DRAFT

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

Michigan Medicaid Recovery Incentives (RI) Pilot Introduction

June 1, 2023

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Agenda

- Substance Use Disorder Crisis in Michigan
- What is Contingency Management?
- Recovery Incentives Pilot: Overview and Timeline
- Discussion

Today's Objectives

- Introduce contingency management as an evidence-based treatment for stimulant use disorder (StimUD) and opioid use disorder (OUD)
- Outline proposed design and timeline for Recovery Incentives pilot
- Begin dialogue and solicit input on Recovery Incentives pilot design

Substance Use and Overdose Deaths in Michigan

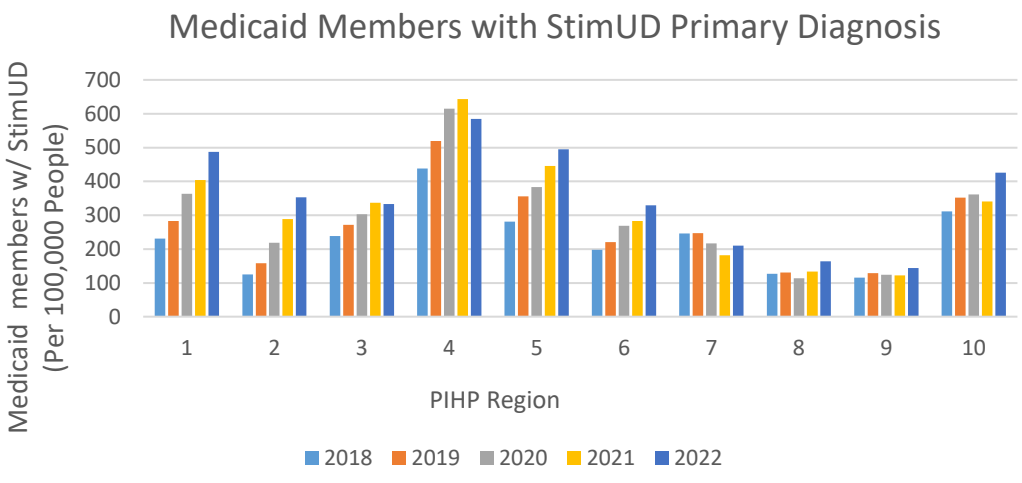
Michigan is grappling with a persistent and shifting substance use disorder (SUD) crisis.

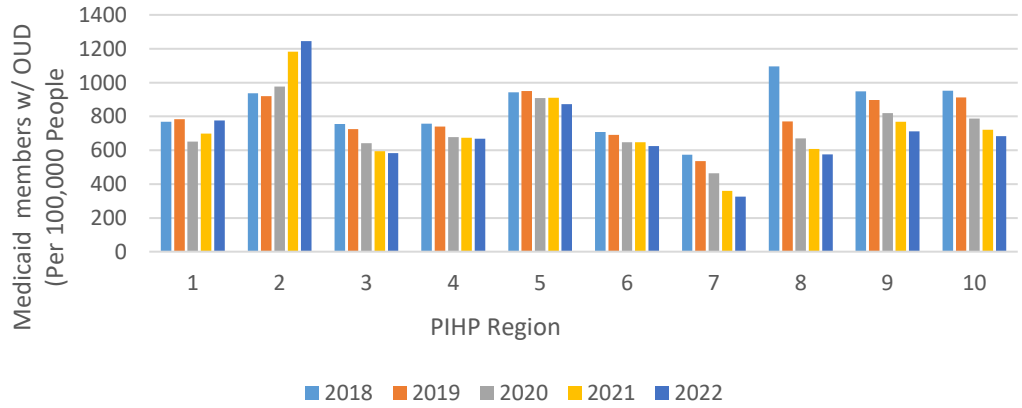
- Since 2000, opioid overdose deaths have grown ten-fold in Michigan.[1]
- In 2020, 83.5% of overdose deaths involved at least one opioid and 43.4% involved at least one stimulant.[2]
- In 2022, the prevalence of a primary diagnosis of stimulant use disorder (StimUD) reached a four-year peak among Medicaid enrollees in Michigan in seven of the state's ten Prepaid Inpatient Health Plans (PIHPs).
- In 2022, the rate of drug overdose deaths was 65.9 per 100,000 for Black Michigan residents, double the rate for whites.[3]

