REPORT / USE OF THE PEER SUPPORT SERVICES MEDICAID BENEFIT

August 31, 2022

Use of the Peer Support Services Medicaid Benefit:

Perspectives of LMHAs/LBHAs in Texas

Submitted to Texas Health and Human Services Commission

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Introduction

Texas House Bill 1486 established the development of a peer support Medicaid benefit and defined the training requirements for peer specialists who provide services under the new benefit effective January 1, 2019. To become certified to provide peer support as a Medicaid service, peer specialists must complete the core peer services training, complete the substance use or mental health peer training, and complete 250 hours of supervised work experience. A certified peer specialist employed by Medicaid-enrolled providers may deliver the following peer support services individually or in a group as a Medicaid benefit: recovery and wellness support, mentoring, and advocacy.

Previous research on the use of the Medicaid Peer Support Services benefit in Texas suggests that only about half of local mental health authorities (LMHAs)/local behavioral health authorities (LBHAs) are utilizing the benefit (Peterson, Singh, & Manser, 2021) and that a key reason for that may be the low reimbursement rate relative to the rate for the Medicaid Rehabilitative Services benefit (Lodge, Earley, & Manser, 2021). Qualitative data indicate that due to the lower reimbursement rate for the peer benefit, some peer specialists in Texas work at organizations that choose not to use the Medicaid Peer Support Services benefit, limit its use to particular instances, or require or encourage them to bill for their services using the Medicaid Rehabilitative Services codes despite many peers viewing these services as antithetical to authentic peer work based in mutuality.

However, in response to recent advocacy work and review by the Texas Medicaid program, the Peer Support Services reimbursement rate was raised effective March 1, 2022 from $7.58 to $11.25 per 15-minute increment for individual peer services and from $1.09 to $1.61 per 15-minute increment for group peer services (Texas Council of Community Centers, 2022; Texas Health and Human Services, 2022; Texas Medicaid and Healthcare Partnership, 2022). While these represent substantial increases, these rates remain considerably lower than the reimbursement rates for Medicaid Psychosocial Rehabilitative Services (Texas Medicaid and Healthcare Partnership, 2022). As a result, many LMHAs and LBHAs in Texas may continue to choose not to use the Peer Support Services benefit.

Current Study

The current study seeks to understand the facilitators, challenges, and barriers to using the Medicaid Peer Support Services benefit from the viewpoint of Texas LMHAs and LBHAs. To do so, leadership at LMHAs/LBHAs in Texas were surveyed in the Spring and Summer of 2022 after the Peer Support Services rate increase went into effect. The purpose of the survey was to assess if LMHAs/LBHAs were using the Peer Support Services individual and/or group benefit prior to the March 2022 rate increase, if they planned to use the Peer Support Services individual and/or group benefit in the future after the March 2022 rate increase, barriers to using the Peer Support Services benefit, facilitators to using the Peer Support Services benefit and peer services in general, other funding sources for peer support, and if their organization contracts and/or provides referrals to peer-run organizations.

Method

Procedure and Respondents

In April 2022, a survey was emailed to leadership at the 39 LMHAs/LBHAs in Texas. At least one member of leadership from 20 of these LMHAs/LBHAs responded to the survey. For one of these twenty, three individuals responded to the survey. The data from this LMHA/LBHA were handled as follows: for the quantitative data, duplicate responses were dropped from the analysis and when responses differed among the three individuals (as occurred for three items) the majority response was retained for analysis. For the qualitative data, data were retained that were non-duplicative.

To determine if the survey respondents were primarily from LMHAs/LBHAs currently using the Peer Support Services codes, a comparison was made to determine if there was a relationship between responding to the survey and whether or not an LMHA/LBHA is using or not using one of the Peer Support Services codes (based on data current as of 2021; Peterson, Singh, & Manser, 2022). Table 1 displays all 39 LMHAs/LBHAs in Texas and provides data on whether or not each LMHA/LBHA responded to the survey and whether or not each LMHA/LBHA uses one of the Peer Support Services codes. There was not a relationship between survey response and use of a Peer Support Services code. As illustrated in Table 2, LMHAs/LBHAs that responded to the survey were just as likely to be using one of the Peer Support Services codes as were LMHAs/LBHAs that did not respond to the survey.

Table 1: LMHAs/LBHAs' use of the Peer Support Services codes and survey response.

