PAYING FOR SUD RECOVERY SUPPORTS IN NH - AN ENVIRONMENTAL SCAN AND RECOMMENDATIONS FOR NEXT STEPS

Prepared by the Medicaid Subcommittee of the Governor's Commission Recovery Task Force[1]

September 11, 2015

I. Introduction

New Hampshire is in the initial stages of building a system of recovery supports for people with substance use disorders (SUDs). Reimbursement for peer and non-peer recovery supports offered to New Hampshire's Medicaid Expansion population became available on September 1, 2015; however, providers and programs eligible to provide the services are limited and do not include peer recovery support specialists, recovery community organizations (RCOs), facilitating organizations (FOs), or recovery community centers (RCCs), all of which have been recognized as important components of the recovery support system of care. At its July 10, 2015 meeting, the Recovery Task Force of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery (Governor's Commission) created a subcommittee to explore Medicaid and other reimbursement mechanisms for recovery support services. The charge to the Subcommittee was to review how recovery support services in other states are reimbursed and to make a recommendation to the Recovery Task Force regarding reimbursement, particularly Medicaid reimbursement, for the delivery of recovery support services in New Hampshire. The Subcommittee's review of reimbursement for recovery support services in other states necessarily included a review of related certification and accreditation requirements, in light of the fact that both public and private insurers have established certification and accreditation requirements that are pre-requisite to reimbursement for the services.

It is estimated that up to 100,000 people in New Hampshire are struggling with substance use disorders (SUDs).[2] Despite the fact that SUD treatment is effective, many people with SUD experience repeated cycles of deteriorating health, dysfunctional behaviors, and relapse. Today there is ample evidence that addiction is a treatable disease and recovery is an achievable reality. Approximately 23.5 million people in the United States are living in long term recovery from misuse of drugs and alcohol.[3] SUDs are recognized as chronic rather than acute conditions.[4]

---

[1] Members of the Subcommittee include Linda Saunders Paquette (Chair), Cori Sheedy, Liz Hennig, Holly Cekala, Abby Shockley, Michele Merritt, Cheryle Pacapelli and Sandi Coyle.

[2] SAMHSA's Center for Behavioral Health Statistics and Quality's *National Survey on Drug Use and Health* found that nearly nine percent of individuals age 12 and over in New Hampshire misused alcohol or drugs in 2012. This represents nearly 100,000 New Hampshire residents.

[3] Faces and Voices of Recovery, *Life in Recovery – Report on the Survey Findings,* April 2013.

[4] The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), recognizes substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Similar to recovery from other chronic diseases, recovery from an SUD is best understood as a process that responds effectively to treatment and psychosocial and cultural supports, particularly peer recovery support services (PRSS). As the term implies, these services are designed and delivered by people who have experienced both a substance use disorder and recovery. PRSS have proven effective in engaging people in clinical treatment, extending the effects of such treatment, and reaching well beyond treatment into individuals' everyday environments for the long term.

Enactment of the 2010 Patient Protection and Affordable Care Act (ACA) is having a profound impact on the delivery of healthcare services in the United States. The environment in which PRSS are funded and delivered is rapidly evolving to address the requirements of the ACA. With the passage of the ACA, there is an increased focus on the role of community health workers (CHWs), and on the certification of peers and accreditation of organizations in the addictions field. Two identified trends are (1) the certification of peer specialists that can lead to improved reimbursement status under Medicaid, and (2) the importance of adequate training for peer supervisors. Another trend appears to be increased reimbursement for peer recovery supports by private health insurance plans. The CHW classification was cited as a model for a peer recovery workforce.[5] At the same time, accreditation efforts that position RCOs and other recovery programs providing PRSS for sustained growth are being undertaken by the national addiction recovery organization Faces & Voices of Recovery.