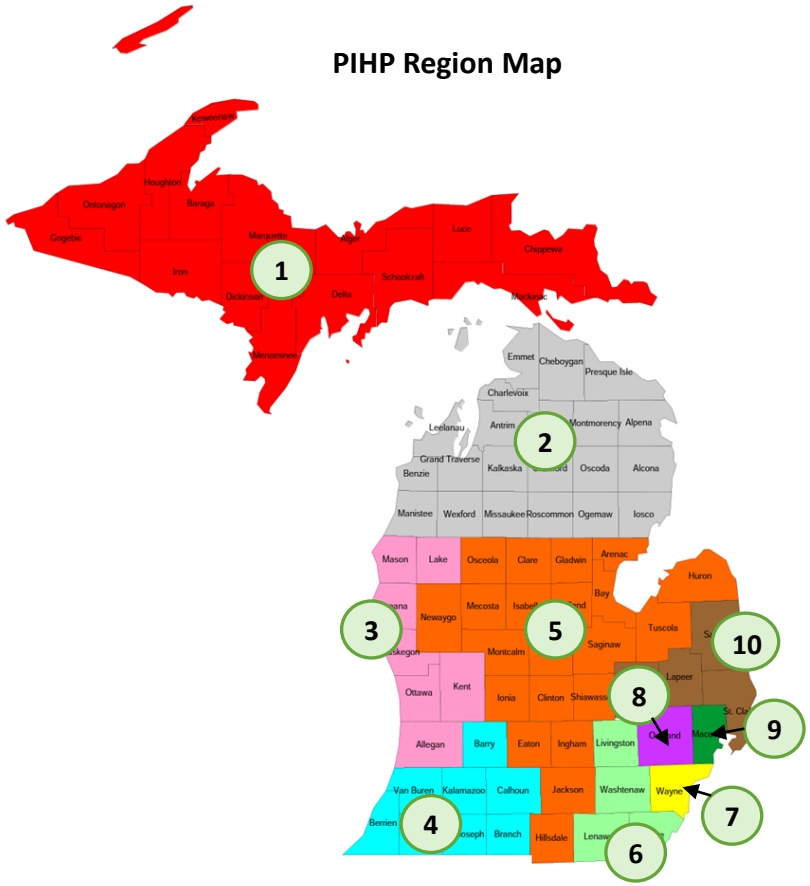
[1] State of Michigan, Opioid Resources, "About the Epidemic".
[2] Centers for Disease Control and Prevention, "SUDORS Dashboard: Fatal Overdose Data".
[3] MDHHS data
[4] Centers for Disease Control and Prevention, "SUDORS Dashboard: Fatal Overdose Data".

DRAFT

Unique Medicaid and HMP Members Living with StimUD & OUD as Primary Diagnosis Per Capita, by PIHP Region and Year (2018 - 2022)







What is Contingency Management?

Contingency management is an evidence-based practice that can be deployed to treat substance use disorder (SUD).

- **Contingency management (CM):**
  - Provides motivational incentives for nonuse of specified substances as evidenced by negative drug tests
  - Uses the immediate delivery of incentives to help tip decision-making toward avoiding substance use
  - Has repeatedly demonstrated robust outcomes, including reduction or cessation of drug use and longer retention in treatment

- **To expand access to evidence-based treatment for SUD, MDHHS intends to:**
  - Pilot Medicaid coverage of CM – also known as Recovery Incentives (RI) - in select Pre-paid Inpatient Health Plans (PIHPs) beginning October 1, 2024
  - Use the pilot as a basis for informing the design and implementation of a statewide RI benefit pending budgetary and statutory authority

