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ORPRN

*Oregon Rural Practice-Based
Research Network*

How Organizations Bill Medicaid for Peer Services

May 13, 2025

Slide 1

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[@Nancy Goff]

Bethany Lowe, 2025-05-08T19:31:13.954

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I don't love the title- open to any ways to zhuzh it up or make more descriptive

Bethany Lowe, 2025-05-08T19:33:50.654

Introductions

Panelists

- Ben Spence- Addictions Recovery Center, Inc.
- Sommer Wolcott- OnTrack Rogue Valley
- Tony Vezina & Nick Crapser- 4D Recovery



Facilitator

KW0

- Bethany Linscott-Lowe- Oregon Rural Practice-based Research Network (ORPRN) at OHSU



Slide 2

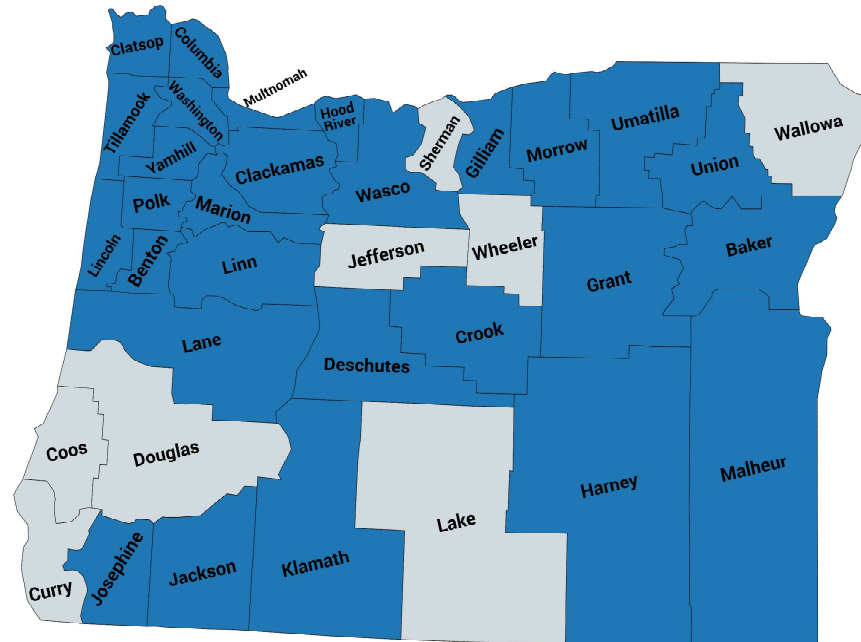
KW0

I'm happy to introduce myself, too as the webinar logistics and Deflection TA.

Kayla Warner, 2025-05-13T20:04:26.862

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Welcome!



Slide 3

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Nancy, I pulled this map from another deflection PPT. I believe this reflects the counties who have Behavioral Health Deflection Grants, which I assume are the counties who will mostly be in attendance. is this map okay?

Bethany Lowe, 2025-05-07T18:37:41.551

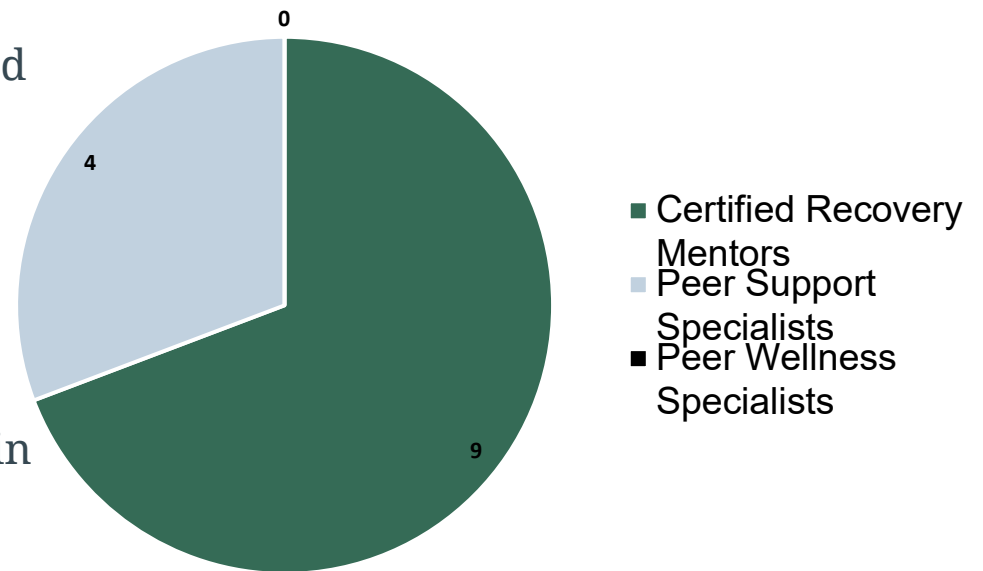
Purpose of today's webinar

- Hear case studies of counties and peer organizations that have used Medicaid to pay for peer services
- Dispel Medicaid billing perceived barriers
- Provide space for participants to ask questions about this funding pathway



