DEPARTMENT OF HUMAN SERVICES

Legislative Report

Peer Recovery Services Engagement

Behavioral Health Division

February 2025

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $9,811.

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Contents

I. Executive summary

Since the designation in 2019 of Peer Recovery Services (PRS) as Medicaid billable services (254B.05, subd. 5, clause 4), revisions to PRS legislation have been needed to both ensure quality services and address ongoing and new concerns about vendor eligibility, statutory requirements, and oversight practices. The planned expansion to counties and Tribes was effective Jan. 1, 2024, and the Minnesota Legislature called for recommendations for adjustments and additions to vendor statutory requirements by Feb. 1, 2024.

In response, DHS enlisted The Improve Group, a Minnesota-based research and evaluation consulting firm, to conduct a study engaging Minnesota's community of individuals and organizations working and accessing substance use recovery resources in feedback sessions to develop the following recommendations:

1. Make organizations meeting Peer Recovery Services (PRS) best practice standards eligible to enroll and provide billable PRS.
2. Vendors providing PRS should meet a common set of standards regardless of the organization type.
3. Assign an oversight body for vendors of PRS.
4. Determine clear standards for certified peer recovery services (CPRS) supervision and provide guidance for vendors on providing and monitoring supervision.
5. Further develop Minnesota standards and guidance for vendor eligibility, supervision and CPRS practice by starting with existing standards and guidance.
6. Create a mechanism for all parties involved with PRS—people in recovery, peers and supervisors—to be able to report concerns to DHS or an oversight body .
7. Create training and awareness campaigns around PRS.

DHS developed these recommendations through the analysis of recovery community feedback on concerns about vendor eligibility, supervisory requirements, and how to ensure quality services in the PRS field.

II. Legislation

Minnesota Session Law 2023, Chapter 61, Article 4, Section 25. ENROLLMENT AND REQUIREMENTS FOR PEER RECOVERY SUPPORT SERVICES VENDORS.

The commissioner of human services must consult with providers, counties, Tribes, recovery community organizations, and the recovery community at large to develop recommendations on whether entities seeking vendor eligibility for medical assistance peer recovery support services should be subject to additional provider statutory and oversight requirements. The commissioner must submit recommendations to the chairs and ranking minority members of the committees with jurisdiction over health and human services by February 1, 2024.

Recommendations must include the additional requirements that may be needed and specify which entities would be subject to the additional requirements. Recommendations must balance the goals of fostering cultures of accountability, applying supportive supervision models, and increasing access to high-quality, culturally responsive medical assistance peer recovery support services.

III. Introduction

Peer Recovery Services (PRS) have been Medicaid-billable services since 2019.[1] The only vendors eligible to bill for these services have been licensed treatment programs (including withdrawal management) and Recovery Community Organizations (RCOs). Effective Jan. 1, 2024, counties and Tribes will also be eligible to bill Medicaid for these services. A 2022 study demonstrated some promising early positive impacts among people in recovery who participated in PRS through Medicaid: notably, their increased likelihood of completing outpatient treatment.[2] Nevertheless, this relatively new legislation has surfaced different interpretations of the law and how best to support and monitor peer services to meet the needs of people in recovery. As a result, PRS have encounter controversy or conflicting views, including related to:

- Vendor statutory requirements
- Accountability expectations for vendors' training and use of Certified Peer Recovery Specialists (CPRS or "Peers")
- The accreditation process for RCOs and if the process ensures quality
- The requirement for time in recovery to become a peer
- The length, cost and content of CPRS training
- The types and quality of billable PRS and activities
- The quality and content of supervision given to peers

While past legislation has addressed some of these concerns (Chapter 50, Article 3), an opportunity remains to engage recovery community partners in further improving PRS legislation.

Terms used in report

This report uses several acronyms or abbreviated references. This table displays the meanings of various acronyms used in the report.

Entity	How referenced throughout report
Peer Recovery Services field	PRS
Certified Peer Recovery Specialist	CPRS or "Peer"

[1] See MN Statute 254B.05, subd. 5, clause (4)
[2] Evaluation of peer recovery services for substance use disorder in Minnesota. 2022. Retrieved 12-22-23 from: https://mn.gov/mmb/assets/MMB_PRS_report_final_20220718_tcm1059-534084.pdf

Entity	How referenced throughout report
Organization qualified to bill for Peer Recovery Services	"Vendor"
Recovery Community Organization	RCO
Substance use disorder treatment facilities	"SUD treatment facility" or "treatment facility"

Study purpose

In recent years, Minnesota has seen the planned expansion of PRS billing eligibility to counties and Tribes; a considerable increase in RCOs; ongoing controversy about how vendor enrollment and requirements do or do not ensure quality PRS; and a legislative call for recommendations. In this context, this study gathered feedback from the recovery community on how to ensure quality care is provided to people in recovery receiving PRS.

To accomplish this, this study sought to examine three overarching questions:

1. What eligibility requirements should exist for vendors of PRS?
2. What supervision requirements should exist for PRS?
3. How should the State ensure quality and accountability within the provision of PRS?

The feedback received informed recommendations for adjustments and additions to vendor enrollment eligibility and requirements for PRS.

Design and methodology

Data collection for this study was primarily qualitative and included three virtual statewide workshops, one Tribally-focused listening session, and eleven (11) key informant interviews with the recovery community in November 2023. A summary of the Tribally-focused listening session in January 2024 is included as an Appendix.

