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Treating Stimulant Use Disorder:
CalAIM's Contingency Management Pilot

In the years before the COVID-19 pandemic, the United States was already seeing increasing numbers of drug overdose deaths. More than 70,000 people died of an overdose in 2019.[1] Today, many health care providers and public officials are actively promoting evidence-based treatments to help people recover from substance misuse and substance use disorder. Medication-assisted treatment (MAT) continues to be the gold standard of care for opioid and alcohol use disorders, and states like California have made considerable progress in ensuring access to these services for Medicaid enrollees. However, the overdose epidemic in California has changed significantly in the last decade. Each year an increasing number of people die from an overdose resulting from stimulants, which include both illicit drugs, such as cocaine and methamphetamine, and prescription drugs, such as amphetamine.[2]

While there are currently no Food and Drug Administration (FDA)–approved medications to address stimulant use disorders, contingency management (CM) is a proven, effective non-medication approach. CM is a treatment service that relies on reinforcing substance use reduction and abstinence with positive rewards. California recently received authorization through a Medicaid waiver from the federal Centers for Medicare & Medicaid Services (CMS) to include CM as a Medi-Cal covered service under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. In fall 2022, California will become the first state in the nation to cover CM as a Medicaid benefit, and to evaluate its effectiveness when launched at scale in a large state.

What is the current state of the stimulant use crisis in California?

While California has fared better than other states when it comes to the overdose epidemic, it has nonetheless been unable to stop the accelerated increase of overdose deaths. In 2020, the California Department of Public Health (CDPH) reported 8,894 deaths due to an overdose, an increase of 43% from 2019.[3] Of those deaths, more than half involved use of a stimulant, such as methamphetamine or cocaine. In addition, the rate of stimulant use disorder–related overdose deaths in California almost quadrupled between 2011 and 2019.[4] Although many of these stimulant use–related deaths also involved fentanyl or another opioid, most people who consume fentanyl are unaware that their stimulant drugs contain dangerous amounts of the potent opioid, which means they inadvertently consume fentanyl while using stimulants.[5]

The number of people diagnosed with substance use disorders (SUDs) in California has also continued to trend upwards, and stimulant use disorders now represent a significant portion of these conditions. The state experienced a reduction in misuse of pain medications in the five-year period from 2014 to 2019, but use of stimulants increased during that same time frame. Reported cocaine use rose by 27% from 2014 to 2019, and use of methamphetamine increased by 25% from 2016 to 2019.[6] The number of nonfatal emergency department visits due to amphetamine use also doubled from 2018 to 2020. Latino/x Californians accounted for 40% of those ED visits, while Black Californians had the highest rate of nonfatal ED visits

