PEER SUPPORT BILLING PATHWAYS
Peer Support Billing Pathways

In 1999, the emerging practice of behavioral health-oriented Peer Support radically advanced when the state of Georgia worked with the Centers for Medicare and Medicaid Services (CMS) to secure billing policy for the provision of Peer Support through the Medicaid Rehabilitation Option. Since that time, Peer Support has grown to be recognized by public and private payers, multiple state and federal agencies, and is implemented in many countries throughout the world (Puchner, 2018; Shalaby, 2020; AAFP, 2014). The White House has further reinforced the importance of the Peer Support workforce, recognizing the need to “[b]uild a national certification program for peer specialists...which will accelerate universal adoption, recognition, and integration of the peer mental health workforce across all elements of the health care system” (The White House, 2022).

While payers and governing bodies vary in their definitions of behavioral health Peer Support, the definition recognized by the U.S. Health & Human Services’ Substance Abuse and Mental Health Services Administration is the most generally accepted definition:

**DEFINITION:**

Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both. This mutuality—often called “peerness”—between a peer support worker and a person in or seeking recovery promotes connection and inspires hope.

Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships (Mead & McNeil, 2006). By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves (SAMHSA, 2017).
The individuals who provide this crucial recovery support intervention are called by a variety of titles in different jurisdictions (SAMHSA, 2017). States vary in the titles assigned to Peer Support Workers (referred to as PSWs henceforth in this paper). The PSW is defined as an individual who has been successful in the recovery process and who helps others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, the PSW helps people become and stay engaged in the recovery process and reduce the likelihood of relapse. Because of their life experience, such persons have expertise that professional training cannot replicate (SAMHSA, 2017). A PSW, for purposes of this paper, can be:

1. A trained and credentialed practitioner who has individual lived experience of either a recovery journey with a behavioral health condition (mental health or substance use)

2. A family member who, by virtue of being a part of a child’s family system, has lived experience of a behavioral health condition within the family system and provides Peer Support through that lens (often referred to as Parent/Family Peer Support).

With the 1999 recognition of the guild of PSWs in the state of Georgia and, subsequently and more formally, with the memorandum specific to Peer Support in 2007, CMS became the first large insurance payer to endorse reimbursement of PSWs (CMS, 2007). CMS further etched their support of reimbursement of this service and the related guild in behavioral health memoranda specific to Supported Employment (CMS, 2011), Substance Use Disorder (CMS, 2015), and Child and Adolescent Peer Support (CMS 2013, 2015) as well as more generalist guidance (HHS, 2013). As the largest payer of behavioral health services in the country (MACPAC, 2015), this public payer plan has slowly built out more pathways within Medicaid for Peer Support and influenced other payers in the health care industry.

These Peer Support payment pathways are the core subject of this paper. Content herein identifies various Medicaid, Medicare, and other payer billing pathways; will identify specific facility/provider types in which PSWs can practice (if defined); and, finally, will consider these unique service model cost and productivity considerations for the successful utilization of PSWs.

**WHAT DOES A PEER SUPPORT WORKER DO?**

A peer support worker is someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. They provide support to others experiencing similar challenges. They provide non-clinical, strengths-based support and are “experientially credentialed” by their own recovery journey (Davidson, et al., 1999). Peer support workers may be referred to by different names depending upon the setting in which they practice. Common titles include peer specialists, peer recovery coaches, peer advocates, and peer recovery support specialists.

**PEER SUPPORT WORKERS:**

- Inspire hope that people can and do recover.
- Walk with people on their recovery journeys.
- Dispel myths about what it means to have a mental health condition or Substance Use Disorder.
- Provide self-help education and link people to tools and resources; and support people in identifying their goals, hopes, and dreams, and creating a roadmap for getting there.

Peer support workers can help break down barriers of experience and understanding, as well as power dynamics that may get in the way of working with other members of the treatment team. The peer support worker’s role is to assist people with finding and following their own recovery paths, without judgment, expectation, rules, or requirements. Peer support workers practice in a range of settings, including peer-run organizations, recovery community centers, recovery residences, drug courts, and other criminal justice settings, hospital emergency departments, child welfare agencies, homeless shelters, and behavioral health and primary care settings. In addition to providing the many types of assistance encompassed in the peer support role, they conduct a variety of outreach and engagement activities (SAMHSA, 2017).
Medicaid Payer Pathways
In accordance with federal regulation (Social Security Act, Sec. 1903. [42 U.S.C. 1396b] (a)), states can define a plan for the provision of Medicaid benefits that is unique to that state and its Medicaid beneficiaries. Further provisions allow states to define innovation and waiver approaches to the provision of state Medicaid initiatives (Social Security Act, Sec.1115, Sec.1905, Sec.1915, Sec.1945, and related provisions granted by CMS). Additionally, several Medicaid service delivery models include multi-disciplinary teams, so while PSWs may not be a specifically named practitioner, there are allowances that can scope-in the use of PSWs within specific billing models.

For the content presented herein, the reader must consider the public health sector adage: “If you’ve seen one Medicaid program, you’ve seen one Medicaid program (Adams, 2013; Olson, 2010).” The very nature of the Social Security Act is premised on state Medicaid programs as unique, state-driven partnerships with the federal Centers for Medicare and Medicaid Services. As such, the following pathways defined herein are prevalent models supported by some state-specific examples. These are offered to assist the reader in seeking knowledge of state-specific Medicaid plans and models which enable peer support.

The Centers for Medicare & Medicaid Services (CMS) has set forth a series of memoranda and guidance which define Peer Support as a distinct service, and which define peer support workers (which are recognized practitioners delivering this specific service or providing another behavioral health service within the scope of generally defined practice). The following are a consolidation of those definitions represented in a series of those documents.

