PEER SPECIALIST CERTIFICATION

June 30, 2020

An analysis of U.S. and Canadian efforts to promote and expand mental health peer specialist workforce capacity

This report identifies and analyzes mental health peer specialist certification programs across the United States and Canada. It is intended to inform initiatives to promote and expand Vermont's peer specialist workforce capacity.

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AN ANALYSIS OF U.S. AND CANADIAN EFFORTS TO PROMOTE AND EXPAND MENTAL HEALTH PEER SPECIALIST WORKFORCE CAPACITY

INTRODUCTION | ONE

This report is intended to inform efforts to promote and expand Vermont's peer specialist workforce capacity.

The report summarizes a review of mental health peer specialist certification programs across the United States and Canada. The report's scope is limited to mental health peer specialist certification programs, including co-occurring substance use. It does not include an assessment of peer specialist certification programs that serve peers with substance use issues alone.

The report provides a general overview of the process of screening, training and certifying peer specialists and sets out detailed information about the certification process in 13 selected states and Canada.

Canada, the New England states and New York were selected because of their proximity to Vermont. Florida, Georgia, Michigan, Oregon, Pennsylvania and Texas were selected because they are geographically diverse states that have mature, well-regarded certification programs and a high incidence of so-called severe mental illness among adults in the state. The report also includes specific information about Wyoming's peer support certification program. Wyoming was chosen because its population size most closely resembles Vermont's although the state's per capita income is significantly greater.

The report also identifies leading practices for peer support certification.

Research was primarily conducted via the internet. Publicly available certification requirements of every state and federal program in the United States and Canada were reviewed. The review also included policy manuals, policy briefs and guidelines, PowerPoint presentations, meeting minutes, research reports, legislative reports and analysis, Medicaid manuals, State Plan Amendments, Medicaid Reimbursement Fee Schedules, application forms, training manuals, training curricula, core competencies, Codes of Ethics, and previous research reports about peer certification programs and peer workforce development. Year 2016 databases compiled by the Copeland Center and the University of Texas were also consulted as was research on the effectiveness of peer support, the availability of peer support funding and surveys on peer support compensation and job satisfaction.

The research also included an examination of core competencies developed by Vermont's Wellness Workforce Coalition, a brief email exchange with Gloria van den Berg, a member of the coalition who spearheaded the development of the core competencies, and a brief telephone call with Sarah Bourne, a consultant who assisted in the development of the core competencies.

Interviews were also conducted with individuals who oversaw peer certification programs in Washington, D.C. (Adrienne Lightfoot) and the State of Wyoming (Lana Mahoney). Telephone calls, letters and emails to programs managers in the State of Alaska (Jennifer Galvan) and the State of North Dakota (Kristy

Johnson and Heather Brandt) were not returned. Washington, D.C., Wyoming, Alaska and North Dakota were targeted because their state populations are comparable to Vermont's.

BACKGROUND | TWO

In the United States, peer support in the context of mental health recovery arose out of the civil rights movements of the 1960s and 1970s in response to forced drugging and involuntary hospitalization and incarceration of people labeled with mental illnesses. In the 1970s, as large state hospitals across the country began to close and release patients into the community without adequate transitional support, ex-patients began to speak out about the systematic mistreatment and human and civil rights violations they endured during their hospitalizations. Small groups of ex-patients also began to organize autonomous peer and mutual support groups as a non-medical alternative to psychiatry.[1] Their aspirations were to help each other and to advocate for themselves.

There is no single definition of peer support and no single term for someone who provides peer support. In this report, individuals who provide peer support will be referred to as "peer specialists."

Peer support has been described as "a system of giving and receiving help" based on key principles that include "shared responsibility, and mutual agreement of what is helpful."[2] Peer specialists use their own personal, lived experience recovering from a mental illness to support others in their recovery. This lived experience of recovery distinguishes peer specialists from traditional mental health service providers.

Over the last two decades, peer support has entered the mainstream mental health system. The Substance Abuse and Mental Health Services Administration (SAMHSA) now defines a peer specialist as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency." It also defines the role of a peer specialist as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations."

In 2001, the State of Georgia began to bill Medicaid for peer support services. Thereafter, a 2003 study compared Georgia patients diagnosed with schizophrenia, bipolar disorder and major depression whose treatment had included peer support with patients who received traditional day treatment services without peers. The patients who had peer support had better health outcome – and at lower cost. The average annual cost of day treatment services was $6,400 per person while support services cost about $1,000.[3]

In the following years, peer-reviewed research found that peer support resulted in a significant reduction in drug/alcohol use, improved mental and physical health, and increased social support for people experiencing homelessness.[4] Peer support is also associated with significantly fewer inpatient and emergency service hours[5] and significant improvements in healing, empowerment, and satisfaction.[6]

In 2003, the President's New Freedom Commission on Mental Health issued a report calling for the mental health system to become person-centered and recovery oriented. To that end, the Commission identified peer support as the vehicle for psychiatric survivors to share their knowledge, skills and experiences of recovery.[7]

In 2007, the Center for Medicare and Medicaid Services (CMS) deemed peer support "an evidence-based mental health model of care" and issued guidelines to states for how to pay for peer services with Medicaid.[8]

In 2014, CMS expanded the type of practitioners who can provide Medicaid prevention services beyond physicians and other licensed practitioners. Under the new rule, at a state's discretion, peer specialists may provide such services.

In 2015, SAMHSA convened a working group of stakeholders to identify the core competencies needed to offer peer support to people in recovery from a mental health condition. Core competencies are often described as clusters of the knowledge, skills, and attitudes a person needs to have to perform successfully a role or job or as the ability to integrate the necessary knowledge, skills, and attitudes.[9] Core competencies are often used to develop training programs, create standards for certification and craft job descriptions.

The SAMHSA group developed 62 core competencies, which it grouped into the following 12 categories: (1) engages peers in collaborative and caring relationships; (2) provides support; (3) shares lived experiences of recovery; (4) personalizes peer support; (5) supports recovery planning; (6) links to resources, services and supports; (7) provides information about skills related to health, wellness, and recovery; (8) helps peers manage crises; (9) values communication; (10) supports collaboration and teamwork; (11) promotes leadership and advocacy; and (12) promotes growth and development.

Each state with a peer specialist certification program has developed its own core competencies. However, many of individual core competencies developed by the states were derived either from SAMHSA's core competencies or the core competencies developed in support of the Georgia certified peer specialist program as Georgia was the first state to bill Medicaid for peer support services. A copy of the SAMHSA and Georgia core competencies are included as Appendix H and C, respectively.

Today, peer specialists engage in a wide range of activities, including advocacy, connecting individuals in recovery to resources, sharing experience, community and relationship building, group facilitation, skill building, mentoring, and goal setting. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.[10] A representative job description can be found in Appendix E.

Peer support is offered in a variety of settings including schools, prisons and jails, hospital emergency departments, outpatient hospital day programs, inpatient psychiatric hospitals, peer respites, community centers, an individual's home, community mental health agencies, peer-run organizations, and support teams in housing agencies. According to research conducted at the University of Michigan, one quarter of all mental health facilities[11] in the United States now offer peer services.[12] By state, the percentage of facilities offering peer services ranges from nine percent in Arkansas to 48 percent in Oregon. This same study identified Vermont as offering the highest ratio of facilities with peer services with 3.19 facilities with peer services per 100,000 population.[13] Wyoming was next highest at 2.25 facilities with peer services per 100,000 population. Nationally, the mean ratio of mental health facilities offering peer services is 0.71 per 100,000 state population.

Mental health peer support is not unique to the United States. Peer support is prevalent in Canada and Japan. France has more than 300 government-funded, self-help groups. Peer-run initiatives in New Zealand are an optional service eligible for healthcare funding and Scotland's government has recommended a country-wide roll-out of peer support services after a successful peer support pilot program.[14]

Mental Health America, a nonprofit offering a national peer specialist certification, estimates that there are 30,000 certified peer specialists in the United States today.[15]

Forty-six states and the District of Columbia certify mental health peer specialists. The Department of Veterans Affairs, the largest employer of peer support specialists in the United States, recognizes state-level certification for peer support specialists although it does not have its own certification process.

The four states that do not offer a statewide, mental health peer specialist certification are California, New Hampshire, South Dakota and Vermont. While New Hampshire does not have a statewide peer certification program for mental health peer specialists, it does have a statewide peer specialist certification for certified recovery support workers. Certified recovery support workers provide peer support to individuals in recovery from substance use.

Canada also has a national peer specialist accreditation and certification program that is valid across Canada.[16] In Canada, certification is voluntary. Peer supporters, as peer specialists are called in Canada, are not required to be certified to work as peer specialists.

Proponents of peer certification say certification validates the discipline of peer support as a distinct practice; defines the scope of practice; standardizes qualifications and competencies; and ensures those engaged in peer support receive the evidence-based benefits of peer support services.

Most peer certification programs in the United States are structured to comply with Medicaid requirements. To receive Medicaid reimbursement for peer support services, peer specialists must be trained and credentialed with mandatory continuing education requirements that ensure peer specialists have a basic set of competencies necessary to support the recovery of others.

Medicaid does not dictate what form peer specialist certification must take. States have flexibility to create their own certification programs.

Assessment-based versus Professional Certification Programs

Peer specialist certification programs fall roughly into two types: assessment-based certificate programs and professional certification programs.

An assessment-based certificate program provides training and then determines whether applicants successfully met the learning objectives of that training through testing.

The Commonwealth of Massachusetts peer certification program is an example of an assessment-based certificate program. Applicants for peer specialist certification in Massachusetts enroll in a training class offered by the state and at the end of the training are given an examination, which if passed, entitles them to certification.

A professional certification program does not provide training. Such programs are independent of the training. They evaluate applicants' knowledge, skills or competencies against a predetermined standard usually through a written test.

The State of Rhode Island's peer certification program is an example of a professional certification program. Applicants for peer certification in Rhode Island must take and pass the Rhode Island Peer Recovery Specialist Certification Exam. The exam was developed by the International Certification & Reciprocity Consortium (IC&RC), an organization that sets standards and develops credentials for the credentialing of prevention, substance use treatment, and recovery professionals.

Peer Specialist Certification Process

There are essentially three steps in any peer specialist certification program: (1) Screening; (2) Training; and (3) Credentialing.

Screening

Screening involves setting the minimum standards that an applicant must meet before applying for certification and creating a process to determine whether those minimum standards have been met. All U.S. programs use a written application for screening.

Although minimum standards vary, most certification programs screen for (1) lived experience of a mental health condition from which the applicant is in recovery; (2) a willingness on the part of applicants to speak publicly about their recovery; (3) minimum age; (4) minimum education; and (5) minimum number of hours of relevant volunteer or paid work experience.

All states require some form of lived experience of a mental health condition and a willingness to share that experience publicly. Applicants are also asked to certify in writing that they are in recovery from a mental health condition. Many states require the applicant to have been in recovery for at least two years before applying for certification. Some states require just one year.

In most states, 18 is the minimum age to become certified. However, some states require a peer specialist to be at least 21years old to bill Medicaid.

Most, but not all, states require a high school diploma or equivalent. Oregon, for example, does not require a high school diploma or equivalent.

Many states require at least 250 hours of relevant and supervised volunteer or paid work experience. New York requires 2,000 hours. Some states, such as New York and Florida, will issue provisional certifications to applicants who have not met the minimum number of peer support hours if they satisfy all other certification requirements. They then have a certain period of time (up to one year in Florida, for example) to fulfill the work requirement.

Many states require letters of reference or recommendation. In some states, supplying letters of recommendation are optional. In states that do require a letter of reference, most will not accept such letters from clinicians.

The application in nearly all states requires applicants to respond in writing to questions about their recovery, their views on the mental health system, and why they want to become a certified peer specialist. Oregon, which has no minimum education requirement, uses these responses to evaluate the applicant's literacy and communication skills.

There are wide variations in how states handle applications that disclose a criminal record. In some states, Texas, for example, it is automatically disqualifying. In Pennsylvania, most convictions will not impact a candidate's ability to obtain peer certification. Pennsylvania does require candidates to disclose convictions for "information purposes only."[17] In those states that do not disqualify applicants based solely on a criminal record, there is a recognition of the bumpy path that many in recovery have trod. Canada does not require a criminal records or police check.

Some states, Michigan, for example, interview each applicant for certification. Most states do not.

In some states, certification is a competitive process with limits on the numbers chosen each year. Other states take all who meet the minimum qualifications.

Some states also have residency requirements. Applicants must live or work in the state at least 51 percent of the time.

The entity that screens applications varies by state. In some states, the screening entity is a peer-run organization. For example, the screening entity in Massachusetts is The Transformation Center, a peer-run organization. In other states, the screening entity is a division of state government. In Texas and Pennsylvania, for example, the screening entity is that state's certification board.

Some states subcontract the entire certification role, including screening, to an outside organization, usually a nonprofit. In Colorado, the Colorado Providers Association, a professional trade association representing substance use disorder prevention, intervention, treatment and recovery providers, oversees Colorado's peer and family specialist certification program.

The following are specific screening requirements for the selected states and Canada.

	Screening Requirement				
State	**State certification title**	**Level of Education**	**Prior work or volunteer experience**	**Number and type of letters of recommendation**	**Recovery experience**
Connecticut	Certified Recovery Support Specialist	No minimum requirement	No minimum requirement	One letter of recommendation	Individuals must have direct lived experience of receiving mental health services and/or mental health hospitalization and that these experiences have seriously impacted their lives and relationships for an extended time; be willing to use their lived expertise in their role as a Recovery Support Specialist
Maine	Certified Intentional Peer Support Specialist	No minimum requirement	Completion of three-hour Peer Support 101 Workshop before submitting application	Not required	Must have experienced a mental health challenge that has seriously impacted one's life and relationships for an extended period of time

	Screening Requirement				
State	State certification title	Level of Education	Prior work or volunteer experience	Number and type of letters of recommendation	Recovery experience
Massachusetts	Certified Peer Specialist	High school diploma or equivalent	None	Two letters of reference	Individuals must have lived experience of mental health condition or emotional distress or trauma resulting in significant life disruption; be active in their mental health recovery/wellness for at least one year; and be willing to share aspects of that experience
New Hampshire	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
New York	Certified Peer Specialist	High school diploma/GED	Documentation of 2,000 hours of work experience for standard level of certification	Three references	Must publicly identify as a person who has direct personal experience living a life of recovery, overcoming challenges resulting from a diagnosis of mental illness; have sufficient knowledge of recovery, overcoming challenges; be a current or former recipient of mental health or dual disorder services; and not currently hospitalized
Rhode Island	Peer Recovery Specialist	High school diploma/GED from an accredited school	500 hours of volunteer or paid experience specific to peer recovery services; 25 hours of supervision specific to the core competencies; hours may be included in total experience	Not required	Individuals must acknowledge a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and have received or are currently receiving treatment and/or community support for it.

	Screening Requirement				
State	**State certification title**	**Level of Education**	**Prior work or volunteer experience**	**Number and type of letters of recommendation**	**Recovery experience**
Wyoming	Peer Specialist	High school diploma or equivalent	None	Applicants have option of submitting up to two letters of support from anyone who can speak about the applicant's recovery journey and why applicant should be selected for the training	Must identify themselves as former or current consumer of mental health or dual diagnoses services or substance use disorder treatment and/or recovery services; must be well grounded in own recovery, with at least two years of continuous recovery
Canada	Certified Peer Supporter	No minimum requirement	Experience delivering 200 hours of formalized peer support with a focus on supporting a peer in their recovery process	Three references	Must disclose lived experience through to a path of recovery (either personally or as a family member)
Florida	Certified recovery peer specialist	High school or equivalent	500 hours; direct one-on-one supervision of on-the-job performance of peer support services	One supervisory, one professional, one personal	Must have lived experience with a mental illness or substance use disorder and have been in recovery for a minimum of two years
Georgia	Certified peer specialist	High school or equivalent	Not required	Not required	Must have been in recovery for at least one year between diagnosis of mental health or substance use condition and application for training program
Michigan	Certified peer support specialist	High school or equivalent	At least 10 hours per week for the past three months	Two professional references	Must have a serious mental health illness, received public mental health services currently or in the past and been in recovery for a minimum of one year
Oregon	Peer support specialist	Not required	Varies	Varies	Must currently be or formerly have been receiving services for a mental illness

	Screening Requirement				
State	**State certification title**	**Level of Education**	**Prior work or volunteer experience**	**Number and type of letters of recommendation**	**Recovery experience**
Pennsylvania	Certified peer specialist	None	Within the last three (3) years, have either maintained at least 12 months of successful work or earned at least 24 credit hours at a college or post-secondary education institution.	None	Must be a person "with serious mental health or co-occurring (mental health and substance use disorder) lived experience"
Texas	Mental health peer specialist	High school or equivalent	250 hours initial supervised work experience	Two references	Must have lived with a mental health condition, substance use issue or both; be willing to appropriately share one's recovery story

Training

Nearly all state certification programs require applicants to attend a training program before becoming eligible for certification. The only exception to this requirement is states that grant reciprocity to applicants who hold a certification from another jurisdiction. In that instance, an applicant may be permitted to take the certification test without completing a training in the new state.

Although all states require training, the length, cost, curricula, and approved training vendor varies across jurisdictions. The Appalachian Consulting Group (ACG) has trained peer specialists in 35 states. ACG created the Georgia Certified Peer Specialist Curriculum, which was first introduced in 2001 and used to train the first peer specialists eligible for Medicaid reimbursement. ACG's curriculum and state-approved modifications to it are now used in most states.[18] A copy of the curriculum is included in Appendix G.

Some states allow applicants to select from approved training vendors, each of which has its own training curricula and sets its own fees. Some states include state-specific training about their state's mental health system. Georgia's training curriculum, for example, includes training that focuses specifically on providing peer support services in Georgia. Such training includes medical record documentation and working as part of a treatment team.

Canada requires a Practicum. Most are completed through a candidate's current (paid or unpaid) work. The length and focus of the practicum are individually tailored and self-paced. Practicums typically take about 10 hours a week over the course of one to four months. During the Practicum, each candidate is paired with a Certified Peer Support Mentor who provides constructive criticism, discusses challenges, and encourages self-reflection as the candidate provides peer support. The Certified Peer Support Mentor

completes a final assessment of the candidate and Canada's national certification committee reviews the entire package and makes a recommendation whether to certify the candidate.

Most programs require at least 40 hours of in-person training. However, New York offers an option of online training. Canada's training program takes 12 to 24 months to complete.

Some states charge for the training, other states do not. Some of the states that charge for the training have scholarship programs to defray the out-of-pocket cost of training to the applicant. Training fees run from zero to $1,400.

Specific information about training in the selected states and Canada follows.