As the health care environment changes with the implementation of the 2008 Mental Health Parity and Addiction Equity Act and the ACA, traditional notions of segregating substance use services from the rest of medical care will recede. Addictions will be addressed as a chronic disease, and the recovery community and the Recovery Community Services Program (RCSP) have prepared the way for PRSS to be a part of the expanded and integrated continuum of health services that emerges as part of the changing health care environment.

a) Medicaid Reimbursement for Peer Recovery Support Services

On August 15, 2007, the Center for Medicare and Medicaid Services (CMS) issued a letter to state Medicaid directors, the purpose of which was to provide guidance to states interested in reimbursement for peer recovery support services under the Medicaid program. The letter set forth the following guidance regarding the delivery of peer supports under the Medicaid program:

> **Delivery of Peer Support Services**
>
> Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for

[5] *See* Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (September, 2012). Perspectives on the Evolution and Future of Peer Recovery Support Services. Rockville, MD., piii

peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing

Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

In a subsequent communication issued by CMS on May 1, 2013, CMS peer support policy was further clarified. The communication indicated that reimbursable peer support is available to parents of Medicaid eligible children when the service is directed exclusively toward the benefit of a Medicaid-eligible child and is aimed at assisting the parents/legal guardians during the child's recovery process. The requirements set forth in the August 2007 letter must be met in order for peer support services to be reimbursable under the Medicaid program.

In March 2014, NH Governor Maggie Hassan signed into law Senate Bill (SB) 413, the NH Health Protection Program – New Hampshire's version of Medicaid expansion. Under this law, New Hampshire is required to provide substance use disorder services, one of the ten required essential health benefits, to eligible recipients. As a result of intense advocacy by New Futures, the NH Providers Association, and other partners, the NH Department of Health and Human Services (DHHS) developed a robust array of services, including peer and non-peer recovery supports and recovery monitory, available to the NH Health Protection population.

Eligible recipients, initially enrolled in managed care plans, will be transitioned to private plans on the Marketplace for coverage beginning on January 1, 2016. The law also contains a sunset provision requiring the legislature to reauthorize the program in order to extend the program beyond December 31, 2016.

Over 41,000 people have enrolled in the NH Health Protection Program. It is estimated that 18% of these people are in need of SUD services and that 14% of them will likely access those services. Furthermore, the state budget for FY 2016-17 passed by the NH Legislature includes a provision that would extend the SUD benefit to the standard Medicaid population in SFY 2017.

SB 413 also mandated that DHHS submit a so-called 1115 demonstration waiver request to CMS. If approved by CMS, funding through this waiver will be used to build and expand behavioral health services in New Hampshire, including expansion of SUD and mental health recovery supports as part of the continuums of care developed in each Integrated Delivery Network anticipated under the waiver.

Medicaid reimbursement for peer and non-peer Recovery Support Services for the NH Health Protection Program (NHHPP) population will become available on September 1, 2015. It is likely that NH Medicaid will also begin reimbursing for these services when an array of SUD services become available to NH's standard Medicaid population some time during the SFY 2016-17. Medicaid reimbursement for recovery support services provided to the NHPPH population is regulated under administrative rule He-W 513, promulgated by the Department of Health and Human Services. Amendments to this rule, which set forth requirements for the delivery of recovery support services in line with CMS requirements, were approved by the Joint Legislative Committee on Administrative Rules (JLCAR) on August 20, 2015. Current requirements for Medicaid reimbursement under He-W 513 are discussed in detail below.

The NH Department of Health and Human Services (DHHS) readily acknowledges the need to develop a credential and certification requirements for peer recovery support specialists, and accreditation standards for RCOs, FOs, and RCCs, for this provider type and these program types to be eligible for Medicaid reimbursement. It is anticipated that through the work of the Recovery Task Force and efforts of the NH BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance Center Strategy) initiative, in partnership with the Bureau of Drug and Alcohol Services (BDAS), requirements for certification of peer recovery support specialists and accreditation standards for RCCs will be developed and implemented through changes to current law and administrative rules.

b) Private Insurance

In addition to Medicaid reimbursement of PRSS, pursuing reimbursement for peer recovery supports through private insurance plans is a critical piece of a funding strategy for this service. Carriers need to be educated about the value of peer recovery support services, and an analysis of parity requirements as they relate to recovery supports should occur. As NH Medicaid recipients are transitioned to private plans on the Marketplace, ensuring that carriers

will provide coverage for recovery supports becomes increasingly important. Requirements for peer recovery support credentialing must take into account the National Council on Quality Assurance's (NCQA) standards for reimbursement.