Outreach and recruitment

In September 2023, the Minnesota Department of Human Services (DHS) sent a pre-registration form to gather a list of partners who were interested in participating in an interview. DHS sent the form to many partners groups within the recovery community, including but not limited to individuals and representatives of vendor organizations and SUD treatment facilities, counties, and Tribes. Individuals who responded were invited to register for one or more of the two-hour statewide virtual workshops facilitated by The Improve Group (IG)

evaluation team. IG encouraged recipients to forward the invitation to other colleagues working in PRS. Eighty individuals were contacted directly, and 40 participated in at least one workshop.

IG recruited individuals for key informant interviews using three methods. IG sent email invitations to respondents of the above pre-registration form who indicated interest in only participating in interviews. IG also sent emails to recovery organizations to help in recruiting individuals who are currently or have recently worked with a peer in their recovery journey. IG also supported organizations with public outreach by providing flyers and content for message board posts to those in recovery. Using these methods, 41 individuals were identified and contacted for participation, 11 of whom participated in an interview.

Statewide workshops

Three virtual statewide workshops engaged partners of the recovery community, including providers of licensed treatment centers, RCOs, vendors and peers. Each workshop focused on one of the three study questions above. Facilitating one workshop per study question made the time investment more accessible for participants, as they could engage in three two-hour sessions rather than a day-long workshop.

Workshops collected qualitative and quantitative data through polling in the online presentation software Mentimeter, open discussion and using the online discussion board Padlet to document participant responses to open-ended questions.

The following table shows the number and type of participants attending each workshop.

Workshop attendance by participant type

Workshop	Providers of Substance Use Disorder services	Recovery Community Organizations	Other recovery community parters
Vendor Eligibility	10	15	8
Supervision	5	10	0
Quality and Accountability	9	10	3

Key informant interviews

Key informant interviews targeted a mix of SUD treatment facilities, RCOs, individuals who are currently or recently engaging with a peer, peers, counties and other groups. The table below shows the number of key informant interviewees by type.

Interviewees by participant type

Participant type	Number of interviewees
Counties	1
SUD licensed treatment centers	3
RCOs	2
Individuals with SUD	5

Analysis

The evaluation team analyzed qualitative data through grouping discrete ideas under overarching finding statements that responded to study questions. The evaluation team then presented draft findings statements to DHS and representatives of the recovery community in a two-hour virtual workshop. The purpose of the meeting was for parts to provide feedback and revisions on the findings statements to ensure accuracy.

Crafting recommendations

Following the findings workshop, the evaluation team and DHS reviewed and discussed what the findings point to as feasible and actionable legislative recommendations, and drafted recommendations.

Limitations

The study timeline was short and did not include significant time for outreach. The findings presented reflect input from a wide variety of groups but does not represent a substantial sample of the overall population. If more time was available, the study could have increased the number of total unique peer recovery partners giving their input as well as gotten more precise input and details for recommended policy change. As such the findings below reflect initial high-level sentiments on the three study questions.

IV. Findings

The creation of billable PRS was rooted in the hope of having trained CPRS or “Peers” serve as quality mentors to people in their recovery journey. These Peers could serve as people in recovery’s confidantes and guides in navigating available recovery services and the challenges associated with being in active recovery. Amid the ongoing substance use crisis, the initial implementation of PRS sought to make the Peer role and vendor eligibility widely accessible to reduce barriers to entry for individuals in recovery to become Peers. Since implementation, community partners and the State of Minnesota have recognized refinements or changes are

needed concerning vendor eligibility, supervisory requirements and how to ensure quality services in the PRS field. PRS community partners have, therefore, brought their experiences and foresight to bear in this study. Ensuring quality is a **delicate balance of creating regulations to protect the services and community served while reducing barriers to entry to meet the demand for the service.** It is also important to accommodate the need for adaptability of services across the many contexts of recovery services.

The findings present insights from study participants on how to strike this balance. Throughout data collection, participants suggested aligning standards with existing national best practices such as those listed below.

Peer Recovery Support Best Practice Guidelines

- Center for Substance Abuse Treatment, *What are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.
- Minnesota Certification Board. https://www.mcboard.org/peer-recovery/
- National Association of Peer Supporters (2019). *National Practice Guidelines for Peer Specialists and Supervisors.* Washington, DC: N.A.P.S.

A. Vendor eligibility

Vendors should have a transparent governance structure demonstrating their ability to support Peers.

Multiple community groups strongly agreed that it is critical for vendors to have a transparent governance structure and clear articulation of who is providing support to supervisors and the Peers they supervise. This can provide evidence that a vendor organization can support its Peer employees and/or contractors and has the capacity to provide this support on an ongoing basis. For example, an organization could show the calculation of the number of CPRS on staff, CPRS average billable day, the total number of supervision hours needed per week (based on 1:20 requirement) and the total number of supervisors providing support. While participants did not describe what the base level of capacity should be for organizations to provide adequate management of CPRS, calculating FTE for supervision and potential training time may be a starting place. Likewise, some workshop participants proposed that organizations publicly post how and who funds their work, indicating that it would be helpful to enable people in recovery to understand an organizations' management of CPRS staff and their practices. Participants said a transparent governance structure should include:

- a quality assurance plan
- leadership transition contingency plans
- transparent funding structures
- demonstrated capacity to manage contractors and/or employees

Workshop and interview participants acknowledged the tension between creating more strict standards to support Peers, while decreasing barriers to entry for organizations to become PRS vendors. Community partners recognize that demand is still high for PRS and having more vendors would enable those in recovery greater access to a Peer. A few interview and workshop participants said vendors should provide Peers with tailored training based on the type of the vendor organization, for example, how to operate effectively when working in

a treatment facility. Some workshop participants representing RCOs said another benefit of a formalized governance and organizational structure is increased opportunities for CPRS training and advancement.

