MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

November 30, 2018

The Honorable Larry Hogan
Governor
State of Maryland
Annapolis, MD 21401–1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401–1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401–1991

Re: House Bill 772, Chapter 323 of the Acts of 2018, and Senate Bill 765, Chapter 324 of the Acts of 2018—Maryland Department of Health—Reimbursement for Services Provided by Certified Peer Recovery Specialists—Workgroup and Report

Dear Governor Hogan, President Miller, and Speaker Busch:

Pursuant to House Bill 772, Chapter 323, and Senate Bill 765, Chapter 324, Reimbursement for Services Provided by Certified Peer Recovery Specialists—Workgroup and Report, the Maryland Department of Health respectfully submits the attached report detailing the findings and recommendations of the stakeholder workgroup on the issues related to the reimbursement of certified peer recovery specialists.

If you have any questions regarding this report, please contact Webster Ye, Deputy Chief of Staff, at (410) 767–6480 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Report on the Reimbursement for Services Provided by Certified Peer Recovery Specialists

Submitted by the Maryland Department of Health
November 30, 2018

House Bill 772, Chapter 323 of the Acts of 2018
Senate Bill 765, Chapter 324 of the Acts of 2018

I. Executive Summary

Certified Peer Recovery Specialists (CPRS) are individuals living in recovery from or with their behavioral health conditions. Using their lived experience CPRS assist others in navigating local treatment systems and recovery support services to initiate and strengthen the individual's recovery. A CPRS works with those individuals interested in improving their wellness to reduce barriers which may hinder or limit that individual's recovery potential. The Behavioral Health Administration (BHA) has seen an increase in the number of individuals working as a CPRS.

The Administration currently utilizes grant funds to support this expanding service. In 2018 the Maryland General Assembly introduced and passed House Bill 772, Senate Bill 765. This legislation required the Maryland Department of Health (Department) to convene a workgroup comprised of stakeholders to review and provide recommendations related to the reimbursement of services provided by CPRS within Maryland's Public Behavioral Health System (PBHS).

The workgroup identified six barriers to transitioning funding currently supporting the CPRS workforce to a Medicaid funded fee for service system: (1) the majority of the peer-operated organizations that provide peer support services may not be eligible for or interested in submitting reimbursement claims for services delivered under a traditional Medicaid model; (2) the supervision structure which currently exists for individuals providing peer support services varies dramatically by provider; (3) there are no state-identified requirements in place regarding mandated education for the peer recovery specialist supervisors; (4) the number of CPRS and the number of services they provide may increase after moving from a grant funded service to a fee-for-service model; (5) there is a philosophical dilemma of how "peer support services" are defined and delivered within diverse service delivery settings and (6) there is a lack of consistent outcomes data that result from the interventions and services delivered by peer recovery specialist. Considering these barriers, the workgroup recommends 12 reimbursement strategies to support the delivery of services.

II. Introduction and Background: Maryland's CPRS Workforce

For the better part of a decade, BHA has sought opportunities to include individuals, who have lived experience with behavioral health needs, in the design and delivery of behavioral health treatment and recovery support services. As a result, the peer recovery specialist[1] workforce emerged to ensure that the voice of individuals with lived experience in recovery was reflected in both the system design and the delivery of services across the system.

A CPRS is an individual who has lived experience with behavioral health needs and support others in navigating the local treatment system and recovery support services to initiate and strengthen their recovery. Certification for this role is provided by the Maryland Addiction and Behavioral-health Professionals Certification Board (MABPCB). Using their lived experience, combined with training and education programs, a CPRS works with those individuals seeking an increase in wellness to reduce barriers which may hinder or limit that individual's recovery potential. Over the last few years BHA has seen an increase not only in the number of individuals working as a

[1] Peer recovery specialist workforce is inclusive of both the credentialed peer service provider (CPRS) and those individuals working towards the attainment of the CPRS credential.

CPRS, but also a vast diversification of providers utilizing peers in a wide array of service delivery settings.

Behavioral health residential treatment programs, behavioral health outpatient treatment programs, and peer-operated wellness recovery and recovery community centers have been using peer recovery specialists for several years. As this workforce continues to expand, the recognized value of peer support also increases. Peers are demonstrating their ability to connect with individuals seeking recovery by working within local hospitals, detention centers, and other crisis response services, such as first responders and emergency medical services that are deployed for overdose response calls and the State's Safe Station programs. As a result of the expansion of this workforce, the Department identified that ongoing and sustainable funding sources would need to be developed within the PBHS.