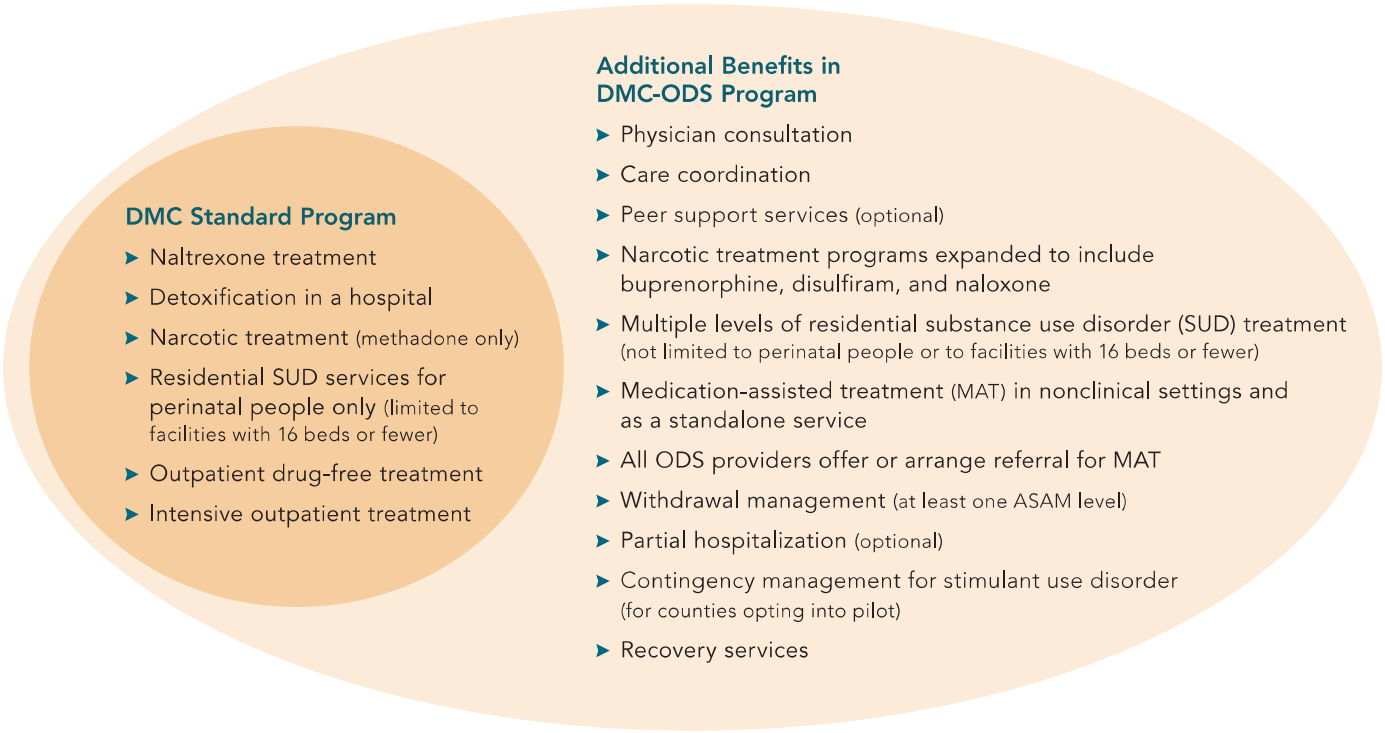
for amphetamine, highlighting the need to care for people with stimulant use disorders as a measure to address health disparities among Californians.[7]

How is SUD care delivered in Medi-Cal, and what changes does CalAIM introduce?

Medi-Cal pays for 28% of all SUD treatment in California, making the program the single largest source of insurance coverage for Californians with SUDs.[8] Medi-Cal SUD services are provided primarily through county-based drug and alcohol plans under the statewide Drug Medi-Cal (DMC) program. As part of DMC, all counties are responsible for contracting with SUD providers for delivery of basic services at various levels of care, including outpatient services, intensive outpatient treatment, residential services in facilities with up to 16 beds, and MAT when delivered or administered at narcotic treatment programs (NTPs).[9] In addition, Medi-Cal covers, on a fee-for-service basis, all FDA-approved medications for treating alcohol and opioid use disorders, as well as naloxone, the opioid overdose–reversal medication.[10]

Since 2015, counties have the option of participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) program, a component of California's Medicaid federal waiver program.[11] Under DMC-ODS, participating counties are responsible for providing, in addition to all DMC services, residential services in facilities with more than 16 beds, NTP services not limited to methadone treatment, at least one American Society of Addiction Medicine (ASAM) level of withdrawal management, recovery services, care coordination, MAT provided in nonclinical settings (such as street-based outreach programs) and as a standalone service, and clinician consultation (Figure 1).[12] In addition, counties participating in DMC-ODS have the option of providing partial hospitalization and additional levels of inpatient, residential, and withdrawal management services. As of January 2022, 37 counties, accounting for 96% of California's population, have opted to participate in the DMC-ODS program.[13]

Figure 1. Services Covered in Drug Medi-Cal Organized Delivery System (DMC-ODS)



In December 2021, CMS approved the CalAIM waiver request. In so doing, CMS reaffirmed various changes implemented as part of a one-year extension to the original section 1115 waiver, and authorized new changes to the DMC-ODS benefit structure.[14] First, CalAIM removed limitations on the number of residential treatment episodes that can be reimbursed in a one-year period and on the maximum number of days in a residential stay, calling instead for an individualized clinical needs assessment. At the same time, CalAIM now requires all SUD providers, including residential facilities, to either offer or have effective referral mechanisms for MAT in place. The approved waiver also clarifies that NTPs may be reimbursed for ordering, prescribing, administering, and monitoring of all medications for SUDs, as well as for counseling associated with MAT.

