

POLICY BRIEF

Scopes of Practice and Reimbursement Patterns of Addiction Counselors, Community Health Workers, and Peer Recovery Specialists in the Behavioral Health Workforce



Project Team

Angela J. Beck, PhD, MPH
Jessica Buche, MPH, MA

Cory Page, MPH, MPP
Danielle Rittman

Maria Gaiser

Background

The field of behavioral health is experiencing a shortfall of licensed providers.¹ Community health workers and peer recovery specialists function as critical components of the workforce that can mitigate access and treatment gaps.²⁻⁶ Increasing demand for behavioral health services, exacerbated by the ongoing opioid epidemic, has intensified the need for addiction counselors, who have multiple categories of credentialing, some of which require less formal education than clinical mental health counselors.^{7,8}

The purpose of this study was to catalog the most current information on state scopes of practice (SOPs), training requirements, and Medicaid reimbursement rates for all available addiction counselors, community health workers, and peer recovery specialists credentials across all 50 states and the District of Columbia to better understand how these workers can contribute to behavioral health service delivery.

Methods

Online state repositories of statutes and administrative codes were searched for SOP and requirements for all addiction counselors, community health workers, and peer recovery specialists credentials. The data were coded into variables related to regulatory information, certification requirements, and service authorization using a coding scheme developed for previous SOP studies conducted by the Behavioral Health Workforce Research Center.⁹ Service authorization variables were expanded for community health workers and peer recovery specialists based on a recursive search of their respective SOP materials. Online state Medicaid provider manuals, statutes/administrative codes, and fee schedules were also collected to analyze reimbursement differences.

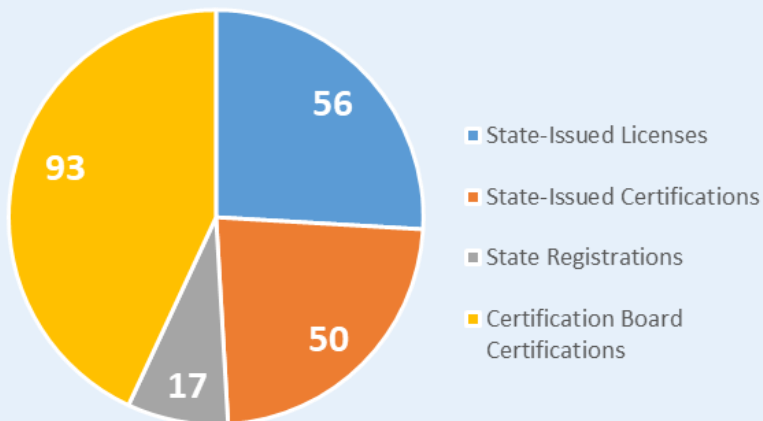
Key Findings

Addiction Counselors

A total of 216 addiction counselor credentials were identified across the 50 states and the District of Columbia. Of these, 56 were state-issued licenses, 50 were state-issued certifications, 17 were “registered” positions with a state, and 93 were certifications issued by certification boards (Figure 1).

Credentials for addiction counselors tended to vary in their service authorization based on education achievement. Credentials that required a minimum of a graduate degree tended to be for “advanced” or “clinical” credentials that authorized the holder to perform diagnosis, engage in psychotherapy, and work

Figure 1. Addiction Counselor Credential Types (n=216)



without supervision. Credentials that required an undergraduate degree tended to be for “assisting” or “training” credentials that required supervision, and may have authorized fewer services than a clinical credential. Credentials that do not require a degree beyond a high school diploma/GED vary widely in the services authorized. Practice/supervision hour requirements seemed inversely correlated with degree requirements, in that credentials that did not require a degree often had much higher practice requirements. Fittingly, 39 states offered direct experience

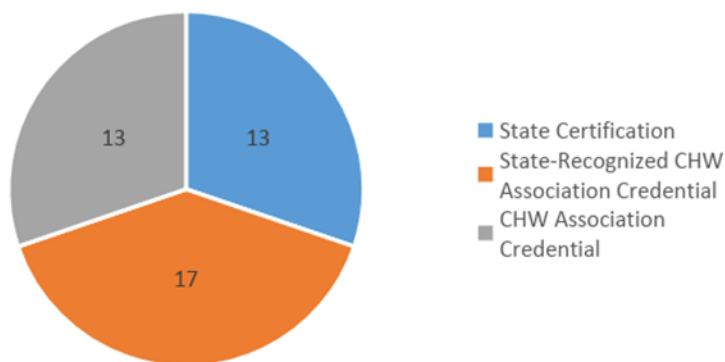
substitutions for at least one addiction counselor credential for applicants who had earned a degree. An associate’s degree tended to be worth 1000 practice hours and 50 direct supervision hours, a bachelor’s degree was worth 2000 practice hours and 100 direct supervision hours, and a master’s degree was worth 4000 practice hours and 200 direct supervision hours.

State Medicaid programs tended to only reimburse licensed, master’s-level addiction counselors. Individual therapy and group therapy were most commonly authorized (93 and 92 addiction counselor credentials, respectively). An hour of individual therapy was reimbursed at an average of \$84.03 and an hour of group therapy was reimbursed at an average of \$24.19 per client involved. Rather than being reimbursed for a mental health diagnosis, Medicaid programs typically reimbursed addiction counselors for an addiction assessment, which averaged \$95.15 per assessment.