II. Process[6]

The Medicaid Subcommittee (Subcommittee) of the Recovery Task Force met 3 times – on July 22nd, August 11th, and September 1st. During and immediately after the July 22nd meeting, members of the Subcommittee agreed on the domains of a template to be used for recording PRSS and RCC reimbursement approaches in other states. Based on her broad work experience and knowledge of PRSS development in other states, Subcommittee member Cori Sheedy suggested that the Subcommittee gather information regarding reimbursement for PRSS from the following states: Georgia, Texas, Pennsylvania, Alaska, Oregon, North Carolina, Maryland, Alabama, Colorado, Indiana, Michigan, and Ohio. These states were recommended for review because they are known to provide Medicaid reimbursement for a variety of recovery supports, including SUD and mental health recovery supports, family supports, and youth peer supports. Subcommittee members concurred with the suggestion. Research regarding each state's approach to reimbursement for PRSS was divided among the participating members of the Subcommittee, who populated template domains with information related to their respective states.[7] Additionally, Subcommittee member Holly Cekala provided information on Rhode Island.

At the August 11th meeting, the Subcommittee agreed to a context for moving its work forward.[8] The context includes key recovery concepts, terms, and principles. In addition, the Subcommittee reviewed the scan of reimbursement of PRSS in the identified states and made the following observations:

- All states reviewed recognize the value of PRSS as a critical component of supporting individuals with or in recovery from a SUD. Most of the states reviewed reimburse PRSS through Medicaid; those that do not yet reimburse these services through Medicaid are moving in that direction.
- Numerous states provide Medicaid reimbursement for mental health peer supports, SUD peer supports, family supports, and youth peer supports. States have leveraged Medicaid funding for peer and recovery support services using the following authorities allowed by federal Medicaid regulations under the Social Security Act Title XIX:
    - Section 1905(a)(13), the rehabilitation services option (rehab option)
    - Section 1915(b), managed care/freedom of choice waivers
    - Section 1915(i), Deficit Reduction Act Authority

[6] A list of resources consulted in the drafting of this report is included at Appendix A.
[7] A copy of the completed template is attached to this report as Appendix B.
[8] The agreed upon context entitled, "Context for Discussion of Peer Support Reimbursement," is attached to this report as Appendix C.

- Section 1115 of the Social Security Act

  Most recovery support services currently funded through Medicaid are reimbursed through the rehab option.

- Of the 10 states reviewed by the Subcommittee, Medicaid reimburses recovery supports as reflected in this table:

Type of Support	Number of States
SUD Peer Support	14
MH Peer Support	11
Family Support	2
Youth Peer Support	1

  States other than those reviewed by the Subcommittee utilize Medicaid reimbursement for family and youth peer supports.

- All states reviewed that reimburse PRSS through Medicaid have developed state specific certification requirements for peer recovery support specialists, require that the supports be delivered by individuals with lived experience holding at least a high school diploma or GED, have established supervision requirements, and have established requirements for continuing education for peer provider types.

- Other sources of funding for PRSS include Substance Abuse Prevention and Treatment (SAPT) Block Grant funding, SAMHSA's Access to Recovery (ATR) program and the Recovery Community Services Program (RCSP), state and local funding, and other funding streams such as Temporary Assistance for Needy Families (TANF), drug courts, and private funding.

- PRSS are provided in a variety of settings, including but not limited to RCCs, SUD treatment programs, sober-living housing, drug courts, health care facilities, community mental health centers, and churches.

- Many states have adopted the "Georgia model" as a framework for Medicaid reimbursement for PRSS. Georgia was the first state to seek Medicaid reimbursement for PRSS and has an evolved regulatory framework in support of its approach.

- Commercial plans are inclined to provide aftercare supports in-house; there is a need to educate private carriers regarding the value of PRSS.