LMHA/LBHA	Responded to Survey	Uses Individual Peer Support Code	Uses Group Peer Support Code	Uses Re-entry Peer Support Code
Anderson Cherokee Community Enrichment Services		Yes		
Andrews Center		Yes		
Behavioral Health Center of Nueces County				
Betty Hardwick Center	Yes	Yes		
Bluebonnet Trails Community Services	Yes		Yes	
Border Region MHMR Community Center				
Burke Center	Yes	Yes	Yes	
Camino Real Community Services	Yes	Yes	Yes	
Center for Health Care Services				
Center for Life Resources	Yes		Yes	
Central Counties Center for MHMR Services				
Central Plains Center	Yes			
Coastal Plains Community MHMR Center			Yes	
Community Healthcore	Yes			
Denton County MHMR Center		Yes	Yes	
Emergence Health Network	Yes	Yes		
Gulf Bend MHMR Center		Yes		

The Gulf Coast Center				
The Harris Center for Mental Health and IDD				Yes
Heart of Texas Region MHMR Center				
Helen Farabee Centers		Yes	Yes	
Hill Country MHDD Centers	Yes	Yes	Yes	
Integral Care	Yes			
Lakes Regional Community Center		Yes		
LifePath Systems	Yes	Yes	Yes	
MHMR Authority of Brazos Valley	Yes			
MHMR of Tarrant County	Yes	Yes	Yes	
MHMR Services for the Concho Valley	Yes			
North Texas Behavioral Health Authority		Yes	Yes	
Pecan Valley Centers	Yes	Yes	Yes	
Permiacare		Yes	Yes	
Spindletop Center	Yes	Yes		
StarCare Specialty Health	Yes	Yes	Yes	
Texana Center		Yes		
Texas Panhandle Centers	Yes	Yes	Yes	
Texoma Community Center				
Tri-County Behavioral Healthcare		Yes		
Tropical Texas Behavioral Health	Yes			
West Texas Centers for MHMR	Yes			
Total (n=39)	n=20	n=21	n=15	n=1

Table 2: Comparison of use of one of the Peer Support Services codes and survey response.

	Responded to Survey: Yes	Responded to Survey: No	Total
Bills: Yes	13	12	25
Bills: No	7	7	14
Total	20	19	39

LMHA/LBHA leadership who responded to the survey reported a variety of job titles. The most common job titles included: Director of Behavioral Health (n=4), CEO (n=3), and Executive Director (n=3). Other director and supervisory titles included Assistant Director of Behavioral Health (n=1), Director of Quality Management and Compliance (n=1), Director of Business Development (n=1), Director of Specialized Programs (n=1), Contracts Management Director (n=1), CAO/CFO (n=1), Peer Supervisor (n=1), QMHP & Supervisor (n=1), Chief Clinical Officer (n=1), and Chief of Counseling (n=1).

Analysis

Survey data were downloaded from Qualtrics and cleaned and analyzed with SPSS v27. Basic descriptive statistics were run for all variables using SPSS v27 and are presented in this report. The qualitative responses were analyzed using NVIVO qualitative data analysis software. Qualitative codes were developed based on the data and were not predetermined prior to analysis.

Results

Utilization of the Peer Support Medicaid Benefit

Use of the Peer Support Benefit before the March 2022 Reimbursement Rate Increase

Leadership were asked if their organizations used the individual and/or the group Peer Support billing code prior to March 1, 2022. Of the 20 LMHAs/LBHAs that responded to this question, 14 (70%) reported that they used the individual Peer Support Medicaid billing code prior to March 1, 2022, while 6 (30%) reported that they did not use the individual billing code. Of the 20 LMHAs/LBHAs that responded to this question, 10 (50%) reported that they used the group Peer Support Medicaid billing code prior to March 1, 2022, while 10 (50%) reported that they did not use the group billing code. As indicated in Table 3, four organizations reported using the individual billing code, but not the group billing code while no organizations reported the reverse (i.e., using the group billing code, but not the individual billing code).

Table 3: Use of individual and group Peer Support Medicaid billing codes prior to March 1, 2022.

	Group billing code: yes	Group billing code: no	Total
Individual billing code: yes	10 (50%)	4 (20%)	14 (70%)
Individual billing code: no	0 (0%)	6 (30%)	6 (30%)
Total	10 (50%)	10 (50%)	20 (100%)

Leadership who reported that they did not use the individual and/or group Medicaid Peer Support billing code(s) prior to March 1, 2022 were asked to describe what barriers prohibited the use of the code(s). Two organizational leadership reported two barriers to utilizing the group peer support service Medicaid billing code prior to March 1, 2022: the reimbursement rate was too low (n=1) and the LMHA/LBHA does not offer peer groups (n=1). Five organizational leaders reported three barriers to utilizing the individual and group Peer Support Services billing code prior to March 1, 2022: the reimbursement rate was too low (n=2), the organization lacked certified peer specialists (n=2), and peer specialists at the organization were not providing peer services (n=1).