PEER SUPPORT AS DEFINED BY THE FEDERAL CENTERS FOR MEDICARE & MEDICAID SERVICES:
Peer support services are an evidence-based mental health model of care consisting of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders, particularly helping 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. Supervision and care coordination are core components of peer support services.

Specific to youth supports, the parents/legal guardians of Medicaid-eligible children can receive Peer Support services when the service is directed exclusively toward the benefit of a Medicaid-eligible child. Activities could include but are not limited to, developing formal and informal supports, instilling confidence, assisting in the development of goals, and serving as an advocate, mentor, or facilitator for the resolution of issues and skills necessary to enhance and improve the health of a child with emotional, behavioral, or co-occurring disorders. Peer supports are a set of peer-based activities that engage, educate, and support youth to successfully make behavioral changes necessary to recover from disabling substance use/mental health disorder conditions. Service activities include assisting the individual in developing self-management strategies, conducting one-on-one support sessions, organizing structured pro-social activities, developing goals and recovery/wellness plans, and providing crisis support and linkage to natural supports in the workplace and other environments. The individual providing peer support can perform a range of tasks to assist the parents/legal guardians of a Medicaid-eligible child during the recovery process (CMS, 2007, 2013, 2015; HHS, 2013).
Traditional Outpatient BH Services
Peer Support services are a part of most state Medicaid behavioral health system designs. In most state outpatient models, this code is billed as H0038 - Self-Help/Peer Services (individual model) or as H0038 HQ Self-Help/Peer Services (group model) (HCPCS, 2022). The individual model is generally billed in 15-minute increments while the group models may be billed in either 15-minute or 1-hour increments.

In some states, modifiers are required by Medicaid policy to denote when a different type of lived experience is carried by the peer support worker. See these examples:

- A peer support worker with mental health lived experience may be required to use a mental health specific modifier such as HE (mental health program) when supporting someone with a mental health condition; or
- A peer support worker with substance use recovery experience may be required to use a substance use specific modifier such as HF (substance use program) when supporting someone with a substance use disorder.

For child-centered Peer Support services, states have more variable approaches to the billing mechanism and codes (Schober, 2019). Many states have specifically identified the H0038 code named above as this specific pathway for billing. For instance, Georgia and Alabama use the H0038 base code with an HA modifier (Child/Adolescent Program) or an HS modifier (Family-specific) denoting that the service is targeted to youth. Other states such as Michigan use the TJ modifier (program type child/adolescent) along with the H0038 base code (Schober, 2019).

Other states define youth-targeted peer support services in policy, but the billing code naming conventions are more generic (Schober, 2019). Examples of these include:

- HCPCS Code SS110: Home care training, family (Kansas, Louisiana)
- HCPCS Code T1027: Family training and counseling for child development (Oklahoma)
- HCPCS Code H0046: Mental health services, not otherwise specified (Idaho)

PEER SUPPORT WORKER AS DEFINED BY THE FEDERAL CENTERS FOR MEDICARE & MEDICAID SERVICES:
CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a state's delivery of effective treatment. Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Additionally, peer support providers must be sufficiently trained to deliver services. 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. Like other provider types, ongoing continuing education requirements for peer support providers must be in place.

Specific to youth, individuals providing services to a youth may meet the definition above or, when providing peer support to the parents/legal guardians of a Medicaid-eligible child, can be a parent of a child with a similar mental illness and/or substance use disorder, or an adult with an ongoing and/or personal experience with a family member with a similar mental illness and/or substance use disorder (CMS, 2007, 2013, 2015; HHS, 2013).
When peer support is delivered as a part of a Medicaid outpatient state plan benefit, there is generally an expectation that the service is provided via a credentialed agency model. States vary in their qualifications for these agencies with the prevalent agency models defined here:

**Community Behavioral Health Center Models**
Generally, governmental or quasi-governmental agency types identified in law as providing comprehensive behavioral health services to a designated geographic area. These public frameworks provide the necessary clinical infrastructure to support and supervise the peer support workers within a broad scope of multi-disciplinary practice.

**Comprehensive Behavioral Health Service Agencies:**
Stand-alone non-profit or for-profit agencies who provide comprehensive behavioral health services. The comprehensive nature of these agencies provides the necessary clinical infrastructure to support and supervise the peer support workers within a broad scope of multi-disciplinary practice.

**Specialty Provider Agencies**
Stand-alone non-profit or for-profit agencies who provide more specialized behavioral health services. For instance, an Opioid Treatment Program or a Psychosocial Rehabilitation agency may desire and be qualified to provide peer support under its unique mission. The agency will likely be required to demonstrate a defined infrastructure (perhaps through licensing, accreditation, or certification) which provides the necessary clinical infrastructure to support and supervise the peer support workers through its staffing and policy.

**Peer-Run/Family-Run Organizations**
Stand-alone non-profit or for-profit agencies who provide more specialized behavioral health services, specifically offering themselves as a lived-experience organization. For instance, a peer-run agency may desire and be qualified to provide peer support under a unique lived experience mission. The agency will likely be required to demonstrate a defined infrastructure (perhaps through licensing, accreditation, or certification) which provides the necessary clinical infrastructure to support and supervise the peer support workers through its staffing and policy.