In 2018, the Maryland General Assembly introduced and passed House Bill 772, Senate Bill 765, which requires the Department to convene a workgroup comprised of stakeholders who will review and provide recommendations related to the reimbursement of CPRS within Maryland's PBHS. This report is the result of that work and is reflective of the workgroup's final recommendations regarding the future funding of peer support services within the PBHS.

III. The Workgroup

With key stakeholders, the Department undertook the process of reviewing the current funding mechanisms which support peer recovery specialist services across the State and identifying recommendations regarding the future funding of this vital recovery support service. Efforts by BHA have allowed the peer workforce to expand into every jurisdiction in the State by utilizing grant dollars to support emerging positions. The statewide outcomes being demonstrated as a result of these investments illustrate the valuable work peers perform. Both quantitative and qualitative evidence indicate that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates, the number of days spent in inpatient services, and increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management.

House Bill 772, Senate Bill 765, mandated the workgroup to include representatives from Maryland Medicaid, Beacon Health Options Maryland, behavioral health treatment providers, recovery community advocates from both the mental health and substance use perspective, the Maryland Association of Behavioral Health Authorities, MABPCB, and CPRS.[2] The workgroup participated in a total of four meetings over seven weeks to discuss issues related to the reimbursement of services provided by the CPRS. The topics discussed include concerns and barriers that would disrupt or hinder a CPRS's ability to provide services within a funding model that differs from the current funding structure and how the Department would need to respond in order to avoid the loss of any peer support services that would not be reimbursable in a Medicaid model.

Additionally, the group reviewed the current and anticipated system infrastructure needs, provider definitions, service definitions, current funding amounts, and other system requirements that need

[2] See Appendix.

further consideration prior to moving towards a reimbursable service delivery system through Maryland Medicaid. It was agreed that in order to move forward with developing a new funding structure to support the delivery of CPRS services, careful consideration would need to be paid to the services CPRS deliver that would not be reimbursable under a Medicaid model. These services would need continued financial support through ongoing federal, state, and local grants. This would ensure that all community members have access to these important and lifesaving services, regardless of where they sought connection with a CPRS.

IV. Identified Barriers and Issues

The workgroup convened its first meeting on June 26, 2018, to discuss issues and barriers related to transitioning funding currently supporting the CPRS workforce to a Medicaid funded fee for service system. Currently, this recovery support service is funded using a combination of state general dollars and other grant-based initiatives that support the BHA's mission. In Fiscal Year 2018, the Department noted a 40% growth in the peer recovery specialist workforce in Maryland.[3] The funding mechanisms currently in place do not allow for long-term program sustainability or ongoing workforce expansion. As a result, the working group's discussion was focused around the effort of creating long-term sustainable funding for this service.

A. Ineligibility or Disinterest in Submitting Reimbursement Claims

The State has made significant investments into diversifying the locations where peer services can be accessed in order to ensure those services are available to all who seek them in hospital, clinical, or peer operated programs across Maryland. The working group identified a number of issues related to a lack of current program accreditation standards and the existing supervision structure of peer-operated organizations within Maryland's network of wellness recovery centers and recovery community centers. These issues could affect a programs eligibility to submit reimbursement claims under a traditional Medicaid model. A recommendation around the development of a dual funding stream model was proposed by the group. This model would allow for the reimbursement of services provided by CPRS in licensed, clinical settings through the Medicaid system. This model would also provide grant funding for those peer-operated recovery programs which would not be eligible for reimbursement through the Medicaid system.

B. Varying Supervision Structure

Additionally, the workgroup identified that the supervision structure which currently exists for individuals providing peer support services varies dramatically by provider. According to federal Medicaid requirements, peer recovery services must be supervised by a mental health professional (as defined by the State). Clear guidelines, identified levels of education, and related professional experience need to be articulated in order to meet Medicaid's reimbursement guidelines related to supervision requirements for service reimbursement. It was echoed by multiple workgroup members that workforce-specific needs should be considered when developing the CPRS supervision requirements within the Medicaid reimbursement model. Consideration of the diverse service settings CPRS are employed within raised concerns when discussing supervision within

[3] BHA annual CPRS workforce survey.

substance use programs and hospitals. Often times CPRS in these settings are receiving supervision from credentialed addictions counselors, CPRS who are trained registered peer supervisors, nurses, and other medical professionals. The workgroup made formal recommendations to expand the definition for CPRS supervision requirements to be inclusive of credentialed addiction counselors, licensed mental health professionals, and nurses.

