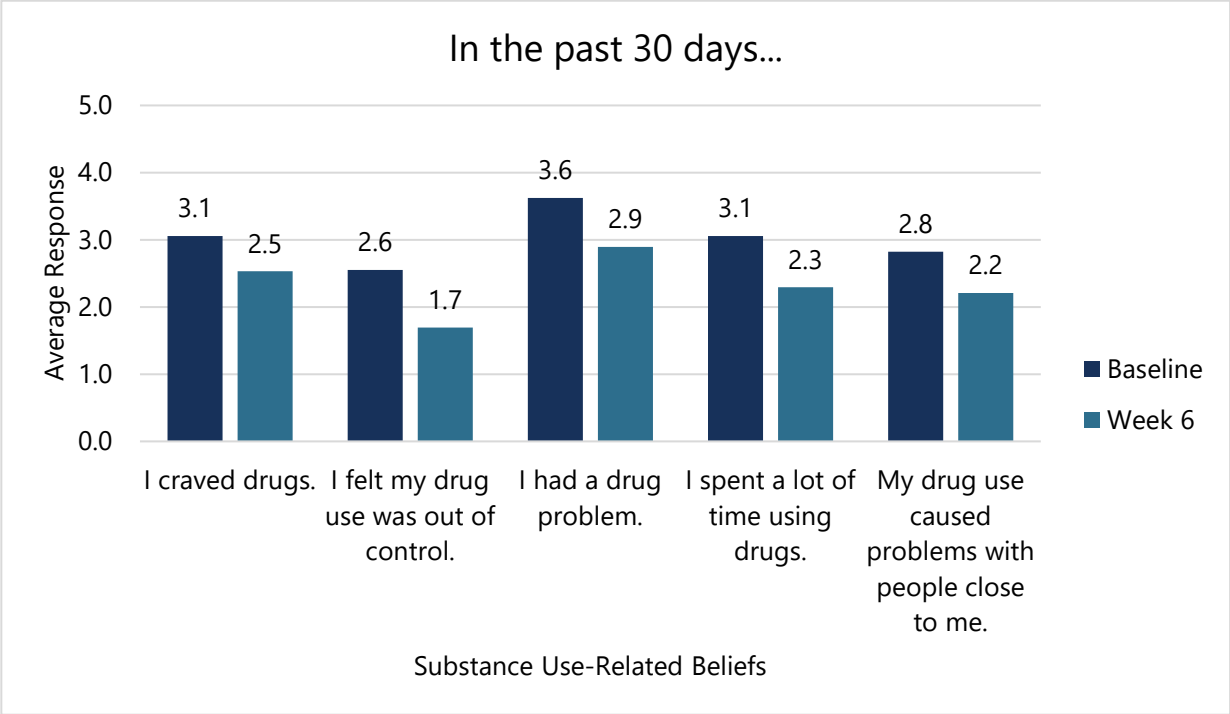
As described in the methodology section, the cross-sectional client survey laid the foundation for a longitudinal survey now underway. As with the cross-sectional survey, longitudinal study results were analyzed by demographic variables (race/ethnicity, gender identity, sexual orientation, and age), but no statistically significant, meaningful

differences were detected between groups. The results below are therefore reported in aggregate across all demographic groups.

Figures F18-F20 below show preliminary results from clients who had taken both the baseline and week 6 surveys (N = 145) as of the data cut-off date of 7/31/2025. These results will be updated after the survey progresses through weeks 14 and 28.

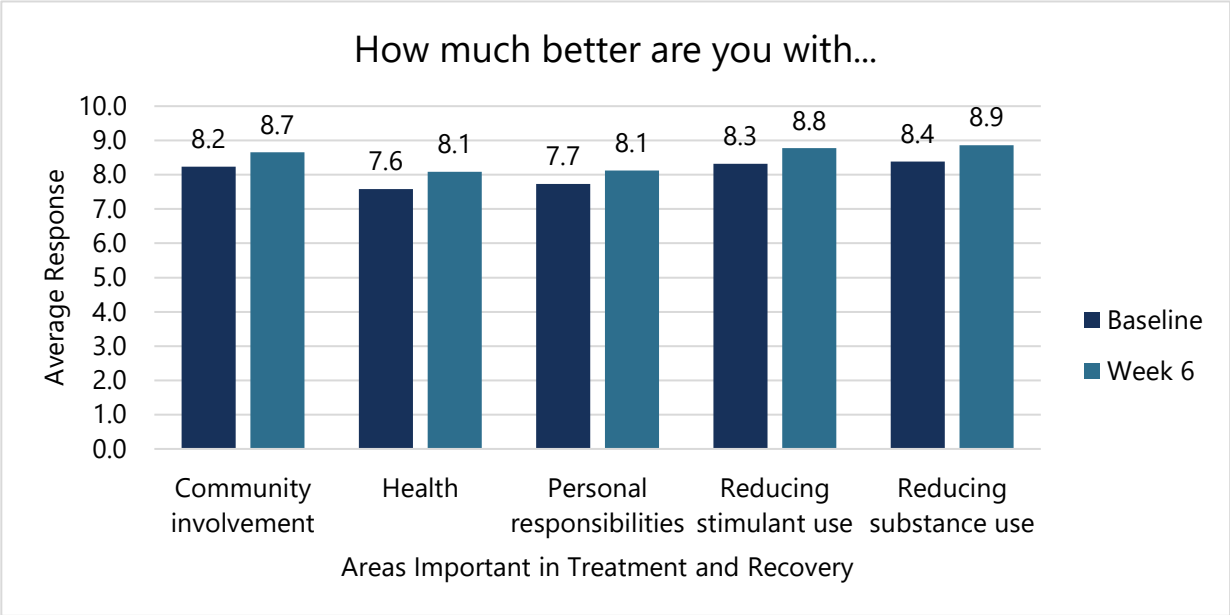
These figures show how clients have progressed during the first six weeks of the program. The measures shown represent all the questions asked at baseline and at week six and every measure showed improvement. Clients on average felt better about their drug use, cravings, overall health and responsibilities, and have reported less stimulant and other drug use. Though preliminary, these results indicate that clients are improving in many different facets of their life while in the Recovery Incentives Program.

Figure F18. *Client ratings of substance use-related beliefs in the last 30 days at baseline and week 6 (1=Not at all, 5=Very much).*



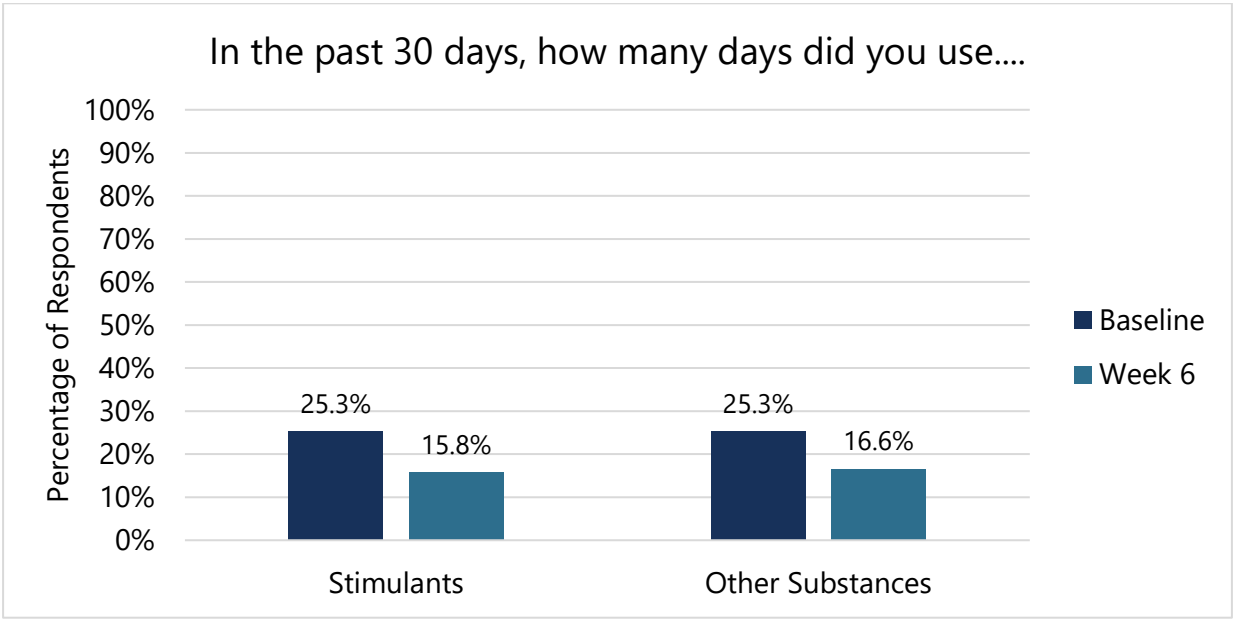
Data source: CM Client Longitudinal Survey. PROMIS Scale. (N=145)

Figure F19. *Client ratings on their health, lifestyle, and community at baseline and week 6 (1=Not at all, 10=Much better).*



Data source: CM Client Longitudinal Survey. TEA Assessment. (N=145)

Figure F20. *Client reports of substance use in the past 30 days at baseline and week 6.*



Data source: CM Client Longitudinal Survey. (N=145)

UCLA plans to ask clients for consent for additional follow-up data collection beyond the planned final Week 28 survey, and will assess the feasibility of further data collection after receiving client responses.

Implementation of an effective and accessible CM program

County administrators, treatment providers, and clients all provided feedback on the Recovery Incentives Program that was consistent across groups. See Attachment E for a summary table of survey and qualitative responses by group.

County Administrator Survey Results

Three key themes emerged from responses to qualitative open-ended County Administrator Survey questions regarding the Recovery Incentives Program: (1) positive clinical impacts, (2) implementation facilitators and barriers, and (3) reasons counties chose not to participate.

Positive clinical impacts

Administrators in counties that were implementing the Recovery Incentives Program reported that the service was having a positive impact. Respondents wrote that their Recovery Incentives Programs had *"wonderful participation, retention, and outcomes"* and *"high abstinence rates among participants,"* while clients participating in the program *"tend to be more engaged with their other services and tend to stay in the program longer."* Beyond positive outcomes and increased engagement, administrators reported that the Recovery Incentives Program also helped motivate clients to engage in treatment and make positive change. *"(The) Recovery Incentives Program has provide(d) motivation to our clients,"* wrote one respondent. *"Clients look forward to their testing days, as it brings a boost (to) their confidence and (shows) recovery is achievable."* County administrators reported that client success in the Recovery Incentives Program has provided positive examples of recovery and countered stigma. One administrator highlighted the fact that progress in recovery is not always linear, and that does not take a punitive approach towards substance-positive UDT results. *"It does not eliminate members for not being perfect,"* this administrator wrote, *"but allows members to continue in the program"* regardless of their test results. As such, the Recovery Incentives Program created a *"supportive network"* that did not previously exist for many clients.

Implementation facilitators and barriers

Overall, administrators reported that the Recovery Incentives Program has been a wonderful opportunity to expand services in an innovative, thorough, and well-designed manner. *"It's great to be able to offer a new benefit to clients with stimulant use disorders,"* wrote one respondent, while another commented that the program was *"a thoughtful introduction of an evidence-based practice into the system of care through an approach that includes clear guidelines for fidelity to the model, training, and ongoing monitoring of the implementation and its outcomes."*

Some respondents noted that the training and support that has been provided to programs statewide has been particularly helpful since it has reduced the amount of work that counties have had to do to support implementation. *O*ne administrator explained that it *"reduces the burden on the county and ensures closer fidelity."* Others reported appreciating the straightforward mechanisms for billing and *"streamlined standards for service"* in the program, since it facilitated easy administrative implementation, though some suggested that program sustainability could be enhanced if reimbursement rates for Recovery Incentives Program services were higher.

Overall, however, providers reported that *"this (Recovery Incentives Program) is a very good model for rolling out any new benefit/service."* Yet, some counties reported having initial challenges implementing the Recovery Incentives Program benefit. The most pressing concern respondents reported were the *"burdensome"* requirements that sites needed to fulfill before they could begin delivering services. As one county reported, it was *"way too difficult to get going."* In particular, county administrators reported that delays receiving approval for CLIA Waivers were *"painful,"* running so long that it negatively impacted implementation. One county reported that it took 18 months to get approval to launch their Recovery Incentives Program, and that *"by the time we got close to implementing, [the] start-up funds were no longer available,"* further complicating efforts to begin delivering services. Another county administrator described how *"because of delayed implementation of the program, enthusiasm waned dramatically and eroded trust in the sustainability and viability of the program."* Nearly all providers who were originally planning to participate in the Recovery Incentives Program in this county chose not to participate by the time they were approved for service delivery. However, one administrator noted recent improvements in CLIA processing, "Originally lab (registration) time was very long but we just did another, and it was fast."

Other barriers to implementation included staffing and concern about future resources. Counties reported that *"staff turnover has impacted (providers') ability to effectively implement and sustain the program"* and that staffing shortages has served to *"limit (the) number of clients enrolled"* in Recovery Incentives Program services. Several counties also reported that ambiguity about future funding to support Recovery Incentives Program has made it difficult for them and their providers to make plans to promote future sustainability of the service.

Despite these concerns, administrators from counties participating in the Recovery Incentives Program had positive opinions of the program in their survey comments. As one administrator summarized, *"California has led in this area, in terms of offering this option (for contingency management services) through Medicaid, which is fantastic."* Many administrators reported that the program was working well enough that they would like to see the Recovery Incentives Program benefit expanded to be available to all clients, not just those with StimUD. In particular, they suggested that contingency management could be effective with individuals who have opioid use disorders or cannabis use disorders.

