Recovery Community Organization Medicaid Billing Considerations

RCO Sustainability Guide

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Introduction

A Recovery Community Organization (RCO) is an independent, grassroots, nonprofit which is led and governed by representatives of local communities of addiction recovery (SAMHSA, 2017). SAMHSA, by reference, refers to this definition to more fully define the RCO:

> *These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services (P-BRSS). The broadly defined recovery community — people in long-term recovery, their families, friends and allies, including recovery-focused addiction and recovery professionals — includes organizations whose members reflect religious, spiritual and secular pathways of recovery. The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Public education, policy advocacy and peer-based recovery support services are the strategies through which this mission is achieved.*

(Valentine, White, Taylor, 2007)

Many Recovery Community Organizations (RCOs) are launched with short-term funds which are term-limited, often through one-time federal or state grant initiatives. There are myriad alternatives to sustain funds, many of which are also term-limited but many of which can be sustained for a much longer time period.

Premise for Financial Sustainability

Sustainable funds are at the heart of any non-profit agency's stability — sustainable funding allows the strategic continuation of the agency's primary mission, which in the case of the RCO, is to promote community-based recovery for those it serves. Specifically, RCOs provide a place for recovery support to occur and provide staff who offer that support with constancy. The space and staff require funding and one of the most stable healthcare fund sources in the country is the Medicaid program. This paper will explore the various pathways for Medicaid funding and consider the risks and benefits of that fund source with candor. Medicaid is a complex reimbursement model and requires substantial partnership with state authorities to create and develop Medicaid capacities. Even when Medicaid financing can be enabled through one of many methods, each have requisites and stipulations which require deep consideration for the RCO to assess for financial outlay, human resource capital, and cultural sacrifice. Medicaid funding will not be a match for every RCO and each should consider whether "the juice (sustainable funding) is worth the squeeze (the effort and sacrifice which the Medicaid funds may demand.)"

Terminology

If your agency is to embark on any consideration of Medicaid financing, it is crucial to understand some basic definitions that are central to a partnership with Medicaid. And while RCOs may not be pursing the traditional model of a Medicaid-reimbursable Peer

Support program, that definition may be the most common basis from which you begin in this dialogue. For instance, consider that a Medicaid Director may not be deeply understanding of a Peer Support program model, but there are memoranda from the federal Medicaid agency which define Peer Support and enable it (in addition to SAMHSA and White House memoranda and guidance).

So while you may not be asking to implement a traditional Peer Support model, the central themes between an RCO line of work and Peer Support provide a communication foundation (recovery-focused, driven by lived experience, community-embedded, etc.). The most generally accepted definition of behavioral health **Peer Support** is the definition recognized by the US Health & Human Services' Substance Abuse and Mental Health Services Administration:

> *Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both. This mutuality — often called "peerness" — between a peer support worker and person in or seeking recovery promotes connection and inspires hope. Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships (Mead & McNeil, 2006). By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves.*

(SAMHSA, 2017)

Recovery Community Organizations in general are predominantly or fully staffed by individuals who are in recovery. In many states, policy defines that these individuals are trained and certified in using their lived experience as a tool in helping others. Individuals with lived experience who provide this crucial recovery support intervention are called by a variety of titles in different jurisdictions (SAMHSA, 2017). States may vary in the official naming conventions assigned to **Peer Support Workers** (referenced as PSWs henceforth in this paper). Generally, a PSW is defined as an individual who has been successful in their own recovery process who helps others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, the PSW helps people become and stay engaged in the recovery process and reduce the likelihood of recurrence. Because of their life experience, such persons have expertise that professionel training cannot replicate (SAMHSA, 2017). While there are many types of PSWs, for purposes of this paper, the PSW reference is limited to an adult who is a trained and credentialed practitioner who has individual lived experience of either a recovery journey with a behavioral health condition (mental health or substance use). Medicaid federal and state agencies are generally knowledgeable about PSWs and can reference federal Medicaid memoranda or can reference the U.S. Department of Labor citation of Peer Support Specialist (under the umbrella of Community Health Worker), recognizing PSWs as an official occupation.

