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Medicaid Coverage of Peer Support for People with Mental Illness: Available Research and State Examples

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Medicaid Coverage of Peer Support for People with Mental Illness: Available Research and State Examples

State mental health systems across the country are changing their mental health systems to emphasize recovery.[1] This transition is informed by the experiences of people with serious mental illness who live, work, and learn in the community. These individuals have increased awareness among policy makers that individuals can recover from even the most serious mental illnesses to live fulfilling and productive lives.[2] In addition to these life changes, recovery may also involve a reduction or remission of symptoms, depending on the individual.[3] The National Consensus Statement on Mental Health Recovery, developed by a panel of over 110 experts, defines recovery as follows:

> Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.[4]

The President's New Freedom Initiative Commission on Mental Health identified two principles for a system focused on recovery, rather than symptom management. First, people must have meaningful choices about their treatment options and providers so services are centered on the person's needs and preferences. Second, services must focus on increasing resiliency, the ability cope with the challenges inherent in life.[5]

As part of pursuing a recovery-based system, States have increasingly expressed interest in covering peer support as a specific type of service and/or provider in the Medicaid program. Peer support – services from staff who have experienced a serious mental illness and who relate to participants based on their experience in the recovery process – can play an important role in recovery. Peer providers teach social and coping skills essential to increasing resiliency and provide a model of recovery.

In a 2007 letter to State Medicaid Directors, the Centers for Medicare & Medicaid Services (CMS) declared peer support an "evidence-based mental health model of care" and specified requirements for Medicaid-funded peer support, including:

1. Supervision by a mental health professional (as defined by the State)
2. Care-coordination within a comprehensive, individualized plan of care with specific, individualized goals
3. Training and credentialing, including continuing education requirements, that ensure providers have a basic set of competences necessary to support the recovery of others[6]

States also must meet requirements that apply to any Medicaid service. For example, 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

[1] For examples of transformation efforts supported by Federal grants, see Research Triangle Institute, 2008 and U.S. Substance Abuse and Mental Health Services Administration, 2006a.
[2] Campbell, 1996
[3] U.S. Public Health Service, 1999
[4] U.S. Substance Abuse and Mental Health Services Administration, 2006b
[5] President's New Freedom Commission on Mental Health, 2003
[6] U.S. Centers for Medicare & Medicaid Services, 2007

rehabilitative service or a waiver authorized by Section 1915(b) or Section 1915(c) of the Social Security Act).[7]

This report provides information to assist State Medicaid Agencies and their partner mental health agencies in efforts to incorporate peer support into the Medicaid program. First, the report provides an overview of peer support, including a definition of peer support and examples of services furnished by peer providers. Second, it summarizes the available research to date regarding the effectiveness of peer support. Finally, the report presents State examples of peer support within three different Medicaid authorities. Information for this report was gathered through reviews of journal articles;[8] technical reports on Medicaid services; State policy documents such as waiver applications and regulations; and interviews with state Medicaid and mental health agency personnel.

Overview of Peer Support

Peer support is provided by specially trained individuals with a mental illness who are focused on extending services to others and who relate to participants in part based on their personal recovery experience.[9] Peer support features a one-way relationship where the provider assists the participant using particular expertise that includes but is not limited to his/her experience in recovery.

Two types of support are excluded in the definition of peer support because of the report's focus on services States may want to add to their Medicaid program. First, peer support does not include services where a person with mental illness is a mental health professional as defined by the State (e.g., a psychiatrist). These services are already covered in most State Medicaid programs. Second, peer support does not include mutual support groups where experience with mental illness is the primary qualification for a facilitator. These groups are not eligible for Medicaid reimbursement because they are not provided by staff with specific expertise.[10]

Peer support can be provided wherever community mental health services are provided, including:

- Facilities where other outpatient mental health services are provided, such as at a psychosocial rehabilitation provider
- Freestanding peer support locations, such as consumer-operated drop-in centers
- Natural community settings where mobile services meet the person, such as coffee shops or a person's home or job site

Peer support can also be furnished in a hospital, where peer support staff can support a person's recovery and connect people to community supports they can use upon discharge.[11]