Reasons counties chose not to participate

Of the 15 respondents who reported that their counties were not participating in the Recovery Incentives Program, nine reported that they declined to participate because they did not have enough staff. Respondents reported that staffing issues at both the county- and provider- levels stopped them from participating in the program since they needed to focus on other priorities. At the county level, respondents reported that administrative staff did "not have the (staffing) to oversee a pilot program that is optional" and that they needed to dedicate their "limited infrastructure" towards initiatives that were "mandates" and "required services".[54] They noted that keeping up with CalAIM-required policy changes was time-consuming and left them little capacity to begin delivering another service. At the provider level, administrators noted that treatment programs "(already) struggle with staffing for all levels of care…providers are not ready to add this…providers were not interested." Respondents also reported that the program had "too many requirements," and two counties reported that they originally wanted to participate, but they were unable to finalize their Recovery Incentives Program processes and start implementing services. Other reasons for non-participation reported by counties included lack of support from their board of supervisors and county counsel, already implementing another form of contingency

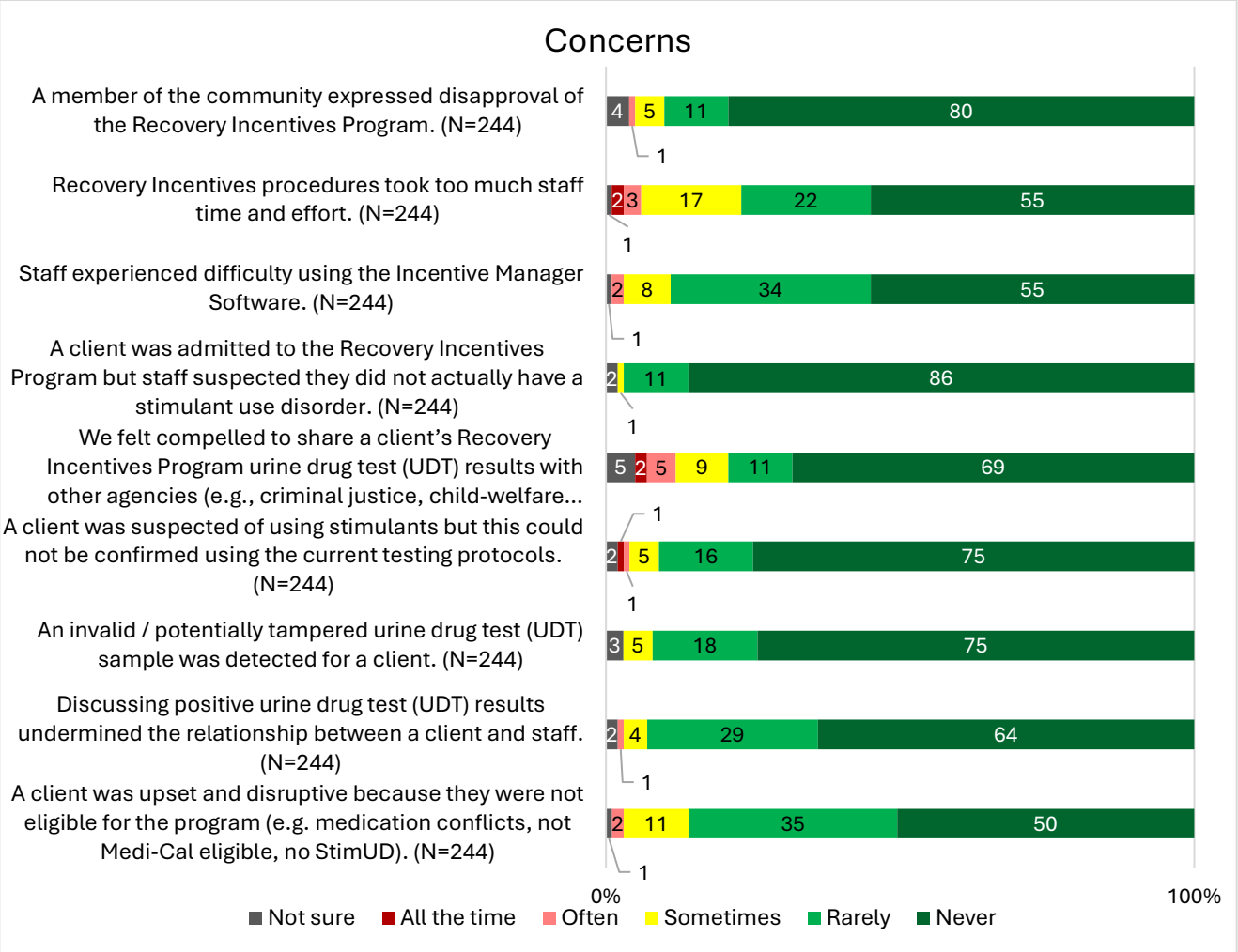
[54] CalAIM did not require any new DMC-ODS services, but respondents may have been referring to other Medi-Cal benefits and mandates more generally.

management outside of the Recovery Incentives Program (one response), and a belief that they did not have enough clients with StimUD to justify participation (small county response).

Provider Survey Results

Initial Implementation Concerns Reported from Readiness Assessments

Figure F21. *Provider reports on the observed frequencies of initial concerns surrounding the implementation of the Recovery Incentives Program.*



Data source: CM Provider Survey. Responses from 244 providers.

The concerns in Figure F21 were generated from Program Readiness Assessments conducted prior to implementation. After five months of implementation, providers were asked via survey how frequently these issues actually occurred. Overall, despite their initial concerns,

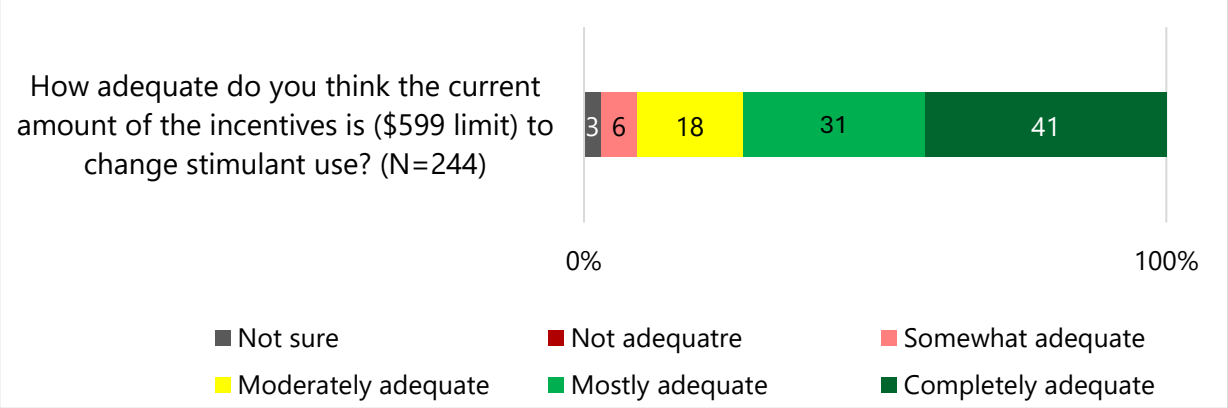
once they started implementing the program, providers reported that these issues generally rarely or never occurred (Figure F21).

Training and Readiness

Most respondents (91%) rated the training as either 'Mostly' or 'Completely' sufficient on a scale ranging from "not sufficient" to "completely sufficient." This indicates that most found the training adequate for their needs. Similarly, the vast majority of respondents (89%) also felt qualified or properly trained to deliver the CM intervention. Only a small number disagreed or were unsure.

Impressions about the Incentive Amount

Figure F22. Provider impressions of the adequacy of incentive amounts from the Recovery Incentives Program.



Data source: CM Provider Survey. Responses from providers who have answered the question (N=244).

Providers were asked their thoughts on the adequacy of the current amount of the incentives ($599 annual limit) to change stimulant use. Using a scale from "Not adequate" to "Completely adequate," most providers (72%) reported that the incentive amounts were mostly or completely adequate to change stimulant use (Figure F22). At the same time, 55% did not feel the amount was completely adequate, or they were unsure. This suggests providers felt the amount is adequate to create change, but that higher amounts would be needed to be completely adequate. A review of contingency management incentive

amounts[55] concluded the median inflation-adjusted incentive amounts used in studies that achieved a medium to high effect size was $128/week, which would translate to $1,536 for a 12-week program, far higher than the program's current $599 limit.

Incentive Manager Software

Providers reported generally positive ratings across all aspects of the Incentive Manager software, with 95 percent rating it good to excellent overall. Among individual elements, "Customer support" was rated especially high (93%).

Qualitative Analysis of Open-Ended Client Survey Responses

Two key themes that emerged in client survey comments on the Recovery Incentives Program, both related to program effectiveness: (1) Incentives as drivers of recovery; and (2) Building towards a better future.

Incentives as drivers of recovery

Participants reported that at a basic level, the benefits of negative UDT results in the Recovery Incentives Program were highly motivating. For many clients, receiving incentives while proceeding in their recovery was what one termed a "*'a win-win situation*" that allows clients to get something they want while also engaging in the work of overcoming their StimUDs. One client described how the positive reinforcement of the Recovery Incentives Program transformed abstinence from stimulants from an unpleasant task into a desirable goal. "*It made me want to collect more vouchers instead of doing more drugs*." As another participant wrote, "*the idea of getting a lump sum of money at the end of my testing period gets me so excited to come back clean*" that it sparked recovery. "*Now*," another client explained, "*I feel rewarded for being sober*."

For some clients, the promise of positive reinforcement helped them through moments of craving and temptation to use stimulants. One participant described how the prospect of not receiving an incentive "*made me think twice every time I wanted to use*," and how "*it was a reminder not to use every time I had a trigger*." Others described how the contingency

[55] Rash CJ, Black SI, Parent SC, Erath TG, McDonell MG. Data-Driven Contingency Management Incentive Magnitudes: A Review. JAMA Psychiatry. Published online July 2, 2025. doi:10.1001/jamapsychiatry.2025.1341

management intervention enabled them to "*rationalize the pros and cons between using (stimulants) or getting that incentive*" and think about how "(*if they used stimulants) I would not make my next incentive, so I didn't even want to do drugs*." As one participant elaborated, "*even when I craved to use drugs or alcohol, I knew it would give me a positive test when I go for my incentive drug screen test…it made me aware that (drug use) is going to mess up the good things I have going on in my life*."

For many clients, the Recovery Incentives Program created a sense of accountability that motivated positive change. "*The program kept me accountable for my actions and rewarded me for good behavior*" explained one client, while another noted how "*having any sort of attainable achievements for recovering addicts who start from nothing helps build confidence*." Conversely, the potential frustration of not receiving an incentive was highly motivating; one individual described how "*having a dirty UA (UDT result) in the first part of the program really bugged me*" and changing behavior because "*I didn't want to keep showing up with dirty UAs*." For these clients, focusing on trying to receive incentives "*helped me stay positive and set a goal for myself*" and made "*it feels like I'm working towards something*."

Overall, the ability to provide for themselves and others thanks to the financial resources they gained from the Recovery Incentives Program was significant for many participants. As one survey respondent described, thanks to the program "*I was able to get things that I didn't have to steal. I was able to buy food and clothes and be happy about not going to the store to steal something*."

Building toward a better future

For many clients, the Recovery Incentives Program has helped them progress towards recovery after years of trying with other treatments. "*I've been in drug treatment programs since I was 16 years old*," wrote one participant. "*I'm 43 years old now. And I had never passed a drug test—until I started here*!" Another client wrote "*I'm a chronic relapser—and this has made me want to stay sober*."

Beyond helping them abstain from stimulants, Recovery Incentives Program participants reported how the program has kickstarted them on a broader journey towards improved health and better lives. They described how their reductions in stimulant use have brought about significant improvements in sleep, diet, blood pressure, kidney function, liver function, breathing, physical activity, physical strength, and a general sense that "*I don't feel sick anymore*." They described how mentally they now feel more "*clear minded*," understand

things better, and are no longer "*hearing voices*" or "*seeing meth monsters*." As one participant elaborated, "*I feel and look healthier, my mind is clear, and I am starting to feel human again*!"

Other clients reported that incentives were also helping them start rebuilding their lives in recovery. "*It helped me start saving for my future*," said one client, while many described how they purchased clothing, work boots, or equipment they would use to re-enter the workforce. Others described how they used their incentives to begin healing relationships that had been damaged while they were using stimulants, purchasing pizza or holiday gifts for their children, family members, and other loved ones.

Participants also reported dramatic improvements in their self-care, functioning, and social lives since beginning the Recovery Incentives Program. One described finally going to see a dentist for the first time in years after neglecting their teeth, a pregnant woman reported that she went to an Ob-Gyn for the first time to tend to her health and that of her baby. Others described how they now feel more responsible than they were before, that they socialize more, and that they are starting to rebuild relationships in recovery. Several wrote about becoming more engaged in their communities, contributing with acts of kindness and service (e.g. "*I make time to pick up trash in my community*", "*I help others in sobriety by taking them to (12-step) meetings and supporting them*"). One dramatically contrasted life before the Recovery Incentives Program and life now. "*I'm no longer stealing, running around late hours of the night committing crimes*," this person wrote. "*I'm now paying taxes and helping out in the community*."

Overall, participant comments highlighted how much the Recovery Incentives Program helped them not only reduce substance use, but also salvage their lives. As one participant summed up, "*I'm a productive member of society and happy*."

Qualitative Analysis of Provider Interviews

Provider Interview Findings

The following themes emerged from provider interviews: (1) spreading awareness of the Recovery Incentives Program and encouraging participation (program reach); (2) barriers to Recovery Incentives Program participation (program reach); (3) how incentives facilitate recovery (program effectiveness); (4) the Recovery Incentives Program's impacts on client engagement (program effectiveness); (5) implementation barriers and facilitators (program

implementation) ; and (6) shifting beliefs about contingency management over time (program effectiveness).

Spreading Awareness of the Recovery Incentives Program and Encouraging Participation

Providers reported engaging in some efforts to publicize the Recovery Incentives Program in their communities, putting up flyers and making presentations at health centers, homeless shelters, homeless encampments, bus stations, schools, colleges, and libraries. In some places, providers reported that this type of community outreach required significant efforts since *"it's not as easy as just like putting up a flier—you have to go through (administrative) channels and get approval"* to publicize contingency management services. Despite these efforts, providers did not report receiving large numbers of new clients coming to their program specifically seeking out CM services.

However, providers reported that for clients who were already participating in their program or who were starting treatment without knowing about CM were relatively easy to engage in the Recovery Incentives Program. As one counselor summarized, whenever seeing a client with a StimUD diagnosis, they explain the program and *"They go 'OK, I'm in. Sign me up.' It's really just like a self-promoting program."*

One provider used a different approach, describing how they would "pitch" CM to clients as a way to achieve their treatment goals without having to utilize a higher level of care in plain language:

> *"When doing outreach, 'recovery incentive contingency management' is too long. You've already lost their (potential participants) attention. You're not gonna grab them with that. We talk about reframing the incentives program, that 'what we're trying to do is encourage you to not use on a regular basis, and try to address barriers to that without you having to go to detox or residential'…(I) talk to them about it being a positive treatment asset."*

While many clients are eager to participate in the Recovery Incentives Program as soon as they learn about it, providers reported that there are some clients who are more reluctant. Providers described these clients as being in the *"pre-contemplative or contemplative"* stages of change, and not yet ready to commit to abstinence from stimulants. *"Sometimes they (clients) feel like 'oh, it's gonna be too much—I'm not gonna be able to do it."* As one provider explained, their approach was to wait until clients were ready to engage in contingency

management and be ready to support them when they were prepared to consider participating.

