Scope of Services and Deliverables

Contingency Management Pilot Programs (COMPP)

Applications due June 6, 2025

Contents

About this Document

This document contains sections C.2. Need, C.3. Funding Purpose and Scope of Services, and C.4. Deliverables and Performance Measures of the Contingency Management Pilot Programs (COMPP) Notice of Funding Opportunity (NOFO). All application materials are available on the Illinois Regional Care Coordination Agency website via the Funding Opportunities page.

C.2. Need

The funds from the settlements will support prevention efforts in communities hardest hit by the opioid crisis and throughout the state. Fund distributions must be used equitably in service areas disproportionately affected by the opioid crisis as outlined in the Illinois Opioid Allocation Agreement, such as, areas with the following characteristics:

- High opioid fatality rates, including;
  - Counties other than Cook County with a crude rate of 1.8 or greater per 100,000 people

    - Zip codes within Cook County with more than 100 overdoses (fatal and nonfatal) within the most recent year.
  - Concentrated poverty, including;
    - Counties other than Cook County with a poverty rate greater than twelve (12) percent
    - Zip codes within Cook County with a poverty rate greater than twelve (12) percent, per the U.S. Census Bureau, https://www.census.gov/quickfacts/fact/map/IL/
- Concentrated firearm violence, including communities eligible for Reimagine Public Safety Act funding, https://www.dhs.state.il.us/page.aspx?item=144282
- Other conditions that hinder the communities from reaching their full potential for health and well-being, including counties other than Cook with a crude nonfatal overdose rate of 4.0 or greater per 100,000 people, as listed in the Illinois Opioid Data Dashboard, http://idph.illinois.gov/opioiddatadashboard/

Contingency management (CM) involves encouraging or discouraging a behavior to increase or decrease its frequency respectively. CM is a widely researched and shown to be effective in the treatment of opioid use disorder (OUD)—when deployed in conjunction with medication-assisted recovery (MAR)[1], which is standard of care—and other SUDs.[2] A January 2025 SAMHSA Advisory identifies three outcomes for which CM is effective: abstinence, treatment attendance, and medication adherence. Although the SAMHSA Advisory cautions that "CM services should not be used to promote abstinence from opioids," the guidance notes that CM can be effective in promoting abstinence from stimulant use "among those with concurrent stimulant and opioid use disorder."

This funding is intended to support pilot CM programs across the state, which includes start-up costs for program set-up, acquiring staffing, training staff, and acquiring resources and incentives. Interventions will include non-cash monetary value incentives with a maximum value of $750 per program participant per year and no/minimal monetary value incentives, in accordance with legislative and regulatory requirements, focused on necessary behaviors for treatment success and longer-term recovery. Examples of no/minimal monetary value incentives may include take-home dosages of medications (in compliance with current Methadone Take-Home Flexibilities Extension Guidance), recognition certificates or ceremonies, or increased responsibilities or autonomy. Longer-

[1] Marino, E. N., Karns-Wright, T., Perez, M. C., & Potter, J. S. (2024). Smartphone app-based contingency management and opioid use disorder treatment outcomes. *JAMA Network Open*, *7*(12), e2448405. https://doi.org/10.1001/jamanetworkopen.2024.48405

[2] Wells, M., Kelly, P. J., Robson, D., Haynes, C., Hatton, E., & Larance, B. (2024). Systematic review of treatment completion rates and correlates among young people accessing alcohol and other drug treatment. *Drug and Alcohol Dependence, 262*, 111376. https://doi.org/10.1016/j.drugalcdep.2024.111376

term incentivized recovery behaviors may include attendance at mutual aid meetings, engaging in healthy social events, engaging in education or work, developing a supportive social network, etc.

C.3. Funding Purpose and Scope of Services

A minimum of two (2) and maximum of five (5) organizations will be awarded COMPP funding to increase treatment retention, increase medication compliance, and reduce opioid use.