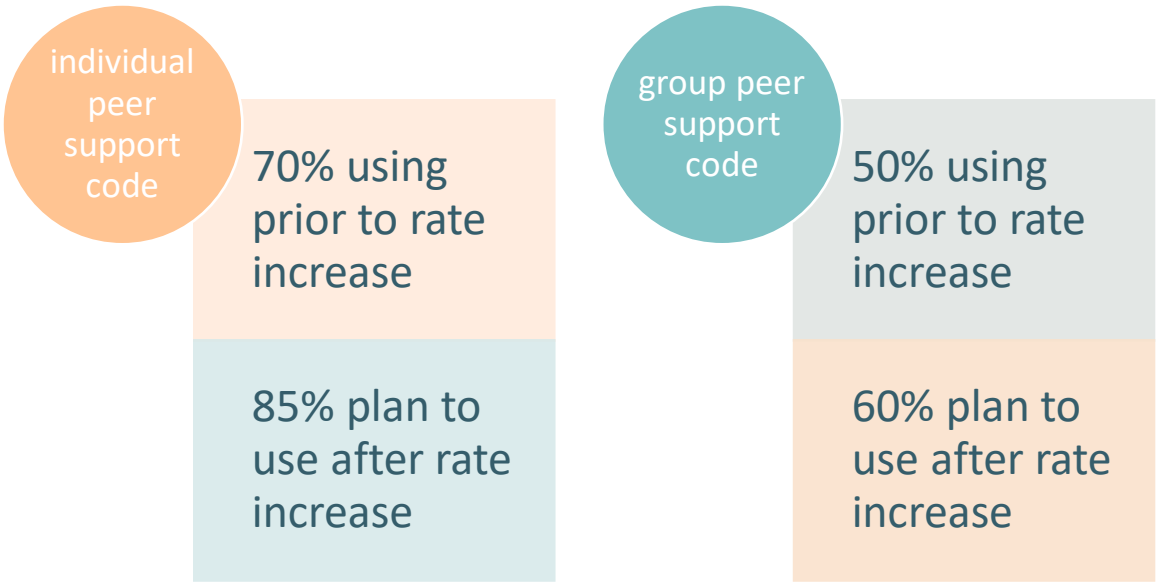
Plans to Use the Peer Support Benefit after the March 2022 Reimbursement Rate Increase

Leadership were asked if their organization plans to use the individual and/or the group Medicaid Peer Support billing code(s) going forward given the rate increase effective March 1, 2022 (from $7.58 to $11.25 for individual peer support and from $1.09 to $1.61 for group peer support). Of the 20 LMHAs/LBHAs that responded to this question, 17 (85%) reported that they plan to use the individual Peer Support Services Medicaid billing code going forward while 3 (15%) reported that they do not plan to use the individual billing code. Of the 20 LMHAs/LBHAs that responded to this question, 12 (60%) reported that they plan to use the group Peer Support code going forward while 8 (40%) reported that they do not plan to use the group billing code. As indicated in Table 4, five LMHAs/LBHAs reported plans to use the individual billing code going forward, but not the group billing code while none reported the reverse (i.e., plans to use the group billing code, but not the individual billing code). Figure 1 displays the percent of LMHAs/LBHAs reporting usage of the individual and group Peer Support billing codes prior to and post-rate increase.

Table 4: Plans to use the individual and group Peer Support Services billing codes given the March 2022 reimbursement rate increase.

	Group billing code: yes	Group billing code: no	Total
Individual billing code: yes	12 (60%)	5 (25%)	17 (85%)
Individual billing code: no	0 (0%)	3 (15%)	3 (15%)
Total	12 (60%)	8 (40%)	20 (100%)

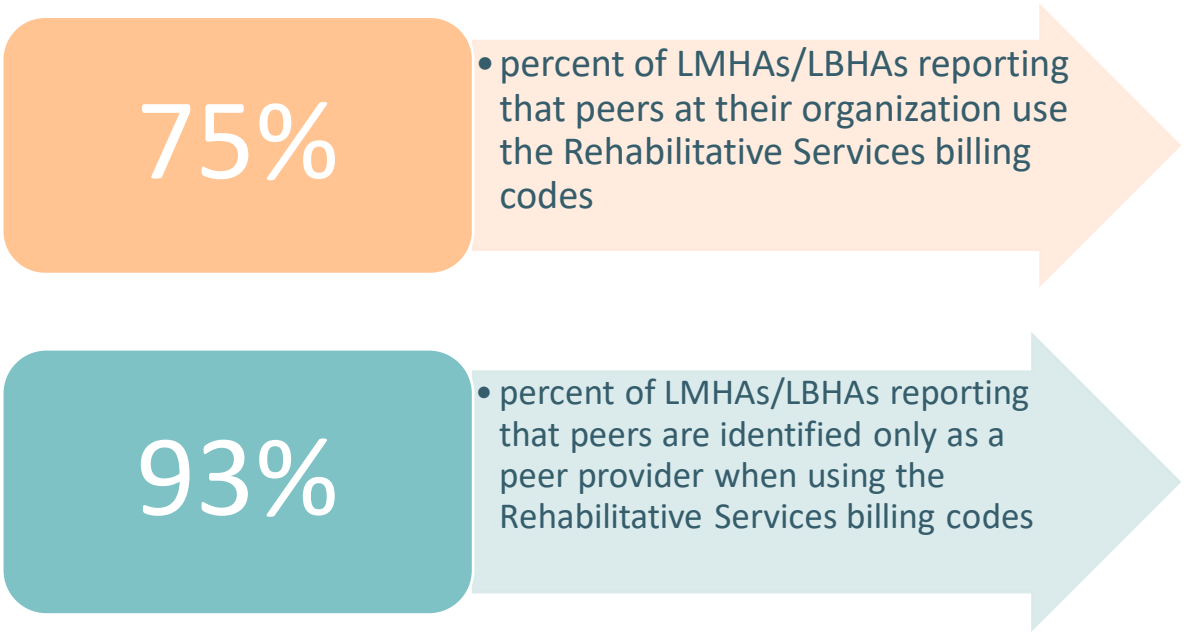
Figure 1: Percent of LMHAs/LBHAs reporting usage of individual and group Peer Support codes prior to and post-rate increase.