Vendors providing PRS should meet a common standards regardless of the organization type.

Workshop and interview participants representing multiple groups said vendors should meet a common baseline standards verified through an application process, akin to licensed treatment facility requirements. They agreed that organizations of all types should be held to these common standards. To develop the standards, the State could look to U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) guidance on quality PRS and adapt the guidance to accommodate needs and contexts unique to Minnesota.[3] There was a strong consensus among RCO vendors in the workshop that current vendors should be grandfathered into new vendor requirements rather than being required to reapply.

As part of these standards, vendors should be required to report and document outcomes and practices, both for required reporting and in case of auditing. Additionally, the application and eligibility should require vendor completion of training regarding the purpose and use of Peers. This training should provide an overview of the CPRS role, how it is unique compared to other treatment-related roles and appropriate activities for the role.

Partners described situations when CPRS services could be beneficial but are not eligible for billing.

In general, interview and workshop participants across multiple groups noted circumstances where PRS were not eligible for billing, and this ineligibility created a gap in services or a difficult hand-off between one billable setting and another. From the perspective of someone in recovery receiving PRS, this would manifest as not having the option of working with a Peer or having to abruptly stop seeing one of their current Peers until they could find a Peer through a new vendor that would be eligible to bill for their new service setting. Mental health and SUD treatment professionals expressed in workshops that vendor eligibility should be expanded to include organizations or entities in tangential fields that may work with individuals with SUD, such as organizations providing mental health, housing, and employment support. Providers recommended that rural federally qualified health clinics (FQHCs) that provide SUD and mental health services also be eligible to provide PRS. The took the position that rural areas have a dearth of vendors and that co-locating PRS with other services people in recovery are likely to use would support greater access to the health care they need.

Workshop participants representing SUD treatment facilities said organizations that provide multiple services (e.g. SUD treatment, housing services, targeted case management, etc.) could benefit from having PRS as a standalone service to support individuals before and after entering a licensed treatment facility. Similarly, a representative of a youth-serving RCO said in an interview that PRS provided as part of a prevention initiative for youth beginning to experiment with substance use but not diagnosed with SUD are not currently eligible for reimbursement.

[3] Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009. Retrieved 12/13/2023 from: https://store.samhsa.gov/sites/default/files/sma09-4454.pdf

B. Supervision

An oversight body should hold vendors and supervisors responsible for the quality of services provided by the Peers they supervise.

Workshop and interview participants representing multiple groups identified the need for an oversight body—such as DHS—to hold vendors and their Peer supervisors responsible for the quality of services provided by their Peers. Participants did not agree upon, nor have strong feelings about, who should be the oversight body. Similarly, there was no comment about whether the oversight body should be the same as that which approves PRS vendors, though the oversight body was assumed to have purview over all vendor types (e.g. RCOs, treatment centers, and additional entities meeting vendor criteria). Supervisors should be accountable for ensuring Peers provide appropriate services in alignment with the purpose of PRS, including ensuring Peers have no prior or current personal relationships with the people in recovery they are supporting. In interviews and workshops, participants representing RCOs and other vendor types said supervisors should also have to complete the required training that their Peer supervisees complete or a training that could be developed about the intent and use of PRS.

All supervisory meetings should include administrative, clinical, supportive and educational components that meet existing standards.

Participants representing multiple groups said in interviews and workshops that supervision standards and expectations should specify that supervision covers multiple topics. These include administrative supervision, clinical supervision, supporting a Peer in their wellness and self-care plans and providing oversight of professional development and education. Interviewees representing vendors and SUD treatment facilities said requiring a certain percentage of all supervision hours be dedicated to clinical support would better ensure quality services, as Peers would review cases of people receiving PRS with a supervisor to troubleshoot and improve care. Supervisors should also support and promote Peer well-being and self-care. An interview participant suggested there may be existing guidance regarding best practices in supervising PRS services. A representative from the Minnesota Certification Board suggested drawing on the Board's existing supervision best practices.

Partners are generally in agreement about the structure of supervision, with disagreement between virtual and in-person requirements.

Many participants, in interviews and workshops, agreed that most supervision should be one-on-one and that a smaller portion of supervision (such as administrative supervision) should occur in a group setting. There was general agreement across community partners with the current standard of one hour of supervision per 20 hours of people in recovery interaction. Some workshop participants representing RCOs noted that certain Peers may not provide frequent services, leading to large gaps between supervision meetings under this standard. For this reason, some agreed with amending the requirement to be one hour of supervision per every 20 hours of people in recovery interaction or once every three weeks, whichever comes first.

Participants' views differed on the format of supervisory meetings, with some interviewees suggesting a certain number of meetings be in person. Conversely, some workshop participants representing rural RCOs, as well as a

different interview participant representing a treatment facility, raised the value of solely virtual supervision, particularly in rural communities.

Supervisors should be required to meet minimum standards related to training and education on PRS.

