The Value Proposition for Peer Recovery Support Services Delivered through Community-Based Organizations

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INTRODUCTION

As the ongoing effects of substance use and mental health challenges persist, communities are searching for better ways to engage, support, and transition individuals. Health and social systems are developing recovery-oriented systems of care—a coordinated network of community-based services that is person-centered and supports improved quality of life for people who have experienced behavioral health conditions in response to this need. Peer recovery support services (PRSS) have surfaced as arguably the most effective way to enhance long-term recovery outcomes for individuals.

PRSS play a critical and emerging role in the continuum of care for individuals with substance use and mental health concerns. Individuals with lived experience of recovery from substance use or mental health conditions deliver these services. These individuals, called peer support specialists, are trained to offer non-judgmental support and guidance to others facing similar challenges, fostering a sense of hope and empowerment through mutual understanding and shared experiences. They also assist with navigating health care and social service systems and help connect individuals with community resources and support networks (Office of Recovery). Their lived and living experience allows them to offer a level of authenticity and relatability that can be particularly effective in building trust and motivating individuals to pursue and sustain their health, wellness, and recovery goals. Thus, peer support specialists are recognized for their unique ability to engage in ways that traditional service providers may not be able to due to their personal experiences with recovery.

To date, federal, state, and local government-capped grant awards have primarily supported PRSS innovation in communities.[i] These funding pathways, although flexible and supportive of innovation in this domain since 1998, have provided limited opportunities for scaling PRSS to all communities needing these services. Due to the success of these historical funding streams,[ii] Medicaid and other third-party payers are increasingly surfacing as pathways to underwrite PRSS for all beneficiaries of their programs.

PRSS is a broad construct focusing on peers' recovery support services regardless of their employment, certification, or licensure circumstances. Peer workers can be employed in various settings, such as hospitals and emergency departments, jails and prisons, and treatment facilities.[iii] This paper focuses on peers working in dedicated Community-Based Organizations (CBOs), often referred to in the mental health (MH) field as “Peer-Run and Family Peer-Run Organizations” or in the substance use disorder (SUD) field known as “Recovery Community Organizations (RCOs).” CBOs are located in the communities they serve and are intrinsically linked with that community. Community members design all programs and services based on needs acknowledged by those members.[iv] Peer-Run and Family Peer-Run Organizations declare that 51 percent or more of the Board of Directors disclose an MH condition or are family members of a child who has received services in the children’s MH system.[v] Similarly, RCOs are a type of CBO governed by people in recovery from SUD or MH concerns or their families and use public education, policy advocacy, and PRSS to better the lives of individuals in recovery.[vi] Since both Peer-Run and Family Peer-Run Organizations and RCOs are a sub-type of CBO, this paper will describe PRSS operating in a CBO to encapsulate both settings.

The transformation of the PRSS landscape hinges on systemic changes that fully integrate peers working alongside CBOs in diverse settings. By standardizing certification, improving funding mechanisms, revising supervision guidelines, and advocating for policy reforms, a more inclusive and sustainable system can be created that supports the continued delivery of high-quality and sustainable PRSS. These efforts will not only enhance recovery outcomes for individuals and families but also strengthen the overall well-being of communities across the nation.

This paper provides evidence of PRSS's benefits when deployed in CBO settings to increase access to these important services and supports. It also reviews existing policy challenges impeding the ability to scale the delivery of PRSS services in CBOs and provides practical and near-term pathways to address these limitations.

IMPORTANCE OF PEER RECOVERY SUPPORT SERVICES PROVIDED BY COMMUNITY-BASED ORGANIZATIONS (CBOs)

There is a growing recognition that community-based care models emphasizing localized, personalized support are more effective for long-term wellness and recovery. This shift is reflected in various initiatives and funding priorities that favor decentralized community-led approaches over traditional centralized health care systems. A recent report published by the Substance Abuse and Mental Health Services Administration (SAMHSA) highlights the need to maintain the unique contributions of the peer recovery support services model as being in conflict at times with traditional clinically driven treatment models.[vii] This is further underscored by the impact the peer's employment setting has on the overall satisfaction and quality of their services.

CBOs are crucial in delivering PRSS, often providing a more effective and culturally sensitive alternative to traditional health care settings such as hospitals or clinical treatment centers. These organizations are deeply embedded within their communities, allowing them to offer more personalized support attuned to the unique needs and experiences of the individuals they serve. Unlike traditional health care organizations, CBOs often have a more holistic approach, addressing individuals' social, emotional, environmental, and practical challenges in seeking and sustaining recovery.

Peer-based recovery support services delivered by recovery community organizations (RCOs) assist in significantly improving individual recovery capital, as well as helping to facilitate involvement with an array of recovery support services that may contribute to other functional social determinant domain improvements and lower negative health events. [viii]

CBOs typically provide a supportive work environment that values the unique contributions of peer support specialists in ways that are difficult for clinical institutions to replicate, given the culture of the traditional health professional hierarchy. CBOs can foster environments to fuel professional growth and can ensure that peers feel valued and respected while meaningfully impacting their communities.

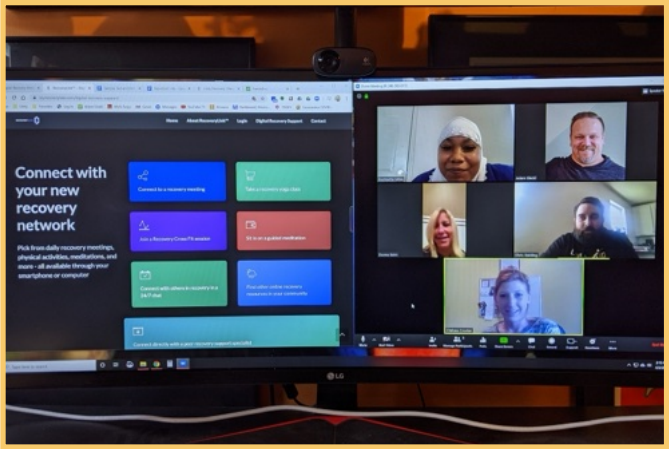
SAMHSA National Model Standards for Peer Support Certification

In July 2023, SAMHSA released National Model Standards for Peer Support Certification (Standards), making a significant step forward to bring fidelity across states concerning the elements of certification for peer workers.[ix] The Standards emphasize the importance of certification and training for peer workers to ensure they are well equipped to perform their roles effectively and ethically, including understanding the boundaries of their role, adhering to confidentiality standards, and being knowledgeable about the resources and services available within the community. PRSS training also covers strategies for self-care and managing the potential stresses associated with providing peer support.

For CBOs, the Standards offer a clear and consistent framework for training and certifying peer recovery support specialists. The Standards also facilitate the integration of peer support specialists into various programs and services, enhancing the overall capacity of CBOs to meet their communities' needs. The Standards emphasize the importance of lived experience and recovery principles, aligning closely with peer-run, family-run, and RCOs' mission and values.

The Standards aim to significantly enhance the ability of states to empower CBOs to recruit and retain workers by promoting reciprocity across state lines and consistency across the peer support workforce. By publishing uniform Standards, peer recovery support specialists will be able to move between states and organizations over time without needing to undergo redundant certification processes similar to other clinical roles in the behavioral health field. Furthermore, recognizing standardized credentials increases job security and career development opportunities for peer support specialists.

Workers are more likely to stay with organizations that offer recognized transferable certifications that enhance their professional credibility and future employment prospects. This consistency and mobility can create a more robust and flexible workforce, allowing CBOs to maintain a stable and competent team of peer workers.