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[7] Ibid.
[8] An initial set of articles were identified by Dr. Jean Campbell based on her knowledge of this field. Additional articles were identified by searching the PsycINFO database using two-word phrases that combined "peer" or "consumer" with words indicating provider staff (i.e., "provider", "specialist", and "staff").
[9] Solomon and Draine, 2001
[10] Section 4390(e) of the State Medicaid Manual
[11] Chinman et al., 2006; Chinman et al., 2001; Dumont and Jones, 2002; Edmunson et al., 1982; Sells et al., 2006

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Peer support is often provided by consumer-run organizations, in which most or all staff and at least 51 percent of board members have a history of mental illness.[12] Services provided by these organizations are called consumer-operated services. For these services, the Medicaid requirement of supervision by a mental health professional can be realized when services are supervised by a person with mental illness who meets the State standards for a mental health professional. Consumer-run organizations also provide peer support as a distinct service. In addition, many mental health agencies lead by non-consumers provide peer support.

Studies of peer support have examined three different types of peer support that reflect different structures for the relationship between the peer and non-peer providers: 1) peer support as a distinct service; 2) peer providers that are part of a service delivered by a team, such as Assertive Community Treatment (ACT); and 3) services other than peer support (e.g., crisis intervention or supported employment) provided entirely by peers who relate to participants in part based on their personal recovery experience.

When provided as a distinct service, the specific assistance provided varies based on program design. Common tasks performed by peer providers include:

- Assisting the participant in developing coping and problem-solving strategies to improve the person's self-management of his/her mental illness
- Contacting participants in-person and by phone on a one-on-one basis frequently to offer support and assistance and to encourage engagement in mutual support groups and other mental health services
- Organizing structured leisure and recreational activities – based on participants' preferences – in order to provide opportunities for participants to practice social and coping skills.[13]

When peer support is provided as part of another service, the assistance is consistent with that service. Two studies have evaluated the impact of peers as part of an Assertive Community Treatment (ACT) team.[14] Additional studies examined teams of peers providing case management, supported employment, and crisis intervention.

In a 2007 survey of 173 peer support providers, The National Association of Peer Specialists found that peers perform a more diverse array of tasks, including individual counseling; teaching; medication monitoring; benefits counseling; staffing crisis intervention and jail diversion programs; family and community education; and assistance in obtaining or using housing, transportation, and employment.[15]

Peer Support Research

The majority of available research suggests that peer support is a promising practice when provided in addition to traditional mental health services. *Mental Health: A Report of the Surgeon General* recognized self-help and consumer-operated supports as an important adjunct to traditional mental health services.[16] Also, the President's New Freedom Commission on

[12] Mowbray and Moxley, 1997
[13] Chinman, et al., 2001; Edmundson, et al., 1982; Min et al., 2007; Rivera et al., 2007
[14] Sells et al., 2006 and Clarke et al., 2000
[15] National Association of Peer Specialists, 2008
[16] U.S. Public Health Service, 1999

Mental Health called for increased roles for mental illness survivors in service provision, especially for promoting "consumer-operated services for which an evidence base is emerging."[17]

This section summarizes research regarding the effectiveness of peer support. This section is organized based on the three types of peer support described above:

1. Peer support as a distinct service
2. Services delivered by a team of peers and non-peers
3. Peer-delivered services other than peer support

Two common themes arise in the literature. First, when provided in addition to traditional mental health services, a majority of studies show peer support improves psychological outcomes such as empowerment. Some studies also show improvement in clinical outcomes, such as reduced hospitalization, beyond the improvement in clinical outcomes attributable to traditional mental health services. Second, when working as a substitute for traditional mental health providers, peer providers typically perform as well as non-peer providers furnishing the same service.

Peer Support as a Distinct Service

Six studies have examined the effect of peer support as a distinct service provided in addition to other mental health services. Four of these studies reported positive findings and one study reported no statistically significant differences in outcomes. The sixth study used two methodologies and obtained mixed results. These studies are described below.

