

**NASMHPD**

**National Association of State Mental Health Program Directors**  
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**Alexandria, Virginia 22314**

## **Assessment #8**

# **Older Adults Peer Support: Finding a Source for Funding**

**August 2017**

**Alexandria, Virginia**

Sixth in a Series of Ten Briefs Addressing: *What Is the Inpatient Bed Need if You  
Have a Best Practice Continuum of Care?*

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# Older Adults Peer Support: Finding a Funding Source

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## Executive Summary

An evidence-based practice important in reducing re-hospitalizations generally and re-hospitalization in inpatient psychiatric and residential substance use treatment facilities specifically is the use of peer support services. Established in the public mental health system and now moving into the private sector, peer support services are behavioral health model of care which consists of a qualified peer support provider with his or her own “lived experience” assisting individuals with their recovery from mental illness or substance use disorders. The Substance Abuse and Mental Health Services Administration (SAMHSA), which considers peer support an evidence-based practice, [defines](#) a “peer provider” 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. 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.

With peer support available in all 50 states and Medicaid-reimbursable in 43 states and the District of Columbia, research that began in New Zealand and has continued in the United States has found that peer support services:

- address mental health symptoms and reduce hospitalizations, the durations of hospital stays, and re-hospitalizations;
- increase adherence to treatment and satisfaction with services and providers, leading to a reduction in the costs of services;
- reduce perceptions of stigma which often accompany mental illness and substance use disorders;
- increase feelings of autonomy, thereby improving well-being, self-esteem, and self-determination;
- improve social functioning, which leads to expanded social networks and participation in the community; and
- facilitate more thorough and longer-lasting recoveries.<sup>1</sup>

In addition to improving the condition of the individual receiving the peer support services, peer support improves the self-esteem and confidence of the person in recovery providing the service.

While a 2007 Centers for Medicare and Medicaid Services (CMMS) State Medicaid Director Letter<sup>2</sup> authorized the offering of, and reimbursement for, peer support services under Medicaid as a component of a comprehensive mental health and substance use service delivery system, similar authorization has not been provided under Medicare. The latter program is perceived as more of a Medical program, using medical necessity standards for services, and only recently has begun to reimburse for community-based services under various demonstration pilots. As a result, unless an

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<sup>1</sup> Briscoe J., Orwin D., Ashton L., & Burdett J., Being there: A peer support service for older adults with mental illness, Health Research Council of New Zealand (2005); Campbell J. & Leaver J., Emerging new practices in organized peer support. Report from NTAC’s National Experts Meeting on Emerging New Practices in Organized Peer Support (pp. 17-18) (2003); Davidson L., Chinman M., Kloos B., Weingarten R., Stayner D., & Tebes J. K., Peer support among individuals with severe mental illness: A review of the evidence, *Journal of Clinical Psychology: Science and Practice* 6(2), 165-187 (1999); Salzer M.S. & Shear S.L., Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal* 25(3), 281(2002); and Solomon P., Peer support/peer provided services underlying processes, benefits, and critical ingredients, *Psychiatric Rehabilitation Journal*, 27(4), 392 (2004).

<sup>2</sup> State Medicaid Director Letter #07-011, Center for Medicaid and State Operations, August 15, 2007.

older adult covered by Medicare who is receiving peer support services is also covered by Medicaid as well as a “dual eligible,” peer support services for that individual are not reimbursable.

This lack of funding led the National Association of State Mental Health Program Directors (NASMHPD) to pull together more than three dozen experts from the Medicaid and Medicare programs, the Center for Medicare and Medicaid Innovation (CMMI), the Administration for Community Living, behavioral health and Medicare Special Needs Plan (SNP) insurers, provider associations, the National Association of Medicaid Directors (NASMHPD), the National Association of Medicaid Directors (NAMMD), National Association of States United for Aging and Disabilities (NASUAD), State Mental Health Agencies, and peer support specialist programs and agencies for a four-hour roundtable to discuss potential funding streams and strategies that could lead to capturing those funding streams to support Older Adult Peer Support Programs.<sup>3</sup> The roundtable was co-moderated by the co-author of this report, Dr. Cynthia Zubritsky, director of the Certified Older Adult Peer Specialists (COAPS) program run out of the Perelman School of Medicine at the University of Pennsylvania and by NASMHPD staff.