The Behavioral Health Excellence-Technical Assistance Center provides training and technical assistance for HRSA's Behavioral Health Workforce Development Grantees. Learn more at bhe-tac.org.
Rehabilitative/Non-Traditional Outpatient Services

While Peer Support generally has clear billing parameters for Medicaid Behavioral Health Outpatient service delivery, there remain several other non-traditional outpatient services through which PSWs can provide peer-oriented service through alternate mechanisms. A few of those models are:

**Assertive Community Treatment (ACT)** is a multi-disciplinary group of professionals including a psychiatrist, a nurse, a social worker, a substance use disorder specialist, a vocational rehabilitation specialist, and a PSW who provide intensive treatment to individuals with severe and persistent mental illness. ACT supports individuals to function in community living, with an approach to coordinating care across multiple systems (e.g., social services, housing services, health care) (SAMHSA, 2008).

**Opioid Treatment Programs** as federally defined programs for the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to an opioid use disorder. This term includes a mandatory range of services including detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment, comprehensive maintenance treatment, and interim maintenance treatment (Social Security Act, 42 CFR § 8.2). Under the direction of a physician, Recovery Support and Peer Support are provided as a part of a comprehensive set of wrap-around services for individuals in opioid treatment. Specifically, the Medication Assisted Treatment model also incorporates Peer and Recovery Support services as well. This allowance has been promoted by the Association for Addiction Professionals (NAADAC, 2022).

**Child/Family Team Services for Children, Adolescents, And Young Adults** are child-centered, family-driven models using a Child-Family Team (CFT) approach to structuring flexible wrap-around support to a young person in need. Parent and/or Youth Peer Support are named as essential elements of this team services array in many states including Georgia, Maryland, and Wyoming.
Residential, Sub-Acute, and Acute Services

**Behavioral Health Residential Facilities:** There are a range of types of interventions and levels of care which are provided in various residential models. Policy and regulation for these service levels include allowances for variety of personnel. While some states clearly define that PSWs can be members of these treatment teams, others use generalist terms such as Behavioral Health Parapersonnel (Arizona, Georgia), Behavioral Health Technicians (Arizona) or even general terms such as “sufficient number of staff” (Washington) which can include PSWs (WAC, 2018). Given the references provided above, PSWs can be integrated into meaningful peer support roles within these programs.

**Behavioral Health Inpatient Facility** treatment provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to be a threat to self or others. This is an acute level of care. Regulations generally allow Behavioral Health Technicians and Behavioral Health Parapersonnel as described above to be staff in these service settings.

**Medicaid Managed Care**

With federal CMS approval, Medicaid managed care arrangements can be entered into between states and selected accredited vendors for the provision of health service delivery. Through agreements with CMS and/or via the state Medicaid authority, vendors can deploy innovative practice to pilot or target serving Medicaid beneficiaries in the most efficient and effective manner. Per CMS, “improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care” (Medicaid, 2022).

State managed care is authorized by federal CMS through several mechanisms (1932(a), 1915(a), 1915(b) or 1115 waiver models) which waive certain provisions of federal Medicaid rule and regulation in accordance with agreed upon parameters between the state and CMS (Medicaid, 2022). Managed care plans have the flexibilities to offer value-added benefits to members (additional benefits beyond what is required by the state Medicaid agency to reduce costs or promote outcomes) or “in lieu of services” (ILOS) which are alternatives to state plan services or settings and, again, offered to reduce costs/achieve quality (CMS-2390-F, 2022). This gives plans the option to adopt and test emerging practice designs in healthcare delivery, allowing innovation to emerge. For instance, in North Carolina, Mental Health Intensive Outpatient Program services (including Peer Support) are offered in lieu of other Medicaid State Plan services (WellCare, 2022). In Arizona, the Comprehensive Medical and Dental Program (CMMDP) for foster care youth allows “in lieu of” alternatives to inpatient psychiatric treatment (ADCS, 2018). This allows a PSW-delivered approach to be negotiated with a managed care vendor. Through this pathway, almost any emerging practice with sound medical necessity underpinnings and outcomes may be considered, including a variety of peer-delivered models.
Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is a community-based health provider who meets rigorous standards to be designated as such and to receive funds from the Health Resources and Services Administration (HRSA) as well as through Medicaid. Services are comprehensive, include direct care as well as supportive services (health education, transportation, etc.), and must be provided regardless of an individual’s ability to pay (including billing Medicaid, providing sliding fee scales, etc.) (HRSA, n.d.). An FQHC has a set of mandatory services which must be provided and then can provide additional services based on needs in the community and patient base. Mandatory services which are behavioral health-related include assessment, evaluation for medication needs, referral to behavioral health practitioners, social determinants support, and case management. Optionally, the FQHC can provide “behavioral and mental health and substance use disorder services (42 USC 254b).” When a service is delivered to a person, the FQHC bills what is called a Prospective Payment System rate which includes healthcare costs and utilization trends in a formula which yields a daily payment when an individual is seen.

States can define many aspects of FQHC policy through Medicaid payment policy or through other health certification policy statements. For instance, in Arizona, the state health authority defines parameters for the provision of behavioral health services in specific policy guidance (AHCCCS FQHC, n.d.). Per the guidance, when behavioral health services are adopted for provision by an FQHC, Behavioral Health Technicians (BHTs) can be recognized as a part of the FQHC team composition if they are providing services which are defined as “incident to.” “Incident to” other FQHC services mean that they must be “of a type commonly furnished in a physician’s office;” “furnished as an incidental, although integral, part of the professional’s service;” and “furnished under the direct supervision of the professional” (AHCCCS, n.d.). PSWs working as BHTs would be providing service intervention which would be supportive of FQHC health intervention plans. (AHCCCS, n.d.). This type of work can include health/wellness activation, skills to promote recovery/psychosocial rehabilitation, and psychosocial interventions.

