Incentivizing Recovery
Contingency Management and Exploring Barriers to SUDs Treatment

Benicio Beatty
Mentor: Dr. Zachary Meisel MD, MPH, MSHP
Roadmap

01  CHERISH: Contingency Management Conference
02  Urban Health Lab: SPARROw Project
03  Skills Assessment
04  Acknowledgements
What is Contingency Management?
contingency management

noun

a behavior-modification method of providing reinforcement in exchange for objective evidence of a desired behavior (1)

Source: Gold, 1996
INCENTIVIZING RECOVERY
Payment, Policy, and Implementation of Contingency Management
"Contingency management (CM) is a proven and promising treatment for certain substance use disorders, especially stimulant use disorder. However, major gaps in knowledge regarding the economic, conceptual, policy, political and legal barriers have prevented widespread use. Important considerations such as equity and adaptations to the current substance use treatment environment have yet to be fully explored".
Project Aims

- Complete an extensive CM literature briefing for use at the conference
- Develop a tracking sheet of CM provisions in Medicaid 1115 waivers
- Develop a tracking sheet for CM grants nationwide
Methods

- **Step 1:** Literature search by policy area
- **Step 2:** Systematic Review of Medicaid 1115 Demonstration Waivers
- **Step 3:** Literature search of NIH RePorter
Outcomes

The Center for Health Economics of Treatment Interventions
for Substance Use Disorder HIV and HCV
(CHERSI)

CONFERENCE BRIEF

INCENTIVIZING RECOVERY: PAYMENT, POLICY, AND IMPLEMENTATION OF CONTINGENCY MANAGEMENT

Anaya Kanazangi
Bernice Battey

July 2023
Efficacy

- CM has demonstrated efficacy for improving drug abstinence rates during treatment (2,3) and treatment attendance (4) for patients with substance use disorders.

Source: Roll, 2006
Significance

Although there are a number of medications under consideration to treat stimulant use disorder, the evidence is mixed, and there is currently no FDA-approved medication (5). For this reason, understanding and implementing contingency management programs is critical to improving outcomes for stimulant use disorder treatment.
Barrier #1: Federal Regulation

- The Federal Anti-Kickback Statute & Stark Law
- Federal Beneficiary Inducement Statute
- Civil Monetary Penalties Law (CMPL)
A 2020 ruling from the Officer of the Inspector General (OIG) ensures that CM is not prohibited. The ruling permits CM if providers use appropriate safeguards and are not engaging in criminal fraud and abuse practices (6).
Barrier #2: Funding

$15/$75 annual cap
Barrier #2: Funding

For programs including contingency management as a component of the treatment program, each individual contingency must be $15 or less in value and clients may not receive contingencies totaling more than $75 per budget period (7)
Barrier #2: Funding