Roundtable participants reached a consensus that funding is unlikely to ever be readily available under the Medicare Part B fee-for-service program, so much of the discussion centered on potential funding sources, and existing barriers to capturing those sources, within Medicare Advantage (MA) managed care. Potential approaches considered by the group included covering older adult peer support as a service provided: (1) under a Dual Eligible Financial Alignment pilot; (2) under a CMMI demonstration; (3) as part of the Medicare Collaborative Care pilot model; or (4) as an MA supplemental service provided with plan “rebate savings,” either within a traditional MA plan or within Dual-SNP (D-SNP) or Chronic Condition-SNP (C-SNP) Special Needs Plans. Another potential avenue discussed was to cover the cost of older adult peer support services as a staff cost under a Medicare-participating hospital’s person-centered care program, to ensure that a hospital’s patients transition smoothly into the community upon release and avoid re-hospitalization.

The Roundtable participants concluded that the approach most likely to succeed would be through one of the integrated care initiatives, whether under a demonstration project or an existing Medicare Advantage managed care or Special Needs Plan

Whatever approach or approaches are taken, the roundtable participants all agreed that any advocacy focused on achieving full Medicare funding would require a massive education effort by a broad coalition of organizations, and that the education effort would need to include supportive data showing quantifiable positive patient and program outcomes through the use of evidence-based practices.

## Introduction

An evidence-based practice important in reducing re-hospitalizations generally and re-hospitalization in inpatient psychiatric and residential substance use treatment facilities specifically is the use of peer support services. Established in the public mental health system and now moving into the private sector, peer support services are a behavioral health model of care which consists of a qualified peer support provider with his or her own “lived experience” assisting individuals with their recovery from mental illness or substance use disorders.

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<sup>3</sup> See Appendix A - April 10, 2017 Senior Peer Support Roundtable Attendees.

Research initially in New Zealand and subsequently in the United States has found that peer support services:

- Address mental health symptoms and reduce hospitalizations, the durations of hospital stays, and re-hospitalizations;
- Increase adherence to treatment and satisfaction with services and providers, leading to a reduction in the costs of services;
- Reduce perceptions of stigma which often accompany mental illness and substance use disorders;
- Increase feelings of autonomy, thereby improving well-being, self-esteem, and self-determination;
- Improve social functioning, which leads to expanded social networks and participation in the community; and
- Encourage more thorough and longer-lasting recoveries.<sup>4</sup>

Since August 2007,<sup>5</sup> the Centers for Medicare and Medicaid Services has recognized peer support services for individuals with mental illness and substance use, performed by a certified peer support specialist, to be a Medicaid-reimbursable service. As a result, Medicaid programs in 43 states and in the District of Columbia are reimbursing for those services, either as part of a bundled service package or as a stand-alone service.

In contrast, the Medicare program does not reimburse for services provided by certified peer support specialists, despite pilot programs showing that peer support helps with transitions from institutional care to the community, and reduces re-hospitalizations. Unless a Medicare beneficiary—either an older adult or an individual with a disability—is dually eligible for the Medicaid program as well as Medicare, there is little government funding to help him or her achieve recovery and avoid hospitalization or re-hospitalization.

The National Association of State Mental Health Program Directors called together more than three dozen experts from the Medicaid and Medicare programs, the Center for Medicare and Medicaid Innovation (CMCS), the Administration for Community Living (ACL), behavioral health and Medicare Special Needs Plan (SNP) insurers, provider associations, the National Association of Medicaid Directors (NASMHPD), the National Association of Medicaid Directors (NAMD), National Association of States United for Aging and Disabilities (NASUAD), State Mental Health Agencies, and peer support specialist programs and agencies for a four-hour roundtable to discuss what barriers exist to Medicare funding and what strategies might be undertaken to capture Medicare as a funding source for peer support services.

This paper reports on those discussions and outlines what strategies might help achieve greater access to peer support services for Medicare beneficiaries.