Federal HRSA guidance through FQHC behavioral health expansion grants also clearly indicate that “Other Mental Health staff” (unlicensed) are allowable staff as well as “Substance Use Disorder Providers.” “Other Mental Health staff” are defined as “certified” individuals who provide counseling, treatment, or support to mental health providers. An additional approved category of staff is defined as “Enabling Staff” under which PSWs may be hired. The functional list of descriptions for this staff include the following: Patient Education, Community Education, Outreach Workers, and Care Coordination support (HRSA-SIF, n.d.).
**Rural Health Clinics (RHC)**
This practice model is quite like an FQHC model except for a few parameters, primarily that the RHC has some flexibilities regarding physician access and oversight and that the clinic must meet slightly differing expectation regarding its location in underserved areas/population as defined by the state or federal sources (HRSA-ORH, n.d.).

**Collaborative Care Models (CoCM)**
Collaborative Care Models (CoCM) are team-based approaches through which integrated physical and behavioral health are provided and coordinated. Medicare policy is generally conservative and per Medicare, a Psychiatric Collaborative Care Model (CPT Billing Codes 99492, 99493, and 99494 or G0512 when provided by an FQHC) “…enhances ‘usual’ primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving” (Medicare, 2018). The model is defined by Medicare as having a treating practitioner as the billing agent and two other team members who provide services “incident to” the treating practitioner. Team member definitions are provided (Medicare, 2018):

- **Treating Practitioner**: A physician or non-physician who can serve as a recognized medical billing practitioner (such as a Physician’s Assistant, Nurse Practitioner, etc.).
- **Psychiatric Consultant**: A medical professional trained in psychiatry and qualified to prescribe the full range of medications.
- **Behavioral Health Care Manager**: A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner. Further, guidance offers that this position may or may not be a professional who meets all the requirements to independently furnish and report services to Medicare giving flexibility to allow PSWs on these teams. Additional CMS Frequently Asked Questions indicate that the Behavioral Health Care Manager does not have to be an employee of the Treating Practitioner (the PSW could work for another behavioral health entity and provide service for the CoCM team as a contractor, employee, or employee of another partner organization) (CMS, 2018). The FAQ also states that specialized training in behavioral health is required for this role, but Medicare does not specify a minimum education requirement. Further guidance reinforces that the care manager “need not be licensed” (AIMS, 2021).

The Behavioral Health Care Manager provides behavioral health continuous care planning in relation to behavioral/psychiatric health problems; provides brief psychosocial interventions, such as behavioral activation, problem-solving treatment, and other focused treatment activities; builds a relationship with the person receiving treatment; and has a collaborative, and integrated relationship with the rest of the care team. Finally, the care manager provides assessment (through use of scale tools) and care management services. While the definition does not specifically call for a peer practitioner, the scope of role can allow a PSW to function in this role, particularly considering the charge for activation, problem-solving, and motivational aspects of the service model (Medicare, 2022).

Components of CoCM models generally include outreach and engagement, initial assessment, treatment planning, progress monitoring/adjustment, behavioral activation, problem-solving treatment, focused-treatment activities; ongoing collaboration and coordination with other treating providers, and relapse prevention planning and preparation for discharge from active treatment (AIMS, 2019).

There is a 2021 behavioral health refinement to the CoCM model which enables specific billing codes for this Psychiatric CoCM model. This service is titled Behavioral Health Integration Services (BHI) and codes are designated for implementation of the CoCM model, allowing different billing intervals and emphasis on behavioral health while still maintaining integrity to the delivery model and staffing patterns above (Medicare, 2021). The reimbursement rate is set annually based on practice trends and averages for collaborative codes (FQHC Center, n.d.).
Emerging Healthcare Opportunities

9-8-8 and Related Crisis Infrastructure
In accordance with federal law passed in Summer 2020, the Federal Communications Commission was charged with designating 9-8-8 as a simple, easy-to-remember, 3-digit dialing code for the National Suicide Prevention Lifeline (Lifeline). The law requires all covered telecommunications providers to implement 9-8-8 in their networks by July 16, 2022.

Later, in the Fall of 2020, the U.S. Congress passed the National Suicide Hotline Designation Act of 2020 which was signed into law as PL 116-172. The law reinforced the designation of the 9-8-8 number and specifically set forth expectations related to how 9-8-8 should be implemented. While much of the law emphasizes the response expectations for the crisis call centers, it also defined the expectation for expansion of mobile crisis response, emergency receiving (such as Crisis Stabilization Units), and emergency department/psychiatric bed capacity, which has been reinforced in subsequent law and appropriations to states.

This massive expansion is yielding a tremendous amount of dialogue regarding PSWs in crisis support roles. The Substance Use and Mental Health Services Administration (SAMHSA) has stated that the “significant use of peers” is essential and must “be ‘baked into’ comprehensive crisis systems” (SAMHSA-Crisis Toolkit, n.d.). Many states support PSWs working in all (Georgia [DBHDD, n.d.]; Arizona, [AHCCCS-CH, n.d., AHCCCS- BHCSCC, n.d.]) or selected aspects of these crisis services which are summarized here:

Crisis Call Center: There are a range of behavioral health call center models around the country. For this paper, only professional models (paid call responders) are presented. Call respondents are trained crisis specialists, which in most states are not limited to licensed professionals but include trained individuals including those with high school level education plus experience. This can include a PSW. Functionally, the crisis specialists respond to crisis calls, texts, or live chat to effectively coordinate care and resolve crisis situations, quickly determining urgent needs and offering compassionate and skilled response through interaction, assessment, and intervention.