CalAIM also extends coverage for nonresidential DMC-ODS services to include the 30-day period following an assessment, regardless of whether an SUD was diagnosed. After this period, adult enrollees are eligible for services if they have an SUD diagnosis. People leaving incarceration are also eligible for services if they had an SUD diagnosis prior to incarceration. Meanwhile, enrollees under 21 are still covered by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) medical necessity criteria.[15] In fact, CalAIM clarifies that, in order to comply with EPSDT requirements, early intervention services (ASAM level 0.5) are available for enrollees under 21 in DMC-ODS counties without the requirement of an SUD diagnosis, and that all DMC-ODS services are available for enrollees under 21 even in DMC counties that do not participate in the DMC-ODS program.[16]

Finally, CalAIM requested coverage for three specific new benefits: traditional healers and natural helper services for American Indian and Alaska Native enrollees (proposed to be required for DMC-ODS counties but not yet approved by CMS); peer support specialist services (optional for DMC-ODS counties, covered effective July 1, 2022); and CM for stimulant use disorders (optional for counties wishing to participate in the pilot program, covered effective fall 2022).[17]

What is contingency management, and what does the research show about its effectiveness?

Contingency management consists of behavioral health interventions that positively reinforce desired outcomes. The program typically consists of providing participants with prizes or vouchers exchangeable for goods and services each time a desired behavior is achieved (incentives typically reset to their starting levels when the behavior is not achieved). A recent example of CM in a non-SUD context is the use of payment to reward people who receive the COVID-19 vaccine. California implemented such a program and targeted Medicaid enrollees specifically in order to improve vaccination rates among this population. In the case of CM for people with SUDs, participants are usually rewarded each time they return a negative test for the presence of a particular substance. The goal of the treatment service is to eliminate the use of substances that may be contributing to an SUD, at least for the duration of the treatment course, followed by other types of interventions to prevent relapse and reoccurrence of the SUD.

CM services are effective in treating various SUDs among different age groups, ranging from adolescents to adults.[18] CM has a positive impact on the use of opioids, marijuana, alcohol, nicotine, and stimulants.[19] The service increases levels of abstinence, medication adherence, and treatment engagement at all levels of care, including outpatient and residential settings. CM interventions are particularly effective in treating stimulant use disorders. A recent meta-analysis found that 18 of 22 studies (81.8%) evaluated reported that CM had statistically significant effects on reducing stimulant use.[20] The results demonstrated that 75.8% of CM participants had a better outcome than the mean outcome in the control group. Another meta-analysis of studies on treating veterans enrolled in CM programs

found that the average abstinence rate, based on negative test results, exceeded 90%.[21]

While CM increases abstinence during the course of treatment, evidence around sustained effectiveness post-CM treatment period is weaker. In some studies, the average effect of CM was not sustained significantly six months after CM ended.[22] However, other findings indicate that establishing and maintaining abstinence during treatment facilitates overall recovery by allowing patients to engage productively in other services that prioritize broader psychosocial aspects of recovery.[23] In addition, some studies have found that, because of the importance of social determinants of health on the prevalence of SUDs, offering incentives that help people develop skills that can then be useful in gaining employment may be more effective for maintaining healthy habits in the long run than other interventions.[24]

CM has been implemented in private settings across the US, which has prompted some legal analysts to question the legality of potentially using federal funds to pay for the incentives in the face of federal anti-kickback laws and laws prohibiting certain kinds of inducements for services among enrollees. In a 2008 advisory opinion, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) analyzed whether CM incentives would violate the federal anti-kickback statute or prohibitions against inducements to enrollees of public programs to access certain services.[25] This advisory opinion concluded there are ways to design CM programs that do not violate federal law. In particular, the opinion concluded that factors such as incentives being provided in the form of gift cards instead of cash and the program not being widely advertised contribute to the conclusion that CM programs may incorporate safeguards that ensure compliance with federal anti-kickback laws. In an advisory opinion issued in March 2022 related to a different CM program, HHS-OIG reaffirmed the 2008 conclusion and identified additional potential guardrails that could help avoid illegal action, including offering low-value incentives and loading incentives into smart debit cards, which allow vendors to monitor use of the cards.[26] The approval of CM as a Medicaid benefit is further federal reassurance that CM is considered a legitimate SUD treatment, lowering the concern about violation of anti-kickback laws.