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<sup>4</sup> Briscoe J., Orwin D., Ashton L., & Burdett J., Being there: A peer support service for older adults with mental illness, Health Research Council of New Zealand (2005); Campbell J. & Leaver J., Emerging new practices in organized peer support. Report from NTAC's National Experts Meeting on Emerging New Practices in Organized Peer Support (pp. 17-18) (2003); Davidson L., Chinman M., Kloos B., Weingarten R., Stayner D., & Tebes J. K., Peer support among individuals with severe mental illness: A review of the evidence, *Journal of Clinical Psychology: Science and Practice* 6(2), 165-187 (1999); Salzer M.S. & Shear S.L., Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal* 25(3), 281(2002); and Solomon P., Peer support/peer provided services underlying processes, benefits, and critical ingredients, *Psychiatric Rehabilitation Journal*, 27(4), 392 (2004).

<sup>5</sup> State Medicaid Director Letter #07-011, Center for Medicaid and State Operations, August 15, 2007.

## What Peer Support Has Achieved without Medicare Funding

Peer support is an evidence-based practice, [defined](#) by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a “peer provider” using 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. 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.

CMCS recognized the value of peer support services in an August 15, 2007, State Medicaid Director Letter which stated that the agency recognized

*that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. ...*

*... Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State’s delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services.<sup>6</sup>*

In that State Medicaid Director Letter, CMS said states could choose to deliver peer support services directly to Medicaid beneficiaries with mental illness or substance use disorders under three provisions of the Social Security Act: § 1905(a)(13), § 1915(b) waiver authority, and § 1915(c) waiver authority. The agency said states must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. It required that states applying to cover peer services specifically describe reimbursement methodologies and utilization review. Reimbursement had to be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States would have to provide an assurance that there were mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

The 2007 SMDL required that peer support providers be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Additionally, peer support providers had to be sufficiently trained to deliver services. Supervision by a competent mental health provider acting within his or her scope of practice and care coordination would have to be core components of peer support services.

The amount, duration and scope of supervision would be expected to vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider and the service mix, and could range from direct oversight to periodic care consultation. As to care coordination, peer support services would have to be coordinated within the context of a

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<sup>6</sup> *Ibid.*

comprehensive, individualized plan of care that includes specific individualized goals. States would be expected to use a person-centered planning process to help promote participant ownership of the plan of care and actively engage and empower the participant and individuals selected by the participant, in leading and directing the design of a service plan that reflects the needs and preferences of the participant in achieving specific, individualized goals that have measurable results.

Finally a state would be expected to ensure that peer support providers complete training in the basic set of competencies necessary to perform the peer support function and that they obtain certification defined by the state. In addition, similar to other provider types, ongoing continuing educational requirements for peer support providers would have to be in place.

By July 2016, 41 states and the District of Columbia had established programs to train and certify peer specialists and two other states were in the process of developing and/or implementing a certification program.<sup>7</sup> As of July 2016, 42 state Medicaid programs and the District of Columbia Medicaid program were reimbursing for peer support services, and since that time an additional state, Arkansas, has been added to the list.<sup>8 9</sup> That reimbursement takes many forms, with some states reimbursing under the Medicaid rehabilitation option, some states reimbursing services on a stand-alone basis, a few states reimbursing in a bundled rate for Assertive Community Treatment Teams, and a number of states reimbursing through the capitated rates paid managed care organizations that include the services in their benefit structure.

Where state Medicaid programs were reimbursing on a stand-alone basis, rates in July 2016 ranged for a 15-minute session range from less than \$6 to almost \$30, depending on the population being served and whether or not the peer support was in an individual or group setting. The average wage appeared to be about \$20 per quarter-hour, although a January 2016 wage survey of peer support specialists in all 50 states found that the average quarter-hourly wage rate earned by those surveyed was about \$15.42.<sup>10</sup> The significant difference in those numbers may reflect the overhead margins of the organizations employing individual peer specialists, which included community behavioral health organizations, consumer/peer-run organizations, health care providers, psychiatric inpatient facilities, and managed care organizations/health plans. It is also unknown how many of the peer specialists surveyed worked within the provider network of the state's Medicaid program and how many received reimbursement from private payers.

