

Recommendations for Implementing Mental Health Recovery through Medicaid Reform

**Presented to Cindy Mann
Director of the Center for Medicaid and State Operations (CMSO)**

**By the National Coalition of Mental Health Consumer/Survivors
Organizations - November 3, 2009**

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Twenty-six states presently employ mental health peer specialists to coach people in their recovery from severe mental health issues and their wellbeing. This use of peers is in keeping with the recommendations of the President's New Freedom Commission on Mental Health (2003). Many of these peers are underutilized and frustrated, however, by being expected to work within a limited set of clinical parameters. Their expertise could more effectively be utilized by assisting persons with mental illness to become more engaged in the wellness aspects of recovery and by becoming more integrated in the community.

Recommendation A. We request the following five points related to Peer Support be contained in a letter from the CMSO and to the Regional and State Medicaid Directors.

We propose that the CMSO office send a letter to the Regional and State Medicaid Directors highlighting ways that state level changes in Medicaid policies, which are allowable under Federal Medicaid policies, could enable peers and other mental health workers to be reimbursable in the provision of cost-effective recovery-oriented services. These changes would enable more peers to be employed, which would both decrease the number of consumers on Medicaid and Social Security, and decrease the use of more costly clinical services such as hospitalization and nursing homes. It is likely it would also decrease the use of costly medications, because when people are heard, validated, and engaged in working on their own goals, their need for medication decreases. CMS, in collaboration with SAMHSA, could provide funding for national consumer organizations to provide technical assistance to state peer-run organizations to carry this out these modifications.

A 1. Supervision of Peers. Please revise the language of the August, 2007 CMS letter to state Medicaid Directors, which specified that "mental health professionals should supervise peer specialists, " to read as the Pennsylvania Medicaid office is using: " Peer specialists can be supervised by either a mental health professional **or** a person with a bachelor's degree and 2 years of direct care as a peer and/or mental health worker or a person with a high school diploma

or general equivalency degree and four years of mental health direct care experience, which may include experience in peer support services" (see appendix 1 for description of requirements of supervisors in PA for Medicaid reimbursable services).

A 2. Medicaid should reimburse peers to work in a variety of roles. these include Personal Care Attendants (PCAs) in mental health, peer bridgers in inpatient settings, members of crisis teams, and wellbeing coaches in addition to the role of Certified Peer Specialist. Most states incorrectly limit the use of PCAs for assisting persons with mental health needs, by saying that persons with psychiatric disabilities do not need assistance with ADLs. However, most persons with psychiatric disabilities need assistance in the area of instrumental ADLs or iADLs to facilitate their recovery and those are Medicaid reimbursable services. The Oregon State Medicaid Office has developed a set of policies for carrying out this role of peers as PCAs in mental health.

A 3. Self-determination Care Accounts. Peers can be optimally hired when consumers are able to set up a self-determination care account, as done in Florida. The consumer works out a life recovery plan with their recovery broker. The life plan is based on their own dreams and goals. Having such a plan enables the consumer to prioritize their expenditures and set up their own budget. The consumer then has greater control over their allocated dollars and has an expanded choice of services. Some of these services may be provided by peers, while other services are provided by clinical staff.

A 4. Expand medical necessity to include community integration. Peers can be more widely employed in mental health if all the states would follow the lead of the Michigan Medicaid Department and expand the definition of medical necessity to include community integration. In addition, the Pennsylvania Medicaid Department has expanded medical necessity to facilitate the reimbursement of peer delivered services.

A 5. Peers should be centrally involved in the evaluation of services. Three states, Massachusetts, Pennsylvania, and Michigan, use peers to administer, analyze, and report the results of consumer-directed evaluations. These evaluations measure the degree to which providers inspire hope, facilitate empowerment, and promote recovery among those receiving services. CMS and Joint Accreditation themselves could utilize peers in their direct audit of mental health facilities.

Recommendation B. Ensure significant participation by mental health peers on the state Medicaid Advisory Councils.

Code of Federal Regulations 42, Section 431.12 requires that states form committees to advise Medicaid agencies. Those committees must include recipients of services and they must provide financial arrangements, if necessary, to make recipient participation possible. Yet these councils rarely include mental health peers, and when they do the councils rarely have influence on state Medicaid Policy decisions.