At its September 1st meeting, the Subcommittee reviewed the draft report and finalized it for submission to the Recovery Task Force.

III. Reimbursement for Recovery Support Services in NH as of September 1, 2015

Requirements for Medicaid reimbursement for peer and non-peer recovery supports, and continuous recovery monitoring are set forth in He-W 513, approved by JLCAR on August 20, 2015. Reimbursement for the covered services described in this rule are available as of September 1, 2015 to recipients eligible for coverage under the NHHPP. Of particular interest is the fact that the covered services described below may be provided by a Certified Recovery Support Worker (CRSW), defined in Administrative Rule Alc 301.01 (a) as "an individual certified by the board to provide recovery support to persons with substance use disorders."

Eligibility Requirements for Initial Certification as a Recovery Support Worker are set forth in Alc 302.01 and state that "an individual shall be eligible for certification as a recovery support worker" if:

a) the individual is at least 18 years of age;

b) reads and writes English;

c) has a high school diploma or equivalent;

d) has completed at least 900 hours of paid or volunteer work experience as described in the rule;

e) Has completed at least 100 hours of education as described in the rule;

f) has committed none of the prohibited acts set forth in RSA 330-C:27, III for which sufficient restitution has not been made;

g) Has no independently verified mental disability which significantly impairs professional ability or judgment for which he or she has not taken remedial action;

h) Has had no felony convictions which have not been waived by the board;

i) Is of good character as demonstrated by required documentation under the rule.

There is no requirement that a CRSW have "lived experience" by being a person in long term recovery.

The scope of practice for a CRSW is established in RSA 330-C:13, and includes:

- The provision of basic screening of persons with substance use and co-occurring mental health disorders to determine whether referral for further assessment and formal diagnosis is needed and the making of appropriate referrals.
- The provision of monitoring of clients' health and safety including basic recognition of signs and symptoms of addiction, intoxication, and withdrawal, and the implementation of structured interventions to ensure the immediate safety of clients demonstrating such symptoms.
- The provision of recovery support including practical support, mentoring, and education about addiction, community peer support, role of medication and co-occurring disorders in addiction.
- Adherence to the ethical standards of the substance use treatment profession as determined by the board.

Provisions of He-W 513 applicable to reimbursement for peer and non-peer recovery supports include:

A. He-W 513.04(b)(2), which provides that CRSWs shall only provide SUD treatment and recovery support services under the supervision of:

a. An MLADC who is on the staff of a Medicaid enrolled outpatient SUD program or comprehensive SUD program;

b. A LADC who is permitted to engage in independent practice in accordance with Chapter Law 189:2, II, Laws of 2008, and Chapter Law 249:24, V, Laws of 2010, who also is an LCS and who is on the staff of a medicaid enrolled outpatient SUD program or comprehensive SUD program; or

c. A licensed mental health provider approved to provide supervision to CRSWs in accordance with RSA 330-C and who is on the staff of a medicaid enrolled outpatient SUD program or comprehensive SUD program.

B. He-W 513.05(b), requires that all covered services, including SUD recovery supports, shall be:

(1) Delivered in accordance with appropriate guidelines that are consistent with generally accepted standards of care in the ASAM Criteria (2013), available as noted in Appendix A; and

(2) Evidence based, as demonstrated by meeting one of the following criteria:

a. The service shall be included as an evidence-based mental health and substance abuse intervention on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) http://www.nrepp.samhsa.gov/ViewAll.aspx;

b. The services shall be published in a peer-reviewed journal and found to have positive effects; or

c. The SUD treatment and recovery support service provider shall be able to document the services' effectiveness based on the following:

1. The service is based on a theoretical perspective that has validated research; or

2. The service is supported by a documented body of knowledge generated from similar or related services that indicate effectiveness.