CM Evidence for Treating SUD

- Multiple studies conducted over the past 30+ years demonstrate that **CM is the most effective intervention for stimulant use disorders**, including methamphetamine, amphetamine, and cocaine use disorders.[1-5]
  - Given the lack of other treatment options for stimulant drugs, such as methamphetamine and cocaine (there are currently no FDA-approved medications for StimUD), CM is an important clinical tool in the treatment of StimUD.
- CM also works well for treating **opioid use disorder and other substance use disorders**.
  - A 2021 meta-analysis found that use of CM for individuals receiving medication treatment for OUD was associated with increased abstinence from illicit opioid use at end-of-treatment.[5]
  - A 2020 systematic review of five reviews found that CM programs were associated with consistently positive results, demonstrating their effectiveness compared to treatment as usual, as well as other interventions, including community reinforcement, pharmacotherapy, and CBT.[6]
- **Research also finds that the effect of CM can last**. A 2021 meta-analysis of 23 trials found that people who participate in CM had 22% higher odds of being abstinent 6 months after treatment ended compared to people who received other forms of treatment.[7]

MDHHS Recovery Incentives (RI) Pilot Overview

MDHHS intends to pilot Medicaid coverage of contingency management through the *Recovery Incentives Pilot* in PIHPs that elect and are approved to participate.

Eligible Medicaid beneficiaries will participate in a **structured 24-week outpatient Recovery Incentives (RI) Pilot,** followed by 6+ months of additional recovery support. Beneficiaries diagnosed with stimulant use disorder (StimUD) or opioid use disorder (OUD) will be eligible to participate in the pilot.

Beneficiaries will receive incentives for **completed urine drug tests (UDTs), with larger rewards for negative test results**. The larger incentives will be earned by testing negative for a narrow set of specified substances (i.e., simulants and/or opioids) even if the test returns positive for other illicit drugs.

Incentives earned over the treatment period will be in the **form of low-denomination gift cards.** Individuals will be eligible to receive a maximum of $599 in incentives over a 12-month period.

A web-based incentive manager will track progress and calculate and disburse incentives.

Basic Treatment Framework (1/2)

While the details of the duration and size of incentive payments may undergo further refinement, MDHHS anticipates that the basic design will be a 24-week outpatient treatment experience followed by a six month or longer period of aftercare and recovery support services.

Initial 12-Week Period (Weeks 1-12)

- Two in-person treatment sessions per week where beneficiaries can receive incentives.
- The size of incentives a beneficiary will be eligible to receive will increase each week they demonstrate non-use of stimulants.
- A **"reset"** will occur when a beneficiary submits a positive sample or has an unexcused absence.
- The next time they submit a stimulant-negative sample, the incentive will return to the initial value.
- A **"recovery"** of the pre-reset value will occur after two consecutive stimulant-negative urine samples.
- During the visit, the RI Coordinator will discuss the results of the urine drug test with the beneficiary and offer other services if/as appropriate, including encouragement, motivational interviewing, and education.

Basic Treatment Framework (2/2)

While the details of the duration and size of incentive payments may undergo further refinement, MDHHS anticipates that the basic design will be a 24-week outpatient treatment experience followed by a six month or longer period of aftercare and recovery support services.

Maintenance Period (Weeks 13-24)

- One in-person treatment session per week where beneficiaries can receive incentives.
- Incentive limits may change throughout the weeks of the maintenance period.
- Following the maintenance period, beneficiaries may participate in an additional 6 month or longer period of aftercare and recovery support services.

California's Incentive Schedule for CM (*Illustrative)*

California's incentive schedule follows an Escalation, Reset, and Recovery (ERR) approach.

The table at right shows the expected incentive deliverable schedule assuming perfect performance. Perfect performance is when the participant has a consistent attendance record **and** submits samples that are stimulant negative over the 24-week period.

Table 1: Sample Incentive Delivery Schedule	
Week	**Incentive for Stimulant-Free Test**
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15.00 per week/test
Weeks 19-23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

Other Program Elements

RI services will be complemented by ongoing training and technical assistance and a robust evaluation process, while protecting against fraud, waste, and abuse.

