May 12, 2022

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Becerra:

The Motivational Incentives Policy Group (MIPG) has been working these past two years to increase implementation of the evidence-based practice of Contingency Management (CM). As you may know, overdose deaths involving largely methamphetamine more than doubled between 2016 and 2019, and increased 46% between 2018 and 2020. As a result, the Biden Administration’s year one priority has been implementation of evidence-based practices to stem these increases. But that implementation is obstructed by federal policy. We ask you to join us now in calling for change.

CM has undergone five decades of NIH-sponsored research. This includes the use of CM for alcohol and stimulant use disorders and as an adjunct to medications for opioid use disorders. A recent meta-analysis shows 22% greater likelihood of abstinence 24 weeks after the cessation of incentives. Also, the longer the CM intervention, the more robust are the sustained effects. The evidence from these decades of research suggests that incentives at the level of $100-200 per month is most effective. At this full-value level, incentives have a 77% likelihood of producing benefits that exceed the costs – beginning in the first year. However, federal policy continues to pose serious obstacles to implementation of CM.

Between 2008 and 2020 the OIG had been a perceived obstacle to implementation of CM: it had suggested that providers could be investigated for fraud and abuse simply by implementing CM. In addition, it was broadly perceived that the OIG required that the amount that could be used for incentives be limited to $75 and that only non-monetary rewards were acceptable. While SAMHSA provided guidance in 2020 that the State Opioid Response (SOR) grant funds could be used for CM, it also limited the use of monetary incentives to $75, which is not effective.

In December 2020 a new OIG Final Rule sought to reassure providers that CM use is not prohibited. The Final Rule permits CM if providers use appropriate safeguards, are not engaging in criminal fraud and abuse practices, are not using incentives or other inducements as a way of paying for referrals or for marketing with the aim of getting potential patients to select a particular provider. In addition, the Final Rule did not specify any limit for incentives included as part of CM.

Unfortunately, the language of request for proposals (RFPs) issued for SAMHSA grants continues to reflect the ineffective limit of $75.

We are writing to ask for your support to assure that the policies of DHHS agencies are in alignment with the OIG’s December 2020 opinion and a recent OIG opinion.
The arbitrary $75 ceiling is forcing some states to produce RFPs with this ceiling on incentives. The evidence shows that the $75 ceiling is ineffective. Adhering to this limit wastes federal dollars, jeopardizes both clinical and scientific integrity, and undermines the entire effort at implementation of CM as an evidence-based practice. This practice ensures that CM will fail. Although HHS agencies should have the authority to reverse the misperception about the $75 limit, no action is evident.

SAMHSA’s grant portfolio includes Standard Funding Restrictions that state that SAMHSA’s recipients must comply with its restrictions. The language in the Standard Funding Restrictions includes the following:

“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.”

This language is included in and applies to the large majority of SAMHSA’s grant portfolio related to substance use disorders and mental health disorders—regardless of the population. This restriction effectively prevents states, tribes and local providers from determining whether full value incentives are best for their populations. The restriction is discriminatory and inequitable and must be amended, if not eliminated.

The MIPG continues to work with HHS agencies to align the language in their RFPs with not only the OIG’s language but with the evidence.

We are asking that you advise these agencies to remove the language in their grant portfolios that reflects a $75 limit on incentives and instead align the language with the scientific evidence.

Urgent action is needed, as some state RFPs have been issued and are due back in May.

Sincerely,

H. Westley Clark
H. Westley Clark, MD, JD, MPH
for the Motivational Incentives Policy Group
References


SUPPORTING ORGANIZATIONS

- Affect Therapeutics, Inc.
- American Academy of Addiction Psychiatry (AAAP)
- American Association for the Treatment of Opioid Dependence (AATOD)
- American Osteopathic Academy of Addiction Medicine (AOAAM)
  - American Psychiatric Association
  - American Society of Addiction Medicine (ASAM)
  - Association for Behavioral Health and Wellness
- Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA)
  - Behavioral Health Association of Providers
  - Black Psychiatrists of America
- California Consortium of Addiction Programs & Professionals
- The College on Problems of Drug Dependence (CPDD)
  - DynamiCare Health, Inc.
  - Faces and Voices of Recovery
  - HIV Alliance (Oregon)
  - The Kennedy Forum
  - Legal Action Center
- NAADAC, the Association for Addiction Professionals
- National Association of State Alcohol and Drug Abuse Directors (NASADAD)
  - National Alliance for Medication Assisted Recovery
- National Association of Addiction Treatment Providers (NAATP)
- National Association for Behavioral Healthcare (NABH)
  - National Council for Mental Wellbeing
  - National Health Care for the Homeless Council
- New England Association of Recovery Court Professionals (NEARCP)
  - Partnership to End Addiction
  - Pathfinder Solutions, PBC
    - Ria Health
  - San Francisco AIDS Foundation
    - Shatterproof
  - Treatment Communities of America
  - WEconnect Health Management, SPC
    - Young People in Recovery