Peers' Use of the Medicaid Rehabilitative Services Billing Codes

LMHA/LBHA leadership were asked if peers at their organization utilize the Medicaid Mental Health Rehabilitative Services billing codes (i.e., Skills Training & Development, Psychosocial Rehabilitative Services, Medication Management & Training). Of the 20 LMHAs/LBHAs that responded to this question, 15 (75%) reported that peers at their organization do use the Medicaid Rehabilitative Services billing codes, while 5 (25%) reported that peers at their organization do not use these codes. LMHAs/LBHAs that reported that peers at their organization use the Medicaid Rehabilitative Services billing codes were asked to specify how peers are identified as a provider type when billing for the service (i.e., are they identified as a Peer Provider or QMHP). Of the 14 LMHAs/LBHAs that responded to this question, 13 (93%) reported that peers are identified as peer providers while one (7%) reported that peers are identified as both a peer and a QMHP.

Figure 2: Peers use of the Medicaid Rehabilitative Services billing codes.



Barriers to Using the Peer Support Services Benefit

LMHA/LBHA leadership were asked to describe what other barriers may exist to their organization using the Medicaid Peer Support Services benefit. Of the 16 LMHAs/LBHAs that responded to this question, the most commonly reported barrier was low reimbursement rates particularly that the rate did not cover salary, benefits, supervision costs, and overhead costs to hire peers (n=7). For example, one LMHA/LBHA leadership wrote that a barrier to using the peer support Medicaid benefit is difficulty with: "Attracting qualified staff for the salary we can pay with the low rate." Similarly, another wrote: "Need rate of about $22.50 per unit to cover 100 hours per month of peer services based on $20 per hour pay rate plus benefits, supervision and overhead." As a result of the lower reimbursement rate, peers may continue to bill using Psychosocial Medicaid Rehabilitative Services billing codes, as one LMHA/LBHA leader explained: "Rehab services continue to be the gold standard. We only utilize the Medicaid Peer Support Service codes when there is not an option to utilize a rehab code due to the dramatic difference in the reimbursement rate."

"[A barrier is we] "need rate of about $22.50 per unit to cover 100 hours per month of peer services based on $20 per hour pay rate plus benefits, supervision and overhead."

A second and related barrier to using the Medicaid Peer Support Service benefit reported by LMHA/LBHA leadership (n=5) is a lack of certified peer specialists due to workforce shortages and/or a lack of time and money to train and certify employed peers. For example, one LMHA/LBHA leader wrote: "Don't have certified staff yet so cannot bill for this yet." Another three leadership reported no barriers to utilizing the Medicaid Peer Support Service benefit while another two LMHA/LBHA leadership reported being unsure what barriers exist to

"[A barrier is] attracting qualified staff for the salary we can pay with the low rate."

"Rehab services continue to be the gold standard. We only utilize the Medicaid Peer Support Service codes when there is not an option to utilize a rehab code due to the dramatic difference in the reimbursement rate."

utilizing the benefit. Additional barriers reported included: the need to train peers to document (n=1), the need to update person-centered plans to include peer services (n=1), and MCOs not paying the increased reimbursement rate (n=1).

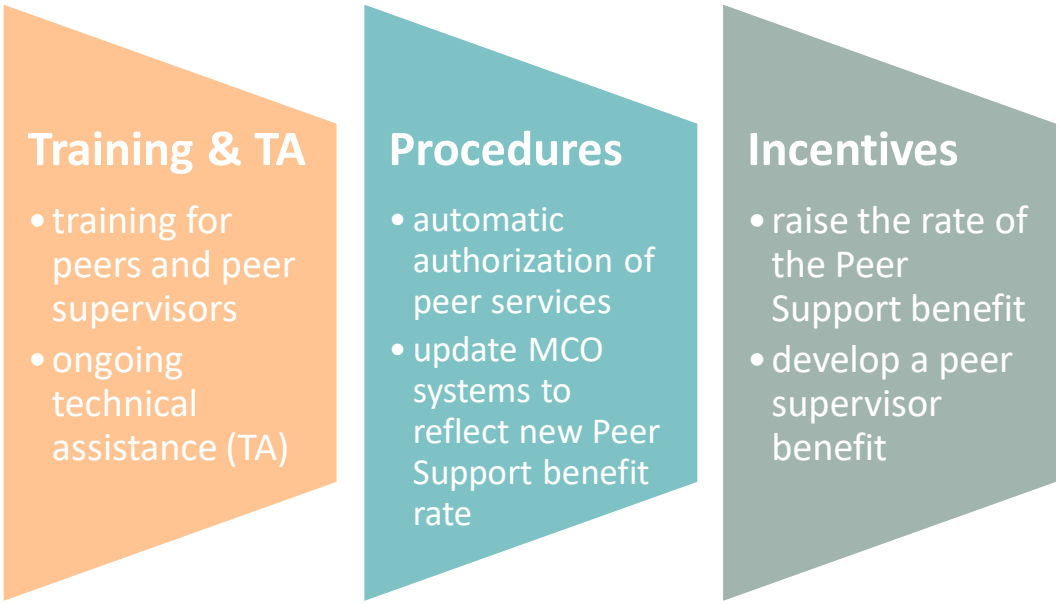
Facilitators to Using the Peer Support Services Benefit