What does DHCS's contingency management pilot program entail?

California's Department of Health Care Services (DHCS) received approval from CMS to use federal matching funds to implement a contingency management pilot program starting no earlier than July 1, 2022, to December 31, 2026. Funding was approved through the Home and Community-Based Services Spending Plan through March 2024. DHCS now formally calls the program "Recovery Incentives: California's Contingency Management Program." While the state intends to expand availability of CM to all counties if the pilot is successful, only DMC-ODS counties may participate in the initial period of the pilot, running from 2022 through March 2024. The pilot will roll out in two phases, the first launching in fall 2022 with seven participating DMC-ODS counties. DHCS expects to publish a final report on the two phases of the pilot program in July 2024.[27]

Contingency Management Pilot Program Is Not Tied to SB 110

CalAIM's contingency management pilot program is not tied to Senate Bill 110. This bill was passed by the California legislature in 2021 but then vetoed by Governor Gavin Newsom.[28] SB 110 would have clarified that CM programs are not in violation of state anti-kickback laws and would have additionally required Medi-Cal to cover CM programs. Governor Newsom's stated reason for his veto was that the 2021 budget included the proposal to incorporate federal funds for CM programs under a pilot that would inform future action to permanently authorize CM coverage under Medi-Cal (the DMC-ODS pilot program).[29]

Responsibilities of Participating Counties and Providers

DHCS has approved 24 counties to participate in the pilot. Criteria for approval included:

- Developing a network of DMC-certified and DMC-ODS–contracted CM providers and ensuring providers comply with federal guidance around CM
- Providing training and technical assistance to participating providers
- Administering funding and reimbursement for CM while adhering to state guidance on funding and reimbursement
- Collecting information from providers and sharing it with the state to support oversight and monitoring
- Monitoring quality of care and implementing necessary changes

All SUD providers seeking to provide the CM benefit must be able to participate in state training that takes place prior to and during the pilot program. Pursuant to state policy, provider organizations are also responsible for assessing each enrollee for eligibility to participate in the CM program, and screening and assessing enrollees for eligibility for other DMC-ODS services. This includes conducting an ASAM assessment within 30 days of entry into care (or 60 days in the case of people experiencing homelessness) to determine the appropriate level of care needed.[30] Providers must also adopt mechanisms to report data to DHCS and the University of California, Los Angeles Integrated Substance Abuse Programs (UCLA ISAP) for monitoring and evaluation of the pilot program.[31]

In addition, each SUD provider organization must designate a CM coordinator, who may be a Licensed Practitioner of the Healing Arts (LPHA), an SUD counselor certified or registered by a DHCS-recognized organization and accredited with the National Commission for Certifying Agencies or a certified peer support specialist. While DHCS recommends counties hire a full-time or part-time CM coordinator, who would focus exclusively on this work, counties are allowed to assign the responsibilities to existing staff when hiring constraints exist. The CM coordinator will be responsible for collecting urine samples, entering test results into the database, and supporting delivery of incentives to enrollees. The CM coordinator will also be responsible for maintaining ongoing communication with enrollees, including explaining and collecting consent forms from them; referring them to additional treatment, such as MAT and naloxone, when necessary; and attempting to contact them after a missed appointment.[32]

Eligibility

While CMS did not explicitly limit the contingency management pilot program to stimulant use disorders, California has elected to focus solely on CM for stimulant use disorders, at least during the initial period of the program. All Medi-Cal enrollees (including those under 21) will be eligible for CM services if they have been diagnosed with a qualifying stimulant use disorder and after an assessment has determined that CM is medically appropriate for the diagnosed stimulant use disorder.[33]

In addition, Medi-Cal enrollees must meet all of the following requirements:[34]

- Reside in a DMC-ODS county that elects and is approved to participate in the CM pilot.
- Have an ASAM multidimensional assessment completed that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0 to 2.5).
- Not be enrolled in another CM program for their SUD (based on the enrollee's electronic health record).
- Not be receiving residential DMC-ODS services.