To accomplish these goals, subrecipients of COMPP funding will:

1. Design and staff a CM program for eligible participants based upon evidence-based or evidence informed approaches.
2. Train clinical staff in delivering evidence-based CM practices
3. Administer, through clinical staff, monetary value incentives and/or no/minimal monetary value incentives in compliance with state and federal laws and regulations
4. Document participant outcomes, including incentives received and abstinence, attendance, and adherence, as applicable

All subrecipients are required to obtain and/or maintain licensing by SUPR and must accept people who receive Medicaid/Medicare and/or are uninsured. All subrecipients must offer access to MAR, but an individual does not need to participate in MAR to receive incentives related to abstinence or treatment adherence outcomes. They should, however, be engaged with other treatment or recovery services to be eligible for incentives.

The tasks required and associated performance measures, standards, and potential metrics to be collected are as follows:

Task 1. Fulfill Award Administration Requirements

COMPP subrecipients shall fulfill obligations detailed in Section H.10. Reporting and Grants Administration Requirements, including:

- Complete an organizational needs assessment (ONA) survey
- Develop and update an implementation and sustainability plan (ISP), which informs the performance metric used for program activities
- Develop and implement an equity and racial justice (ERJ) plan
- Complete monthly periodic performance reporting (PPR)
- Complete monthly program fiscal reporting (PFR)

- Participate in program status meetings and training/technical assistance (TTA) as prescribed
- Conduct data collection and complete monthly evaluation reporting

Anticipated performance measures for these activities are detailed in Section C.4. Deliverables and Performance Measures.

Task 2. Staff and Administer COMPP

The subrecipient shall establish and maintain program leadership and staffing, subject matter experts, operations, information technology, and other administrative infrastructure required to support program activities pursuant to administrative and legislative requirements.

The following deliverables shall be required:

Task 2.a. Identify Program Staff

The subrecipient shall allocate or hire sufficient staff to support the delivery of the tasks.

The subrecipient shall identify a program director who shall ensure that program requirements are met and shall act as a "champion" for CM implementation. Responsibilities, per SAMHSA Advisory, shall include the following:

- Securing the necessary training for clinicians and staff
- Monitoring for fidelity to evidence-based practice
- Connecting CM providers with coaching as needed
- Monitoring the safe storage of monetary value incentives, and tracking the release of incentives based on objective evidence of achieving the desired behavior
- Documenting the disbursement of CM incentives

Contingency management shall always be delivered, per the SAMHSA Advisory, by a "health care practitioner who is authorized to provide SUD treatment services in that state." Examples of authorized health care practitioners include the following:

- IAODAPCA (ICB) certified alcohol & drug abuse counselor
- Licensed social worker or clinical social worker
- Licensed professional counselor or licensed clinical professional counselor
- Physician, providing direct patient care
- Licensed psychologists

Although subrecipients are encouraged to use peer specialists to provide other services to individuals participating in CM, the SAMHSA Advisory states that "**Peer specialists are not permitted to deliver CM**, as many components of the intervention fall outside of their

traditional scope of activities and can place them in a role of authority that conflicts with the peer-to-peer relationship." Therefore, expenses related to peer specialists shall not be included in program budgets.

Leadership and direct service staff shall be reflective of the community/population being served. Preference is given to subrecipients that commit to having direct service staff who both live and work in their communities.

Task 2.a.i. Performance Measures

The subrecipient shall submit a Program Organizational Chart detailing assigned staff (or designated to-be-hired), their roles, and matrixed supports within fifteen (15) days from the beginning of the period of performance. This organizational chart shall include a list of names and emails of all individuals assigned to work on the program in any capacity.

Task 2.b. Oversee Procurement and Monitoring of Subcontracts and Subawards of SMEs

The subrecipient shall recruit and/or sub-contract with subject matter experts to provide services in communities disproportionately impacted by opioid overdoses, and multigenerational harms associated with structural racism and health inequities.

The subrecipient shall administer procurement and monitoring procedures in accordance with the authorizing statutes and regulations in Section C.6.

Task 2.b.i. Performance Measure

The subrecipient shall submit a program administration manual that details procurement and monitoring procedures within ninety (90) days of the beginning of the period of performance.