Positive Findings

The four studies with positive findings include the earliest study of peer support services. In a 1982 study, a peer specialist program was established for people to use upon discharge from a psychiatric residential treatment facility. The facility was not a hospital, but a community-based facility that provided rehabilitative services after a hospitalization. In a randomized controlled trial, people with access to peer support had fewer hospital admissions and one-third the number of inpatient hospital days in a 10-month period, when compared to people who did not have access to peer support.[18]

More recent studies have produced similar results. These studies used participant choice to divide study participants into experimental and control groups, rather than use a randomized, controlled trial. For example, Felton and colleagues compared outcomes for people received one of three case management options: 1) a case manager and a peer specialist, 2) a case manager and a non-consumer assistant, or 3) a case manager working alone. In each option, the case manager provided counseling services as well as assistance in helping the participant access necessary supports. "Case management" as described in this and other studies may differ from the case management service in a particular State Medicaid program. During an 18-month

[17] President's New Freedom Commission on Mental Health, 2003, p. 37
[18] Edmunson et al., 1982

period, people served by a peer specialist and case manager showed greater improvements in several quality of life measures than people in the other two groups.[19]

Two studies, published in 1998 and 2007, examined a peer support program serving people with co-occurring serious mental illness and substance abuse. Both studies compared people receiving intensive case management services and peer support to people who received only intensive case management. Specific case management activities were not defined and the intensive case management service may or may not have been the same as Medicaid case management service in that State. The 1998 study measured outcomes after six months of peer support, while the 2007 study measured outcomes after one, two, and three years of support. Both studies found that people receiving peer support had fewer hospitalizations. The 1998 study also found lower drug use and greater quality of life among peer support participants. The studies used different control groups. The 1998 study compared all peer support users to all people using intensive case management in that community not using peer support.[20] The 2007 study used Medicaid administrative data to identify a control group with diagnoses and demographic characteristics (e.g., age, race, and gender) similar to the peer support participants.[21]

Mixed Findings

Chinman and colleagues studied a consumer-operated program targeting people leaving a psychiatric hospital in a 2001 study. Peer specialists first met with the participant while he or she was in the hospital to introduce the project and ask the participant if he or she wants to be involved. During the first three months after discharge, the peer providers meet with the participant several times and arrange weekly recreational outings to facilitate development of social and coping skills. In the program's first year, 15% of participants were readmitted to the hospital. By comparison, 30% of people served by the local community mental health center were hospitalized in that year. The researched considered this a promising finding because the peer support participants were considered a higher risk for hospitalization. However, when the researchers identified a control group of mental health center participants with similar diagnoses and demographics, they found no significant differences in hospitalizations or hospitalized days.[22]

Neutral Findings

A 2007 study randomly assigned participants with hospitalizations in the past two years into three types of case management: 1) strengths-based intensive case management, which encouraged use of natural community resources and included 24-hour telephone coverage; 2) strengths-based intensive case management with a peer specialist; 3) strengths-based case management without 24-hour telephone coverage and with all services restricted to an office setting. The service may or may not have been the same as Medicaid case management service in that State. After 12 months, there no differences between the three groups regarding hospitalized days, symptoms, satisfaction, quality of life, or contacts with family or friends.[23]

[19] Felton et al., 1995
[20] Klein et al., 1998
[21] Min et al., 2007
[22] Chinman et al., 2001
[23] Rivera et al., 2007

Services Delivered by a Team of Peers and Non-Peers

Two studies examined the effect of peer providers working as case managers on Assertive Community Treatment (ACT) teams. Clarke et al., found people served by peer providers had fewer hospitalizations and inpatient days, while Sells et al., found no significant differences in people served by peer providers.

Clarke et al. randomly assigned people with chronic mental illness into three types of service: 1) an ACT team in which five staff members were peers; 2) an ACT team in which staff did not have a mental illness; and 3) "usual care" from community mental health providers. Both ACT teams were supervised by the same clinical director and worked with the same psychiatrist and nurse practitioner. During a 24-month period, people served by the team with peer providers had fewer hospitalizations and inpatient hospital days, but no differences in number of arrests or percentage of participants who were homeless.[24]

Sells et al. focused on people with serious mental illness who were not engaged in mental health treatment. A randomized, controlled trial in three sites compared an ACT team with two peer specialists to other services from a local mental health center. After 12 months, they found no differences between the groups in service utilization or motivation for treatment.[25]

Peer-Delivered Services Other than Peer Support

Three studies have evaluated the effect of services other than peer support provided entirely by peers who relate to participants in part based on their personal recovery experience. The three studies focused on different services: case management, a crisis intervention facility, and supported employment.[26]