State	Training Requirement			
	State certification title	**Length of core training**	**Training curriculum**	**Fees**
Connecticut	Certified Recovery Support Specialist (RSS)	80-hour advanced training and certification course; two times per week, six hours each day	Foundations for RSS RSS Role Effective and Empathic Communication Partnering and Mutuality WRAP and IPS Advocacy Community and Natural Resources Peer Modalities, Group Facilitation, Self-Care	Application Processing Fee: $25 Training Couse Fee: $100 Certification Exam Fee: $75
Maine	Certified Intentional Peer Support Specialist	Certification includes eight days of core training and a year of continuing education and skill building groups	Intentional Peer Support	Training is free, including mileage reimbursement

State	Training Requirement			
	State certification title	**Length of core training**	**Training curriculum**	**Fees**
Massachusetts	Certified Peer Specialist (CPS)	Program can take four to 10 weeks; combination of single-day trainings and a three-day retreat; CPS training is not an entry-level training; it is designed for people who have already done some work in peer support roles	The Three Core Competencies: Peer Support, "In" but not "Of" the System, Change Agent The Shoulders Upon Which We Stand Advanced Fundamentals of Peer Support Human Experience Language Cross-Cultural Partnering Fear: Friend and Foe Group Facilitation and Self-Help Tools Power, Conflict and Integrity Creating the Life One Wants	None
New Hampshire	Not applicable	Not Applicable	Not Applicable	Not applicable

State	Training Requirement			
	State certification title	**Length of core training**	**Training curriculum**	**Fees**
New York	Certified Peer Specialist	Option 1 – Online training through the Academy of Peer Services (APS) website -- 45 hours Option 2 – Skills training obtained through other programs or on-the-job training; must pass the competency test for each of the classes for the "Core Courses" on the APS website.	Option 1 – Online training through the Academy of Peer Services (APS) website - 13 Modules Option 2 – Skills training obtained through other programs or on-the-job training Examples of other trainings include: In person training offered by various peer run agencies Peer support trainings through national programs On the job training through a peer run agency Self-taught through various activities and experiences	Currently funded by the New York State Office of Mental Health
Rhode Island	Peer Recovery Specialist	45 hours	Advocacy (10 hours); Mentoring/Education (10 hours); Recovery/Wellness Support (10 hours); Ethical Responsibility (16 hours)	Application Fee: $175 Retest Fee: $100 Exam Cancellation Fee: $100

State	Training Requirement			
	State certification title	Length of core training	Training curriculum	Fees
Wyoming	Peer Specialist	36+ hours Wyoming New Peer Specialist Training	Peer Specialist Basics Basic Work Competencies Sharing Your Recovery Story Confidentiality Medicaid Documentation Requirements Group Work and Mutuality Conflict in the Workplace Reporting to Supervisor/Clinician Coping Strategies & The Grief Process Behavior/Physical Health Interactions Positive Relationships Community Resources Natural Supports Cultural Competency Resiliency Person Centered Recovery Hope and Recovery Using Recovery Language Trauma Informed Care Self-Care Advocacy Written Test	Tuition is covered through a grant from the Wyoming Department of Health, Behavioral Health Division and the Substance Abuse and Mental Health Services Administration. Value of the tuition is about $1,500 per person.
Canada	Peer Supporter	Certification process typically takes 12 – 24 months to complete	Fundamental Principles of Peer Support Social and Historical Context of Peer Support Concepts and Methods that Promote Peer-to-Peer Effectiveness	Application: $90 + tax Assessment of Knowledge through written exam: $440 + tax Final assessment of competencies and review by Certification Committee: $750 + tax

State	Training Requirement			
	State certification title	**Length of core training**	**Training curriculum**	**Fees**
Florida	Certified recovery peer specialist	40 hours	CORE REQUIREMENTS – MINIMUM 28 HOURS Advocacy: 4 hours minimum Mentoring: 6 hours minimum Recovery Support: 6 hours minimum Cultural and Linguistic Competence: 2 hours minimum Motivational Interviewing: 4 hours minimum Vicarious Trauma/Self-Care: 2 hours minimum Professional responsibility: 4 hours	Certification application fee: $100 Recovery Peer Specialist Exam: $65 Renewal: $75
Georgia	Certified peer specialist	72 hours (9 days)	Single, approved core training curriculum	Registration Fee: $85
Michigan	Certified peer support specialist	56 hours	Single, approved core training curriculum	$600
Oregon	Peer support specialist	40 hours	Single, approved core training curriculum, including training in oral health	Training fees vary by vendors who set their own fees
Pennsylvania	Certified peer specialist	75 hours	Copeland Center, The Institute for Recovery or RI Consulting are approved vendors for training	Application Fee: $125 Retest Fee: $75 Exam Cancellation Fee: $75 Training costs vary by approved vendor and range from $900 to $1400
Texas	Mental health peer specialist	One Saturday class plus 40-hour, 5-day classroom-style interactive supplemental training in mental health	Applicant chooses training from list of approved training vendors	Core Training: $65 Supplemental Training: $650 Certification Application: $65

Certification

Certification is that step in the process where the certifying body determines whether the applicant has met the requirements for certification. It is the step in the certification process that has the most variability among the states and Canada.

Every state with a peer specialist certification program as well as Canada require candidates to sign a Code of Ethics as a condition of peer certification. A sample Code of Ethics is included in Appendix D.

The elements of the certification process that vary across the states and Canada include (1) who administers the exam and what exam is administered; (2) required fees; (3) recertification requirements; (4) characteristics and role of the certifying entity; and (5) duration of the certification.

Some states, such as Georgia, administer a single, statewide exam. In other states, applicants need only pass an approved vendor's exam.

Certification fees vary considerably from no charge in Massachusetts to $750 in Canada.

The duration of certification before it expires also varies across states from six months to a lifetime.

Continuing education requirements also vary. All programs that qualify for Medicaid reimbursement have continuing education requirements. Generally, the requirement mandates a minimum number of additional hours of training periodically. That period ranges from one to three years.

Recertification requirements also vary. Recertification usually involves renewing one's certification before its expiration date. Some states require the applicant to pass a statewide test to become recertified. Others require only the payment of a fee with no re-testing requirement. Canada's four-year old program has yet to establish recertification standards.

The type of certifying entity also varies. The different types of certifying entities include peer-run organizations that both train and certify applicants and state departments of mental health and state certification boards that certify applicants but do not train applicants.

The following are the certification requirements for the selected states and Canada.

State	Certification Requirement			
	State certification title	**Certification**	**Recertification**	**Certification Body**
Connecticut	Certified Recovery Support Specialist (RSS)	Successful completion of statewide certification examination	60 hours of continuing education every three years to maintain certification	Advocacy Unlimited, a peer-run organization, trains and certifies peer specialists

State	Certification Requirement			
	State certification title	**Certification**	**Recertification**	**Certification Body**
Maine	Certified Intentional Peer Support Specialist	Certification includes eight days of core training and a year of continuing education and skill building groups	Maintaining certification requires (1) completion of eight or more hours of continuing education; (2) participation in 12 hours of skill-building groups; and (3) biannual review to insure commitment to core concepts	Maine Department of Health and Human Services Substance Abuse and Mental Health Services
Massachusetts	Certified Peer Specialist	There is a written certification exam, which is given approximately two weeks after last training class, with three hours given to complete	None	The Transformation Center, a peer-run organization, trains and certifies peer specialist
New Hampshire	Not Applicable	Not Applicable	Not Applicable	Not Applicable
New York	Certified Peer Specialist	Meet all standards for NYCPS certification established by certification board Complete either the NYCPS or NYCPS-Provisional application and submit it and all required documentation to the certification board Read and agree to abide by the Code of Ethical Conduct and Disciplinary Procedures Successfully complete post-tests for all 13 core courses of the Academy of Peer Services and complete a minimum of five additional APS electives (15 hours)	20 hours of continuing education annually plus $100 fee, currently paid by NYS OMH for New York residents and workers	New York Peer Specialist Certification Board
Rhode Island	Peer Recovery Specialist	Successful completion of computer-based, 75 multiple choice questions offered on-demand basis at an approved testing site	Re-testing every two years	Rhode Island Certification Board

State	Certification Requirement			
	State certification title	**Certification**	**Recertification**	**Certification Body**
Wyoming	Peer Specialist	Document successful completion of a peer specialist basic competency course of no less than 36 contact hours, which includes all of the Core Competencies for Wyoming's Peer Specialists	Wyoming Peer Specialist Annual Meeting (14+ hours) 5 hours of in-person or virtual training via computer that involves interacting with other people Participation in pre-approved trainings for Peer Specialist Re-certification	Wyoming Behavioral Health Division
Canada	Peer Supporter	Four phase certification process: (1) initial screening; (2) successful completion of knowledge standard; (3) successful completion of acquired experience; (4) final assessment of competencies, knowledge and lived experience verified by certification board based on mentor, supervisor, peer evaluations	Recertification requirements have yet to be specified	Peer Support Canada, a peer-run, national charity, offers a national peer support certification
Florida	Certified Recovery Peer Specialist	(1) Level 2 background screening; (2) lived experience; (3) content specific training; (4) related work experience; (5) on-the-job supervision; (6) three professional recommendations; (7) certified recovery peer specialist exam; (8) fee payment	Renewal, annual on June 30th of each calendar year Continuing education, 10 hours per year	Florida Certification Board

State	Certification Requirement			
	State certification title	**Certification**	**Recertification**	**Certification Body**
Georgia	Certified peer specialist	(1) willing to use lived experience to support others in recovery; (2) well-grounded in recovery; (3) strong reading, comprehension and written communication skills as indicated by answers on application; (4) demonstrated experience with leadership, advocacy or governance; (5) successful completion of training and examination	Submit documentation of a minimum of 12 continuing education units per calendar year	Georgia Mental Health Consumer Network
Michigan	Certified peer support specialist	(1) Have a serious mental illness outlined in the Medicaid Provider Manual; (2) Have received public mental health services currently or in the past outlined in the Medicaid Provider Manual; (3) Provide at least 10 hours per week of peer support services with supported documentation written in the IPOS; and (4) Meet the specialized training and certification requirements for MDHHS approval	Not required; lifetime certification	Two trainers of the state curriculum, who are Certified Peer Support Specialists, review the application to assure all documents are included The trainers conduct a peer to peer interview and determine eligibility based on criteria outlined in the Medicaid Provider Manual Final determination is provided to Michigan Department of Health and Human Services

State	Certification Requirement			
	State certification title	**Certification**	**Recertification**	**Certification Body**
Oregon	Peer support specialist	(1) Complete an approved training program; **or** Provide documentation of certification by a group other than the Oregon Health Authority that requires completion of an approved training program and at least 20 hours of continuing education every three years; **or** provide documentation of having worked or volunteered as a peer support specialist for at least 2000 hours in Oregon from January 1, 2004 to June 30, 2019; (2) complete THW Oral Health for Peer Support and Peer Wellness Training Program (3) not be listed on Medicaid provider exclusion list	20 hours continuing education every three years Take an approved oral health training	Oregon Health Authority, Office of Equity and Inclusion
Pennsylvania	Certified peer specialist	(1) Signed and dated Code of Ethical Conduct; (2) Signed, dated and notarized Release; (3) Live or work in Pennsylvania at time of application; (4) 18 years of age or older; (5) submit application fee; (6) Pass examination for certified peer specialists and receive certification	Recertification before the end of two-year certification period Recertification requires 36 continuing education units every two years and $50 two-year recertification fee	Pennsylvania Certification Board

State	Certification Requirement			
	State certification title	**Certification**	**Recertification**	**Certification Body**
Texas	Mental health peer specialist	(1) Complete online self-assessment and orientation; (2) apply for training with certified training entity; (3) compete core peer services training; (4) complete the SUD Recovery Coach or mental health peer training; (5) apply for certification; (6) complete 250 hours of supervised work experience; (7) signed ethics statement; (8) state-issued identification; (9) receive two-year certification	(1) Absence of any ethical or malpractice violations; (2) submission of an application including a signed coy of the ethical standards for mental health peer specialist; (3) completion of 20 continuing education hours, including three hours of ethics; (4) clear background check within 30 days of application; (5) $60 renewal fee	Texas Certification Board or Wales Education Services

LEADING PRACTICES TO CERTIFY PEER SPECIALISTS | FOUR

There does not exist any research to indicate that a particular set of screening, training and certification standards leads to better outcomes for individuals receiving peer support. One study did identify leading practices to certify peer specialists.

The 21st Century Cures Act included a provision for the United States General Accounting Office (GAO) to conduct a study to identify best practices related to training and certifying peer specialists in states that receive SAMHSA funding.

In the course of conducting that study, the GAO interviewed state program officials in six selected states and reviewed online, publicly available information about their peer support programs. GAO also interviewed SAMHSA officials and 10 stakeholders familiar with peer support certification, including mental health researchers and representatives of training organizations. The states were chosen based on the programs being well-established, their use of SAMHSA funds, and stakeholder recommendations. The states included Florida, Georgia, Michigan, Oregon, Pennsylvania and Texas. These same states have been highlighted in this report. However, since the GAO completed its study, the programs in Texas and Pennsylvania have undergone significant changes to comply with Medicaid requirements.

The GAO commenced the study in 2016 and published its results in November 2018. GAO identified the following six, leading practices for programs that certify peer support specialists.[19]

Practice 1: Systematic screening of applicants

The program should have a systematic and objective screening process to assess the applicant's understanding of recovery and the peer role.

Practice 2: Conducting core training in person

The program should offer or ensure approved training vendors offer in-person, core training to foster relationship building and allow peers to develop and practice their interpersonal skills.

Practice 3: Incorporating physical health and wellness into training or continuing education

The program should ensure that peer support specialists are trained during core training or continuing education to help others manage their physical health in addition to their mental health.

Practice 4: Preparing organizations to use effectively peers

The program should have efforts in place to educate staff at provider organizations about the peer support role and should help ensure that supervisors are prepared to supervise peers.

Practice 5: Continuing education requirements specific to peer support

The program should ensure the peer support specialists take continuing education that is specific to the peer support role.

Practice 6: Engaging peers in the leadership and development of certification programs

The program should ensure that peer support specialists who have been certified and are working in the field are involved throughout the certification process, including helping screen applicants, providing training or developing standards.

PAYING FOR PEER SPECIALIST SERVICES| FIVE

Peer services are funded through a variety of payment sources including grants, county or local government funds, Community Mental Health Block Grants, Community Service Block Grants, Tribal funds, Medicare, Medicaid, military insurance, other state funds, private health insurance, state corrections or juvenile justice funds, state education funds, self-pay, state-financed health insurance plans other than Medicaid, state mental health agency funds, state welfare or child and family services funds, and U.S. Department of Veterans Affairs funds.[20]

Most states with peer specialist certification programs have designed their programs to qualify for Medicaid reimbursement. Thus, this section of the report will review Medicaid requirements for reimbursement of peer specialist services.

Overview of Medicaid

Medicaid is the United States' publicly financed health and long-term care coverage for people with low incomes. It was created in 1965 as Title XIX of the Social Security Act. Medicaid provides coverage to all individuals who meet the eligibility criteria. Enrollment freezes and waiting lists are not permitted.

Although the Centers for Medicare and Medicaid Services (CMS) is responsible for Medicaid program administration at the federal level, individual state Medicaid agencies establish many policies and manage their own programs on a day-to-day basis. Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency

will often contract with other public or private entities to perform various program functions. For example, most states contract with the private sector to operate their Medicaid Management Information Systems, which are used to process claims for payment to providers, determine eligibility, and perform a variety of other tasks (e.g., monitor service utilization and provide data to meet federal reporting requirements). In addition, state and local agencies, such as child welfare and mental health agencies, may be responsible for various aspects of a state's Medicaid program.[21]

In Vermont, the Department of Vermont Health Access (DVHA) is responsible for the administration of the State of Vermont's publicly funded health insurance programs, including Medicaid. Green Mountain Care is the brand name for the family of publicly funded health coverage programs offered by the State of Vermont. Programs include Medicaid, Dr. Dynasaur and premium assistance pharmacy-only programs.

As a condition of receiving federal Medicaid funds, Section 1902 of the Social Security Act requires states to have a state plan on file with CMS that demonstrates an understanding of all federal Medicaid requirements. States are required to submit state plan amendments (SPAs) to CMS for review and approval prior to making program modifications. In addition to reviewing these SPAs, CMS works with state Medicaid agencies to review and approve applications for waivers of certain federal requirements. Once states opt to participate in Medicaid, as all currently do, they are obligated to administer their programs within federal guidelines and requirements.

Medicaid is financed through a partnership between the federal government and the states. The federal government matches state Medicaid spending according to a formula in the federal Medicaid law. The federal match rate, known as the Federal Medical Assistance Percentage, or FMAP, varies based on state per capita income – the lower a state's per capita income, the higher the state's FMAP.

By law, the Secretary of the United States Department of Health and Human Services calculates the FMAP each year. The FMAP is calculated based on a three-year average of state per capita personal income compared to the national average. For example, Federal Fiscal Year (FFY) 2021 FMAPs are based on data from calendar year 2016 to 2018. No state can receive less than 50 percent or more than 83 percent. The federal government funds about 57 percent of Medicaid spending overall. Current Medicaid program financing guarantees federal financial support to states with no pre-set limit.

Vermont's FFY 2021 FMAP is 54.39 percent.[22] In other words, for every dollar Vermont spends for Medicaid, the federal government matches it with $1.20 for a gross of $2.20.

States also receive Enhanced Federal Medical Assistance Percentage (E-FMAP) for the Children's Health Insurance Program (CHIP) and for adults newly eligible for Medicaid under the Affordable Care Act (ACA) Medicaid expansion. The E-FMAP for individuals covered under Medicaid expansion under the ACA is 90 percent. For every dollar Vermont spends, the federal government matches it with nine dollars, for a gross of 10 dollars.

Medicaid is a major source of funding for mental health care. In 2015, Medicaid covered 21 percent of adults with a mental health condition, 26 percent of adults with so-called serious mental illness and 17 percent of adults with substance use issues.[23] In comparison, Medicaid covered 14 percent of the general adult population.[24]

Many adults with mental health diagnoses qualify for Medicaid because of low income. For example, adults may be eligible for Medicaid if they live in a state that expanded its Medicaid program under the Affordable Care Act and have incomes up to 138 percent of the federal poverty level (in 2020, $12,760 per year for an individual). In states that did not expand their Medicaid programs, coverage

for non-disabled individuals is typically limited to parents, pregnant women and children. Vermont expanded its Medicaid program under the Affordable Care Act.

People with mental health diagnoses may also qualify for Medicaid based on having a disability. In most states, individuals who have a mental illness that qualifies them for Supplemental Security Income (SSI), the federal cash assistance program for elderly, blind or disabled individuals with low incomes, are automatically eligible for Medicaid.[25]

Mental health services are not a specifically defined category of Medicaid benefits, but Medicaid covers many mental health services. Some mental health services fall under mandatory Medicaid benefit categories that all states must cover by federal law. For example, psychiatrist services may be covered under the "physician services" category, and inpatient psychiatric treatment for individuals under age 21 or over age 65 may be covered under the "inpatient hospital services" category. Historically, federal law has prohibited federal Medicaid payments for services provided in "institutions for mental disease" (IMD) (generally defined as having more than 16 beds) to adults age 21 to 64. However, there are several exceptions to this rule.

States also cover mental health services through optional Medicaid benefit categories that they may choose to include in their Medicaid programs, such as case management services and prescription drugs. One well-used benefit category for mental health services is the rehabilitative services option, through which states commonly cover non-clinical mental health services such as peer support and community residential services. In addition, under certain conditions, states can provide home and community-based long-term care mental health services that support independent community living, such as day treatment, and psychosocial rehabilitation services.

Fee for Service and Managed Care Plans

States may offer Medicaid benefits on a fee-for-service basis, through managed care plans or both. Under the fee-for-service model, the state pays providers directly for each covered service received by a Medicaid recipient. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the managed care plan pays providers for all of the Medicaid services a recipient may require that are included in the plan's contract with the state.

The majority of Medicaid recipients, largely non-disabled children and adults under age 65, are in managed care plans. However, the majority of Medicaid spending still occurs under fee-for-service arrangements.

In general, states set provider payments under fee for service. Section 1902(a)(3)(A) of the Social Security Act requires that such payments be consistent with efficiency, economy and quality of care and are sufficient to provide access equivalent to the general population.

Waivers

States seeking additional flexibility in the design of their Medicaid programs may apply for formal waivers of some statutory requirements from the Secretary of the U.S. Department of Health and Human Services. For example, certain eligibility and benefit provisions of the Medicaid statute may be waived to explore new approaches to the delivery of and payment for acute care and long-term services and supports. States can use waivers to offer a specialized benefit package to a subset of Medicaid beneficiaries, to restrict enrollees to a specific network of providers or to extend coverage to groups beyond those defined in Medicaid law.

All states operate one or more Medicaid waivers, which are generally referred to by the section of the Social Security Act that grants the waiver authority. The waivers are categorized either as program waivers or research and demonstration projects. Approval of a state's waiver applications is at the discretion of the Secretary. In some cases, waivers may be coordinated with efforts involving other programs, such as Medicare or health insurance exchanges.

For Section 1115 and 1915(c) waivers discussed below, estimated federal spending over the period for which the waiver is in effect cannot be greater than it would have been without the waiver, referred to as budget or cost neutrality.

Section 1915(b): freedom of choice waiver

Section 1915(b) of the Social Security Act allows states to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewide-ness, and freedom of choice. States typically use these waivers to mandate enrollment in a managed care plan or a primary care case management (PCCM) program or to limit the number or type of providers who can provide specific Medicaid services.