While most enrollees who receive services through the CM pilot are likely to be eligible for and actively receiving other DMC-ODS services, eligibility for CM is not dependent on participation in other outpatient

treatment programs. In fact, DHCS's policy provides that an enrollee whose SUD provider recommends other treatment in conjunction with CM "will not be penalized, chastised, criticized, or discharged from the [CM] program for failure to participate in all recommended treatment."[35] Similarly, enrollees who voluntarily stop participating in the CM program during a course of treatment or who test positive for stimulant use disorders, making them ineligible to receive CM incentives, will be invited to reenter other forms of treatment.

Services

Eligible Medi-Cal enrollees will participate in a 24-week course of CM treatment, which will be followed by six or more months of recovery support services, as needed. DHCS policy designates weeks 1 to 12 as the escalation/reset/recovery period, and weeks 13 to 24 as the maintenance period.[36] Throughout these 24 weeks, an enrollee may concurrently receive, either through the SUD provider providing CM or through a different SUD provider, the following services: individual, group, or family counseling; MAT; patient education; care coordination; peer support; withdrawal management; and recovery services.[37] During the escalation/reset/recovery period, enrollees will be asked to visit the CM provider/testing site at least twice a week, with each session separated by at least 72 hours for higher testing accuracy. During each visit, the provider will collect a urine sample and test it for the presence of stimulants. For every negative test, the enrollee receives an incentive starting at $10 for the first week and increasing in value by $1.50 per week of treatment. The maximum amount enrollees can receive during these first 12 weeks of treatment (for a total of 24 negative urine tests) is $438.[38]

While an enrollee is not kicked out of the program if they test positive for stimulants, the enrollee receives no incentive in those situations. The enrollee regains eligibility for the incentives as soon as the enrollee tests negative in a subsequent test. At this point, the "reset" period begins, which allows the enrollee to earn $10 for two consecutive negative tests, followed by incentives in the amount the enrollee received immediately prior to testing negative (and increasing by $1.50 for each subsequent week thereafter).[39]

During the maintenance period (weeks 13 to 24), visits to the testing site are reduced to once a week. In weeks 13 to 18, enrollees are eligible to receive an incentive of $15 for each negative test; in weeks 19 to 23, the enrollee receives an incentive of $10 for each negative test; and during week 24, the enrollee receives a final incentive of $21 for a final negative stimulant test. The maximum amount enrollees may receive as incentives during this maintenance period is $161 and, combined with the incentives during the escalation/reset/recovery period, the maximum aggregate incentive amount is $599 per enrollee.[40]

DHCS plans to provide the incentives in the form of gift cards from retail stores, grocery stores, and gas stations. Enrollees will be unable to purchase cannabis, tobacco, alcohol, or lottery tickets with the gift cards, although the mechanisms to enforce these restrictions remain unclear. During the first months of the pilot program, DHCS intends to contract with a web-based incentive manager vendor to manage the tracking and distribution of incentives, which will be provided in the form of printed gift cards. Starting in December 2022, DHCS will contract with a mobile incentive manager vendor to provide access to incentives through smartphones and other mobile devices.[41]

What are some of the challenges the state may face in implementing the contingency management pilot program?

Because California's CM Pilot Program is a novel initiative and the first CM program financed with federal Medicaid funding, the state will likely face challenges during the initial rollout. Since CMS approved CalAIM, DHCS has actively engaged county officials, behavioral health providers, and other stakeholders in

conversations to answer questions and anticipate problems that may arise in real-world scenarios. Some of these potential challenge areas are described below.

CHALLENGE #1

Compliance with Federal Rules

The CalAIM waiver includes an agreement by the state to adhere to federally established conditions (called "Special Terms and Conditions"), which specifically state that California's CM pilot program does not violate federal anti-kickback laws or civil monetary penalty provisions prohibiting inducements to enrollees.[42] This condition responds to DHCS's careful delineation of the program in a way that addresses some of the issues that might contravene these laws. As part of its statewide CM policy, the state has incorporated some of the factors discussed in the 2008 HHS-OIG advisory opinion that shield CM programs from legal liability. Nonetheless, as the program is rolled out, consideration must be given to continuous compliance with federal laws, both at the state level and at the county and provider levels.