States most often used the Healthcare Common Procedure Coding System (HCPCS) code H0038, with its various modifiers, to bill for stand-alone peer support services.<sup>11</sup>

Are the expenditures worth it? In New York State, UnitedHealth Care's Optum Behavioral Health subsidiary found a 71 percent reduction in hospitalizations among its 229 older adult members receiving peer support services in 2009 through its Peer Bridger Project, according to former Optum National Vice President of Consumer and Family Affairs for Government Programs, Sue Bergeson.<sup>12</sup>

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<sup>7</sup> *Ibid.*

<sup>8</sup> Kaufman L., Kuhn WB and Manser SS, Peer Specialist Training and Certification Programs: National Overview, Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin, January 2017,

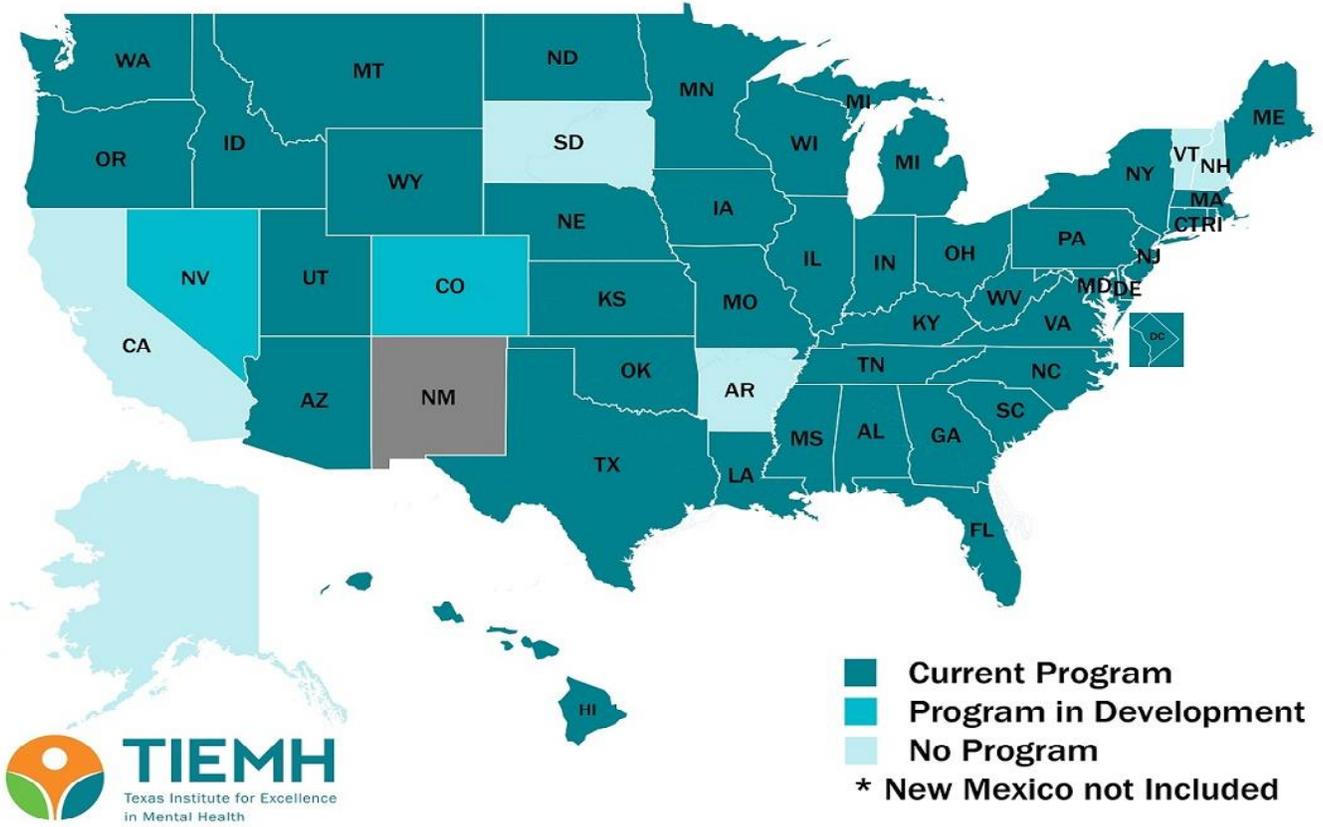
<sup>9</sup> The exceptions were Alabama, Arkansas, Maryland, Nebraska, New Hampshire, North Dakota, Rhode Island. At the time the states were surveyed, Arkansas had proposed a State Plan amendment under § 1915(i) to provide coverage, and now reimburses for "Family Support Partners."

<sup>10</sup> National Survey of Compensation Among Peer Support Specialists, Daniels A.S., Ashenden P., Goodale L., Stevens T., The College for Behavioral Health Leadership, [www.leaders4health.org](http://www.leaders4health.org), January 2016.