Because these program designs restrict enrollees' freedom of choice, Section 1915(b) waivers are often referred to as freedom-of-choice waivers. It should also be noted that managed care programs can also be implemented under state plan authority.

Section 1915(c): home and community-based services waiver

Section 1915(c) waivers authorize states to provide home and community-based services (HCBC) as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with intellectual disabilities, and hospitals. The statute identifies services that may be considered HCBS, including case management, homemaker/home health aide, personal care, adult day programs, habilitation, and respite care services. The Secretary may also approve other services needed to avoid institutionalization. Under HCBS waivers, states can provide targeted sets of services to specific populations including, for example, seniors, people with mental illnesses, people with physical or developmental disabilities, and individuals with specific conditions such as HIV/AIDS or traumatic brain injuries. States are permitted to impose caps on waiver program enrollment and average costs per person to ensure that they do not exceed the waiver's cost-neutrality limit. HCBS waivers are generally approved for three years (five years may be provided for those serving persons dually enrolled in Medicaid and Medicare) with five-year renewal periods.

Section 1115 waiver: experimental, pilot or demonstration project

Section 1115 of the Social Security Act gives broad authority to the Secretary to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives" of the programs. Under Section 1115 research and demonstration authority, the Secretary may waive certain provisions of the Medicaid statutes related to state program design. Section 1115 waivers have been used to focus on specific services or populations, such as family planning, people with HIV/AIDS, and to expand substance use disorder treatment benefits to provide residential treatment in institutions for mental diseases. The Secretary does not have the authority to waive certain program elements such as the federal matching payment system for states.

To meet budget neutrality requirements, states must identify savings in their proposed 1115 demonstrations that will offset the cost of any program expansion. Section 1115 demonstrations include a research or evaluation component and usually are approved for a five-year period, with a possible three-year renewal period after the first five years.

Health Homes

The Affordable Care Act created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects state health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, mental health, and long-term services and supports to treat the whole person.

Medicaid Coverage for Peer Support Services

Medicaid billing for peer support services began in Georgia in 2001, and quickly expanded nationally after the CMS issued a letter outlining the requirements for Medicaid reimbursement of peer support services. Under the 2007 letter, to qualify for Medicaid funding:

1. Peer specialists must be supervised by a mental health professional, as defined by the State;

2. The peer support services must be coordinated within a comprehensive, individualized plan of care with specific, individualized goals; and

3. Peer specialists must be trained and credentialed with mandatory continuing education requirements that ensure peer specialists have a basic set of competencies necessary to support the recovery of others.[26]

In 2013, CMS issued “Clarifying Guidance on Peer Services Policy” that any peer provider must "complete training and certification as defined by the state" before providing billable services.

States also must meet requirements that apply to any Medicaid service. For example, in their state plans, states must describe the service and provider qualifications in detail and must establish utilization review and reimbursement methodologies. Also, states must meet the requirements of the particular Medicaid authority used for covering peer support (e.g., the Medicaid State Plan rehabilitative service or a waiver authorized by Section 1915(b) or Section 1915(c) of the Social Security Act).

In 2012, CMC approved Georgia as the first state to bill Medicaid for a peer whole health and wellness service delivered by Whole Health Action Management-trained peer specialists.

Beginning January 1, 2014, CMS expanded the type of practitioners who can provide Medicaid prevention services beyond physicians and other licensed practitioners, to include peer specialists, at a state’s discretion.

How States Use Medicaid to fund Peer Support Services

The mechanism for using Medicaid to fund peer support services differs from state to state. Some states fund peer support as a part of their fee-for-service Medicaid program. Others reimburse peer support services under Medicaid waiver sections 1915(b), 1115, or 2703. Many states provide peer support through Medicaid Managed Care Organizations.

States that fund peer support services as part of their fee-for-service program must amend their state plans to do so. States that fund peer support services through waivers must receive approval for their waivers.

Specific Examples of Peer Services Reimbursed through Medicaid

Georgia – State Plan Rehabilitation Services

Georgia was the first state to offer peer support services as part of the Medicaid State Plan rehabilitative services benefit. Many peer specialists offered peer support as a distinct service through freestanding peer support locations such as drop-in centers. Peer specialists also work for community mental health providers, including as part of a team with non-peer specialists. Peer specialists also provide other rehabilitative services such as Assertive Community Treatment and psychosocial rehabilitation.

Georgia prefers peer specialist supervisors be (1) credentialed as a psychiatric rehabilitation professional by the U.S. Psychiatric Rehabilitation Association and (2) be a certified peer specialist.

Peer specialists must record weekly progress notes to document a participant's progress towards goals specified in the service plan.

In June 2012, the State of Georgia became the first state to have Medicaid-sanctioned whole health and wellness peer support provided by certified peer specialists who receive technical, medical advice and referral support from behavioral health nurses. Peer support whole health and wellness coaches are certified in Whole Health Action Management (WHAM). The goal of the WHAM program is to integrate health self-management and preventive resiliency.

WHAM peer specialists receive additional training that enables them to (1) engage in person-centered planning to identify strengths and supports in 10 science-based whole health and resiliency factors; (2) support the person in creating a whole health goal based on personal motivation and person-centered planning; (3) support the person in creating and logging a weekly action plan; (4) facilitate WHAM peer support groups which create new health behaviors; (5) build the person's relaxation response skills to manage stress; and (6) build the person's cognitive self-management skills to avoid negative thinking.

Iowa – Additional Services Authorized Under Section 1915(b)(3)

Iowa has contracted a single managed mental health organization under a statewide 1915(b) waiver since 1995. Since 1996, the state and managed care organization have invested some of the program's cost savings to a community reinvestment fund that provides one-year grants to invest in new services. Several grants were provided to peer support programs. Within a few years, the managed care organization began paying for peer support on a fee-for-service basis.[27]

A mental health supervisor must be available by telephone at all times to provide peer specialist supervision. There are no requirements that the supervisor be a peer specialist or hold a credential.

For people receiving multiple mental health services, the State requires joint treatment planning involving the participant, a case manager, other providers and other individuals important to the participant. Peer support must be part of the participant's service plan, which specifies an activity plan for peer support and goals for the service. Peer specialists are part of the participant's treatment team and coordinate with other providers.

Peer specialists must be trained using a locally modified version of the Georgia certified peer specialist training or equivalent. The managed care organization worked with the State and other stakeholders to develop the local training curriculum, including monthly ongoing training. A peer support program must submit its proposed curriculum for approval by the managed care organization when applying to provide peer support.[28]

Wisconsin – Home and Community-Based Services Waiver

Wisconsin offers a "Peer/Advocate Supports" service as part of a Home and Community-Based Services (HCBS) Waiver for people who have both a physical disability and "severe and persistent mental illness." The State designed the Community Opportunities and Recovery (COR) waiver to provide community services to such individuals relocating from nursing homes. Wisconsin's waiver offers Peer Advocate/Supports as a participant-directed service using employer authority, which allows participants to hire, manage, and if necessary, terminate their provider. CMS approved the waiver in 2007.

Peer/Advocate Supports are provided by Recovery Coaches, who must be supervised by a mental health professional. The mental health professional could be the person's case manager or an employee of another provider. If Peer Advocate/Support is provided as a participant-directed service, the case manager is considered the supervising mental health professional.

As is required for all HCBS waivers, all services must be authorized in a plan of care that is developed by a case manager in partnership with the participant.

Recovery Coaches must receive training in recovery and person-centered planning using a state-approved training curriculum. The provider must complete additional training regarding mental illness and related medical, physical and social conditions. Required training topics include risk management, safety, and recognizing and responding to emergency situations.[29]

Reimbursement Rates for Peer Support Services

As mentioned above, states set their own reimbursement rates within federal guidelines. Reimbursement is generally made to the organization employing the certified peer specialists rather than to the peer specialist as a distinct Medicaid clinical professional.

When states reimburse for peer services, there are several Healthcare Common Procedure Coding System (HCPCS) codes used for services provided by peer specialists. The codes include:

For general services:

H0038: Self-help/peer services, per 15 minutes

For specific services:

G0177: Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)

H0023: Peer-Directed and Operated Support Services

H0025: Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)

H0039: Assertive community treatment program, per diem

H0040: Assertive community treatment, face-to-face, per 15 minutes

H2014: Skills training and development

H2015: Community Support

H2017: Psychiatric Rehabilitation

H2019: Wellness Action Recovery Planning

H2021: Community-Based Wraparound

H2023: Supported Employment/Supported Education

H2027: Psychoeducational Services

T1016: Case Management

Below is a sampling of maximum Medicaid reimbursement rates for peer services delivered under Medicaid fee-for-service or waiver programs.

Selected State Fee-for-Service Reimbursement Rates for Peer Support Services (2019-2020)[30]							
HCPCS	**GA**	**OR**	**RI**	**NY**	**MA**	**ME**	**OH**
G0177		$17.86 - $18.83					
H0023		$16.88					
H0025	$15.13 - $36.68						

Selected State Fee-for-Service Reimbursement Rates for Peer Support Services (2019-2020)[30]							
HCPCS	**GA**	**OR**	**RI**	**NY**	**MA**	**ME**	**OH**
H0038	$15.13 - $24.36	$17.70	$13.50	$15.68 - $21.17	$5.82		$15.51
H0039		$27.25					
H0040		$28.60					
H2014		$17.56					
H2019						$10.68	
H2023		$17.56					
T1016		$22.56					

Steps to Establish a Medicaid-Compliant Peer Specialist Certification Program

The steps to establish a peer support specialist certification program for purposes of receiving Medicaid reimbursement include the following.

1. Establish a certifying body to certify peer specialists; leading practices suggests this should be a peer-run organization;
2. Provide for statewide certification of peer specialists;
3. Define the range of responsibilities, practice guidelines, and supervision standards for peer specialists;
4. Determine the curriculum and core competencies, including areas of specialization, such as transition-age youth, veterans, gender identity, and sexual orientation;
5. Specify training requirements;
6. Establish a code of ethics and processes for investigations and corrective action;
7. Determine a process for certification renewal; and
8. Determine a process for allowing existing peer support workers to obtain certification.

Some states have used Mental Health Medicaid Administrative Activities (MMA) to fund initial certification infrastructure needs. Under section 1903(a)(7) of the Social Security Act, federal payment is available at a rate of 50 percent for amounts expended by a state "as found necessary by the Secretary for the proper and efficient administration of the state plan," per 42 Code of Federal Regulations (CFR) 433.15(b)(7). The Secretary is the final arbiter of which administrative activities are eligible for funding

Program Startup Case Study -- Massachusetts

Massachusetts used a federal Transformation Grant to fund the development of its peer certification program. In 2004, stakeholders formed the Transformation Committee, which comprised diverse stakeholders, including people with lived experience, staff from provider agencies, the Association for

Behavioral Health, Massachusetts Behavioral Health Partnership, the Department of Mental Health (DMH), the Department of Public Health, UMass Medical Center, Recovery Learning Communities (RLCs), Consumer Quality Initiatives, the Transformation Center, and the Massachusetts Rehabilitation Commission.

Following conversations with representatives from the State of Georgia and the Appalachian Consulting Group, the parties agreed that a group of Massachusetts peers would be trained in Georgia, and that the Georgia Training team would then come to Massachusetts to train certified peer specialist trainers and help kick off the first two Massachusetts classes. Massachusetts adopted the "Georgia" model of peer specialist training because it was firmly established, was already Medicaid-approved, and had overcome any state and federal regulatory challenges.

In 2005, five advocates from Massachusetts attended the Certified Peer Specialist (CPS) training offered in Georgia and passed the CPS exam. The first Massachusetts class was held in August 2005, co-taught by the Georgia and Massachusetts training teams. In November 2005, the Massachusetts team taught the class under the supervision of the Georgia team. Massachusetts held its first certified peer specialist class on its own in 2006. Since that time, CPS classes have been held at least annually across the state.

Over the course of the first four trainings, while the Massachusetts training team honed its skills to deliver the training and examination, the program was delivered exactly as it is done in Georgia. The original Georgia training was 8 days long, held over 8 days in a row with a weekend off in the middle. Groups would come to a hotel on Sunday and classes would be held all day Monday through Friday. People would leave for the weekend, returning again on Sunday, with classes held from Monday through mid-afternoon Wednesday.

Since that time, the curriculum has been modified to address the specific needs of service providers and service users in Massachusetts and to maximize the skills of the evolving training team. These modifications have included some shifts in the curriculum and a change in the overall format of the training. The format was changed to provide participants with more time to absorb the material, to have the opportunity to reflect upon and use their new skills during the training, and to make stronger connections with other peers in the Commonwealth.

Program Startup Case Study -- New York

The New York State Office of Mental Health began to develop a peer specialist certification process in consultation with peer leaders from across New York State with the goal of ensuring continued peer services opportunities. The Academy of Peer Services was launched in January 2014. At the same time, the State of New York awarded the Alcoholism and Substance Abuse Providers of New York State a contract to administer certification.

Rutgers University in collaboration with peer leaders developed the Academy of Peer Services' online courses which candidates are required to take and successfully complete to meet the training requirement for certification.

The New York Peer Specialist Certification Board first met in 2014 to issue the first New York Certified Peer Specialist certifications.

New York offered a Provisional certification to "jump start" the certification process and certify as many professionals as quickly as possible. The Provisional certification does not have a supervised work experience requirement. New York continues to offer a Provisional Certificate and a non-Provisional Certificate.[31]

The difference between the Provisional Certificate and the non-Provisional Certificate is illustrated in the below chart.

Requirements	NYCPS-Provisional Certification	NYCPS Certification
Peer Status	Must identify as actively in recovery from a mental health condition or major life disruption and self-disclose one's mental health journey	Same as provisional
Education	High school diploma or equivalent	Same as provisional
Training	• Complete all 13 core courses of the Academy of Peer Services (APS) • Successfully complete post-tests for all core courses	• Complete all 13 core courses of the Academy of Peer Services • Successfully complete post-tests for all core courses • Complete a minimum of five additional APS electives (15 hours)
Professional References	Submit directly to the NYPSCB three signed references from individuals able to attest to ability as peer specialist	Same as provisional
Supervised work experience	None	Document 2,000 hours of peer specialist experience under supervision of a qualified supervisor
Supervised internship	None	Same as provisional
Renewal Standards	20 hours of peer specialist specific training annually	Same as provisional
Renewal Fee	$100, currently funded by NYS OMH for all individuals living or working in New York State	Same as provisional

New York has certified more than 1,000 peer specialists since 2014.

Medicaid Reimbursement Without State Certification

In California, the services of peer support specialists are billed to Medi-Cal, the name California gives to its Medicaid program, without a statewide certification. Nearly 6,000 peer specialists work in a variety of settings across the state including county clinics, schools, and primary care.

California included certified peer specialists as a component in its most recent Section 1115 Waiver renewal, known as Medi-Cal 2020, by providing financial incentives to managed care plans to support non-physician community providers, promoting both physical and mental health care integration and team-based care. Counties are currently able to seek reimbursement for peer support services under the "other qualified provider" provider type under the Medicaid state plan using service codes for rehabilitation, collateral and targeted case management.

In September 2020, after the first draft of this report was released, California passed the Peer Support Specialist Certification Program Act of 2020. The Act requires the State entity that oversees California's Medicaid program to establish statewide requirements for counties to use in developing peer specialist certification programs.[32] The legislation authorizes voluntary, county-wide certification programs rather than a mandatory state-wide certification program.

The credentialing of peer specialists is not without controversy. Some believe that certification, particularly for the purposes of billing Medicaid, is inconsistent with the principles and values of authentic peer support. One activist has argued that the professionalization of peer support has "demobilized the very social justice movement from which it was birthed." Social worker and activist Brooke M. Feldman writing in the online forum, *Medium*, went on to say:

> "The co-option of people with lived experience into the system has essentially oppressed and marginalized a substantially large number of the very people who would be the ones to dismantle and transform these broken systems. We see evidence of the oppression and marginalization of professional peer staff in multiple studies reporting low wages, high burnout, low job satisfaction, high role confusions, lack of perceived power and influence, etc."[33]

Research has documented a degree of job dissatisfaction among certified peer specialists, particularly in the areas of training, compensation, supervision and career advancement. Any program to enhance peer specialist workforce capacity must address these issues.

Training

In a 2018 study, researchers administered an online, 3-part survey to 195 peer specialists who were members of the International Association of Peer Specialists. The study was designed to examine the impact of role clarity and job training on job satisfaction among peer specialists. The study found that self-study and online training methods were negatively correlated with job satisfaction while job shadowing was positively correlated with job satisfaction.[34]

The report's authors concluded that the use of self-study and online training for peer specialists should be avoided. Rather, training methods should allow for personal interaction with other peer specialists.

Compensation

SAMHSA and others have advocated for the integration of peer specialists into traditional mental health settings to address workforce shortages in the mental health workforce.[35] There is also the view that peer specialists are a source of cheap labor. In a 2018 survey of certified peer specialists in the state of Michigan, 38 percent were "certain" they could not address a common financial shock, which the report's authors concluded was suggestive of financial vulnerability due to inadequate compensation.[36]

To enhance peer specialist workforce capacity, states need to be mindful of how they set Medicaid reimbursement rates to ensure that peer specialists earn a living wage.

A 2016 national survey of compensation among peer specialists revealed a wide range in the wage structure of peer specialists. The survey identified significant differences in average compensation rates between those who work variable hours ($15.42) and those who work only full-time ($16.36). There were also different wage rates by organization type (peer-run organizations, community mental health organizations, health care provider organizations, inpatient psychiatric facilities, and health plan and managed care organizations).

An analysis of the wages of peer specialists in the 10, U.S. Department of Health and Human Services (HHS) regions also revealed geographic differences in compensation rates. The study also identified

inequities in compensation rates between male and female peer specialists, with men receiving on average in excess of $2.00 more per hour than women.[37]

The average peer specialist wage in New England in 2016 was $16.18, with men earning $17.59 an hour and women earning $15.12 an hour. Wages varied by setting as follows:

	Peer Run	Community Behavioral Health	Health Care Provider	Psychiatric Inpatient	Health Plan/ Managed Care	Multiple	No Survey Response	Total
New England	$16.68	$17.62	$14.44	$20.24	$12.71	$15.77	$19.68	$17.73
National Average	$13.73	$14.18	$17.23	$15.85	$17.96	$16.43	$17.76	$15.42

The authors of the same peer specialist wage survey also calculated the maximum peer specialist salary potential based on assumptions about productivity, Medicaid reimbursement rates, and staff benefits and agency operating expenses. Based on their analysis, the maximum peer specialist salary potential was $17.13 an hour in 2016.[38] Detailed information about the methodology for calculating a potential peer specialist salary is included in Appendix I.

Supervision

The supervision of peer specialists is a recognized challenge for peer support programs. The results of a 2015 survey of Texas certified peer specialists suggested that supervisor understanding of the peer specialist job role has a significant impact on job satisfaction.[39]

Thus, any effort to enhance peer specialist workforce capacity must include targeted efforts to educate supervisors about peer specialist roles.

Pennsylvania, for example, offers a peer specialist supervisor certification. In Pennsylvania, anyone who supervises certified peer specialists in a Medicaid-billable program must be either a mental health professional who has completed an approved certified peer specialist supervisor training, or an individual who has certain minimum qualifications that include (1) a bachelor's degree; and two years of mental health direct care experience, which may include experience in peer support services; or (2) a high school diploma or general equivalency degree (GED); and four years of mental health direct care experience, which may include experience in peer support services.

Anyone who becomes a certified peer specialist supervisor in a Medicaid-billable program must complete the peer specialist supervisor training within six months of taking the position of peer support supervisor. The supervisor training is a two-day course provided by Pennsylvania's three approved training vendors: Institute for Recovery, RI Consulting, and the Copeland Center for Wellness and Recovery.

In Massachusetts, the peer-run organization that trains and certifies peer specialists has also developed a training program for peer specialist supervisors.[40]

Career Advancement

A 2018 study of peer specialist job satisfaction revealed that less than one-half were satisfied with their promotion opportunities.[41]

Some states have enhanced the career prospects for peer specialists by offering endorsements to the basic peer specialist certification.