Tracking matrix of NIH funded Contingency Management studies

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Project Leader</th>
<th>Other PI(s)</th>
<th>Program Officer</th>
<th>Project Number</th>
<th>Project Start Date</th>
<th>Project End Date</th>
<th>Target Substance</th>
<th>Measurement</th>
<th>Link</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>Dual Diagnosis, Contingency Management for Alcohol Use Disorders</td>
<td>Sheila Allen, <a href="mailto:salen@uchc.edu">salen@uchc.edu</a></td>
<td></td>
<td></td>
<td>S04DA02705S</td>
<td>6/30/10</td>
<td>5/31/14 Alcohol</td>
<td>Attendance/ Abstinence</td>
<td></td>
<td></td>
<td>Part of study A3</td>
</tr>
<tr>
<td>Etiology and Treatment of Alcohol Dependence, Research Project #2</td>
<td>Laron G. Baker, <a href="mailto:laron@uchc.edu">laron@uchc.edu</a></td>
<td>Maritza Shirley, <a href="mailto:maritza.shirley@nicd.nih.gov">maritza.shirley@nicd.nih.gov</a></td>
<td></td>
<td>S04DA02705S</td>
<td>6/30/10</td>
<td>5/31/14 Alcohol</td>
<td>Attendance/ Abstinence</td>
<td></td>
<td></td>
<td>Study in A2 is part of this project</td>
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<tr>
<td>S-DARS: P2: Implementing contingency management for intermittent use in specialty addiction treatment organizations</td>
<td>Sara J. Jenkins, <a href="mailto:saraj@brown.edu">saraj@brown.edu</a></td>
<td></td>
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<td>S00DA054472</td>
<td>8/1/12</td>
<td>5/31/17 Stimulants</td>
<td>Implementation</td>
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<tr>
<td>Implementing contingency management in opioid treatment centers across New England: A hybrid of behavioral reinforcement-based technology to improve opioid use disorder treatment initiation after an ED visit</td>
<td>Sara J. Jenkins, <a href="mailto:saraj@brown.edu">saraj@brown.edu</a></td>
<td>Bryan R. Cramer</td>
<td></td>
<td>S01DA043684</td>
<td>8/1/12</td>
<td>7/31/14 Opioids</td>
<td>Implementation</td>
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<tr>
<td>Reward-based technology to improve opioid use disorder treatment initiation after an ED visit</td>
<td>Evan G. Benkert, <a href="mailto:evan@brown.edu">evan@brown.edu</a></td>
<td></td>
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<td>S04DA054495</td>
<td>8/1/12</td>
<td>5/31/14 Opioids</td>
<td>Treatment Initiation/ Adherence</td>
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<tr>
<td>PRIME: PEP intervention for people who inject IDUs/ methadone</td>
<td>Philip G. Coffin, <a href="mailto:philip.g.coffin@gmail.com">philip.g.coffin@gmail.com</a></td>
<td></td>
<td></td>
<td>S01DA051820</td>
<td>8/1/12</td>
<td>4/30/15 PEP</td>
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<tr>
<td>Transporting treatment effects from clinical trials to real-world populations with co-occurring opioid and stimulant use disorders</td>
<td>Pam Clee, <a href="mailto:cleeja@uchc.edu">cleeja@uchc.edu</a></td>
<td>Nancy M. Farmer, <a href="mailto:nma1@uchc.edu">nma1@uchc.edu</a></td>
<td></td>
<td>S01DA051515</td>
<td>7/1/12</td>
<td>6/30/16 Stimulants</td>
<td>Treatment Initiation/ Adherence</td>
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<td>USING CONTINGENCY MANAGEMENT TO PROMOTE ADHERENCE TO SMOKING CESSATION TREATMENT AMONG HOSPITALIZED SMOKEERS</td>
<td>N. Thomas Croswell, <a href="mailto:ntcroswell@uchc.edu">ntcroswell@uchc.edu</a></td>
<td></td>
<td></td>
<td>S01DA055130</td>
<td>8/1/12</td>
<td>7/31/17 Smoking/ Tobacco</td>
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<td>For data from National Drug Abuse Treatment Clinical Trial Network R01s and National Survey on Drug Use and Health is estimated/Performance of mediations, CM, motivational interviewing, counseling, and exercise for OUD and Stimuli</td>
<td></td>
</tr>
<tr>
<td>CIT-SMART for Treatment of PTSD and Cocaine Addiction</td>
<td>Eric A. Sabat, <a href="mailto:eric_sabat@ucsd.edu">eric_sabat@ucsd.edu</a></td>
<td></td>
<td></td>
<td>S10DA006737</td>
<td>10/1/12</td>
<td>12/31/13 Smoking/ Alcohol</td>
<td>Adherence</td>
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<td></td>
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<tr>
<td>Effectiveness and Outcome of Combined Contingency Management and CBT for Alcohol Use Disorder</td>
<td>Eric A. Sabat, <a href="mailto:eric_sabat@ucsd.edu">eric_sabat@ucsd.edu</a></td>
<td>Patrick S. Cahoun, <a href="mailto:Patrick.Cahoun@nicd.nih.gov">Patrick.Cahoun@nicd.nih.gov</a></td>
<td></td>
<td>S05DA057225</td>
<td>6/1/12</td>
<td>5/31/14 Alcohol</td>
<td>Abstinence</td>
<td></td>
<td></td>
<td>CIT-CM, brief mobile app-based CM (nCM)</td>
</tr>
</tbody>
</table>
Barrier #3: Stigma

Public:
- Emotion-based criticism
- Political/Ideological criticism
- False perception that CM = Bribery

Clinician:
- Infantilizing view of patient
- General distrust of the patient
- Belief that patient is undeserving of incentive

