

FINANCING STRATEGIES FOR SUBSTANCE USE DISORDER TREATMENT

Expanding Access to Peer Supports for People with Substance Use Disorder: A Checklist for States

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Increasingly, states recognize the value of **peer supports** for promoting recovery among people with substance use disorders (SUDs). Peers — who may be known by other titles across states — leverage their lived experiences of addiction and recovery to support others on the path to recovery.^{1,2} There is growing evidence that shows peer support services address the needs of people with SUD and help improve outcomes, including reductions in emergency department (ED) visits for certain patients (those with a history of SUD-related ED visits).³

Evidence-based SUD services, including peer supports, are critical to populations disproportionately affected by SUD. For example, Black, American Indian, and Alaska Native people face higher rates of SUD-related mortality when compared to white people.⁴ Evidence shows that Black and Latino people have lower rates for SUD treatment utilization compared to white people.⁵ Emerging evidence shows peers can provide culturally appropriate services — grounded in relationships built on empathy, trust, and shared experiences — to address these disparities.⁶ States that invest in peer supports and other evidence-based services can achieve higher engagement rates in SUD treatment and other necessary services among these and other key populations.

Drawing from [State Principles for Financing Substance Use Care, Treatment, and Support Services](#), this checklist identifies four areas for states to explore as they consider expanding peer supports for people with SUD:



1. Assess the status of publicly financed peer support services;



3. Select approaches to embed peer supports across the SUD continuum of care; and



2. Identify strategies to grow the peer workforce;



4. Target peer supports to address SUD care inequities.

PRINCIPLES-IN-ACTION SERIES: Financing Strategies for Substance Use Disorder Treatment

This checklist is part of a series detailing practical steps to guide state policy development aimed at strengthening substance use disorder (SUD) treatment systems, with a focus on sustainability and equity. It draws from the report *State Principles for Financing Substance Use Care, Treatment, and Support Services*. The report and series were developed by the Center for Health Care Strategies through a partnership with The Pew Charitable Trusts and support from Bloomberg Philanthropies. [VIEW THE SERIES »](#) | [READ THE FULL REPORT »](#)

Why expand access to peer supports?

Peers (also known as peer specialists, peer recovery coaches, etc.) are people with lived experience of addiction and recovery who provide nonclinical support to people with SUD. Because of their own lived experience and training, peers possess unique engagement skills grounded in trust, respect, and empowerment that can support others seeking recovery.



Encouraging treatment engagement. Peers can play a role across the continuum of care — including prevention, early intervention, treatment, recovery supports, and harm reduction services — to support people who use drugs and may not be ready or willing to engage in treatment. The Centers for Medicare & Medicaid Services (CMS) provides some parameters for states seeking reimbursement for peer supports under Medicaid, including that peers must receive supervision and some level of training or certification (defined differently in each state), in order for them to be part of a person’s treatment plan.⁷

Demonstrated evidence. Growing evidence shows that peer supports can:

- **Decrease hospital use and increase engagement in outpatient SUD services**, including among populations with co-occurring disorders.⁸
- **Increase the number of patients receiving medications for addiction treatment**, through the navigation and advocate role peers play on multidisciplinary addiction consult teams. These teams include prescribers, hospital settings (ED, inpatient), and primary care settings.^{9,10,11}
- **Reduce substance use** and increase commitment to reducing drug use.^{12,13}
- **Reduce recidivism** for people with SUD returning to their communities from incarceration.¹⁴
- **Improve overall wellbeing**, including quality of life, social functioning, and activation (a patient’s ability to self-manage their health care).¹⁵

Adopt a Comprehensive Approach to Increasing Access to SUD Services

Expanding peer supports — or any service or support for SUD — should be a goal developed as part of a larger gap analysis process that examines needs and strengths across the entire SUD continuum of care. Given that many different agencies oversee and fund services that are relevant to the care of people with SUD, a first step is to **establish an interagency workgroup**. Key stakeholders likely include representatives from the governor’s office, Medicaid, substance use, mental health, public health, corrections, children and families, education, and housing departments. The workgroup should also include people with lived experience and subject matter experts knowledgeable about peer supports.

Many states already fund some level of SUD peer support services through a variety of public funding streams. The fragmented nature of this funding, however, can make it

difficult to assess whether the funding is adequate to increase engagement of SUD treatment services, among other expected outcomes.

