Topic Brief: Peer Recovery Support Services Payment Models for Substance Abuse

Date: 6/11/2021
Nomination Number: 0957

Purpose: This document summarizes the information addressing a nomination submitted on June 11, 2021, through the Effective Health Care Website. This information was used to inform the Evidence-based Practice Center (EPC) Program decisions about whether to produce an evidence report on the topic, and if so, what type of evidence report would be most suitable.

Issue:

Substance use disorders (SUDs) present a significant public health burden in the United States. As addiction has become increasingly recognized as a chronic condition, the treatment of SUDs has shifted towards a recovery oriented, coordinated chronic care approach.[1] Peer recovery support services (PRSS) are provided by peer coaches who use their lived experience of recovery from addiction to assist others in initiating and maintaining recovery. Integrating PRSS as a part of SUD treatment has been associated with improved outcomes, including decreased substance use and increased abstinence.[2] However, the existing payment models make funding for PRSS challenging.[3] The Recovery Coalition of Texas, an advocacy coalition of state recovery community organizations, is interested in a new evidence review on the effectiveness of alternative payment models for PRSS coverage.

Program Decision

The EPC Program will not develop a new evidence review on this topic because the volume of primary literature addressing the question of this nomination is too small.

Key Findings

- We found one systematic review[4] assessing the effectiveness of several alternative payment models (some of which included PRSS coverage) for adults with SUDs and/or mental health conditions.
- We found two randomized controlled trials (RCTs)[5, 6] examining the effectiveness of two alternative payment models, one for self-directed mental health care for adults with serious mental illness, and another for community-based treatment of young adults with SUDs, both of which incorporated reimbursement for some PRSS coverage.
- Neither the systematic review nor the two RCTs examined alternative payment models specific to PRSS.
- We identified several additional resources that may be helpful to the nominator. Specifically, we found five systematic reviews, one narrative review, eight research and policy briefs, and two federal agency reports describing the existing Medicaid-based coverage of PRSS across different states and evaluating a range of alternative payment models for the treatment of SUDs and, more broadly, for adults with chronic conditions.

Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines SUDs as the "recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." In 2019, 19.3 million (approximately 8%) American adults had SUDs.[7] Most people struggling with addiction require some combination of acute and long-term care that incorporates peer-support services to achieve lasting recovery.

SAMHSA defines a peer provider as "a person who uses his or her lived experience of recovery from addiction, and skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience."[8] Peer recovery support services are provided across multiple settings, including community mental health centers, residential homes, workplaces, and peer recovery organizations.

As of 2019, 37 state Medicaid programs covered PRSS for adults with SUDs, with the remainder being covered through SAMHSA programs (e.g., Substance Abuse Prevention and Treatment Block grants) and local state budgets. Most states use a combination of different Medicaid reimbursement mechanisms and waivers to fund PRSS using either fee-for-service or managed-care payment models.[9]

The existing payment models for PRSS coverage have shortcomings. Medicaid billing processes are complex and require that reimbursements be based on an identified unit of service delivered by a single peer provider and based on a pre-approved treatment plan, which does now allow sufficient flexibility to adjust the frequency or intensity of services based on individual patients' needs.[10] Additionally, most state Medicaid plans do not cover the full spectrum of peer services, particularly those delivered outside the context of outpatient SUD treatment through either community outreach or harm-reduction programs.[3] As a result, the American Society of Addiction Medicine along with other professional societies[11] and addiction recovery advocacy organizations call for alternative models of payment reimbursement for PRSS.

Nomination Summary

The nomination was submitted by the Recovery Coalition of Texas, an advocacy organization dedicated to advancing PRSS for adults with SUDs. With input from the nominator, the nomination scope was narrowed to focus on the effectiveness and comparative effectiveness of alternative payment models for PRSS for adults with SUDs. The nominator hopes to use the findings from this potential review to assist their member recovery community organizations to negotiate contracts for peer support services with healthcare payers.

