May 28, 2024

Deputy Administrator and Director Daniel Tsai
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Deputy Administrator Daniel Tsai:

The undersigned national mental health and substance use advocacy organizations, representing consumers, providers, caregivers, and community partners, are writing to provide input on newly required guidance on the behavioral health workforce, particularly with respect to the sections discussing peer support specialists. We would like to thank you for all the work you have done to promote behavioral health as an important part of health care. From convening stakeholders to listen to community needs to providing technical assistance and guidance for states, the actions you have taken to transform Medicaid throughout the public health emergency and beyond have been very impactful for people with mental health and substance use conditions. We especially appreciate your guidance on EPSDT, school mental health, and health-related social needs. We believe that new CMS guidance on the behavioral health workforce as required by Sec. 207 of the 2024 Consolidated Appropriations Act, enacted on March 9, 2024, can also be extremely important and address gaps in access to care.

The newly enacted legislation specifically notes the importance of peer specialists, thus, this guidance should clarify and provide direction for growing peer support services and the certified peer support specialist workforce. Peer support is the mutually beneficial act of helping someone get into recovery or stay in recovery from a mental health condition and/or substance use disorder and peer support services are evidence based. Terms describing individuals providing peer services across Medicaid programs include peer support specialist, peer recovery support specialist, peer wellness coach, peer recovery coach, peer mentor, youth peer specialist and youth peer mentor. Family members also provide peer support to other families as family peer specialists and are experts in caregiving. Nearly all 50 states offer a certification for peer specialists to practice.

CMS can greatly impact the behavioral health workforce and provision of mental health and substance use services by addressing in its guidance: supervision, training, mental health promotion and early intervention, and reimbursement of certified peer specialists.

Key Issues That Would Be Helpful to Address in New Medicaid Guidance

1. **Clarify that supervision of peer specialists can be provided by senior peer specialists or other MH and SUD professionals trained to supervise peer support**. In its 2007 guidance on peer support, CMS stated that supervision of peer support "must be provided by a competent mental health professional (as defined by the state)." Thirty states interpreted this or are bound to a state regulation defining "mental health professional" which limits supervisors to clinically trained staff and thus does not allow experienced senior peer specialists to supervise. This interpretation creates significant conflict as clinicians do not receive training in peer support as part of their training and licensing and may unknowingly offer instruction which is counter to the principles of peer support and core competencies of peer specialists.

SAMHSA's national model standard on peer supervision recommends states should require supervisors to have direct experience as a peer worker. Texas and several other states allow experienced certified peer specialists to supervise level one certified peer specialists. We urge CMS to align with the model standard and clarify that supervisors of providers of peer support are most effective when they are trained and understand peer support services. This could be a competent mental health professional, addiction professional, and a peer support worker that has undergone additional training on peer supervision. Clarifying that peer support specialists can be supervisors would also open opportunities for meaningful career advancement for peer specialists to stay in the field long term.

2. **Emphasize the importance of training all administrative and clinical staff on the value of peer support to improve culture and retention of peer support specialists.** Peer support services evolved as a response to receipt of clinical care that was often unsatisfactory and inhumane within clinical settings and are shown to effectively reduce social isolation and grow a sense of belonging and hope. Peer specialists promote lifesaving self-help and self-advocacy skills as well as awareness of community-based resources that help fulfill an individual's health-related social needs. However, most clinical and administrative staff are unaware of the tremendous value peer specialists bring to patients and never receive training on how to work with peer specialists. Unless providers and administrative staff receive education about the role and responsibilities of peer specialists as a valuable part of interdisciplinary care teams, integrated clinical settings will not see high retention of peer specialists and will not realize the benefits of improved experience for the individual receiving support and care. CMS guidance should encourage the education and training of all providers and staff who interact with peer specialists on the role of peer specialists to improve culture and retention of peer specialists as part of care teams and should provide resources to assist with this training. The core competencies, national model standards, and other federal and state resources created by peer technical assistance centers are a good start to educating providers and staff. Necessary additional training and education materials should be developed and led by senior peer specialists and could be carried out in collaboration with SAMHSA, SAMHSA's technical assistance centers and HRSA's behavioral health workforce education and training programs.

3. **Urge states to define eligibility for peer support services to include mental health promotion and prevention, and promote youth peer support.** Many states require an individual to be in a severe state of their condition and receive a diagnosis to qualify for peer services (due to a narrow definition of medical necessity). This approach fails to recognize that offering services up front can prevent disease progression to the point of clinical intervention, especially for adolescents. Access to timely mental health care for children remains especially limited due to lack of providers, low reimbursement rates, and high out of pocket costs, yet research points to the effectiveness of primary prevention. Making available peer support as a preventive or early intervention service before a clinical diagnosis promotes help-seeking behavior and gives individuals more options for addressing their health concerns before they become debilitating. Outreach by a peer support specialist may be needed after a traumatic experience or at the onset of an illness, but before a young person is officially diagnosed and part of the mental health system.