TYPES OF PRSS OFFERED AT CBOs

- Peer Recovery Support (In-Person and via Telerecovery)
- Recovery Community Centers
- Drop-In Centers
- Employment Support
- Transportation
- Outreach and Engagement
- Harm Reduction/ Overdose Prevention Services
- Training
- Educational Support
- Re-entry Support
- Recovery Housing

THE CHALLENGING FUNDING LANDSCAPE OF PRSS FOR CBOs

Funding for PRSS in CBOs has been challenging, particularly because they have historically been funded by annual or time-limited grants or public contracts rather than third-party payers who provide ongoing funding to all eligible beneficiaries. Grants can be a great way for non-profits to develop an initial service offering, provide non-reimbursable services, and supplement other funding streams. However, there are immediate downsides to funding organizations or programs solely on grant funding. Grants have time constraints, often complex administrative and reporting burdens, and re-application processes. The funding can be discontinued if not appropriated by legislative bodies or if grant administrators elect to realign priorities.

In 2023, SAMHSA published a key report on Optimizing Recovery Funding, Volumes 1 & 2.[x] This report surveyed the national landscape for PRSS and identified key challenges that exist across all states concerning the existing funding streams for CBOs (Figure 1).

PRSS Services Funded by Medicaid

The availability of PRSS service reimbursement through third-party payers, like Medicaid, has slowly increased in recent years. Today, 49 of the 50 states and Washington D.C. provide reimbursement for PRSS in some capacity. However, there are significant variations across states related to the type of services eligible for reimbursement, the funding authorities utilized by each state, and the reimbursement rates provided for services rendered.

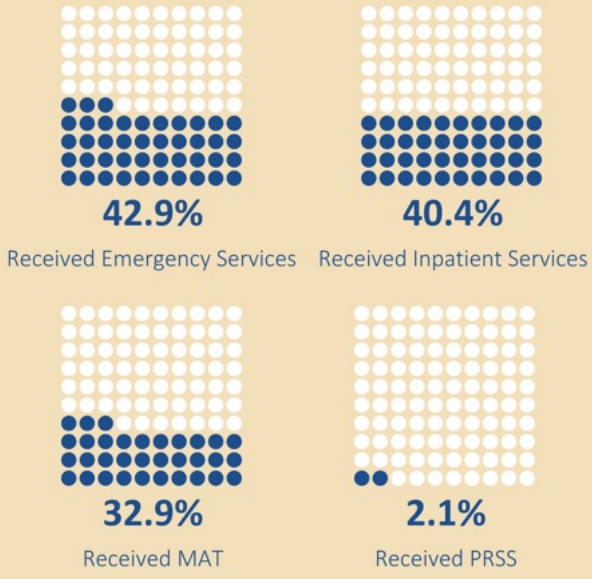
Medicaid funding authorities to reimburse for PRSS under Title XIX of the Social Security Act include state plan and waiver programs. Key waivers for PRSS include 1915(b) managed care waivers for cost-effective service delivery models, 1915(c) for home and community-based services (HCBS) as an alternative to institutional care, 1915(i) for similar services to 1915(c) waiver without having to demonstrate cost neutrality and 1115 for experimental or pilot projects with a cost neutrality requirement.[xi] Figure 2 highlights some of the most recent SUD service utilization in Medicaid released by the Transformed Medicaid Statistical Information System (T-MSIS).

FIGURE 1: KEY FINDINGS FROM OPTIMIZING RECOVERY FUNDING REPORTS

- Federal grant request for proposals (RFPs) are highly complex and organizations do not receive useful feedback or resources on how to improve their submissions.
- Requirements for the receipt of federal funding often necessitate resources for organizational grant administration, which are not allowable expenses in the grants.
- Organizations primarily serving underserved and historically marginalized communities feel excluded from existing funding opportunities.
- Existing funding streams often have restrictions that limit their utility in supporting the implementation of recovery support services, requiring diversified funding for sustainability.
- Spending by source shows that discretionary funding, which could include time-limited funds, makes up one-third of the total RSS spend.
- Both community and government stakeholders noted the need for clear reporting requirements and standardization of definitions of recovery support services to adequately track and report what was offered to whom and with what effect.

FIGURE 2: T-MSIS UTILIZATION DATA FROM 2021

- CMS reports that only 2.1 percent of the 4.9 million Medicaid members with a confirmed SUD in 2021 were delivered PRSS, while 42.9 percent of the same identified group received emergency services, 40.4 percent inpatient care, and 32.9 percent Medication-assisted treatment (MAT).[xii]



A May 2024 report released by the Peer Recovery Center of Excellence examined rates, processes, and procedures for Medicaid reimbursement of PRSS across states.[xiii] The analysis provides a national overview of states offering Medicaid reimbursement, reimbursement rates, and funding authorities. Nineteen states streamline the process for one-on-one peer support by combining billing for both MH and SUD PRSS, offering rates between $7.36 and $23.09 per 15 minutes. Conversely, 15 states reimburse for both services but require separate billing, with rates for MH ranging from $7.34 to $221.00 and SUD from $7.34 to $110. A smaller subset of states focus exclusively on one type of support: six states reimburse only for MH with rates between $10 and $31.50, while another six states cover only SUD with rates ranging from $15.07 to $24.94.

Group peer support services reflect a similar diversity in billing practices. Twenty-seven states reimburse for these services, with rates spanning from $1.26 to $49.17 per 15 minutes per person. Among these, 11 states combine billing for MH and SUD, offering rates from $1.26 to $9.32. Seven states reimburse both but require separate billing, with varying rates from $1.61 to $49.17. Additionally, three states exclusively reimburse for substance use group support with rates between $1.94 and $9.76. Twenty-four states do not reimburse for these services at all. This variation highlights the complex and multifaceted nature of funding peer support services across the United States.

New Hampshire currently reimburses only for SUD one-on-one and group PRSS at a rate of $24.94 per 15 minutes and for group peer support at $9.76 per person per 15 minutes. They utilize state plan funding authorities under both fee-for-service (FFS) and managed care organization reimbursement models.

Pennsylvania currently reimburses for only MH one-on-one PRSS, and not group PRSS. Pennsylvania reimburses at a rate of $10 per 15 minutes for one-on-one peer recovery support services. The state utilizes state plan funding authorities under both fee-for-service and managed care organization reimbursement models.

Texas currently reimburses for both MH and SUD one-on-one and group PRSS. However, Texas requires separate billing for these services. The same rates are identified for MH and SUD one-on-one services at $11.25 per 15 minutes as well as the same rates for MH and SUD group services at $1.61 per person per 15 minutes. The state utilizes state plan funding authorities under fee-for-service, managed care organization reimbursement models, and a 1915(i) waiver.

FIGURE 3: DEVELOPING PEER SUPERVISOR CERTIFICATIONS

SAMHSA recommends that state certification entities consider the development and implementation of a certification process for peer supervisors that includes the following characteristics:[xix]

- State certification entities require prospective certified peer supervisors to have direct experience as peer workers, relevant lived experience, and a deep understanding of the skills, values, and principles of the peer role.
- State certification entities require certified peer supervisors to receive training that includes, at a minimum, the recommendations outlined in Model Standard #2 (Training).
- State certification entities incorporate the recommendations outlined in Model Standard #4 (Formal Education) into peer supervisor certifications.
- State certification entities incorporate, at a minimum, the strategies outlined in Model Standard #8 (Diversity, Equity, Inclusion, and Accessibility) into peer supervisor certifications.
- State certification entities require certified peer supervisors to adhere to a code of ethics that includes, at a minimum, the recommendations outlined in Model Standard #9 (Ethics).

The Centers for Medicare & Medicaid Services (CMS) issued guidance that has significantly shaped the evolution of Medicaid reimbursement for PRSS. Prior to 2007, Medicaid did not allow for reimbursement of PRSS for behavioral health services, limiting their availability and integration into health care systems and CBOs. However, recognizing the effectiveness of PRSS in improving MH and SUD outcomes, CMS issued guidance in 2007 that provided a framework for states to develop Medicaid reimbursement mechanisms for these services. This guidance encouraged states to establish certification standards, training requirements, and supervision protocols for peer support specialists, ensuring quality and consistency.[xiv] One of the key features of this guidance that has impacted CBO's ability to engage with Medicaid programs for PRSS is that it states, "supervision must be provided by a competent mental health professional (as defined by the State)."[xv] States have largely interpreted "competent mental health professionals" as licensed, clinical professionals and, therefore, have limited the types of entities that can provide Medicaid-billable PRSS if a CBO does not employ licensed counselors or clinicians to supervise the peer workers.

