The Centers for Medicare and Medicaid Services: SUPPORT Act Section 1003 Grant

SUD Technical Assistance Webinar Series #34

Virginia Medicaid Contingency Management

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Department of Medical Assistance Services
Welcome & Meeting Information

• WebEx participants are muted
  ▪ Please use Q&A feature for questions
  ▪ Please use chat feature for technical issues

• Focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

• We are unable to offer CEUs for this webinar series
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Naloxone Resources

Get trained now on naloxone distribution
- REVIVE! Online training provided by DBHDS every Wednesday
  - [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    - Register and enter your zip code to access free online training

Medicaid provides naloxone to members at no cost and without prior authorization!
Call your pharmacy before you go to pick it up!

Getting naloxone via mail
- Contact the Chris Atwood Foundation
  - [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
  - Available only to Virginia residents, intramuscular administration
SUPPORT ACT GRANT WEBSITE - HTTPS://WWW.DMAS.VIRGINIA.GOV/#/ARTSSUPPORT
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
Adam A. Creveling, MSW, CPRS
SUPPORT Act Grant Program Specialist, DMAS

Adam Creveling provides subject matter expertise on the intersection of peer recovery support services and Medicaid operations. Prior to working for DMAS, Adam worked for the Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia as a Behavioral Health Clinician focusing on addiction, trauma, in addition to implementing evidence-based peer models.

Adam has also worked for the Virginia Department of Behavioral Health & Developmental Services (DBHDS) in the Office of Recovery as the Recovery Community Liaison. Through this role, he implemented and monitored evidence-based services through a trauma informed lens relating to substance misuse and recovery initiatives across the state. Adam also participated in capacity building among the state recovery and treatment community ensuring best practices and client-centered service approaches were utilized.

Adam is a person in long term recovery and is evidence that second chances and recovery are possible.
We want to use “Person-Centered language”
- Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
- Not “Addiction,” but Substance Use Disorder (SUD)
- Not “Abuse,” but Use
- Not “Clean,” but In Recovery or Testing Negative
- Not “Dirty,” but Testing Positive
- Not “Relapse,” but Return to Use

At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms

Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)
Rewarding Positive Behavior is Not a New Concept

- Children obtaining incentives for doing chores or getting good grades.
- Companies offering sign on bonuses, performance based salaries, and sales commission.
- Early release from the criminal and legal system for “good behavior”.
- Drug court program compliance.

When it comes to the carrot or the stick metaphor, folks with SUD historically have been given the stick.
Contingency Management (CM) & Stimulant Use Disorder

• Fatal non-opioid illicit drug overdoses are on the rise in Virginia. In 2020 compared to 2019, fatal cocaine overdoses increased 33.0% and fatal methamphetamine overdoses increased 95.5% (VDH first Quarterly report, 2021).

• In 2020, 2.5 million Americans aged 12 or older reported having used methamphetamine in the past year.

• No approved FDA medications for Stimulant Use Disorder to date.
Stimulant Use Disorder Treatment Interventions

- Motivational Interviewing
- Contingency Management
- Community Reinforcement Approach
  - Commonly used in combination with CM to identify behaviors reinforcing stimulant use while rewarding a chemical free lifestyle
- Cognitive Behavioral Therapy
Research Landscape on CM

• The literature over the last ten years and current day demonstrate an 86% and 88% efficacy rate, respectively. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5385000/]

• The empirical support for efficacy is so striking that in 2007, the National Institute of Clinical Excellence recommended CM nationwide for intensive outpatient treatment for SUD in the UK. [https://www.bmj.com/content/bmj/335/7612/203.full.pdf?casa_token=_ahCGNFtHsYAAAAA.Rw4PZUZnpN1EzD9Vmlb1kMSqRufMtLKe7mkFVfQMlgub0Cuyj1_sXKxORPPpK2byeJ8fhzJp-u]

• In 2011, The US Veteran Administration hospital system also adapted similar actions within their system of care. [https://pubmed.ncbi.nlm.nih.gov/24724876/]

CM & Substance Use Disorder Treatment Capacity

- Reducing Alcohol Use
- Reducing Marijuana Use
- Reducing Benzodiazepine Use
- Reducing Opioid Use
- Reducing Stimulate use (Cocaine and Methamphetamine)
- Effective treatment for poly-drug use among those with co-morbid mental illness
- Health and abstinence in HIV patients
- Homeless populations
- Veterans struggling with SUD
- Community Reinforcement Approach (CRA)
- Inpatient SUD treatment/ Outpatient SUD treatment
- CM can also be used within Drug Treatment Courts
Current National Headlines on CM

To Combat Meth, California Will Try A Bold Treatment: Pay Drug Users To Stop Using

The New York Times

This Addiction Treatment Works. Why Is It So Underused?

