



# Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness

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## Introduction:

People with mental illnesses use more resources and are more expensive to cover than Medicaid enrollees without these disorders.<sup>1</sup> Moreover, the subset of adults with serious mental illness (SMI) has the highest per person cost of all disabled, non-dually eligible individuals enrolled in state Medicaid programs.<sup>2</sup>

While using more physical and behavioral health care services, outcomes for individuals with SMI are poor: people with SMI die, on average, 25 years earlier than the general population, and at rates 2-3 times higher from conditions such as diabetes, cardiovascular disease and respiratory illnesses.<sup>3</sup> This population is also less likely to have a regular primary care provider.<sup>4</sup> Therefore, integrated care strategies that focus on primary care settings may not be as effective in addressing the complex physical and behavioral health needs of this population. For Medicaid enrollees with SMI, integrated care strategies that leverage the services and supports offered through the mental health system – where they are more likely to receive regular care - may be a more effective approach to improving physical health outcomes and reducing cost.

Trained peer support specialists are well positioned to bridge the gap between physical and behavioral health services for people with SMI as part of whole-person, recovery-oriented system of care. For state policymakers interested in better integrating care for individuals with SMI, this brief provides an overview of the use of peer supports in state mental health systems, and offers examples of the emerging use of these non-clinical staff as part of an integrated care approach. The brief also includes some key questions for state policymakers to consider as they explore the use of peer services to promote integrated care for Medicaid enrollees with SMI in their state.

This brief was based on interviews with state mental health and Medicaid policymakers in three states that fund peer support services designed to promote integrated physical and behavioral health for individuals with SMI. These states - Georgia, Kansas,

## Why Use Peer Supports to Promote Physical and Mental Health Integration?

- Peer supports are already funded in a majority of state Medicaid systems and can be supported using a number of Medicaid authorities.
- States can leverage their existing peer service systems to improve/enhance integrated care specifically for the SMI population
- Peer supports provide an opportunity to expand the mental health workforce
- Peers can be integrated into a number of service delivery models and approaches.

and Oregon - were selected based on their innovative initiatives, the diversity of funding approaches represented, and their leadership in this area. Key state contact information can be found in Appendix A.

## Peer Supports – The Current Landscape

Most state Medicaid programs reimburse for peer support services for individuals with SMI.<sup>5</sup> These services are delivered in a variety of ways, including peer-led curriculum-based programs; peer coaches or navigators who assist with accessing and better understanding the mental health system and services; and peer mentors, who provide one-on-one support to individuals to help them with their physical and/or mental health recovery goals. Peer supports may be offered as a stand-alone service, or incorporated into other Medicaid-covered services as part of a bundled payment or team approach, as in Assertive Community Treatment or health homes. The essential principles of peer support include shared personal experience and empathy, a focus on individual strengths, and supporting individuals as they work toward recovery pursuant to a person-centered plan of care.

Peer supports are recognized as a promising practice, with emerging evidence to support their effectiveness in promoting recovery for adults with SMI. Studies of peer-led curriculum-based self-management groups have shown significant positive changes for participants in self-management attitudes, skills and behaviors.<sup>6</sup> Other studies indicate promise in the use of peer supports to reduce hospital readmissions,<sup>7</sup> reduce the symptoms of depression,<sup>8</sup> and in providing the information, skills and support needed by individuals with serious mental illness to be more fully engaged in their care.<sup>9</sup> However, a recent meta-analysis cautions that further research is needed: the evidence on specific outcomes for peer supports is mixed, hampered by the lack of a consistent definition and service modality, as well as the lack of high-quality research.<sup>10</sup>

### What are Peer Supports?

Peer Supports are delivered by people with lived experience of mental illness. State Medicaid programs that reimburse for these services identify state-specific supervision, training, and/or certification requirements as required by CMS guidance. Services delivered by peer support providers may include:

- Linking to resources
- Group facilitation
- Skill-building
- Mentoring
- Goal-setting
- Other recovery-oriented supports per individual plan of care

Medicaid programs define, cover, and pay for peer support services in a variety of ways (see Table 1). State Medicaid agencies can refer to CMS guidance released in 2007 (SMDL #07-011),<sup>11</sup> which advises on how to structure and fund these services. In addition to citing specific Medicaid authorities, the guidance includes key service design components that state Medicaid agencies must consider when funding the service, including supervision by a competent mental health professional (as defined by the State), coordination of the service within a comprehensive, individualized plan of care that includes specific individualized goals, and training and credentialing for peer providers that delineates core competencies necessary to perform the peer support function.<sup>12</sup>