Scope

- Key Question: What is the effectiveness and comparative effectiveness of different alternative payment models for peer recovery support services for adults with substance use disorders?

Table 1. Question and PICOTS (population, intervention, comparator, outcome, and setting)

Population	Adults with SUD eligible to PRSS
Interventions	APMs for PRSS, including but not limited to: • Pay-for-performance (payments directly linked to support services providers' performance)

	• Fee-for-service without link to service quality • Fee-for-service with link to quality • Condition-specific population-based payment (per-member per-month payments or non-fee-for-service payments for services treating populations defined by MH/SUD diagnosis) • Comprehensive population-based payment (non-fee-for-service global budgets or full/percentage of premium payments for defined populations not based on diagnosis or condition (e.g., commercial payer accountable care organization) • Integrated finance and delivery system (non-fee-for-service global budgets or full/percentage of premium payments in integrated systems (e.g., Kaiser Permanente) • Capitated payments not linked to quality • Blended or mixed payment models • Other alternative payment models
Comparator	Standard PRSS payment model or a comparator alternative payment model
Outcomes	**Patient health and satisfaction outcomes:** • Improvement in recovery capital measures assessed using BARC-10, ARC, or other validated recovery capital scales • Health related quality of life • Mortality • Morbidity • Rates of abstinence or reduced substance use • Rates of return to substance use • Length of time between relapse and returning into recovery program • Satisfaction with PRSS program **Non-clinical patient outcomes:** • Proportion of PRSS participants living in stable housing • Proportion of PRSS participants who are employed • Average monthly wages • Incarceration rate • Criminal offending rate **Healthcare utilization and cost outcomes:** • Total healthcare services utilization (e.g., inpatient/outpatient admissions, delayed discharges, nursing home admissions, etc.) • Total mental health services utilization • Total drug and alcohol services utilization • Total behavioral health services utilization • Cost per unit of peer recovery support services • Quantity of peer recovery support services provided per participant **Unintended or adverse effects** Neglect of non-incentivized services, etc.
Setting	Outpatient and community settings

Abbreviations: APMs=alternative payment models; ARC=assessment of recovery capital 50-item scale BARC-10=brief assessment of recovery capital 10-item scale; MH=mental health; PRSS=peer recovery support services; SUD=substance use disorders.

Assessment Methods

See Appendix A.

Summary of Literature Findings

One systematic review[4] from 2020 and two RCTs[5, 6] partially addressed the topic of this nomination. The systematic review[4] examined the effectiveness of 17 different alternative payment models to improve clinical, care process, healthcare utilization, and cost outcomes in adults with mental health conditions and/or SUDs. Only few of the included payment models, such as Oregon Coordinated Care Organizations and Massachusetts Alternative Quality Contract, integrated coverage for PRSS.

Since the systematic review only partially addressed the nomination's key question, we also searched for primary studies. Two RCTs[5, 6] evaluated two additional payment models. The first RCT[5] examined the effectiveness of a self-directed financing model to access a range of services, including PRSS, in adults with serious mental illness. The second cluster RCT[6] additionally compared the effectiveness of a pay-for-performance payment strategy compared to conventional payment models for implementation of the Adolescent Community Reinforcement Approach, which integrates peer coaching, in young adults with SUDs.

Table 2. Literature Findings

Question	Systematic reviews (8/2018-8/2021)	Primary studies (8/2016-8/2021)
Effectiveness and comparative effectiveness of APMs for PRSS for adults with SUDs	Total: 1[4] • Other – 1[4]	Total: 2[5, 6] • RCTs – 2[5, 6] • Clinicaltrials.gov – 0

Abbreviations: APMs=alternative payment models; PRSS=peer recovery support services; SUDs=substance use disorders; RCT=randomized controlled trial.

See Appendix B for detailed assessments of all EPC selection criteria.