An approach called contingency management rewards drug users with money and prizes for staying abstinent. But few programs offer it, in part because of moral objections to the concept.
CM: A New Way of Conceptualizing SUD Treatment

Rewards positive/desired behaviors with nominal rewards (e.g., gift cards/vouchers) that can increase in value the longer a person continues the desired behavior.

These behaviors can be abstinence from chemical use (e.g., negative drug screens) or participation in treatment.

Recurrence of drug use are teachable moments, with the value of the vouchers/rewards being reduced.

Typically used in treating drugs that are easily detected in a POC urine drug screen or breathalyzer.

About half of the people who engage in CM tend to respond quickly, with the other half not responding at all.
CM: A New Way of Conceptualizing SUD Treatment

• Drug Use provides powerful, immediate reinforcement upon consumption, and the rewards from recovery can be unpleasant in the beginning.

• The small payments or prizes aim to rewire the brain's reward system and further provide opportunities to build self-worth and achievement. (dopamine reward system demand is met in another function).

• Helpful method to use to explore SUD ambivalence and recovery possibilities.

• Research demonstrates that individuals who received CM earlier in treatment continue to benefit even after tangible reinforcers (prizes) are no longer available.

• Longer duration of documented continuous abstinence compared with participants in non-CM SUD treatment.
"Won't Clients Sell Or Exchanged Prizes For Drugs?"

- Effective CM interventions are designed to reduce the probability of drug recurrence.
- There is no data that supports this claim that providing incentives increase drug trade or sell of prices.
- Prizes and incentives encourage and celebrate drug use regression (not the opposite).
- Internal behavioral change is a result of effective treatment and recovery.
- If drugs are consumed clients are not eligible for the CM program.
- A recurrence of SUD symptom for clients can be offset through CM.
## Contingency Management Objective

<table>
<thead>
<tr>
<th>Low program threshold all-inclusiveness celebrating each client along their recovery experience</th>
<th>Everyone who attends treatment today is a success regardless if they consumed chemicals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term behavioral change</td>
<td>Magnitude of incentives correlated to drug abstinence</td>
</tr>
<tr>
<td>Capacity to enhance and expand Evidence-Based Practices within a treatment modality</td>
<td>Program impact potential to be more effective than standard treatment</td>
</tr>
</tbody>
</table>

**Source:** [PDF](https://pdfs.semanticscholar.org/24be/8c5af734e7227faa271cf4dcfd741ae914e.pdf)
Magnitude of Incentives Effects Outcomes

• The research on this subject varies…….

• Using very low magnitude incentives no change to drug use outcomes.

• Studies have shown direct relationships between magnitude of reinforcement and drug abstinence.

• The cost of incentives creates a challenge for treatment providers to implement and maintain programs due to costs.

• What we saw at the Daily Planet, even small gifts had a large impact on an individuals outlook and treatment progress.
Remote Behavior-Monitoring Technology Methods

DynamiCare app: https://www.dynamicarehealth.com/program-overview

Interactive Voice Response (IVR) Compliance: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3818436/

ReSET/ReSET-O: https://www.resetforrecovery.com/our-treatments/

Different Examples of CM

The Fishbowl Drawing and the Voucher Model
Contingency management has been used the most by the Department of Veterans Affairs, where 110 clinics and hospitals have employed it since 2011 to try to help more than 5,100 veterans stay off drugs.

The VA initiative is the largest implementation of CM in history.

Vouchers: For rewards, the department’s treatment programs give vouchers for $1, $20 or $100 donated by the Veterans Canteen Service, which runs cafeterias, coffee shops and retail stores in many of the department’s medical centers. Patients receive an average $200 in coupons over 12 weeks, which they can spend only in those outlets.

The VA reported the average percent of samples that tested negative for the target substance was 91.1% as a result of the CM coaching program 12 weeks in treatment.
Veterans Affairs (VA) CM Model

• Two clinical outcomes: attendance and reducing stimulant drug use.

• Each urine sample that tests negative, the patient earns draws from a fishbowl.

• Draws start at one for the first stimulant-negative sample and increase by one for each consecutive negative sample up to a maximum of eight draws.

• A refused, stimulant-positive, or missed sample (i.e., an unexcused absence on a testing day) resets draws for the next negative sample down to one with escalation resuming for sustained abstinence.

• With these probabilities and magnitudes, each draw costs on average $2.22, and patients can earn 164 draws over 12 weeks, with an average expected maximum of about $364 in prizes.
Daily Planet Health Services CM Model

All MOUD clinics will have their own fish bowl and point person, and will take responsibility for updating and routing identifiers to promote equality.