**Table 1. Peer Supports- Examples of State Medicaid Funding Strategies**

| Medicaid Authority                        | State | Approach  |
|---|-------|---|
| Rehabilitative Services State Plan Option | GA    | Peer supports are reimbursed as a stand-alone Medicaid-funded service provided to individuals or in groups. Services are reimbursed within a range of fees depending on factors such as practitioner level and location of service. <sup>13</sup> Certified peer support providers are also qualified to provide and be reimbursed for other services, such as Community Support and Psychosocial Rehabilitation. |
| 1915(b) Waiver                            | WA    | Peer supports are required as one of a menu of services offered by Washington's Regional Service Networks. <sup>14</sup> Peer supports are reimbursed as a standalone service; certified peer support providers are also qualified to provide and be reimbursed for other services. <sup>15</sup>   |
| 1115 Waiver                               | OR    | Contracts with Coordinated Care Organizations (CCOs) require that members have access to Peer Wellness Specialists; CCOs report encounter data on peer services delivered, and the state tracks development of the service in its quarterly 1115 Waiver report to CMS. <sup>16</sup>  |
| 2703 Waiver                               | KS    | Peer supports are required as part of the team-based behavioral health home model; they provide member and family support services and referral. The cost for peer support providers was factored into the state's per member, per month payment for health home services. <sup>17</sup>  |

## The Emerging Role of Peer Supports in Integrated Mental and Physical Health Care

State Medicaid agencies striving to reduce high cost and high utilization while improving the health outcomes of Medicaid members with SMI are increasingly looking to integrated approaches that build on community mental health systems; these approaches may include expanding the role of peers to promote health and wellness. State Medicaid programs support this expanded role of peers in a number of ways: broadening the scope of services in existing state plan options; building the role of peers into broad integrated systems of care; and including peer support providers as part of the team in health homes for people with SMI. This section provides a brief description of these diverse state approaches, summarizing the evolution of the service, key funding strategies, and models.

### Expanding the Role of Peers in Community Mental Health Settings: Georgia's Peer Support Whole Health and Wellness Program

Georgia has a well-established peer support program, and was the first state in the country to provide Medicaid funding for services delivered by certified peer support specialists starting in 2001 under its rehabilitative services state plan option. In evaluating the first three years of this program compared to treatment as usual (typically day support programs), Georgia's Department of Behavioral Health and Developmental Disabilities found that individuals using certified peer specialists saw a reduction in symptoms and an increase in self-management skills and abilities. Moreover, the service cost Georgia on average \$997 per year compared to \$6,491 in day treatment – a savings of \$5,494 per person.

### Promising Practice:

The Whole Health Action Management Program (WHAM) was developed by the SAMHSA-HRSA Center for Integrated Health Solutions and is a peer-led, research-informed program that includes:

- Person-Centered Goals
- Weekly Action Plan
- Daily/Weekly Personal Log
- One-to-One Peer Support
- Weekly Peer Support Group

The state built on this peer support foundation in 2012 when CMS approved a state plan amendment to add a whole health and wellness component to the service. The goal of this enhanced service is to promote “recovery, wellness, and healthy lifestyles; reduce identifiable behavioral health and physical health risks; and increase the healthy behaviors that are likely to prevent disease onset.”<sup>18</sup> Training for peer whole health and wellness providers includes tools and concepts from the Health and Recovery Peer Project (HARP), based on the Chronic Disease Self-Management Program developed at Stanford University. State Medicaid guidelines also require that these providers be certified in the WHAM Program (see box above), a curriculum-based model endorsed by SAMHSA and HRSA that promotes activation and self-management. Peers work in collaboration with a nurse who provides clinical consultation on identified health issues. Across both traditional peer support and the Whole Health and Wellness program, the state has added over 1,000 trained and certified peer support providers to the mental health system; state mental health policymakers cite the success of the peer support and peer wellness programs in helping them meet access to service requirements of the state’s mental health consent decree, at a relatively low cost when compared with licensed clinicians. State policymakers note that peers work not only in community mental health centers but also within, and in partnership with, federally qualified health centers, in crisis services, and other settings. Georgia’s Department of Behav-

ioral Health and Developmental Services plans to conduct further evaluation of its Whole Health and Wellness program in the future, as resources are available.