Finally, there are federal and state Medicaid agencies, which are crucial to understand in role and in function. The **Centers for Medicare and Medicaid Services (CMS)** is a federal agency under the Department of Health and Human Services. CMS is the entity that provides health benefits through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace (CMS, 2024). In the remainder of this document, we will be focused on the Medicaid arm of CMS policy, which is defined as

a network of statewide programs administered by state governments following broad national guidelines established by federal statutes, regulations, and policies. It provides health benefits for low-income adults, individuals with disabilities, pregnant people, and children (depending on unique eligibility qualifications which are generally state-defined) (CMS, 2018).

Because Medicaid is a joint federal/state program, it is important to define the local **State Medicaid Agency (SMA)**. The SMA is defined as the single state agency designated to administer the state's Medicaid plan. Each SMA designs, establishes, and administers the state's Medicaid design defining the type, amount, duration, and scope of benefits which are allowed with federal guidelines set forth by CMS (CMS, 2024).

Medicaid Introduction

So with the agencies defined in the previous section, consider the nature of the Medicaid as a potential fund source for RCO reimbursement. Because Medicaid is a state + federal partnership, this allows SMAs to consider what its locally-defined members need in the way of health coverage. Federal regulation (Social Security Act, Sec. 1903. [42 U.S.C. 1396b] (a)) defines that states can create a formal plan for Medicaid benefits which is specific to that state and its Medicaid beneficiaries. Further allowances of the Act enable states to define innovation and waiver approaches to the provision of state Medicaid initiatives (Social Security Act, Sec.1115, Sec.1905, Sec.1915, Sec.1945, and related provisions granted by CMS). In summary, this means that within the bounds that are set by the federal entity, each state can define their local services and benefits differently, resulting in variations in Medicaid coverage across the country. In effect, "If you've seen one Medicaid program, you've seen one Medicaid program (Adams, 2013; Olson, 2010)." This gives an RCO incredible opportunity to engage at the state level for enabling services recognition which can create enduring and sustained funding.

In the case of an RCO, the state would have to define the actual service. Many states have forms of Peer Support or Recovery Support approved in current Medicaid State Plans; however, there are often systemic barriers which prohibit an RCO from taking advantage of that service funding. Below we discuss the most common of the Medicaid billing pathways to access funding opportunities and then consider the specific risks and challenges which should be considered in each of these models.

In general, there are three primary funding models for consideration:

1 Traditional Fee-for-Service

The most common reimbursement model of reimbursement of Medicaid services is a traditional fee-for-service payment framework. The term fee-for-service is commonly used to describe the payment method when a practitioner delivers a service, submits a claim to Medicaid or other payer, and then receives reimbursement for that service. This model is the most common payment method in healthcare yet is flawed because of its emphasis on production of units of service for payment instead of targeting the most effective and efficient mode of delivery. That said, the majority of Medicaid Peer Support and Recovery Support in the U.S. is delivered in this very traditional framework through Medicaid. (Tiegreen, 2022).

Some fundamental research by the RCO at the state level is likely necessary in order to

determine what peer-delivered recovery supports are already included in the Medicaid State Plan. Coming to understand what is in that service model and what services your RCO provides is what gives you the foundation for a "gap" analysis. If, for instance, you read that a certain ratio is required which is not feasible for your RCO, then your negotiating dialogue with the state is critically informed and you can make clear asks of the Medicaid agency as to what is desired for change. So if a current recovery support service requires a minimum 3 hours/day and your model is a drop-in model, you can approach the Medicaid authority with an idea to create a new service intensity level which has no minimum utilization. This "gap" analysis between what is currently enabled and what your RCO does/could do is the key to engaging with the Medicaid authority about what you may need from them to build a service which could provide a viable funding source.