The point person will collect a list of clients who tested negative for illicit drugs and positive for Buprenorphine from MOUD Nurse prior to group.

Participants opt into the program.

Participants are given prize options (A,B,C,D) categories.

Each program will track and report data monthly.

Every client is celebrated as a “winner” for showing up and being active in their recovery journey in the program that day. Regardless if they are not eligible for the fishbowl drawing.
Program Qualifications

- Negative Drug Screen (Illicit Drugs, Non-prescribed)
- Arrives on Time for Group and Submits Drug Screen
- Test positive for Buprenorphine
Program Prizes Structure

The proportion of fish bowl identifiers will be the following:

- **48% no prize** but a motivational quote on the back and additional piece of candy
- **40% small prize option** ($5) clients pick their reward
- **10% large prize option** ($10) clients pick their reward and
- **2% jumbo prize** ($20) clients pick their reward
Prizes

All prizes will be logged by point person and immediately awarded to participant after each group.

Clients can give their prizes to others in the group.

All prizes will be locked up and replenish monthly.

Prizes will vary and clients are encouraged to offer feedback regarding prize rotation.

All fish-bowl drawing identifiers must be returned after each pick to maintain consistency.

Clients with gambling related disorders need to be screened out.
Different Ways to Make CM Work In Your Clinic

• The program will support quarterly ice cream socials dependent all above qualifiers have been met.

• Clinics can encourage other group members to work on their recovery by throwing a breakfast party at the end of the month dependently that all qualifiers have been met ($20 budget).

• Clients interested in additional support outside of assigned MOUD clinics (12-Yoga, Peer Support, Therapy) will be rewarded with an additional chance to draw the following week.

• Offering certificates to celebrate each clients achievement.

• Draws increased by 1 for each week in which all the submitted samples were free of the primary target drugs.

• Bonus draws, available to all the participants in this condition, depended on total abstinence (from primary and secondary target drugs).

• Participants also earned drawings for completing steps related to their treatment goals (verification methods would need to be outlined).
Benefits & Challenges to Implementing CM
Challenges for Implementing CM

• Miss understood by clinicians—requires additional training (a new way of thinking about SUD treatment)
• Discussing desired prizes to be purchased with one’s earnings, also is associated with better outcomes in CM (consistency)
• Drug testing frequency and length of CM program:
  • Stocking and maintaining the prize cabinet
  • Collecting and maintaining outcomes and results
• Insufficient resources
• Attempting to altering the CM program protocol to fit agency specifics (not adhering to fidelity practices).
• Ongoing fidelity assessment and CM implementation training/oversight
• Drug abstinence from one substance or all illicit substances
• This evidence based practice is concerned “controversial”.
• Stigma about who and how prizes are used
Challenges for Implementing CM

- Moral Objection: The idea of rewarding someone for staying off drugs.
- Providers wary of giving prizes that they say patients could sell or trade for drugs.
- Some view CM as “counterproductive” similarly mindset to MOUD “replace a drug for a drug”.
- No public or private insurer will pay for contingency management.
- Providers believe CM is “unethical or a bribe”.
- Concerns about the benefits of CM dwindling once treatment ends.
What Happens after Treatment Ends?

- Research suggests that some people have less success staying abstinent after the treatment ends when given CM.
- Some programs provide a follow-up assessment after the incentive's intervention was discontinued.
- CM interventions are not a perfect for everyone.
- Recovery intrinsically is a gift; however, CM can help many build/sustain confidence in their newly chosen pathway.
- Some researchers believe that CM should be used indefinitely, just as medications for opioid addiction often are.

“Unfortunately, addiction is a chronic brain disease and treatments need to be designed to accommodate this reality”.
Impact of Contingency Management

• Promoting pro-social, non-chemical related activities:
  • Recovery capital
  • Incentive capability transcends treatment to the outside family
  • Deeper sense of self-worth and achievement

• Client quote:
  “This was the only Christmas gift I received and I earned it”
CM Interpreted as Violating the Federal Anti-Kickback Statute

These laws are intended to prevent fraud, waste, and abuse and provide a mechanism to penalize providers that try to induce patients to access services (for example, unnecessary use) or direct patients toward a specific treatment program or health insurance plan.

Unlawful to provide contingency management to patients who are enrolled in health plans or programs that are funded by federal or state dollars.

Under federal laws, incentives can be considered kickbacks or inducements when they exceed monetary values that are considered nominal.

The Centers for Medicare and Medicaid Services (CMS) imposes annual limits on incentives to a maximum monetary value of $75.
References


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