### Including Peer Supports in an Integrated Systems Approach: Oregon’s CCOs and Peer Wellness<sup>19</sup>

Oregon had previously funded peer support services through a 1915(i) Home and Community Based Services state plan option. In 2011, House Bill 3650 ushered in Oregon’s Health Transformation initiative, creating CCOs, the organizing structure for Oregon’s health care reform. Legislation was followed by Oregon’s 1115 waiver, which identified the integration of physical and behavioral health as a key lever to achieving the state’s goals of slowing the rate of cost growth in its Medicaid program while improving quality and access. Peer wellness specialists were created as part of House Bill 3650, requiring that covered members have access to qualified peer wellness specialists as a part of their care team, providing supports to “access appropriate services and participate in processes affecting the member’s care and services”.<sup>20</sup> Peer wellness specialists were written into the 1115 waiver, added to its Medicaid service array, and incorporated into the contracts of the Coordinated Care Organizations. The Oregon Health Authority approves the curriculum for peer wellness specialists, which includes developing skills to address physical health conditions and to work in medical settings. Peer wellness services are offered in diverse settings; the service supports programs focuses on accessing primary care, supporting self-management skills for co-occurring chronic conditions, smoking cessation, weight management, and other health issues commonly encountered by people with SMI, as well as more traditional peer support services. State policymakers report that uptake of the service varies across CCOs. Identification of procedure codes for providers to use in billing was an initial barrier, and much work remains in developing the peer workforce and educating providers on the “value-add” of these new health care workers.

**Table 2. Summary of Integrated Peer Support Programs**

| State | Federal Authority & Reimbursement Strategy  | Setting                                | Training   | Key Services that Support Integration   |
|-------|---|--|--|---|
| GA    | <p>Rehabilitative services option</p> <p>Fee for service; range from \$18.15 to \$36.65 per 15 minute unit</p>  | Community mental health centers, other | Community mental health centers, other   | <ul style="list-style-type: none"> <li>• Building skills that enable health improvements</li> <li>• Providing health support and coaching interventions</li> <li>• Promoting discussion about health issues to support self-advocacy and early intervention</li> <li>• Promoting effective wellness self-management skills</li> <li>• Helping individuals set wellness goals and providing ongoing support</li> </ul> |
| OR    | <p>1115 waiver</p> <p>Payment included in capitation payment to CCO; average payments vary depending on CCO and member eligibility category, with weighted averages generally between \$322.00 and \$460.00 PMPM for 2015.<sup>21</sup></p> | Community mental health centers, other | Two-week (80 hour) core competency training that includes chronic disease management, health promotion, health literacy.   | <ul style="list-style-type: none"> <li>• Community outreach</li> <li>• Assisting with access to available services</li> <li>• Addressing barriers to services</li> <li>• Providing education and information about available resources and mental health issues</li> <li>• Provide direct services to assist in creating and maintaining recovery, health and wellness.</li> </ul>                                    |
| KS    | <p>2703 Health Homes</p> <p>Per member per month payment includes peers as part of the health home team; payment range from \$117.21 to \$327.48.<sup>22</sup></p>  | Behavioral health homes                | Five-day training that includes recovery, establishing healing relationships, and the role of trauma. Curriculum may be reviewed to incorporate health home role and responsibilities. | <ul style="list-style-type: none"> <li>• Identifying supports needed to manage conditions;</li> <li>• Assisting individual with access to services;</li> <li>• Identifying barriers</li> <li>• Locating resources</li> <li>• Advocating on behalf of individual to ensure that they have supports necessary for improved health.</li> </ul>   |



## Including Peer Supports as Part of a Health Home: Kansas Health Homes for Individuals with Serious Mental Illness

Kansas, through its Medicaid organization KanCare, received approval for its Health Home for Individuals with Serious Mental Illness in 2014. KanCare partners with three Medicaid managed care organizations that serve as the lead entities in managing and delivering health home services. These lead entities in turn partner with community providers, such as mental health agencies, to provide comprehensive health home services. Beginning June 30, 2016, certified peer support specialists will be required members of the team for health homes serving people with SMI and reimbursed as part of the team-based model. Peer support specialists deliver individual and family support, one of the five core services required as part of the health home. Kansas is building on its existing peer support training and workforce infrastructure, overseen by Wichita State University. Plans are underway to review and potentially modify this training in preparation for new service requirements under health homes. Measures that will be used to evaluate the success of the Kansas Health Home for Individuals with Serious Mental Illness include HbA1C testing, LDL-C screening, body mass index (BMI), tobacco use, and similar measures that target the integrated nature of the service.

