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IN FOCUS

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Contingency Management for Substance Use Disorders

Treatment for substance use disorders (SUDs) typically involves pharmacological or psychosocial therapies. For instance, certain medications are used in treatment for alcohol, tobacco, or opioid use. Meanwhile, for substances such as methamphetamine, cocaine, and marijuana, there are no comparable Food and Drug Administration (FDA)-approved medications for treatment. Research shows that psychosocial interventions are the most effective treatment for stimulant use and marijuana use. More specifically, an intervention known as *contingency management* (CM) has thus far had the most empirical support for effectiveness. This In Focus provides an introduction to CM, examples of federal support for CM, and an overview of certain federal fraud and abuse laws that may apply to CM programs.

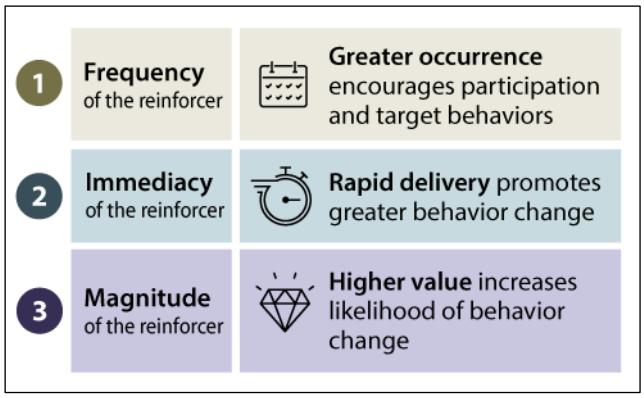
Background

Contingency management is a behavioral intervention that involves giving individuals tangible rewards to reinforce desired behaviors. CM for SUDs comes in several forms, but all provide something tangible of value to participants for achieving a target behavior—usually participation in treatment, or reduction or elimination of substance use (often measured through urine screenings). Rewards (known as *motivational incentives*, *reinforcers*, or *contingencies*) can include privileges, prizes, vouchers for goods or services, gift cards, or direct cash payments. Some CM programs guarantee a reward—a set amount per opportunity or an escalating schedule of increasing value as treatment progresses. Other CM methods provide chances for awards via pulls from a *fishbowl* containing incentives of varying value.

One notable finding in the research is that higher monetary value and more frequent and immediate delivery of rewards are typically associated with a larger effect on behavior change (**Figure 1**). For example, one study found that immediate rewards increased steadily over the course of treatment performed better than a single lump sum. Other studies have found little difference between fixed versus varying amounts of rewards. Most studies have generally found that higher rewards are more effective. Yet no consensus currently exists in the empirical literature on specific thresholds for incentives in CM. Generally, a total maximum award of under $100 is considered low, while treatments providing totals of over $1,000 are considered high.

Although most CM remains in person, new technologies have allowed for greater flexibilities in treatment delivery. Digital therapeutics such as smartphone applications or internet-based methods can provide remote monitoring and incentive delivery. Technology-based CM interventions that allow patients to participate remotely avoid common obstacles to SUD treatment, such as requirements for frequent in-person visits.

Figure 1. Components of Effective Contingency Management



Source: CRS, based on Sterling M. McPherson, Sara Parent, Andre Miguel, et al., "Contingency Management is a Powerful Clinical Tool for Treating Substance Use Research Evidence and New Practice Guidelines," *Psychiatric Times*, vol. 39, no. 9 (September 9, 2022).

SUD treatment using CM does not have a prescribed time period. Many clinical evaluations of CM have followed 12- or 16-week schedules, though many patients may need longer intervals to achieve desired outcomes. Practitioners can discontinue CM if participants stop responding to the treatment. Participants can engage in a course of CM treatment multiples times, as needed. CM is often used in combination with other therapies and has been found to be effective for diverse populations. For example, CM can be paired with medication as an adjunctive treatment for SUDs. Evaluations of CM have generally found it to be cost-effective given the potential benefits of reduced substance use. The long-term effects of CM on substance use await further research.

Federal Support for CM

Executive agencies responsible for SUD treatment—such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA), and the Office of National Drug Control Policy (ONDCP)—promote the use of motivational incentives via CM to improve treatment outcomes for certain SUDs. For example, the Department of Veterans Affairs (VA) has integrated CM into many of its intensive outpatient SUD treatment clinics for veterans since 2011. While some people may have moral or practical concerns about paying substance users to reduce drug use (or concerns about fraud), federal programs have generally supported the use of CM.

Federal financial support for outpatient SUD treatment comes in two main forms: (1) Medicare and Medicaid, and (2) discretionary grant programs, mostly administered by SAMHSA. For instance, in 2020, Congress added treatment for psychostimulants to the allowable uses of State Opioid Response (SOR) grant funds. The SOR Notice of Funding Opportunity (NOFO) explicitly permits CM as an allowable use of funds. SAMHSA has historically limited each incentive to a value of $15 (not cash), and the total amount per patient to $75 per year.