Workshop participants suggested one set of shared standards across the state, regardless of vendor type or setting, could better ensure quality supervision. They agreed that supervisors should be required to demonstrate some level of understanding of the work of Peers and demonstrate a dedication to ongoing education about PRS, such as through training and the requirement of ongoing Continuing Education Units (CEUs). A baseline training for supervisors could cover the purpose, intent and appropriate services for Peers. Workshop participants acknowledged that supervisors would ideally be individuals trained in supervision with personal experience as a Peer themselves, but that the newness of the field makes that a challenge. Interview participants representing treatment facilities and members of the larger recovery community agreed that supervisors should have some experience providing treatment services or being a licensed alcohol and drug counselor (LADC).

A set of minimum standards and guidance for supervisor training and activities would also support vendors in better understanding how to provide quality supervision to Peers. Workshop participants representing both RCOs and SUD treatment facilities acknowledged the challenge of finding highly qualified candidates meeting all the criteria above. In discussions with DHS concerning these suggested standards for supervisors, DHS staff suggested allowing for multiple supervisors per Peer, providing the Peer with either a single supervisor or supervision team that meets the above criteria.

C. Quality and accountability

Time in recovery, lived experience and self-care plans emerged as eligibility criteria for CPRS.

Many interview and workshop participants discussed creating criteria that ensure quality, safety and accessibility for people in recovery to serve their community as Peers. The current criterion of “12 months in recovery,” which requires considerable nuance and definition to accurately enforce or measure, was described as a criterion but often used as a general benchmark. To better ensure potential Peers are further along in their recovery, some workshop and interview participants suggested increasing this requirement to 18-24 months. Conversely, a few workshop and interview participants expressed disagreement with this, noting other systems are in place to ensure Peer safety and stability.

Lived experience in recovery was a strongly agreed-upon requirement, who said lived experience equips Peers with the knowledge of how to navigate the treatment world and an understanding of common challenges and barriers. Criteria could also require plans for Peers to take care of themselves, like committing to creating a self-care and wellness plan and having a plan for navigating threats to their sobriety and potential relapse. Many workshop and interview participants agreed that Peers should be able to be credentialed as a Peer in more than one area, such as also being a mental health Peer, and have endorsements that better describe their lived experience in treatment.

There is a need for an overarching review body.

Many interview and workshop participants said they see the need for an overarching PRS review body to promote quality and accountability and ensure consistent services across the state. This overarching body, whether it be DHS or another entity, could:

- Conduct vendor audits
- Monitor and analyze billing data (i.e., billable hours and activities) to identify abuse, promote quality and identify trends
- Provide overarching guidance to the field

At the same time, most participants were strongly opposed to a common data entry platform. Participants suggested instead that DHS communicate the data they would like to collect and accept organizations' forms to submit that data.

Multiple levels of feedback loops need to be established and clear.

Most workshop and interview participants representing multiple groups called for transparent reporting systems for airing concerns with services, supervision or vendors. This includes mechanisms for:

- People receiving PRS reporting concerns regarding their Peer to supervisors, vendors or DHS
- Peers reporting concerns regarding their supervisor or vendor to DHS
- Supervisors reporting concerns regarding their supervisee or vendor to their vendor or DHS

All supervisors should have a defined process to document the quality and accountability of Peers.

Many workshop and interview participants representing multiple groups pointed to ways supervisors can document Peer activities to improve quality and accountability. They suggested supervisors track by individual Peer:

- Date, duration, and completion of Peer appointments with people receiving PRS
- Peer wellness and progress toward their wellness goals
- Recertification and CEUs

Many of these participants also said supervisors should ensure proper supervision by documenting CPRS career and educational goals, progress toward these goals and job performance. This documentation should be done for internal use and communication, supporting their supervisee with time to reflect on these indicators and use them as a discussion point to support the Peer and ensure the quality of their services.

CPRS documentation should support billing requirements and monitor people in recovery progress.

In addition to what supervisors track, many workshop and interview participants representing multiple groups said Peers should track the following with people in recovery to monitor their progress and support billing requirements:

- Date, duration and completion of each appointment

- Goals and progress toward goals, including alignment of activities to goals
- People in recovery wellness plans

The intention of completing this documentation with people in recovery is to create an opportunity for reflection and planning around people in recovery activities with Peers.

Most PRS vendors have existing practices to handle relapse occurrences and want to continue navigating this in-house.

Many workshop and interview participants agreed that vendors should be responsible for providing oversight and support for maintaining the health and safety of their Peers. Opinions diverged on how to handle relapse. Many workshop and interview participants said they believe addiction should be treated as a chronic health condition, in which symptoms—in this instance, substance use—are monitored for their impact on fulfilling job responsibilities. Conversely, a few workshop and interview participants said they believe a relapse should lead to a complete suspension of CPRS certification and require an extended period of sobriety before delivering services, as compared to the original 1-year in recovery for initial credentialing.

Most partners feel current continuing education requirements are satisfactory, while some feel they are excessive compared to similar roles.

Most workshop and interview participants said current continuing education requirements are satisfactory. Some workshop participants representing SUD treatment facilities expressed, however, that CPRS CEU requirements exceed those required in similar roles, such as for LADCs.

A peer support network would benefit Peers.

Some participants in both workshops and interviews said a peer support network across the state could benefit Peers with learning, support and ensuring quality.

There should be a standardized base training curriculum to become a Peer, with additions and tailoring permitted per credentialing vendor.