Warm Call Line Response: There are a range of models around the country. For this paper, only professional models are presented. Arizona has a variety of Warm Call Line models including Peer-specific warm lines whereas Georgia has warmlines only staffed by PSWs. Peer Support warm lines provide phone line support and connection to support the caller in their recovery. Specifically, the PSW uses their own personal experience to engage the person in a collaborative conversation with respect and acceptance. The PSW helps the caller to clarify and validate the situation and/or their responses/feelings and identify effective coping strategies, or the PSW determines the need for a referral to a more formal response.
**Mobile Crisis Models:** Mobile Crisis Services are provided by a multidisciplinary Mobile Crisis Team which travels throughout the community to the place where the individual is experiencing the crisis to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop a plan to meet the needs of the individual served. Response team members include Behavioral Health Paraprofessionals or Behavioral Health Technicians (who may be PSWs) under the supervision of other behavioral health professionals.

**Crisis Stabilization Unit Services:** Crisis Stabilization Unit services are immediate, unscheduled, facility-based behavioral health service provided in response to an individual's behavioral health issue to prevent imminent harm, to stabilize, or resolve an acute behavioral health issue. Individuals may walk-in or be referred or transported to these settings. These services generally also include temporary observation and detoxification services. The service is provided by a multi-disciplinary team. Many states’ policies articulate that this team includes credentialed PSWs [e.g., Arizona, Georgia, Ohio].

**Living Room Models:** The “living room” model is a community-based crisis respite model which is anchored in recovery concepts, providing non-traditional yet safe crisis intervention, delivered by PSWs (with supervision) (SMI, 2020). Also called Peer Crisis Respite, this type of intervention provides a more recovery-oriented alternative to an Emergency Department or Crisis Stabilization unit for individuals experiencing crisis (Heyland, 2013). Several states (e.g., Arizona, Georgia, Illinois, North Carolina, Ohio, South Carolina) have these facilities operational with more likely to emerge with the rolling implementation of 9-8-8 supporting services (Vestal, 2020). Arizona and Georgia authorities have billing codes emerging to codify the model (ACH, n.d.; DBHDD-PM, 2022). As these facilities are staffed, almost in full, by PSWs, they are an excellent pathway for this workforce to practice.

**Co-Responder Models:** These models are emerging in certain municipalities and regions where a clinician or PSW are partnering with law enforcement on responding to community concerns where an individual may have a behavioral health condition (Richmond, 2022; Casanova, 2021; Schmidt, 2021; Bunts, 2021). Co-responder teams are law enforcement response models which emanate from the 9-1-1 pathway (versus 9-8-8) yet seek to provide similar crisis intervention strategies. The program models provide community-based crisis response/de-escalation, screening/triage, brief assessment, referrals and linkages to community-based services, peer support and care coordination. This model is further promoted through Congress with bills introduced, most known as Crisis Assistance Helping Out on The Streets (CAHOOTS) proposals. It should be noted that some states are developing targeted crisis training models for PSWs (Oklahoma, Indiana).
School-Based Mental Health

Many states are promoting the use of Parent, Family, and/or Youth PSWs in the delivery of school-based mental health services. Per the U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare and Medicaid Services (CMS), behavioral health services in schools may be organized into “a multi-tiered system of supports (MTSS) ranging from offering services universally to all students to providing more intensive services for select students based on medical necessity” (CMS/SAMHSA, 2019).

In Tier 3 of the model, services are generally for students identified as “experiencing mental health or substance-related difficulties and may include individual or family/caregiver treatment or other individualized interventions to address the identified illness or condition” (CMS/SAMHSA, 2019). In a joint informational bulletin, SAMHSA and CMS provide guidance for behavioral health treatment services and supports in schools and includes the identification of Peer Support as an intervention strategy for school-based mental health (CMS/SAMHSA, 2019). The joint memorandum is specific in identifying that “Support from...peers can be critical to help children and adolescents and their families and caregivers navigate challenges associated with mental and substance use issues, and can enhance efforts of practitioners and others in the school and health system” and further reinforces this service by stating “Peer and family support is critical to help children, adolescents and their families with serious emotional disturbance engage in and navigate complex systems of care” (CMS/SAMHSA, 2019).

Arizona is an example of a state that has adopted this collaborative agency approach locally to not only build school-based mental health service, but to also reinforce the role of peer support as a primary element of that intervention. The Arizona Health Care Cost Containment System (AHCCCS) and state Department of Education have guidance to the field related to school-based mental health service delivery. In the brief titled School & Behavioral Health Partnerships: A Resource Guide, Peer Support and Family Peer Support are named as Tier 3 interventions “to address mental health concerns...to meet the unique needs of each student who is already displaying a particular concern or problem and displaying significant functional impairment” (AHCCCS/DOE, 2021).
Certified Community Behavioral Health Clinic (CCBHC)

CCBHC models provide a comprehensive range of outreach, screening, assessment, treatment, care coordination, and recovery supports, and support recovery from mental illness and/or substance use disorders (SUD) by providing access to high-quality mental health and SUD services, regardless of an individual’s ability to pay. There are currently more than 450 CCBHCs named and operating in the U.S. and territories and the list is expanding each year (National Council, n.d.; HHS, 2022).

Peer Support and Family Support are mandatory services which must be provided by the CCBHC. Specifically, the CCBHC is responsible for employing PSWs and family/caregiver supports. Stretching beyond the mandatory service and staff requirements, CCBHC standards require that the CCBHC recovery-oriented systems of care embrace recovery as emerging from hope; interventions are person-driven; occur via many pathways; are holistic; are supported by peers and allies; are culturally-based and influenced; are supported through relationship and social networks; involve individual, family, and community strengths and responsibility; are supported by addressing trauma; and based on respect (SAMHSA, 2022).