Training

- Participating PIHPs and SUD providers will be required to participate in start-up training and ongoing technical assistance.
- Training will be provided virtually and will be live and synchronous to accommodate diverse program schedules across Michigan.

Evaluation

- The impact of the Pilot will be measured through a robust evaluation process.
- MDHHS will contract with an evaluation partner to develop and implement the evaluation plan.
- Evaluation reports will include an interim and a final evaluation report.

Oversight

- Each treatment program will have a policies and procedures manual.
- MDHHS will work with PIHPs to determine and ensure appropriate monitoring and oversight of RI providers as part of their regular on-site reviews of providers

Anticipated Timeline for RI Pilot

2023 will focus on designing the program and obtaining federal approval for the Pilot. The state intends to submit a waiver application to CMS in late 2023 requesting authorization for the RI pilot.

		Milestones
2023	Q1	Begin stakeholder engagement on design of RI program (ongoing)
		Begin developing waiver for RI Pilot
	Q2	Release Expression of Interest (EOI) for PIHPs
		Continue to develop waiver for RI Pilot
		Release request for proposal (RFP) for partner to assist in program design and provider training/technical assistance
	Q3	Release RFP for web-based incentive manager vendor
		Submit waiver amendment for RI Pilot to CMS
	Q4	Release request for applications (RFA) for PIHPs

Anticipated Timeline for RI Pilot

In 2024, the State will select PIHPs and an Incentive Manager partner and deliver training and technical assistance in preparation to launch the Pilot by October 2024.

		Milestones
2024	**Q1-Q3**	Identify participating PIHPs
		Develop and release Provider Bulletin
		Conduct training and technical assistance (T/TA) for PIHPs, providers and vendors
		Conduct provider readiness reviews
2024 - 2026	***Q4 2024 – Q4 2026***	**Launch RI Pilot *(October 2024)***
		Conduct provider fidelity reviews
		Release interim and final evaluation report
		Conclude RI pilot *(September 2026)*