> *"I let 'em know they can think about it, (say) 'Just let me know' whenever they wanna join. I give 'em the consent form so they can go over it and then I let them know to circle any questions (they have) and come see me—I'm here all the time and we can go over it together. Usually, I'll follow up with them or their counselor to see if they're interested. And then most of the time they're like 'Yeah, sign me up.'"*

Providers also said that information about the Recovery Incentives Program spread quickly through word of mouth in waiting rooms, groups, and sober livings where clients frequently interact. Once clients hear about the program and the potential to receive incentives, according to these providers, they begin asking if they can participate.

Barriers to Recovery Incentives Program Participation

Though most interviewees did not report significant difficulty enrolling clients in the Recovery Incentives Program, they did mention three barriers to program participation: transportation issues, telehealth, and busy schedules.

Several providers reported that transportation barriers preclude participation in the program for some individuals. For clients who live far from outpatient programs or who cannot access public transportation easily, the Recovery Incentives Program requirement to physically visit a program twice each week can be too time-consuming for clients. Even for those who try to access transportation services through Medi-Cal, providers reported that limited availability and logistical challenges (e.g. needing to schedule rides over a week in advance, drivers who sometimes don't show up) can create difficulties. Although these challenges are not specific to the Recovery Incentives Program, the consequences of these barriers are heightened by the twice-weekly testing requirement with incentive value resets for missed tests.

One provider reported that engaging clients accustomed to receiving treatment via telehealth in the Recovery Incentives Program is difficult because they do not want to travel to the clinic for testing:

> *"We have a problem here because we do Zoom. We do telehealth. That's the challenge here, is that a lot of people do all their sessions using telehealth, and they don't want to come here twice a week to do the contingency management.*

That's why we haven't had a ton of people. That's always the reason. 'I don't wanna travel there two days a week.'"

The literature on contingency management delivered by telehealth and mobile phone applications is mixed, and it has not been established that it will work as well as in-person treatment.[56,57] While some studies have shown promise, some were published with reported conflicts of interest, and at least one small study found that patient engagement was low[58] While these technologies hold great promise for increasing access, a cautious approach is warranted.

Providers also reported that clients who are required to engage in other activities as part of their treatment and recovery plan (which in some cases may be intertwined with mandates from the criminal justice system) can have difficulty fulfilling Recovery Incentives Program requirements for in-person testing twice a week. As one provider explained:

"For (clients) doing alternative sentences it's a very intense program…they're attending about nine groups a week. They are required to look for employment, work, go to twelve-step meetings, work with the sponsor, meet with their counselors on a weekly basis. So, we are already putting so much on their plate. And we understand…now adding the contingency management program where they have to come in twice a week is just another thing they have to do."

How Incentives Facilitate Recovery

In interviews, providers consistently reported that the Recovery Incentives Program is highly effective, even for clients who have historically had difficulty abstaining from stimulant use. *"We have (clients with) twenty-seven and a half years of stimulant use, so this is a way of life*

[56] McKetin R., & Clay S. (2024). Virtual contingency management, what is it worth and who will pay for it? *Addiction, 119*(9), 1517-1518.
[57] Khazanov G. K., McKay J.R., & Rawson R. (2024). Should contingency management protocols and dissemination practices be modified to accommodate rising stimulant use and harm reduction frameworks? *Addiction, 119*(9),1505-1514.
[58] Stitzer, M., Fletcher, J.B., Gryczynski, J., Mitchell, S.G., (2024). App-based contingency management for polysubstance use: An exploratory analysis of engagement and spending patterns. Poster presented at the College on Problems of Drug Dependence, June 16, 2024. Montreal, Canada.

(for them)," explained one provider. "Seeing the response (to contingency management) has been wonderful."

Providers reported that as clients reduced their stimulant use, they would begin to make other positive changes in their lives, testing negative for use of substances other than stimulants, finding jobs, and successfully completing treatment. They also described intangible yet significant changes in clients as they progressed through the protocol.

Clients would *"get excited about it (treatment)"* and begin displaying improvements in their physical appearance, grooming, and self-confidence as they progressed through the program. One provider described how positive experiences in the Recovery Incentives Program helped clients realize *"oh, I can have my regular life back"* and facilitate positive change. Another described this metamorphosis in detail:

> *"Their demeanor changes. They started (the Recovery Incentives Program) first being doubtful…(Then) you see this shift where they go from being discouraged in the beginning to them coming in with more confidence and more trust in themselves…. When they're close to finishing up (the program) and moving forward, like they've got a job. They're finishing up their court cases. It's just that huge shift…. They look lighter than when they started."*

Most strikingly, providers reported that unlike other interventions, clients actually *"like"* contingency management, and that they are often *"cheerful"* when coming to Recovery Incentives Program appointments.

Providers described how within the Recovery Incentives Program, the incentives themselves had an extremely positive impact for clients. *"A lot of these clients don't have much, so this (incentive) is a big thing for them,"* explained one provider, and many interviewees described tremendous client *"excitement"* for urine drug testing and incentives. *"That instant gratification of the incentive really does play a role in (replacing) the instant gratification that the person (used to) get from stimulant use."*

Providers also believed that for many clients, items purchased with incentives are investments in making a "fresh start" in a life after substance use. One client, for example, saved up incentives so they could purchase new curtains, paint, and furniture so they could reconfigure their apartment to make it feel different from the space where they had used drugs previously. For many clients, providers described how they used incentives as means towards the greater end of *"repairing relationships"* in recovery. *"Earning this money themselves allows them to show care and support for others."* Providers described how Recovery Incentives

clients would use gift cards to purchase things for their children or parents, using incentives as tools to help rebuild connections with loved ones that had been damaged by their substance use. One provider told the story of a client who had previously been a carpenter and used his incentives to buy materials and tools at Home Depot to build a loft bed for his daughter.

Beyond their material benefits, providers also reported that incentives play a powerful role in building clients' self-esteem every time they provide a negative urine drug test sample. Contrasting the experience of positive reinforcement to the cycle of addiction, one provider described how when receiving incentives *"they (clients) are able to acknowledge that today they get to spend their money on things they need, and not on destroying themselves or damaging their health and whatnot."* When they complete the protocol and receive their laminated certificate documenting their accomplishment, providers report that clients feel a particularly strong sense of pride. This is important for many clients, as one provider who had personally experience substance use disorders explained, because *"in active addiction, we don't complete anything. We're lucky to remember how we got through the day. So, something like this, it's 24 weeks. That's a long time!"* Consequently, *"when they (clients) get that completion (certificate), they're so proud. So proud."* One provider observed that by giving them this sense of accomplishment, *"the contingency management program (has) filled a gap I didn't even realize was there (for clients)—confidence."*

Despite all the benefits of incentives, several providers reported that the positive impact of incentives decreased over time, particularly in the second period of the Recovery Incentives Program when incentive amounts stop increasing and become smaller. Levels of *"no shows"* tend to increase during the stabilizing period of Recovery Incentives Program, and some providers hypothesized that this was because incentives *"trail off"* in this phase of the program. Providers also reported that the reduced frequency of testing coincided with many clients *"getting busy with work, at school, whatever"* as they recover, making it difficult for them to come in for testing. In these cases, providers reported that disengagement from the contingency management protocol and reduced utilization of incentives to motivate behavior change is not necessarily problematic. *"It's something to assist them (by) motivating them to stay sober"* one provider explained, so if clients are doing well without the services, it is acceptable for them to discontinue them.

The Recovery Incentives Program's Impacts on Client Engagement in Treatment

Beyond incentivizing abstinence from stimulants, providers reported that one of the most notable impacts of the Recovery Incentives Program is how it increases client engagement with treatment. As one provider summarized:

> *"It (Recovery Incentives) keeps them consistent. They are more likely to be consistent with their groups because they're on that schedule of coming in twice (a week) and testing. We plan it (testing) around their groups, (so) they make their groups, which is (normally) a struggle for us overall, to get them to come consistently. I've noticed the ones that are enrolled in the Recovery Incentives Program have done well with coming to their two or three groups a week. It's helped 'em engage in treatment for sure."*

One interviewee, who provides Recovery Incentives Program services in an Opioid Treatment Program (OTP) highlighted how well the program engages clients in treatment compared to regular services:

> *"When you enter into an OTP, the retention rate at the 30-day mark is about 80 percent. Then it drops to about 60 percent at 60 days. With the addition of contingency management here, we've had members go all the way through the 24 weeks—our retention rate for the OTP is 100% so far. We haven't had anybody drop out at 30 or 60 days. We haven't had one dropout—that's the significant part (of the program) to me, our retention."*

What this provider found particularly striking about these high retention rates was the fact that many participants did not achieve abstinence from stimulants but nonetheless kept coming in for Recovery Incentives Program appointments. *"Sometimes they test negative, maybe once, twice, but then get back to it (stimulant use),"* he observed. *"Yet they continually want to come in and get the interaction in the office."* Another interviewee concurred, describing how Recovery Incentives Program visits are invaluable non-clinical touchpoints for participants.

> *"For the clients that are enrolled in this (Recovery Incentives) Program, getting those two fifteen-minute sessions a week is so beneficial. It's not a therapeutic session, (but more like) 'How are you? Tell me about the dogs!' It gives them fifteen minutes to sit and talk to someone."*

Implementation Barriers and Facilitators

Providers noted some barriers that have impeded Recovery Incentives Program implementation at times. One early barrier was the lack of gift card options available for retail vendors in their communities. It should be noted that most interviewees reported the variety of vendors offering gift cards under the program was a strength of the Recovery Incentives Program, so this concern was not widespread. Providers who reported this barrier to program effectiveness reported that when clients could not access vendors that they wanted to use, they settled for gift cards to fast food restaurants. It should also be noted that based on provider input, the incentive manager vendor has quickly added new gift cards for the Recovery Incentives Program, improving participants' ability to find gift cards that they want to use in their communities moving forward. A list of the current vendors as of July 2025 can be found here.

The other problems related to incentives providers reported occurred when retailers did not accept gift cards and claimed that they were "fake." Describing how programs often print out gift cards for clients who do not have phones or data plans that support electronic gift cards, one provider explained that it creates awkward situations for clients since *"cashiers often don't trust gift cards printed on a sheet of paper—they might think the QR code isn't real or assume the client is scamming them."* When this occurs, it is not only inconvenient for clients, but also potentially damaging to their progress in recovery. As the provider explained:

> *"This skepticism (from retailers) can hurt clients, especially if they have a history of problematic behavior. Being accused of scamming while trying to use a legitimate gift card after testing negative and progressing on their recovery journey is very discouraging (for clients). It undermines their efforts and adds unnecessary stress to their situation."*

Other reported barriers regarding implementation of the Recovery Incentives Program included long transportation times for clients, and challenges using the Medi-Cal transportation on short notice (other providers found it to be successful). In addition, many providers reported that many Recovery Incentives Programs clients do not have cell phones, frequently lose them, or frequently change their phone numbers, it can be difficult for them to utilize Recovery Incentives Program gift cards and hard to reach them with texts/calls they send to help clients remember to come in for testing.

Providers reported that generally, the ease of using the Incentive Manager software portal has helped facilitate smooth program implementation. They have had some suggestions on how the portal could be improved (e.g, occasional glitches on the analytics page, wishing they could enter and track client testing by date and not just by week in the program). They also reported that the software is very intuitive and easy to use. In particular, they reported that the technical support that is available to help whenever they have software challenges is extremely helpful and responsive to all queries, making the Incentive Manager software a strong asset for the Recovery Incentives Program.

Providers also reported that, in general, the training and implementation support provided by the training team has been helpful in educating them about how to implement the Recovery Incentives Program effectively. Several interviewees reported that while the training support for the Recovery Incentives Program has been effective, they have found coaching calls to be too *"congested"* (i.e. have too many participants at a time) and time-consuming. These providers reported that they would like to see participation requirements related to coaching calls be loosened or removed. However, it should be noted that most providers did not report coaching calls to be too burdensome in their interviews. UCLA will survey providers on this topic to better quantify provider feedback.

The most prominent barriers to the implementation of the Recovery Incentives Program reported by providers were related to staffing, particularly in smaller programs. Providers reported that, even though some staff are assigned to provide contingency management services as part of the program, they frequently have difficulties when staff call in sick or go on leave. One supervisor reported that even though she has ensured all of her staff are trained in the CM protocol and able to provide the services if needed, adding Recovery Incentives Program activities to people's already busy schedules is difficult. *"I can't just pull staff at random (to do UDT testing),"*, she elaborated, *"because they likely have back-to-back groups or are stationed at different service sites."* Another provider concurred, describing how chaotic the program becomes on UDT testing days. *"It's really hard on staff during UA (UDT) days,"* she explained. *"It's always too much. (On those days) we're like 'Oh God, it's Tuesday, Oh God it's Friday (testing days at this program)."* Providers reported that these challenges are exacerbated by high levels of staff turnover and ongoing workforce constraints in the SUD treatment field, particularly when a staff member who leaves is one of the people who had been trained and designated for the Recovery Incentives Program.

Another interviewee reported that at their program, they try to avoid involving too many staff members in Recovery Incentives Program service delivery because of workload concerns.

However, as a result, contingency management is only available when designated staff have scheduled time to provide it. *"Our coordinator isn't just available whenever someone wants to come in (for a urine drug test). We really have to schedule,"* she explained. Due to staffing limitations, she continued, her clinic may need to limit the number of clients it enrolls in the program because *"if we continue to enroll and our census goes up in this program, I can potentially see some challenges."*

When asked about ways that staffing issues could potentially be addressed, one interviewee suggested that the Recovery Incentives Program require that programs have staff who only provide contingency management services, and do not have other clinical or administrative duties. As this person, who is a clinical supervisor, explained:

> *"I would love to be able to have one person designated just for the program. (But) it's not required that you have a person designated for contingency management alone. The words "standalone" or "separate from" or "in addition to" does not exist that I know of in the contract. If my staff were at full census, and if we had full caseloads, then sure, they (program management) would say "sure, hire somebody (just for the Recovery Incentives Program." But (it depends) on how you describe need…If my staff were at full census (their caseload would be) 25, but (in reality) caseloads always vary, from 20 to 23 (for example). Until we can prove that it's needed (that all caseloads are at 25), they (won't) hire somebody for that.*

To address this phenomenon, the interviewee suggested that a separate standalone position for Recovery Incentives Program staff could be required. "The word 'mandated' is unequivocal," she said.