Summary of Selection Criteria Assessment

Substance use disorders are associated with significant morbidity, mortality, and healthcare costs. The use of PRSS for the treatment of SUDs has been shown to improve outcomes, however, their delivery is constrained by existing payment models. Therefore, a new evidence review on the effectiveness of alternative payment models for PRSS coverage for adults with SUDs would be appropriate, important, and impactful.

One published systematic review[4] evaluating different alternative payment models for adults with SUDs and mental health disorders partially addressed the key question of this nomination. While we also found two RCTs[5, 6] examining two additional alternative payment models (both of which included some coverage for PRSS), the primary literature is too scant to develop a new evidence review on this topic.

Related Resources

We found five systematic reviews[12-16] (including two Cochrane reviews[12, 13] and one in-progress AHRQ realist review),[15] one narrative review,[17] eight research and policy briefs,[11, 18-24] and two federal agency reports[9, 25] describing the existing Medicaid based coverage for PRSS, evaluating state-by-state availability of PRSS as a function of reimbursement models and funding sources and examining alternative payment models for PRSS, and for delivering care for adults with SUDs and other chronic conditions.

One systematic review,[14] two federal agency reports,[9, 25] and one secondary analysis of national registry data evaluated funding and care delivery strategies *specific to PRSS in SUD care*.

- One 2021 systematic review[14] synthesized the existing evidence regarding implementation of PRSS, including common barriers and facilitators, and recommended best practices for the implementation using the Consolidated Framework for Implementation Research.
- A 2020 report by the U.S. Government Accountability Office[9] and a 2019 brief by the U.S. Medicaid and CHIP Payment and Access Commission[25] summarized payment coverage and delivery methods for PRSS by different state Medicaid programs and outlined opportunities for coordinating clinical and peer support services in SUD care.
- A 2019 report by the University of Michigan Behavioral Health Research Center[18] conducted secondary analysis of data from SAMHSA's National Mental Health Services Survey (N-MHSS) and National Survey of Substance Abuse Treatment Services (N-SSATS) directories to determine state-by-state availability of PRSS as a function of payment models and funding sources analyzed national registry data for peer support providers in the treatment of SUDs.

Four policy and research briefs[11, 19-21] examined alternative payment models for SUD care *(not PRSS specific)*.

- A 2018 research brief[19] by the Technical Assistance Collaborative and the Center for Healthcare Strategies examined considerations of implementing value-based payment models for SUD care across different states.
- A 2018 policy brief[11] by the American Society of Addiction Medicine (ASAM) and the American Medical Association (AMA) described the Patient Centered Opioid Addiction Treatment, the ASAM-AMA consensus alternative payment model for the office-based treatment of SUDs.
- A 2018 white paper[20] by the Alliance for Recovery Center Dejection Health Services described another alternative payment model, Addiction Recovery Medical Home (ARMH), which integrates evidence-based SUD treatment and payment system for chronic disease care.
- A 2020 report[21] of proceedings of the Forum on Mental Health and Substance Use Disorders by the National Academy of Sciences, Engineering and Medicine (NASEM) discussed the ARHM Model, which combined integrated addiction and mental health treatment with primary care and an alternative payment model.

Four systematic reviews[12, 13, 15, 16] (including two Cochrane reviews[12, 13] and one in-progress AHRQ realist review[15]), one narrative review,[17] and three policy reports[22-24] assessed alternative payment models for *coverage of integrated mental health and primary care services*.

- One narrative review[17] described payment models for the Collaborative Care, that integrates evidence-based and will health and primary care services.
- Two Cochrane reviews[12, 13] evaluated the effectiveness of different alternative payment models for outpatient primary care services.
- One in-progress AHRQ realist review[15] and another published systematic review from 2021[16] assessed the effectiveness of different payment models for primary care services for adults classified as high need high cost patients.
- Two policy briefs by the Technical Assistance Collaborative and the Center for Healthcare Quality and Payment Reform[23, 24] considered the effectiveness of the

Alternative Payment Model for Chronic Conditions and the Patient Centered Primary Care Payment Model for adults with chronic conditions.