"Given the rapid expansion of PRSS, the field needs supervisors who are knowledgeable about peer recovery support specialists and who embrace a recovery-oriented, strengths-based, trauma-informed approach to supervision."[xvi] In June 2024, CMS released clarification regarding the supervision of peer support specialists, stating, "supervisors of peer support providers may include other peers with more experience and training in the provision of peer support services, even if the supervising peer support provider does not have formal behavioral health training or licensure."[xvii] In 2023, the Foundation for Opioid Response Efforts (FORE) released a report entitled "Supporting the Building and Recovery Peer Workforce: Lessons from the Foundation for Opioid Response Efforts 2023 Survey of Peer Recovery Coaches" which further supports the value of PRSSs who have a solid understanding of the role of peer support supervising other peers.[xviii] Importantly, when PRSS are supervised by individuals who truly understand their role, there is a decreased potential for peers to be asked to engage in work duties outside of their scope of

expertise and skill set. This guidance also represents a pivotal development in the evolution of Medicaid reimbursement for PRSS. It increases the potential for CBOs who do not employ clinical staff to potentially tap into Medicaid funding to grow and sustain their historically largely grant-funded peer workforce.

Including experienced peers in supervisory roles promotes a more empathetic and peer-led approach, enhancing the potential quality and authenticity of the PRSS provided. The new guidance offers clearer career advancement pathways for peer support specialists, allowing them to progress into supervisory roles and enhance their professional development opportunities. This potential for career growth can improve job satisfaction and retention rates within the peer support workforce. Additionally, this broader supervisory pool facilitates easier recruitment and retention of supervisors, reducing bottlenecks previously caused by the scarcity of qualified or available licensed professionals to supervise peers.

Other Payer Advances to Cover Peer Recovery Support Services

In addition to Medicaid funding for PRSS, private insurance reimbursement illustrates the continued recognition of the importance of expanding these types of services. In 2019, Aetna became one of the first commercial insurers to cover MH peer support for members.[xx] Beginning January 1, 2024, Blue Cross and Blue Shield of Minnesota became the first nonprofit plan in Minnesota to cover both MH and SUD peer recovery services at no cost to members enrolled in employer-offered health insurance and those with individual and family coverage.[xxi] Peer recovery specialists must be credentialed according to SAMHSA's Standards to bill the insurance.

On the Medicare side, PRSS was only authorized as a reimbursable service after the Consolidated Appropriations Act of 2023 went into effect beginning January 1, 2024.[xxii] CMS finalized new Principal Illness Navigation codes within Medicare to describe services involving auxiliary personnel, such as peer support specialists, to support individuals with severe mental illness (SMI) and SUD.[xxiii] CMS clarified that community health workers, care navigators, peer support specialists, and similar personnel can be employed by CBOs, provided there is appropriate supervision by the billing practitioner.[xxiv] Effective January 2024, these new codes pay nearly $80 per hour with adjustments based on region and site of service.

Additionally, there is an increase in private venture investments to bolster the availability of peer recovery support services nationwide. One example is a digital peer recovery technology offered by Marigold Health, which recently announced $11 million in Series A venture funding to expand services into four additional states by the end of 2025.[xxv] Services are currently available to 25,000 members in Delaware, Rhode Island, and Massachusetts.[xxvi] Other investments, such as the $550,000 pre-seed funding into RecoveryLink,[xxvii] are being used to strengthen the digital recovery support services infrastructure and analytical and evaluation capabilities of in-person PRSS CBOs and other providers.

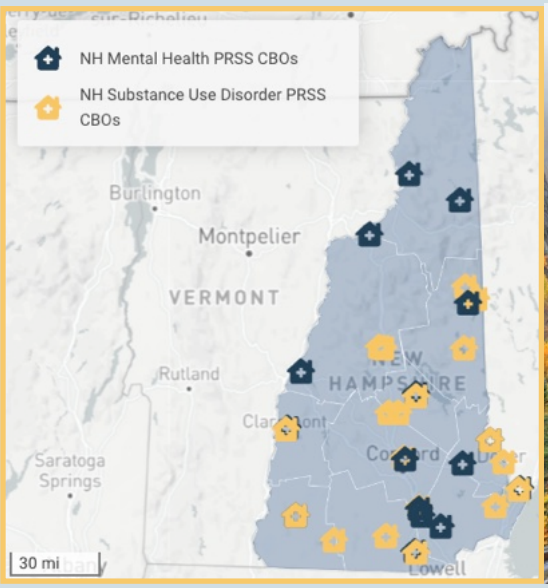
The development of new funding streams presents significant opportunities for CBOs to expand the availability of PRSS in communities. However, the mechanisms of how third-party payments are structured, and the state regulatory structure for certification and licensure surrounding CBOs and peer supervision continue to hinder adoption. The following sections of the paper will review how states are implementing new regulations for CBOs delivering PRSS and the evolving alternative payment landscape.

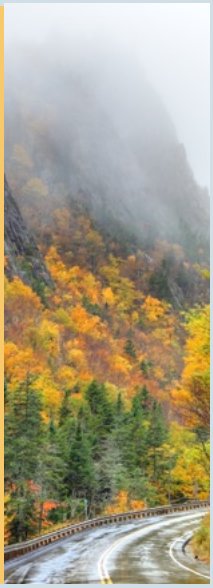
PRSS REGULATORY LANDSCAPE AT THE STATE LEVEL

Ultimately, regulations pertaining to PRSS fall to state regulatory bodies, who in turn leverage guidance supplied at the federal level through organizations like CMS. This is relevant to how PRSS are delivered through various Medicaid agencies across the county. For instance, some State Medicaid Plans may include background checks that exclude individuals with criminal histories, undermining the consideration of the unique nature and qualifications for the role.[xxviii] Another obstacle is that the clinical requirements of a covered service may not align with the spirit of the PRSS. For instance, some states or plans may require an individual to obtain authorization or be recommended by a licensed practitioner of the healing arts (LPHA) for PRSS, which does not fit well into the nature of CBO-delivered PRSS without clinical staff present or a defined clinical service. Essentially this policy forces non-clinical CBOs to establish clinical partnerships to determine PRSS necessity before being able to bill for a covered service. Given persistent workforce issues and the recent Medicaid guidance around peer supervision, it is anticipated that CMS and states will begin to allow certified peer supervisors to provide oversight for the developed recommended care plans or be explicit that a certified peer supervisor in a state can serve in the LPHA role for PRSS.

In October 2020, the Legislative Analysis and Public Policy Association (LAPPA) published a model ACT[xxix] for expanding access to PRSS that encourages states to adopt similar approaches to the regulation of PRSS. Here are three state-specific examples:

New Hampshire





PRSS in New Hampshire are regulated and managed through a combination of state initiatives, federal funding, and strategic frameworks that have developed the foundation for twelve independent non-profits operating 20 Recovery Community Centers. The MH PRSS is managed separately from the SUD-focused CBOs.[xxx]

One of the primary regulatory frameworks for managing PRSS in New Hampshire has been to leverage the CMS 1115 Waiver program in Medicaid. Certified recovery support workers (CRSWs) are licensed and regulated by the New Hampshire Board of Licensing for Alcohol and Other Drug Use Professionals to provide peer support to individuals in recovery from SUD.[xxxi] To be eligible for certification as a CRSW, an individual must meet these requirements:[xxxii]

- hold a minimum high school diploma or its equivalent
- complete 500 hours of paid or volunteer work within 10 years of the date of the application, 25 hours of which must be under the supervision of a qualified recovery coach
- complete at least 46 hours of education
- pass IC&RC Peer Recovery Exam
- self-identify as a person with lived experience in SUD recovery
- obtain a criminal background check as detailed by the certification requirements; however, New Hampshire does not exclude individuals who have a criminal record from obtaining their CRSW as described in regulation Alc. 303.01
- The board shall waive an applicant's felony conviction, if any, if:
  - The applicant has corrected the deficiency which led to the felonious act or omission; and
  - The board has determined, after considering complete information about the conviction, that it does not impair the applicant's ability to conduct with safety to the public the practices for which the applicant seeks certification.