LMHA/LBHA leadership were asked to describe what would be helpful to support their organization using the Medicaid Peer Support Services benefit. Of the 15 LMHAs/LBHAs that responded to this question, the most commonly reported facilitator to using the Peer Support Services benefit was to increase the reimbursement rate (n=8). For example, one LMHA/LBHA leadership wrote about the need for: "adequate rates covering the cost of the salary and benefits recognizing the value of certified professionals." Some LMHA/LBHA leadership specified that the rate should be raised to be comparable to the Medicaid Rehabilitative Services billing codes. LMHA/LBHA leadership also wrote that training for peers and peer supervisors (n=3) as well as ongoing technical assistance (TA; n=2) would be helpful to support their organization using the Medicaid Peer Support Services benefit. For example, one leadership wrote: "More resources for peers and peer supervisors to get the required (and quality) CEUs at no cost [and] TAC training for peer supervisors and others."

> *"Continued TA support in monthly meetings to stay current on requirements and learn from other centers using [the Peer Support benefit.]"*

Another leadership wrote of the need for: "Continued TA support in monthly meetings to stay current on requirements and learn from other centers using this service." Additional facilitators reported by LMHA/LBHA leadership included: unsure (n=2), the development of a peer supervisor benefit (n=1), the automatic authorization of peer services (i.e., peer services not required on care plans; n=1), and for MCOs to update their systems to reflect the new Peer Support Services rates effective March 1, 2022. See Figure 3 for a full list of facilitators.

Figure 3: Facilitators to using the Peer Support Services benefit.

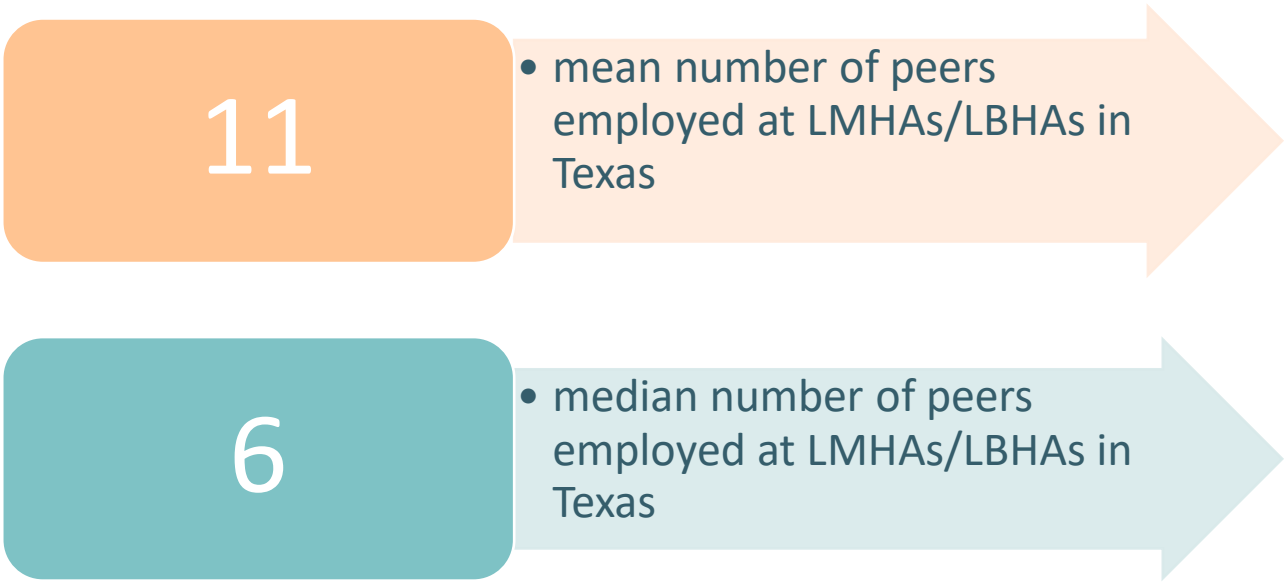


Supporting Peer Support Services

Number of Peers Employed at LMHAs/LBHAs

LMHA/LBHA leadership were asked how many peers are employed at their organization. Of the 19 that responded to this question, the mean number of peers employed was 11 while the median number of peers was 6 (range 1 to 57; See Figure 4).