Most states report that Medicaid is their largest public funder of SUD treatment. Some states have leveraged their Medicaid programs to support the use of CM. For example, California is piloting a Medicaid program that rewards CM participants with up to $599 a year for reduced substance use. (The maximum reward is just below the Internal Revenue Service's [IRS's] $600 threshold for providers to report payments to participants via the issuance of an IRS 1099 form as part of the federal tax filing process.)

SAMHSA has encouraged clinics with CM programs that exceed federal incentive limits to solicit in-kind donations or use volunteers to supplement costs. Some localities, such as San Francisco, have relied on philanthropic funding to implement innovative CM programs above public funding limits.

Federal Fraud and Abuse Laws

One alleged obstacle to more expansive use of CM is the potential application of certain fraud and abuse laws to these programs. Some health care providers have raised concerns about possible liability under laws such as the federal Anti-Kickback Statute (42 U.S.C. §1320a-7b) and the Beneficiary Inducements civil monetary penalties provision (Beneficiary Inducements CMP, 42 U.S.C. §1320a-7a), collectively referred to here as *fraud and abuse laws*, particularly with respect to monetary or other rewards provided to patients that participate in health care programs such as Medicare or Medicaid.

Background

The basic thrust of the Anti-Kickback Statute is to limit health care provider actions that are improperly influenced by a profit motive, and to protect federal health care programs from unnecessary costs. Under this criminal statute, it is a felony for any person to knowingly and willfully offer, pay, solicit, or receive "remuneration" (i.e., monetary compensation or nonmonetary items of value) in return for a patient referral or other generation of business reimbursable under a federal health care program. Given the broad scope of the Anti-Kickback Statute and its potential application to legitimate business arrangements, the statute authorizes the Department of Health and Human Service's (HHS's) Office of Inspector General (OIG) to issue regulatory *safe harbors* to the statute. OIG has also said that the safe harbor provisions do not indicate the only acceptable business arrangements, and arrangements that do not fall within a safe harbor are not necessarily in violation of the statute.

A separate provision, the Beneficiary Inducements CMP, expressly applies to financial or other incentives given to patients. Under this provision, civil monetary penalties may be imposed against persons who offer or transfer remuneration to a federal health care program beneficiary that the person knows or should know is likely to influence the beneficiary's selection of a particular provider or other entity for a reimbursable item or service under Medicare, Medicaid, or other federal health care programs. However, pursuant to a 2016 OIG policy statement, the agency does not deem gifts of "nominal value" (i.e., retail value of no more than $15 per item or $75 in the aggregate per patient on an annual basis) to be enforceable violations of the statute. Notably, by statute, an arrangement permissible under the Anti-Kickback Statute or its safe harbor regulations is generally excepted from the Beneficiary Inducements CMP.

OIG Actions and CM Incentives

Federal statutes and regulations do not squarely address the full extent to which CM incentives may be provided to health care program beneficiaries without violating the fraud and abuse laws. Although OIG has indicated that CM incentives that are a part of a covered service under a federal health care program would not violate the Anti-Kickback Statute or the Beneficiary Inducements CMP because "the coverage includes the incentive itself," other CM incentives given to program beneficiaries may violate these statutes.

As part of a 2020 rulemaking, OIG addressed CM incentives as part of the creation of a new *patient engagement and support* safe harbor from the fraud and abuse laws. This new safe harbor protects the provision of remuneration to health care program beneficiaries, in part to foster certain value-based care and coordinated care arrangements. In creating the safe harbor, OIG allowed for *in-kind* goods and services (such as health-related technology and monitoring tools) to be given to beneficiaries, but it declined to extend the safe harbor to include explicit protection for cash, cash-equivalent payments, or gift cards, due to concerns over a "heightened fraud and abuse risk." The safe harbor also included a $500 annual cap on acceptable tools and supports.

In the preamble to the 2020 final rule, OIG addressed CM incentives and application of the federal fraud and abuse laws. It also clarified that the agency's 2016 policy statement concerning gifts of nominal value *does not* impose a $75 annual limit on CM incentives. Additionally, OIG stated that the agency would examine CM programs that do not meet the patient engagement and support safe harbor (or another safe harbor) on a case-by-case basis.

More recently, the Consolidated Appropriations Act, 2023 (P.L. 117-328), directed OIG to review whether to establish a safe harbor for "evidence-based contingency management incentives" and "the parameters for such a safe harbor," and to provide recommendations to Congress regarding the issue by December 29, 2024. In a November 2023 report, HHS noted that its consideration of a potential safe harbor was ongoing.

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