Related to business operations, in considering basic staffing costs in conjunction with the potential for reimbursement, it is necessary to consider whether the current Medicaid reimbursement will cover the cost of the PSW you have employed. In general, agencies must consider direct (e.g., staff salary, training, malpractice coverage, travel costs, etc.) and indirect costs (e.g., spread costs of agency leadership, payroll, electronic health records, etc.) of employing the PSW, the potential for productivity (how many units the PSW can/will bill), the reimbursement rate, and the back-office support to administratively pursue the authorization and reimbursement of services delivered by the practitioner. It is crucial for the RCO to know its business model/costs and that the reimbursement covers the costs of the practitioner and agency support of the practitioner based on a certain standard of productivity (Tiegreen, 2022). If the rate does not cover the cost, this can be added to the potential "gap" considerations for dialogue with the Medicaid agency or may simply be a signal that a Medicaid fee-for-service fund source may not be an approach worth considering based on your business model.

Medicaid billing documentation varies among states yet most require "medical necessity" determination from a mental health/substance use professional, services/recovery plans, and electronic health record documentation for each contact with the individual.

2 Managed Care

If a state has managed care plans which are identified to manage Medicaid treatment and recovery benefits for adults with substance use conditions, the Managed Care Organizations (MCOs) can be individually approached to support the funding of the RCO. Medicaid Managed Care is deployed when a state organizes its health delivery system to be delivered through a contract arrangement with an MCO to manage cost, utilization, and quality. When the SMA selects a vendor as an MCO, it creates a set per member per month (capitation) payment for Medicaid plan benefits and other benefits as the state and MCO decide to offer. States generally select this model to reduce Medicaid program costs and more effectively manage utilization and quality of health services. The per member/per month payment model is set forth to give the state predictability in cost management (it gives the MCO a set fee per person each month), but then generally the MCO's goal is to coordinate services, direct the member to the most efficient services, and carefully conduct the use of those services to be cost beneficial and outcome-oriented.

While the MCO may be given a per member/per month reimbursement, generally, the MCO continues to pay providers in their network in a fee-for-service approach. There are some emerging innovation models where states are implementing a range of initiatives

to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care (CMS, 2024).

MCOs can also implement what are called “in lieu of services” – this means that an MCO can consider offering a service which is not in the state benefit plan, but can consider services which are effective, target a unique social related health need, and address a specific medically-necessary condition (CMS, 2023). This does give an RCO a unique opportunity to work with a MCO in the state to create an agreement (contract) with that MCO to deliver RCO supports.

In this case, the RCO should research who are the MCOs in their particular geographic area and review any substance use plan and data available from that company. Find out who the behavioral health director for that company is and do in-reach with that person to begin building relationship (send introductory emails, ask for introductions from other providers in that MCO provider network, etc.). Ultimately, the RCO will want to present a brief proposal to the one or more MCOs who support Medicaid covered individuals in the community. The proposal should include actual or estimated numbers of individuals served by your RCO (or could be served by your RCO) who are enrolled with that MCO or should propose a strategy to receive referrals of new individuals from that managed care plan. Depending on those estimated numbers to be served, a cost proposal should be included which is a proportional estimate of costs for the persons covered. For instance, if the RCO serves 100 persons/week and it is estimated that 10% are covered by MCO 1, then a budget proposal of approximately 10% of the operating budget could be included in the managed care proposal for funding (Tiegreen, 2022).

The key to a successful proposal acceptance for the MCO will be based upon whether they believe that there is a significant return on investment for them. MCOs are generally for-profit entities. They are seeking products which are affordable innovations which keep health care costs low. In the case of an RCO, you are promoting that engagement with your service, will keep a Medicaid member actively in recovery, relying less on high-cost formal treatment (such as emergency department use, treatment of risk-behavior impacts, etc.) by promoting lived experience support, mutuality, health-focused mindset, and recovery-oriented engagement. If you have studies or outcomes, those should be prominently featured in verbal or written proposals, along with recovery testimonies. Your role is to convince the MCO that your product is absolutely crucial to their wholistic approach to substance use treatment and support.