For example, in June 2012, the State of Georgia became the first state to have Medicaid-sanctioned whole health and wellness peer support provided by certified peer specialists who receive technical, medical advice and referral support from behavioral health nurses. Peer support whole health and wellness coaches are certified in Whole Health Action Management (WHAM). The goal of the WHAM program is to integrate health self-management and preventive resiliency.

The reimbursement rate for these services is higher than other peer services, which can allow for salary increases to peer specialists who provide these services. The rate for 15-minute unit ranges from $15.13 to $36.68 depending on the location of the service and the experience and education of the certified peer specialist. The fee-for-service reimbursement rates for peer specialists providing more traditional peer support services range from $15.13 to $24.26 for 15-minute units.

Wyoming, a rural state less populous than Vermont, offers several endorsements that peer specialists may earn. They include (1) a Mastery Endorsement for peer specialists who have completed two or more community-based advocacy or leadership accomplishments in the previous 12 months; (2) a Whole Health endorsement; and (3) a Forensic Peer Specialist endorsement. With the exception of the Mastery Endorsement, each endorsement requires additional training.[42]

Canada also certifies Peer Support Mentors and Peer Support Practice Leaders. A Peer Support Mentor is someone who has significant experience and success as a Peer Supporter, and has demonstrated the additional knowledge, skills and competencies that are required to mentor peer supporters. Certified Peer Support Mentors teach, guide and assess peer supporters as they develop skills and progress through the certification process.

To become a Peer Support Mentor, a candidate must be a Certified Peer Supporter in good standing, have at least five years' work experience in peer support, pass the knowledge assessment, successfully co-mentor two certified peer supporter applicants in conjunction with a certified peer support mentor, and meet the mentor competencies.

A Peer Support Practice Leader is someone who has significant experience and success as a Peer Supporter and as a Mentor, and has the additional knowledge, skills and competencies that are required to develop and/or lead a peer support community of practice, including teaching, guiding and assessing Peer Support Mentors.

Both of these roles create a career path for peer specialists.

Mental Health America also offers an advanced certification that it says is designed to enhance career prospects for peer specialists. Mental Health America describes its National Certified Peer Specialist Certification (NCPS) as a voluntary, examination-based certification that allows peers to demonstrate a high level of experience and competencies in peer support. The NCPS does not replace state certification but is an add-on to required state certifications.

To apply for the examination-based certification, applicants must (1) hold current state certification with a minimum of 40 hours of training or have completed an MHA-approved training; (2) have a minimum of 3,000 hours of supervised work or volunteer experience providing direct peer support; (3) provide one professional letter of recommendation for the certification; and (4) provide one supervisory letter of recommendation for certification. The application fee is currently $225.

Once approved, applicants take a 125-question, three-hour examination at an approved testing location. The examination fee is $200. To maintain certification, peer specialists must complete 20 hours of continuing education every two years, practice according to the NCPS Code of Ethics and pay the $200 biennial renewal fee.

ANALYSIS OF VERMONT CORE COMPETENCIES | SEVEN

Core competencies are the capacity to easily perform a role or function. They are often described as clusters of knowledge, skills, and attitudes a person needs to have in order to successfully perform a role or job or as the ability to integrate the necessary knowledge, skills and attitudes.[43] Core competencies can be used to develop peer training programs, create standards for certification and craft job descriptions.

Core competencies for peer workers should reflect the following foundational principles identified by psychiatric survivors.

RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker.

VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.

RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.

TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Vermont's Wellness Workforce Coalition (WWC) established a Core Competencies Workgroup to develop core competencies for its member organizations' peer specialists. The core competencies are the result of several years discussion and effort by the WWC. In developing the core competencies, the Workgroup reviewed the competencies and values developed by several peer organizations and oversight bodies.

The following are the competencies developed by Core Competencies Workgroup. The WWC has not formally adopted these core competencies.

Chapter	Topic	Description
1	**Peer support values and orientation**	Peer support workers are trained in and have an understanding of: the human rights issues and history of peer support and the peer movement; individuals' stories; peer support values and why they are important; differences between traditional mental health care and peer support; and the importance of relational support that is free of judgment and hierarchy.
2	**Lived Experience**	Peer support workers are thoughtful in telling their personal stories and sharing their lived experience when it is useful to the relationship, along with the skills and tools they have developed based on their own experience, to inspire and support the individuals with whom they work. Through mutual sharing of lived experience, peer support workers create connection with those they support.
3	**Self-Awareness**	Peer support workers build a capacity for introspection and self-reflection, can voice their own discomfort and needs and have the ability to recognize themselves as individuals.
4	**Boundaries**	Peer support workers create clear and respectful personal limits and boundaries which are essential to effective peer support relationships. They recognize that personal limits and boundaries are complex and can be physical, emotional, sexual, verbal and/or energetic. Boundary setting can change internal and relational dynamics.

Chapter	Topic	Description
5	**Worldview and cultural awareness**	Peer support workers are aware that everyone has their own values, beliefs, cultural experiences, familial influences and relationships which create a personal worldview. This worldview is the lens through which reality is experienced and influences individual attitudes, biases and judgments. Sharing this worldview can create connection, relationship and growth. Peer support workers develop the ability to work in a non-judgmental and compassionate manner, meeting individuals where they are at, regardless of differences in worldview.
6	**Communication, dialogue and active listening**	To create connection, peer support workers understand the components of dialogue, non-verbal dialogue, collaborative problem solving and remaining curious. They are able to clearly communicate their needs and the needs of the job or organization according to their particular role. They are able to be reflective and transparent in what they share and how they respond. They also enable effective engagement, networking, teamwork and conflict management.
7	**Authentic and mutual relationships**	Peer support workers are encouraged to be honest with themselves and genuine when providing peer support and to approach relationships with a sense of curiosity. They consider the individuals with whom they work as equals while acknowledging relative power, privilege and status.
8	**Wellness, resilience and self-care**	Peer support workers understand, demonstrate and actively practice self-care strategies. They are aware of their own personal limits and recognize signs of becoming overwhelmed (e.g., burn out, compassion fatigue, vicarious or secondary trauma, over-engagement, over-identifying). They actively aspire to approach challenges with equanimity, to remain composed when under strain or tension and to acknowledge when this is difficult. Peer support workers often rely on their relationships as a source of support.
9	**Self-determination**	Peer support workers focus on learning, exploring and growing together rather than on helping. They validate, encourage and support individuals in determining what they want their lives to be like by encouraging them to reflect on their needs and pursue their aspirations.

Chapter	Topic	Description
10	**Trauma-informed**	Peer support workers are aware of the short- and long-term impact of personal history and trauma on all aspects of an individual's life. They recognize that certain actions (e.g., violence, substance use, anger) are coping mechanisms and that most challenges and forms of adversity experienced by individuals may result from personal history and trauma. Peer support workers' orientation is not "what is wrong with you" but "what has happened to you;" they see crisis as an opportunity to grow and change.
11	**Safety**	Peer support workers identify potential risks and seek to work collaboratively with individuals to reduce risk to themselves and others. They may have to manage situations in which there is intense distress and work to ensure the safety and well-being of themselves and others and learn when to step out of harm's way. In peer support, mutual safety is enhanced through relationship and connection.
12	**Collaboration and teamwork**	Peer support workers develop and maintain effective working relationships with team members, professional colleagues and other organizations, including policy makers and funders. All peer support workers seek to balance the needs of the program or organization with peer support values, but particularly when working in more traditional mental health settings (designated agencies, hospitals, etc.). Peer support workers may see themselves as representatives of a collaborative movement striving to improve the quality of life for individuals experiencing various forms of adversity.
13	**Professional development, leadership and privacy**	Peer support workers seek and pursue opportunities for personal and professional growth and development, including opportunities to provide leadership. They see themselves as ambassadors of the peer support movement and commit to acting in a respectful and responsible manner. At all levels, peer support workers honor the privacy and confidentiality of individuals and embrace peer support values regarding the sharing and disclosure of information.
14	**Links to resources, services and supports**	Peer support workers help individuals acquire the resources, services and supports they need by connecting them to resources or services within mental health and community settings. Peer support workers have knowledge of resources within their communities as well as on-line and learn when and to whom to reach out for assistance.

Chapter	Topic	Description
15	**Human Rights-based Approach and Advocacy**	Peer support workers understand a Human Rights-Based Approach and how various forms of systemic oppression (racism, sexism, ableism, classism, homophobia, transphobia, etc.) intersect with mental health and the mental health system. They work to examine and reduce the impact of stigma and discrimination on mental health through advocacy and a social justice lens. They believe that individuals have a right to receive the services and supports of their choosing and will advocate for individuals to receive these services and supports within communities of their choosing.
16	**Medicaid/Insurance-related Requirements**	Peer support workers and supervisors in programs receiving federal (Medicaid, Medicare) or insurance reimbursement will abide by certain requirements pertaining to assessment, treatment planning, progress notes and program supervision in accordance with peer support values to the extent possible.

Vermont Core Competencies Compared to Georgia Core Competencies

Georgia's peer specialist core competencies form the basis of peer specialist training in 35 states. That training, developed by the Appalachian Consulting Group (hereafter "Appalachian") was first used in 2001 to train peer specialists in Georgia, the first state to bill Medicaid for peer specialist services. A copy of Georgia's core competencies and training curriculum are included in Appendix C and G, respectively.

Most of Vermont's core competencies are similar to Georgia's core competencies. However, there is at least one significant difference.

The Vermont core competencies do not center the concept of "recovery" in the way that the Georgia core competencies do. In fact, the Vermont core competencies do not appear even to mention the word "recovery."

The recovery process and planning is one of four, Georgia core competencies. The Georgia training, which is based on the competencies, devotes seven sessions to different elements of recovery.

The title and description of the seven sessions are as follows:

1) "The Shift to Recovery and Resiliency" explains the shift in the mental health system focus from stabilization and maintenance to recovery and resiliency;

2) "Five Stages in the Recovery Process" begins to build a common framework for discussing recovery by presenting five basic stages in the recovery process, and exploring the dangers and role of services at each stage;

3) "Using Your Recovery Story as a Recovery Tool" explores the differences in an illness story and a recovery story and giving trainees the opportunity to share their recovery stories in small groups;

4) "Creating Recovery Cultures" explores how negative messages are sent in the mental health system, how these messages work against recovery, and what can be done to counter them;

5) "Exploring Beliefs that Promote Recovery" explains how the beliefs in the mental health system determine how services are designed and delivered and examining some of the emerging beliefs that support and promote recovery;

6) "Facilitating Recovery Dialogues" introduces a structured group discussion process that facilitates recovery dialogues and gives attendees an opportunity to practice in small group settings; and

7) "Creating the Life One Wants: Accomplishing One's Recovery Goals" introduces a 10-step process for accomplishing a goal once the goal is set.

The Georgia competencies also refer explicitly to a Code of Ethics and the Georgia curriculum includes two sessions on peer specialist ethics that explore the meaning of ethics and boundaries as they apply to peer specialists and provide some guidelines for decision-making in situations with possible ethical implications. While Vermont's core competencies do include a module on boundaries, it does not appear to be framed in terms of ethics and ethical decision-making.

Vermont Core Competencies Compared to SAMHSA Core Competencies

In 2015, the Substance Abuse Mental Health Services Administration (SAMHSA) led a group that included individuals with lived experience to develop core competencies for peer specialists. A copy of the SAMHSA competencies is included in Appendix H.

Vermont's core competencies appear largely consistent with SAMHSA's core competencies with the possible exception of recovery planning. Vermont's core competencies do not explicitly identify recovery planning as a core competency.

Status of Vermont's Peer Specialist Training Curriculum

Vermont, through its Wellness Workforce Coalition, initially set out to develop a peer specialist curriculum unique to Vermont based on the proposed core competencies. As that process got underway, some advocated for the adoption of a more generic curriculum, e.g., Wellness Recovery Action Planning (WRAP) or Intentional Peer Support (IPS). Created in the 1990s, IPS, according to its creator, is:

> "… a way of thinking about and inviting transformative relationships. Practitioners learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things."[44]

For a variety of reasons, work on the development of a peer specialist curriculum unique to Vermont has stalled.[45]

A few states with peer specialist certification programs have adopted IPS as the lone training program for peer specialist certification. For example, the State of Maine uses IPS to train its certified peer specialists. Those who successfully complete the IPS training are titled "Certified Intentional Peer Support Specialists." However, IPS as the sole training for certified peer specialists is not a leading practice.

The leading practice in peer certification training is a core curriculum grounded in recovery such as the Georgia curriculum coupled with a supplemental curriculum unique to a particular jurisdiction that also incorporates physical health and wellness, and ongoing training in practicing interpersonal skills.

IMAGINING A PEER CERTIFICATION PROGRAM IN VERMONT | EIGHT

Members of the Peer Workforce Development Initiative Steering Committee were asked to complete a multiple-choice survey intended to gauge preferences in the design of a Vermont mental health peer certification program. The results of the survey were discussed at a December 2020 meeting of the Steering Committee.

For each question, respondents were asked to select the option that best represented their preferences. Copies of the survey and survey results are included in Appendix K.

The survey had an 88 percent response rate. One Steering Committee member, who currently supervises peer support workers in a community mental health agency, chose not to respond to the survey because she is opposed to a statewide peer certification program. Based on her experience, the requirements of Medicaid-compliant billing conflict with peer support values and roles and also compromise the integrity of peer support as a political movement.

Among the respondents, there was general agreement among the majority of program design choices. "General agreement" means at least half of respondents agreed. Where responses diverged widely, individual members explained their rationale for the choices they made. Some survey responses that appeared more divergent based on survey results, became less divergent after discussion.

A degree of divergence was noted even after discussion around the following two survey questions:

1. What type of organization should be responsible for the certification process?
    a. A peer-run organization that both trains and certifies applicants. (25%)
    b. A peer-run organization that only certifies applicants with a separate organization conducting training and screening. (50%)
    c. A state certification board. (12.5%)
    d. Inclusion of mental health providers and collaborators in the process. (12.5%)
    e. The state department of mental health. (0%)

2. Whether Vermont should require peer specialists to pass a statewide examination to become re-certified or should recertification only require the payment of a fee and/or registration without a fee.
    a. Applicants should be required to pass an examination to become re-certified. (25%)
    b. Applicants should only be required to pay a fee to become re-certified. (12.5%)
    c. Applicants should only be required to register without any additional fee to become re-certified. (25%)
    d. Re-certification should only be required if a peer specialist does not work in the field for a specified period of time (e.g., three to five years). (12.5%)
    e. Continuing education requirement should be only requirement for re-certification. (25%)

Design of a Vermont Peer Certification Program Based on Survey Results

A little more than 87 percent of the members of the Peer Workforce Development Initiative Steering Committee supported a professional peer specialist certification program, overseen by a peer-run organization, which separates screening and training from testing and certification.

The matrix below illustrates the design of a Vermont peer certification program based on results of the survey completed by members of the Peer Workforce Development Initiative Steering Committee. Design elements were selected based on the elements that received the most votes. The percent supporting a particular design element is indicated in parenthesis in the matrix.

SCREENING					
Minimum Age	**Minimum Education**	**Criminal Conviction Disqualifying?**	**Prior work or volunteer experience**	**Letters of Reference Required**	**Recovery experience and other requirements**
18 (85.7%)	None (62.5%)	No 87.5%)	250 hours 50%)	Yes 87.5%)	• Lived experience required (62.5%) • Must be willing to speak publicly about personal recovery (75%) • Must live or work at least 51% of time in Vermont (50%) • Must submit to an interview (75%)

TRAINING				
Is admission to training a competitive process?	**Is in-person training required?**	**How will curriculum be developed?**	**Who conducts the training?**	**Is completing the training sufficient for certification?**
No; training is open to all applicants who successfully complete screening (87.5%)	Yes (50%)	Vermont should develop its own curriculum or adapt an existing curriculum for Vermont (75%)	Peer-run organization (75%)	No; applicants must pass a statewide exam administered by an independent entity. (62.5%)

CERTIFICATION				
How Certified	**Duration of Certification**	**Recertification Exam**	**Certification Body**	**Is certification mandatory?**
Successful completion of statewide certification examination (62.5%)	Lifetime, with mandatory continuing education (37.5%)	None (75%)	Peer-run organization separate from screening and training organization (75%)	No; however, certification is required to bill Medicaid for peer support services (100%)

Stakeholder Impressions of a Vermont Peer Certification Program

Vermont Care Partners (VCP) and the Vermont Association of Hospitals and Health Systems (VAHHS) were asked about their initial reactions to a peer certification program in Vermont whose design roughly followed the survey results. Both stakeholders were told that the certification would be mandatory for peer specialists working in non-peer run organizations.

Vermont Care Partners (VCP)

VCP is a statewide network of sixteen non-profit community-based agencies providing mental health, substance use, and intellectual and developmental disability services and supports.

VCP reported that it was "open to the concept of creating a peer certification program as outlined. Agencies value the peer specialists they employ, particularly for their efficacy in recovery."

VCP posed the following questions:

1. What is the experience in other states that have a peer certification programs?
2. Could the certification process create a bar too high for some people, deterring them from applying to be a peer specialist?
3. Could people who don't want to go through the training and certification still provide services and supports to peers?
4. Is training available to Agency staff on the duality of the peer specialists and how to respect their boundaries? (already identified as a need)
5. How would the curriculum differ from Intentional Peer Support and why create a Vermont-specific program?
6. Will there be adequate revenue for enhance payment for Peer Supports?

Vermont Care Partners also asked that designated agency representatives be a part of any decision making and design processes regarding peer certification or funding as the initiative moves forward.[46]

Vermont Association of Hospitals and Health Systems

Vermont Association of Hospitals and Health Systems (VAHHS) is a member-owned organization comprised of Vermont's network of not-for-profit hospitals.

VAHHS reported that "reactions to the proposal have been positive. We can't wait to see what the final proposal looks like."[47]

Department of Vermont Health Access

The Department of Vermont Health Access (DHVA) is a stakeholder in the sense that it would be the entity most likely charged with seeking the necessary program approvals for a Medicaid-compliant peer certification program.

DHVA reported that there is nothing in the Global Commitment waiver that would prevent Vermont from pursuing a state plan amendment to allow new provider types to enroll in support of peer service expansion.[48]

Projected Program Costs

To assist in the projection of programs costs, interviews were conducted with peer certification program managers in Washington, D.C. and the State of Wyoming. These localities were chosen because of their small populations. Washington, D.C. has a population of 705,749; the State of Wyoming has a population of 578,759. Vermont's population is 623,989.

Washington, D.C.[49]

Washington, D.C. began its peer certification program in 2011. It is an assessment-based certificate program. The same entity that screens, and trains also tests and certifies.

Washington, D.C. initially offered two trainings per year with a class size of 25. In 2016, it began to offer three trainings a year and reduced the class size to 15. It found a class size of 25 to be too large.

Washington, D.C. receives 50 to 75 applications for 15 slots. A committee reviews each application according to a rubric. Twenty to 25 applicants are invited to interview, and 15 applicants are selected for the training program. The average age of applicants is 40. The training completion rate averages 60 percent. Applicants do not have to pay for training. They also receive a stipend

Currently, the training program is 70 hours, conducted over six weeks. There is a plan to reduce the training to 50 hours because of cost.

Washington, D.C. retained Appalachian Consulting Group to develop its curriculum.

The certification program is run one full-time person and three part-time contractors who help with training. Certified peer specialists assist with interviewing applicants.

Washington, D.C. developed its own test. The test is a 100-question, multiple choice or true or false test. The test is an open-book exam. The pass rate is 100 percent.

State of Wyoming[50]

Wyoming's Department of Mental Health commenced a peer specialist certification program in 2005. From 2005 to 2013, Wyoming sent prospective peer specialists to other states to be trained. In 2014, Wyoming began to train prospective peer specialists in-state. In 2017, the non-profit organization, Recovery Wyoming began to provide all training.

Wyoming offers training to prospective peer specialists at no cost. The training is 36 hours conducted over five-days. Wyoming estimates the value of the training at $1,500 per person. It pays its training facilitators a competitive rate of $40 an hour as well as hotel and travel costs. It also pays stipends to training participants.

In 2017 and 2018, Wyoming offered two trainings a year. In 2019 and 2020, it offered four trainings a year.