Figure 4: Mean and median number of peers employed at LMHAs/LBHAs.

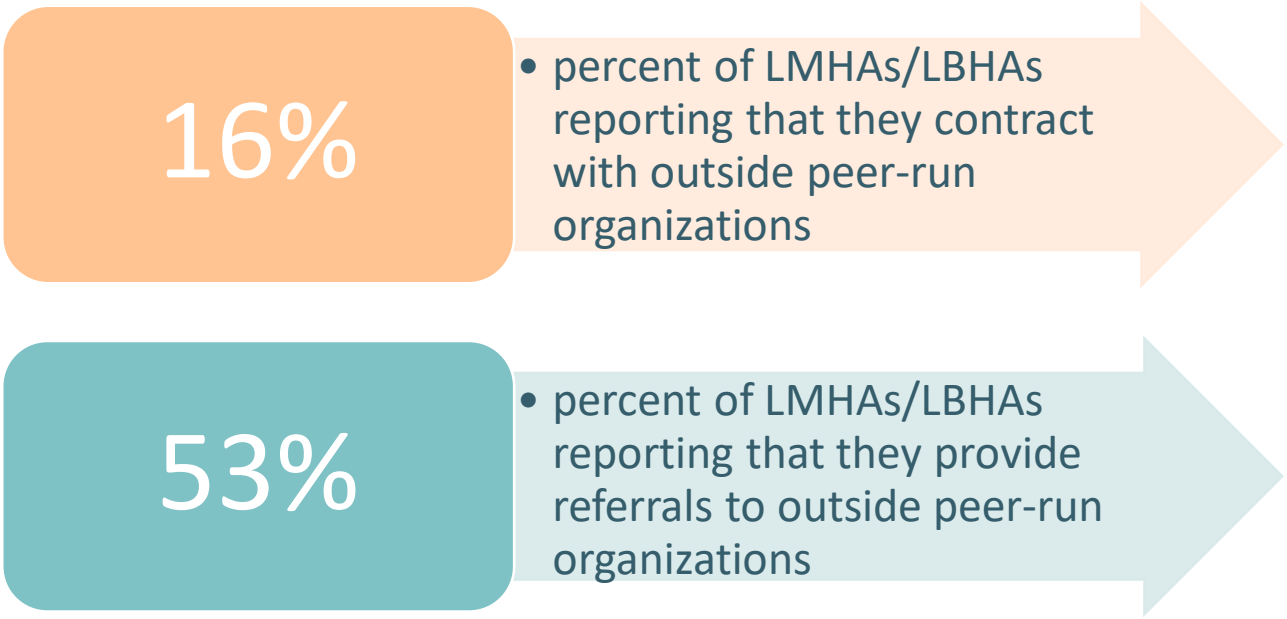


LMHA/LBHA Collaboration with Peer-Run Organizations

LMHA/LBHA leadership were asked if their organization contracts with any outside peer-run organizations to provide peer support services. Of the 19 that responded to this question, 16 (84%) reported that they do not contract with any outside peer-run organizations to provide peer support services while 3 (16%) reported that they do contract with outside peer-run organizations (see Figure 5). The three LMHAs/LBHAs that reported contracting with outside peer-run organizations were asked to specify which peer-run organization(s) they contract with. All three reported contracting with their local Consumer Operated Service Provider (COSP).

LMHA/LBHA leadership were also asked if their organization provides referrals to any outside peer-run organizations to provide peer support services. Of the 19 LMHAs/LBHAs that responded to this question, 10 (53%) reported that they do provide referrals to outside peer-run organizations to provide peer support services while 9 (47%) reported that they do not provide referrals to outside peer-run organizations. The 10 LMHAs/LBHAs that reported providing referrals to outside peer-organizations were asked to specify which peer-run organization(s) they provide referrals to. The following organizations were listed: COSPs (n=3), clubhouses (n=3), NAMI Phoenix House (n=1), faith-based organization (n=1), 12-step program (n=1), other LMHAs/LBHAs (n=1), and NAMI peer and family groups (n=1).

Figure 5: Percent of LMHAs/LBHAs reporting contracting with and providing referrals to outside peer-run organizations.



Additional Funding Sources

LMHA/LBHA leadership were asked to describe what other funding sources their organization uses to pay for peer support services or peer specialist salaries. Leadership from 18 LMHAs/LBHAs responded to this question. The most commonly described funding source was federal grants (e.g., Certified Community Behavioral Health Clinic, Community Mental Health Center grants, n=10). Other commonly reported sources of funding included: general revenue (n=5), grant funded (not specified, n=5), and DSRIP (Delivery System Reform Incentive Payment) programs (n=3). A full list of reported funding sources for peer support services or peer specialist salaries (excluding the Medicaid benefit) are available in Table 5.