Q
A

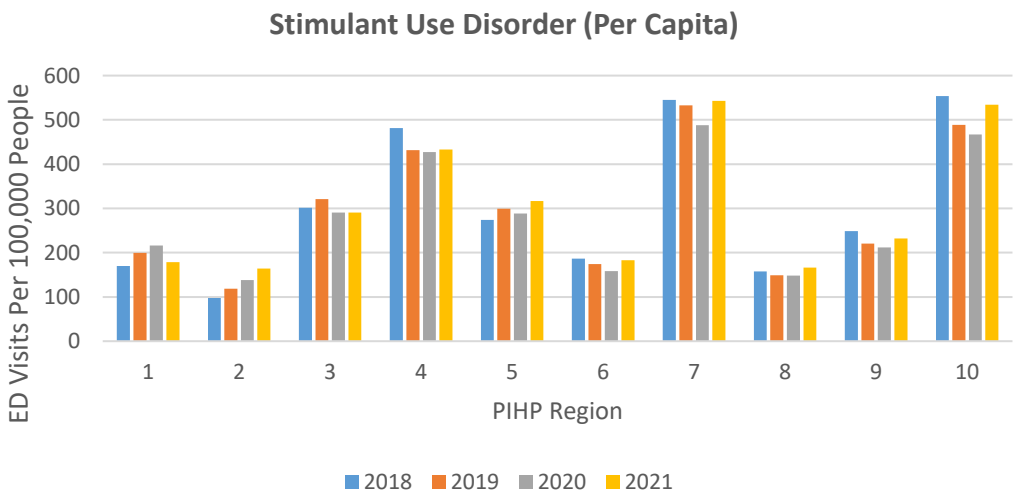
Discussion

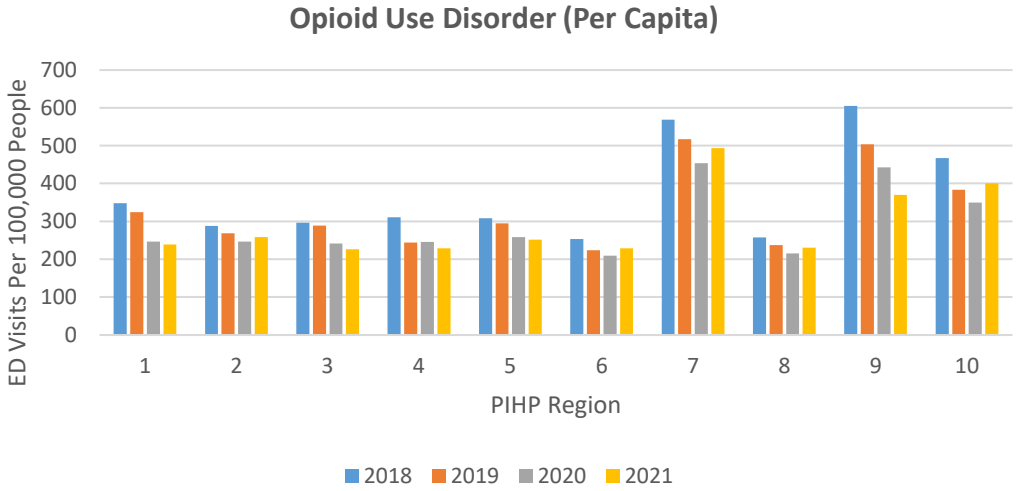
- What feedback do you have about the information shared today?
- What factors, opportunities, or challenges should be considered in designing the RI Pilot?
- How do you think the community(ies) you serve would benefit from participating in the RI Pilot?
  - What information will be critical to engaging your community(ies) in the RI Pilot?
  - What do you anticipate will be barriers to their participation?
- What questions do you have?

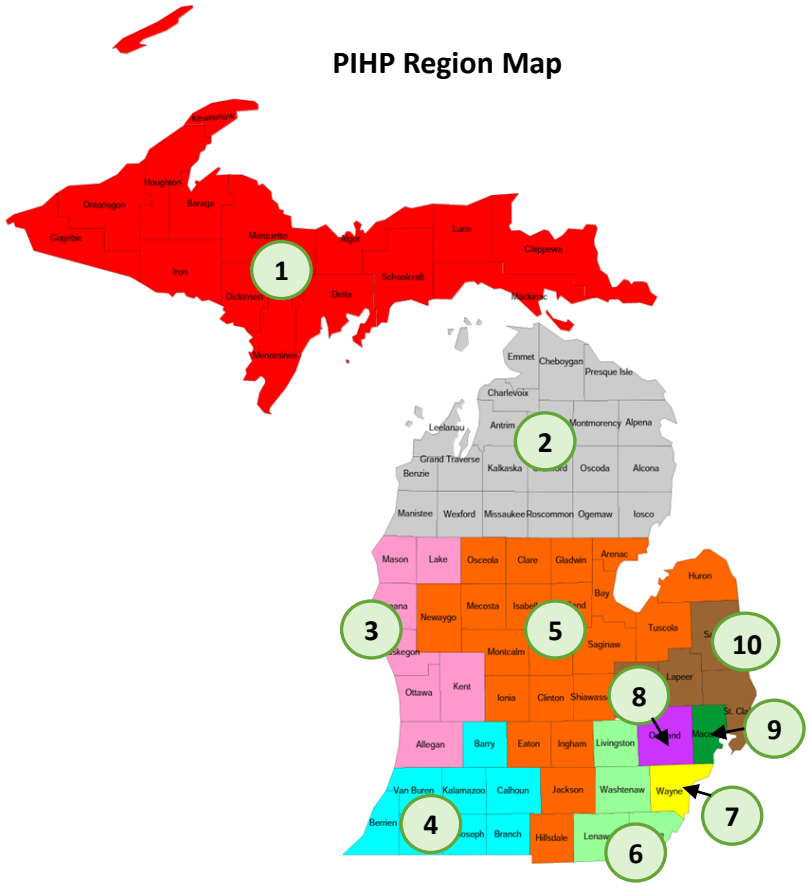
Appendix

DRAFT

Per Capita Emergency Department Visits with Stimulant Use Disorder & Opioid Use Disorder Diagnoses, by PIHP Region and Year (2018 - 2021)