Task 2.b.ii. Performance Measure

The subrecipient shall submit and maintain a list of subject matter experts, organized by topic, within ninety (90) days of the beginning of the period of performance.

Task 3. Design COMPP

A subrecipient shall provide the following deliverables:

Task 3.a. Develop Treatment Guidelines

The subrecipient shall develop and submit for approval a set of clinical guidelines for achieving the goals of the program. To avoid potential violations of the Federal Anti-Kickback Statute (42 USC § 1320a-7b), the subrecipient shall clearly demonstrate that the incentives are provided to improve treatment outcomes among individuals receiving treatment from the subrecipient, rather than as a marketing tool to attract clients to the subrecipient.

The clinical guidelines shall address the following elements:

- Length of the intervention (minimum 3 months, maximum 1 year), along with an explanation of why the length of intervention was chosen
- Population of focus (geographic, demographic, and risk factors)
- Behaviors to be incentivized (reduction in substance use, treatment adherence, and/or participation on longer-term recovery activities) (42 CFR § 1001.952(hh)(3)(iv))
- Methods for monitoring compliance with incentivized behaviors
- If abstinence (from substances used concurrently with opioids) is selected as an incentivized behavior, a description of rapid point-of-care (POC) testing procedures that comply with the SAMHSA Advisory, including the test having a Clinical Laboratory Improvement Amendments (CLIA) waiver
- Staffing by a licensed clinician
- Procedures for ensuring that peer specialists do not administer CM services
- Procedures for limiting participation in more than one CM program
- Fidelity monitoring protocols
- Staff training requirements
- Procedures for disenrolling and reenrolling participants, including but not limited to the disenrollment of participants who have participated for twelve (12) consecutive months, have enrolled in another CM program, or who enter residential treatment
- Procedures for ensuring incentives are not dependent on type of insurance coverage (42 CFR § 1001.952(hh)(8))
- Approach to integrating CM into comprehensive array of services, counseling, and treatment activities

Guidelines shall be supported by evidence-based or evidence-informed sources.

Task 3.a. Performance Measures

The subrecipient shall submit Clinical Treatment Guidelines within sixty (60) days of the beginning of the period of performance.

Task 3.b. Develop Incentive Protocols

The subrecipient shall develop written Incentive Protocols for ensuring that incentives comply with Safe Harbor provisions relating to contingency management programs established by the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS) (42 CFR § 1001.952(hh)). At minimum, these protocols shall address the following incentives, which shall be non-cash:

- Whether incentives are prize-based or voucher-based
- Magnitude of incentives, along with evidence base

- Annual cap on monetary value of incentives
- Procedures for documenting distribution of incentives (42 CFR § 1001.952(hh)(7))
- Procedures for compliance with marketing prohibitions (42 CFR § 1001.952(hh)(6))

The Incentive Protocols shall identify the incentives. Per 42 CFR § 1001.952(hh) and the SAMHSA Guidance, the following incentives are **prohibited**:

- Monetary value incentives
    - Cash
    - Unrestricted cash equivalents (e.g., debit cards)
    - Weapons
    - Tobacco, nicotine products, alcohol, or cannabis
    - Dextromethorphan, pseudoephedrine, or other over-the-counter medications with abuse or misuse potential
    - Pornographic materials
    - Lottery tickets or other gambling products
    - Any gift card that allows for the purchase of a prohibited item
- No/minimal monetary value incentives
    - Parenting time
    - Enhanced or expedited access to SUD treatment or recovery supports

Protocols shall be supported by evidence-based or evidence-informed sources.

Task 3.b. Performance Measures

Submit Incentive Protocols within 60 days of the beginning of the period of performance.