Recommendation. DHCS should establish guardrails for counties and providers to avoid noncompliance with federal law. These guardrails should provide examples of practices that may be considered to be inducing referrals to certain SUD providers in violation of federal anti-kickback laws. Moreover, DHCS should provide counties and providers with guidance regarding permissible marketing tactics that call attention to the CM program and other DMC-ODS services without preferentially inducing attendees to certain providers. This is particularly important in large counties that may have a higher number of CM providers. DHCS should clearly communicate these guardrails to counties and providers through state guidance, provider bulletins, and continual training.

CHALLENGE #2

Intake

The success of California's CM program will depend largely on the number of people with stimulant use disorders that it reaches. Because most people with stimulant use disorders are low-income, they are likely eligible for Medi-Cal and, thus, DMC-ODS and CM services, as long as they live in a participating county. However, most people with stimulant use disorders do not know about CM as a service, much less about its new availability in Medi-Cal. People with stimulant use disorders who have no co-occurring SUDs and who are currently not receiving DMC-ODS services for their stimulant use disorders will be harder to reach.

Recommendation. DHCS should engage a varied group of stakeholders in the Medi-Cal system to provide information to enrollees about availability of the CM program. For example, given that some potential enrollees who could benefit from CM are not yet receiving DMC-ODS services, DHCS should engage Medi-Cal managed care plans as well as county mental health plans in DMC-ODS counties, so that they inform and train providers who may be in a position to refer enrollees for CM services. Additionally, DHCS should require residential SUD facilities to incorporate potential referrals to CM providers as part of discharge planning, so that patients with stimulant use disorders can access timely behavioral treatment in their communities. DHCS should also remove the limitation on CM eligibility for patients actively receiving residential treatment. While there are important reasons not to overly incentivize residential treatment by expanding CM in institutional settings, DHCS could address these concerns by requiring residential facilities to connect patients with stimulant use disorders with community-based CM providers rather than offering CM on-site.

The state should also engage jails and prisons to identify inmates who need access to CM quickly upon release. Furthermore, DHCS should identify people who receive SUD care at emergency departments (EDs) or through mobile crisis teams, which for many

people with SUD is the first point of contact with the health care system. ED and mobile crisis providers should be properly informed about the CM pilot, so they can convey information to patients and refer them for treatment as appropriate. Finally, DHCS should engage providers, advocates, activists, and researchers to disseminate information about the program and encourage eligible beneficiaries to participate.

CHALLENGE #3

Provider Participation

Lack of availability of SUD providers is an issue in all California counties but is particularly a barrier in rural counties, where enrollees have to travel long distances to access services. While telehealth has helped address some of these issues, many SUD services, including urine testing as part of the CM program, still require an in-person visit. The few providers available may also be hesitant to take on a novel service like CM, especially considering the additional staffing needs and legal liability risks (perceived or actual) that are attached to it.

Recommendation. DHCS will allow all DMC-certified and DMC-ODS–contracted providers to participate in the CM pilot. This is a necessary prerequisite to expanding the number of available providers; however, DHCS should also ensure that the conditions of participation are favorable for providers, including ensuring that reimbursement is sufficient to cover all expenses, such as testing and staffing. DHCS should mandate that CM providers require in-person visits only for testing services, while urging providers to set up telehealth capabilities for additional communication regarding the enrollee's participation in the CM program. DHCS should explore allowing CM providers to subcontract with testing sites in rural counties to facilitate in-person access in areas with a dearth of providers. Finally, DHCS could offer free legal consultation, as part of or in addition to the recurring training, to address providers' concerns related to risk management.

CHALLENGE #4

Care Coordination

Medi-Cal's behavioral delivery system is complex for enrollees to navigate on their own. Coordination of care between the different payers (managed care plans, county mental health plans, DMC-ODS programs, etc.) and providers (primary care and other physical health providers, mental health providers, and SUD providers) is often lacking. The CM program will open the door for people with stimulant use disorders to access needed care that was previously unavailable, but may also represent a point of entry for some enrollees who may need services for which they were already eligible but which they were not yet accessing. Proper care coordination will prevent people with stimulant use disorders and co-occurring disorders from continuing to fall through the cracks.