C. He-W 513.05(r) provides that peer recovery support shall be a covered service when provided as follows:

(1) Peer recovery support services shall include non-clinical services to help NHHPP recipients and families identify and work toward strategies and goals around stabilizing and sustaining recovery and, as applicable, providing links to professional treatment and community supports;

(2) Peer recovery support services shall be provided by a medicaid enrolled outpatient or comprehensive SUD treatment program;

(3) Peer recovery support services shall be delivered by a CRSW certified by the NH board of licensing for alcohol and other drug use professionals or by a LADC or MLADC licensed by the board of licensing for alcohol and other drug use professionals, all of whom have at least 30 contact hours of recovery coach training approved by:

a. NH Training Institute on Addictive Disorders;

b. NAADAC, The Association for Addiction Professionals;

c. New England Institute of Addiction Studies;

d. Addiction Technology Transfer Center; or

e. Connecticut Communities for Addiction Recovery (CCAR) Recovery Coach Academy

(RCA);

(4) The CRSW or LADC shall be under the supervision of an MLADC who shall be on the staff of, or under contract with, the outpatient or comprehensive SUD program;

(5) The practitioners in (2)-(3) above shall not be required to be individually enrolled in medicaid; and

(6) Peer recovery support services shall be billed by the outpatient or comprehensive SUD program.

1. He-W 513.05(s) provides that non-peer recovery support shall be a covered service when provided as follows:

(1) Non-peer recovery support services shall include non-clinical group or individual services consistent with a NHHPP recipient's treatment plan that help to prevent relapse and promote recovery;

(2) Non-peer recovery support services shall be provided by a medicaid enrolled outpatient or comprehensive SUD treatment program;

(3) Non-peer recovery support services shall be provided by a CRSW certified by the NH board of licensing for alcohol and other drug use professionals or by a LADC or MLADC licensed by the board of licensing for alcohol and other drug use professionals;

(4) The CRSW or LADC shall be under the direct supervision of an MLADC who shall be on the staff of, or under contract with, the outpatient or comprehensive SUD program;

(5) The practitioners in (2)-(3) above shall not be required to be individually enrolled in medicaid; and

(6) Non-peer recovery support shall be billed by the outpatient or comprehensive SUD program.

E. He-W 513.05 (t) provides that continuous recovery monitoring shall be a covered service when provided as follows:

(1) Continuous recovery monitoring shall include recovery check-ups with NHHPP recipients on a regular basis, assessments of the status of the NHHPP recipient's recovery, consideration of a broad array of NHHPP recipient needs, and provision of active referral to community resources

as applicable;

(2) Continuous recovery monitoring shall be provided by a medicaid enrolled outpatient or comprehensive SUD treatment program;

(3) Continuous recovery monitoring shall be provided by a CRSW who is certified by the NH board of licensing for alcohol and other drug use professionals, or a LADC or MLADC licensed by the board of licensing for alcohol and other drug use professionals;

(4) The CRSW or LADC shall be under direct supervision of an MLADC who shall be on the staff of, or under contract with, the outpatient or comprehensive SUD program;

(5) The practitioners in (2)-(3) above shall not be required to be individually enrolled in medicaid; and

(6) Continuous recovery monitoring shall be billed by the outpatient or comprehensive SUD program.

Current NH law and regulations do not recognize peer recovery support specialists as a provider type eligible for Medicaid reimbursement; similarly, FOs, RCOs, and RCCs are not

recognized as program types eligible for Medicaid reimbursement. To establish peer recovery support specialists as a provider type eligible for Medicaid reimbursement, the credential and associated certification requirements must be established by the state. To establish recovery organizations as program types eligible for Medicaid reimbursement, accreditation standards for these organizations must also be established by the state.