Wyoming's pre-COVID class size was 16; it found that 20 was too many. It is still conducting in-person training during the coronavirus pandemic; however, it has reduced its class size to 12 to 14. It receives about 40 applications for 12 to 16 spots.

Wyoming is in the process of becoming a professional certification program. Wyoming has recently contracted with International Certification & Reciprocity Consortium (IC & RC) to serve as its certifying entity. IC & RC sets standards and develops examinations for the credentialing and licensing of prevention, substance use treatment, and recovery professionals. IC & RC charges an application fee to Recover Wyoming of approximately $1,000, and an annual fee of approximately $1,000. It also assesses a certificate holder fee of approximately $2.50 per certification.

Wyoming's collaboration with IC & RC will require changes to its certification program. For example, prospective peer specialists will now pay to take the certification examination. Prospective peer specialists must also have 500 hours of supervised work experience (either paid or voluntary) before they can become certified.

One-time costs

Development of program standards could be accomplished by a peer-run organization at a cost of approximately $150,000 to $200,000. This estimate is based on the fiscal analysis of the California Department of Finance of SB 10 (2019) and SB 906 (2018), which would have required the California Department of Health Care Services to establish a certifying body, either through contract or interagency agreement, to provide a statewide certification for peer support specialists and develop practice guidelines for peer support specialists.

There would also be staff costs associated with seeking federal approval of the peer certification program. Up to 50 percent of these costs would likely be eligible for reimbursement through Medicaid. These costs are best estimated by the Department of Vermont Health Access.

Ongoing costs

Ongoing costs include screening and training and certification program management (administration and enforcement).

The State of Wyoming runs its professional certification program at a cost of approximately $275,000 per year.

Washington, D.C., runs its assessment-based certificate program through its mental health department, with one full-time staff and three part-time contractors. It also provides training without costs to participants and also pays stipends to participants. Washington, D.C.'s program is estimated to cost approximately $250,000 per year.

Vermont's ongoing costs would likely be within these ranges, assuming a similar number of trainings and a similar class size.

These estimates assume no certification fee schedule to support administration and enforcement costs. If a certification fee schedule were established, it would assist in offsetting operational costs.

Cost-avoidance and long-term savings

There are potentially significant cost-avoidance and long-term savings to Vermont's mental health system to the extent that peer support services provide support and assistance to Medicaid beneficiaries and reduce the need for more expensive downstream services such as inpatient hospitalization.

Next Steps

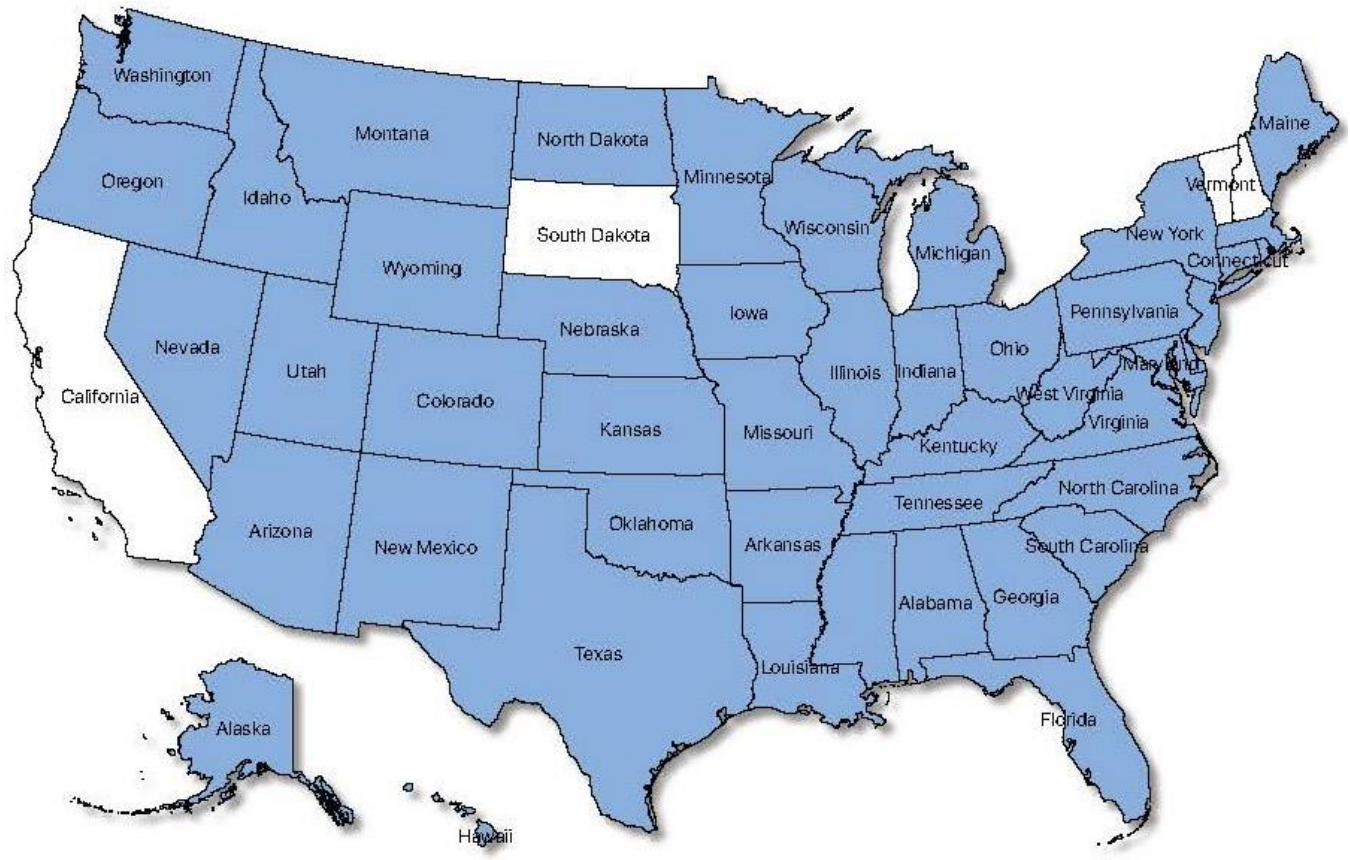
- ☐ Define a range of responsibilities and practice guidelines for peer support specialists, determine curriculum, and core competencies required for certification, and determine continuing education requirements for certification renewal.

- ☐ Determine a process for complaint investigation and corrective action, which may include suspension and certification revocation.

- ☐ Determine a process for an individual employed as a peer support specialist as of a certain date, to obtain certification.

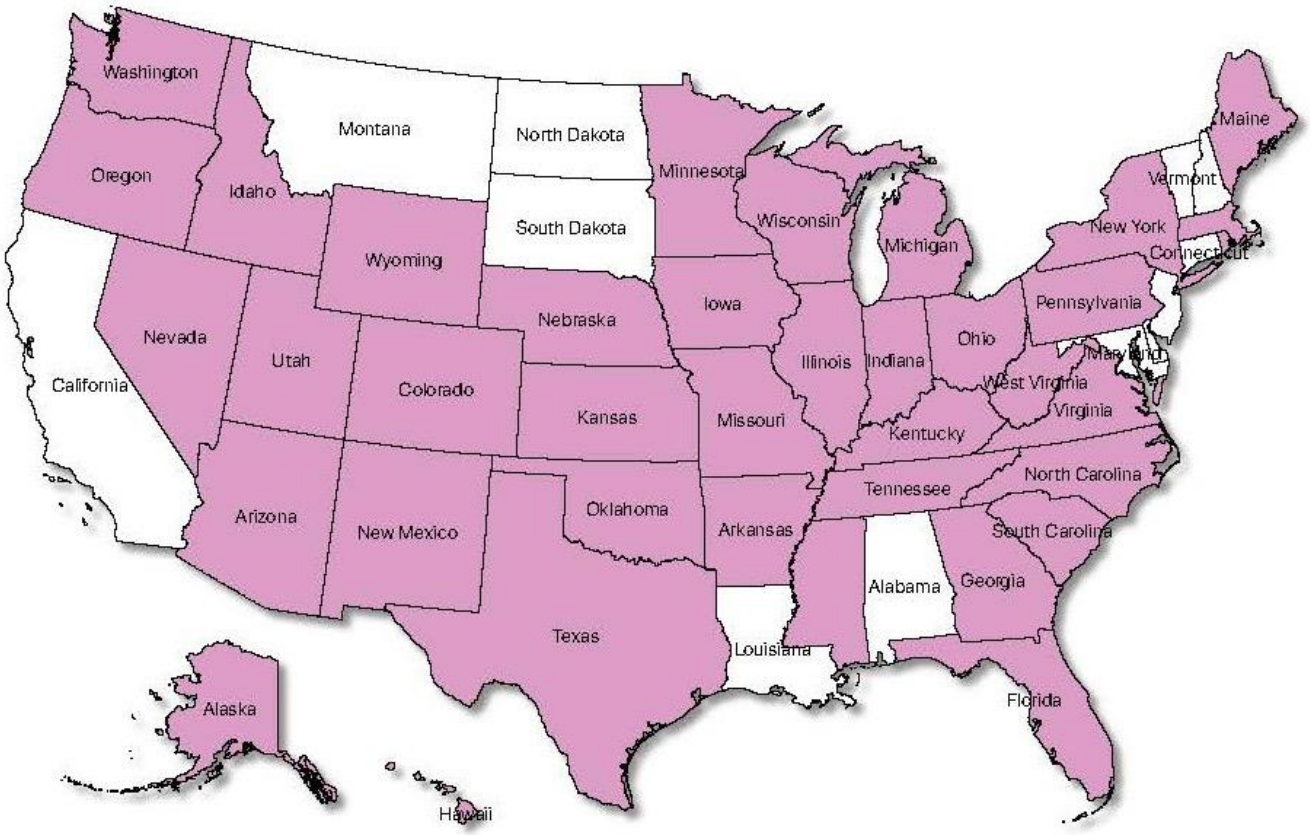
- ☐ Amend state plan to include peer support specialist as a provider type and to include peer support specialist services as a distinct service, which may be provided to eligible Medicaid beneficiaries enrolled in a managed care plan or a mental health plan. Seek any federal waivers or other state plan amendments to implement the certification program.

APPENDIX A – U.S. MAP OF PEER SPECIALIST CERTIFICATION PROGRAMS



States with statewide mental health peer specialist certification programs

APPENDIX B – U.S. MAP OF MEDICAID REIMBURSEMENT FOR PEER SERVICES



States with Medicaid-reimbursable peer support services

APPENDIX C – GEORGIA PEER SPECIALIST CORE COMPETENCIES

A Certified Peer Specialist (CPS) should possess the following competencies:

1. An understanding of their job and the skills to do that job;

    a. Understand the basic structure of the state Mental Health System and how it works
    b. Understand the CPS job description and Code of Ethics within the state MHS
    c. Understand the meaning and role of peer support
    d. Understand the difference in treatment goals and recovery goals
    e. Be able to create and facilitate a variety of group activities that support and strengthen recovery
    f. Be able to do the necessary documentation required by the state
    g. Be able to support a consumer combat negative self-talk, overcome fears, and solve problems
    h. Be able to support a consumer articulate, set and accomplish his/her goals
    i. Be able to teach other consumers to create their own Wellness Recovery Action Plan
    j. Be able to teach other consumers to advocate for the services that they want
    k. Be able to support a consumer create a Person-Centered Plan

2. An understanding of the recovery process and how to use their own recovery story to support others

    a. Understand the five stages in the recovery process and what is helpful and not helpful at each stage
    b. Understand the role of peer support at each stage of the recovery process
    c. Understand the power of beliefs/values and how they support or work against recovery
    d. Understand the basic philosophy and principles of psychosocial rehabilitation
    e. Understand the basic definition and dynamics of recovery
    f. Be able to articulate what has been useful and what not useful in his/her own recovery
    g. Be able to identify beliefs and values a consumer holds that works against his/her recovery
    h. Be able to discern when and how much of their recovery story to share with whom

3. An understanding of and the ability to establish healing relationships

    a. Understand the dynamics of power, conflict and integrity in the workplace
    b. Understand the concept of 'seeking out common ground'
    c. Understand the meaning and importance of cultural competency
    d. Be able to ask open-ended questions that relate a person to his/her inner wisdom
    e. Be able to personally deal with conflict and difficult interpersonal relations in the workplace
    f. Be able to demonstrate an ability to participate in 'healing communication'
    g. Be able to interact sensitively and effectively with people of other cultures

4. An understanding of the importance of and have the ability to take care of oneself

    a. Understand the dynamics of stress and burnout
    b. Understand the role and parts of the Wellness Recovery Action Plan (WRAP)
    c. Be able to discuss his/her own tools for taking care of him/herself

APPENDIX D – GEORGIA CERTIFIED PEER SPECIALIST CODE OF ETHICS

The following principles will guide Certified Peer Specialists in their various roles, relationships and levels of responsibility in which they function professionally.

1. The primary responsibility of Certified Peer Specialists is to help individuals achieve their own needs, wants, and goals. Certified Peer Specialists will be guided by the principle of self-determination for all.

2. Certified Peer Specialists will maintain high standards of personal conduct. Certified Peer Specialists will also conduct themselves in a manner that fosters their own recovery.

3. Certified Peer Specialists will openly share with consumers and colleagues their recovery stories from mental illness and will likewise be able to identify and describe the supports that promote their recovery.

4. Certified Peer Specialists will, at all times, respect the rights and dignity of those they serve.

5. Certified Peer Specialists will never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.

6. Certified Peer Specialists will not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition or state.

7. Certified Peer Specialists will advocate for those they serve that they may make their own decisions in all matters when dealing with other professionals.

8. Certified Peer Specialists will respect the privacy and confidentiality of those they serve.

9. Certified Peer Specialists will advocate for the full integration of individuals into the communities of their choice and will promote the inherent value of these individuals to those communities. Certified Peer Specialists will be directed by the knowledge that all individuals have the right to live in the least restrictive and least intrusive environment.

10. Certified Peer Specialists will not enter into dual relationships or commitments that conflict with the interests of those they serve.

11. Certified Peer Specialists will never engage in sexual/intimate activities with the consumers they serve.

12. Certified Peer Specialists will not abuse substances under any circumstance.

13. Certified Peers Specialists will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues.

14. Certified Peer Specialists will not accept gifts of significant value from those they serve.

APPENDIX E -- GEORGIA CERTIFIED PEER SPECIALIST JOB DESCRIPTION

Under immediate to general supervision, the Certified Peer Specialist (CPS) provides peer support services; serves as a consumer advocate; provides consumer information and peer support for consumers in a variety of settings.

The CPS performs a wide range of tasks to support consumers in living their own lives and directing their own recovery and wellness process. The CPS will model competency in recovery and wellness.

1. Using the 10-step goal setting process the CPS will:
    a. Support consumers in articulating personal goals for recovery and wellness.
    b. Support consumers in articulating the objectives necessary to reach his or her recovery and wellness goals.

2. The CPS will document the following on the Individual Recovery/Resiliency Plan (IR/RP) by:
    a. Assisting consumers in identifying strengths.
    b. Assisting consumers in identifying recovery and wellness goals.
    c. Assisting consumers in setting objectives.
    d. Assisting consumers in identifying barriers
    e. Support consumer in determining recovery and wellness interventions based on consumers' life goals.
    f. Recognizing and reporting progress consumers make toward meeting objectives.
    g. Understanding and utilizing specific interventions necessary to support consumers in meeting their recovery and wellness goals.

3. Utilizing their specific training, the CPS will:
    a. Lead as well as teach consumers how to facilitate Recovery Dialogues
    b. Support consumers in creating a Wellness Recovery Action Plan (WRAP).
    c. Utilize and teach problem solving techniques with individuals and groups.
    d. Teach consumers techniques for identifying and combating negative self-talk.
    e. Teach consumers techniques for identifying and overcoming fears.
    f. Support the vocational choices consumers make and support them in overcoming job-related anxiety.
    g. Support consumers in building social skills in the community that will enhance job acquisition and tenure.
    h. Support non-consumer staff in identifying program environments that are conducive to recovery; lend their unique insight into mental illness and what makes recovery possible.
    i. Attend treatment team meetings to promote consumer's use of self-directed recovery tools.

4. Utilizing their unique recovery experience, the CPSs will:
    a. Teach and role model the value of every individual's recovery experience.
    b. Support the consumer in obtaining decent and affordable housing of his or her choice in the most integrated, independent, and least intrusive or restrictive environment.
    c. Model effective coping techniques and self-help strategies.

5. The CPSs will maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relevant material.
    a. Continue to develop and share recovery-oriented material with other CPSs at the continuing education assemblies and on the CPS electronic bulletin board.

b. Attend continuing education sessions when offered by the CPS Project.
c. Attend relevant seminars, meetings, and in-service trainings whenever offered.

6. The CPSs will serve as a recovery agent by:
   a. Providing and advocating for effective recovery-based services.
   b. Support consumers in obtaining services that suit that individual's recovery needs.
   c. Inform consumers about community and natural supports and how to utilize these in the recovery process.
   d. Support consumers in developing empowerment skill through self-advocacy and the use of Human
   e. Experience Language to combat stigma.
   f. Support consumers in setting up and sustaining Self-Help support groups.