Task 4. Train Staff in COMPP Practices

A subrecipient shall provide the following deliverables:

Task 4.a. Develop Training Plan

To ensure fidelity to evidence-based practice, those who will implement, administer, and supervise CM interventions shall participate in CM-specific training prior to services starting. Training shall be delivered by an advanced degree holder who is experienced in the implementation of evidence-based CM. Training shall be easily accessible and can be delivered live or through pre-recorded training sessions. When participants receive training through pre-recorded sessions, they shall have an opportunity to pose questions and to receive responses in a timely manner. Training shall contain the following elements:

- Behavior of focus
- Considerations for serving the population of focus
- Permissible and impermissible incentives
- Amount of incentives
- Frequency of CM sessions and incentives

- Timing of incentives (soon after behavior or test)
- Duration of the intervention
- Evidence base for CM
- How to describe CM to eligible and ineligible participants
- Safeguards to prevent fraud and abuse
- Recordkeeping requirements and their legal importance
- Testing protocols and due process for challenging results
- How CM fits in with MOUD, other SUD treatment, and recovery supports
- Roles and responsibilities
- (For supervisors) oversight and coaching strategies

Task 4.a. Performance Measures

The subrecipient shall submit Training Plan within ninety (90) days of the beginning of the period of performance.

Task 4.b. Complete Training

Task 4.b. Performance Measures

The subrecipient shall submit a Training Log within 180 days of the beginning of the period of performance indicating the staff name, staff role, the subject of each training participated in, the name and credentials of the training provider, how the training was delivered, and the date of completion.

Task 5. Manage, Monitor, and Report on COMPP Activities

The subrecipient shall participate in monitoring and evaluation of services. For each of the Subtasks below, the subrecipient shall report a Monthly Activities Report, within fifteen (15) days of the completion of any month in which the subrecipient delivers services, in a format prescribed by AHP and/or the external evaluator. Alongside data collection on the implementation and reach of services, the subrecipient shall work with an external evaluator to identify additional outcome indicators for subrecipient scopes of services as described in Section H.10. Task 1.g. Evaluation Reports.

The subrecipient shall provide the following deliverables:

Task 5.a. Evaluate Individual Participants for Clinical Need

Before any individual participates in CM services, the individual's licensed health care professional shall document in the individual's health record the types of CM that would be appropriate for the individual.

The subrecipient shall report any month in which the subrecipient provides CM services, indicating for each individual (de-indentified using a unique code) the date on which CM was found to be clinically appropriate by a licensed health care professional.

Task 5.a. Performance Measures

The subrecipient shall submit required information in a Monthly Activities Report within fifteen (15) days of the completion of any month in which the subrecipient delivers CM services.

Task 5.b. Monitor Compliance with Incentivized Behavior

The subrecipient shall monitor compliance with the incentivized behavior, through the following measures:

- For abstinence from substances (e.g., stimulants) used concurrently with opioids, administering rapid POC tests two to three times per week.
- For medication adherence, recording when doses of methadone or long-acting injectables are administered to the individual.
- For treatment attendance, documentation thereof (e.g., treatment notes or signed attendance logs for group meetings)
- For recovery-behaviors, documentation thereof (e.g., log or notes documenting engagement in healthy social events, education or work, development of a supportive social network, etc.)

Each month, the subrecipient shall prepare a list of individuals (identified by a unique code rather than by name) in compliance with and out of compliance with incentivized behaviors.

Task 5.b. Performance Measures

The subrecipient shall submit required information in a Monthly Activities Report within fifteen (15) days of the completion of any month in which the subrecipient delivers CM services.

Task 5.c. Distribute Incentives

For each participant who meets treatment goals specified in the individual's health record, the CM staff shall distribute the type and amount of incentive called for by the plan.

The subrecipient shall include in each participant's health record the following information:

- The health care professional's recommendation of CM
- The type of CM model used
- A description of CM incentives furnished and (when applicable) their monetary value

- Health outcomes and/or specific behaviors achieved
- A cumulative tally of the monetary value of incentives received by the patient

Each month, the subrecipient shall note in a Monthly Report the description, value, and cumulative total of the monetary value of incentives provided to each individual (identified by a unique code rather than by name).