> *"You can't wait to see if you need somebody in the department, if there's enough budget for it, etc. There (are already) so many dot-the-i, cross-the-t mandatory steps that you (already) have to follow in order for you to create a billable unit of service that's going to be approved, I don't see why Recovery Incentives can't follow suit.*

It should be noted that this idea of requiring standalone staff for Recovery Incentives Program implementation—while perhaps suitable for larger programs — would not be practicable in many settings currently providing Recovery Incentives Programs services. A significant portion of interviewees reported working in programs that only have three or four

staff members and requiring such programs to have standalone staff dedicated exclusively to contingency management could have the unintended consequence of making Recovery Incentives Program participation difficult or impossible for many providers across California

Shifting Beliefs about Contingency Management Over Time

Many providers reported that at the beginning of the Recovery Incentives Program, they were skeptical about the protocol. In interviews, providers described how they initially believed contingency management would not help clients *"develop any relapse prevention (or) relational skills"* they would need to sustain recovery.

Some interviewees reported that their perspectives shifted when they learned about contingency management's effectiveness during Recovery Incentives Program trainings. *"When they presented certain evidence of how well it works…. I had a change of heart," said one provider.* Others reported that they remained skeptical until they saw how well the program worked. *"Now if I look beyond the whole idea (of incentives) and what it represented to me, and see the changes in people (who complete the program), I would say I'm really glad to be a part of it"* said one provider. *"Regardless of how people get sober, they're sober."* Another interviewee told a similar story, describing how she was skeptical about contingency management until she saw a client *"who had been in and out of treatment for years who finished the program— (and now) he's got a job…. That's when I was like "OK, this might be doing something. (Now) I'm a convert."*

1: Anabel (pseudonym)

Anabel has some cognitive delays, but she completed 90 days of residential treatment. She came to outpatient and to recovery bridge (housing). She struggled with setting boundaries with other people, setting boundaries around other people, and trying to meet their needs. And the other day, she was sitting with the case manager, taking care of her employment.

She's got two jobs. We didn't think she was ever going to be able to work, but she is. She managed to have two jobs, and her family has welcomed her back home. She's one of the ones who's going to move back into her home and change her room around. She has given 100% negative, stimulant and every other substance. She has engaged in the 12-step community. She's working, she has access to her children. And she runs my (clinical) group more often than not.

She's learned so many new ways to cope…it's just, you know, taking a walk, taking a deep breath, writing in the journal, those kinds of things. And she has almost six months worth of journal entries that she shares in (our) individual sessions. She takes full advantage of outpatient treatment and everything we have to offer.

She does this Recovery Incentives thing and she's set her own Tuesday and Thursday (testing) times and shows up. She's never late. She's prepared. She washes her hands, she does it all, and she's just perfect almost. I think it gave her a sense of self and pride. She has something she can say she has completed successfully. And she did that not by doing the thing she's always done. This is how she kind of describes it to me: "I've never been honest about being clean ever in my life. And this program kind of keeps me honest. I've always wanted it." But she'd never been able to just be honest about slipping up here and slipping up there. But having this program and that incentive, she said "It keeps me honest. It makes me feel good that I can do that."

2: Edward (pseudonym)

Edward was super hesitant to join in (the Recovery Incentives Program). When he joined, I was his counselor and his contingency management person. When he first talked to me, he was just like "I know I have to do this. I've been struggling with this for a long time. I've been in and out of treatment. I've been an inpatient, outpatient. Nothing's worked." He's just like "I have a kid now, and something's gotta give."

I remember when I told him about the contingency management program, he was just like, "No, I'm good." I said, "You've been clean for this long, it's gonna help you, right?" He just said "No, I don't think I can do it, I don't think I need it." So, I tried to go back every once in a while and say "Hey, have you thought about going on contingency management?"

I told him, "You've been struggling with cravings. This is gonna help," and so he finally got on it. I'll never forget when he started. He got motivated, and then he got a job. He said, "Can I still come back for contingency management because that'll help me because I know (if I don't come in) I'm not gonna see you…because of work." So, he would come in punctually on Fridays every time at 3:00. He would be there. Even if I was in a meeting or if I was running late, he would wait. He wouldn't leave. He would just sit there and wait. I asked "How come you didn't text me?" and he said, "It's OK, I knew I was gonna see you eventually. I'm here. I make sure I plan out my day to be here."

On the last day (of Edward's Recovery Incentives Program protocol) I said "Hey, this is your last test. Here's your certificate. Let's cash you out. I'm super proud of you. You did so good. You finished it—24 weeks. And not only that, you're still clean. You're working." And he said, "Man, I can't believe I did it. I didn't think I was gonna do it." I said, "I know, but you did it."

Then he asked "What if I can't do it afterwards (once the Recovery Incentives Program is over)?" I said, "You've done it already. You were just coming in to test—this (ending) is nothing. You're doing fine. If anything else (happens) you can always come back." And he was just like "OK."

It was just one of those things where you saw the shift of someone who was so ambivalent to it and then realizing "No, maybe I do need this, and I deserve to do this." (Before the Recovery Incentives Program) he was very much having a hard time doing things for himself, like self-care. With (Recovery Incentives Program) was this change where he trimmed his beard, and he cut his hair. Before you could tell he wasn't really caring about his appearance, and then he was taking care of himself. He said, "I just went out and I bought some stuff for myself." I said, "Oh my God, you're taking care of yourself! You're doing it!"

G-I. Conclusions, Interpretations, Lessons Learned, and Recommendations

Conclusions and Interpretations

DMC-ODS has been largely successful at maintaining or making additional progress toward the goals of the demonstration project, though challenges remain. A summary of progress toward goals follows:

Goal 1: Increased rates of identification, initiation, and engagement in SUD treatment services. (maintain or increase)

Measures of initiation and timely admissions have exhibited an upward trend. Treatment engagement was maintained.

The weight of current evidence suggests: **Progress toward goal**

Goal 2: Increased adherence to and retention in Treatment (maintain or increase)

Rates of continuity of pharmacotherapy have been maintained at benchmark (2021) levels.

The weight of current evidence suggests: **Progress toward goal**

Goal 3: Reductions in overdose deaths, particularly those due to opioids.

While the evaluation team is awaiting death data to test this hypothesis within DMC-ODS, statewide trends in opioid and stimulant deaths are down. These outcomes from the recovery incentives program suggest reductions in use, which indicate reduced risks among clients.

The weight of current evidence suggests: **Progress toward goal**

Goal 4: Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

Recovery Incentives Program participants have self-reported reduced use of emergency departments and inpatient hospital settings, which is consistent with their reduced use as verified by urinalysis. Further analysis is needed for the broader DMC-ODS population.

The weight of current evidence suggests: **Progress toward goal**

Goal 5: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.

Readmissions to withdrawal management were maintained from 2021 to 2022, but unexpectedly increased in 2023, counter to the goal. However, in 2025, 84 percent of county administrators reported that DMC-ODS had positively impacted transitions of care. This mixed evidence warrants further exploration and analysis.

The weight of current evidence suggests: **Mixed evidence**

Goal 6: Improved access to care for physical health conditions among beneficiaries.

Clients rated their providers' coordination with physical health at a high and steady rate (about 84 percent positive from 2021-2024). The majority (59%) of county administrators also say DMC-ODS improved coordination with physical health. However, the percentage reporting a positive impact was down from 2021.

The weight of current evidence suggests: **Progress toward goal**

Goal 7: Improved health equity

Access appears to have favored White clients, but this was a change from previous findings. In earlier analyses, DMC-ODS had a significant impact on access for Black members. Additional preliminary analyses suggest that COVID-19 may have had a disproportionate impact on access among Black members through the end of 2023. COVID-19, combined with the recent addition of new DMC-ODS counties with relatively higher White populations may have driven this result.

On other measures of access, initiation, timely admission to indicated level of care, and engagement, no meaningful health disparities among age, racial/ethnic group, and gender were identified. One exception is that older clients tended to do better than younger clients on engagement and continuity of pharmacotherapy. Additionally, AIANs were the only racial/ethnic group to improve on readmissions to withdrawal management.

The weight of current evidence suggests: **Mixed evidence**

Goal 8: An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes.

A wide array of evidence suggests the Recovery Incentives Program is very effective and improved beneficiary outcomes. Data suggest it has expanded to reach about one quarter of clients with Medi-Cal in outpatient treatment for stimulant problems. While this is considerable reach for a new program, there remains room to continue expansion to additional counties and programs, as well as increasing participation within each site.

According to the National Survey on Drug Use and Health (SAMHSA, 2025), about 448,000 Californians used methamphetamines in the past year in 2021-2022. Although many of these individuals would not need or seek treatment, there are likely additional opportunities to reach more individuals outside of specialty care settings. Such efforts would require careful consideration to avoid undermining the fidelity of the program, as the careful implementation of a standardized program and the delivery of highly-rated intensive training and technical support appear to be strengths of the current program, but may be challenging in other settings. Due to the complexity of these issues, UCLA recommends the formation of an advisory group with experts and stakeholder participation to consider and discuss future changes to the program.

The weight of current evidence suggests: **Progress toward goal**

Summary of conclusions and interpretations

While more data and analyses are needed, the current interim evidence supports progress toward most of DMC-ODS' goals. For two, evidence is more mixed but is expected to clarify as more data becomes available. Overall, the state is making clear progress toward achieving most DMC-ODS goals.

Lessons Learned and Recommendations

Lessons Learned and Recommendation for other states interested in implementing a similar approach

The DMC-ODS summative report[59] submitted in 2022 listed a number of lessons learned for other states that hold true today, including the value of:

- A one-page client perception of care survey
- Providing adequate technical assistance to plans/providers on data to be collected, and providing feedback on this data to minimize missing and inaccurate data.
- Balancing the minimum requirements for participation in the waiver against the potential exclusion of smaller, less populated geographies that may struggle to meet these requirements.

In addition, the Recovery Incentives Program has generated new lessons learned in its first years of implementation. The most concrete example of this is the need to address Clinical Laboratory Improvement Amendments (CLIA)-waiver requirements, which initially delayed the implementation of the Recovery Incentives Program in many treatment programs. The state has demonstrated success in addressing this barrier, however. Based on these experiences, UCLA recommends the following to other states interested in implementing contingency management programs:

- Prioritize training and technical assistance when implementing contingency management programs. California's training materials are available to other states at no charge.[60]
- Plan ahead for CLIA-waiver requirements.
- Invest in reliable software to manage incentives and collect data.

[59] https://www.uclaisap.org/dmc-ods-eval/assets/documents/20220422-DMC-ODS-FY-2021-Evaluation-Report-with-Appendices_V2.pdf
[60] https://uclaisap.org/recoveryincentives/

Recommendations for California

- Explore and address the underlying causes of increasing readmissions to withdrawal management. The evaluation team will continue exploration of potential data explanations as well as reach out to stakeholders for input.
- Explore and address the underlying causes for mixed results on health equity. The evaluation team will continue exploration of potential data explanations as well as reach out to stakeholders for input.
- Continue efforts to expand treatment capacity and support workforce development, both of which are commonly cited barriers within DMC-ODS.
- Convene an advisory group to discuss possible alterations to the Recovery Incentives Program, including:
    - The $599 limit in light of SAMHSA setting a $750 limit on contingency management in State Opioid Response grants.
    - Revisiting the escalation-reset design of the incentive schedule, particularly whether to retain the "reset" portion, and whether to start with higher amounts to strengthen early engagement. Vermont and Maine use flat amounts with a higher first incentive ($20).
    - Ways to expand the number of participating counties and providers.
    - Ways to facilitate greater use of the program for new clients entering from the community, in addition to its common appropriate use for clients stepping down from residential treatment.
    - The viability of expanding contingency management to other settings, including primary care.

Interpretations, Policy Implications, and Interactions with Other State Initiatives

There are a number of other California initiatives that could interact with DMC-ODS, with one of the most important being Behavioral Health Transformation, [61] which builds directly on CalAIM and other major initiatives. DHCS has begun implementing changes through this

[61] https://www.dhcs.ca.gov/BHT/Pages/home.aspx

initiative following the passage of Proposition 1 in 2024, which included up to $6.4 billion in bonds to build new supportive housing and community-based treatment settings.

Another set of initiatives that may have an effect is DHCS' extensive Opioid Response efforts[62] funded by SAMHSA's State Opioid Response grants. This would mainly have an impact on the treatment of opioid use disorder, which may have played a role in the increased use of MAT, particularly the increase in buprenorphine prescribing in narcotic treatment program/opioid treatment program settings, in the state. These funds are also being used to address stimulant use disorder. While other states can also use these funds to pay for contingency management programs, California opted to maintain a focus on DMC-ODS contingency management rather than potentially cause confusion by attempting to implement parallel programs under different funding sources.

Another initiative that could affect DMC-ODS in the future is Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), which is comprised of a new Medicaid Section 1115 demonstration and State Plan Amendments.[63] While much of BH-CONNECT is focused on mental health services, some efforts will overlap with and could affect future DMC-ODS outcomes, including a workforce initiative, an access, reform, and outcomes incentive program for behavioral health plans, coverage for Enhanced Community Health Workers, and Individual Placement and Support-supported employment services.

In spite of these initiatives, there is strong evidence that DMC-ODS has had a positive impact independent of other external influences, as determined by difference-in-difference analyses to examine the causal effect of DMC-ODS, as well as input from stakeholders on the impact of DMC-ODS specifically. Given the continuing overlap between programs, it will be important to continue to collect and analyze such data to specifically measure the effect of DMC-ODS, or parallel efforts in other states with similar waivers.

[62] https://californiaopioidresponse.org/

[63] https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

Attachments

Attachment A: Approved Evaluation Design

Please see the approved DMC-ODS Evaluation Design included as a separate document (Attachment A) within this submission.

Attachment B: Evaluation of 2021 and assessment of appropriateness as a baseline year

In DMC-ODS Evaluation Design, it was agreed that calendar year 2021 would be included in the current evaluation, since the state received a temporary COVID-19-related extension of the previous Medi-Cal 2020 waiver and data for this year was not entirely available for the Summative Report of that waiver, which was submitted to CMS in 2022. Importantly, 2021 was also proposed as a baseline year for this evaluation, so it is important to assess its appropriateness given the COVID-19 public health emergency that encompassed 2020-2023. To this end, the measures examined in this report were compared for 2019, 2020, and 2021 to explore whether 2021 or an alternative might be a more appropriate baseline. The following is a summary of the results of these comparisons.

