Recommendations for Changing Medicaid Regulations for Peer Recovery Support Services

A Report to the Virginia General Assembly

May 26, 2021

Report Mandate:

Acts of the Assembly – 2020 Session, Section 313.PPPP states:

The Department of Medical Assistance Services shall review and consider amending regulations governing the practice and requirements for peer recovery services for individuals with mental illness and/or substance use disorder. In reviewing the regulations, the department shall convene stakeholders to assess the existing barriers to providing the service and assist in the development of emergency regulations. Stakeholders shall include, but not be limited to, the Virginia Organization of Consumers Asserting Leadership (VOCAL), Substance Abuse Addiction Recovery Alliance (SAARA), Virginia Network of Private Providers (VNPP), Mental Health America-Virginia (MHA-V), Virginia Association of Community Services Boards (VACSB), and National Alliance for Mental Illness-Virginia (NAMI-V). The department shall have the authority to promulgate emergency regulations to implement changes that are budget neutral within 280 days or less from the enactment of this act. The department shall submit changes that have a fiscal impact as part of the normal budget process for consideration in the 2021 Session.

Background

Effective July 1, 2017, the Department of Medical Assistance Services (DMAS) expanded the Medicaid benefit to allow for credentialing and reimbursement of Peer Recovery Support Services to include Peer Support Services and Family Support Partners. This was in response to a legislative mandate to implement peer recovery support services to eligible children and adults who have mental health conditions and/or substance use disorders. This expansion is supported by the recognition by the Centers for Medicare and Medicaid Services (CMS) that the integration of experiences of peer support providers, as consumers of mental health and substance use services, is an important component in a State's delivery of effective treatment.

Utilization of Peer Recovery Support Services within the Medicaid benefit has been low since implementation. DMAS met with several stakeholders in 2019 to review their feedback and recommendations regarding coverage, provider requirements and documentation to help streamline services so that more

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 500,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

members would access the Medicaid reimbursable Peer Recovery Support Services benefit. DMAS responded to stakeholders and identified recommendations that DMAS was able to take action on that did not require General Assembly or Budget allocation.

As of April 2021, there are a total of 636 Peer Recovery Support Specialists who are certified through the Department of Behavioral Health and Developmental Services (DBHDS) recognized certifying body. Out of those certified, 334 are registered through the Board of Counseling. Registration with the Board is a requirement per 12VAC30-130-5190 and 12VAC30-50-226 for Medicaid reimbursement. Medicaid paid claims analysis in 2019, shows a total of just over 775 members participating in Peer Recovery Support Services, still an increase of over 700 from 2017. Although the use of Peer Recovery Support Services has increased greatly between 2017 and 2019, there is still relatively little billing for Peer Recovery Support Services.

Workgroup Outcomes

DMAS facilitated a meeting on August 25, 2020 per the 2019 General Assembly requirement and included the following representatives: DBHDS, Virginia Center for Addiction Medicine, Virginia Organization of Consumers Asserting Leadership (VOCAL), Substance Abuse Addiction Recovery Alliance (SAARA), Virginia Network of Private Providers, Virginia Association for Community Services Boards, National Alliance for Mental Illness-Virginia (NAMI), Chesapeake Community Services Board, Mental Health America, and B2L Consulting. DMAS also facilitated a meeting on February 24, 2021 with this stakeholder group to review the requirements of the Recovery Resiliency Wellness Plan to help streamline the documentation.

The purpose of these meetings was to review current Medicaid policies and documentation requirements for Peer Recovery Support Services, review budget language for workgroup mandate, set goals for the group and ultimately to develop a report for the legislature and stakeholders. Attendees also shared current and past challenges with the Medicaid benefit for Peer Recovery Support Services.

Stakeholder concerns:

- Burdensome intake process and supervisions/documentation requirements
- Low reimbursement rates that do not cover the cost of the service or salary of the peer staff member
- DMAS policies for medical necessity criteria when Peer Recovery Support Services is not a medical or clinical model.
- DMAS limiting of the service delivery of Peer Recovery Support Services via telephone at 25%.
- Caseload minimum and maximum per year.
- Not being able to provide services if staff has a barrier crime.
- Caseload limitations for the number of individuals that can be served at any given time as well as annual caseload limitations.
- Not able to bill for emergency services (short term Peer Recovery Support Services).

Impact for DMAS

Changes DMAS Implemented

DMAS initiated changes to the Peer Recovery Support Services Provider Manual based on previous feedback from stakeholders. These changes, which did not have a fiscal or regulatory impact, were implemented July 2019 and included the following:

- Removing the annual caseload limits
- Clarification of who can initiate a referral for Peer Recovery Support Services

- Clarification of distinct separation between services when a provider is delivering Peer Recovery Support Services with another Medicaid covered service.
- Clarification on how to incorporate the Peer Assessment and Recovery, Resiliency, and Wellness Plan, with other services the member may be participating in to streamline the process.

Other Recommendations to Consider

Other recommendations from the Workgroup that DMAS is currently reviewing include:

- Removing caseloads of 15 individuals for a full time Peer Recovery Support Specialist and the limit of 9 individuals for a part-time Peer Recovery Support Specialist at a specific point in time.
- Removing the 25% limit telephonic delivery of services.
- Amending who can determine medical necessity and oversight of services.
- Amending the medical necessity criteria.
- Streamline managed care documentation processes.
- The following items would have a cost to implement however would be critical to increasing the access to Medicaid funded Peer Recovery Support Services:
    - Increasing the reimbursement rate.
    - Implementing a tiered approach that would allow for short-term intervention of Peer Recovery Support Services, such as in emergency departments.

DMAS will continue to work with DBHDS Office of Recovery and the stakeholder community to implement changes to increase access, remove unnecessary administrative processes and determine recommendations that will have a budgetary impact.

Note: DMAS is not able to address the concerns regarding barrier crimes. The laws governing this issue does not fall within the Agency's statutory purview. Thus the agency is not in a position to advocate or change the current statutory protections.

Conclusion and Next Steps:

- DMAS will determine changes to the Peer Recovery Support Services Medicaid benefit that would have a fiscal impact and submit requests through the normal budget process for agency prioritization and consideration for funding through the General Assembly session.
- A cost study for Virginia Peer Recovery Support Services would be appropriate to address concerns about the current reimbursement rate.
- DMAS will continue to engage stakeholders in streamlining documentation requirements and in standardizing the Recovery, Resiliency, and Wellness Plan.
- DMAS will work with DBHDS to develop a guidance document to help clarify documentation requirements for both DBHDS and DMAS.
- DMAS will work with DBHDS to coordinate a Symposium to further explore technical assistance and training for providers to help incorporate Peer Recovery Support Services in both mental health and substance use disorder service delivery.

DMAS would like to acknowledge the members of the Workgroup and thank them for contributing their time and expertise to help to increase access to Medicaid reimbursable Peer Recovery Support Services.