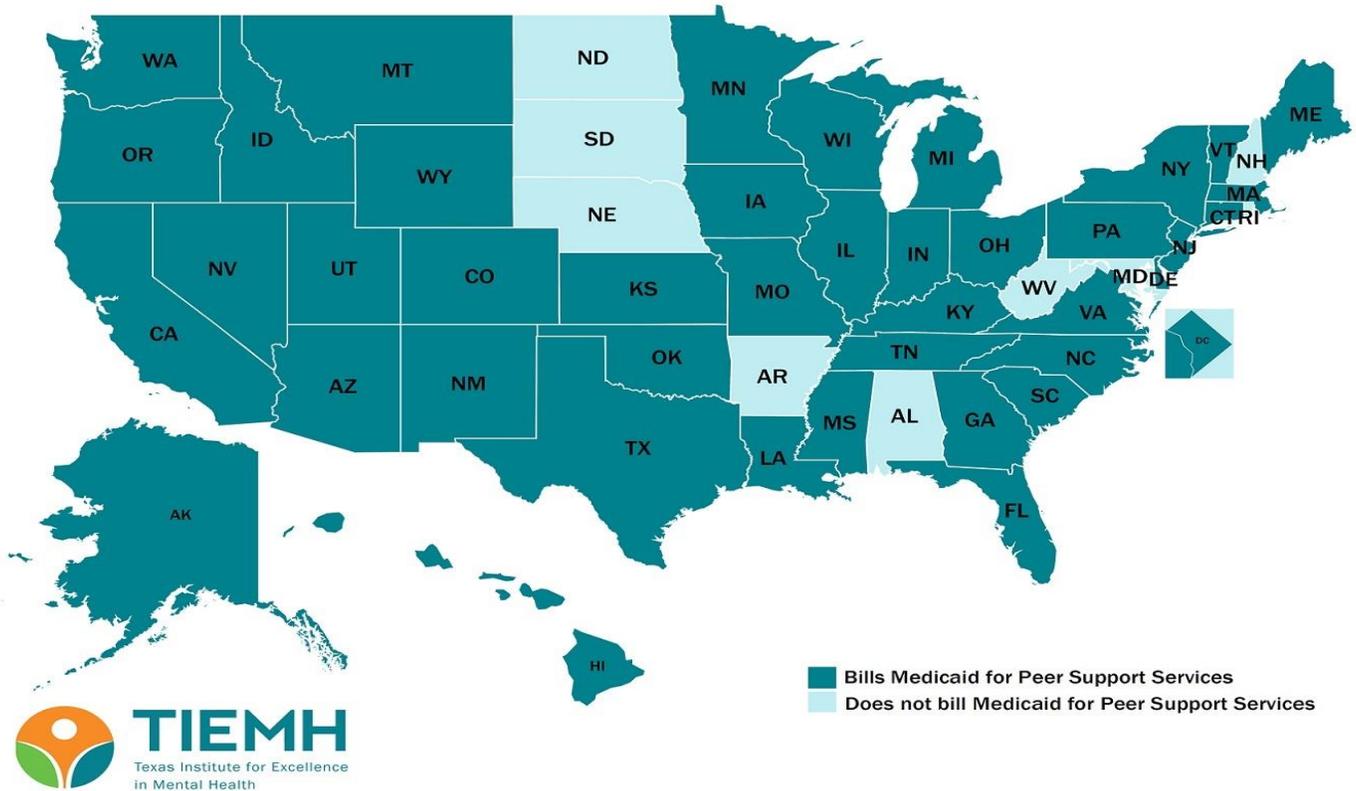
<sup>11</sup> Kaufman.

<sup>12</sup> Comments at April 10, 2017 NASMHPD-Sponsored Roundtable on Behavioral Health Peer Support for Older Adults.