- ASAM Criteria-based assessment counts were generally stable from 2019 through 2021, though there was a temporary dip in 2020.
- Rates of initiation after an ASAM Criteria-based brief screening rose from 2019 (10.8%) to 2020 (12.2%), and 2021 (13.5%)
- Timely admission to the indicated level of care within 30 days after brief screening among clients who received treatment were fairly stable but dipped slightly from 2019 (72.4%) to 2020 (72.2%) and 2021 (70.4%).
- Engagement rates dropped slightly from 2019 (88.5%) to 2020 (87.4%) and 2021 (86.3%).
- Treatment Perception Survey Adult overall satisfaction ratings were very similar in 2019 (91.0%), 2020 (91.8%), and 2021 (90.8%).
- Continuity of pharmacotherapy for 180 days dropped from 2019 (30.2%) to 2020 (22.7%) and 2021 (21.1%).
- Readmissions to withdrawal managment rates rose from 2019 (58.3%) to 2020 (63.1%) and 2021 (65.5%).

On many of the measures the onset of COVID-19 was associated with poorer rates compared to the pre-pandemic year of 2019, while only one improved (initiation). Since the national COVID-19 Public Health Emergency did not expire until May 11, 2023, the year 2021 is therefore a better and more proximal baseline year for the CalAIM years 2022 and 2023, compared to the pre-pandemic 2019 or more temporally distal 2020 as alternatives. For these reasons, 2021 is used as the primary baseline year in this Interim Evaluation Report.

Attachment C: TPS Survey Items by Domain

TPS Adult Survey Items by Domain

Access

- The location was convenient (public transportation, distance, parking, etc.).
- Services were available when I needed them.

Quality

- I chose the treatment goals with my provider's help.
- Staff gave me enough time in my treatment sessions.
- Staff treated me with respect.
- Staff spoke to me in a way I understood.
- Staff were sensitive to my cultural background (race, religion, language, etc.).

General Satisfaction

- I felt welcomed here.
- Overall, I am satisfied with the services I received.
- I was able to get all the help/services that I needed.
- I would recommend this agency to a friend or family member.

Outcome

- As a direct result of the services I am receiving, I am better able to do things that I want to do.
- As a direct result of the services I am receiving, I feel less craving for drugs and alcohol.*

Care Coordination

- Staff here work with my PH care providers to support my wellness.
- Staff here work with my MH care providers to support my wellness.
- Staff here helped me to connect with other services as needed (social services, housing, etc.) *

Telehealth

- Now thinking about the services you received how much of it was by telehealth (by telephone or video-conferencing)? (Response options: None, Very little, About half, Almost all, All)

- How helpful were your telehealth visits compared to traditional in-person visits? (Response option: Much better, Somewhat better, About the same, Somewhat worse, Not applicable)*

**New item added in the 2023 TPS survey administration*

TPS Youth Survey Items by Domain

Access

- The location of services was convenient for me.
- Services were available at times that were convenient for me.
- I had a good experience enrolling in treatment.

Quality

- I received services that were right for me.
- Staff treated me with respect.
- Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).
- My counselor provided necessary services for my family.

General Satisfaction

- Overall, I am satisfied with the services I received.
- I would recommend the services to a friend who is need of similar help.

Outcome

- As a direct result of the services I am receiving, I am better able to do things I want to do.
- As a direct result of the services I am receiving, I feel less cravings for drugs and alcohol.*

Care Coordination

- Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).
- Staff here helped me with other issues and concerns I had related to legal/probation, family, and educational systems.

Therapeutic Alliance

- My counselor and I work on treatment goals together.
- I feel my counselor took the time to listen to what I had to say.
- I developed a positive, trusting relationship with my counselor.
- I feel my counselor was sincerely interested in me and understood me.
- I like my counselor here.
- My counselor is capable of helping me.

Telehealth

- Now thinking about the services you received, how much of it was by telehealth (by telephone or video-conferencing)? (Response options: None, Very little, About half, Almost all, All)
- How helpful were your telehealth visits compared to traditional in-person visits? (Response option: Much better, Somewhat better, About the same, Somewhat worse, Not applicable)*

**New item added in the 2023 TPS survey administration*

Attachment D: Recovery Incentive Program Incentive Schedule

Week	Tests per week	Payout per Negative Test	Weekly Total
Period 1			
1	2	$10.00	$20.00
2	2	$11.50	$23.00
3	2	$13.00	$26.00
4	2	$14.50	$29.00
5	2	$16.00	$32.00
6	2	$17.50	$35.00
7	2	$19.00	$38.00
8	2	$20.50	$41.00
9	2	$22.00	$44.00
10	2	$23.50	$47.00
11	2	$25.00	$50.00
12	2	$26.50	$53.00
Period 2			
13	1	$15.00	$15.00
14	1	$15.00	$15.00
15	1	$15.00	$15.00
16	1	$15.00	$15.00
17	1	$15.00	$15.00
18	1	$15.00	$15.00
19	1	$10.00	$10.00
20	1	$10.00	$10.00
21	1	$10.00	$10.00
22	1	$10.00	$10.00
23	1	$10.00	$10.00
24	1	$21.00	$21.00

Reinforcement/Incentive schedule. During Period 1, which lasts 12 weeks, clients take two drug tests a week with increasing incentives. During Period 2, the 12-week maintenance period, clients take one test a week without an escalating incentive schedule. For additional details, the program manual, requirements, and training materials are available at: *https://www.uclaisap.org/recoveryincentives/*

Attachment E: Survey and Qualitative Data Summary Table

County Administrator Perceptions

Strengths	Barriers
The program is having a positive impact on client participation, engagement, retention, and outcomes.	*"Burdensome"* requirements needed to be fulfilled before sites could launch, particularly delays receiving approval for CLIA Waivers.
Opportunity to expand services in an innovative, thorough, and well-designed manner	Implementation delays "eroded trust in the sustainability and viability of the program"
Training, support, fidelity monitoring were reported to be helpful and reduced the burden on the counties.	Staff turnover and shortages affected implementation and sustainability.
Straightforward billing mechanism, easy administrative implementation	Concerns about counties needing to cover the non-federal share of the program beginning in 2024.
California has led the nation in terms of offering contingency management through Medicaid.	Counties that chose not to participate in the Recovery Incentives Program largely made the decision due to shortages in staffing or their administrative inability to keep up with this program in addition to other CalAIM requirements.

Provider Perceptions

Strengths	Barriers
Initial concerns reported prior to implementation (e.g. tampering of UAs, discussing positive results, clients falsifying StimUD to enter program) rarely or never occurred.	Spreading awareness about the program took time to introduce and develop language about the incentives.
Recovery Incentives Program is highly effective, even for clients who have historically had difficulty abstaining from stimulant use.	Busy schedules, transportation issues were barriers to enroll patients.
A majority of providers think the current incentive amount (up to $599/year) is "adequate," but a majority also felt it is not "completely" adequate.	Incentives' impact were reduced in the second phase of the Program when incentive amounts stopped increasing.
As clients reduce stimulant use, they make other positive changes in their lives	Lack of gift card options available for retail vendors in their communities
Unlike other interventions, clients actually *"like"* contingency management, and are often *"cheerful"* when coming to appointments.	Some vendors did not accept gift cards and thought that they were "fake." The incentive manager software vendor reported that this has since been resolved.
Items purchased with incentives were more than just material goods for clients	Staffing was a barrier, particularly in smaller programs.
Incentives build client self-esteem every time they provide a negative urine drug test sample	Challenges exacerbated by the high staff turnover endemic in the SUD treatment field
Recovery Incentives Program increases client engagement with treatment	
Recovery Incentives Program visits are invaluable non-clinical touchpoints for participants.	

Strengths	Barriers
Paradigm shift in SUD Treatment; shift from the punitive to the positive	
Incentive Manager software portal was easy to use, technical support was responsive & helpful.	
The training and implementation support provided has been helpful.	
Initial skepticism about contingency management disappeared after learning about its effectiveness through trainings and experience.	

Client Perceptions

Strengths	Barriers
Most clients reported that the program helped them stop using stimulants and had a positive impact economically and on their response to treatment.	Challenges using the printed incentives at some vendor locations. The incentive manager software vendor reported that this has since been resolved.
Clients reported that as a result of their treatment, they experienced better health, were better able to take care of personal responsibilities, and were a better member of the community.	Some clients requested more local vendor and/or transportation options to be available in the incentive manager system.
Clients reported that the program's procedures were easy to understand	
Each aspect of the program (UDTs, gift cards, counseling, case management, etc) was rated as beneficial, with gift cards rated highest.	

Strengths	Barriers
Incentives were highly motivating; transformed abstinence from stimulants from an unpleasant task into a desirable goal.	
The promise of positive reinforcement helped clients through moments of craving and temptation to use stimulants.	
Gift cards helped some clients raise their standard of living above bare subsistence. For others, the gift cards enhanced their emotional well-being or were helpful to begin rebuilding lives and healing relationships that had been damaged while they were using stimulants.	
Clients reported the Recovery Incentives Program helped them progress towards recovery after years of trying with other treatments.	

UCLA Recovery Incentives Evaluation: Client Survey - Cross Sectional design

(Collected during a one-week collection period in early 2024)

Introduction

As part of the evaluation of the California Recovery Incentives Program (also known as the Contingency Management (CM) Program), we would like to extend an invitation for you to take a 10–15-minute survey.

Clients who are involved in the Recovery Incentives Program during the one-week data collection period (XXX-XXX), are eligible.

We would like to hear from you on how incentives influence your treatment experience. Your individual responses will remain confidential and will not be shared with your treatment program. The data will be compiled and will not contain any personally identifying information in UCLA's evaluation reports.

Participation is voluntary.

UCLA will send you a $10 e-gift card as a token of appreciation for your time.

- ○ Yes, I agree to start the survey.
- ○ No, I do not wish to proceed or complete the survey.

Skip To: End of Survey If response = No, I do not wish to proceed or complete the survey.

Q1. Which week of the Recovery Incentives Program are you in?

Drop Down selection options ▼:

- This is my first visit. I have not officially started the program
- Week 1 or 2
- Week 3 or 4
- Week 5-12
- Week 13-24
- Week 24 onwards

PROMIS items

Q2. Please respond to each question or statement by marking one box per row.

In the past 30 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I felt that my drug use was out of control.	○	○	○	○	○
I had a drug problem.	○	○	○	○	○

In the past 30 days...

	Never	Rarely	Sometimes	Often	Almost always
My drug use caused problems with people close to me.	○	○	○	○	○
I craved drugs.	○	○	○	○	○
I spent a lot of time using drugs.	○	○	○	○	○

Last 30 days use - counts data

Q3. In the last 30 days, how many days have you used stimulants?

Drop down selection options: ▼ 0 ... 30 days

Q4. In the last 30 days, how many days have you used drugs and alcohol, other than stimulants?

Drop down selection options: ▼ 0 ... 30 days

Rating of program impact on physical health

Q5. How much of a positive impact did the Recovery Incentives Program have on how often you visited an emergency room or stayed overnight in a hospital for a physical health problem?

Had no impact								Had a definite impact		Not Applicable
1	2	3	4	5	6	7	8	9	10	

Contingency Management questionnaire (Miguel et al)

Q6. How easy or difficult was it for you to understand the Recovery Incentives Program procedure? (for example, testing requirements, attendance requirements, gift card amounts)

- ○ Very easy
- ○ Relatively easy
- ○ Not very easy
- ○ Very difficult

Q7. In your opinion, did the Recovery Incentives Program have any effect on your response to treatment?

- ○ Yes, it helped me a lot
- ○ Yes, it helped me a little
- ○ No, it made no difference
- ○ Yes, it had a negative impact

Q8. From one (had no impact) to ten (had a definite impact), how much of an impact did the intervention have on your treatment response?

Had no impact								Had a definite impact		Not Applicable
1	2	3	4	5	6	7	8	9	10	

Q9. In your opinion, would the Recovery Incentives Program help other people who seek treatment for stimulant use?

- ○ Yes, it would help them a lot
- ○ Yes, it would help them a little
- ○ No, it would make no difference
- ○ No, it would have a negative impact

Q10. In your opinion, did the Recovery Incentives Program help you stop using stimulants?

- ○ Yes, it helped me a lot
- ○ Yes, it helped me a little
- ○ No, it made no difference
- ○ No, it had a negative impact

Please explain: _____

Q11. Did Recovery Incentives Program significantly help you economically?

- ○ Yes, it helped me a lot
- ○ Yes, it helped me a little
- ○ No, it made no difference
- ○ No, it had a negative impact

Please explain: _____

Treatment Effectiveness Assessment (TEA-2012 version)

The following questions ask you to express the extent of changes for the better from your involvement in the program to this point in four areas: stimulant use, health, lifestyle, and community. For each area, think about how things have become better and select the results on the scale below: the more you have improved, the higher the number – from 1 (none or not much) to 10 (much better).

Feel free to write down the one or two changes most important to you in the Remarks section.

Q12. Stimulant Use: How much better are you with stimulant use?

Consider the frequency and amount of use, money spent on stimulants, amount of drug craving, time spent being high/drunk, being sick, in trouble, and in other drug-using activities, etc.

None or not much			Better				Much better		
1	2	3	4	5	6	7	8	9	10

Remarks: _____

Q13. Health: Has your health improved?

In what way and how much? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc.?

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks: _____

Q14. Lifestyle: How much better are you in taking care of personal responsibilities?

Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks: _____

Q15. Community: Are you a better member of the community?

Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks: _____

Treatment Perceptions

Q16. Please answer these questions about your experience with the Recovery Incentives Program to help improve services.

	Strongly agree	Agree	I am neutral	Disagree	Strongly disagree
As a direct result of the services I am receiving, I am better able to do things that I want to do.	○	○	○	○	○
Overall, I am satisfied with the services I received.	○	○	○	○	○
I was able to get all the help/services that I needed.	○	○	○	○	○
I would recommend this agency to a friend or a family member.	○	○	○	○	○

Q17. Please answer these questions about your experience with the Recovery Incentives Program to help improve services.

Please use "Not Applicable" if the question is about something you have not experienced.