C. No State-Mandated Supervisory Certification

Concerns surrounding the current availability of peer supervision training programs were also raised during the work group discussions. These training programs are intended to educate supervisors about effective supervision techniques when working with peer professionals. Currently, there are no state-identified requirements in place regarding mandated education for the peer recovery specialist supervisor. However, a process is in place for interested individuals to become registered peer supervisors through MABPCB. That process requires individuals to have a year of experience in providing supervision to peer recovery specialists, the completion of a six hour training program for initial certification as a registered peer supervisor, and a refresher course every two years to maintain their supervisory status. If Medicaid reimbursement for services provided by the certified peer recovery specialist is pursued, there would be a significant and overwhelming demand for these training programs in order to meet provider compliance with Medicaid regulations. At a minimum, a temporary expansion of these courses would be needed to meet the provider demand during the ramp up period.

D. Potential Increase in CPRS

Close attention must also be paid to the availability of training programs for the rapidly expanding peer recovery specialist workforce. Ongoing efforts by both state leadership and local authorities have developed a complex and abundant training catalog for current peer recovery specialist providers. However, if Medicaid reimbursement for the recovery support service is developed, a potentially explosive expansion of this workforce could result. Ensuring that there are adequate training hours and content available to meet the demands for both initial certification and re-certification must remain a priority of the State, local authorities, and peer-operated programs throughout the community. An expansion of the workforce as a result of transitioning what has traditionally been grant funded services to a fee-for-service model may increase the number of CPRS and the number of services they provide. This increase on the system may require additional fiscal resources to ensure the allocation of appropriate resources during this transition period.

E. Varying Definitions and Delivery Method

The philosophical dilemma of how the peer support service is defined and delivered within Maryland's diverse behavioral health service settings was another area of discussion focused on by the working group. The entire peer recovery specialist service delivery system must be considered when making changes to any of the funding mechanisms that currently exist.

In licensed community based and residential behavioral health programs, we see peers delivering care coordination and engagement services intended to reduce barriers and bridge resources which stabilize an individual's recovery. These barriers and identified resources are contained within the

individual's person-centered recovery plan and specific documentation is completed by the peer recovery specialist at the conclusion of an encounter. This peer recovery specialist provider is supervised by a licensed or certified mental health professional within a setting that reimburses Medicaid for behavioral health services.

Within Maryland's wellness recovery centers, recovery community centers, and other peer-operated programs, peer recovery specialists provide services to individuals in a different and uniquely valuable way. These services connect community members together in order to find mutual support through shared experiences. These experiences lead to reduced isolation, greater community connection, higher independent functioning, and overall improved health and wellness outcomes for those participating with these programs. These nonclinical recovery support services are essential to the development of the integrated, recovery-oriented system of care that Maryland has invested in over the last decade. However, these extremely valuable programs would not be eligible for reimbursement in a Medicaid funding model as they currently exist. It is important that all planning regarding future funding is inclusive of multiple funding mechanisms to include these organizations and others that fall outside of Medicaid's reimbursement criteria.

F. Inconsistent Outcomes Data

A major barrier that exists is a lack of consistent outcome data related to the interventions and services delivered by peer recovery specialists. This significant barrier has caused issues when attempting to demonstrate the cost savings that result from encounters with peer recovery specialists nationwide. Any future funding for this vital service must come with the stipulation that consistent and measureable outcomes be reported for all funding received. Utilization of system-wide data collection tools must be considered for required implementation when receiving funding for this and other recovery support services. In this way the State and other interested stakeholders can demonstrate consistent and robust system outcomes that are a result of the work being performed by the peer recovery specialists in the State.

V. Identified Workgroup Recommendations

The workgroup developed recommendations to address reimbursement strategies and the barriers described in the section above.

Recommendation 1: Support ongoing recovery services and positively impact the total cost of care by pursuing Medicaid reimbursement for defined services provided by CPRS in designated service settings in addition to maintaining the current infrastructure which supports peer recovery services.

Recommendation 2: Base reimbursement eligibility for CPRS services upon a primary behavioral health diagnosis inclusive of needs related to substance use, problem gambling, and mental health.

Recommendation 3: Require a state-approved certification through MABPCB to provide Medicaid reimbursable peer recovery services.

Recommendation 4: Make a Medicaid reimbursement for CPRS services eligible in any setting where individuals could present as needed behavioral health recovery support services to include

hospitals, primary medical care settings, and specialty health services for women, children, and families.