- Lastly, a 2021 NASEM report[22] examined several payment models for integrated primary and behavioral health.

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Conflict of Interest: None of the investigators have any affiliations or financial involvement that conflicts with the material presented in this report.

Acknowledgements
Christine Chang, MD, MPH
Robin Paynter, LMIS
Charlotte Armstrong, BA

This report was developed by the Scientific Resource Center under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract No. HHSA 290-2017-00003C). The findings and conclusions in this document are those of the author(s) who are responsible for its contents; the findings and conclusions do not necessarily represent the views of AHRQ. No statement in this article should be construed as an official position of the Agency for Healthcare Research and Quality or of the U.S. Department of Health and Human Services.

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Appendix A: Methods

We assessed nomination for priority for a systematic review or other AHRQ Effective Health Care report with a hierarchical process using established selection criteria. Assessment of each criteria determined the need to evaluate the next one. See Appendix B for detailed description of the criteria.

Appropriateness and Importance

We assessed the nomination for appropriateness and importance.

Desirability of New Review/Absence of Duplication

We searched for high-quality, completed or in-process evidence reviews published between 8/19/2019 and 8/19/2021, relevant to the question of the nomination from these sources:

- AHRQ: Evidence reports and technology assessments
  - AHRQ Evidence Reports https://www.ahrq.gov/research/findings/evidence-based-reports/index.html
  - EHC Program https://effectivehealthcare.ahrq.gov/
  - US Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/
  - AHRQ Technology Assessment Program https://www.ahrq.gov/research/findings/ta/index.html
- US Department of Veterans Affairs Products publications
  - Evidence Synthesis Program https://www.hsrd.research.va.gov/publications/esp/
  - VA/Department of Defense Evidence-Based Clinical Practice Guideline Program https://www.healthquality.va.gov/
- Cochrane Systematic Reviews https://www.cochranelibrary.com/
- University of York Centre for Reviews and Dissemination database https://www.crd.york.ac.uk/CRDWeb/
- PROSPERO Database (international prospective register of systematic reviews and protocols) http://www.crd.york.ac.uk/prospero/
- PubMed https://www.ncbi.nlm.nih.gov/pubmed/
- Campbell Collaboration http://www.campbellcollaboration.org/
- McMaster Health System Evidence https://www.healthsystemsevidence.org/
- UBC Centre for Health Services and Policy Research http://chspr.ubc.ca/
- Joanna Briggs Institute http://joannabriggs.org/
- WHO Health Evidence Network http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/health-evidence-network-hen

Impact of a New Evidence Review.

The impact of a new evidence review was qualitatively assessed by analyzing the current standard of care, the existence of potential knowledge gaps, and practice variation. We considered whether it was possible for this review to influence the current state of practice through various dissemination pathways (practice recommendation, clinical guidelines, etc.).

Feasibility of New Evidence Review

We searched Ovid Medline, APA PsycInfo, and Cochrane Central Register of Controlled Trials (CENTRAL) for primary studies published between 8/19/2017 and 8/19/2021 and found 536 titles and abstracts. We initially reviewed a random sample of 200 titles and abstracts and found no relevant studies. We then reviewed the entire search yield and classified relevant studies by

study design to estimate the size and scope of a potential evidence review. We also searched ClinicalTrials.gov for a recently completed or in-progress trials. Table A provides search strategies for Medline, APA PsycInfo, and CENTRAL databases and a link to the ClinicalTrials.gov search results).