Case Management

Solomon and Draine randomly assigned people with serious mental illness into two case management teams: a team of peers working at a local mental health association and a team of non-peers working at a community mental health center. As in other studies involving case management, the service may or may not have been the same as Medicaid case management service in that State. After two years, they found no significant differences between the two groups in several outcomes including hospitalized days, quality of life, and social functioning.[27]

[24] Clarke et al., 2000
[25] Sells et al., 2006
[26] Two recent multi-site studies that focused on consumer-run organizations, rather than particular services those organizations provide, are not included because this review is focused on services that may be incorporated into the Medicaid program. While some consumer-operated services are Medicaid-eligible; others are not and it is not possible to distinguish the two in these studies. Both studies showed positive results associated with participation in consumer-operated services (See Nelson et al., 2006; Nelson et al., 2007; Rogers et al., 2007; Campbell et al., 2008).
[27] Solomon and Draine, 1995

Crisis Intervention Facility

Dumont and Jones studied the affect of access to a consumer-operated, five-bed crisis facility. The facility was a voluntary facility that provided an alternative to involuntary treatment. People with previously hospital stays were randomly assigned into an experimental group with access to the facility and a control group that did not have access. Both groups also could access other community mental health services. Over two years of operation, people with access to the crisis facility had fewer hospital days and higher measures of satisfaction, empowerment, and healing.[28]

Supported Employment

Kaufmann used a randomized controlled trial to compare a peer-staffed supported employment program to local vocational rehab services. After 12 months, people served by the supported employment were more likely to be employed than people using traditional vocational services.[29]

State Examples of Medicaid Peer Support Services

As described in the introduction, CMS has specified requirements for covering peer support as a distinct service in the Medicaid program. This section of the report describes one State example for each Medicaid authority in the Social Security Act that States have used to cover peer support. Several states offer peer support under two Medicaid authorities:

- Section 1905 (a)(13), which allows States to provide rehabilitative services in the Medicaid State Plan
- Section 1915(b)(3), which allows States to use cost savings from a Freedom of Choice Waiver to provide additional services

To illustrate another possibility for offering peer support, we highlight an example using Section 1915(c), which allows States to obtain waivers to provide Home and Community-Based Services to people who require institutional level of care[30]

The descriptions below focus on peer support delivered as a distinct service. When peer providers furnish other services such as supported employment, peers must meet the provider standards for that particular service.

Each example briefly describes the peer support service and explains how the State has implemented the requirements mentioned in a 2007 letter to State Medicaid Directors:

1. Supervision by a mental health professional
2. Care-coordination
3. Training and credentialing[31]

[28] Dumont and Jones, 2002
[29] Kaufmann, 1995
[30] All three Medicaid authorities were identified in the 2007 State Medicaid Director Letter (U.S. Centers for Medicare & Medicaid Services, 2007). In addition to these three authorities, it is possible to authorize peer support under Section 1915(i), which allows States to add home and community-based services listed in Section 1915(c)(4)(B) to the Medicaid State Plan.

Georgia - State Plan Rehabilitative Services

Georgia was the first state to offer a peer support service as part of the Medicaid State Plan rehabilitative services benefit, starting in 2001.[32] Many of Georgia's Certified Peer Specialists provide a distinct peer support service through freestanding peer support locations, such as drop-in centers. Specialists also work for community mental health providers, including as part of a team with non-peers. In addition to providing peer support as a distinct service, peer specialists also provide other rehabilitative services as Assertive Community Treatment and psychosocial rehabilitation.[33]

Supervision

As required by CMS, Certified Peer Specialist services must be supervised by a mental health professional. The State prefers supervising professionals be credentialed as a psychiatric rehabilitation professional by the U.S. Psychiatric Rehabilitation Association (formerly IAPSRS). The State also prefers supervising professionals themselves be a Certified Peer Specialist, which is important for consumer-operated service models where most or all staff have a mental illness.[34]

Care Coordination

Peer support activities must be consistent with an Individual Services Plan developed by the participant with assistance from a peer specialist. The peer support program must record weekly progress notes document the participant's progress toward goals specified in the services plan.[35]

Training and Certification

The State and the Georgia Mental Health Consumer Network developed a standard training and certification process. People must apply to the State to participate in the training program. The state selects training participants, giving priority to a) people employed by a provider of Medicaid mental health services; and b) consumers who have demonstrated peer leadership and are sponsored by a Medicaid mental health provider.