APPENDIX F -- GEORGIA CORE CURRICULUM LEARNING OBJECTIVES

The Core Recovery Curriculum should give the trainees the following competencies:
They should have a working knowledge of:

- the difference in focusing on the symptoms of the illness and the impact of the illness
- the basic structure of the state Mental Health System (MHS) and how it works
- the Peer Specialist's job description within the state MHS
- the difference in services that focus on stabilization and those that focus on recovery
- the meaning and role of peer support services
- the difference in treatment goals and recovery goals
- the basic five stages in the recovery process and what is helpful and not helpful at each stage
- the role of peer support services at each stage of the recovery process
- the basic definition and dynamics of recovery
- the difference in an illness story and a recovery story
- the difference in agency environments that promote recovery and those that do not
- the meaning of Trauma Informed Services
- the five steps of PICBA as a problem-solving process
- the five steps in Igniting the Spark of Hope
- the concept of Shared Decision Making
- the dynamics of power, conflict and integrity in the workplace
- the three steps in the Process of Effective Communication

They should be able to:

- use their own recovery experience to help a peer recover
- articulate what has been helpful and what has not been helpful in their own recovery
- identify beliefs and values a peer holds that works against recovery
- discern when and how much of their recovery story to share and with whom
- be able to discuss their own tools for taking care of themselves
- facilitate a Recovery Dialogue
- use questions to help a peer get in touch with the life they want
- use a person's dissatisfaction as an avenue to set recovery goals
- use the PICBA problem solving process with a peer
- use questions to help a peer identify and move through their fears
- use the Catch it! Check it! Change it! process to help a peer combat negative self-talk
- use the Shared Decision-Making process to help a peer prepare for a doctor's visit
- teach peers to advocate for the services that they want

APPENDIX G –GEORGIA PEER SPECIALIST CORE CURRICULUM

Session	Description	Method
Session 1, Day 1 Welcome, Introductions and Overview	This session sets the stage for the training by getting everyone introduced, presenting an overview of the philosophy and content of the training, reviewing the training manual and creating guidelines for how the group will operate using a Comfort Contract.	Presentation of materials, group discussion and questions.
Session 2, Day 1 State System and the Role of the Training	This session is usually presented by someone from the state. It should set a context for the training, how the peer specialist program relates to what is happening at the state level and answer questions regarding job descriptions and employment opportunities.	To be determined by the presenter.
Session 3, Day 1 The Shift to Recovery and Resiliency	This session explains the shift in system focus from stabilization and maintenance to recovery and resiliency and begins to explore the peer specialist role as change agent, bridge builder, peer supporter and recovery advocate.	Presentation, worksheets and group discussion.
Session 4, Day 1 Five Stages in the Recovery Process	This session begins to build a common framework for discussing recovery by presenting five basic stages in the recovery process and exploring the dangers and role of services at each stage.	Presentation and group discussion.
Session 5, Day 1 The Role of Peer Support Services	This session explores the role of the peer specialist within peer support services and how those services differ from clinical services.	Presentation, worksheets, and group discussion.
Session 6, Day 1 Using Your Recovery Story as a Recovery Tool	This session explores the differences in an illness story and a recovery story and gives the group the opportunity to share their recovery stories in small groups.	Presentation, worksheets and small group sharing
Session 7, Day 2 Creating Recovery Cultures	This session explores how negative messages are sent in the mental health system, how these messages work against recovery, and what can be done to counter them.	Presentation, worksheets and group discussion.
Session 8, Day 2 Exploring Beliefs that Promote Recovery	This session explains how the beliefs of the mental health system determine how services are designed and delivered and examines some of the emerging beliefs that support and promote recovery.	Presentation, worksheets and group discussion.
Session 9, Day 2 Facilitating Recovery Dialogues	This session introduces a structured group discussion process and gives participants an opportunity to practice in small group setting.	Presentation, demonstration and practice in small groups
Session 10, Day 2 Effective Listening and the Art of Asking Questions: Part 1	This session focuses on the difference in the 'fixer' and 'supporter' roles and presents some guidelines for listening and asking questions that help another person get in touch with the kind of life they want to create and the motivation to do it.	Presentation, demonstration and practice in role-playing situations

Session	Description	Method
Session 11, Day 2 Dissatisfaction as an Avenue for Change	This session applies the process of asking questions to help a person identify an area of dissatisfaction and use this as a means of identifying something that can be worked into a goal.	Presentation, demonstration and practice in role-playing situations.
Session 12, Day 2 Trauma Informed Care	This session explores the impact of trauma and explains what it means to create trauma informed services.	Presentation and group discussion.
Session 13, Day 3 Problem Solving with Individuals	This session introduces a five-step problem solving process that helps the person stand outside the problem, clearly state the problem and become aware of and prioritize all of the options.	Presentation, demonstration and practice in pairs.
Session 14, Day 3 Facing Your Fears	This session provides a safe environment for discussing uncomfortable thoughts and feelings and introduces a way to help another person learn to handle them.	Presentation, demonstration and practice in pairs.
Session 15, Day 3 Combating Negative Self-talk	This session explores the power and prevalence of negative self-talk and shares a process for combating it called Catch it! Check it! Change it!	Presentation, demonstration and practice in pairs.
Session 16, Day 3 Shared Decision Making	This session presents a way of working with another person to prepare them to get the most benefit from their meeting with their psychiatrist.	Presentation, demonstration and role-playing
Session 17, Day 3 Peer Specialist Ethics: Part 1	This session explores the meaning of ethics and boundaries as they apply to peer specialists and provides some guidelines for decision-making in situations with possible ethical implications.	Group discussion of a variety of scenarios and role-playing.
Session 18, Day 3 Peer Specialist Ethics: Part 2	This session explores the meaning of ethics and boundaries as they apply to peer specialists and provides some guidelines for decision-making in situations with possible ethical implications.	Group discussion of a variety of scenarios and role-playing.
Session 19, Day 4 Power, Conflict and Integrity in the Workplace: Part 1	This session explores a variety of potential areas of conflict in the workplace and presents some of the basic techniques of mediation and conflict resolution.	Presentation, small group work and role-playing.
Session 20, Day 4 Power, Conflict and Integrity in the Workplace: Part 2	This session explores a variety of potential areas of conflict in the workplace and presents some of the basic techniques of mediation and conflict resolution.	Presentation, small group work and role-playing.
Session 21, Day 4 Practicing the Skills Taught in the Training	This session provides a two-hour block of time to further practice the skills shared in the previous ten sessions.	Practice in pairs, small group, and role-playing situations.
Session 22, Day 4 Practicing the Skills Taught in the Training	This session provides a two-hour block of time to further practice the skills shared in the previous ten sessions.	Practice in pairs, small group, and role-playing situations.

Session	Description	Method
Session 23, Day 4 Creating the Life One Wants: Accomplishing one's Recovery Goals	This session introduces a 10-step process for accomplishing a goal once the goal is set.	Presentation, and group work.
Session 24, Day 4 Final Reflections, Evaluation and Next Steps	This session uses a sample test as a teaching tool, allows time for questions and comments about the training from the participants, looks at next steps and collects the evaluations of the training from the participants.	Presentation, discussion and small group work.

APPENDIX H – SAMHSA CORE COMPETENCIES FOR MENTAL HEALTH PEER WORKERS

Category I: Engages peers in collaborative and caring relationships

This category of competencies emphasized peer workers' ability to initiate and develop on-going relationships with people who have behavioral health condition and/or family members. These competencies include interpersonal skills, knowledge about recovery from behavioral health conditions and attitudes consistent with a recovery orientation.

1. Initiates contact with peers
2. Listens to peers with careful attention to the content and emotion being communicated
3. Reaches out to engage peers across the whole continuum of the recovery process
4. Demonstrates genuine acceptance and respect
5. Demonstrates understanding of peers' experiences and feelings

Category II: Provides support

The competencies in this category are critical for the peer worker to be able to provide the mutual support people living with behavioral health conditions may want.

1. Validates peers' experiences and feelings
2. Encourages the exploration and pursuit of community roles
3. Conveys hope to peers about their own recovery
4. Celebrates peers' efforts and accomplishments
5. Provides concrete assistance to help peers accomplish tasks and goals

Category III: Shares lived experiences of recovery

These competencies are unique to peer support, as most roles in behavioral health services do not emphasize or even prohibit the sharing of lived experiences. Peer workers need to be skillful in telling their recovery stories and using their lived experiences as a way of inspiring and supporting a person living with behavioral health conditions. Family peer support worker likewise share their personal experiences of self-care and supporting a family-member who is living with behavioral health conditions.

1. Relates their own recovery stories, and with permission, the recovery stories of others to inspire hope
2. Discusses ongoing personal efforts to enhance health, wellness, and recovery
3. Recognizes when to share experiences and when to listen
4. Describes personal recovery practices and helps peers discover recovery practices that work for them

Category IV: Personalizes peer support

These competencies help peer workers to tailor or individualize the support services provided to and with a peer. By personalizing peer support, the peer worker operationalizes the notion that there are multiple pathways to recovery.

1. Understands his/her own personal values and culture and how these may contribute to biases, judgments and beliefs
2. Appreciates and respects the cultural and spiritual beliefs and practices of peers and their families
3. Recognizes and responds to the complexities and uniqueness of each peer's process of recovery
4. Tailors services and support to meet the preferences and unique needs of peers and their families

Category V: Supports recovery planning

These competencies enable peer workers to support other peers to take charge of their lives. Recovery often leads people to want to make changes in their lives. Recovery planning assists people to set and accomplish goals related to home, work, community and health.

1. Assists and supports peers to set goals and to dream of future possibilities
2. Proposes strategies to help a peer accomplish tasks or goals
3. Supports peers to use decision-making strategies when choosing services and supports
4. Helps peers to function as a member of their treatment/recovery support team
5. Researches and identifies credible information and options from various resources

Category VI: Links to resources, services, and supports

These competencies assist peer workers to help other peers acquire the resources, services, and supports they need to enhance their recovery. Peer workers apply these competencies to assist other peers to link to resources or services both within behavioral health settings and in the community. It is critical that peer workers have knowledge of resources within their communities as well as on-line resources.

1. Develops and maintains up-to-date information about community resources and services
2. Assists peers to investigate, select, and use needed and desired resources and services
3. Helps peers to find and use health services and supports
4. Accompanies peers to community activities and appointments when requested
5. Participates in community activities with peers when requested

Category VII: Provides information about skills related to health, wellness, and recovery

These competencies describe how peer workers coach, model or provide information about skills that enhance recovery. These competencies recognize that peer workers have knowledge, skills and experiences to offer others in recovery and that the recovery process often involves learning and growth.

1. Educates peers about health, wellness, recovery and recovery supports
2. Participates with peers in discovery or co-learning to enhance recovery experiences
3. Coaches peers about how to access treatment and services and navigate systems of care
4. Coaches peers in desired skills and strategies
5. Educates family members and other supportive individuals about recovery and recovery supports
6. Uses approaches that match the preferences and needs of peers

Category VIII: Helps peers to manage crises

These competencies assist peer workers to identify potential risks and to use procedures that reduce risks to peers and others. Peer workers may have to manage situations, in which there is intense distress and work to ensure the safety and well-being of themselves and other peers.

1. Recognizes signs of distress and threats to safety among peers and in their environments
2. Provides reassurance to peers in distress
3. Strives to create safe spaces when meeting with peers
4. Takes action to address distress or a crisis by using knowledge of local resources, treatment, services and support preferences of peers
5. Assists peers in developing advance directives and other crisis prevention tools

Category IX: Values communication

These competencies provide guidance on how peer workers interact verbally and in writing with colleagues and others. These competencies suggest language and processes used to communicate and reflect the value of respect.

1. Uses respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others
2. Uses active listening skills
3. Clarifies their understanding of information when in doubt of the meaning
4. Conveys their point of view when working with colleagues
5. Documents information as required by program policies and procedures
6. Follows laws and rules concerning confidentiality and respects others' rights for privacy

Category X: Supports collaboration and teamwork

These competencies provide direction on how peer workers can develop and maintain effective relationships with colleagues and others to enhance the peer support provided. These competencies involve not only interpersonal skills but also organizational skills.

1. Works together with other colleagues to enhance the provision of services and supports
2. Assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of peers
3. Coordinates efforts with health care providers to enhance the health and wellness of peers
4. Coordinates efforts with peers' family members and other natural supports
5. Partners with community members and organizations to strengthen opportunities for peers
6. Strives to resolve conflicts in relationships with peers and others in their support network

Category XI: Promotes leadership and advocacy

These competencies describe actions that peer workers use to provide leadership within behavioral health programs to advance a recovery-oriented mission of the services. They also guide peer workers on how to advocate for the legal and human rights of other peers.

1. Uses knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that peer's rights are respected
2. Advocates for the needs and desires of peers in treatment team meetings, community services, living situations, and with family
3. Uses knowledge of legal resources and advocacy organization to build an advocacy plan
4. Participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families
5. Educates colleagues about the process of recovery and the use of recovery support services
6. Actively participates in efforts to improve the organization
7. Maintains a positive reputation in peer/professional communities

Category XII: Promotes growth and development

These competencies describe how peer workers become more reflective and competent in their practice. The competencies recommend specific actions that may serve to increase peer workers' success and satisfaction in their current roles and contribute to career advancement.

1. Recognizes the limits of their knowledge and seeks assistance from others when needed

2. Uses supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer)
3. Reflects and examines own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support
4. Seeks opportunities to increase knowledge and skills of peer support

APPENDIX I – CALCULATING PEER SUPPORT SPECIALIST WAGES BASED ON FEE-FOR-SERVICE REIMBURSEMENT MODELS [1]

As states are increasingly establishing peer support services as reimbursable under their Medicaid plans, they are also turning to managed care organizations to help administer these benefits. Many managed care payers are reimbursing peer support services on fee-for-service payment models. In these arrangements there is an established fee schedule and provider organizations bill and are reimbursed on direct (face-to-face) service encounters provided by peer support specialists. Based on a series of assumptions for peer specialist productivity, organizational overhead, and reimbursement rates it is possible to calculate what average wages should be paid. The model below provides a series of assumptions that have been collected from existing state, provider organizations (for both clinicians and peer specialists), and managed care reimbursement examples. These assumptions are collectively used for the case example. And, while it is possible to challenge or change the assumptions, the basic formula can be used with specific real-time data to formulate what average wages should be paid for peer support services.

Assumptions for Productivity

- A Peer Specialist can average 60% direct billable service over the course of a week/month/year.
- A full-time work year is 2080 hours X 60% = 1248 hours/year direct service
- Full-time work hours less 20 days (vacation, sick, and holidays) = 160 Hours/year or, 1920 total worked hours/year = 48 weeks
- 1248 hours direct service over 48 weeks = 26 billable hours/week

Assumptions for Reimbursement

- Fee for Service reimbursement rate = $15 per 15 minute unit of service, or $60/hour (note – this example is based on individual services and could be modified to include different group based services and rates)
- $60 X 1248 hours/year = $74,880 (at an unlikely 100% reimbursement rate)
- Total annual reimbursement potential for a Peer Specialist = 85% collection rate or,

  $74,880 X .85 = $63,648

Staff Benefits and Agency Operating Expense Assumptions (Direct and Indirect) – based on an existing state example

- Peer Specialist annual/hourly salaries carry Fringe Benefits of about 30%

[1] Daniels, A.S., Ashenden, P., Goodale, L., Stevens, T. "National Survey of Compensation Among Peer Support Specialists." The College for Behavioral Health Leadership, January 2016 at p. 35. Accessed May 23, 2020. https://papeersupportcoalition.org/wpcontent/uploads/2016/01/CPS_Compensation_Report.pdf

- Agency direct costs include program clinical supervisors and support staff; staff training costs; mileage and vehicle costs; telephone costs; office supplies; computer and technology costs; office space/staff; liability/malpractice insurance
- Agency indirect costs include management and personnel costs (CEO, Medical Director, CFO); support staff personnel costs including human resources, payroll, quality improvement/accreditation, procurement, accounting, IT systems including health records, billing, and accounting systems; IT system staff; other professional costs such as audits and legal fees
- Total Operating Expenses = 20% of revenues (low end of average). Note – productivity expectations above reflect the peer specialist covering a 52-week workload over 48 weeks. In some cases where organizations only require productivity for 48 weeks worked, then operating expenses will result in a higher rate to cover these lost hours.

Calculating Peer Specialist Hourly/Annual Salary in Fee-For-Service Reimbursement

- Total annual reimbursement potential/Peer Specialist = $63,648
- $ 63,648 less 20% Organizational Overhead = $50,918.40
- $50,918.40/2080 hours (1 FTE/year) = $24.48 per hour
- $24.48 X .70 (30% employee benefits) = $17.13
- Maximum Peer Specialist salary potential based on established assumptions = $17.13, or annual wages of 35,630.40 per year

Based on the assumptions listed above it is reasonable in this scenario that a peer support specialist should be compensated in the range described above. As with any model the accuracy is only as good as the validity of the assumptions. However, if there are different factors than those described, the model can still be used to project alternative scenarios and provide guidance and direction to both peer specialists and their employers. It is also noteworthy that the estimated hourly wage in this example is $.77 greater than the average hourly full-time wages reported in this survey, and slightly more than $1,600 per year.

APPENDIX J – SAMPLE MEDICAID STATE PLAN AMENDMENT – STATE OF TEXAS

Table of Contents

State Plan Amendment

SPA 18-0011 Peer Specialist Services - Effective 01/01/2019

This file contains the following documents in order listed:

1. CMS Approval Letter
2. CMS Form 179
3. Superseding Page Listing (Attachment to Blocks 8 & 9 of CMS Form 179)
4. Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

December 14, 2018

Our Reference: TX SPA 18-0011

Ms. Stephanie Muth
State Medicaid Director
Texas Health and Human Services Commission
Mail Code: H100
P.O. Box 13247
Austin, Texas 78711

Dear Ms. Muth:

We have reviewed the State's proposed amendment to your Medicaid State Plan submitted under Transmittal Number (TN) 18-0011, dated October 8, 2018. This amendment implements Texas Human Resources Code Section 32.024(kk), which requires the Health and Human Services Commission (HHSC) to include peer services by certified peer specialists in the state plan.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State plan with an effective date of January 1, 2019, as requested. A copy of the CMS-179 form as well as the approved plan pages are included with this letter.

If you have any questions, please contact Ford Blunt of my staff. Mr. Blunt may be reached at (214) 767-6381 or by e-mail at Ford.Blunt@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

Cc: Dana Williamson, Manager, Policy Development Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **18-0011**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
January 1, 2019

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.130(d)

7. FEDERAL BUDGET IMPACT: **SEE ATTACHMENT**
a. **FFY 2019** **$907,052**
b. **FFY 2020** **$1,892,914**
c. **FFY 2021** **$2,236,146**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT TO BLOCKS 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 & 9

10. SUBJECT OF AMENDMENT:
The proposed amendment implements Texas Human Resources Code §32.024(kk), which requires HHSC to include peer services provided by certified peer specialists in the state plan.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Stephanie Muth

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
October 8, 2018

16. RETURN TO:
Stephanie Muth
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
October 8, 2018

18. DATE APPROVED:
December 14, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Bill Brooks

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 18-0011

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Appendix 1 to Attachment 3.1-A	Appendix 1 to Attachment 3.1-A
Page 31p	N/A - New Page
Page 31q	N/A - New Page
Page 31r	N/A - New Page
Page 31s	N/A - New Page
Page 31t	N/A - New Page
Attachment 4.19-B	Attachment 4.19-B
Page 1a.3	Page 1a.3 (TN 18-0016)
Page 22	Page 22 (TN 11-22)

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

13.d Rehabilitative Services, continued

Peer Specialist Services

(a) Definition:

Peer specialist services are provided under 42 CFR 440.130(d) as a rehabilitative services benefit. Peer specialist services are recovery-oriented, person-centered, relationship-focused, and trauma-informed.

These non-clinical services are based on a relationship between the peer specialist and the Medicaid-eligible individual. A peer specialist uses his or her lived experience to assist an individual in developing skills, problem solving strategies, and coping mechanisms for stressors and barriers encountered when recovering from a mental health condition or a substance use disorder as well as achieving goals and objectives in the individual's person-centered recovery plan, which serves as the plan of care.

Peer specialist services are designed to improve quality of life for the individual, help the individual avoid more restrictive levels of care such as psychiatric inpatient hospitalization, and help the individual achieve long-term recovery from symptoms related to the individual's mental health condition and/or substance use disorder.

(b) Services:

Peer specialist services (provided individually or in a group setting) may include:

(1) Recovery and wellness support, which includes providing information on, support with, and assistance planning for recovery;
(2) Mentoring, which includes serving as a role model and providing assistance in finding needed community resources and services; and
(3) Advocacy, which includes providing support in stressful or urgent situations, and helping to ensure that the recipient's rights are respected. Advocacy may also include encouraging the recipient to advocate for him- or herself to obtain services.

Peer specialists who are employed by Medicaid-enrolled providers delivering behavioral health services may deliver peer specialist services. A peer specialist may not practice psychotherapy, create plans of care, or engage in any service that requires a license.

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

13.d Rehabilitative Services, continued

Peer Specialist Services, Continued

(c) Eligibility to Receive Services:

Peer specialist services are available to individuals 21 years of age or older who have a mental health condition and/or substance use disorder and who have peer specialist services included as a component of their person-centered recovery plan, which serves as the plan of care.

(d) Care Coordination:

Peer specialists who are employed by Medicaid-enrolled providers delivering behavioral health services must deliver peer specialist services as part of a coordinated, comprehensive, and individualized approach to treating an individual's mental health and/or substance use condition. Providers of peer specialist services shall coordinate with all behavioral health service providers involved in the individual's care, and utilize a person-centered approach to treatment planning and service delivery, in collaboration with the individual.

(e) Exclusions:

The following services are not billable as peer specialist services:

1) Record keeping or documentation activities;
2) Peer specialist services delivered in the course of delivery of other behavioral health services; and
3) Services provided without the individual present.

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

13.d Rehabilitative Services, continued

Peer Specialist Services, Continued

(f) Peer Specialist Qualifications:

A peer specialist must:

1) be at least 18 years of age;
2) have lived experience with a mental health condition, substance use disorder, or both;
3) have a high school diploma or General Equivalency Diploma (GED);
4) be willing to appropriately share his or her own recovery story with clients;
5) be able to demonstrate current self-directed recovery;
6) pass criminal history and registry checks as described in state regulations governing certification for peer specialists; and
7) Demonstrate the ability to support the recovery of others from mental illness and/or substance use disorder.

A peer specialist must complete all required training and be certified before providing services, and fulfill ongoing education requirements.

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

13.d Rehabilitative Services, continued

Peer Specialist Services, Continued

(g) Peer Specialist Certification:

In order to deliver peer specialist services, an individual must first complete required orientation and self-assessment activities as outlined in state regulations governing certification for peer specialists and then complete a core training delivered by a certified training entity.

Upon completion of the core training, supplemental training as either a mental health peer specialist or a recovery support peer specialist must be completed. Upon completion of the core and supplemental training, a person may apply for initial certification to an approved certification body.