Participants recommended standardized training for Peers. They noted many existing resources can be referenced for a standardized training curriculum, including national standards. There was strong agreement that the current required 46 hours of training was adequate, while some recommended spreading the training hours out, theorizing that it would increase knowledge retention. Some participants said that the standardized curriculum should include topics on de-escalation, crisis management and the intent of PRS. A few also suggested requiring practicums or internships as part of the certification training. Additionally, participants noted it would be beneficial to provide vendor-tailored training, such as on how the role of a Peer looks different in a treatment facility compared to an RCO.

V. Report recommendations

The following recommendations are in response to the legislative request.

1. Make organizations meeting Peer Recovery Services (PRS) best practice standards eligible to enroll and provide billable PRS.

The recovery community suggests that Minnesota create its own standards for eligibility to be a vendor rather than have different standards based on organizational type. These standards, so long as they are applied no matter the setting or organization type, can be used to determine eligibility. This will expand the pool of potential vendors—and thus Peers who can serve the community—while maintaining quality. It will increase opportunities for vendors providing similar or aligned services in other areas, such as mental health, to serve the same people in recovery and better meet people in recoverys' needs. Due to current billing structure and systems, hospitals may be excluded from those eligible to provide billable PRS.

Some standards and best practice resources as useful in determining requirements in Minnesota that were referenced in workshops were:

- Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.
- Minnesota Certification Board. https://www.mcboard.org/peer-recovery/
- National Association of Peer Supporters (2019). *National Practice Guidelines for Peer Specialists and Supervisors.* Washington, DC: N.A.P.S.

2. Vendors providing PRS should meet a common set of standards regardless of the organization type.

Minimum statutory requirement standards should include evidence of the following:

- Financial transparency to the public. Organizations must post on their website and provide in their vendor application, who major funders are for its work and/or the funding streams which allow it to operate.
- Adequate supervisors to support the supervision requirements
- Multiple non-CPRS staff who have completed training that covers in-depth knowledge of the scope of PRS
- CPRS supervision that provides clinical, administrative and lived experience support

3. Assign an oversight body for vendors of PRS.

Community partners suggested an existing body may be able to provide this oversight with additional support and some adaptation in purpose and structure. Monitoring processes should be developed to ensure vendors continue to meet minimum statutory requirements beyond their initial approval and entry into billable PRS.

4. Determine clear standards for CPRS supervision and provide guidance for vendors on providing and monitoring supervision.

Standards for supervision should include:

- Guidance concerning appropriate activities for providing CPRS support
- Clinical support and supervision
- Administrative supervision tasks
- Attending to CPRS well-being and self-care

Recognizing that it may be difficult to identify one individual supervisor with all ideal qualifications, more than one supervisor could supervise a Peer.

5. Craft Minnesota standards and guidance for vendor eligibility, supervision and CPRS practice by starting with existing standards and guidance.

Multiple national and state entities have already created guidance around practices in PRS and CPRS services (see list of existing resources above). Even more, complementary or aligned professions (e.g. mental health) that have been practicing for longer may also have effective content, furthering cross-sector alignment across health care practices people in recovery may experience. Gathering existing resources and practices and selecting relevant points will allow Minnesota to align with national efforts, customize for the Minnesota context, and efficiently decide on requirements. Moreover, leveraging existing examples will improve communication and awareness-building as professionals in the field will likely already be knowledgeable on this content.

6. Create a mechanism for all parties involved with PRS—people in recovery, Peers and supervisors—to be able to report concerns to DHS or the oversight body noted above.

Everyone involved with PRS should be able to anonymously report concerns about safety, eligibility and exploitation. Some mechanisms already exist for some of these groups to report concerns, but they are not well-known.

7. Create training and awareness campaigns around PRS.

Vendors of PRS and their supervisors need better training on the intention behind PRS, the ethical requirements for service delivery and how to report concerns about Peers. Peers, supervisors and people in recoverys' need better communication about how to report concerns. Communication about reporting concerns should include both existing mechanisms as well as new processes and pathways once they are established. CPRS certification bodies, the oversight body, or DHS could implement this training and/or communication campaign.

VI. Appendices

Appendix A. Workshop One Agenda

- **Welcome**
- **Overview of project & aims**
- **Project background presentation**
- **Instructions on small groups**
- **Small group breakouts (3 groups, combine individuals with SUD with counties)**
    - Brainstorm individually. As you think about what you understand about the different vendors and what is expected of them, what should eligibility/requirements look like in order to be an RCO, CPRS or a County provider? What kind of processes should be in place? These can be existing or new. What considerations should DHS hold as it makes recommendations to the legislature about any changes it should or should not make to eligibility? Everyone turn on camera or raise hand once you've written at least seven ideas and feel ready.
    - Review those of others and use a thumbs up or thumbs down to show agreement or disagreement where applicable.
    - Discuss as a small group what you notice. *Some potential prompts:*
        - Where do you agree with what someone else said?
        - Where do you disagree or need clarification?
        - What else is missing? Look at the ideas you didn't add to the padlet – do you have others you'd consider to be of high priority? Add them to the padlet.
- **Next steps**

Appendix B. Workshop Two Agenda

- **Welcome**
- **Overview of project & aims**
- **Project background presentation**
- **Instructions on small groups**
- **Small group breakouts (3 groups, combine individuals with SUD with counties)**
    - What supervision practices make sense?
    - Revisiting what we just populated when thinking about requirements you would add for CPRS – which of these stood out to you as a good idea, and why?
    - What supervision practices are unclear or vague or you have concerns?
    - There is concern that people in recovery who are CPRS may need their own support to remain in recovery when working with other people on their recovery journey, or that this work could cause relapse. What support would you suggest offering?
    - If a supervisor or other individual has concerns about a CPRS' recovery, what is the current process for them to bring up their concerns? What systems are in place to address this? To what extent is this needed?