If the business proposal is accepted, the RCO should carefully enter into agreements with the MCO. You should be excited about the prospects yet be mindful that MCOs are generally huge corporate entities and broker large contracts everyday — legal advisement on this process is crucial to the RCO. If you are a small non-profit, risk mitigation in this contracting process should be paramount to protect the interests of your small, yet impactful business niche. Be attuned to fine print, the cost negotiation, and performance benefits/penalties on your way to brokering your successful contract and reimbursement.

Administrative Claiming

The informal nature of RCOs often do not naturally align with billing traditional Medicaid in a fee-for-service format. As an alternative, state behavioral health lead authorities may work with the state's Medicaid agency to consider whether RCOs may be considered for Medicaid Administrative Claiming.

Medicaid Administrative Claiming is defined by the federal Centers for Medicare & Medicaid Services (CMS) and in federal regulation as "...necessary...for the proper and efficient administration of the state plan," per 42 Code of Federal Regulations (CFR) 433.15(b)(7). As RCOs often serve as a point of first engagement for individuals who may not have been willing or able to go through traditional medical treatment pathways, the state can make a global proposal to qualify the work of the RCO network as necessary for the proper and efficient complement to the state's Medicaid plan services. As this is an administratively complex request of the state Medicaid agency, this is generally not an option for a single-RCO approach but could be a comprehensive state approach to leverage sustained funds for an RCO network.

As defined in the Managed Care considerations above, a successful proposal acceptance for return on investment would be necessary by the SMA. This may be proposed by a single RCO or a collective approach by a large group of RCOs. A partnership of support from the state's behavioral health authority will propel the dialogue (and without it, the SMA may not entertain the proposal given the current administrative demands on those authorities. While the profit factor associated with MCOs is removed in this model, the state officials are still seeking products which are affordable innovations which keep health care costs low, promote engagement, rely less on high-cost formal treatment, and promote lived experience support, mutuality, health-focused mindset, and sustained recovery. Again, if you have studies or outcomes, those should be prominently featured in verbal or written proposals, along with recovery testimonies. Your continued role is to convince the state that your product is absolutely crucial to their wholistic approach to substance use treatment and support.

Assessing Your Potential Medicaid Pathways

Now that a few of the Medicaid pathways are identified in this learning framework, it is necessary to assess how you as a RCO might consider whether Medicaid is a possible and feasible alternative for your agency within your state's Medicaid plan and culture. Here is a link to a framework your RCO can utilize to self-assess your readiness for seeking Medicaid reimbursement. Set aside time to discuss the questions included at the bottom of the chart with your RCO's leadership, staff, volunteers, and board of directors.

Risks and Benefits Analysis

Having considered the self-assessment content above, the final and most critical question to consider for the RCO is this: Given our answers to the previous questions, do we assess that we can benefit from sustained Medicaid reimbursement beyond what its cost for implementation will be? In other words, is the Medicaid reimbursement "juice that is worth the squeeze?"

There is a financial and human capital cost for building a provider infrastructure which is usually required by SMAs. The RCO should consider all of the questions in the framework with an eye to those costs, weighing that against the potential gain in the Medicaid reimbursement. The answer should be quite different from RCO to RCO, understanding that many of your entities have different histories, board expertise, different directors, and different community-based infrastructure. Those variabilities change the lens through which these answers are considered and will shape how the "juice worth the squeeze" question is processed.

Finally, the RCO should consider the nature of its recovery culture in the final assessment process. Consider the culture of your agency, team, vision, and mission. Medicaid funds come with high accountability and performance demands — if this has been the nature of your culture already, then this will seem natural to your RCO. If, however, this is not the current culture, this may seem more daunting. Your self-assessment then must consider how much the Medicaid documentation, supervision, policy, and oversight will change the nature of your recovery-oriented culture and what that "cost" is assessed to be for your RCO. This is a more philosophical self-examination, but not one that should be left off your consideration list. Keep the RCO vision and mission at the heart of the agency's final decision-making process.