States can use the following checklist in assessing current funding streams and determining approaches to strengthen peer support services.

1. Assess the status of publicly financed peer support services.



❑ How is the state currently funding peer supports?

States should leverage the knowledge of the interagency workgroup to identify all the funding streams directed towards peer supports. As an initial step, it may be helpful to complete a [fiscal mapping process](#) to inventory funds that support peer services, including key information such as source, amount, limitations on funding (e.g., time-limited discretionary grants), and number of people being served.

❑ Where are there opportunities for expanded coverage of peer supports under the state's Medicaid program?

A 2019 MACPAC scan of all 50 states and the District of Columbia found 37 states [use the Medicaid state plan, waivers, or demonstration programs](#) to fund peer support services for SUD, though some of these states limit coverage to certain subpopulations.¹⁶ To the extent services are currently funded through other non-Medicaid sources, shifting coverage to Medicaid could increase sustainability and expand reach for eligible populations while freeing up other funding sources for additional purposes.

❑ Are there opportunities to pilot peer support models, which may later be included in the state's Medicaid program?

Flexible federal funds provide states with ways to experiment with care models before bringing the model to scale statewide. If a pilot demonstrates the desired impact, the state could explore building statewide capacity under Medicaid.

For example, **Rhode Island** piloted an ED-based peer support program (the AnchorED program) starting in 2014 with funding from the state's block grant (formerly the Prevention and Treatment Block Grant; now referred to as Substance Use Prevention, Treatment, and Recovery Services), which is administered by the U.S. Department of Health and Human Services.¹⁷ An evaluation showed the program improved the post-discharge referral rate to ongoing treatment in the community for patients with opioid-related ED visits from nine to 21%.¹⁸ In 2018, CMS authorized reimbursement of peer supports in Rhode Island under an 1115 demonstration waiver. The AnchorED program

continues to rely on the flexibility of grant funds to cover program expenses that Medicaid cannot. Peer supports are now Medicaid reimbursable and available 24/7 in all Rhode Island hospitals (except for Veterans Affairs hospitals).¹⁹

❑ Are there opportunities to expand access to peer supports through opioid settlement funds?

States (and localities) receiving opioid settlement funds have a historic opportunity over the next decade to invest these funds on certain evidence-based/evidence-informed strategies, including peer supports.²⁰ Given peers' expertise in this evidence-based service, it is valuable to invite peers into decision-making groups about these funds to lend their expertise on key services.

❑ Are there value-based payment (VBP) models in the state under Medicaid managed care that incentivize peer supports?

VBP models reward value and are tied to performance on targeted quality measures, thereby incentivizing the expansion of SUD services that demonstrate better outcomes for patients. States could implement quality measures most likely to be impacted by peer support services (e.g., Initiation and Engagement in Treatment) as well as measure outcomes for beneficiaries who receive peer support services compared with those who do not.

❑ Do data-sharing restrictions limit referrals to peer support services?

Given the confidentiality and information-sharing restrictions particularly related to SUD, peers, peer support providers, and potential referring entities like health systems and other provider organizations may benefit from technical assistance (TA) on the sharing of 42 CFR Part II-compliant releases of information to maximize referral opportunities and understand patient treatment histories, across various health care settings, as well as correctional settings.

2. Identify strategies to develop the peer workforce.

❑ Has the state funded peer support services training programs?

There is variability in how states integrate peers into the behavioral health workforce, including different requirements on education and training. Training is critical to expand the peer workforce. Most states require peers to complete an in-person, one- or two-week training course (often provided by a state health agency) and pass a certification exam.²¹ States are well-positioned to use flexible funds to support state-recognized training programs within peer-led



organizations, which serves the purpose of developing the peer workforce while also supporting community-based, peer-led organizations.

❑ Has the state aligned the peer certification with [SAMHSA’s National Model Standards for Peer Support Certification](#)?

Currently, states vary considerably in how they approach peer certification, with many employing state-developed certification exams.²² States that align certification standards with SAMHSA’s National Model Standards for Peer Support Certification can benefit on multiple fronts, including supporting reciprocity across states and promoting quality of services.²³ The standards also support states tackle common barriers to developing the peer workforce. For example, [Model Standard #6](#) offers several background check-related recommendations, such as placing the responsibility of background checks with the hiring organization (not the state certification entity) or limiting the list of disqualifying offenses.