We recommend this regulation be expanded to state that at least two representatives from each major disability group be on the MAC. These representatives need to represent a large proportion

of the persons with the disability, and themselves have the disability of the group they represent. They need not however, presently be Medicaid recipients. The representatives from the disability groups need to be informed of the appropriate Federal and State Medicaid regulations by consumer-run Technical Assistance Centers (TACs). The participants' transportation and time should be covered by the State Medicaid Office.

Appendices and References

Appendix 1: The basics of Certified Peer Specialist (CPS) supervision in Pennsylvania

Standards for supervision are laid out in the Pennsylvania Provider Handbook Pages for Psychiatric and Partial Hospitalization Services: Section VII—Other Services.

All CPS supervisors (in a Medicaid-billable peer support program) must complete a two-day supervisory training within six months of assuming the supervisory role.

"A supervisor of peer specialists is either a mental health professional who has completed the peer specialist supervisory training, which is offered in accordance with guidelines defined by the Department, or an individual who has the following minimum qualifications:

- (i) A bachelor's degree; and
- (ii) Two years of mental health direct care experience, which may include experience in peer support services;

OR

- (i) A high school diploma or general equivalency degree; and
- (ii) Four years of mental health direct care experience, which may include experience in peer support services, and the completion of a peer specialist supervisory training curriculum approved by the Department within 6 months of assuming the position of peer support supervisor."

Reference:

Pennsylvania Medical Assistance Handbook, Psychiatric Services, May 2007

Appendix 2: Peer Personal Care Attendants in Mental Health in Oregon

Types services carried out by PCAs approved by Oregon Medicaid under the category of instrumental ADLs (the person with mental health issues is the employer):

- Assist employer with housing cleaning and organizing clutter.
- Support employer to learn city bus system.
- Assist employer to learn healthy meal planning.
- Assist with medication management.
- Arrange necessary medical appointments as directed by the employer.
- Help employer minimize isolation by helping employer locate social opportunities that are inexpensive and accessible.
- Help employer calm down during anxiety attacks using techniques the employer has taught the employee.

Reference:

"Recovery through 20 Hours of Personal Care Services: A Guide for Consumers, Case Managers, and Personal Care Assistants," 2006, Oregon Department of Social Services.

Appendix 3: Florida Self-directed Care Model

Outcome studies comparing self-directed care with traditional, professionally directed care are very positive.

References:

Haines, S. LMHC, Spaulding-Givens, J. MSW (2007). *The Philosophy, Principles, and Practice of Florida Self-Directed Care and Recovery Coaches*. Florida Department of Children & Families, Substance Abuse & Mental Health Program Office.

Hall, R. Ph.D. (2007). *Report on the Effectiveness of the Self-Directed Care Community Mental Health Treatment Program*. Florida Department of Children & Families, Substance Abuse & Mental Health Program Office.

Appendix 4: Medical Necessity Criteria

The *Michigan Medicaid Provider Manual*, "Mental Health and Substance Abuse" chapter:

"Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

**Required to identify and evaluate a mental illness, developmental disability, or substance abuse disorder that is inferred or suspected; and/or

**Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability, or substance abuse including impairment in functioning; and/or

**Expected to arrest or delay the progression of a mental illness, developmental disability, or substance abuse disorder; and/or

**Designed to assist the consumer to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity."

Appendix 5: Peers working as evaluators

1. In Massachusetts, peers work for a peer-run, Medicaid-funded nonprofit, Consumer Quality Initiatives (CQI), through which peers assess quality of services, and share the results with decision makers (www.cqi-mass.org/index.php4).

2. In Pennsylvania, peer-run, county-funded evaluation teams survey services using an instrument called the Recovery Oriented Services Inventory (ROSI). The state compares the results from each of the counties to determine the degree to which their services are implementing recovery.

Appendix 6: Ensuring a significant number of peers are on the State Medicaid Advisory Councils

Presently, Code of Federal Regulations 42, Section 431.12 requires that states form committees to advise Medicaid agencies, and those committees should include recipients of services.