- A knowledge assessment is required to complete both the core and supplemental trainings.

A peer specialist who has received initial certification may begin delivering Medicaid-billable services while participating in a supervised internship at the peer specialist's place of employment.

- The internship consists of 250 hours of supervised work experience that should be completed within a six-month period.

After completing the required internship hours, peer specialists may apply for renewed certification through the certification body.

- Certification must then be renewed every two years, including any required continuing education hours.
- Peer specialists may only deliver services within their specialty area.
- Certification must be maintained in good standing with the certification body.

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

13.d Rehabilitative Services, continued

Peer Specialist Services, Continued

(h) Peer Specialist Supervision:

An organization in which peer specialists deliver services must provide supervision for peer specialists.

Peer specialist supervision must be provided by a:

1. Qualified Credentialed Counselor (QCC);
2. Licensed Practitioner of the Healing Arts (LPHA);
3. Qualified Mental Health Practitioner-Community Services (QMHP-CS), with a QCC or LPHA supervising the QMHP-CS; or
4. Qualified Peer Supervisor (QPS), with a QCC or LPHA supervising the QPS.

Peer specialist supervision must focus on a peer specialist's provision of services, including review of cases and activities, skill building, problem resolution, and professional growth. Supervision may also include aspects specific to the organization, such as following organizational policy or other administrative matters.

Peer specialist supervision must occur at least once weekly for a peer specialist with an initial certification, at least once monthly for a peer specialist with a two-year certification, or more frequently at the request of the peer specialist. Peer specialist supervisors must document all supervisory sessions and maintain records in the peer specialist's employee personnel file.

A QCC or LPHA supervising a QMHP-CS or QPS must provide individual or group supervision at least once monthly, and conduct an observation of the QMHP-CS or QPS conducting peer specialist supervision at a frequency determined by the LPHA or QCC based on the QMHP-CS's or QPS's skill level.

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

1. Physicians and Other Practitioners (continued)

(f) When a procedure code is nationally discontinued, a replacement procedure code is nationally assigned for the discontinued procedure code, and Medicaid implements the replacement procedure code, a state plan amendment will not be submitted since the fee for the service has not changed.

(g) To ensure access to care and prompt provider reimbursement, when a new national procedure code is assigned to a physician-administered drug or biological product, a preliminary reimbursement rate will be established by the Texas Health and Human Services Commission (HHSC) based on the published Medicare reimbursement rate; or the average wholesale price (AWP) in the absence of a Medicare reimbursement rate for the procedure code or the comparable code. In accordance with 42 CFR §447.205(b)(1), a public notice and state plan amendment will not be submitted for this preliminary reimbursement rate. This will allow the new procedure code to be payable as the reimbursement process is completed with a public notice published and a state plan amendment submitted.

(h) All fee schedules are available through the agency's website, as outlined on Attachment 4.19-B, page 1.

(i) The agency's fee schedule was revised with new fees for services provided by physicians and other practitioners affiliated with tuberculosis clinics or employed by tuberculosis clinics, effective July 1, 2018, and this fee schedule was posted on the agency's website on July 6, 2018.

(j) The agency's fee schedule was revised with new fees for therapy assistants. Effective December 1, 2017, the reimbursement for therapy assistants will equal 85 percent of the payment to a therapist. Effective September 1, 2018, the reimbursement for therapy assistants will equal 70 percent of the payment to a therapist.

(k) The agency's fee schedule was revised with new fees for physicians and other practitioners including peer specialists effective January 1, 2019, and this fee schedule was posted on the agency's website on January 7, 2019.

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

29. Peer Specialist Services (13.d. Rehabilitative Services)

The agency's fee schedule was revised with new fees for peer specialists. Effective January 1, 2019, peer specialists will be reimbursed in an individual and group setting. The reimbursement can be found in the physician's fee schedule.

State: Texas
Date Received: 10-08-18
Date Approved: 12-14-18
Date Effective: 01-01-19
Transmittal Number: 18-0011

APPENDIX K – SURVEY DESIGNING A MENTAL HEALTH PEER CERTIFICATION PROGRAM IN VERMONT

Designing a mental health peer certification program in Vermont

This is a survey to gauge preferences in the design of a Vermont mental health peer certification program. For each question, please select the option that best represents your preference.

* Required

1. Email address *

Assessment-based program versus professional certification program

An assessment-based certification program provides training and then determines whether applicants successfully met the learning objectives of that training through testing. A professional certification program does not provide training. Such programs are independent of training. They evaluate applicants' knowledge, skills or competencies against a predetermined standard usually through a written test.

2. Should Vermont adopt an assessment-based program or a professional certification program?

Mark only one oval.

- Assessment-based certification program
- Professional certification program
- No opinion

Screening Criteria

Screening involves setting the minimum standards that an applicant must meet before applying for certification and creating a process to determine whether those minimum standards have been met. All U.S. programs use a written application for screening.

Although minimum standards vary, most certification programs screen for (1) lived experience of a mental health condition from which the applicant is in recovery; (2) a willingness on the part of applicants to speak publicly about their recovery; (3) minimum age; (4) minimum education; and (5) minimum number of hours of relevant volunteer or paid work experience. Many states require at least 250 hours of relevant and supervised volunteer or paid work experience. New York requires 2,000 hours.

3. Should Vermont's peer certification program require applicants to have lived experience of a mental health condition from which the applicant is in recovery?

Mark only one oval.

- Yes
- No

4. Should Vermont's peer certification program require applicants to affirm that they are willing to speak publicly about their recovery?

   Mark only one oval.

   - Yes
   - No

5. Should Vermont's peer certification program require applicants to be a minimum age to receive certification?

   Mark only one oval.

   - Yes
   - No

6. If Vermont's peer certification program should require applicants to be a minimum age to receive certification, what should be that age?

   Mark only one oval.

   - 18 years old
   - 21 years old
   - Other: _____

7. Should Vermont's peer certification program have a minimum education requirement of high school or equivalent (e.g., GED)?

   Mark only one oval.

- Yes
- No

8. Should Vermont's peer certification program disqualify applicants who have a criminal conviction?

   Mark only one oval.

   - Yes
   - No
   - Other: _____

9. Should Vermont's peer certification program require applicants to work a minimum number of hours of relevant volunteer or paid work experience before becoming certified?

   Mark only one oval.

   - No, there should not be a minimum number of hours of relevant volunteer or paid work experience.
   - Yes, there should be a 250 hour-minimum of relevant volunteer or paid work experience before becoming certified.
   - Yes, there should be 500 hour-minimum of relevant volunteer or paid work experience before becoming certified.
   - Other: _____

10. Should Vermont's peer certification program require letters of reference or recommendation?

    Mark only one oval.

    - Yes
    - No

Other: _____

11. Should Vermont's peer certification program interview each applicant?

Mark only one oval.

Yes
No
Other: _____

12. In some states, certification is a competitive process with limits on the numbers chosen each year. Other states take all who meet the minimum qualifications. Should Vermont's program be a competitive process with limits on the numbers chosen each year?

Mark only one oval.

Yes
No
Other: _____

13. Some states have residency requirements. Applicants must live or work in the state at least 51 percent of their time. Should Vermont's peer certification program have a residency requirement?

Mark only one oval.

Yes
No

Other: _____

Screening Organization

The entity that screens applications varies by state. In some states, the screening entity is a peer-run organization. For example, the screening entity in Massachusetts is The Transformation Center, a peer-run organization. In other states, the screening entity is a division of state government. In Texas and Pennsylvania, for example, the screening entity is that state's certification board. Some states subcontract the entire certification role, including screening, to an outside organization, usually a nonprofit. In Colorado, the Colorado Providers Association, a professional trade association representing substance use disorder prevention, intervention, treatment and recovery providers, oversees Colorado's peer and family specialist certification program.

14. What entity should screen applicants in Vermont?

Mark only one oval.

- Peer-run organization
- Division of state government
- Subcontractor (non-government, non-peer organization)
- Other: _____

Training

Although all states require training, the length, cost, curricula, and approved training vendor varies across jurisdictions. The Appalachian Consulting Group (ACG) has trained peer specialists in 35 states. ACG created the Georgia Certified Peer Specialist Curriculum, which was first introduced in 2001 and used to train the first peer specialists eligible for Medicaid reimbursement. ACG's curriculum and state-approved modifications to it are now used in most states. Most programs require at least 40 hours of in-person training. At least one State offers the option of online training. In-person training is considered a best practice because it fosters relationship building and allows peers to develop and practice their interpersonal skills.

15. Should Vermont require in-person training in the absence of extraordinary circumstances, such as a pandemic?

Mark only one oval.

- Yes, in-person training should be mandatory, absent extraordinary circumstances.
- No, online training should be an option
- Other: _____

16. Should Vermont develop its own peer certification training curriculum, adapt a curriculum developed by another state or allow prospective peer specialists to select from approved training vendors, each of which has its own training curricula and sets its own fees?

Mark only one oval.

- ◯ Vermont should develop its own peer certification training curriculum.
- ◯ Vermont should adapt to Vermont a curriculum developed by another state.
- ◯ Vermont should allow prospective peer specialists to select from approved training vendors.
- ◯ Other: _____

17. If Vermont should develop its own peer certification training curriculum or if it should adapt a curriculum, which entity should be responsible for developing the curriculum?

Mark only one oval.

- ◯ The curriculum should be developed through a competitive, request for proposal process.
- ◯ The curriculum should be developed under the auspices of the Peer Workforce Development Initiative
- ◯ Other: _____

Certification

Certification is that step in the process where the certifying body determines whether the applicant has met the requirements for certification.

The elements of the certification process include (1) who administers the exam and what exam is administered; (2) required fees; (3) recertification requirements; (4) characteristics and role of the certifying entity; and (5) duration of the certification.

18. Should Vermont administer a single, statewide exam or should applicants only be required to pass an approved vendor's exam?

Mark only one oval.

- ◯ Single, statewide exam

- [ ] Approved vendor's exam
- [ ] Other: _____

19. What should be the duration of the peer certification before its expires?

Mark only one oval.

- [ ] Lifetime; it should not expire
- [ ] One year
- [ ] Two years
- [ ] Other: _____

20. Should Vermont require applicants to pass a statewide examination to become re-certified or should recertification require only the payment of a fee and/or registration without a fee?

Mark only one oval.

- [ ] Applicants should be required to pass an examination to become re-certified.
- [ ] Applicants should only be required to pay a fee to become re-certified.
- [ ] Applicants should only be required to register without any additional fee to become re-certified.
- [ ] Other: _____

21. What type of organization should be responsible for the certification process?

Mark only one oval.

- [ ] A peer-run organization that both trains and certify applicants
- [ ] A peer-run organization that only certifies applicants with a separate peer-run organization that trains applicants.
- [ ] The state department of mental health
- [ ] A state certification board.
- [ ] Other: _____

Peer certification requirement	A state must have a peer certification program in order to bill Medicaid for peer support services. However, the program need not be mandatory.

requirement

22. Should Vermont require peer support workers to be certified in order to offer peer support in the State of Vermont?

Mark only one oval.

- Yes
- No
- Other: _____

Comments

Feel free to leave a comment about any issue not covered or to offer more explanation about your responses.

23. Feel free to leave a comment.

_____

_____

_____

_____

_____

Thank you

Thank you for taking the time to complete the survey.

APPENDIX L – SURVEY RESULTS – DEISGNING A MENTAL HEALTH PEER CERTIFICATION PROGRAM IN VERMONT

Designing a mental health peer certification program in Vermont

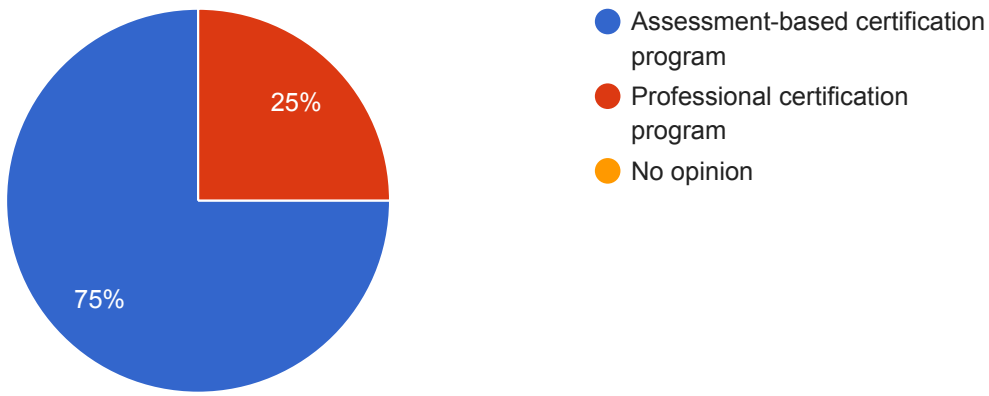
8 responses

Publish analytics

Assessment-based program versus professional certification program

Should Vermont adopt an assessment-based program or a professional certification program?

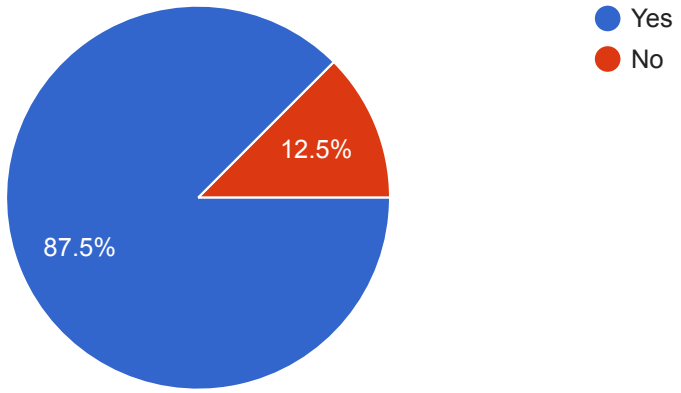
8 responses



Screening Criteria

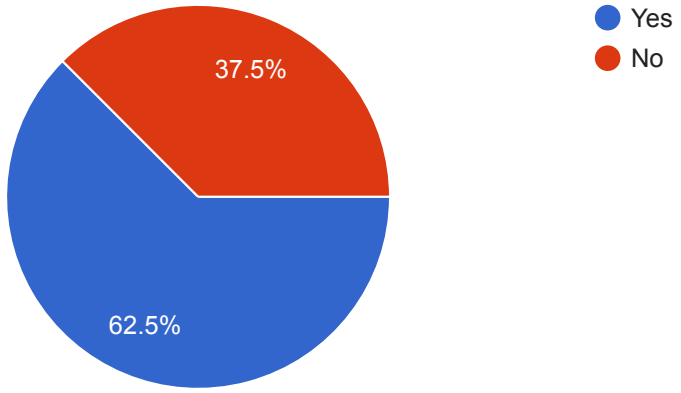
Should Vermont's peer certification program require applicants to have lived experience of a mental health condition from which the applicant is in recovery?

8 responses



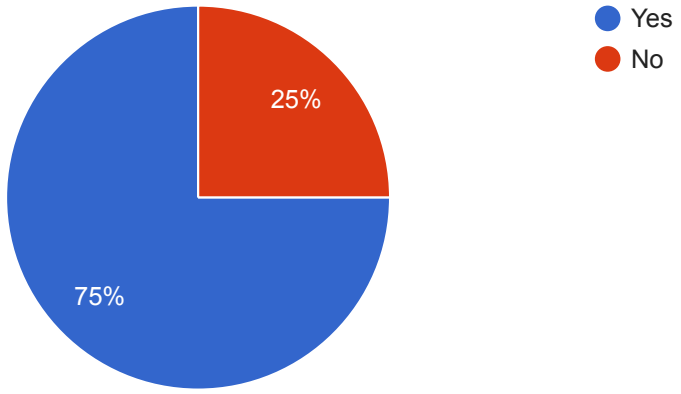
Should Vermont's peer certification program require applicants to affirm that they are willing to speak publicly about their recovery?

8 responses



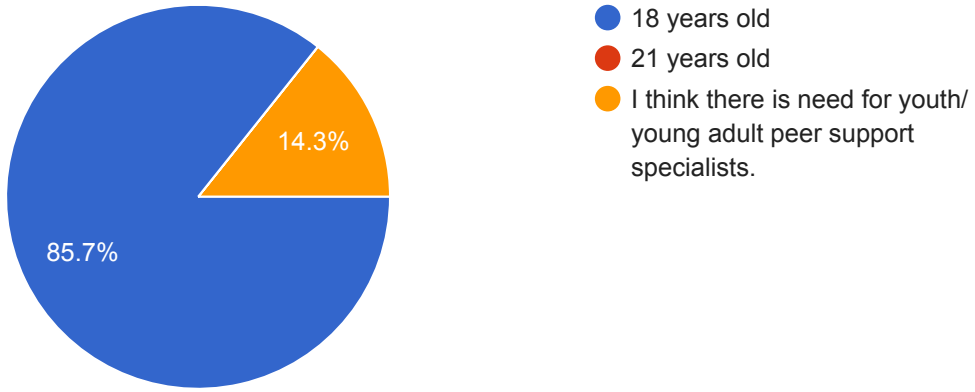
Should Vermont's peer certification program require applicants to be a minimum age to receive certification?

8 responses



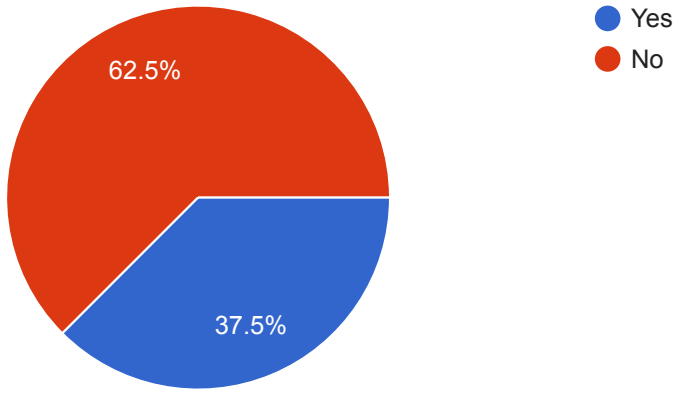
If Vermont's peer certification program should require applicants to be a minimum age to receive certification, what should be that age?

7 responses



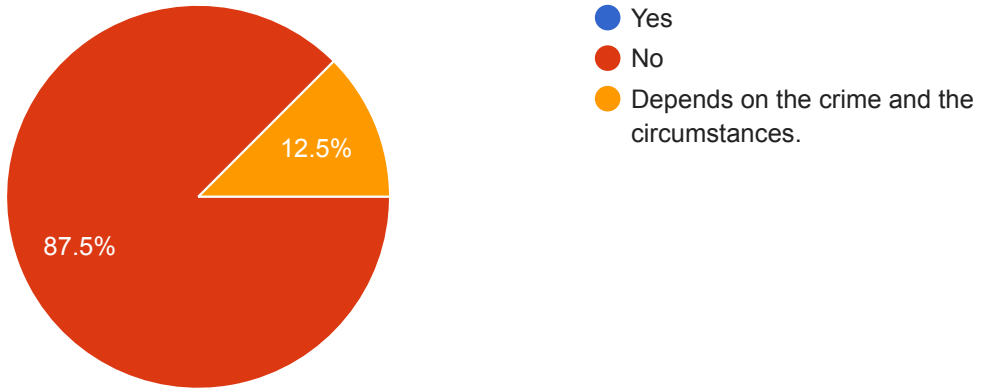
Should Vermont's peer certification program have a minimum education requirement of high school or equivalent (e.g., GED)?

8 responses



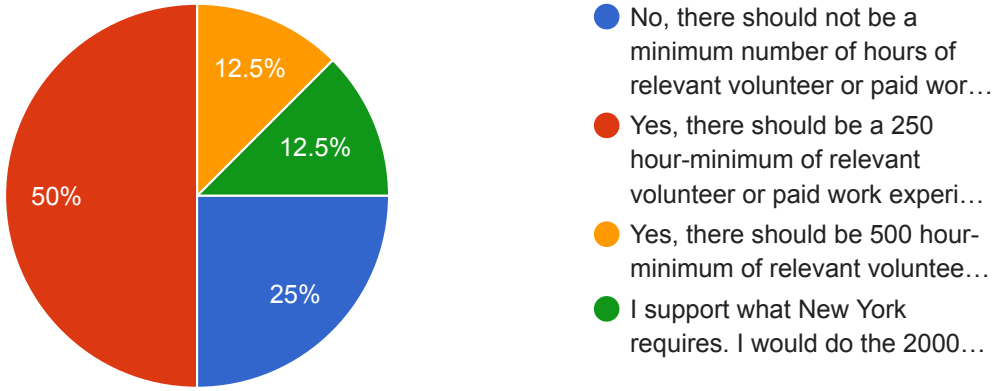
Should Vermont's peer certification program disqualify applicants who have a criminal conviction?