In New Hampshire, the Medicaid program Administrative Code He-W 513.05 recognizes a specific Medicaid provider type for an RCO called a "Peer Recovery Program" that allows for a specialized eligibility:[xxxiii]

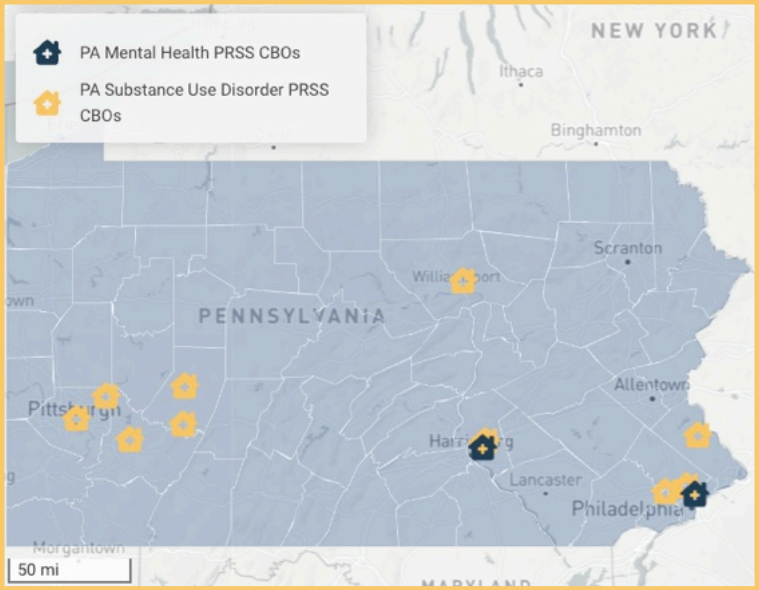
> "Peer recovery program" means a recovery community organization or program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS), is accredited by Clubhouse International, is under contract with the department's contracted facilitating organization, or is under contract with the department's BDAS to provide peer recovery support services.

This provider-type allowance in Medicaid for RCOs is unique and has offered FFS opportunities for New Hampshire RCOs who have opted into the program to bill for certain PRSS provided by their employed CRSWs. Services provided by a CRSW in a Medicaid-enrolled peer recovery program is billed by the organization with the supervising practitioner listed as rendering. Many RCOs in New Hampshire subcontract with a Master Licensed Addiction Counselor (MLADC) to serve as the supervisor. However, He-W 513.04 does allow for CRSWs to be credentialed as eligible supervisors upon meeting additional requirements:

- certified for at least one year
- six hours of supervisory training
- six hours of practical training

Additional details of the eligible services and individual provider qualifications and supervision requirements for the relevant section of the existing Medicaid administrative code is described on the New Hampshire Department of Health and Human Services website.[xxxiv] Other eligible supervisors include Licensed Alcohol and Drug Counselors (LADCs)and licensed mental health professionals (MHP).

Pennsylvania



The Pennsylvania Certification Board regulates PRSS in Pennsylvania.[xxxv] Through the board, individuals can receive certification as a Certified Peer Specialist, Certified Recovery Specialist, Certified Family Recovery Specialist, and a Certified Recovery Specialist Supervisor, along with several other certifications that are not directly related to PRSS. Each certification has different certification requirements.

However, in Pennsylvania, non-clinical peer organizations are not currently a licensable entity type, and individuals in the state are not eligible to receive assistance from PRSS if they do not also have a co-occurring mental illness.[xxxvi] Similarly, while peer services have a service-level license type in Pennsylvania, it is only available as an additional license to already licensed clinical and medical providers in the state.

On April 10, 2024, State Representative Tarik Khan announced bipartisan legislation aimed at preventing opioid overdoses and supporting long-term recovery for individuals with SUDs[xxxvii] This proposed legislation seeks to mandate new Medicaid coverage and establish licensure for peer provider organizations that provide PRSS. The new proposed legislation aims to address this SUD gap to enable more individuals to access these crucial services equitably across MH and SUD. This type of legislation would bridge the current gap between peers working in CBOs and third-party payers like Medicaid.

The legislation has garnered support from both legislative and advocacy circles. Lauryn Wicks, a family member and advocate, said, “As a family member and Pennsylvanian, to fathom, we've not yet broadly implemented reimbursable peer support services as standard in the substance use health and mental health care continuum by now - in 2024 - feels like blatant negligence and othering. Peer recovery support services should be accessible and covered for everyone.”

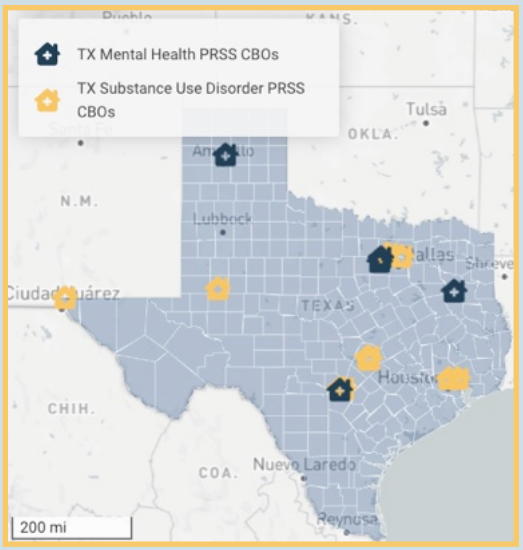
Texas

The Texas Health and Human Services Commission (HHSC) regulates the state's PRSS.[xxxviii] The HHSC sets the standards for the certification and training of peer support specialists, ensuring they meet specific criteria to provide high-quality support. Certification involves completing an approved training program and passing a competency examination.

Funding for PRSS in Texas primarily comes from a combination of state and federal sources. The HHSC administers several funding streams, including federal grants like the Substance Abuse Prevention and Treatment Block Grant (SABG) and State Opioid Response (SOR) grants. These funds are allocated to various service providers, including RCOs, to support the delivery of peer recovery support services. Additionally, Medicaid in Texas covers certain PRSS, making them accessible to Medicaid beneficiaries with SUD. This funding structure helps ensure that peer recovery support services are available to a broad population, enhancing the overall continuum of care for individuals seeking recovery.

While PRSS services for both MH and SUD are deliverable, billable services in the state, limitations currently prevent CBOs and RCOs from becoming providers under Texas state Medicaid regulations. Certified peers must deliver services in conjunction with a facility, provider group, community center, etc., as they cannot yet separately enroll in Medicaid as a Medicaid provider or be separately credentialed by a Managed Care Organization (MCO). Alternatively, peer specialists without certification can provide MH rehabilitative services and provide peer services through the 1915i and YES Waivers.

House Bill 705, introduced in 2021, aimed to create a new provider type for RCOs to provide peer support services. The bill ultimately failed, resulting in RCO's inability to bill for peer support services.[xxxix] It has been estimated that adding RCOs to the system would cost approximately $1 million to implement. Because of this infrastructure cost, system advocates are exploring options to add RCOs as a sub-type to an existing provider type. In addition, efforts are underway to define peer recovery organizations as part of state statutes with the goal of earmarking future funding. While CBOs also cannot bill for peer support services, they can contract with state MCOs to provide value-added services to state Medicaid members. A recent report published by the Episcopal Health Foundation provides recommendations to expand the level of MCO support given to CBOs beyond small pilot programs and expand access to services, especially Non-Medical Determinants of Health (NMDOH) programming.