	Strongly agree	Agree	I am neutral	Disagree	Strongly disagree	Not Applicable
As a direct result of the services I am receiving, my depression and/or anxiety has improved.	○	○	○	○	○	○
As a direct result of the services I am receiving, my living situation is more stable.	○	○	○	○	○	○

Recovery Incentives Impact on use – Rating

Q18 When you get into a situation where you would have used in the past, how does being in a Program that offers incentives help you not use?

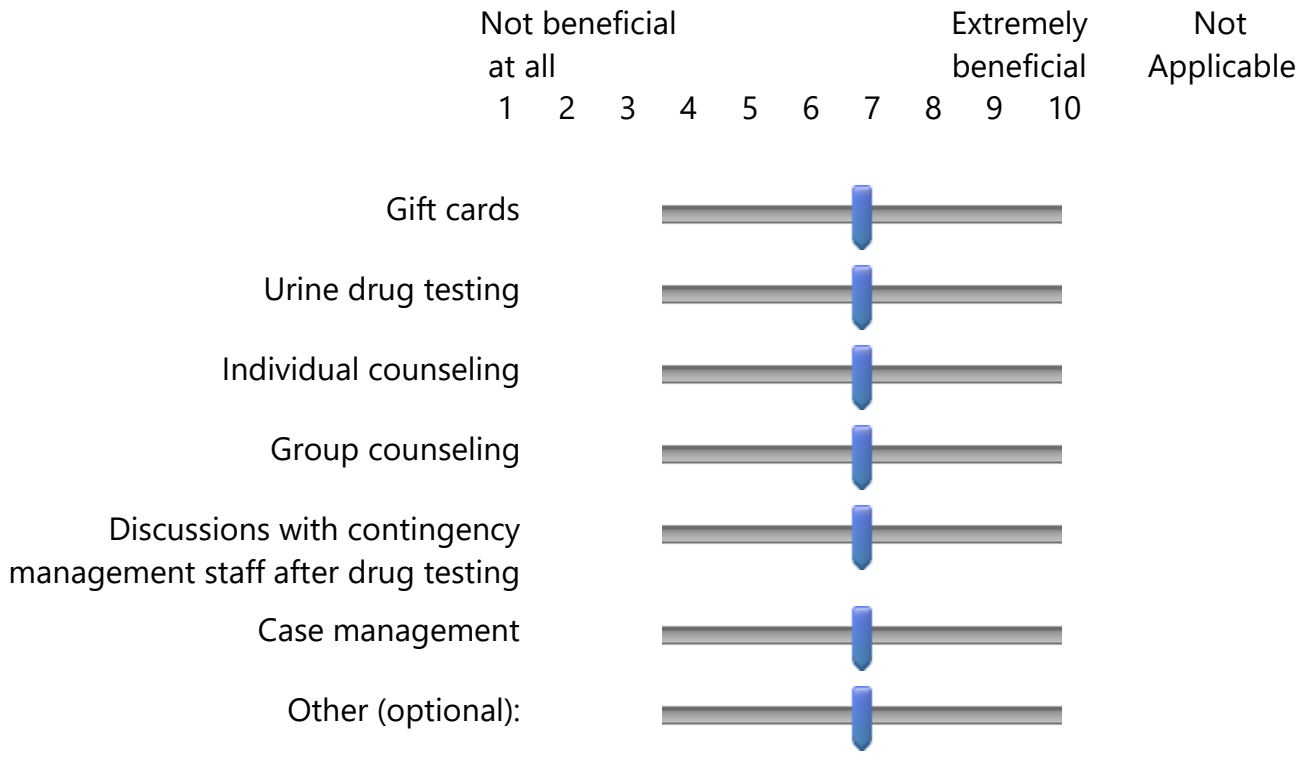
Please select all that apply.

- ☐ I don't get triggered
- ☐ I don't crave
- ☐ I think of the incentive and don't want to lose the money
- ☐ I think about how proud I feel when I earn the gift cards and I don't want to mess up
- ☐ I think about how happy I am that I can buy things for my family and I don't want to mess up
- ☐ I don't want to disappoint the program staff
- ☐ I don't want to disappoint my counselor
- ☐ Others (please specify): _____
- ☐ Being in a program that offers incentives does not help me

Recovery Incentives Program Elements - Rating

Q19. From 1(Not beneficial at all) to 10 (Extremely beneficial), how beneficial is each of the below aspects of your treatment for stimulant use?

If some aspects do not apply to you, please select "Not Applicable".



Q20. How satisfied are you with the gift card incentive options offered as part of the Recovery Incentive Program?

- ○ Not at all
- ○ A little bit
- ○ Somewhat
- ○ Quite a bit
- ○ Very much

Q21. Is there anything else that you would like to share about your experience with the Recovery Incentives Program? (For example, likes/dislikes, benefits/difficulties, etc.)

Your feedback is important in helping us understand your experience in of the Recovery Incentives Program and how we can improve it in the future.

_____

_____

_____

Demographics

Please tell us a little about yourself. This helps us make sure that all persons are represented in our results.

Q 22. Gender Identity

Q 23. Sexual Orientation

Q 24. Race/Ethnicity

Q 25 Age

Consent for Follow up

Q26. Additionally, would you also be willing to be contacted for a follow up interview in the coming months?

The interviews will allow for a more in-depth understanding of your treatment experience. Your participation will be compensated with an additional gift card of up to $50.

- ○ Yes
- ○ No

Thank you for completing this survey!

The information below is required for UCLA to issue you a $10 e-gift card as compensation for participating in this survey. This will be electronically issued (sent via email/text), but can be used in-store or online:

Your Name: _____

Which type of e-gift card would you like to receive? (Select all that apply.)

- ☐ Amazon
- ☐ Kroger (Food4Less, Ralphs, etc.)
- ☐ Target

Please enter your preferred email address to receive e-gift cards:

_____

Please enter your mobile phone number (with text/short message services (SMS), and internet capabilities):

_____

Please indicate your preference on how to receive the gift card electronically after completing this survey?

- ○ Email
- ○ Mobile phone number (via text/short message services (SMS), with internet capabilities)
- ○ Both are fine
- ○ I do not have an email or a mobile phone number

Please provide a reliable mailing address. Please note that we will not be able to reissue gift cards once mailed.

_____

Display This Question:

If, they endorsed Yes to be contacted for a follow up interview

Can we use the same information above to contact you for a follow-up interview?

- ○ Yes
- ○ No, please contact me at this email/phone number:

_____

We thank you for your time spent taking this survey.

UCLA study staff will follow up soon with your issued e-gift card.

If you have any questions, please contact study staff at healthstudy@mednet.ucla.edu.

UCLA Recovery Incentives Client Survey - Longitudinal Baseline

(Collected during a specified two-week collection period in May-June 2025)

Introduction and consent

University of California, Los Angeles

INFORMATION SHEET

Recovery Incentives Program: California's Contingency Management Benefit

Evaluation Program – Member Surveys

INTRODUCTION

Researchers at UCLA are studying the California Recovery Incentives Program, which is part of your treatment. This study is funded by the CA Department of Health Care Services (DHCS). We want to survey and possibly interview clients like you, also referred to as "members" who are participating in the Recovery Incentive Program. Your participation in the UCLA Evaluation study is voluntary.

WHY IS THIS EVALUATION BEING DONE?

This is the first time the Recovery Incentives Program is offered across California as a Medi-Cal benefit. We want to see how well it works and how we can improve it. Your feedback is important. It helps us understand what works and what doesn't. Your responses will be kept private and will not be shared with your treatment provider.

WHAT WILL I NEED TO DO?

You will take up to 4 surveys during your treatment. Each survey takes 5-10 minutes.

- **First Survey**: Near the start of your treatment.
- **Second Survey**: About 6 weeks later.
- **Third Survey**: About 14 weeks later.
- **Fourth Survey**: Near the end of your treatment (about 6 months later). In each survey, you can choose to be contacted for a follow-up interview.

WILL I BE PAID FOR MY PARTICIPATION?

Yes, you will receive an electronic gift card for each survey and interview you complete:

- **First Survey**: $20 e-gift card
- **Second Survey**: $40 e-gift card
- **Third Survey**: $60 e-gift card
- **Fourth Survey**: $80 e-gift card
- **Possible Follow-up Interview** (if you are selected and you agree to this): $50 e-gift card per interview

WHAT ELSE SHOULD I KNOW?

You can choose not to take part.

You can agree to take part and later change your mind.

Your decision will not affect your relationship with your treatment provider.

You can ask any questions before deciding.

ARE THERE ANY RISKS?

There are no expected risks or discomforts.

ARE THERE ANY BENEFITS?

By participating, you help shape the future of the Recovery Incentives Program. Your involvement can make a big difference and help bring this program to more people. You can also help influence future policies in California and other states.

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

The UCLA Evaluation team will keep your information private. All data will be stored securely. However, there is a small risk of a data breach. This study is covered by a Certificate of Confidentiality from the National Institutes of Health, which protects your information from being released without your permission. There are some important things that you need to know. The Certificate DOES NOT stop reporting that federal, state or local laws require. For example, there are laws that require reporting of child or elder abuse, some communicable diseases, and threats to harm yourself or others. The Certificate of Confidentiality does not stop you from willingly releasing information about your involvement in this research. It also does not prevent you from having access to your own information.

WHO CAN I CONTACT IF I HAVE QUESTIONS?

- **Evaluation Team**: Darren Urada at (310) 267-5227 or durada@mednet.ucla.edu or Howard Padwa at hpadwa@mednet.ucla.edu
- **UCLA Office of the Human Research Protection Program (OHRPP)**: (310) 206-2040; participants@research.ucla.edu; Box 951406, Los Angeles, CA 90095-1406

WHAT ARE MY RIGHTS?

You can choose whether or not to participate.

You can stop participating at any time without penalty.

You can refuse to answer any questions and still complete the surveys and interviews.

DO YOU CONSENT TO START THE SURVEY?

- ○ Yes, I consent to start the survey.
- ○ No, I do not consent to start the survey.
- ○

Skip To: End of Survey If University of California, Los Angeles INFORMATION SHEET Recovery Incentives Program: California's... = No, I do not consent to start the survey.

Site: (prefilled)

_____

Eligibility items

Your Name:

Note: Your name must match your enrolled name in the Incentive Manager portal for us to verify your identity and offer you payment.

_____

Which week of the Recovery Incentives Program are you in?

▼ I have not officially started the program. ... Weeks 13 to 24

Do you have a mobile phone number (with text/short message services [SMS], and internet capabilities) and/or email address that we can use to directly contact you for follow-up surveys and to pay you for participation?

- ○ Yes
- ○ No

How long have you been in substance use disorder treatment before starting the Recovery Incentives Program?

- ○ I started treatment this week
- ○ One month or less
- ○ More than one month
- ○ Other (please explain): _____

Client motivation

Think about your motivation to start the Recovery Incentives Program. Please share why you chose to join.

_____

_____

_____

PROMIS items

Please respond to each question or statement by marking one box per row.

In the past 30 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I felt that my drug use was out of control.	○	○	○	○	○
I had a drug problem.	○	○	○	○	○

In the past 30 days...

	Never	Rarely	Sometimes	Often	Almost always
My drug use caused problems with people close to me.	○	○	○	○	○
I craved drugs.	○	○	○	○	○
I spent a lot of time using drugs.	○	○	○	○	○

Last 30 days use-counts data

In the last 30 days, how many days have you used stimulants?

This includes substances like amphetamines, methamphetamines, and cocaine.

▼ 0 ... 30

Display this question:

If In the last 30 days, how many days have you used stimulants? This includes substances like amphet... = 0

You reported that you did not use stimulants in the last 30 days, which includes weeks before you entered the Recovery Incentives Program. Is this correct?

○ Yes

○ No

Display this question:

If You reported that you did not use stimulants in the last 30 days, which includes weeks before you... = Yes

Congratulations on achieving zero days of stimulant use in the past month. What are some factors or reasons that helped you not use? (Check all that apply)

During the last 30 days before entering the Recovery Incentives Program...

- ☐ I received outpatient treatment
- ☐ I lived in a residential treatment program
- ☐ I lived in a Recovery Residence / Sober Living Environment
- ☐ I was in a controlled environment where access to substances are restricted (hospital, incarcerated, etc)
- ☐ I avoided triggers or high-risk situations
- ☐ I didn't have a stimulant addiction
- ☐ Other (please describe): _____

Display this question:

If You reported that you did not use stimulants in the last 30 days, which includes weeks before you... = No

In the last 30 days, how many days have you used stimulants? ***This includes substances like amphetamines, methamphetamines, and cocaine.***

▼ 0 ... 30

In the last 30 days, how many days have you used drugs and alcohol, other than stimulants?

▼ 0 ... 30

RSUDA Items

The following questions are about your stimulant use. Please respond to each question or statement by marking one box per row.

Did you ever need to use more stimulants to get the same high as when you first started using stimulants?

	Yes	No
In your life	○	○
In the past 12 months	○	○
In the past 3 months	○	○

Did the idea of missing a fix (or dose) ever make you anxious or worried?

	Yes	No
In your life	○	○
In the past 12 months	○	○
In the past 3 months	○	○

In the morning, did you ever use stimulants to keep from feeling "the crash"/depressed or did you ever feel "the crash"/depressed?

	Yes	No
In your life	○	○
In the past 12 months	○	○
In the past 3 months	○	○

Did you worry about your use of stimulants?

	Yes	No
In your life	○	○
In the past 12 months	○	○
In the past 3 months	○	○

Did you find it difficult to stop or not use stimulants?

	Yes	No
In your life	○	○
In the past 12 months	○	○
In the past 3 months	○	○

Did you ever need to spend a lot of time/energy on finding stimulants or recovering from feeling high?

	Yes	No
In your life	○	○
In the past 12 months	○	○
In the past 3 months	○	○

Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of stimulants?

	Yes	No
In your life	○	○
In the past 12 months	○	○
In the past 3 months	○	○

Treatment Effectiveness Assessment (2019 version)

The following questions ask you how you are doing in four areas that are important in your treatment and recovery: stimulant use, substance use, health, lifestyle, and community. Think about how things are for you in those areas and select the number that best describes your situation: the more you have improved, the higher the number – from 1 (not well at all) to 10 (extremely well). Feel free to write down the one or two changes most important to you in the Remarks section.

Stimulant Use: How are you doing with reducing stimulant use? Consider the frequency and amount of use, money spent on stimulants, amount of drug craving, time spent being high, being sick, in trouble, and in other drug-using activities, etc.