    - What standards are needed to ensure a person in recovery is getting help? (e.g. think of what activities people currently bill for. Should there be any changes to these activities?) the Services could be thought of as: content (i.e. activities/topics), frequency (daily/weekly), amount (max 1 hour).
- **Next steps**

Appendix C. Workshop Three Agenda

- **Welcome**
- **Overview of project & aims**
- **Project background presentation**
- **Instructions on small groups**
- **Small group breakouts (3 groups, combine individuals with SUD with counties)**
    - **PART 1**
    - Take time to think by yourself and then add your ideas to the padlet.
    - Move your ideas from the brainstorming columns to the appropriate column that describes why you would suggest these ideas.
    - Vote on items according to what you agree and disagree with, as applicable.
    - Prompts
        - **What should recording and tracking of people in recovery work look like?**
        - **What should recording and tracking of supervision look like?**
        - CPRS monitoring pathway –
        - Supervisor doing their job, helping them with performance, does any further/higher level accountability loop needed?
        - When should supervisors NOT be responsible?
        - What should DHS be doing/their role?
- **Next steps**

Appendix D. Tribal Listening Session Agenda

- **Welcome, land acknowledgement**
- **Overview of project & aims**
- **Guardrails/foundational elements of the topic**
    - Recap of question areas:
    - What requirements do you want CPRS to follow or achieve in order to be eligible to provide Peer Services for a Tribe or American Indians?
    - What do you think supervision should look like to ensure Peer Services are helping your community members? What support or expectations do you have of DHS in this space?
    - What should accountability measures look like between those billing for Peer Services and the state (who is charged with disbursing funding)? What system are you currently using to bill for services? What do you suggest in order to now expand to bill Medicaid? How does this opportunity to bill through Medicaid affect your processes?
        - What advice do you have on the above topics?
- **Next steps**

Appendix E Tribal Listening Session Summary

Background and purpose

Peer Recovery Services (PRS) have been Medicaid billable services since 2019 and the only vendors eligible to bill for these services have been Substance Use Disorder (SUD) licensed treatment programs, Recovery Community Organizations (RCO), and licensed professionals in private practices who meet the requirements of section 245G.11, subdivisions 1 and 4. Tribes and American Indian-serving organizations have been providing PRS, either unpaid or through alternative funding streams, or through billing their tribally licensed SUD programs. Effective January 1, 2024 or upon federal approval, whichever is later, counties will also be eligible to bill for Medicaid for these services. .

In December 2023, The Improve Group (IG) hosted a listening session with sovereign Tribal Nations in the shared geographic region of the State of Minnesota. The scope of this session was to gather feedback related to the three study questions, focusing on points of intersection and topics salient to Tribes:

1. What eligibility requirements should exist to bill for peer recovery services?
2. What supervision requirements should exist for peer recovery services?
3. How should DHS ensure quality and accountability of peer recovery services?

The listening session format and invitation was intended to provide a culturally responsive method for Tribes to give voice to their specific context—and sovereign status—in using and billing for PRS. Several individuals also attended to learn more about the existing PRS system and how Certified Peer Recovery Specialists (CPRS or "Peers") are implementing peer recovery services. Seven individuals belonging to several Tribes attended the workshop, with some having experience providing PRS as a non-Medicaid-billable service through their Tribe or American Indian-serving organization. The group represented organizations serving both urban and rural communities. This document summarizes the information shared during the session.

Summary

Overall, the group emphasized the importance of connection or reconnection to one's Tribe and culture in an individual's recovery journey. Attendees referenced this as best practice; thus, appropriate billable activities must include connecting or reconnecting to one's Tribe and culture. Current billing parameters cap CPRS billable time per individual client (one Tribe prefers the term "relative," which will therefore be used in the rest of the report) at 2 hours a day; however, Tribal cultural activities are often full or multiple-day events. This tension will need to be resolved in order to recognize the ways Peers support their relatives.

Current practices

Participants described how they are currently required to provide PRS in some situations; an attendee said, "We have effectively provided it as an unfunded mandate." Several attendees also said they provide PRS because they see the benefits it has in supporting an individual's recovery, centering this outcome despite the service being under or un-resourced. The **need to provide a nonbillable service has been a point of frustration**. To

date, Tribes have used different funding sources and rates to support PRS when possible; therefore, funding is inconsistent.

Participants expressed a **lack of clarity** around the eligibility for a service to be billable through Medicaid starting January 1, 2024 or upon federal approval, whichever is later. One person described being able to bill for PRS during outpatient treatment under the encounter rate if a health plan is present or within the behavioral health fund if there isn't a health plan.

A couple participants referenced using the CPRS training provided by White Earth Tribal and Community College. However, a few other participants expressed **uncertainty surrounding future training requirements**, like who can provide certification at the completion of training and to what extent, if at all, training is a billable activity. One attendee said that the Upper Midwest Indian Council on Addictive Disorders (UMICAD) currently, and should in the future, provide certification. Attendees discussed the desire for culturally specific CPRS training and its importance in providing PRS services within Tribal Nations and with American Indians not served through their Tribe.