With respect to PRSS effectiveness, one Texas Health and Human Services long-term study[xl] states that SUD peer specialists demonstrated the following results at 12 months:

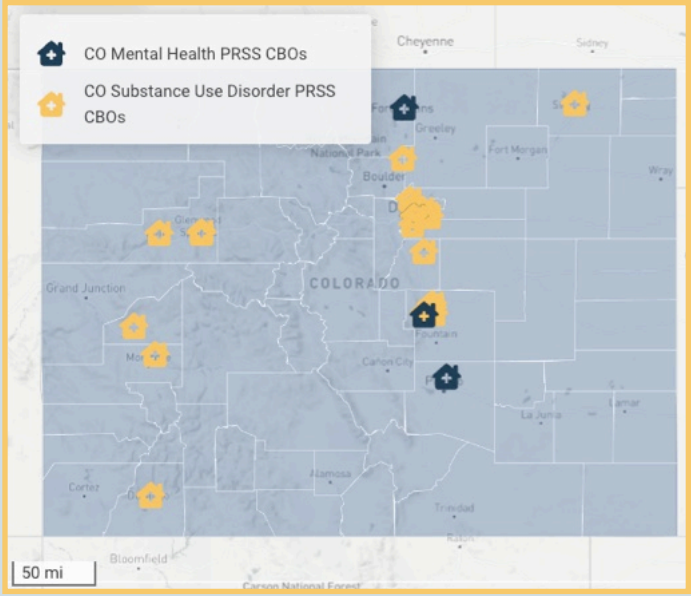
- Housing status improved
- Overall employment increased
- Average wages increased
- Health care utilization dropped
- Outpatient visits dropped
- Inpatient care days dropped
- Emergency room visits dropped
- In total, direct peer services saved $3,422,632 in health care costs

Colorado

The Colorado Department of Human Services (CDHS) regulates the state's PRSS under the Behavioral Health Administration (BHA). House Bill 21-1021 directed CDHS and the Department of Healthcare Policy and Financing (HCPF) to establish minimum standards for Recovery Support Services Organizations (RSSO). RSSOs, as defined by CDHS rules, are peer-run organizations providing peer support to individuals with behavioral health disorders. [xli]

To ensure quality and compliance, peer support specialists delivering Medicaid-billable services must work under the supervision of licensed clinical supervisors who oversee the appropriateness and effectiveness of the services provided. These services can be reimbursable under Medicaid if they are rendered to individuals with covered diagnoses and align with the State Behavioral Health Services Billing Manual – which details the covered services, billing codes, and necessary documentation.[xlii] Certification for peer support professionals is generally not mandatory unless they are working within RSSOs, where certification is required.

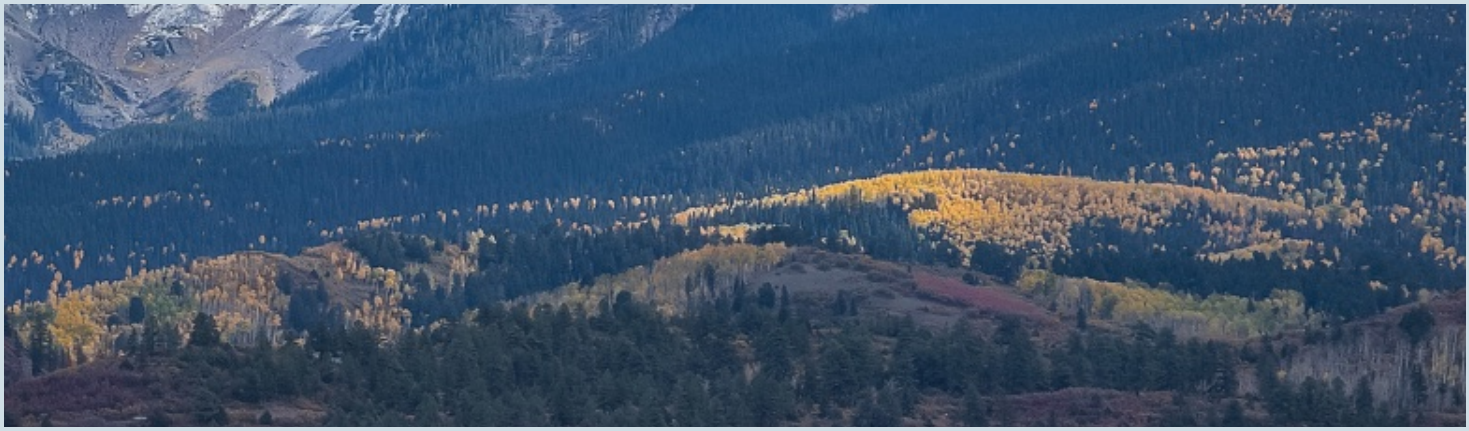
The BHA supports the development of the peer support workforce through quarterly collaborative meetings and a Peer Support Steering Committee that guides the standardization and enhancement of professional standards. Continuous professional development and training are emphasized to maintain a competent workforce. RSSOs in Colorado must follow several key steps to receive Medicaid reimbursement. First, they must obtain licensure through the BHA by meeting specific regulatory standards. Then, they must enroll with Health First Colorado, the state's Medicaid program,



identifying themselves as RSSOs. Lastly, RSSOs need to contract with the Regional Accountable Entities (RAEs), which are the Medicaid Managed Care Entities (MCEs) in Colorado. RSSOs may also contract with Managed Service Organizations (MSOs) to provide services to non-Medicaid clients.

For reimbursement, RSSOs must submit claims for PRSS provided to Medicaid members, ensuring these services adhere to Medicaid guidelines and are billed under the licensed individual overseeing the clinical care. RSSOs must also comply with the State Behavioral Health Services Billing Manual for successful reimbursement.

Additional details of the eligible services, individual provider qualifications, and supervision requirements can be found in the relevant sections of the State Behavioral Health Services Billing Manual and the Code of Colorado Regulations 2-CCR 502-1.



Peer Recovery Support Services and Telerecovery

Telerecovery PRSS is a form of telehealth services that has grown since the start of the COVID-19 pandemic to support digital-only, virtual-only, in-person, and hybrid service delivery models. Telerecovery services have grown significantly in recent years, similar to other telehealth services across the broader health care system. The 2022 National Institutes of Health publication, "The Competencies of Telehealth Peer Support: Perceptions of Peer Support Specialists and Supervisors During the COVID-19 Pandemic," highlights core competencies required for PRSSs through telerecovery.[xliii] Through expert consensus among peer specialists and supervisors, this study identifies essential competencies for delivering PRSS via telerecovery, including empathy, active listening, and completing and submitting documentation online, highlighting the need for technological skills. These competencies can guide training and performance-based supervision, ensuring the unique qualities of peer support services are maintained in the evolving telerecovery landscape. The study's findings empower the peer workforce, highlighting the importance of adequate training in core values, principles, skills, and tasks. Further analysis is needed to see how these competencies align with the Standards, including the impact of PRSS delivered in CBOs.

Unity Recovery developed a telerecovery standard operating procedure guide in 2020.[xliv] The guide outlines the full scope of when telerecovery may be applicable, what is needed for telerecovery, and how to operationalize the services. Telerecovery is a unique type of virtual service because communication and relationships are at the core of PRSS, making it paramount for peers and organizations to leverage telerecovery in an effective way. One potentially helpful partner in leveraging digital recovery resources is RecoveryLink[xlv] – a digital recovery platform with the mission to provide a suite of accessible and impactful recovery support tools, such as an electronic recovery record (ERR), designed to elevate collective impact. This platform is accessible to individuals in recovery or those entities, such as CBOs, supporting individuals in recovery.