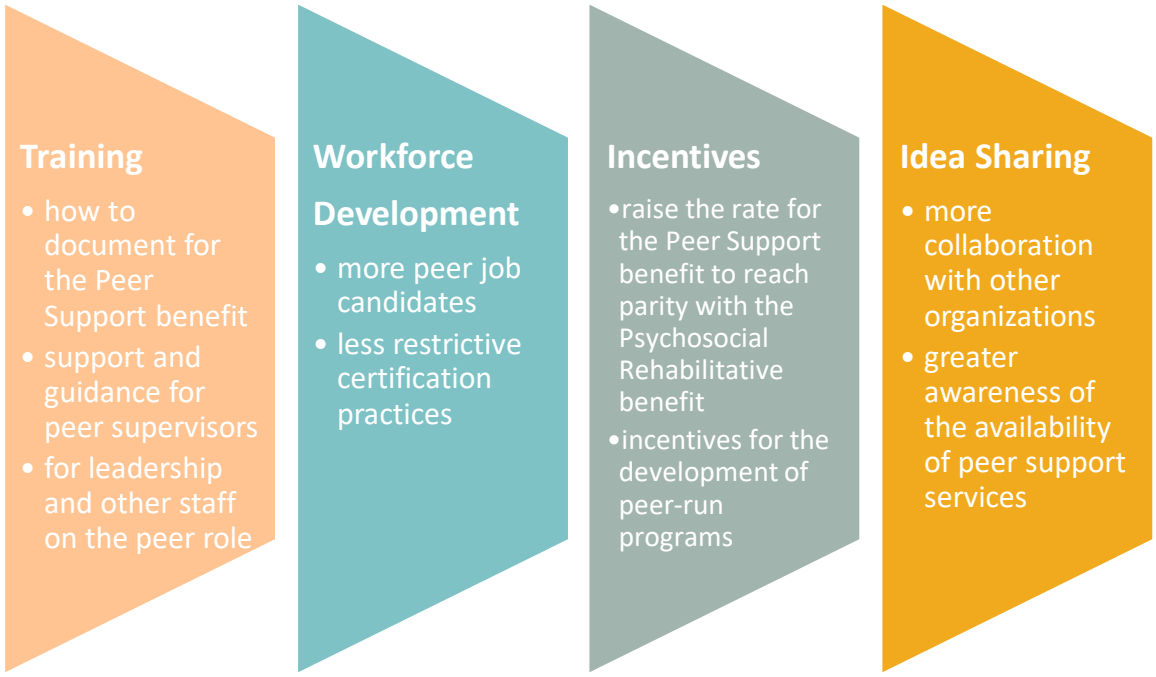
Table 5: Reported additional funding sources for peer support services or peer specialist salaries.

Funding Source	Number of LMHAs/LBHAs reporting
Federal grants (e.g., CCBHC, CMHC grants, other SAMHSA grants)	n=10
General revenue	n=5
Delivery System Reform Incentive Payment (DSRIP) program	n=3
Specialty programs funding (e.g., Community Specialty Care Community, Early Onset Psychosis)	n=2
Military Veteran Peer Network funding	n=1
1115 waiver funding	n=1
Local funds	n=1
QMHP billable services	n=1

Facilitators to the Utilization of Peer Support Services

LMHA/LBHA leadership were asked to describe what would be helpful for their organization to utilize peer support services, regardless of the funding source. Leadership from twelve LMHAs/LBHAs responded to this question. The following facilitators were raised by leadership at two LMHAs/LBHAs: training or guidance on documentation for the Peer Support Services benefit, more support and guidance for peer supervisors, training in general, and raising the rate for the Peer Support Services benefit to reach parity with the Rehabilitative Services benefit. The following facilitators were raised by leadership at one LMHA/LBHA: more peer job candidates, more collaboration with other organizations, less restrictive certification practices, incentives for the development of peer-run programs, training for leadership and other staff on the peer specialist role, and greater awareness of the availability of peer support services. See Figure 6 for a full list of facilitators to the utilization of peer support services.

Figure 6: Facilitators to the utilization of peer support services.



Conclusion and Recommendations

Utilization of the Peer Support Services Medicaid Benefit

Results from a survey of LMHA/LBHA leadership in Texas (n=20) suggest that prior to the March 1, 2022 rate increase, most (70%) reported using the individual Peer Support Services benefit while half (50%) reported that they used the group peer support service Medicaid billing code. Among those that did not use the peer benefit, reported barriers to its use included:

- low reimbursement rates,
- a lack of certified peer specialists, and
- not providing individual or group peer support services.

Effective March 1, 2022 the rates for the individual and group Medicaid Peer Support Services benefit were raised (from $7.58 to $11.25 for individual peer support services and from $1.09 to $1.61 for group peer support services). When LMHA/LBHA leadership were asked if they planned to use the benefit going forward, 85% reported that they plan to use the individual Peer Support Services Medicaid billing code going forward (from 70% using prior) while 60% reported that they plan to use the group Peer Support Services code going forward (from 50% using prior).

75% reported they will also continue using Rehabilitative Services billing codes since the rate is higher and reflective of the cost of the peer support service provided.