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Substance Use: How are you doing with reducing substance use? Consider the frequency and amount of use, money spent on drugs and alcohol, amount of drug craving, time spent being high/drunk, being sick, in trouble, and in other drug-using activities, etc.

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Health: How are you doing with your health? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc.?

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Lifestyle: How are you doing in terms of your personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Community: How are you doing in the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Gift Card items

Are there any gift cards that are not offered in the Recovery Incentives Program that you wish were?

_____

_____

_____

Is there anything else that you would like to share about your expectations or experience so far with the Recovery Incentives Program?

Your feedback is important in helping us understand your experience in the Recovery Incentives Program and how we can improve it in the future.

_____

_____

_____

Demographics

Please tell us a little about yourself. This helps us make sure that all persons are represented in our results.

Gender Identity

Sexual Orientation

Race/Ethnicity

Age

In addition to the follow up surveys, would you be willing to be contacted for a follow up interview in the coming weeks?

The interviews offer a more in-depth understanding of your treatment experience. Your participation in follow up interviews will also be compensated with an additional gift card.

- ○ Yes
- ○ No

The information below is required for UCLA to issue you a $20 electronic gift card as compensation for participating in this survey. This will be electronically issued (sent via email/text), but can be used in-store or online.

Which type of e-gift card would you like to receive? (Select all that apply.) Gift cards are subject to availability.

- ☐ Amazon
- ☐ Kroger (Food4Less, Ralphs, etc.)
- ☐ Target

Please enter your preferred email address to receive the e-gift card:

_____

Please enter your mobile phone number (with text/short message services (SMS), and internet capabilities):

_____

Please indicate your preference on how to receive the gift card electronically after completing this survey:

- ○ Email
- ○ Mobile phone number (via text/short message services (SMS), with internet capabilities)
- ○ Both are fine
- ○ I do not have an email or a mobile phone number

Display this question:

If Please indicate your preference on how to receive the gift card electronically after completing t... = I do not have an email or a mobile phone number

Please provide a reliable mailing address. Please note that we will not be able to reissue gift cards once mailed.

_____

Display this question:

If In addition to the follow up surveys, would you be willing to be contacted for a follow up interv... = Yes

Can we use the same information above to contact you for a follow-up interview?

- ○ Yes
- ○ No, please contact me at this email/phone number:

_____

- ○ I do not want to be contacted for any future surveys or interviews about the Recovery Incentives Program

Do you have someone who can serve as your backup contact in case we are unable to contact you? If so, please **list up to three contacts** along with their name, their relationship with you, and contact information: We will only mention that we are trying to reach you for a "UCLA Health Study". We will not disclose information that may identify your involvement in the treatment program.

- ○ Name (Contact 1; e.g., Jane Doe) _____
- ○ Relationship (Contact 1; e.g., Mother)
  _____
- ○ Contact information (Contact 1; e.g., janedoe@yahoo.com)
  _____

Would you like to add a second contact?

- ○ Yes
- ○ No

If yes, repeat.

If no, SURVEY END

We thank you for your time spent taking this survey.

UCLA study staff will follow up soon with your issued e-gift card.

If you have any questions, please contact study staff at healthstudy@mednet.ucla.edu.

UCLA Recovery Incentives Client Survey - Longitudinal Week 6

(Collected among clients 6-weeks after completing the Longitudinal Baseline survey

Introduction and ongoing consent

Thank you for continuing to share your experience with the California Recovery Incentives Program (also known as the Contingency Management or CM Program).

This is your 6-week follow-up survey, and we'd like to hear how you're doing. It should take about 10 minutes to complete.

As a thank you, UCLA will send you a $40 e-gift card after you finish the survey.

Please note: Even if you are no longer participating in the program, your feedback is still very important. We want to understand what worked well, what didn't, and how we can improve the program for others. Your insights will help shape future treatment experiences.

Your responses are confidential and will not be shared with your treatment provider. All information is securely stored on encrypted systems with dual authentication. Any data used in UCLA's reports will be combined and will not include your name or any identifying details. Participation is completely voluntary. At the end of the survey, we'll ask for your preferred contact information so we can send your e-card. Our goal is to deliver it within 48 hours (Monday–Friday) after you complete the survey.

Please complete the survey only once.

- ○ Yes, I agree to start the survey.
- ○ No, I do not wish to proceed or complete the survey.

Skip To: End of Survey If Thank you for continuing to share your experience with the California Recovery Incentives Program... = No, I do not wish to proceed or complete the survey.

Client Verification

Your First and Last Name: *Note: Your name must match your enrolled name in the Recovery Incentives Program for us to verify your identity and offer you payment.*

_____

Please enter your age in years: _____

Client status

Are you still active in the Recovery Incentives program? *(In other words, you are continuing to earn gift cards by testing negative for meth, cocaine, and other stimulants at your outpatient center)*

- ○ Yes
- ○ No

Display this question:

If Are you still active in the Recovery Incentives program? (In other words, you are continuing to e... = No

Why did you leave the Recovery Incentives program? (Select all that apply)

- ☐ Transportation issues
- ☐ Hard to attend the scheduled testing appointments due to other responsibilities (for example, family/work/school)
- ☐ I got a job/ I enrolled in school
- ☐ I moved somewhere else
- ☐ Recommendations from my provider (for example: I was recommended to a higher level of care)
- ☐ The incentives were not helpful for me
- ☐ I could not produce a negative stimulant urine drug test
- ☐ Concerns about the program environment
- ☐ Other (please explain):_____

Open response feedback

If you were the leader of the Recovery Incentives Program, how would you change it for the better?

_____

_____

_____

_____

_____

PROMIS items

Please respond to each question or statement by marking one box per row.

In the past 30 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I felt that my drug use was out of control.	○	○	○	○	○
I had a drug problem.	○	○	○	○	○

In the past 30 days...

	Never	Rarely	Sometimes	Often	Almost always
My drug use caused problems with people close to me.	○	○	○	○	○
I craved drugs.	○	○	○	○	○
I spent a lot of time using drugs.	○	○	○	○	○

Last 30 days use - counts data

In the last 30 days, how many days have you used stimulants? *Stimulants include cocaine, methamphetamine, and amphetamines.*

▼ 0 ... 30

In the last 30 days, how many days have you used drugs and alcohol, other than stimulants?

▼ 0 ... 30

Contingency Management impact-Miguel

In your opinion, did the Recovery Incentives Program help you stop using stimulants?

- ○ Yes, it helped me a lot
- ○ Yes, it helped me a little
- ○ No, it made no difference
- ○ No, it had a negative impact

Please explain:

_____

Program satisfaction

On a scale of 1-10, with 1 being the least satisfied and 10 being the most satisfied, how satisfied are you with the Recovery Incentives Program?

1 2 3 4 5 6 7 8 9 10

Treatment Effectiveness Assessment

The following questions ask you about how you are doing in areas that are important in your treatment and recovery: Stimulant Use, Substance Use, Health, Lifestyle, and Community. Think about how things are for you in those areas and select the results on the scale that best describes your situation, from 1 (not well at all) to 10 (extremely well). Feel free to write down the one or two changes most important to you in the Remarks section.

Stimulant Use: How are you doing with reducing stimulant use? Consider the frequency and amount of use, money spent on stimulants, amount of drug craving, time spent being high, being sick, in trouble, and in other drug-using activities, etc.

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Substance Use: How are you doing with reducing other drugs and alcohol use? Consider the frequency and amount of use, money spent on drugs and alcohol, amount of drug craving, time spent being high/drunk, being sick, in trouble, and in other drug-using activities, etc.

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Health: How are you doing with your health? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc.?

Not well at all Fair Extremely well
1 2 3 4 5 6 7 8 9 10

Remarks: _____

Lifestyle: How are you doing in terms of personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

Not well at all				Fair					Extremely well
1	2	3	4	5	6	7	8	9	10

Remarks: _____

Community: How are you doing in the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

Not well at all				Fair					Extremely well
1	2	3	4	5	6	7	8	9	10

Remarks:_____

Treatment Perceptions

Please answer these questions about your experience with the Recovery Incentives Program to help improve services. Please use "Not Applicable" if the question is about something you have not experienced.

	Strongly agree	Agree	I am neutral	Disagree	Strongly disagree	Not Applicable
Because of the services I am receiving, my depression and/or anxiety has improved.	○	○	○	○	○	○
Because of the services I am receiving, my living situation is more stable.	○	○	○	○	○	○

Absences

Have you ever had an **unexcused absence** from your Recovery Incentives Program urine drug test (UDT) appointment? *(In other words, you missed a urine drug test and were unable to show documentation excusing your absence.)*

- ○ Yes
- ○ No

Display this question:

If Have you ever had an unexcused absence from your Recovery Incentives Program urine drug test (UDT... = Yes

What were the reasons that you had unexcused absence(s) from your UDT appointment? (Check all that apply)

- ☐ I had transportation issues
- ☐ I had childcare/family obligations
- ☐ I had work/school obligations
- ☐ I had a conflicting appointment related to my treatment
- ☐ I had a conflicting appointment unrelated to my treatment
- ☐ I forgot
- ☐ I was sick
- ☐ I knew I was going to test positive
- ☐ Other: (please describe) _____

Display this question:

If Have you ever had an unexcused absence from your Recovery Incentives Program urine drug test (UDT... = Yes

When you had an unexcused absence, what percentage of the time do you think your urine drug test would have come back negative for stimulants (meaning, no stimulants detected)?

I didn't have unexcused absences

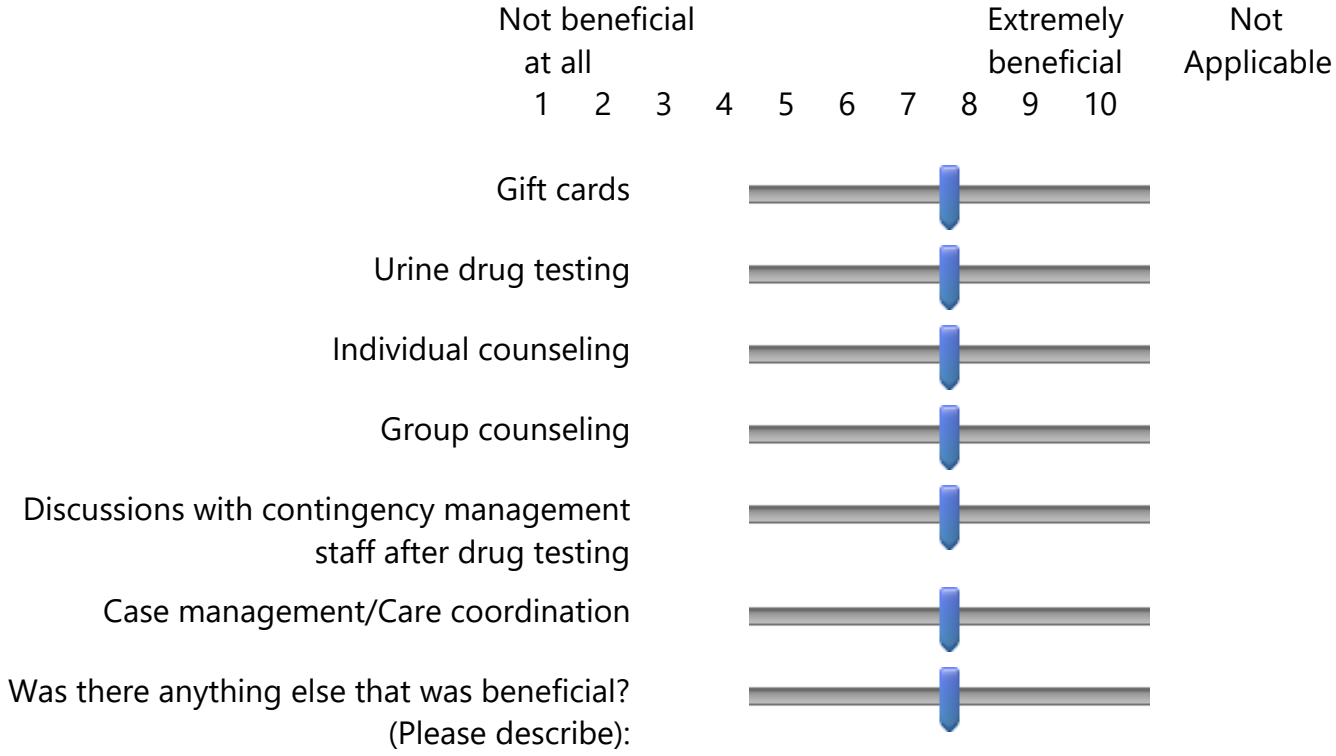
0 10 20 30 40 50 60 70 80 90 100

UDT TESTING

Which of the following experiences did you have with urine drug testing in the Recovery Incentives Program? (Check all that apply)

- ☐ I expected to test positive for stimulants, but I tested negative for stimulants
- ☐ I expected to test negative for stimulants, but I tested positive for stimulants
- ☐ There was not enough privacy when I was providing the urine sample
- ☐ I could not provide a sample that day
- ☐ I would have preferred to provide a saliva sample instead
- ☐ I would have preferred to provide a hair sample instead
- ☐ Other: (please describe) _____
- ☐ None of these apply to me

From 1 (Not beneficial at all) to 10 (Extremely beneficial), how beneficial is each of the below aspects of your treatment for stimulant use? Please move the slider to your desired rating. If some aspects do not apply to you, please select "Not Applicable".



Incentives

How adequate do you think the current amount of the incentives is ($599 limit) to change your stimulant use?

- ○ Not adequate
- ○ Somewhat adequate
- ○ Moderately adequate
- ○ Mostly adequate
- ○ Completely adequate
- ○ **Not sure**

Please explain (optional):

_____

We would like your thoughts about the way the incentive rewards are set up.

For example:

- How the rewards are scheduled,
- How the rewards increase with no use,
- How the rewards reset if a urine drug test is missed,
- How the rewards reset if a urine drug test is positive for stimulants, and
- How you can regain previously earned reward levels

Do you have any suggestions to change how the incentive rewards are set up?

○ Yes

○ No

Display this question:

If We would like your thoughts about the way the incentive rewards are set up. For example: How the... = Yes

What changes would you suggest?