   The Affordable Care Act opened the rehabilitative option to be used for prevention, yet many states have not expanded and added that language in their plans. One exception that would be helpful to highlight in the guidance is Georgia which adopted the rehabilitative option, classified peer support services in a way that allows them to be used to prevent the onset of disease, and then set broad medical necessity criteria ensuring peer services are not contingent upon enrollment in clinical treatment such as case management. This could be especially beneficial for children and families first experiencing signs of a mental health condition or substance use disorder including during the perinatal period. CMS can also remind states that

EPSDT requires youth peer support to those under 21 when peer services are necessary to treat a behavioral health condition.

States also could be encouraged to use a social determinant of health assessment scale to trigger peer support services as Indiana, Minnesota, and Rhode Island do post-discharge from inpatient care. However, CMS should encourage states in the guidance to additionally offer assessment of social needs prior to hospitalization to promote earlier detection, offer peer support, and potentially prevent major life disruption from hospitalization.

CMS can give guidance on billing for services in settings where peer support is provided. Peer respite is a setting that states can be encouraged to reimburse for mental health promotion. Respite offers trauma-informed healing practices from peer specialists in several states including Massachusetts.

CMS can also offer models of how states could bill Medicaid for youth peer services provided in school settings and encourage states to expand access to youth peer services, which are currently reimbursed in 18 states but not in schools. Giving examples of effective state practices in youth peer support would be very helpful in encouraging a more preventive approach to peer support. The guidance can also note that Medicaid funded peer support can be particularly helpful for children involved in the child welfare system and can help states offer services to children who would not otherwise have access to support.

4. **Highlight the importance of adequate reimbursement in ensuring state-wide access to peer support services and adequate networks of peer providers**. Peer support services are reimbursed by states in 15-minute increments through fee-for-service billing which is a restrictive approach. Allowing flexible, innovative payment models to be taken up like CCBHCs or value-based payment models can help give flexibility for peer specialists to personalize their services and not rely on incremental billing. Additionally, many peer specialists do not make a living wage and leave the workforce for better pay though they would prefer to stay in the field. Reimbursement rates are under $8 per unit in five states – Colorado, Kentucky, Nevada, North Dakota, and Mississippi. State Mental Health Agencies in nearly half of states say reimbursement rates are too low; some of these states are employing innovative strategies to raise rates. Virginia and North Carolina recently raised their reimbursement rate significantly for peer specialists citing the state's prioritization of quality behavioral health services. Billing flexibility and adequate reimbursement helps to supplement costs related to an individual's transportation or other social drivers of health. Peer specialists are faring best in states that are increasing their Medicaid reimbursement rates for peer services and in states that are expanding the types of organizations that can bill Medicaid. Minnesota recently expanded to allow recovery community organizations (RCOs) to participate in Medicaid. CMS should encourage states to address low reimbursement rates for peer support specialists, promote innovative payment models such as bundled payment, and highlight the work of states that are expanding coverage of peer-run and peer-informed community organizations that deliver services in non-traditional community settings and schools.

We strongly believe that guidance on these key issues will assist states in delivering peer support services as part of a comprehensive approach to growing behavioral health services and expanding the workforce. If you or your staff have any questions related to these requests please contact Caren Howard, Senior Director of Policy and Advocacy at Mental Health America at choward@mhanational.org. Thank you for your consideration.

Sincerely,

Mental Health America
Active Minds
Addiction Policy Forum
Alliance for Rights and Recovery (formerly NYAPRS)
American Association for Psychoanalysis in Clinical Social Work
American Association on Health and Disability
American Mental Health Counselors Association
Anxiety and Depression Association of America
Bazelon Center for Mental Health Law
Center for Law and Social Policy (CLASP)
Centerstone
Children and Adults with Attention-Deficit/Hyperactivity Disorder
First Focus on Children
Global Alliance for Behavioral Health & Social Justice
HardBeauty
HealthyWomen
Inseparable
International Society of Psychiatric-Mental Health Nurses
Lakeshore Foundation
Legal Action Center
Lifeline for Families Center and Lifeline for Moms Program at the UMass Chan Med
Lines for Life
Maternal Mental Health Leadership Alliance (MMHLA)
NAADAC, the Association for Addiction Professionals
National Alliance on Mental Illness
National Association of Addiction Treatment Providers
National Association of Pediatric Nurse Practitioners
National Association of Peer Supporters
National Association of State Mental Health Program Directors
National Disability Rights Network (NDRN)
National Federation of Families
National League for Nursing
Policy Center for Maternal Mental Health
Postpartum Support International
Psychotherapy Action Network
Recovery Innovations, Inc.
The Jed Foundation
The Kennedy Forum
The National Alliance to Advance Adolescent Health
Trilogy Behavioral Healthcare
Western Youth Services
Young Invincibles
Youth MOVE National
Youth Villages