Table A. Search Strategy

MEDLINE ALL (Ovid) 1946 to August 18, 2021 Date searched: August 19, 2021
1 Ambulatory Care Facilities/ or Intersectoral Collaboration/ or Long-term Care/ or Peer Group/ or Social Determinants of Health/ or Social Support/ or Substance Abuse Treatment Centers/ or Substance-Related Disorders/ (244210) 2 (COCM or addiction or ambulatory or asthma* or chronic or ((collaborative or integrated) adj2 care) or community or diabet* or integrated or intersectoral or inter-sectoral or long-term or opioid or outpatient$1 or out-patient$1 or ((peer$1 or social) adj3 support*) or rehabilitat* or serious-illness* or substance-abuse or substance-use or support).ti,kf. (1739888) 3 or/1-2 (1906946) 4 Accountable Care Organizations/ or Capitation Fee/ or Economics, Medical/ or Insurance, Health, Reimbursement/ or Patient Care Bundles/ or Reimbursement, Incentive/ or Reimbursement Mechanisms/ or Value-Based Insurance/ or Value-Based Purchasing/ (42819) 5 (ACOs or APMs or P4P or "accountable care" or ((alternative or payer) adj3 (mechanism$1 or model$1)) or bundled or bundles or bundling or capitation or capitated or commissioning or contracting or compensation or fee$1 or financ* or funding or "pay-for-performance" or "paying-for-performance" or payment$1 or purchasing or reimburs* or remunerat*).ti,kf. (108015) 6 (((budget-based or episode-based or "episode of care" or "episodes or care" or population-based or value-based) adj15 (ACOs or APMs or P4P or "accountable care" or ((alternative or payer) adj3 model$1) or bundled or bundles or bundling or capitation or capitated or compensation or fee$1 or financ* or funding or "pay-for-performance" or "paying-for-performance" or payment$1 or reimburs* or remunerat*)) or ("Alliance Model" or "Contractor Model" or "Outcomes-based Commissioning and Contracting")).ti,ab,kf. (2257) 7 (((alternative or blended or capitated or mixed or population-based) adj3 payment*) or fee-for-service or "Integrated finance and delivery system" or non-fee-for-service).ti,ab,kf. (6727) 8 or/4-7 (141795) 9 and/3,8 (11058) 10 limit 9 to english language (10287) 11 (systematic review or meta-analysis).pt. or (meta-anal* or metaanal* or ((evidence or scoping or systematic) adj2 (review or synthesis))).ti. (308255) 12 and/10-11 (102) **13 limit 12 to yr="2018 -Current" (46) SYSTEMATIC REVIEW RESULTS** 14 (controlled clinical trial or randomized controlled trial).pt. or (control* or placebo or random* or trial).ti. or (controlled adj5 (before and after)).ti,ab,kf. (1249574) 15 and/10,14 (450) **16 limit 15 to yr="2016 -Current" (219) TRIAL RESULTS**
APA PsycInfo (Ovid) 1806 to August 18, 2021 Date searched: August 19, 2021
1 Integrated Services/ or Community Services/ or Interdisciplinary Treatment Approach/ or exp Long Term Care/ or Multimodal Treatment Approach/ or exp Outpatient Treatment/ or exp Peer Counseling/ or exp "Substance Use Disorder"/ or exp "Substance Use Treatment"/ or exp Support Groups/ (187168) 2 (COCM or addiction or ambulatory or asthma* or chronic or ((collaborative or integrated) adj2 care) or community or diabet* or integrated or intersectoral or inter-sectoral or long-term or opioid