Medicare

Medicare does not currently recognize Peer Support through its general benefits plan; however, there are four encouraging trends to denote:

1. In 2019, CMS released correspondence to Medicare Advantage plans encouraging the coverage of Peer Support for substance use disorder treatment and support. The document specifically names as an example “peer support services’ delivered by qualified individuals may be effective in facilitating recovery and assist in navigating health care resources. For purposes of completing the PBP, peer support services and/or psychosocial services/cognitive behavioral therapy can be included in counseling services.” In the memorandum, CMS identified that the Medicare Advantage Plan can use the Plan Benefit Package citation 14c for Counseling Services as the umbrella for the provision of this support. Medicaid Advantage plan would have to enable this provision for the service to be enabled through a provider to a beneficiary (CMS, 2019).
2. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required federal CMS to implement an incentive program which has been branded the Quality Payment Program. Practitioners can participate one pathway, the Merit-based Incentive Payment System (MIPS) (CMS, n.d.). The MIPS incentive content recognizes certain quality measures. For the Calendar Year 2022 Performance Period/2024 MIPS Payment Year and Future Years, Beneficiary Engagement is a named Subcategory with “Promote Self-Management in Usual Care” as an activity, “peer-led support for self-management” and “condition-specific chronic disease or substance use disorder self-management programs” are each named as part of the activity description. While many entities may not be prepared to actualize this model, it is an emerging opportunity of which to be aware (CMS, n.d.).

3. In July 2022, CMS has signaled proposed changes to the Medicare program to enable new practitioners to provide behavioral health services under more flexible supervision expectations (changing “direct supervision” requirements to “general supervision” requirements). The intent is “to reduce existing barriers and make greater use of the services of behavioral health professionals, such as licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs)” (CMS, 2022). An accompanying CMS blog to the proposal specifically identifies the operational manifestation of the proposal, including the use of PSWs:

> “We are proposing to create an exception to supervision requirements, allowing marriage and family therapists, licensed professional counselors, addiction counselors, certified peer recovery specialists [emphasis added], and others to provide behavioral health services while being under general supervision rather than “direct” supervision. Practically speaking, this means that these behavioral health practitioners would be able to provide services without a doctor or nurse practitioner physically on site, expanding access to behavioral health services like counseling and cognitive behavioral therapy in additional communities, particularly rural or underserved communities where care can be hard to find.” (Seshamani, 2022).

Medicare does also cover the Collaborative Care Model (CoCM) as mentioned earlier in this document.
Veteran’s Health Administration

The Veteran’s Health Administration (VHA) behavioral health program was an early adopter of Peer Support, beginning services in the early part of the century (following a few state model leaders). In 2012, a White House Executive Order charged the VHA with producing a Peer Support Toolkit to further promote expansion of the service delivery (VHA, 2013). The Toolkit defines the two types of Peer Support practitioners recognized by the VHA:

- Peer Specialists (PSs); and
- Peer Support Technicians (PSTs)

The toolkit also defines how PSWs can and should be integrated into VHA behavioral health models:

- VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (2008) mandates the availability of peer support providers: “All Veterans with SMI must have access to peer support services, either on-site or within the community” (p. 28).
- VHA Handbook 1162.02 Mental Health Residential Rehabilitation Programs states, “Programs must engage the Veteran in peer support while enrolled in the program and encourage the extension of peer support to outpatient care following discharge” (p. 38).
- VHA Handbook 1163.05 Psychosocial Rehabilitation and Recovery Centers (PRRC) states, “All facilities must design Peer Support Services for the treatment of Veterans with SMI including those with cooccurring disorders…” (p. 8).
- Public Law 110-387 The Veterans’ Mental Health and Other Care Improvements Act Of 2008 further establishes the requirement for the use of PSs and their qualifications.
- On August 31, 2012, President Obama signed an executive order instructing the VHA to hire 800 peer-to-peer support counselors for mental health care.

More recently, the VHA has promoted using PSWs in blended primary and behavioral healthcare models such as Patient-aligned Care Teams, Primary Care–Mental Health Integration, and its Whole Health Initiative (VHA, 2018). Specifically, the VHA team has underscored the role of PSWs citing them as “…important allies for Veterans in that they understand what they are going through and can offer suggestions to enhance recovery-oriented care.” The VHA published a journal periodical for this work to highlight these emerging models for veterans and “to maintain fidelity to the core elements of the recovery approach, include the use of peer specialists, and promote effective implementation strategies that scale up and spread these effective practices (VHA, 2018). The VHA is continuously hiring for its PSW positions throughout the country.

Local VHA and state resources also promote the use of Peer Support and PSWs. As recently as 2020, the Arizona Coalition for Military Families featured peer support in its VA Be Connected Community Mental Health Summit (Arizona Coalition for Military Families, 2020). The state of Texas complemented the VHA-identified peer service, appropriating funds to train military veterans with peer-to-peer counseling skills (TDSHS, 2016).
Private Insurance

While slow to adopt this recovery-oriented practice, the private insurance industry is slowly releasing peer support coverage. While many of the plans below have their peer support anchor in Medicaid/Medicare plans within states, their adoption of global statements recognizing PSWs, and Peer Support provide a foundation for private health plan adoption. Several examples below show some newly emerging practice within private insurance plans:

<table>
<thead>
<tr>
<th>General Peer Support</th>
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<tbody>
<tr>
<td><strong>Elevance Health (formerly Anthem)</strong></td>
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<tr>
<td>• “Peer Support Can Meet Mental Health Needs with Personal Focus”</td>
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<tr>
<td>• “People experiencing mental health crises often feel more comfortable receiving support from others with a common lived experience”</td>
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<tr>
<td>• “Peer support can supplement or fill the gap for individuals whose mental health needs are not fully met within the traditional system” (Elevance, 2022).</td>
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<tr>
<td><strong>Anthem</strong></td>
</tr>
<tr>
<td>“For individuals enrolled in commercial insurance, Anthem’s affiliated plans provide peer recovery support through programs with local providers” (Anthem, 2019).</td>
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<tr>
<td><strong>Empire BlueCross/Blue Shield of NY, Anthem BlueCross/BlueShield of Kentucky</strong></td>
</tr>
<tr>
<td>“(Empire) believes those with chronic mental health and substance use disorders can benefit from those who have shared in those experiences and improve their road to successful outcomes through collaboration with peers who have worked hard to develop skills and community contacts to provide a team of support” (Empire, 2021; Anthem, 2021).</td>
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<tr>
<td><strong>Optum Health</strong></td>
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<tr>
<td>“Optum has facilitated the incorporation of peer support services into public mental health systems in more than 20 states, resulting in better adherence to follow-up treatment, fewer unnecessary re-hospitalizations and significant cost savings for local governments.” Peer Support features and benefits include: “Better engagement through shared experience,” “Supporting the member’s path to recovery,” “An essential part of our recovery approach,” and “Improving the health of local communities” (Optum, n.d.).</td>
</tr>
<tr>
<td><strong>Magellan Healthcare</strong></td>
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<tr>
<td>“Magellan was among the first companies in the managed care field to adopt the evidence-based practice of peer support for members with serious mental illness (SMI) and substance use disorders (SUDs). Our personalized approach and focus on overall health and wellness are what set apart our peer support services, as we improve health outcomes and decrease utilization of costly inpatient care” (Magellan, n.d.).</td>
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</table>
Digitally Enabled Peer Support

<table>
<thead>
<tr>
<th>Company</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Aetna Corporate (CVS Health)</strong></td>
<td>“Aetna is one of the first commercial insurers to cover peer support for members, an evidence-based behavioral health service that assists people with achieving long-term recovery from a psychiatric disorder or addiction...Virtual peer support has enabled access for more members in addition to in-person specialists” (Aetna, 2019).</td>
</tr>
<tr>
<td><strong>Magellan Healthcare</strong></td>
<td>Peer Support Services are offered “From high-touch in-person services to convenient virtual options” (Magellan, n.d.).</td>
</tr>
<tr>
<td><strong>BlueCross/BlueShield (Anthem)</strong></td>
<td>Plan “features peer support through group chats, online meetings and expert discussions.” “[R]esearch suggests that online peer services can lead to improved engagement and feelings of hope, comfort, and control as well as reduced stress, anxiety and depression” (BlueCross/BlueShield, 2016).</td>
</tr>
<tr>
<td><strong>Horizon BlueCross/Blue Shield (New Jersey)</strong></td>
<td>Horizon is deploying a “tech-enabled Peer Recovery Support service, a discreet and personalized telehealth service for individuals and their family members seeking lasting recovery from addiction” (Horizon, 2018).</td>
</tr>
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</table>

Medicaid Wraparound Housing/Tenancy Services:
Several states recognize the importance of Peer Support as a critical element of behavioral health Housing/Tenancy support services. Examples of how these states are designing the models to include the work of PSWs are included here:

<table>
<thead>
<tr>
<th>State</th>
<th>Models</th>
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<tbody>
<tr>
<td><strong>Arizona</strong></td>
<td>Arizona AHCCCS has proposed a new service/support model for individuals experiencing homelessness (currently under review by CMS) (CMS-MSWL, n.d.). The current plan identifies Peer and Family Support (individual and group models) as targeted behavioral health outpatient services to assist the beneficiary. There are specialized peer approaches for tribal populations and re-entry (post-incarceration/jail) populations. The enrollment of specific peer-run organizations in the Medicaid plan to do this work has been proposed (AHCCCS, 2021).</td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>The Department of Behavioral Health and Developmental Disabilities has a Housing Support program which comprises of a set of interventions inclusive of mental health and substance use peer recovery supports. The aim of intervention is to promote housing stability, wellness, independence, recovery, and community integration (DBHDD-PM, 2022).</td>
</tr>
<tr>
<td><strong>Florida</strong></td>
<td>The state Agency for Health Care Administration has a Medicaid Housing Assistance Waiver which requires peer support as a “person centered service promoting skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills with the assistance of a peer support specialist” (FAHCA, n.d.).</td>
</tr>
<tr>
<td><strong>Ohio</strong></td>
<td>Ohio Mental Health Addiction Services has a model of “Recovery Housing” for individuals recovering from substance use disorders and provides an alcohol-and drug-free living environment, peer support, assistance with obtaining alcohol and drug addiction services, and other recovery assistance (OMHAS, 2021).</td>
</tr>
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</table>
Varieties of Rate Modeling

**Prospective Payment System/Bundled Rate:**

_Certified Clinical Behavioral Health Centers (CCBHC)_

Contrasting with a traditional healthcare fee-for-service model, federal CMS developed Prospective Payment System (PPS) guidance for Certified Clinical Behavioral Health Center (CCBHC) payment against criteria established by the Substance Abuse and Mental Health Services Administration (SAMHSA) with regard to requirements developed for staffing; availability and accessibility of services; care coordination; scope of services; quality and other reporting; and, organizational authority, governance, and accreditation (SAMHSA, 2015). Generally, any PSWs who work for CCBHCs can have all direct and indirect costs included in the total cost accounting for the CCBHC and those costs are included in a formula which yields a set payment rate (either daily or monthly) for the specific CCBHC. Through this type of payment mechanism, direct and indirect costs for staff (and other aspects of treatment and support) are all “bundled” together in a rate with a PPS claim being submitted based upon the provision of certain services set forth by the state. In this way, the CCBHC can build the PSW (and other practitioner) workforce supply based on community health need without managing individual productivity models which are crucial in the fee-for-service models above.