Conclusion

Recovery Community Organizations (RCOs) have emerged as strong community-based recovery hubs to promote recovery health and wellness and Medicaid may be a viable source of reimbursement through which to sustain and grow current and emerging service sites. Yet, this particular fund source is complex and requires state and federal partners to understand the services/supports and to work to enable certain Medicaid mechanisms. RCOs can weigh the risk and benefits herein and use the self-assessing questions to consider whether Medicaid may be a viable alternative to strengthen revenues for the recovery support model. With solid and honest reflection on this content, RCOs can feel knowledgeable and empowered on the journey to this decision, and during the subsequent process.

References

Adams, Rebecca. (April 2013). State Medicaid Officials Consider Multi-Tiered Benefits, Cost-Sharing Under Overhaul. The Commonwealth Fund. https://www.commonwealthfund.org/publications/newsletter-article/state-medicaid-officials-consider-multi-tiered-benefits-cost. Accessed July 3, 2022.

Olson, L. K. (2010). The Politics of Medicaid. Columbia University Press. https://doi.org/10.7312/olso15060

Social Security Act, Sec. 1115[40]. [42 U.S.C. 1315]. https://www.ssa.gov/OP_Home/ssact/title11/1115.htm. Accessed April 18, 2022.

Social Security Act, (Sec. 1903. [42 U.S.C. 1396b] (a)). https://www.ssa.gov/OP_Home/ssact/title19/1903.htm. Accessed April 18, 2022.

Social Security Act, Sec. 1905. [42 U.S.C. 1396d]. https://www.ssa.gov/OP_Home/ssact/title19/1905.htm, Accessed April 18, 2022.

Social Security Act, Sec. 1915. [42 U.S.C. 1396n]. https://www.ssa.gov/OP_Home/ssact/title19/1915.htm. Accessed April 18, 2022.

Social Security Act, Sec. 1945. [42 U.S.C. 1396w-4]. https://www.ssa.gov/OP_Home/ssact/title19/1945.htm. Accessed April 18, 2022.

Tiegreen, Wendy White. Peer Support Billing Pathways. Paper written for the Behavioral Health Excellence Technical Assistance Center, funded project supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). August 2022.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, About Us. Accessed February 28, 2024, from https://www.cms.gov/about-cms.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Managed Care. Accessed February 29, 2024, from https://www.medicaid.gov/medicaid/managed-care/index.html.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicare and Medicaid Basics, Medicare Learning Network Booklet (ICN 909330 July 2018). Accessed February 28, 2024, from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProgramBasicsText-Only.pdf.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Program History. Accessed February 29, 2024, from https://www.medicaid.gov/about-us/program-history/index.html.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Pub 100-15 Medicaid Program Integrity, Transmittal 12467, January 18, 2024. Accessed February 29, 2024, from https://www.cms.gov/files/document/r12467mpi.pdf.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, SMD #: 23-001 - Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care, January 4, 2023.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, FFY 2022-2023 Block Grant Application Community Mental Health Services Block Grant (MHBG) Plan and Report Substance Abuse Prevention and Treatment Block Grant (SABG) Plan and Report (sections 1911-1920 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.CF.§§ 300x300x-9) and sections 1921-1935 of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C.§ 300x-21-35), respectively, and sections 1941-1956 of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§§ 300x-51-66). Accessed September 25, 2023, from https://www.samhsa.gov/sites/default/files/grants/fy22-23-block-grant-application.pdf.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, How to Apply for a SAMHSA Grant, Accessed September 25, 2023, from https://www.samhsa.gov/grants/how-to-apply

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Recovery Community Services Program-Statewide Network (RCSP-SN), Funding Opportunity Announcement (FOA) No. TI-17-006, January 2017. Accessed March 1, 2024, from https://www.samhsa.gov/grants/grant-announcements/ti-17-006.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Contacts. Accessed September 25, 2023 from https://www.samhsa.gov/grants/block-grants/subg/contacts.

Valentine, P., White, W. & Taylor, P. (2007) The recovery community organization: Toward a definition and description.

Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Community Health Workers. Accessed February 26, 2024, from https://www.bls.gov/ooh/community-and-social-service/community-health-workers.htm.

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