Recommendation 5: Include credentialed addiction counselors, licensed mental health professionals, and nurses when developing supervision requirements for Medicaid reimbursable services provided by CPRS.

Recommendation 6: Include the development of population specific credentials that demonstrate an enhanced knowledge for working with special populations who could benefit from recovery support services when implementing Medicaid reimbursement for peer support services.

Populations to consider include justice involved individuals, individuals who would benefit from family peer support, and individuals who would benefit from youth peer support.

Recommendation 7: Explore Medicaid reimbursement for peer support services delivered through standalone peer-operated organizations when a nationally recognized accreditation body provides accreditation of peer support services.

Recommendation 8: Pursue Medicaid reimbursement for group peer support services. This service focuses on building respectful partnerships among group participants; identifying the needs of those involved with the group; and helping those individuals recognize self-efficacy while building partnership between consumers, communities, and stakeholders to achieve the desired outcomes. This service provides the training and support necessary to promote engagement and active participation of the individual in the support, treatment, and recovery planning process for themselves as well as assistance with the ongoing implementation and reinforcement of skills learned throughout the support and treatment process.

Recommendation 9: Pursue Medicaid reimbursement for individual peer support services. This service provides interventions (in an agency or community-based setting) which promote recovery, self-advocacy, relationship enhancement, self-awareness, values, and self-directed care. Individuals served are introduced to the reality that there are many different pathways to recovery and each individual determines his or her own way. Nonclinical recovery support services are recovery-oriented and occur when individuals share the goal of long-term recovery. Each participant identifies his or her own individual goals for recovery. Interventions must promote self-directed recovery by honoring the many pathways to recovery, by tapping into each participant's strengths, and by helping each to recognize his or her "recovery capital."[4] Interventions are approached from a lived experience perspective but also are based upon the Science of Addiction Recovery framework. Supportive interactions include motivational interviewing, recovery planning, resource utilization, strengths identification and development, support in considering theories of change, building recovery empowerment, and self-efficacy. There is also advocacy support with the individual to have recovery dialogues with their identified natural and formal supporters.[5]

[4] "Recovery capital" is the reality that each individual has internal and external resources that they can draw upon to keep them well.
[5] See Georgia Manual.

Recommendation 10: Pursue statutory or regulatory changes as outlined in the above recommendations which support the reimbursement of services delivered by CPRS.

Recommendation 11: Seek guidance from the Centers for Medicare & Medicaid Services (CMS) regarding which funding authority to pursue, either through a State Plan Amendment or waiver under § 1115 of the Social Security Act,[6] for CPRS reimbursement implementation.

[6] 42 U. S. C. § 1315(a).

APPENDIX

Workgroup Membership and Affiliations

Maryland Department of Health		
1.	Barbara J. Bazron, Ph.D.	Behavioral Health Administration
2.	Brendan Welsh, CPRS (Chair)	Behavioral Health Administration
3.	Marian Bland, LCSW-C	Behavioral Health Administration
4.	Sarah Hoyt	Office of the Secretary
5.	Rebecca Frechard, LCPC	Medicaid
6.	Elaine Hall	Medicaid
7.	Nicholas Shearin	Medicaid
8.	Amy Woodrum, MSW	Medicaid
9.	Gordie Burke	Maryland's Commitment to Veterans
10.	Lisa Krugler, PsyD	Beacon Health Options
11.	Jackie Pettis, CPRS	Beacon Health Options
12.	Sue Doyle, RN	Maryland Association of Behavioral Health Authorities
13.	Brandee Izquierdo, MPA, CPRS, RPS	Maryland Addiction and Behavioral-health Professionals Certification Board
Providers		
14.	Vickie Walters	Institutes for Behavior Resources Inc., Mobile Health Services (REACH)
15.	Rhonda Hill	Institutes for Behavior Resources Inc., Mobile Health Services (REACH)
16.	Christopher Carman, LCPC	Mosaic Community Services, Baltimore City
17.	Diane Lane	Chesapeake Voyagers
18.	William Patten	New Day Wellness Recovery Center
19.	Marla Oros, RN, MS	Screening Brief Intervention and Referral to Treatment (SBIRT)
Community Advocates		
20.	Nancy Rosen Cohen, Ph.D.	National Council on Alcoholism and Drug Dependence Maryland
21.	Lauren Grimes	On Our Own of Maryland
22.	Tyrell Moyd	The Light of Truth Center
23.	Ann Ciekot	Public Policy Partners