## Map of Peer Specialist Training & Certification Programs by State



## Medicaid Reimbursement for Peer Services



Georgia Medicaid was the first state Medicaid program to cover peer support services in its Medicaid program, beginning in 2001. It now wraps its Medicaid coverage around private plan coverage and Medicare coverage in providing whole health peer support. A program evaluation conducted by the state's Department of Behavioral Health and Developmental Disabilities found not only positive outcomes for beneficiaries receiving peer support services, but also annual savings of \$5,494 per person in the first three years of a program where peer support was substituted for participation in a day treatment program.<sup>13</sup> A second study found that using certified peer specialists produced 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 – producing the aforementioned savings of \$5,494 per person.<sup>14</sup>

## What is the Need for Older Adult Peer Support Services?

Over 20 percent of older adults (up to 37 percent in community primary care settings), experience depression, and approximately 14 percent have anxiety disorders.<sup>15</sup> Depression is common among individuals receiving long-term care services in all service types; ranging from 22 percent of hospice patients to 48.5 percent of nursing home residents.<sup>16</sup> The number of older adults with behavioral health disorders may actually be higher, as older adults are less likely than younger persons to either report having mental health problems or to seek specialty mental health services.<sup>17</sup> The combination of high rates of chronic disease and co-occurring behavioral health disorders in older adults adversely affects their health, thereby reducing functioning, increasing physical health symptomatology, inhibiting treatment effects, and increasing treatment costs.<sup>18</sup>

Research has demonstrated that rates of incident depression can be reduced by 20 percent to 25 percent over 1 to 2 years through the use of psychoeducational and psychological interventions designed to increase protective factors.<sup>19</sup>

The treatment gap for people with mental disorders has been extensively documented, especially in long term care services, where close to 90 percent of people with mental disorders do not receive cost-effective treatment.<sup>20</sup> The increasing scarcity of mental health specialists—particularly those professionals qualifying as authorized providers under the Medicare program—and the inequity of the distribution in these specialists are major barriers to closing the behavioral health treatment gap.<sup>21</sup> The existence of this treatment gap and the attendant workforce issues underscore the need

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<sup>13</sup> Bachrach D., *et.al.*, [Issue Brief: Medicaid Coverage of Social Interventions: A Road Map for States](#), Milbank Memorial Fund (July 2016).

<sup>14</sup> Purington K., [Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness](#), National Academy for State Health Policy (NASHP) (January 2016).

<sup>15</sup> *Older Adults*, Administration on Aging (AoA). (2013). Retrieved from [http://www.acl.gov/Get\\_Help/Help\\_Older\\_Adults/Index.aspx](http://www.acl.gov/Get_Help/Help_Older_Adults/Index.aspx).

<sup>16</sup> *Long-Term Care Services in the United States: 2013 Overview*, Centers for Disease Control & Prevention (CDC). (2013). Retrieved from [http://www.cdc.gov/nchs/data/nsitcp/long\\_term\\_care\\_services\\_2013.pdf](http://www.cdc.gov/nchs/data/nsitcp/long_term_care_services_2013.pdf).

<sup>17</sup> Mickus M., Colenda CC & Hogan AJ, Knowledge of mental health benefits and preferences for type of mental health providers among the general public, *Psychiatric Services*, 51, 199-202 (2000).

<sup>18</sup> *Ibid.*

<sup>19</sup> Reynolds III C.F., Cuijpers P., Patel V., Cohen A., Dias A., Chowdhary N. & Lotrich F., Early intervention to reduce the global health and economic burden of major depression in older adults, *Annual Review of Public Health*, 33, 123 (2012).

<sup>20</sup> Patel V., Weiss H. A., Chowdhary N., Naik S., Pednekar S., Chatterjee S. & Simon G., The effectiveness of a lay health worker led intervention for depressive and anxiety disorders in primary care: the MANAS cluster randomized trial in Goa, India. *Lancet*, 376(9758), 2086 (London 2010).

<sup>21</sup> Patel *et al.*; Keehan S. P., Poisal J. A., Cuckler G. A., Sisko A. M., Smith S. D., Madison A. J. & Lizonitz J.

for developing effective models of depression treatment and prevention that can be implemented by health workers who have shorter training and fewer qualifications, in order to make more efficient use of the available human resources.<sup>22</sup> The geriatric mental health workforce shortage drives the imperative for devising effective, scalable, depression-prevention models that can be implemented by general medical counselors, lay community health workers, and peer specialists.<sup>23</sup>

## Medicare Spending and Service Utilization to Grow Exponentially with Aging of Baby Boomers

Medicare spending and service utilization is projected to increase as baby-boomers qualify for Medicare services.<sup>24</sup> In 2008, 67 percent had multiple morbidities (two or more chronic conditions), and the prevalence of multiple chronic conditions increased with age.<sup>25</sup> Medicare beneficiaries who have five or more chronic conditions generate two-thirds of all Medicare spending, and those with four or more chronic conditions account for 80 percent of Medicare spending.<sup>26</sup>

Many older adults live in rural counties where even primary care physicians are in short supply. This limited access to mental health services for older Americans both in the community and in long-term services and supports (LTSS), increases placement in nursing facilities.<sup>27</sup>

These inter-relationships between multiple chronic conditions, health care utilization access and outcomes and health care costs (including medication costs and out-of-pocket costs) for older adult populations are troubling and must be addressed as the aging population increases in number.