Community Health Workers

A total of 43 community health workers credentials were identified across 40 states; the remaining states offered no community health worker credential. Of these credentials, 13 were defined by law as a state-issued certification, 17 were certifications issued by a community health worker professional association within the state, and 13 were credentials defined by community health worker movements/association within states that have not yet formally recognized a credential (Figure 2).

Figure 2. Community Health Worker Credential Types (n=43)

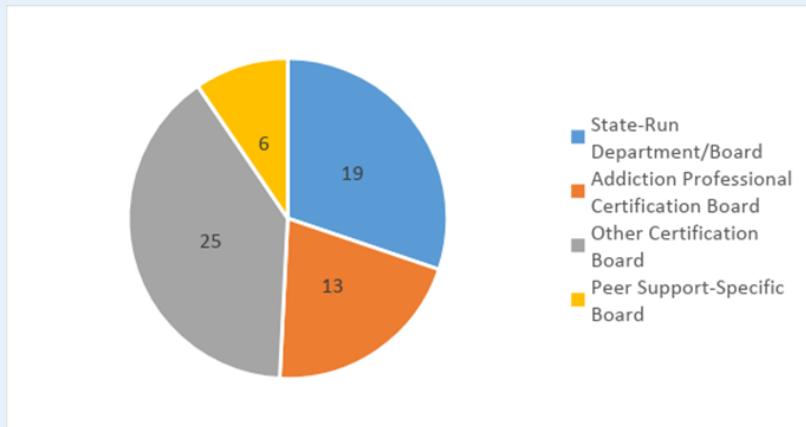


Community health workers are lay citizens who either have in-depth knowledge about a specific community, or are members of that community, and are working to help it. None of the identified credentials required a degree higher than a high school diploma/GED. However, some of the training courses needed for the credentials required semester credit hours at a college. Other training requirements, when mentioned, varied widely by state. Unlike addiction counselors and peer recovery specialists,

which have nationally-accepted, standardized minimum requirements set by the International Certification & Reciprocity Consortium/Association for Addiction Professionals (IC&RC/NAADAC), community health worker models are developed separately in each state.

The five most commonly authorized community health worker services were: health education (39 credentials), system navigation (36), case coordination (34), outreach (28), and advocacy (28). Sixteen credentials were explicitly authorized for reimbursement for health education, according to Medicaid provider manuals. On average, a unit (15 minutes) of individual health education was reimbursed at a rate of \$23.54, and a unit of group health education was reimbursed at a rate of \$8.00 per client.

Figure 3. Peer Recovery Specialist Credential Types (n=63)



Peer Recovery Specialists

A total of 63 peer recovery specialist credentials were identified across 49 states. South Dakota and Vermont did not offer a peer recovery specialist credential. Of the 63 credentials, 18 were offered by state-run departments/boards and the remaining were offered through addiction certification boards or peer recovery-specific certification boards (Figure 3). There appeared to be little functional difference between “addiction professional certification boards” and “other certification boards.”

Similar to community health workers, peer recovery specialists are citizens who have been in recovery for a mental health condition or substance use disorder and offer their experience to

help others who are beginning recovery. None of the peer recovery specialist credentials required a degree beyond a high school diploma/GED. In keeping with the nationally accepted IC&RC and NAADAC models, peer recovery specialists typically needed 500 practice hours and 25 supervision hours before receiving a credential.

The three most common services authorized for peer recovery specialists by states were: recovery assistance (51 credentials), mentorship (45 credentials), and advocacy (43 credentials). It is unclear whether “wellness” and “social/emotional support,” two other commonly authorized peer recovery services, could be interpreted to mean counseling. This could create role confusion between peer recovery specialists and other behavioral health providers, as peer recovery specialists are not formally trained or educated to the same level as clinical behavioral health providers. Of the three studied occupations, peer recovery specialists had the highest percentage of Medicaid-reimbursed credentials (62%, compared with 43% for addiction counselors and 37% for community health workers).

Peer support services often had its own distinct code in State Medicaid programs. Reimbursement data were found for 39 peer recovery specialist credentials, and, on average, a peer recovery specialist was reimbursed \$12.98 per unit (15 minutes) of peer support services.

Conclusions & Policy Implications

Key findings of this study show that addiction counselors, community health workers, and peer recovery specialists could benefit from such policies as:

- States adopting models that incorporate both a voluntary addiction counselor certification and a state-issued clinical practice license. This could increase the supply of licensed behavioral health providers specialized in treating substance use disorders that may be Medicaid- reimbursable. In addition, supporting addiction counselor certification may encourage more behavioral health providers to specialize in addiction counseling without requiring a separate license.
- States filing Medicaid State Plan Amendments to include community health workers for reimbursement. This could increase the supply of such workers in a state.
- States tailoring peer recovery specialist SOPs to clarify this occupation's role relative to other behavioral health providers.

Overall, there is a lack of uniformity in education and practice requirements across states for these three occupations. However, the nationwide acceptance of IC&RC/NAADAC credentials for addiction counselors and peer recovery specialists has somewhat standardized these certification requirements for these professions. Community health workers may benefit from engaging in similar standardization of requirements and SOPs across states.

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