Current context

Participants described the current confusion and concerns surrounding PRS, with uncertainty regarding how issues will be resolved when the new legislation begins. They described how rates are not consistent across services. Participants were unsure why the rates are the same regardless of whether you are providing culturally specific or non-culturally specific services. They acknowledged that clarification may be coming on recommended changes. However, the status of those recommendations and changes remains unclear.

Participants discussed the unique context of providing recovery services to American Indian clients. Disconnection from culture as a result of genocidal and racist practices is a root cause of higher SUD among American Indian populations.[4] Relatives on their recovery journey use connection or reconnection to their Tribe and culture as an anchor within their recovery, participants said. Establishing this connection is a key component of one's recovery plan. Participants gave multiple examples of the positive impact of Peers supporting their relatives to participate in cultural activities.

Who CPRS are

Participants described that Peers are often individuals who are entering a phase of recovery where their lives are stabilizing, and they are seeking opportunities to serve their community. The time in which an individual may become a Peer could be one of transition. A participant reflected that serving as a Peer can be a unique opportunity for someone to find work relatively early on in their recovery while the Peer is still identifying and pursuing a long-term career. This means that there is often a specific window when someone is ready and able to be a Peer (i.e. meets the minimum 1-year in recovery requirement) and when they may be in a place to

[4] Skewes, M. C., & Blume, A. W. (2019). Understanding the link between racial trauma and substance use among American Indians. *American Psychologist, 74*(1), 88–100. https://doi.org/10.1037/amp0000331

transition to a different long-term career. This window should be considered if CPRS eligibility requirements increase the required time in recovery.

Participants also described the challenges of defining "in recovery" for everyone. Several participants pointed out that harm reduction is an effective technique for supporting individuals in their recovery but does not seem to be within the definition of "in recovery" for the CPRS certification. Some participants suggested that not all recovery journeys include abstinence, and this should not bar someone from being able to be a CPRS. Some also suggested that employers of CPRS (e.g. Tribe or American Indian-serving organization) should be able to determine the length of sobriety a Peer should complete prior to certification. Considering these requirements can prevent a shortage of Peers by eliminating barriers to becoming a Peer when someone is considered well-established in their recovery, a unique challenge that can present in rural and Northern Minnesota as well as small Tribes.

Peer requirements

Currently, Tribes train individuals in PRS before they begin supporting relatives. The existing training in one Tribe includes 48 hours of material. A few participants described developing their own training in collaboration with White Earth Tribal and Community College.

For ongoing training, participants suggested that Peers should attest to completing ongoing CEUs and being in a mentally healthy state rather than apply for annual and biannual recertification. They discussed how this is standard for other mental health professionals. Some participants also said that the certification process is less known to Tribes; someone who has worked to certify Peers reported that the application can be challenging to navigate. They described that Peers often feel new in their recovery and can sometimes be recently out of jail; Peers can be navigating barriers of self-doubt that make it challenging to navigate systems.

Supervision

Participants described the importance of supervision, including a strong cultural understanding of the role of the supervisor and Peer's relationship with their Tribe and culture within their recovery journey. This knowledge is essential to supporting a Peer in their own recovery and in their practice of supporting others in recovery. Tribal communities can be small and close-knit, and follow-through care in someone's recovery is important. One Tribe described that their supervisors go through supervision training and practicum and that these supervisors go on to have continuous supervision support (supervisor supervision). They noted that this has been particularly helpful for those who are new to supervision.

In discussing credentialing requirements for supervision, participants described how UMICAD credential levels align with those outside of UMICAD. They stated that UMICAD Levels 2 and 3 should be considered in alignment with that of a Licensed Alcohol and Drug Counselor (LADC), and they should thus be considered eligible to be a supervisor.

Practice of supervision

Participants felt that requiring 50 percent of supervision hours to be in person is a substantial time commitment, and potentially too high of a requirement. When discussing the appropriate amount of time to be spent in supervision in general, participants felt that the requirement should reflect years of service and compared this to similar professions within the recovery field. A participant suggested that if someone is in the field for more years of practice, their required supervision hours should decrease. One suggestion was that after one year of practice, supervision could be decreased to one hour per every 40 hours of service. After five years of practice, supervision requirements could drop completely.

Billable services

Participants discussed the challenges of defining billable services and translating the general state requirements for practices within Tribal Nations. Participants had ongoing questions about whether Peers can bill for group services or only one-to-one services. Several individuals felt that the group settings should be billed because of their importance in recovery and, specifically, in how people learn about their culture.

> *"In Native country, we utilize culture a lot in the recovery process, but there's nothing written about the ceremonial or cultural activities we do that are billable services, and that's something that has to be brought up and talked about."*
> *- Listening Session Participant*

Activities that connect an individual to their Tribe or culture often are much longer than the 120-minute daily cap per individual of billable PRS service. Additionally, these activities often take place in group settings—which multiple individuals in recovery can benefit from doing together—which then fall outside the bounds of one-to-one services. Participants expressed needing guidance on how to navigate billing for activities that emphasize the role of a relationship with the Tribe and one's culture in their recovery journey, such as attending a sweat lodge or Powwow. Additionally, participants felt that a Peer should be able to bill for supporting an individual as they enroll with their Tribe.

Two perspectives emerged about what should be billed in support of culture. One described the role of a Peer to be the "resource broker" who links relatives to the people in the community who do ceremonies or other cultural activities. In doing so, the role of the Peer is to establish the relationship for the relative, which would be the billable activity, and participation in the activity would be a nonbillable engagement that went above and beyond establishing that connection. Others felt that a Peer's attendance at these activities/events with one or more relatives should be billable. Examples of cultural practices as appropriate billable activities included but are not limited to:

- Sweat lodges,
- Skinning a deer,
- Women's singing and dress making,
- Powwow,
- Ricing,
- Maple syrup and sugar collection,

- Hunting and trapping, and
- Language lessons.