8 responses



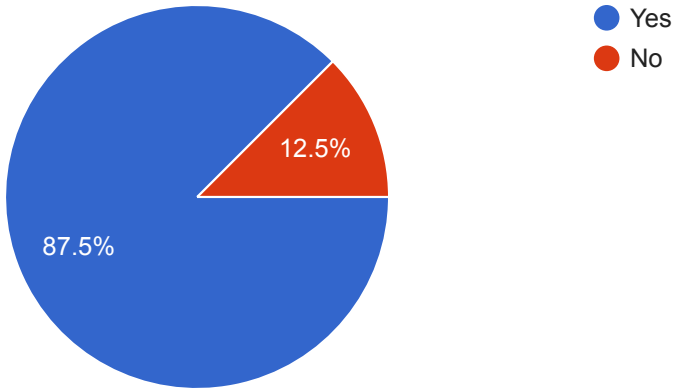
Should Vermont's peer certification program require applicants to work a minimum number of hours of relevant volunteer or paid work experience before becoming certified?

8 responses



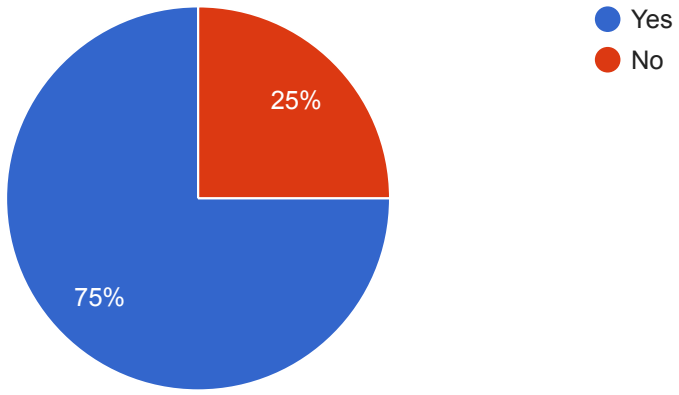
Should Vermont's peer certification program require letters of reference or recommendation?

8 responses



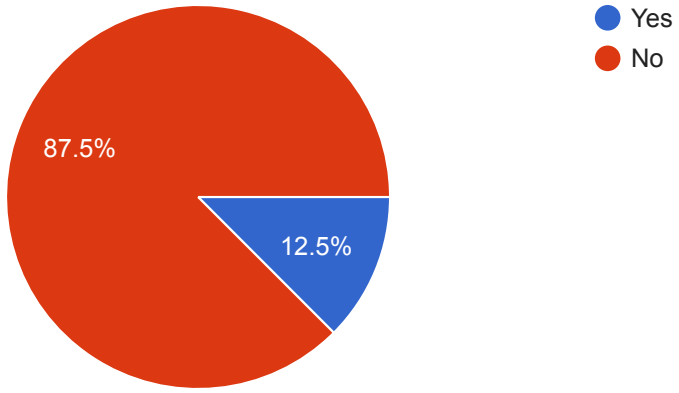
Should Vermont's peer certification program interview each applicant?

8 responses



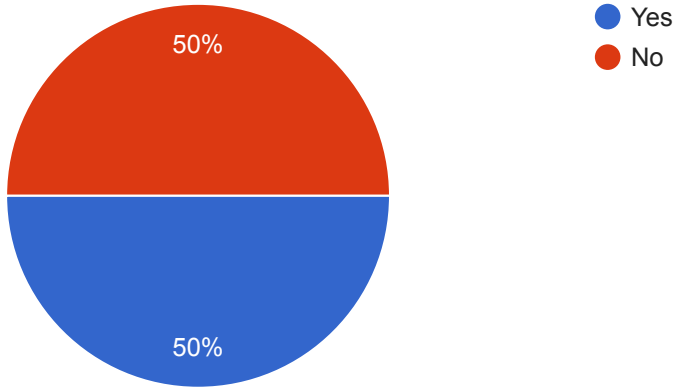
In some states, certification is a competitive process with limits on the numbers chosen each year. Other states take all who meet the minimum qualifications. Should Vermont's program be a competitive process with limits on the numbers chosen each year?

8 responses



Some states have residency requirements. Applicants must live or work in the state at least 51 percent of their time. Should Vermont's peer certification program have a residency requirement?

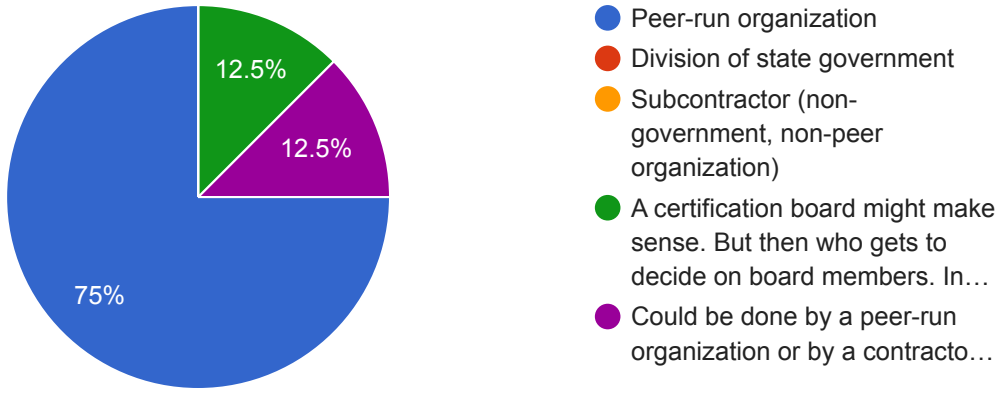
8 responses



Screening Organization

What entity should screen applicants in Vermont?

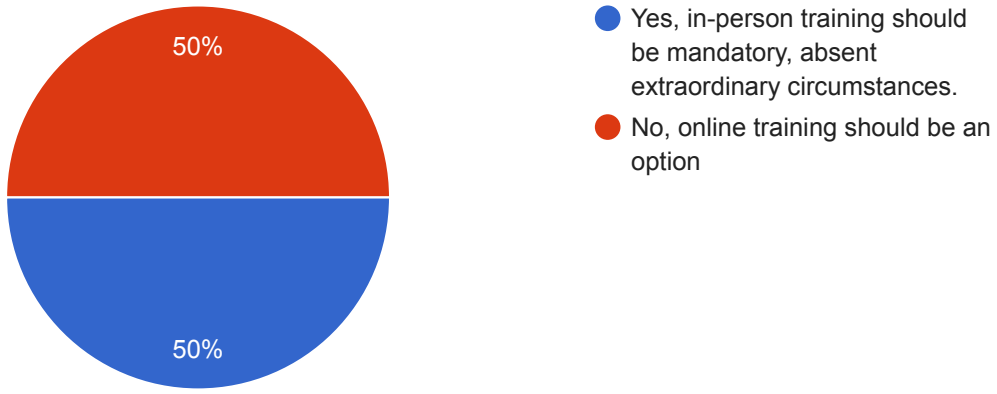
8 responses



Training

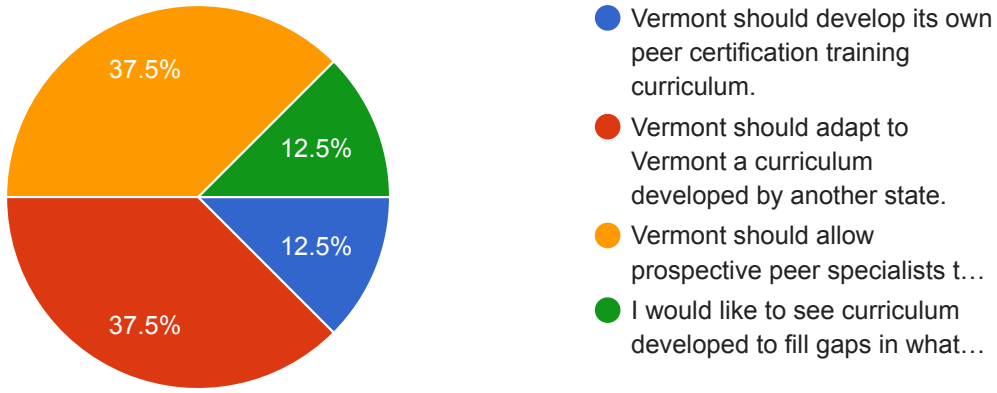
Should Vermont require in-person training in the absence of extraordinary circumstances, such as a pandemic?

8 responses



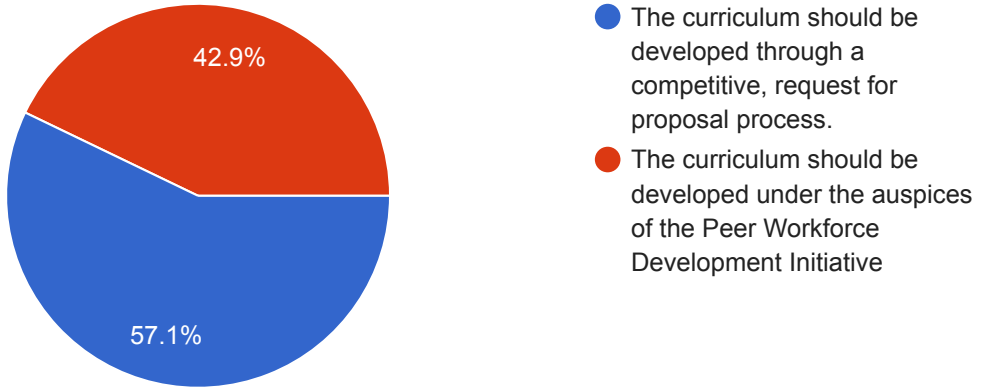
Should Vermont develop its own peer certification training curriculum, adapt a curriculum developed by another state or allow prospective peer specialists to select from approved training vendors, each of which has its own training curricula and sets its own fees?

8 responses



If Vermont should develop its own peer certification training curriculum or if it should adapt a curriculum, which entity should be responsible for developing the curriculum?

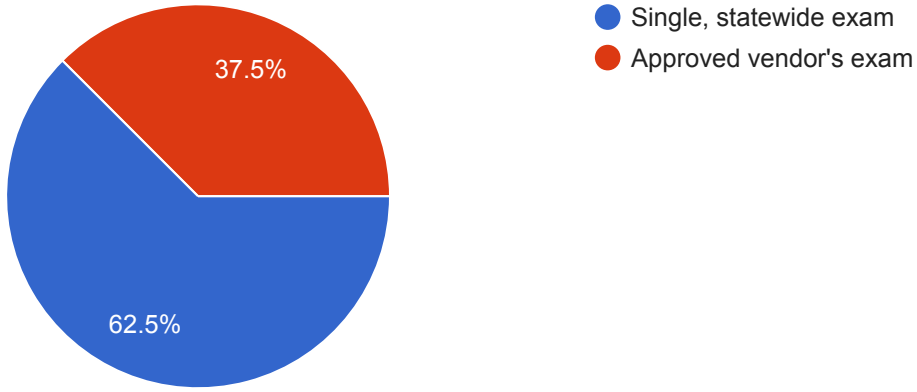
7 responses



Certification

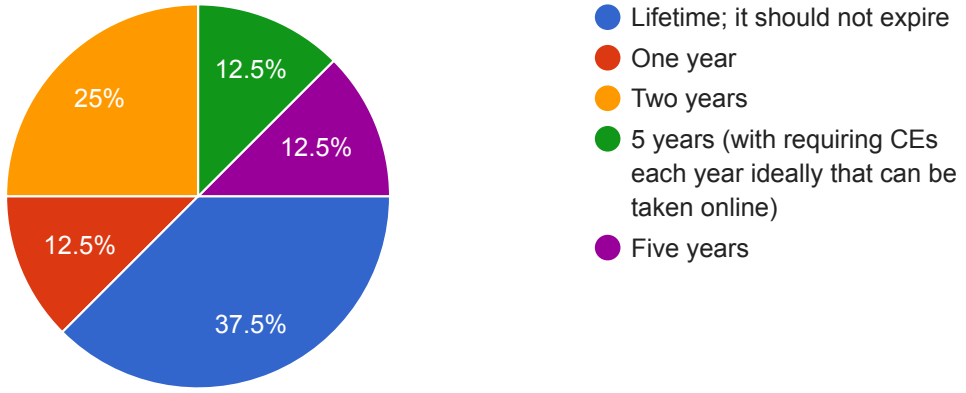
Should Vermont administer a single, statewide exam or should applicants only be required to pass an approved vendor's exam?

8 responses



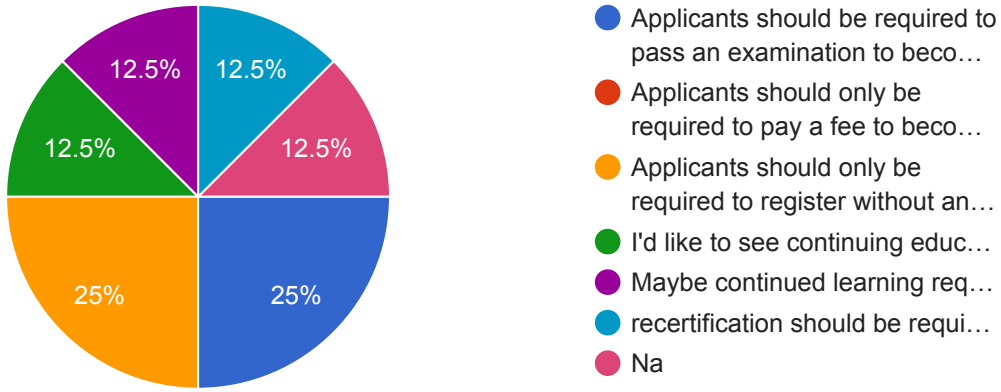
What should be the duration of the peer certification before its expires?

8 responses



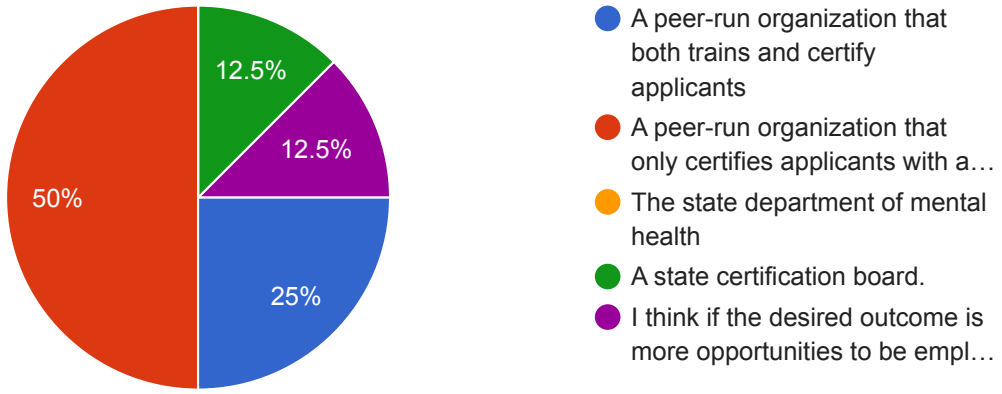
Should Vermont require applicants to pass a statewide examination to become re-certified or should recertification require only the payment of a fee and/or registration without a fee?

8 responses



What type of organization should be responsible for the certification process?

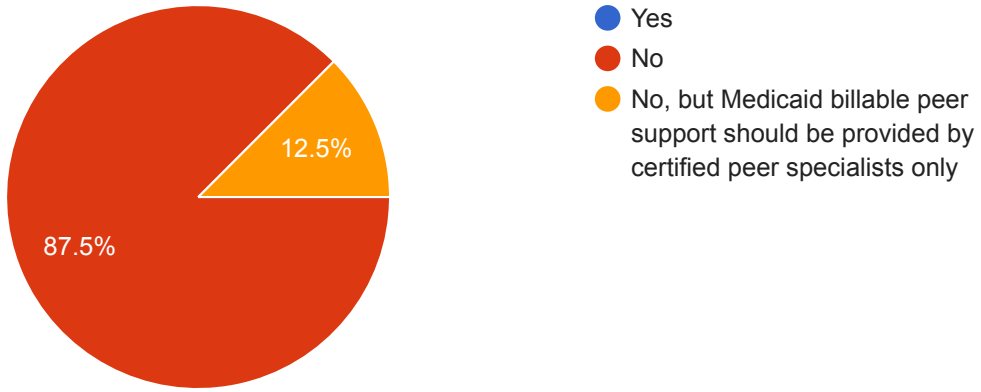
8 responses



Peer certification requirement

Should Vermont require peer support workers to be certified in order to offer peer support in the State of Vermont?

8 responses



Comments

ENDNOTES

[1] Chamberlain, J. (1977) *On Our Own*. National Empowerment Center: Lawrence, Massachusetts, 1977 at p. 1.

[2] Mead, S., Hilton, D. & Curtis, L. (2001). Peer support: A theoretical perspective. Psychiatric Rehabilitation Journal, 25(2), 134-141.

[3] Vestal, C., "'Peers" Seen Easing Mental Health Worker Shortage," Pew Trust, September 11, 2013. Accessed April 1, 2020. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage

[4] Barker, Stephanie L.; Maguire, Nick. "Experts by Experience: Peer Support and its Use with the Homeless," *Community Ment Health J* (2017) 53: 598-612. DOI 10.1007/s/0597-017-0102-2.

[5] Croft, B, & Isvan, N. (2015). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services, Psychiatric Services, 66(6), 632-637

[6] Greenfield, T.K., Stoneking, B, Humphreys, J, Sundby, E, & Bond,
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[8]Department of Health & Human Services, Center for Medicaid and State Operations, Letter to State Medicaid Director, August 15, 2007, SMDL #07-011, accessed March 30, 2020.
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[10] Jacobson, N. et.al. (2012). What do peer support workers do? A job description. BMC Health Services Research. 12:205

[11] Mental health facilities include community mental health centers, multi-setting mental health facility (e.g., residential plus outpatient), outpatient mental health facility, other residential treatment facility, partial hospitalization/day treatment facility, psychiatric hospital or psychiatric unit of a general hospital, residential treatment centers for adults, and residential treatment centers for children.

[12] University of Michigan Behavioral Health Workforce Research Center. National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles and Reimbursement. Ann Arbor, MI: UMSPH; 2019. Last accessed June 17, 2020. http://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf

[13] The ratio is calculated by the number of facilities offering peer services divided by the units of 100,000 state population.

[14]Cyr Céline, McKee Heather, O'Hagan Mary and Priest Robyn, for the Mental Health Commission of Canada (2010 first edition / 2016 second edition). Making the Case for Peer Support: Report to the Peer Support Project Committee of the Mental Health Commission of Canada at pp. 99-100. Retrieved from: http://www.mentalhealthcommission.ca.

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[17] Pennsylvania Certification Board, CPS Application: Certified Peer Specialist, A certification for mental health or co-occurring peer specialists, revised October 2019. Last accessed June 1, 2020. https://www.pacertboard.org/sites/default/files/applications/PCB_CPS%28Peer%29_Application_19_0.pdf

[18] https://www.mhanational.org/national-certified-peer-specialist-ncps-approved-trainings

[19] United States Government Accountability Office, "Mental Health: Leading Practices for State Programs to Certify Peer Support Specialists," GAO-19-41, November 2018 at p. 18.

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[49] The information in this section is based on a telephone interview with Adrienne Lightfoot, Program Coordinator, Washington, D.C. Department of Behavioral Health, Office of Consumer and Family Affairs.

[50] The information in this section is based on a telephone interview and email exchanges with Lana Mahoney, Interim Executive Director, Recover Wyoming.