IV. Recommendations and Next Steps

To ensure that all NH citizens who are in need of supports are able to access SUD treatment and sustain recovery, there is a need to expand provider and program types eligible for reimbursement under Medicaid and through private insurers. To that end, the Medicaid Subcommittee of the Governor's Commission Recovery Task Force submits the following recommendations and suggestions for next steps:

A. Recommendations

1. The Recovery Task Force should authorize the Subcommittee to continue its work in line with the recommendations and next steps set forth below. Subcommittee membership should be reviewed and expanded, if needed, to continue the work recommended below.
2. The Recovery Task Force should rename the Subcommittee to more accurately reflect the scope of the work that needs to be done to access all potential sources of reimbursement for recovery supports. It is suggested that the Subcommittee be called the "Funding Recovery Supports Subcommittee."
3. The Subcommittee, in collaboration with BDAS, NH BRSS TACS, the recovery community, and other stakeholders be charged with developing a peer recovery support specialist credential, including recommendations for scope of practice, and certification and supervision requirements that comport with the Center for Medicare and Medicaid Services' mandates for Medicaid reimbursement.
4. In line with the development and implementation of the Governor's Commission five-year plan to reduce the misuse of alcohol and other drugs, and promote recovery, *Collective Action – Collective Impact,* consideration be given to applying the conditions of Collective Impact to building the system of SUD recovery supports in New Hampshire. This includes identifying and funding a FO as soon as possible to serve the function of a "backbone" (one of the five conditions of collective impact) in developing the peer recovery support system of services in New Hampshire.[9]
5. The Subcommittee, in collaboration with BDAS, NH BRSS TACS, the recovery community, and other stakeholders be charged with developing a peer recovery support specialist credential, including recommendations for scope of practice, and

[9] *See* Kania and Kramer, *Embracing Emergence: How Collective Impact Addresses Complexity,* Stanford Social Innovation Review, 2013. http://ssir.org/pdf/Embracing_Emergence_PDF.pdf

certification and supervision requirements that comport with private health insurer coverage requisites, including NCQA standards.

6. The Subcommittee, in collaboration with BDAS, NH BRSS TACS, the recovery community, and other stakeholders be charged with defining the potential roles of recovery organizations, including FOs, RCOs, and RCCs, developing accreditation standards as needed for each as needed to maximize the potential for Medicaid and private insurance reimbursement.
7. The Subcommittee, in collaboration with BDAS, NH BRSS TACS, the recovery community, and other stakeholders be charged with developing a comprehensive plan for accessing maximum funding for the delivery of SUD recovery supports by exploring all Medicaid funding options, private insurance reimbursement options, SAPT Block Grant support, RCSP, state and local funding, and other funding streams such as TANF, drug courts, and private funding.

B. Next Steps

1. Recovery Task Force approves recommendations of the Subcommittee on September 11, 2015.
2. The Subcommittee reconvenes to develop a peer recovery support specialist credential, including certification requirements, in conjunction with BDAS and the licensing and certification board.
    a. Reserve LSR for needed changes to RSA 330-C by September 18, 2015 (House deadline) or November 13, 2015 (Senate deadline), otherwise there could be a one-year delay in making needed statutory changes.
    b. Submit proposed certification requirements to the Recovery Task Force for review and approval no later than January 8, 2016. However, if certification requirements need to be finalized in time to be included in statutory language creating the peer recovery support specialist credential, proposed certification requirements will be submitted to the Recovery Task Force for approval in time to be included in the statutory amendment creating the credential.
    c. Work with BDAS to identify needed regulatory changes, including proposed language, no later than March 11, 2016.
3. The Subcommittee will coordinate with New Futures and the NH Providers Association to advocate with private carriers to reimburse for recovery supports. This work is already underway and will continue.
4. The Subcommittee, in collaboration with BDAS, NH BRSS TACS, the recovery community, and other stakeholders, will work to develop accreditation standards as needed for recovery organizations, including recovery community organizations and recovery community centers, as needed to maximize the potential for Medicaid and

private insurance reimbursement, and will submit recommendations to the Recovery Task Force no later than March 11, 2016.

5. The Subcommittee, in collaboration with BDAS, NH BRSS TACS, the recovery community, and other stakeholders, will develop a comprehensive plan for accessing maximum funding for the delivery of SUD recovery supports by exploring all Medicaid funding options, private insurance reimbursement options, SAPT Block Grant support, RCSP, state and local funding, and other funding streams such as TANF, drug courts, and private funding. The plan will be submitted to the Recovery Task Force no later than March 11, 2016.