One participant suggested that the determining factor for defining a billable activity should be how it relates to an individual's recovery plan. If the recovery plan includes a connection or reconnection to the individual's Tribe or culture, then activities associated with that should be billable. Several described how useful transporting their clients to activities is for building relationships and providing support, and that providing transportation should be billable.

Appendix F. Interview Protocol

Introduction and consent language.

Warm up

1. How would you describe your role in the recovery community? [if an organization/RCO] Tell me a little about your organization. How many CPRSs do you work with, how does training work?

Billable Peer Recovery Services

Peer Recovery Services are defined as "non-clinical one-to-one support where trained individuals who are more established in recovery come alongside people currently in the recovery journey and provide guidance in the treatment process."

2. What types of peer recovery services do you offer/hope to offer/use?
    a. Frequency? – how often are these services offered or used?
    b. Content? – What types of topics are being covered?
    c. Documentation? – how is participation documented?
    d. Follow-up? – How often do follow-ups occur?
3. The current definition of Peer Recovery Services does not list any minimum standards or restrictions for what services should be billable under Medical Assistance. Do you think there is a need for standard activities?
    a. If yes, what should be included in these standards? E.g. sobriety check-ins, goal setting activities, recovery progress tracking – successes and challenges
    b. If no, help me understand your rationale?
4. Are there any other types of recovery services provided by peers that should be billable as peer recovery services?
5. **Tribes only** – How would you change this definition of billable peer recovery services to better fit in with the needs of your community?

Certified Peer Recovery Specialist

Certified Peer Recovery Specialists are defined as people with a history of substance use disorder who are successful in their recovery and trained and certified to provide support for others in their recovery process.

[Ask only if have this position/role]

Counties and Tribes	**Peers with SUD**
How do you foresee integrating peer recovery specialists into your organization?	Think about a time when you met with a peer recovery specialist, how would you describe this experience?
What barriers might you face in integrating peer recovery specialists into your organization?	How were you matched with this peer recovery specialist?
What support will you need to address these barriers?	What recommendations do you have for what matching should look like?

Eligibility requirements:

Currently the eligibility requirements for Certified Peer Recovery Specialist includes:

A. Have a high school diploma or its equivalent.
B. Have a minimum of one year in recovery from substance use disorder.
C. Hold a current credential from the Minnesota Certification Board, the Upper Midwest Indian Council on Addictive Disorders, or the National Association for Alcoholism and Drug Abuse Counselors. An individual may also receive a credential from a tribal nation when providing peer recovery support services in a tribally licensed program.
D. Receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor.

6. What do you think of the eligibility requirements?
    a. Are any of these requirements unclear or not well defined?
    b. Should any of these requirements be removed?
    c. Are there any additional requirements that should be added to better fit in with the needs of your community?

Certification

For a Peer Recovery Specialist to be certified through an accredited association they must complete 46 hours of training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support.

7. Are these training requirements for peer recovery specialists sufficient?
    a. If yes, why?
    b. If no, what changes would you make to these requirements?

Relapse

8. Peer recovery services are helpful in part because the CPRS has lived and shared experience with recovery. With this benefit comes a shared need to support both the people in recovery and CPRS professional in their sobriety. If any, what role and responsibility should supervisors/employer organizations and/or DHS have in oversight of and consequences to a CPRS relapsing?

Supervision

Supervision is somewhat defined for non-RCOs who employ CPRS's, but not at all for RCOs and DHS-licensed treatment facilities. Knowing that supervision is both helpful for staff to feel supported as well as can provide an oversight mechanism for ensuring quality services, tell us what you think this system should look like.

9. Current Vendors only - How would you describe the supervision model currently being used with CPRSs at your organization?
    a. Frequency? – how often does it happen?
    b. Content? – What types of topics are being covered?
    c. Documentation? – how is participation documented?
    d. Follow-up? – How often do follow-ups occur?
10. While supervision of peer recovery specialists is listed as a requirement, the specific frequency, content, documentation, and follow-up requirements are not specified for RCOs. If the state were to establish a standardized model of supervision for CPRSs, what should they include?
11. What should it look like to provide evidence of supervision to DHS? What role should they play?

Recovery Community Organizations

Recovery Community Organizations are defined as "independent, nonprofit, non-clinical organizations led and governed by representatives of local communities of recovery, including people in recovery from substance use disorder, their families, friends, and allies. RCOs honor all pathways to recovery and are not treatment providers."

Currently, RCOs that hold membership under The Association of Recovery Community Organizations (ARCO) are eligible to bill for peer recovery services through Minnesota Health Care Programs (MHCP).

12. How does membership in a national organization, ARCO, help RCOs in addressing Minnesota's diverse recovery needs?
13. How does membership in a national organization, ARCO, hinder RCOs in addressing Minnesota's diverse recovery needs?
14. Holding membership in ARCO is currently the only requirement for RCOs *to be eligible to bill for peer recovery services*; what, if any, additional requirements do you think are needed for RCOs?

Conclusion

15. As vendor eligibility further expands to include counties and Tribes; what additional recommendations about recovery specialist vendor eligibility requirements and oversight would you like to offer?