Task 5.c. Performance Measures

The subrecipient shall submit required information in a Monthly Activities Report within fifteen (15) days of the completion of any month in which the subrecipient delivers CM services.

Task 5.d. Disenroll Participants

The subrecipient shall disenroll participants who no longer meet the guidelines for CM, according to the subrecipient's Treatment Guidelines. At a minimum, participants shall be disenrolled if they (a) have been enrolled continuously in CM for 12 months, or a shorter time if specified by the Treatment Guidelines; (b) have enrolled in another CM program; (c) have entered residential SUD treatment. Participants may be disenrolled for other valid reasons specified in the Treatment Guidelines, including moving out of state, voluntarily withdrawing from the program, or failing to report for a length of time.

A participant shall not be disenrolled based on insurance status or refusal to participate in specific services (e.g., medications for opioid use disorder) or because of discrimination related to race, gender, religion, sexual orientation, or ability.

The subrecipient shall document the reason(s) for disenrollment in the participant's health record. Additionally, each month, the subrecipient shall note in a Monthly Report the number of clients disenrolled, along with the reason for each disenrollment.

Task 5.d. Performance Measures

The subrecipient shall submit required information in a Monthly Activities Report within fifteen (15) days of the completion of any month in which the subrecipient delivers CM services.

C.4. Deliverables and Performance Measures

The following table details (a) the deliverables required according to the scope of services and (b) associated performance measures, standards, and potential metrics (subject to change) to be collected by task. Time periods refer to the days from the beginning of the period of performance, unless otherwise specified. Standards for activities refer to percentages of those described in the ISP.

Deliverables		Performance Measures	Standards	Metrics
T1	**Fulfill Award Administration Requirements**	(a) Complete ONA survey	100%	ONA survey completed (30 days after distribution)
		(b) Develop ISP	100%	ISP submitted (45 days)
		(c) Develop ERJ Plan	100%	ERJ organizational assessment completed (90 days) ERJ Plan drafted (120 days) ERJ Plan finalized (180 days)
		(d) Complete PPR	100%	Activities and services metrics reported (15th of each month, 15th following each quarter unless otherwise prescribed)
		(e) Complete PFR	100%	Fiscal performance reported (15th of each month; monthly and quarterly reports)
		(f) Participate in TTA	75%	# Bimonthly cohort meetings (initiated within 30 days) # Bimonthly individual meetings (initiated within 30 days) # TTA sessions attended (quarterly or as prescribed)
		(g) Complete data collection and evaluation reporting	100%	Data collected as prescribed Data reported monthly (15th of each month) Data reported quarterly (30th of each quarter)
T2	**Staff and Administer COMPP**	(a) Identify program staff	100%	Organizational chart and staff list submitted (15 days)
		(b) Manage procurement with SMEs	100%	Administration manual submitted (90 days) SME list submitted (90 days)
T3	**Design COMPP**	(a) Develop treatment guidelines	100%	Treatment Guidelines submitted (60 days)
		(b) Develop incentive protocols	100%	Incentive Protocols submitted (60 days)
T4	**Train Staff in COMPP**	(a) Develop training plan	100%	Training Plan submitted (90 days)
		(b) Complete training	100%	Training Log submitted (180 days)

Deliverables		Performance Measures	Standards	Metrics
T5	**Manage, Monitor, and Report on COMPP Activities**	(a) Evaluate individual participants	100%	Monthly Activities Report submitted (15 days end of month) to include: Date on which health care professional made service determination for each de-identified client
		(b) Monitor compliance with incentivized behavior	100%	Monthly Activities Report submitted (15 days end of month) to include: List of de-identified clients in compliance with treatment goals List of de-identified clients not in compliance with treatment goals
		(c) Distribute incentives	100%	Monthly Activities Report submitted (15 days end of month) to include: Description of incentives supplied to each de-identified client Value of incentives supplied to each de-identified client Cumulative total of incentives supplied to each de-identified client
		(d) Disenroll participants	100%	Monthly Activities Report submitted (15 days end of month) to include: Number of clients disenrolled Reason for each disenrollment