Current state* of Medicaid billing for peer deflection services

- All deflection programs that responded are using certified peers
- Most counties surveyed (11 of 13) are already billing Medicaid for peers (although it was unclear if the deflection-related peers are included in billing)
- About half of respondents indicated they are interested in billing



Barriers to billing Medicaid for peer services

- Perception that services are not reimbursable until after a service plan is completed or diagnosis is made
- Perception that case management and service navigation is not billable
- Reimbursement rate is too low to justify the cost of billing
- Organizations are not interested in tailoring client needs to Medicaid requirements
- Medicaid requirements are not a good match with nature of peer role which requires more flexibility (e.g., sometimes driving distances to see clients during a workday)
- Inability to collect demographic and insurance information needed for Medicaid at time of service
- Peer supervision requirements are a barrier

Case study #1: Addictions Recovery, Inc.

- Ben Spence, Community Justice Programs Manager
- Jackson County



Slide 7

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Speakers, you are not limited to these three slides or this format! This is just a potential structure to help you organize your talk. In this first "case study" section, each organization will speak for about 8 minutes to draw a broad picture of how you've done peer Medicaid billing, and then we'll dive into the facilitated panel in the second half of the hour. We included your logo, etc, but feel free to make it your own!

Bethany Lowe, 2025-05-08T19:04:38.617

Case study #2: OnTrack Rogue Valley BLO

- Sommer Wolcott, Executive Director
- Jackson County



Slide 8

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Bethany Lowe, 2025-05-08T19:04:43.071

Jan-March 2025
Revenue for FFS
Billing:
12 Full Time Peers

Row Labels	Sum of Paid
H0023:HF	6244.16
H0038:HF	17366.06
T1016:HF	29739.16
T1016:HF, GT	34.97
Grand Total	53384.35

Medicaid for Peers?

Organizations that already have an existing Fee-For-Service billing infrastructure should add Peer billing.

Peer billing does not pay for itself.

OnTrack currently has FIVE grants partially or fully funding certain peer positions and every peer bills Medicaid.

The Peer Support and Fee for Service

The peer support superpower isn't just lived experience. 85-90% of my staff have lived experience.

The true secret sauce is lived experience PLUS the flexibility and organizational structure that allows peers to connect and engage with people in different ways.

Fully funding positions with FFS billing means booking schedules with billable services, scheduled appointments, deliberate double booking, and all the things that make counselors and medical providers inaccessible.

If you want peers to be accessible and ready for walk-ins/drop offs, while also attending case conferences, trainings, community meetings, ride-alongs, street outreach, etc. then you have to provide funding beyond FFS.

Revenue vs Expense for 12 Peers 1st Quarter 2025

Salary & Benefits Only	Avg Salary	W/ Benes	Avg Monthly	Quarterly
Peer Support Specialist	\$22.50	\$29.25	\$5,070.00	\$15,210.00
12 Peer Support Specialists	\$270.00	\$351.00	\$60,840.00	\$182,520.00
			Quarterly Revenue	\$53,384.35
			GAP	-\$129,135.65

More accurate Quarterly	Salary & Ben	Supervision	Other	Plus Admin	Total
12 Peer Support Specialists	\$182,520.00	\$19,266.00	\$7,200.00	\$23,000.00	\$231,986.00
				Quarterly Revenue	\$53,384.35
					-\$178,601.65

*Other=electronic health record fees, clearing house, training, compliance

Plus Admin=Credentialing requirements, billing, posting revenue, claims processing, authorizations, contracting, etc.

Bottom Line: Bill Medicaid and fund Peers separately

Bill for services if your organization already has that infrastructure.

Assume that FFS billing will pay for about 25% of the true cost of billing.

Ensure that your peers don't become booked out clinical staff with no time to do what peers do best.

The increasingly common narrative that peers are fully funded by Medicaid billing has harmed providers that are already billing. We are now being denied grants because we "should bill Medicaid" while our peers are expected to be accessible, engaged in non-billable services.

Case study #3: 4D Recovery BL0

- Tony Vezina, Executive Director
- Dr. Nick Crapser, Clinical Director
- Portland Metro



Slide 14

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Bethany Lowe, 2025-05-08T19:04:48.915

Panel: Insights & lessons learned

Question & answer

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Thank you

deflection@ohsu.edu



Slide 17

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[@Kayla Warner] I'll give you a verbal prompt to launch the survey if that works for you

Bethany Lowe, 2025-05-13T18:39:54.526