RECOMMENDED FINANCING APPROACHES NEAR-TERM AND LONG-TERM: VALUE-BASED CONTRACTING AND ALTERNATIVE PAYMENT MODELS

The future of new third-party reimbursement for PRSS appears promising, with opportunities for expansion and innovation driven by the recognition of the value of the role in communities to support the MH and SUD needs of individuals, as well as families and loved ones. Although there has been advancement for Medicaid and other payer reimbursements, there remains evidence of limited uptake of public or private payers funding these services, as evidenced by just 2.1 percent of SUD claims in 2022 for individuals with an SUD in Medicaid nationally.[xlvi]

Third-party reimbursement is a feasible option for scaling access to PRSS in new communities, but the most common reimbursement model and the type of providers it is geared towards may not allow for widespread adoption and growth of PRSS in CBOs. There are several reasons the uptake of peer support through third-party reimbursement is not as prolific, although policies and procedures have changed. A recent SAMHSA published report titled Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Peer Workforce identified the most common challenges to growing PRSS through third-party reimbursement (Figure 4).[xlvii]

Many reimbursement challenges are tied to how payers most often pay for services through FFS. This model reimburses a provider for each unique service provided to an individual beneficiary and can incentivize the volume of services rather than the value of services that is incongruent with the historical flexible grant or contract funding provided to CBOs at a program level. In an FFS model, PRSS are most often reimbursed by third-party payers, paying for 15-minute service increments. FFS limits the scope of services peer workers can provide. For instance, outreach and engagement efforts are typically not covered, and neither is more community-centric recovery support, such as engagement in facilitated and informal activities at a recovery community center.[xlviii] One key value of PRSS is the ability to provide holistic, tailored services to individuals rather than the same set of services to each person. FFS models often lack this flexibility.

States, payers, and CBOs can take advantage of several opportunities in the short and long term to develop infrastructure and reimbursement models that align with and meet the needs of individuals receiving PRSS, CBOs, and purchasers of the services.

FIGURE 4: CURRENT FINANCING CHALLENGES

- The National Provider Identifier as a Barrier
- Undervaluing the Unique Contribution of Peers
- Service Delivery Extends Outside of Fee-for-Service Payment Structure
- Clinical Treatment Models
- Infrastructure and Technology Capabilities Are Minimal
- Lack of Diverse Representation in the Peer Workforce

Short-Term Investment Opportunities

Several short-term investment opportunities are available to mitigate the existing challenges with third-party reimbursement and poise a peer-run CBO for success. Short-term strategies can include investing in infrastructure and deepening relationships with other organizations, such as hospitals or other potential referral sources. One of the newest ways peer-run CBOs can bolster infrastructure is by investing in information technology systems specifically targeted to PRSS.

Specialized electronic medical records (EMR) are called electronic recovery records (ERR) in the PRSS field. RecoveryLink, for example, offers recovery support tools that enhance organizational support for individuals. Despite the benefits, only 6 percent of behavioral health facilities and 29 percent of SUD treatment centers reported using an EMR as of 2022.[xlix] The adoption of EMRs can significantly improve patient care by maintaining accurate and up-to-date health-related records.[l] Additionally, these tools are crucial for tracking outcome measures that are vital for third-party reimbursement contracts, as efficient information sharing is critical in many contracts. Although it is not clear how many peer-run CBOs leverage an EMR-type software, RecoveryLink has noted that over 200 peer service providers and over 2,000 peer specialists have used its software in the past 5 years to provide PRSS to over 110,000 individuals and family members.

In June 2024, CMS released a bulletin focused on encouraging adoption for states to invest in information technology for MH and SUD care coordination by announcing an enhanced federal Medicaid match.[li] The memo includes approved use cases for the enhanced match, specifically including functionalities to improve the infrastructure of the recovery care continuum. A non-exhaustive list of examples include:

- Technology to facilitate information exchange between MH and SUD treatment providers and schools, hospitals, primary care, and criminal justice settings
- Data-sharing capabilities between hospitals and community-based MH and SUD treatment providers such that an enrollee's records regarding inpatient or residential treatment could be available to a community-based MH or SUD provider who provides treatment to that individual as well and vice versa

CBOs should also review the recently approved health-related social needs (HRSN) 1115 waivers, which grant states the authority to use Medicaid expenditures for HRSNs, such as housing support, nutrition support, medical respite, and other eligible support services.[lii] Currently, there are limited examples of CBOs providing PRSS included as HRSN; however, the services provided are closely related, and they can work with their Medicaid agencies on qualifying for this funding.

In the short term, CBOs can continue to work with the state Medicaid agency and other payers to identify pathways to specialized licensure or becoming a Medicaid provider type and other associated reimbursement requirements. CBOs should also consider partnering with other community stakeholders with shared goals, such as, hospitals who often have financial incentives to reduce total cost of care and therefore ensure patients can easily access PRSS when presenting with a MH condition or SUD.

Another partnership opportunity is through the Certified Community Behavioral Health Clinic (CCBHC) model – a designation awarded to eligible community behavioral health providers who meet federally established criteria and care delivery requirements.[liii] CCBHCs can directly offer the required services or partner with outside organizations through a Designating Collaborating Organization (DCO) arrangement to meet all requirements. The mandatory scope of services includes Peer and peer-delivered family/caregiver support. CBOs should identify organizations awarded CCBHC grants or that are pursuing CCBHC designation to see if DCO opportunities exist for PRSS.

FIGURE 5: GEORGIA COUNCIL FOR RECOVERY

The CARES program in "partnership with Northeast Georgia Medical Center (NGMC) and Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD), Georgia Council for Recovery (GC4R) provides peer support to individuals having experienced an opioid overdose or any SUD related incident in NGMC's three campus emergency departments in Gainesville, Braselton, and Winder. NE Georgia Community Connections places Certified Addiction Recovery Empowerment Specialists (CARES/CPS-AD) in the NGMC emergency departments. These CARES have received training tailored specifically to assist people in an emergency room setting."

Long-Term Investment Opportunities

While achieving third-party reimbursement may be a sustainable option, CBOs should consider strategies to engage in contract arrangements that extend outside the FFS model. There are several alternative payment models payers and CBOs could engage in, including bundled rates, quality-based incentives, shared savings, and inclusion in broader value-based payment models that manage a recoveree across the care continuum.

Closer to the grant-funding model, a bundled rate is an agreed-upon fixed rate based on an average number and variety of services an individual may receive related to a specified condition rather than an individual reimbursement for a singular service. A bundled rate can be paid daily, weekly, or monthly and provides the provider with the flexibility to meet the unique needs of each person. The bundled rate model can allow the CBO greater autonomy to ensure individuals they support receive the type of PRSS they need outside of a rigid 15-minute billable increment. For example, such a payment model would allow for more direct PRSS services, such as recovery planning engagement, as well as PRSS delivered in a community setting, such as a recovery community center.

Another option to align incentives with payers is to propose reimbursement rates with additional financial opportunities for achieving agreed-upon process or outcome quality measures. By implementing an ERR, peer-run CBOs are well-positioned to track and monitor quality data in real time to ensure the achievement of metrics. There are various sources from which measures can be pulled to tie to financial incentives. In 2024, the Alliance for Addiction Payment Reform published an Environmental Scan of Substance Use Disorder Quality Metrics/Measures Applicable to the Addiction Recovery Medical Home Alternative Payment Model.[liv] This brief and associated measure set show potential options that PRSS can help payers and other health systems achieve.