## Key Questions for State Policymakers

Medicaid and mental health policymakers who are exploring peer support services as a tool to better integrate behavioral and physical health for individuals with SMI may find it helpful to consider the following key questions:

### 1. Are Critical Partners & Stakeholders at the Table?

State policymakers interviewed for this brief noted the importance of working across state agencies and with stakeholders in the development of peer support services generally, and integrated peer supports in particular. States that have successfully implemented these programs did so

through close collaboration across mental health and Medicaid agencies. Early outreach and engagement with stakeholders was also important. In Georgia, for instance, advocates and consumer groups were engaged very early on to develop service definitions and training curricula; this foundational work was cited as a key ingredient in the success of that state's program.

### 2. Is There Already an Existing Peer Support Infrastructure?

Most states already fund peer supports through a variety of Medicaid authorities. States that fund peer supports have laid the groundwork in describing the service, determining training and supervision needs, and developing the workforce to deliver peer supports. Georgia, as mentioned, has funded peer support services as part of its fee-for-service Medicaid program for over a decade; building on its well-developed peer workforce to improve health outcomes was a natural next step. Kansas was able to leverage an established core curriculum and training infrastructure to support its new health home model. States can look to their peer support infrastructure to enhance physical and behavioral health integration by augmenting training, broadening the service definition, and making incremental changes to include a health and wellness focus.

### 3. Where Are the Opportunities Within the Current System?

Peers, as an emerging workforce, can be deployed in a variety of integrated service delivery models and approaches. States are using peers to provide services within FQHCs, as part of the health home model, and in community mental health centers. The role of peers – including their training, supervision, and service modality – is flexible and can be aligned with specific state service delivery needs. In Oregon, peer wellness specialists are being used in diverse settings to target key health concerns for the SMI population, such as smoking and obesity. Georgia has embedded peers throughout its mental health system, including in crisis services and on Assertive Community Treatment teams, to improve care and expand access.

#### 4. Does Your State have Behavioral Health Workforce Challenges?

Peer support providers in both mental health and integrated care settings provide states with the opportunity to expand mental health workforce capacity, a critical issue in many state mental health systems.<sup>23</sup> State policymakers note that the use of peers in community mental health has allowed them to expand the mental health workforce at a relatively low cost in comparison to licensed clinical staff.

#### 5. How Will You Know It Is Adding Value?

Evidence in support of peer services in integrated care is still emerging, and may be difficult to apply broadly given variations in setting, service definition, and target population. Early state leaders in this area, such as Georgia, have documented the value of peer supports through the state's own evaluation efforts: that research supports robust savings in Georgia in the transition from a traditional day treatment model to peer supports. State policymakers that want to understand how the service helps them reach their state's goals may want to include evaluation on both cost and quality as part of their state planning and design.

#### 6. Is Your Primary Care System Ready?

While peer supports can serve an important role in helping people with SMI better manage their health, state Medicaid and mental health policymakers report that additional training, and a better understanding of the value that peer support specialists bring to integrated care, is needed in order to more fully utilize these services as part of an integrated approach. Georgia has included a nurse in its Whole Health and Wellness service structure to enhance its integration capacity; In Kansas, certified peer specialists are members of a multi-disciplinary team, including primary care providers, using the health home model. For adults with serious mental illness, these efforts represent significant strides in the integration of physical and behavioral health care. However, fully engaging primary care to leverage this new workforce may take additional education and incentives.

## Conclusion

States are keenly interested in supporting the integration of physical and behavioral health: for individuals with serious mental illness who often have multiple chronic disorders, better integration of care could provide both cost savings and improved health outcomes. Peer support specialists have gained widespread acceptance in state mental health systems and now deliver Medicaid-billable services and supports in a majority of states. As states look for additional levers and potential resources to integrate care for this often under-served population, peers may be an option that is readily accessible, less costly, and specifically trained to work effectively with people who have significant mental health issues. While work needs to be done to more fully define how peers can operate within integrated care systems, a growing number of states are finding value in this emerging model.

## Appendix A – State Contact Information

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## Endnotes:

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