or outpatient$1 or out-patient$1 or ((peer$1 or social) adj3 support*) or rehabilitat* or serious-illness* or substance-abuse or substance-use or support).ti. (276434)
3 or/1-2 (405320)
4 "Cost Containment"/ or "Costs and Cost Analysis"/ or Fee for Service/ or exp Finance/ or exp Funding/ or Health Care Costs/ or exp Health Insurance/ or exp Incentives/ or exp Insurance/ or exp Managed Care/ or exp Monetary Incentives/ or Professional Fees/ (66056)
5 (ACOs or APMs or P4P or "accountable care" or ((alternative or payer) adj3 (mechanism$1 or model$1)) or bundled or bundles or bundling or capitation or capitated or commissioning or contracting or compensation or fee$1 or financ* or funding or "pay-for-performance" or "paying-for-performance" or payment$1 or purchasing or reimburs* or remunerat*).ti. (18782)
6 (((budget-based or episode-based or "episode of care" or "episodes or care" or population-based or value-based) adj15 (ACOs or APMs or P4P or "accountable care" or ((alternative or payer) adj3 model$1) or bundled or bundles or bundling or capitation or capitated or compensation or fee$1 or financ* or funding or "pay-for-performance" or "paying-for-performance" or payment$1 or reimburs* or remunerat*)) or ("Alliance Model" or "Contractor Model" or "Outcomes-based Commissioning and Contracting")).ti,ab. (326)
7 (((alternative or blended or capitated or mixed or population-based) adj3 payment*) or fee-for-service or "Integrated finance and delivery system" or non-fee-for-service).ti,ab. (1084)
8 or/4-7 (76969)
9 and/3,8 (8750)
10 limit 9 to english language (8513)
11 limit 10 to ("0830 systematic review" or 1200 meta-analysis) (120)
12 10 and (meta-anal* or metaanal* or ((evidence or scoping or systematic) adj2 (review or synthesis))).ti. (84)
13 or/11-12 (126)
14 limit 13 to yr="2018 -Current" (32) SYSTEMATIC REVIEW RESULTS
15 limit 10 to "0300 clinical trial" (151)
16 10 and ((control* or placebo or random* or trial).ti. or (controlled adj5 (before and after)).ti,ab.) (301)
17 or/15-16 (384)
18 limit 17 to yr="2016 -Current" (145) TRIAL RESULTS

Cochrane Central Register of Controlled Trials (CENTRAL) August 18, 2021
Date searched: August 19, 2021

1 Ambulatory Care Facilities/ or Intersectoral Collaboration/ or Long-term Care/ or Peer Group/ or Social Determinants of Health/ or Social Support/ or Substance Abuse Treatment Centers/ or Substance-Related Disorders/ (10347)
2 (COCM or addiction or ambulatory or asthma* or chronic or ((collaborative or integrated) adj2 care) or community or diabet* or integrated or intersectoral or inter-sectoral or long-term or opioid or outpatient$1 or out-patient$1 or ((peer$1 or social) adj3 support*) or rehabilitat* or serious-illness* or substance-abuse or substance-use or support).ti. (552860)
3 or/1-2 (558446)
4 Accountable Care Organizations/ or Capitation Fee/ or Economics, Medical/ or Insurance, Health, Reimbursement/ or Patient Care Bundles/ or Reimbursement, Incentive/ or Reimbursement Mechanisms/ or Value-Based Insurance/ or Value-Based Purchasing/ (294)
5 (ACOs or APMs or P4P or "accountable care" or ((alternative or payer) adj3 (mechanism$1 or model$1)) or bundled or bundles or bundling or capitation or capitated or commissioning or contracting or financ* or funding or "pay-for-performance" or "paying-for-performance" or payment$1 or purchasing or reimburs* or remunerat*).ti. (1590)
6 (((budget-based or episode-based or "episode of care" or "episodes or care" or population-based or value-based) adj15 (ACOs or APMs or P4P or "accountable care" or ((alternative or payer) adj3 model$1) or bundled or bundles or bundling or capitation or capitated or fee or fees or financ* or

funding or "pay-for-performance" or "paying-for-performance" or payment$1 or reimburs* or remunerat*)) or ("Alliance Model" or "Contractor Model" or "Outcomes-based Commissioning and Contracting")).ti. (8)
7 (((alternative or blended or capitated or mixed or population-based) adj3 payment*) or fee-for-service or "Integrated finance and delivery system" or non-fee-for-service).ti. (41)
8 or/4-7 (1794)
9 and/3,8 (492)
10 limit 9 to english language (375)
11 limit 10 to yr="2016 -Current" (221) TRIAL RESULTS