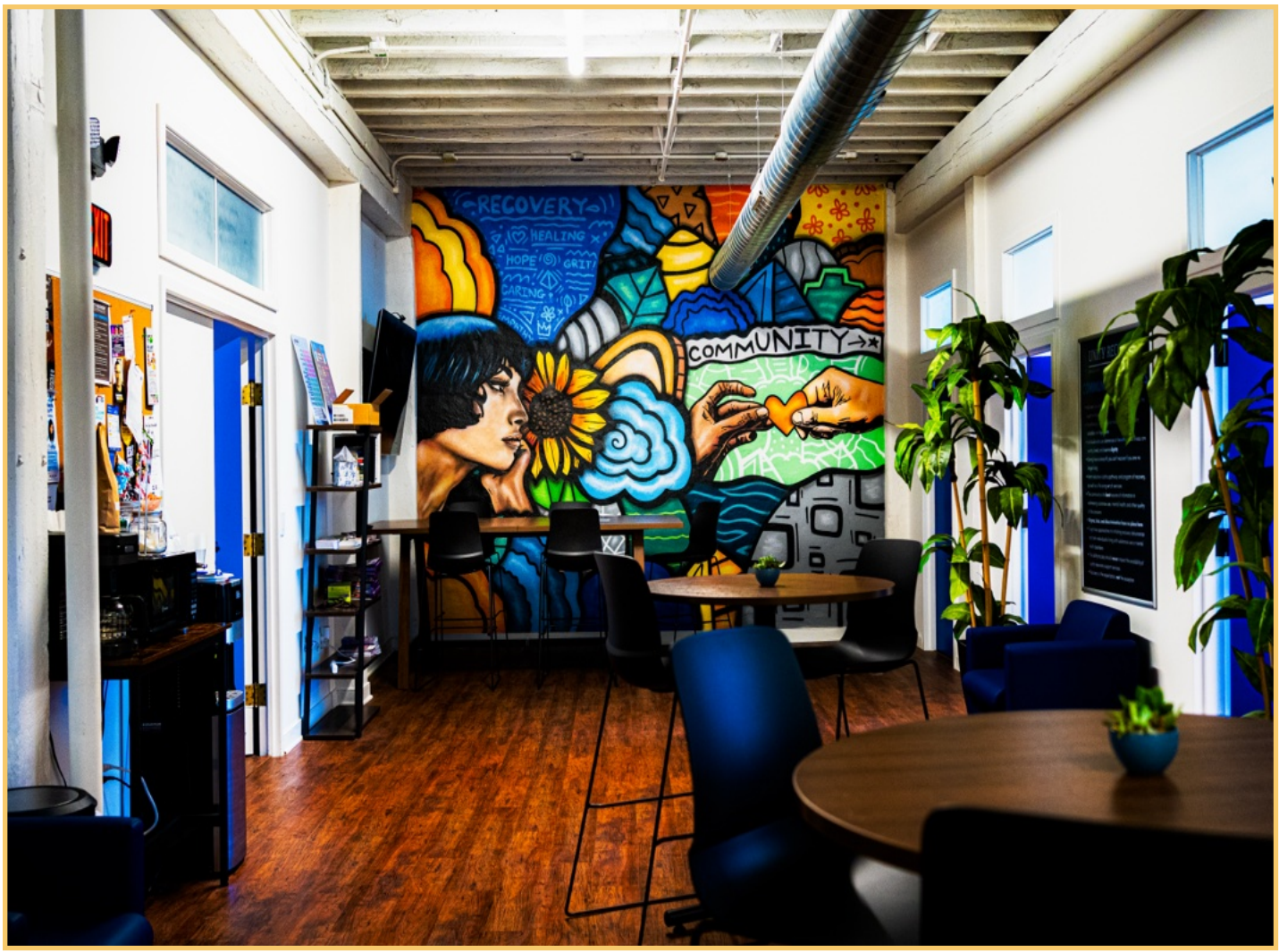
A more complex approach to payer contracting is to engage in a shared savings arrangement. A shared savings arrangement could allow a CBO to earn a portion of the total cost of care saved when a patient is engaged in direct PRSS services. CBOs should encourage payers to look at the total cost of care of a patient rather than just their behavioral health expenditures, as evidence finds the total costs of a patient, including physical health, with an MH condition or SUD is up to 6.2x higher than a patient without.[lv] There are several complexities in this arrangement, such as attribution methodology and total cost of care calculations. However, these types of models may ultimately provide the most significant upside to a CBO with respect to capturing the value and return on investment for PRSS to the health system.

There are also alternative payment models that are not solely focused on recovery but rather on the entire continuum of MH or SUD care. Models like the Addiction Recovery Medical Home Alternative Payment Model[lvi] include bundled payments for designated episodes

during a patient's comprehensive care journey. There are three phases of recovery defined in the model (1) pre-recovery/stabilization, (2) recovery initiation and active treatment, and (3) community-based recovery management. The model pays for PRSS services in phases 2 and 3 to ensure continuity of care and patient-centered care. Peers are also part of the model's interdisciplinary care team approach, which centers the value of the PRSS throughout treatment and sustained recovery. CBOs can explore opportunities to be part of Addiction Recovery Medical Home Networks as they develop or other broad payment models like Accountable Care Organizations to sub-contract outside of the FFS method with largely health care systems.

FIGURE 6: OUTCOMES ACHIEVED THROUGH ENGAGEMENT WITH A CBO

- Decreased substance use
- Reduced re-hospitalization rates
- Lowered emergency department visits
- Improved relationships with SUD and primary care providers
- Improved targeted individuals' recovery capital scores
- Linkage to health-related social needs



CONCLUSION

CBOs provide a holistic and comprehensive approach to PRSS, addressing individuals' social, emotional, environmental, and practical challenges. These organizations are deeply rooted within their communities, allowing them to offer more personalized support and attuned to the unique needs and experiences of the individuals and families they serve. Because they are run by individuals who have experience living with mental health and substance use challenges, they foster a sense of trust and relatability that can be difficult to achieve in traditional health care settings. Peers are more likely to feel valued and understood, which can enhance their ability to provide services and foster a better workplace environment for peers to thrive.

The future of the PRSS movement is marked by advances in standardizing the certification requirements for the peer support workforce, improving reimbursement rates and funding authorities to allow CBOs to bill for PRSS, clarifying supervision requirements to expand the ability for peers to be supervised by other qualified peers, and expanding alternative payment models.

The regulatory landscape for these services varies significantly across states, with individual states establishing unique certification and training standards. This regulatory diversity, while reflecting localized needs and priorities, underscores the importance of a consistent framework allowing CBOs to participate in third-party billing systems to grow and ensure high-quality, impactful PRSS across the nation.

Transforming the landscape of PRSS requires systemic changes that integrate peers working inside CBOs to partner with other health and social systems in diverse settings. CBOs offer a comprehensive, community-rooted approach to PRSS, led by individuals with personal experience and overcoming mental health and substance use challenges, which fosters trust and connection. To drive meaningful change, actions must include unifying certification standards for peer workers across states, revising supervision guidelines to support peer-led organizations to deliver PRSS without clinical oversight, and increasing funding through alternative payment models that can help facilitate more flexible third-party payments to CBOs that better aligns to the nature of the service. Additionally, national advocacy efforts should focus on dismantling policy barriers to create a more inclusive system that supports investing in CBOs to deliver high-quality and sustainable PRSS, ultimately enhancing recovery outcomes nationwide.

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REFERENCES

[i] Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Workforce, March 2024. Accessed from: https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf.

[ii] Ibid.

[iii] Peer Recovery Support Services Across the Continuum: In Community, Hospital, Corrections, and Treatment and Recovery Agency Settings – A narrative review, January 2022. Accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8339174/.

[iv] What is a Community-based Organization (CBO)? Accessed from: https://sph.umich.edu/ncbon/about/whatis.html.

[v] Directory of Peer-Run and Family Peer-Run Organizations. Accessed from: https://peertac.org/resources/directory-of-peer-run-and-family-peer-run-organizations/.

[vi] The Recovery Community Organization: Toward A Working Definition and Description, 2007. Accessed from: https://facesandvoicesofrecovery.org/wp-content/uploads/2019/06/The-Recovery-Community-Organization-Toward-A-Working-Definition-and-Description.pdf.

[vii] Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Workforce, March 2024. Accessed from: https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf.

[viii] Peer-based recovery support services delivered at recovery community organizations: Predictors of improvements in individual recovery capital, August 2021. Accessed from: https://pubmed.ncbi.nlm.nih.gov/33872848/.

[ix] National Model Standards for Peer Support Certification, July 2023. Accessed from: https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf.

[x] Optimizing Recovery Funding, Volumes 1 & 2, January 2023. Accessed from: https://peerrecoverynow.org/wp-content/uploads/orf.1.2023.volume1-2.pdf.

[xi] Medicaid Reimbursement for Peer Support Services: A Detailed Analysis of Rates, Processes, and Procedures, May 2024. Accessed from: https://peerrecoverynow.org/wp-content/uploads/2024-MAY-15-prcoe-prss-medicaid.pdf.

[xii] T-MSIS Substance Use Disorder Data Book 2021, December 2023. Accessed from: https://www.medicaid.gov/medicaid/data-systems/downloads/2021-sud-data-book.pdf.