❑ Is there a robust peer workforce recruitment and training strategy?

Members of the recovery community who could be qualified candidates for peer roles are everywhere — from behavioral health clinics, where they may receive care, to self-help/mutual support groups and beyond. A peer recruitment strategy should target a wide variety of outlets to grow the workforce (e.g., announcements through social media, community centers, faith communities, colleges and universities).²⁴ For example, **Delaware** uses State Opioid Response funds to provide peer training and certification within state prisons for people prior to release, in partnership with their department of corrections.^{25,26}

❑ Has the state examined the adequacy of Medicaid reimbursement rates to attract peer support workers?

To attract and sustain the peer workforce, it is vital that states optimize reimbursement under Medicaid, which is a major payer of peer supports.

3. Embed peer supports across the SUD continuum of care.

❑ Are there opportunities for the state to support expansion of peer supports in EDs and inpatient settings?

There is growing evidence that peers are effective in interdisciplinary team-based hospital settings (including EDs), low-threshold bridge clinics, and inpatient addiction consult teams.²⁷ Given that many people with SUD present in EDs with medical complications of SUD and become hospitalized,



embedding peers in these settings can reduce these costly encounters and set patients up for longer term care in the community. It can be a high-opportunity window for engagement, particularly if an admission is SUD-related. These models are often diverse in funding sources, so states can consider ways to target flexible funds to support peers in these settings, particularly for time that is not Medicaid reimbursable, like on-call waiting time.

For example, **California** uses flexible grant dollars and other funds, such as billing mechanisms (e.g., the community health worker benefit under Medi-Cal, billing code for initiation of MAT) to support the expansion of low-threshold bridge clinics, which are led by peers and clinicians.²⁸ Bridge clinics are evidence-based models that help integrate addiction care in hospital settings. These clinics are often embedded within or adjacent to EDs, where people with SUD present with substance-use related medical needs, including overdoses.²⁹ To date, California has successfully supported the implementation of bridge clinics in 278 hospitals across the state.^{30,31}

□ Are there opportunities to address operational and administrative challenges for expanding peer supports in office-based settings (e.g., primary care, federally qualified health centers)?

Primary care can also be an entry point for people with SUD to be engaged in specialty SUD services, and peer supports can play a key role in this engagement. As there can be many challenges to setting up a strong foundation for integrated care in these medical settings, funding and TA for providers to support readiness and implementation as well as ongoing learning through peer-to-peer networks can be beneficial. States can also consider how to eliminate administrative burdens, such as allowing for same-day billing in federally qualified health centers when there is both a physical and behavioral health-related encounter in a visit.

□ Are community-based, peer-led organizations included in the provider networks of the state's contracted managed care organizations (MCOs)?

Increasingly, health care leaders and providers recognize the health-related social needs that drive health care outcomes and encourage or require MCOs to contract with community-based organizations. Community-based peer providers are positioned to facilitate linkages to nonclinical resources, such as social activities, educational and employment opportunities, etc.

4. Target peer supports to address SUD care inequities.



- ❑ **Are there opportunities to better tailor peer navigator services for people with multi-system involvement?**

Many peer-based initiatives are designed to embed peers in the provider site, such as a hospital or clinic. However, some people with SUD may be involved in multiple social service sectors (such as the child welfare system) and the criminal legal system or receive services from social service agencies (including aging, disability and immigration supports) and would benefit from a peer worker who can assist with navigating these complex bureaucracies as they seek recovery.

- ❑ **Are there opportunities to target workforce development efforts to peer support providers located in under-resourced communities?**

Identifying these providers and learning from them about their TA or resource needs can support increased internal capacity, such as increased recruitment and training of peers from culturally and linguistically diverse populations.

Conclusion

Peers use their lived experience of SUD and recovery to support others on the road to recovery and are integral to effective SUD treatment systems in states. Evidence is growing for the value of peers and their potential to address SUD care inequities. This checklist can guide state policymakers interested in maximizing available funding sources to build a more sustainable, equitable and robust SUD treatment system. The four key areas explored are: (1) assessing the status of public financed peer support services; (2) identifying strategies to develop the peer workforce; (3) embedding peer supports across the SUD continuum of care; (4) and targeting peer supports to address SUD care inequities. Additional policy actions and state examples can be found in the [State Principles for Financing Substance Use Care, Treatment, and Support Services](#) report.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

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ENDNOTES

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