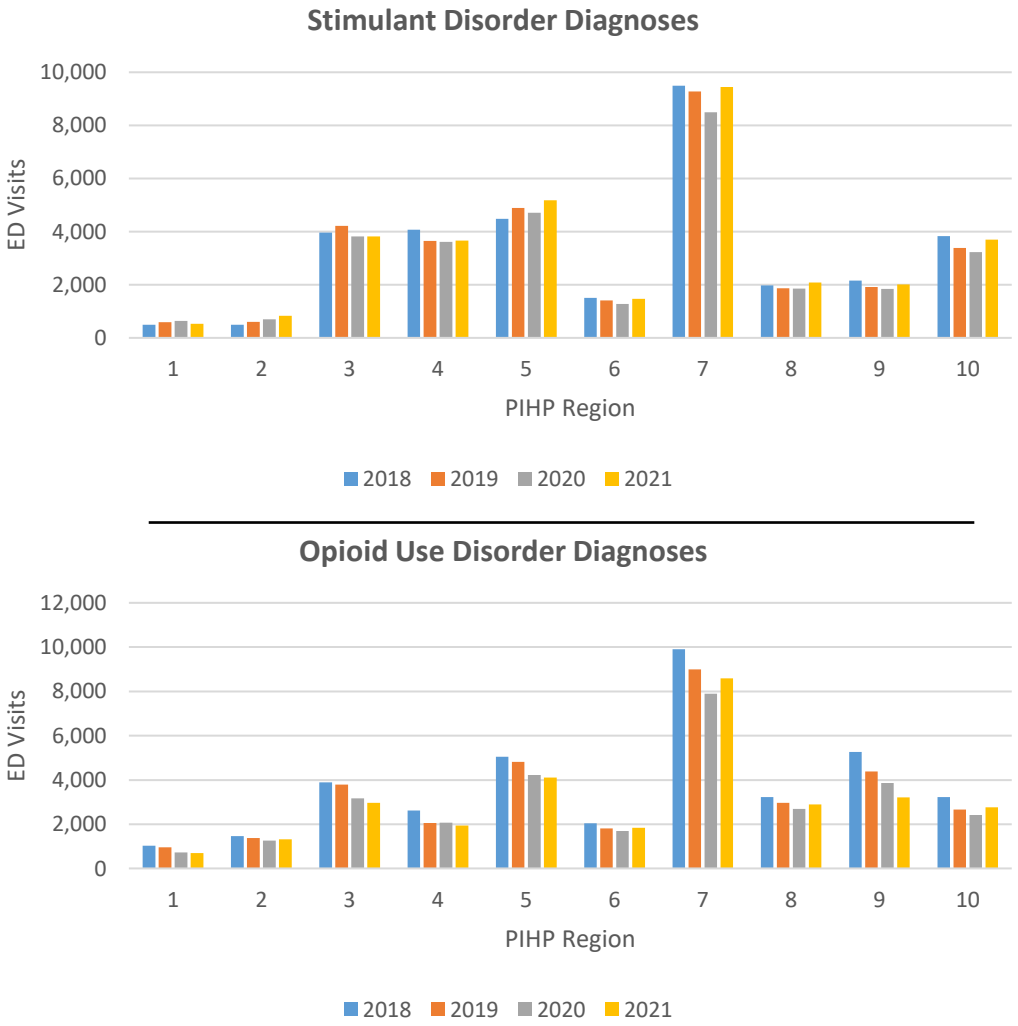






DRAFT

Total Emergency Department Visits with Stimulant Use Disorder & Opioid Use Disorder Diagnoses, by PIHP Region and Year (2018 - 2021)



PIHP Region Map