However, 75% of LMHAs/LBHAs in the survey reported that peers at their organization also use the Medicaid Rehabilitative Services billing codes due to the fact that the reimbursement rate is much higher. In fact, the most commonly reported barrier to using the Medicaid Peer Support Services benefit was low reimbursement rates particularly that the rate does not cover salary, benefits, supervision costs, and overhead costs to hire peers. As a result of the lower reimbursement rate, peers may continue to bill using the Medicaid Rehabilitative Services codes. A second and related barrier to using the Medicaid Peer Support Service benefit reported by LMHA/LBHA leadership is a lack of certified peer specialists due to workforce shortages and/or a lack of time and money to train and certify employed peers.

LMHA/LBHA leadership were also asked to describe what would be helpful to support their organization using the Medicaid Peer Support Services benefit and the most commonly reported facilitator was to increase the reimbursement rate. Some LMHA/LBHA leadership specified that the rate should be raised to be comparable to the Medicaid Rehabilitative Services billing codes and to the value of certified peer professionals. LMHA/LBHA leadership also reported that training for peers and peer supervisors as well as ongoing technical assistance would be helpful to support their organization using the benefit.

[increase use of the benefit] "Adequate rates covering the cost of the salary and benefits recognizing the value of certified professionals."

Supporting Peer Support Services

A support the state could offer: "Incentivizing development of peer-run programs sustainable by contractors as well as LMHAs/LBHAs."

LMHA/LBHA leadership reported a mean number of peers employed at LMHAs/LBHAs was 11 while the median number of employed peers was 6. Perhaps as a result, most LMHAs/LBHAs (84%) reported they do not contract with any outside peer-run organizations to provide peer support services, with one reporting that "incentivizing development of peer-run programs sustainable by contractors as well as LMHAs/LBHAs" would be a support the state could offer.

LMHA/LBHA leadership were also asked if their organization provides referrals to any outside peer-run organizations to provide peer support services and most (53%) reported that they do provide referrals to outside peer-run organizations to provide peer support services. Most commonly, leadership reported their organization provides referrals to COSPs and clubhouses.

LMHA/LBHA leadership were asked to describe what other funding sources their organization uses to pay for peer support services or peer specialist salaries. The most commonly described funding source was federal grants (e.g., Certified Community Behavioral Health Clinic grants, Community Mental Health Center grants). Other commonly reported sources of funding included: general revenue, grant funded (not specified), and DSRIP (Delivery System Reform Incentive Payment) programs.

Other funding for peer support:

- *Federal grants*
- *General revenue*
- *Grant funded (not specified)*
- *DSRIP*

LMHA/LBHA leadership were asked to describe what would be helpful for their organization to utilize peer support services, regardless of the funding source. The following facilitators were raised by leadership at two LMHAs/LBHAs:

- training or guidance for peers on documentation to Medicaid standards and to reflect the peer service model of care,
- more support and guidance for peer supervisors,
- training in general, and
- raising the rate for the Peer Support Services benefit to reach parity with the Rehabilitative Services benefit.

The following facilitators were raised by leadership at one LMHA/LBHA:

- more peer job candidates,
- more collaboration with other organizations,
- less restrictive certification practices,
- incentives for the development of peer-run programs,
- training for leadership and other staff on the peer specialist role, and
- greater awareness of the availability of peer support services.

Recommendations

The following are recommendations to support the use of the Peer Support Services Medicaid benefit as well as peer support services generally. They reflect the data detailed in this report.

Incentives

These data suggest that more LMHAs/LBHAs will likely use the Medicaid Peer Support Services benefit as a result of the March 2022 reimbursement rate increase. However, the data also suggest that the rate increase is not sufficient to cover salary, benefits, supervision costs, and overhead costs to employ certified peers at the level of their professional value. This suggests the importance of further raising the reimbursement rate for the Medicaid Peer Support Services benefit to be more aligned with the Medicaid Rehabilitative Services rates. Otherwise, LMHAs/LBHAs may continue to have certified peer specialists bill using the Rehabilitative Services codes. Less common, but also suggested, were developing a peer supervisor benefit as well as incentives to develop peer-run programs both within LMHAs/LBHAs as well as outside to enhance collaboration with peer-run organizations.

Training and Technical Assistance

Peers and peer supervisors may benefit from training and continued technical assistance on using the Medicaid Peer Support Services benefit (including training and TA on documentation that meets Medicaid standards and reflects the peer service model of care). Data also suggest that peer supervisors would benefit from support and guidance in their roles and that leadership and other staff would benefit from training on the peer role.

Workforce Development

More resources are needed to support certification efforts of peer specialists in Texas, whether that means allocating resources to recruiting and hiring certified peer specialists or to certifying peer specialists that are already employed (or who want to be employed) at LMHAs/LBHAs in Texas. Procedural recommendations include automatic authorization of peer support services and updating Managed Care Organization systems to reflect the new Medicaid Peer Support benefit rates. Ideas shared by some LMHAs/LBHAs reflect a desire for opportunities to share and collaborate with other LMHAs/LBHAs (Certified Community Behavioral Health Centers) including monthly technical assistance support to stay current on requirements and learn from others on use of the benefit and peer support.

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