Source: Fox News, 2023
<table>
<thead>
<tr>
<th>State</th>
<th>Date</th>
<th>Provider/Goal</th>
<th>Eligibility</th>
<th>Reimbursement</th>
<th>Implementation</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Summer 2015 (Pilot program launched)</td>
<td>Receive incentives for testing negative for stimulants only, regardless of finding positive for other illicit drugs</td>
<td>&quot;Are enrolled in Medi-Cal and meet access criteria for a comprehensive, individually tailored course of SSD treatment.&quot;</td>
<td>$75.00 per patient per year with a total budget of $1.5 million from fiscal year 2014-2015 to be forgiven</td>
<td>Four didactic training sessions followed by 4 bi-weekly implementation trainings via Zoom. List of provider sites also offer the recovery incentives program.</td>
<td>First state-wide CM program outside of VA system.</td>
</tr>
<tr>
<td>Washington</td>
<td>Fall 2015 (Pilot Program), Waivers submitted 2015</td>
<td>CM connected to SOP contract</td>
<td>Apple Health (Washington state’s Medicaid program) beneficiaries have been “assessed and determined to have substance use disorder for which the treatment they receive will be medically necessary and appropriate based on the stability of treatment to the evidence-based intervention.”</td>
<td>$125.00 per patient/pilot program</td>
<td>Four didactic training sessions followed by 4 bi-weekly implementation trainings via Zoom. Sites include larger hospital systems and specialty clinics.</td>
<td>Part-time and part-time (part-time) services are available.</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>June 2015</td>
<td>Project Goals a. Train treatment providers at designated sites on the background of CM, the proper implementation of CM, and regulatory requirements and considerations of CM</td>
<td>No eligibility criteria found. Expected to be consistent with the SAMHSA grant funded programs.</td>
<td>Partially funded by SAMHSA grant.</td>
<td>Training sessions, coaching calls, monthly mandatory reviews, provision of CM materials adapted to the unique needs of the target populations. Full list of provider sites can be found <a href="#">here</a>.</td>
<td>Based on the stage of training/information dissemination in partnership with Washington State University.</td>
</tr>
<tr>
<td>West Virginia</td>
<td>2015-2017 (Pilot program timelines)</td>
<td>TRUST Model: CM integrated into other programs which also includes the provision of evidence-based treatments (MD, CBT, Ga, patient education)</td>
<td>Medicaid members ages 18 and older who are diagnosed with stimulant use disorder (e.g., methamphetamine, cocaine, amphetamine) based on a completed ASAM criteria assessment</td>
<td>$75 per participant for 6-month period</td>
<td>6-hour distance training followed by bi-weekly implementation trainings via Zoom. Sites include 1 large hospital system, specialty clinics, and SUD treatment centers.</td>
<td>Matches the criteria for SAMHSA and approved by the state and federal government.</td>
</tr>
<tr>
<td>Montana</td>
<td>Spring 2015 (Pilot Program)</td>
<td>TRUST Model: CM integrated with other behavioral treatments</td>
<td>Medicaid members ages 18 and older who are diagnosed with stimulant use disorder (e.g., methamphetamine, cocaine, amphetamine) based on a completed ASAM criteria assessment</td>
<td>$75.00 per participant per 1-month period</td>
<td>6-hour distance training followed by bi-weekly implementation trainings via Zoom. Sites include 1 large hospital system, specialty clinics, and SUD treatment centers.</td>
<td>Matches the criteria for SAMHSA and approved by the state and federal government.</td>
</tr>
</tbody>
</table>

*ASAM = American Society of Addiction Medicine, CM = Cognitive Mapping, SSD = Structured Substance Disorder.
Future Research

CM and Harm Reduction
Incentivizing harm reduction strategies in addition to abstinence-based approaches

Incentive Changes
Experimenting with the amount and frequency of payments

MIPG
Increased advocacy and action for CM programs and policies
Studying the PhilAdelphia Resilience Project as a Response to Overdose

- Joint project between CECPR and UHL
- PIs: Drs. Gina South and Zack Meisel
- Funding: CDC R01 Grant $1 Million
- Evaluation of 2 City of Philadelphia programs on impact of overdose outcomes
  1. AR-2 Ambulance
  2. Blight Remediation

Source: Dolan, 2023
Project Aims

- Qualitative transcript coding
- Complete micro-costing analysis report based on transcripts
What is Micro-Costing?
Micro-costing

noun

The direct enumeration and costing of every input consumed in the treatment of a particular patient (8)

Micro-costing is a method that allows for more precise assessment of the economic costs of a healthcare intervention. Micro-costing attempts to measure costs of a service as accurately as possible (8)
Methods

- **Step 1**: Material Costs
  Examples: Narcan kits, N-95 masks, PPE, gas

- **Step 2**: Personnel
  Examples: paramedic salary, case manager costs

- **Step 3**: Partners
  Examples: Philadelphia Fire Dept., Rock Ministries, Prevention Point Wound Care Clinic
Report Outcomes: In Progress

- Partnerships with local agencies are critical for managing costs
- Inter-Department Communication is important for mitigating burnout and improving efficiency
- New grants have the potential to alleviate costs
Personal Skills Assessment
Skills Learned

- Literature Review
- Policy Brief
- Manuscript

- MSHP 0600 Course
- Hybrid Working Environment
- Research Blogging

- Micro-cost Analysis
- Qualitative Coding
Acknowledgements

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Joanne Levy & the SUMR Program Staff
References

Questions?

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