Initial training is provided in a nine-day program held three times per year. Topics include skills building, problem solving, starting and maintaining mutual support groups; and helping participants develop their ISP. Peer specialists must complete the training program and pass oral and written competency examinations regarding the principles of recovery, self help, and peer support and other requirements such as the structure of Georgia's mental health system, cultural competency, and confidentiality.

Once certified, the specialists must also meet continuing education requirements. The State holds biannual workshops to keep specialists informed about evolving best

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[31] Ibid.
[32] Sabin and Daniels, 2003
[33] Georgia Certified Peer Specialist Project, 2008a
[34] Georgia Certified Peer Specialist Project, 2008a
[35] Ibid.

practices in mental health recovery. Georgia had trained 437 Certified Peer Specialists as of February 2008.[36]

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

Iowa has contracted with a single managed behavioral 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.[37]

Supervision

Like other mental health services, the peer support must be supervised by a mental health professional, who meets each provider at least twice per month for clinical consultation. A mental health professional must be available at all times for telephone consultation. There are no additional requirements specific to the peer support service, such as certification as psychiatric rehabilitation professional.[38]

Care Coordination

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.[39] Peer support must be part of the person's service plan, which specifies an activity plan for peer support and goals for the service. Like all providers, peer support providers are part of the person's treatment team and coordinate with other providers.

Training and Certification

Peer support providers must be trained using a local adaptation of the Georgia Certified Peer Specialist training curriculum or an equivalent. The managed care organization worked with the State and other stakeholders to develop the local training curriculum, including monthly ongoing training.[40] The peer support program must submit its proposed curriculum for approval by the managed care organization when applying to provide peer support.[41]

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 individuals relocating from nursing homes with this combination of conditions. Wisconsin's waiver

[36] Georgia Certified Peer Specialist Project, 2008b
[37] Sabin and Daniels, 2000
[38] Interview with staff from Iowa Medicaid Enterprise
[39] Iowa Medicaid Enterprise, 2003
[40] Magellan Health, Undated
[41] Interview with staff from Iowa Medicaid Enterprise

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.[42] As of August 2008, this waiver only served four participants, none of whom had used the peer support service.[43]

Supervision

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.[44] If Peer Advocate / Support is provided as a participant-directed service, the case manager is considered the supervising mental health professional.[45]

Care Coordination

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.[46]

Training and Certification

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.[47] If Peer Advocate / Support services are provided as a participant-directed service, the person is more involved in the provider's training to ensure it is directly related to his or her needs, strengths, and preferences. The training requirements remain the same.[48]

Conclusion

States are increasingly considering peer support as they transform their mental health system to emphasize recovery. In order to illustrate different options for Medicaid funding authority and for meeting CMS requirements, this report described a few of the several State Medicaid programs that offer peer support.

The report also included a review of the research literature regarding peer support, which found that 1) when provided in addition to other mental health services, a majority of studies suggest peer support helps participants improve psychological outcomes and reduce hospitalization; and 2) a majority of studies suggest peer providers perform as well as non-peers when peer-delivered services are an alternative to traditional mental health services. Together, these research findings suggest that peer-delivered services can be a useful option for people who choose these supports. However, many of the

[42] Wisconsin Division of Mental Health and Substance Abuse Services, 2007
[43] Interview with staff from Wisconsin Division of Mental Health and Substance Abuse Services
[44] Wisconsin Division of Mental Health and Substance Abuse Services, Undated
[45] Interview with staff from Wisconsin Division of Mental Health and Substance Abuse Services
[46] Interview with staff from Wisconsin Division of Mental Health and Substance Abuse Services
[47] Wisconsin Division of Mental Health and Substance Abuse Services, Undated
[48] Interview with staff from Wisconsin Division of Mental Health and Substance Abuse Services

studies used small sample sizes. More research is necessary to refine our understanding of the effect of various peer support models in promoting recovery from mental illnesses.

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