ClinicalTrials.gov
Date searched: August 19, 2021

AREA[ResultsFirstPostDate] EXPAND[Term] RANGE[08/19/2016, 08/19/2021] | budget-based OR episode-based OR EXPAND[Concept] "episode of care" OR bundled OR capitation OR capitated OR compensation OR fees OR financing OR funding OR pay OR paying OR pays OR payment | budget-based OR episode-based OR EXPAND[Concept] "episode of care" OR bundled OR capitation OR capitated OR compensation OR fees OR financing OR funding OR pay OR paying OR pays OR payment (5)

Link to the ClinicalTrials.gov findings

Appendix B. Selection Criteria Assessment

Selection Criteria	Assessment
1. Appropriateness	
1a. Does the nomination represent a health care drug, intervention, device, technology, or health care system/setting available (or soon to be available) in the U.S.?	Yes. The topic nomination represents an intervention (alternative payment models for peer recovery support services in the treatment of SUDs)
1b. Is the nomination a request for an evidence report?	Yes. This topic is a request for a systematic review.
1c. Is the focus on effectiveness or comparative effectiveness?	Yes. The focus of a proposal review is on both effectiveness and comparative effectiveness.
1d. Is the nomination focus supported by a logic model or biologic plausibility? Is it consistent or coherent with what is known about the topic?	Yes. The existing fee-for-service payment model predominantly used to reimburse for PRSS does not align effectively with recovery centered approach to addiction care and constrains scaling up of peer recovery support services.
2. Importance	
2a. Represents a significant disease burden; large proportion of the population	Yes. 19.3 million Americans (approximately 8% of U.S. adults)[7] qualified as having SUDs in 2019. In 2017, the cost of SUDs in the U.S. was nearly $272 billion, including crime and healthcare related expenditures, lost work productivity and other impacts on society[26].
2b. Is of high public interest; affects health care decision making, outcomes, or costs for a large proportion of the U.S. population or for a vulnerable population	Yes. This topic affects healthcare financing decisions for a large proportion of the U.S. adults, which includes a vulnerable population of individuals with co-occurring mental illness (approximately 50% of individuals with SUDs) and those covered by Medicare and Medicaid plans[7].
2c. Incorporates issues around both clinical benefits and potential clinical harms	Yes. The existing fee-for-service payment model does not allow for effective delivery of PRSS. Uncertainty exists regarding which alternative payment models may provide the effective for coverage of PRSS for adults with SUDs.
2d. Represents high costs due to common use, high unit costs, or high associated costs to consumers, to patients, to health care systems, or to payers	Yes. This nomination addresses both benefits and potential harms (such as unintended neglect of services for SUD care that may not be incentivized by some payment models).
3. Desirability of a New Evidence Review/Absence of Duplication	
3. A recent high-quality systematic review or other evidence review is not available on this topic	Yes. We found one 2020 systematic review[4] examining the effectiveness of 17 alternative payment models for adults with SUDs and/or mental health conditions for clinical, process of care and healthcare utilization and cost outcomes. Notably, none of the included studies examined payment models specifically designed for PRSS.
4. Impact of a New Evidence Review	
4a. Is the standard of care unclear (guidelines not available or guidelines inconsistent, indicating an information gap that may be addressed by a new evidence review)?	Yes. The effectiveness of alternative payment models compared to the standard fee-for-service payment model used to reimburse for PRSS is unclear.
4b. Is there practice variation (guideline inconsistent with current practice, indicating a potential implementation gap and not best addressed by a new evidence review)?	Yes. Different payment models are used to reimburse for PRSS cross state Medicaid plans, and by other state and federal payers, and health systems[9].

5. Primary Research	
5. Effectively utilizes existing research and knowledge by considering: - Adequacy (type and volume) of research for conducting a systematic review - Newly available evidence (particularly for updates or new technologies)	We found only two RCTs[5, 6] partially addressing the nomination's key question. *ClinicalTrials.gov*. We did not identify any ongoing trials of the effectiveness of alternative payment models for PRSS coverage.

Abbreviations: AHRQ=Agency for Healthcare Research and Quality; PRSS=peer recovery support services; RCTs=randomized controlled trials; SUDs=substance use disorders; U.S.=United States.