_____

_____

_____

_____

_____

Recovery Incentives Impact on use – Rating

When you get into a situation where you would have used in the past, how does being in a program that offers incentives help you not use? **Please select all that apply.**

- ☐ I don't get triggered
- ☐ I don't crave
- ☐ I think of the incentive and don't want to lose the money
- ☐ I think about how proud I feel when I earn the gift cards and I don't want to mess up
- ☐ I think about how happy I am that I can buy things for my family and I don't want to mess up
- ☐ I visualize meeting with the CM coordinator and getting praise and my gift card credit.
- ☐ It gives me a positive thought/idea to focus on which replaces my thinking about drug use.
- ☐ I don't want to disappoint the program staff
- ☐ I don't want to disappoint my counselor
- ☐ Others (please specify below): _____
- ☐ Being in a program that offers incentives does not help me

Gift Card – open ended

Are there any gift cards that are not offered in the Recovery Incentives Program that you wish were?

_____

_____

_____

Gift Card-spending

Generally, how did you spend/plan to spend your gift card incentives? (Select all that apply)

- ☐ On food
- ☐ On hygiene (soap, shampoo, etc)
- ☐ On transportation
- ☐ On basic household needs
- ☐ On clothing
- ☐ On hobbies/interests
- ☐ On family members and/or children
- ☐ I don't know yet, I'm saving/banking my earnings
- ☐ Other (please explain): _____

Improvements

Is there anything else that you would like to share about your experience so far with the Recovery Incentives Program? (For example, likes/dislikes, benefits/difficulties, things you would change about the program, etc). Your feedback is important in helping us understand your experience in the Recovery Incentives Program and how we can improve it in the future.

_____

_____

_____

Contact information update

Confirmation of contact preferences

Gift card preference for compensation

Survey end

We thank you for your time spent taking this survey. Your response has been recorded.
If you have any questions, please contact study staff at healthstudy@mednet.ucla.edu.

UCLA Recovery Incentives Provider Survey

Introduction

On behalf of DHCS, the UCLA Evaluation team wants your help assessing the implementation and effectiveness of the *Recovery Incentives Program: California's Contingency Management Benefit*. Your valuable input will help us better understand your experiences with the Recovery Incentives Program and identify areas for improvement.

This survey should take around 10 minutes. We are offering a $30 gift card upon completion of this survey, delivered via email. While your name and e-mail address are required to invite you to this survey and send you a gift card upon completion, **your responses will remain confidential; your answers will not be shared with your agency.**

If you have any questions or need assistance with the survey, please contact Celine Tsoi (szeyicelinetsoi@mednet.ucla.edu).

Role & Experience of Respondent

What is your primary role in the Recovery Incentives Program?

- ☐ Contingency Management Coordinator
- ☐ Contingency Management Supervisor
- ☐ Counselor
- ☐ Contingency Management Backup Coordinator
- ☐ Another (please specify): _____

What is your secondary role in the Recovery Incentives Program? (*Select all that apply*)

- ☐ I don't have a secondary role
- ☐ Contingency Management Supervisor
- ☐ Contingency Management Coordinator
- ☐ Counselor
- ☐ Contingency Management Backup Coordinator
- ☐ Another (please specify): _____

Have you completed any of the DHCS-sponsored Recovery Incentives Program trainings described at https://www.uclaisap.org/recoveryincentives?

- ○ Yes
- ○ No
- ○ Not sure

Have you completed any OTHER contingency management training?

- ○ Yes
- ○ No
- ○ Not sure

How many years of experience do you have working in the field of substance use disorder treatment?

- ○ Less than 1 year
- ○ 1-5 years
- ○ 6-10 years
- ○ 11-20 years
- ○ More than 20 years

CM Knowledge

To start, we want to learn a little bit about your perceptions of contingency management.

Which of the following statements is true?

- ○ Both incentives and punishers can be used to change behaviors
- ○ In most cases, only incentives can change behaviors
- ○ In most cases, only punishers can change behaviors
- ○ In most cases, neither incentives nor punishers can change behaviors effectively

For contingency management procedures to work best:

- ○ The recovery incentive should be given delayed in time, so clients learn to delay gratification
- ○ The recovery incentive should be given as soon as possible after the behavior occurs
- ○ The magnitude of the recovery incentive should decrease over time so long as the client remains abstinent
- ○ The magnitude of the recovery incentive provided should be kept consistent over time

Concerns (Identified from UCLA's Initial Recovery Incentives Report)

The following are concerns raised during the planning phase of the Recovery Incentives Program. We'd like your feedback on how often they have actually occurred.
Please indicate how frequently these issues have occurred in the Recovery Incentives Program at your location to the best of your knowledge**.**

	1- Never	2 - Rarely	3 - Sometimes	4 - Often	5 - All of the time	**Not sure**
A client was upset and disruptive because they were not eligible for the program (e.g. medication conflicts, not Medi-Cal eligible, no StimUD).	○	○	○	○	○	○
Discussing positive urine drug test (UDT) results undermined the relationship between a client and staff.	○	○	○	○	○	○
An invalid / potentially tampered urine drug test (UDT) sample was detected for a client.	○	○	○	○	○	○
A client was suspected of using stimulants but this could not be confirmed using the current testing protocols.	○	○	○	○	○	○
We felt compelled to share a client's Recovery Incentives Program urine drug test (UDT) results with other agencies (e.g., criminal justice, child-welfare programs).	○	○	○	○	○	○
A client was admitted to the Recovery Incentives Program but staff suspected they did not actually have a stimulant use disorder.	○	○	○	○	○	○
Staff experienced difficulty using the Incentive Manager Software.	○	○	○	○	○	○
Recovery Incentives procedures took too much staff time and effort.	○	○	○	○	○	○
A member of the community expressed disapproval of the Recovery Incentives Program.	○	○	○	○	○	○

If you would like to clarify any of your ratings above or identify a concern that isn't listed above, please do so here (optional):

_____

_____

Questions drawn from the CMBQ Questionnaire

Please rate the following statements using the scale:

1 = Strongly Disagree, 5 = Strongly Agree

	1 - Strongly Disagree	2	3	4	5 - Strongly Agree
Contingency Management (CM) doesn't address the underlying cause of addiction.	○	○	○	○	○
My agency / supervisors / administrators do not support CM (e.g., do not provide resources).	○	○	○	○	○
I find CM distasteful because it is basically paying someone to do what they should do already.	○	○	○	○	○
CM is helpful because it helps keep clients engaged in treatment long enough for them to really learn valuable skills.	○	○	○	○	○
I feel qualified/properly trained to administer contingency management interventions.	○	○	○	○	○
Providing financial incentives undermines the clients' internal motivation to refrain from using substances.	○	○	○	○	○
CM helps clients refrain from using substances so that they can work on other aspects of treatment.	○	○	○	○	○

Other Implementation Elements

On a scale of 1 (poor) to 5 (excellent), how would you rate the incentive manager software?

	1 - Poor	2 - Fair	3 - Good	4 - Very good	5 - Excellent	**Not sure**
Overall	○	○	○	○	○	○
User-friendliness	○	○	○	○	○	○
Reliability (whether the site crashes/freezes)	○	○	○	○	○	○
Customer support	○	○	○	○	○	○
Accuracy of algorithm relative to urine drug test (UDT) input and incentive amount	○	○	○	○	○	○

Please explain areas in which the incentive manager software can improve on (optional):

_____

On a scale of 1 (completely disagree) to 5 (completely agree), please rate how much you agree with the following statements about urine drug test (UDT) protocols:

	1 - Completely disagree	2 - Disagree	3 - Neither agree nor disagree	4 - Agree	5 - Completely agree	**Not sure**
The UDT testing protocols are strict enough to prevent potential tampering of results.	○	○	○	○	○	○
The UDT testing protocols are too burdensome to staff and clients	○	○	○	○	○	○

Would you prefer to be using saliva drug testing instead of urine drug testing?

- ○ Yes
- ○ No
- ○ No preference
- ○ Not sure

Please explain (optional):

_____

How adequate do you think the current amount of the incentives is ($599 limit) to change stimulant use?

- ○ 1 - Not adequate
- ○ 2 - Somewhat adequate
- ○ 3 - Moderately adequate
- ○ 4 - Mostly adequate
- ○ 5 - Completely adequate
- ○ **Not sure**

Please explain (optional):

_____

How would you rate the DHCS-sponsored Recovery Incentives Program trainings (*described at* https://www.uclaisap.org/recoveryincentives) you received prior to delivering Contingency Management (CM) services?

- ○ 1 - Not sufficient
- ○ 2 - Somewhat sufficient
- ○ 3 - Moderately sufficient
- ○ 4 - Mostly sufficient
- ○ 5 - Completely sufficient
- ○ **Not applicable**

Please explain (optional):

_____

How concerned are you about maintaining the three staff positions the Recovery Incentives Program requires (*CM Coordinator, Backup Coordinator, Supervisor*) due to staff turnover?

- ○ 1 - Not concerned at all
- ○ 2 - Somewhat concerned
- ○ 3 - Moderately concerned
- ○ 4 - Very concerned
- ○ 5 - Extremely concerned
- ○ **Not applicable**

Please explain (optional):

_____

Additional items

What impact does the Recovery Incentives Program have on clients' engagement with other programs/services at your site?

- ○ 1 - Extremely negative
- ○ 2 - Somewhat negative
- ○ 3 - Neither positive nor negative
- ○ 4 - Somewhat positive
- ○ 5 - Extremely positive
- ○ **Not sure**

Although it is not required as part of the Recovery Incentives Program protocol, are you conducting any separate regular testing for fentanyl use?

- ○ Yes
- ○ No

Display This Question:

If Although it is not required as part of the Recovery Incentives Program protocol, are you conducti... = Yes

Please elaborate on how you are conducting separate regular testing for fentanyl use:

_____

Is there anything else you would like to add as feedback about the Recovery Incentive Program?

_____

Compensation

To receive your gift card, please provide us with your preferred email address.
(If you do not want to receive a gift card, please leave this field blank.)

_____

Your opinions as providers are very important for this evaluation and to the future of the Recovery Incentives Program. To gain more in-depth insights on experiences, a small sample of providers may be selected for a follow-up interview (*for an additional gift card*).

If you are selected, may we contact you?

- ○ Yes
- ○ No

Display This Question:

If Your opinions as providers are very important for this evaluation and to the future of the Recove... = Yes

Thank you. Please confirm the preferred email for the UCLA Evaluation Team to reach you in the year ahead.

- ○ Same as the one I provided for the gift card
- ○ I would like to provide a different email: _____

Demographics

Lastly, please tell us a little bit about yourself:

Have **you** or any of your **loved ones** ever received treatment for a substance use disorder?

- ○ Yes
- ○ No
- ○ Prefer not to say

Gender Identity

Sexual Orientation

Race/Ethnicity

Age

END

PROMPTS FOR SEMI-STRUCTURED INTERVIEWS WITH

PROVIDERS IN RECOVERY INCENTIVES PROGRAM

Thank you for taking the time to speak with us today. The purpose of this interview is for us to learn about your experience in California's Recovery Incentives Program for the treatment of stimulant use disorders. You were selected for an interview because you are a provider in the Recovery Incentives Program. If you agree to participate in this interview, we will use the information from our conversation today for our evaluation of the Recovery Incentives Program, to learn about ways the Recovery Incentives Program may be helpful, and ways that it can be improved. This interview will take approximately 30-45 minutes. The interview will be recorded to ensure we have an accurate record of our conversation, and we have a federal Certificate of Confidentiality for our evaluation, meaning that nobody except staff on the UCLA evaluation team will have access to the recording or any information we discuss unless you disclose information about imminent danger to yourself or others that we are legally required to report. Our recordings and notes will be kept on encrypted, password protected computers to ensure confidentiality.

We do not anticipate any risks from your participation in this interview except for potential discomfort discussing experiences with your job. The benefits of participation include the opportunity to make your voice heard and help improve the experience of treating stimulant use disorders and treatment outcomes in the future. Your participation in this interview is completely voluntary, and there is no penalty for refusing participate or ending the interview early if you choose. If you do complete the interview, you will receive a $50 gift card.

If you have any questions about your rights as a participant in this project, you can contact the UCLA Office of the Human Research Protection Program by phone at (310) 206-2040 or by email at participants@research.ucla.edu. You can also reach out to the study coordinator [insert info].

Do you have any questions for me before we begin? If not, I will turn on the recorder and we will begin our interview now.

1. For starters, tell me about your history working in SUD treatment.
    a. What is your job title?
    b. How long have you been in the field?
    c. Prior to the Recovery Incentives Program, what did you generally do with clients?
    d. Did you have any experience with contingency management prior to the Recovery Incentives Program? If so, tell me a little bit about it.

2. When you first heard about the Recovery Incentives Program, what was your reaction? What sounded good about it? What caused you concern?

3. Tell me a little bit about how you have engaged clients in the Recovery Incentives Program.
    a. How do you make people aware of the program?
    b. How do you describe it to them?

4. Walk me through the process of how a Recovery Incentives visit typically goes.
    a. Urine drug test: How does it usually work? What parts of it seem to go smoothly? Are there any parts of it that have been difficult? If so, what solutions have you used to address these challenges?
    b. Discussing stimulant-negative results with participants – How does it usually work? What parts of it seem to go smoothly? Are there any parts of it that have been difficult? If so, what solutions have you used to address these challenges?
    c. Discussing stimulant-positive results with participants - How does it usually work? What parts of it seem to go smoothly? Are there any parts of it that have been difficult? If so, what solutions have you used to address these challenges?
    d. Giving clients their incentive - How does it usually work? What parts of it seem to go smoothly? Are there any parts of it that have been difficult? If so, what solutions have you used to address these challenges?

5. Based on what you've seen, what impact has the Recovery Incentives program had for clients?
    a. How has it impacted their use of stimulants? Other substances?
    b. How has it impacted other parts of their treatment (use of other services offered by the treatment program)?
    c. How has it impacted their overall health and well-being?
    d. To get a sense of the program's impact, can you tell me a story of a client you would consider to have "succeeded" with the Recovery Incentives Program? One who did "not succeed"?

6. How well does the incentive manager software work for you? What is good about it? What are some ways it could be improved?

7. From a workload and staffing perspective, has it been difficult to implement the Recovery Incentives Program?
    a. Challenges with having enough staff?
    b. Finding time to manage incentives and enter data into incentive manager?
    c. Having enough time to discuss test results with clients?
    d. How would you say it has impacted your job?

8. If I were to put you in charge of the Recovery Incentives Program, what would you change? What would you keep the same?
    a. Clinically (target substance/behavior, combination with other therapies)
    b. Administratively (the procedure itself, training/support, documentation requirements)

9. Beyond what we've already discussed, is there anything else you'd like to share about your experience with the Recovery Incentives Program? Final thoughts on its strengths and ways it could be improved?

Thank you for your time!