Recommendation. In addition to requiring an ASAM assessment for new participants, DHCS should require CM providers to provide warm handoffs to other SUD providers and to other delivery systems, as necessary. For example, CM provider organizations should have mechanisms in place to contact county mental health plans and providers when the CM provider suspects the enrollee would benefit from specialty mental health services. Similarly, when an enrollee requires physical health treatment, CM providers should be able to conduct a warm handoff to the enrollee's managed care plan rather than simply offering a referral and a number for the enrollee to call. CM providers should also be able to recommend that the managed care plan provide the enrollee with Enhanced Care Management, as appropriate.

CHALLENGE #5

Framing and Messaging

The evidence around CM's effectiveness as a behavioral treatment is substantial. However, when implementing the program, the state, counties, plans, and providers must be careful not to contribute inadvertently to the stigma and discrimination that people who use drugs and those with stimulant use disorders or other SUDs

face. Like recurring physical health conditions such as cancer, diabetes, and heart disease, SUD is a treatable chronic condition, and access to evidence-based treatment should remain the ultimate goal. In the case of stimulant use disorders, that evidence-based treatment is based on positive reinforcement. As such, the positive reinforcement component of CM must be emphasized while avoiding practices that chastise or penalize patients who relapse during the course of treatment.

Recommendation. The state policy allowing enrollees to regain eligibility for incentives in the same amount they were receiving before a positive stimulant test, is an important and positive step. Nonetheless, DHCS should take further action to avoid discrimination by emphasizing proper interaction and communication with enrollees during county and provider training, highlighting the need to treat enrollees with kindness and compassion and to avoid judgment. DHCS, counties, plans, and providers should also avoid discriminatory language that incorporates bias and stigma into messaging, such as "failing to pass a drug test" and "achieving sobriety and drug-free status"; they should also avoid stigmatizing terms that have traditionally and regrettably formed the lexicon around drug use, such as referring to patients as "addicts," "dirty," or "clean."

Finally, because an important catalyst for bias and discrimination toward people who use drugs is the involvement of law enforcement, DHCS should clearly communicate to enrollees the department's policy not to share information about the enrollee's stimulant use or participation in the CM program with law enforcement under any circumstance. DHCS should also assure participants about the steps the department will take to avoid unwarranted law enforcement involvement.

Conclusion

CM is a promising, evidence-based practice to treat stimulant use disorders. California has an opportunity to demonstrate its effectiveness among Medi-Cal enrollees and open the door to adoption of CM in other states. A well-designed program is key to ensuring the service reaches the intended populations and is successful in reducing the burden of stimulant use disorders and deaths due to overdoses that involve the use of these drugs. If carefully designed and implemented, the adoption, expansion, and widespread availability of the CM benefit will become an important complement to California's harm reduction approach to the overdose crisis and will greatly aid the state's efforts to address the epidemic.

About the Author

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About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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28. "**SB 110 (2021): Substance Use Disorder Services: Contingency Management Services**," California Legislative Information, September 8, 2021.

29. Governor Gavin Newsom to members of the California State Senate, **SB 110 Veto Message** (PDF), October 8, 2021.

30. To learn more about the ASAM assessment, see "**About the ASAM Criteria**," American Society of Addiction Medicine (ASAM), accessed May 13, 2022.

31. For more information about UCLA ISAP and its role, see **UCLA ISAP**, accessed May 17, 2022.

32. *Medi-Cal CM Pilot Program Policy Design*, 18–19.

33. *Medi-Cal CM Pilot Program Policy Design*, 14.

34. *Medi-Cal CM Pilot Program Policy Design*, 14.

35. *Medi-Cal CM Pilot Program Policy Design*, 16.

36. *Medi-Cal CM Pilot Program Policy Design*, 20.

37. *Medi-Cal CM Pilot Program Policy Design*, 15.

38. *Medi-Cal CM Pilot Program Policy Design*, 20.

39. *Medi-Cal CM Pilot Program Policy Design*, 20–21.

40. *Medi-Cal CM Pilot Program Policy Design*, 21.

41. *Medi-Cal CM Pilot Program Policy Design*, 23–24.

42. California CalAIM Demonstration, 53.