**Federally Qualified Health Centers**

Like the CCBHC model, the FQHC model pays via a PPS, a single, bundled rate which covers all services and supplies in single visit with a designated provider type. The rate is based on allowable costs reported to create a standard PPS nationally and then adjusted based on geography of the center (CMS-FQHC, n.d.). Annual adjustments (following the first year after the implementation year) are made, increasing the rate by the percentage increase in the Medicare Economic Index (MEI). FQHC payment occurs when the health center submits a claim to Medicare, the state Medicaid agency, or Medicaid managed care plan (MACPAC, 2017). Like the benefits in the CCBHC model, this model allows the same provider efficiencies in practice and promotes financial predictability for the FQHC. When staff, as defined in the models above (PSWs functioning as named qualified staff), can provide “incident to” interventions, promoting the advancement of the individual’s treatment goals, a PPS claim can be billed.

**Fee-for-Service (FFS) Reimbursement**

The term fee-for-service is commonly used to describe the payment method when a practitioner delivers a service, submits a claim, and then receives reimbursement for that service. This model is the most common payment method yet is flawed because of its emphasis on production of units of service for payment instead of targeting the most effective and efficient mode of delivery. That said, given that the majority of Peer Support in the U.S. is delivered in this very traditional framework through Medicaid or via state mental health or substance services agencies.
Most often states use the H0038 code as defined in the Traditional Outpatient Services section of this paper.

In considering basic staffing costs in conjunction with the potential for reimbursement, it is necessary to consider whether the reimbursement will cover the cost of the PSW. In general, agencies must consider direct (e.g., staff salary, training, malpractice coverage, travel costs, etc.) and indirect costs (e.g. spread costs of agency leadership, payroll, electronic health records, etc.) of employing the PSW, the potential for productivity (how many units the PSW can/will bill), the reimbursement rate, and the back-office support to administratively pursue the authorization and reimbursement of services delivered by the practitioner. For instance, using a rate from Arizona, if a PSW can earn the agency $85.32/hour based on the H0038 reimbursement for that state (AHCCCS, 2019), it is crucial for the provider agency to know that the reimbursement covers the costs of the practitioner and agency support of the practitioner based on a certain standard of productivity.

For example, if an agency hires a PSW at $40,000/year and the costs of staffing additional direct and indirect costs are 45% of salary, then the cost for the PSW is $40,000 + $18,000 (which is $40,000 x .45) equaling $58,000. The PSW then must bill 680 hours/year at the $85.32 rate to help the agency break even in their investment for the service. The 680 hours divided into 52 weeks demands ~14 hours of billable time/week to earn the PSW cost (35% productivity).

This rudimentary description is variable depending on many more complicated factors, including:

- Salary/wages
- Position status (whether the PSW is hired full-time with benefits, part-time with benefits, 1099 contract, etc.)
- Agency costs for benefits (if applicable)
- Agency costs for staffing overhead
- Benefits, including paid time off
- Staffing demand for non-billable activities (continuing education, general community engagement activities, speaking engagements, etc.)

These variables must be considered in planning for hiring the PSW.

Specific to the Fee-for-Service model, it is important to note that the managed care companies receive a direct payment to the managed care vendor for each member’s whole health cost, generally monthly (commonly referred to as a per member/per month payment [PM/PM]). Then a managed care vendor implements an FFS model for most outpatient service model payments to providers.

Emerging Payment Methods
Value-Based Payment (VBP) and Alternative Payment Models (APM) are emerging as preferred models of payment reimbursement. CMS cites that these types of program reimbursement models are “important because they’re helping us move toward paying providers based on the quality, rather than the quantity of care they give patients” (CMS-VBP, 2022). In these types of models, incentive payments are provided by payers in response to provider performance on certain normed metrics. Learnings are still underway on these models, and there are inherent flaws in current performance benchmarks as they are generally more process-oriented than recovery/wellness based.
Conclusion

Behavioral Health-centered Peer Support services are now generally accepted practice among public payers, and becoming more accepted by private, third-party payers. The Peer Support Workers (PSWs) who provide these services go by a variety of naming conventions, are generally certified by state authorities, and are emerging as a critical and necessary guild in the behavioral healthcare arena. The benefit of this workforce’s lived experience lens is continuing to provide positive impact to individuals served, and as such, PSWs are continuing to find themselves at the fulcrum of emerging practice models. Understanding the billing pathways for the maximum benefit of this workforce is a necessary key to employing these practitioners and enabling peer support to be received by individuals in need.
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BlueCross/BlueShield (2016). Anthem Blue Cross Blue Shield Online Peer Support Frequently Asked Questions [Citation: IN OPS FAQ-C-0516 CMAP 4974-16]. https://mss.anthem.com/in/inin_caid_bigwhitewallfaq_eng.pdf.


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The Behavioral Health Excellence-Technical Assistance Center provides training and technical assistance for HRSA’s Behavioral Health Workforce Development Grantees. Learn more at bhe-tac.org.