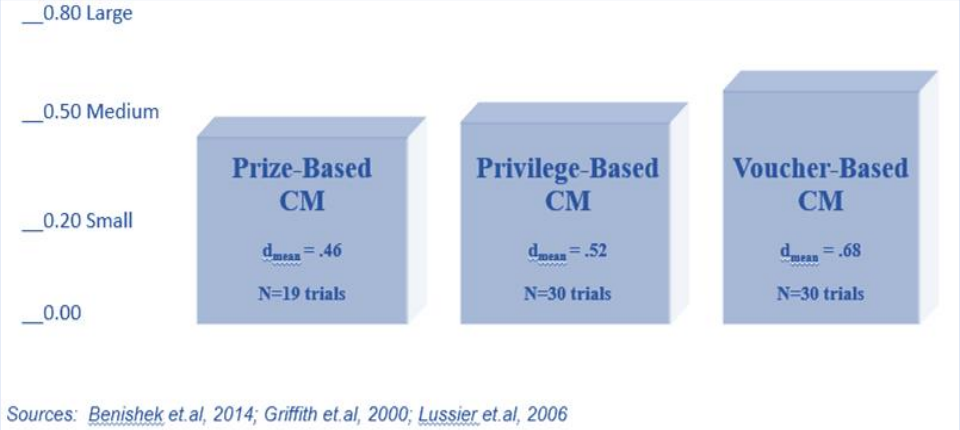
Allowable Client Rewards

Over the past half-century, a host of Contingency Management (CM) protocols have been subjected to empirical testing in addiction treatment settings, and many CM protocols have been **defined by the nature of the rewards** one may earn (e.g., vouchers, prizes, clinic privileges). As illustrated below, meta-analyses of these diverse CM protocols—which include the published results of 79 randomized controlled trials—document comparable average effect sizes in a range (Cohen's *D*=.46-.68) corresponding with medium-sized therapeutic benefits. This compelling evidence suggests that community settings seeking to implement CM should **consider different types of rewards** (or possibly a combination of rewards) during their initial planning efforts.



A well-established principle underlying the success of diverse CM protocols is that reward magnitude be sufficiently high so clients are motivated to demonstrate the targeted, treatment-adherent behavior. Thus, it is recommended that decisions about rewards should be **guided both by relevant scientific evidence** about empirically-supported CM protocols and **local insights of setting staff** about the type and magnitude of rewards that eligible clients are is likely to find motivating.

Recently, there has been much debate about funding of CM programming in community settings, and this has included a focus on the material value of the included rewards. Some have sought to facilitate funding of CM programming by setting a **threshold on the material value of rewards** that a client may earn. An example is SAMHSA's governance of CM efforts funded by State Opioid Response grants, where an annual per-client $75 threshold (including a $15 cap placed on individual 'events,' like attending a therapy visit or providing a drug-free urinalysis result) exists. While many in the scientific community have questioned this, there is **not clear consensus** about what a per-client threshold on material value of earned rewards should be. As of this writing, SAMHSA has maintained this threshold as policy, though notably other funders have not adopted this threshold nor specified an alternative.

In 2021, a national policy group emerged in response to passage of the CMS 1115 Waiver Program. The mission of this group was to **formulate risk management safeguards** intended to govern legal and policy issues concerning CM practices in community settings. In a subsequent public letter, this policy group offered amongst its recommendations to protect against fraud and abuse that community settings seeking to implement CM programming do so with:

- CM protocols that are evidence-based, as validated through research
- Implementation procedures that adhere to a written protocol
- Rewards that do not exceed $200/month per-client

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The policy group also offered the distinctions below concerning what are permissible CM practices:

Permissible as CM Practices	
A	Use of rewards with direct connection* to care coordination and management of targeted clients, to include for participation in community-based services recommended by the licensed health provider
B	Use of rewards via digital health technology (e.g., remote patient monitoring and telehealth)
C	Use of rewards only when the desired health outcome occurs, and for which objective and validated measures consistent with treatment are available (e.g., attendance, abstinent drug tests, and other confirmed behavioral measures)
D	Use of rewards to advance treatment goals, as determined by the licensed health provider, including: (i) adherence to a treatment regimen; (ii) adherence to a drug regimen; (iii) adherence to a follow-up care plan; (iv) management of a disease or condition; (v) improvement in measurable evidence-based health outcomes for the client or targeted client population; or (vi) ensuring client safety
Not Permissible as CM Practices	
A	Use of rewards that result in medically unnecessary or inappropriate items or services reimbursed in whole or in part by a federal health care program
B	Advertisement of the availability of rewards as means either to recruit clients, or to steer clients away from other health care providers
C	Use of rewards for the purpose of increasing fees
D	Use of rewards with inadequate protection against fraud (for further detail, see our supplemental material concerning 'Documentation Practices')

*A direct connection is that which empowers clients to fully participate in care coordination activities, including appointment attendance, medication self-administration, substance testing results, community reinforcement participation, cognitive behavioral therapy effort, and peer recovery coaching participation.

Finally, it bears mention that guidance on allowable client rewards **may continue to change rapidly** in the current environment, as efforts are underway to address other legal/policy issues concerning the use of CM practices by community settings (e.g., differentiating rewards from client income or assets for tax/eligibility purposes). Accordingly, it is **strongly recommended that community settings seeking to implement CM consult** with relevant federal (i.e., SAMHSA, Office of National Drug Control Policy) and state (i.e., Single-State Authorities, State Opioid Response grantees) entities to ensure compliance with newly-emerging standards of practice for CM implementation.