[xiii] Medicaid Reimbursement for Peer Support Services: A Detailed Analysis of Rates, Processes, and Procedures, May 2024. Accessed from: https://peerrecoverynow.org/wp-content/uploads/2024-MAY-15-prcoe-prss-medicaid.pdf.

[xiv] Centers for Medicare & Medicaid Services SMDL #07-011, August 2007. Accessed from: https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf.

[xv] Ibid.

[xvi] Incorporating Peer Support Into Substance Use Disorder Treatment Services, 2023. Accessed from: https://www.ncbi.nlm.nih.gov/books/NBK596264/#:~:text=Peer%20supervision%20can%20promote%20open,with%20immediate%20support%20and%20guidance.

[xvii] Frequently Asked Questions on Medicaid and CHIP Coverage of Peer Support Services, June 2024. Accessed from: https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.

[xviii] Supporting the Building and Recovery Peer Workforce Efforts Response Opioid for Foundation the from Lessons Coaches, June 2023. Accessed from: https://forefdn.org/wp-content/uploads/2023/06/fore-prc-survey-report.pdf.

[xix] National Model Standards for Peer Support Certification, 2023. Accessed from: https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf.

[xx] Certified Peer Support Specialists: Transforming Traditional Recovery for Members, May 2019. Accessed from: https://www.cvshealth.com/news/mental-health/certified-peer-support-specialists-transforming-traditional.html.

[xxi] Blue Cross and Blue Shield of Minnesota adding Mental Health Peer Support Specialist Coverage to Commercial Plans in 2024, June 2023. Accessed from: https://www.bluecrossmn.com/about-us/newsroom/news-releases/blue-cross-and-blue-shield-minnesota-adding-mental-health-peer.

[xxii] Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Workforce, March

2024. Accessed from: https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf.

[xxiii] Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule, November 2023. Accessed from: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule.

[xxiv] Medicare Reforms Support Behavioral Health by Expanding Access to Peer Support Specialists and Community Health Workers, February 2024. Accessed from: https://www.commonwealthfund.org/blog/2024/medicare-reforms-support-behavioral-health-expanding-access-peer-support-specialists-and.

[xxv] Peer-Support Startup Marigold Health Raises $11M, June 2024. Accessed from: https://bhbusiness.com/2024/06/17/peer-support-startup-marigold-health-raises-11m/?utm_campaign=li&utm_source=linkedin&utm_medium=social&utm_content=1718731806.

[xxvi] Ibid.

[xxvii] RecoveryLink and 2 more startups got investments from Penn's new $5M Fund for Health, September 2021. Accessed from: https://technical.ly/startups/recoverylink-penn-fund-health/.

[xxviii] Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Workforce, March 2024. Accessed from: https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf.

[xxix] Legislative Analysis and Public Policy Association (LAPPA) Model for Expanding Access to Peer Recovery Support Services Act, October, 2020. Accessed from: https://legislativeanalysis.org/wp-content/uploads/2021/03/Model-Expanding-Access-to-Peer-Recovery-Support-Services-Act.pdf.

[xxx] Care at the Crossroads: A Financial Stress Test of the New Hampshire Substance Use Disorder Delivery System, June 23, 2023: https://thirdhorizonstrategies.com/wp-content/uploads/NHCF-Paper-FINAL-2.pdf.

[xxxi] State of NH Department of Health and Human Services: Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver, August 2022. Accessed from: https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/sed-extention-request-pn-presentation.pdf.

[xxxii] New Hampshire Board of Licensed Alcohol and Other Drug Use Professionals: Initial applicant checklist for CRSWs, March 2023. Accessed from: https://www.oplc.nh.gov/sites/g/files/ehbemt441/files/inline-documents/ladc-crsw-checklist-for-initial-certification-pg-2-3.pdf.

[xxxiii] Substance Use Disorder Benefits for Medicaid Recipients. Accessed from: https://www.dhhs.nh.gov/programs-services/medicaid/substance-use-disorder-sud-benefit-medicaid-recipients.

[xxxiv] Ibid.

[xxxv] Pennsylvania Certification Board. Accessed from: https://www.pacertboard.org/certifications.

[xxxvi] Khan to introduce bipartisan legislation empowering recovery community organizations: Pennsylvania House Democratic Caucus, April 2024. Accessed from: https://www.pahouse.com/InTheNews/NewsRelease/?id=133638.

[xxxvii] Ibid.

[xxxviii] Texas Health and Human Services: Peer Recovery Services Programs, Planning and Policy, May 2022. Accessed from: https://www.hhs.texas.gov/sites/default/files/documents/may-2022-sbhcc-agenda-item-6.pdf.

[xxxix] Texas House Bill 705. 2021. Accessed from: https://legiscan.com/TX/text/HB705/id/2217851.

[xl] Texas Health and Human Services: Benefits of Peer Support Services. Accessed from: https://www.hhs.texas.gov/providers/behavioral-health-services-providers/peer-support-services/benefits-peer-support-services.

[xli] Code of Colorado Regulations 2CCR 502-1, 2022. Accessed from: https://leg.colorado.gov/bills/hb21-1021.

[xlii] State Behavioral Health Services Billing Manual. July 2024. Accessed from: https://hcpf.colorado.gov/sites/hcpf/files/July%202024%20SBHS%20Billing%20Manual.pdf.

[xliii] The Competencies of Telehealth Peer Support: Perceptions of Peer Support Specialists and Supervisors During the COVID-19 Pandemic, February 2022. Accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8853252/.

[xliv] Unity Recovery Telerecovery Guide, March 2020. Accessed from: https://unityrecovery.org/wp-content/uploads/2020/03/Unity-Recovery-Telerecovery-RSS-Guide-03-26-2020.pdf.

[xlv] RecoveryLink. Accessed from: https://myrecoverylink.com/.

[xlvi] T-MSIS Substance Use Disorder Data Book 2021, December 2023. Accessed from: https://www.medicaid.gov/medicaid/data-systems/downloads/2021-sud-data-book.pdf.

[xlvii] Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Workforce, March 2024. Accessed from: https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf.

[xlviii] Evaluating the feasibility and impact of case rate payment for recovery support navigator services: a mixed methods study, 2020. Accessed from: https://doi.org/10.1186/s12913-020-05861-8.

[xlix] 6% of Behavioral Health Facilities Use EHRs, Incentives and Guidances Could Move the Dial, June 2022. Accessed from:

https://bhbusiness.com/2022/06/17/when-it-comes-to-electronic-health-records-utilization-the-behavioral-health-industry-is-lagging-behind-physical-health-facilities/#:~:text=In%20fact%2C%20only%206%25%20of,partisan%20legislative%20branch%20research%20agency.

[l] Electronic medical records - The good, the bad and the ugly, March 2020. Accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7043175/.

[li] Accessing Enhanced Federal Medicaid Matching Rates for State Information Technology Expenditures to Improve Access to Mental Health and Substance Use Disorder Treatment and Care Coordination, June 2024. Accessed from: https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf.

[lii] Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program, November 2023. Accessed from: https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf.

[liii] Certified Community Behavioral Health Center (CCBHC) Certification Criteria, February 2023. Accessed from https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.

[liv] Environmental Scan of Substance Use Disorder Quality Metrics/Measures Applicable to the Addiction Recovery Medical Home Alternative Payment Model, June 2024. Accessed from: https://incentivizerecovery.org/wp-content/uploads/Alliance-Outcome-Measure-Issue-Brief-FINAL.pdf.

[lv] Environmental Scan of Substance Use Disorder Quality Metrics/Measures Applicable to the Addiction Recovery Medical Home Alternative Payment Model, August 2020. Accessed from: https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx#:~:text=The%20BH%20Group%20accounted%20for,for%20the%20entire%20study%20population.&text=Average%20annual%20costs%20for%20the,with%20no%20behavioral%20health%20condition.

[lvi] Addiction Recovery Medical Home Alternative Payment Model, 2023. Accessed from: https://incentivizerecovery.org/wp-content/uploads/AddictionRecoveryMedicalHome-APM-2023.pdf.