## What are the Issues Preventing Medicare Financing?

The Certified Older Adult Peer Specialists (COAPS) Program—operated since 2008 out of the Center for Mental Health Policy & Services Research Center at the University of Pennsylvania Perelman School of Medicine Department of Psychiatry—had, by 2017, trained more than 350 certified older adult (age 50-plus) peer specialists in six states—Pennsylvania, New Jersey, Massachusetts, Oregon, Delaware, and Rhode Island. COAPS peer support workers, in addition to receiving training for certification, complete a three-day, 18-hour COAPS training.

COAPS peer support workers provide services in a variety of settings, including Federally Qualified Health Centers, state hospitals, psychiatric rehabilitation providers, inpatient psychiatric

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M., National Health Expenditure Projections, 2015–25: Economy, Prices, And Aging Expected To Shape Spending And Enrollment, *Health Affairs*, 10-1377 (2016); Committee on the Future Health Care Workforce for Older Americans, Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*. National Academies Press (2008). Retrieved from [http://www.nap.edu/catalog.php?record\\_id=12089](http://www.nap.edu/catalog.php?record_id=12089).

<sup>22</sup> Araya R., Flynn T., Rojas G., Fritsch R. & Simon G.. Cost-effectiveness of a primary care treatment program for depression in low-income women in Santiago, Chile, *American Journal of Psychiatry* (2006); Petersen I., Lund C., Bhana A. & Flisher A. J., A task shifting approach to primary mental health care for adults in South Africa: human resource requirements and costs for rural settings, *Health Policy and Planning*, 27(1), 42-51 (2012).

<sup>23</sup> Patel *et al.*

<sup>24</sup> Keehan *et al.*

<sup>25</sup> Salive M. E., Multimorbidity in older adults, *Epidemiologic Reviews* 35 (1): 75-83 (2013). Retrieved from <http://epirev.oxfordjournals.org/content/early/2013/01/30/epirev.mxs009.short>.

<sup>26</sup> Wolff J.L., Starfield B., Anderson G., Prevalence, expenditures, and complications of multiple chronic conditions in the elderly, *Arch Intern Med* 162:2269–2276 (2002).

<sup>27</sup> *Mental Health: A Report of the Surgeon General*, Substance Abuse and Mental Health Services Administration, National Institutes of Mental Health, National Institute of Health, U.S. Department of Health and Human Services (Rockville, MD 1999).

services, senior centers, and mental health drop-in centers, and as members of Assertive Community Treatment (ACT) and Intensive Case Management teams.

The COAPS Training Curriculum consists of:

#### Working with Older Adults (Day 1)

- Older adult demographics
- Normal aging – what does it mean to get older, what are the health issues, what are the independence issues, what are the transportation issues
- Special considerations when working with older adults – dementia, legal issues, power of attorney
- Culture and older adults

#### Clinical Issues for Older Adults (Day 2)

- Depression
- Anxiety
- Substance use disorders – Particularly important for older adults who are on painkillers.
- Trauma
- Suicide

#### Implementation (Day 3) - Interventions

- Stages of change and motivational interviewing
- Recovery and older adults
- Introduction to positive psychology
- Working with local behavioral health, health, and aging systems to learn how to access services such as Meals on Wheels or depression groups.
- Group activity

The COAPS Program has obtained funding for its training and work from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association for State Mental Health Program Directors (NASMHPD) through the SAMHSA Transformation Transfer Initiative competitive grant program. In addition, COAPS has received funding from the Pennsylvania Office of Mental Health and Substance Abuse and the Pennsylvania Behavioral Health and Aging Coalition. And the Pennsylvania Department of Aging has supported COAPS through planning and collaborative efforts and some funding.

All training and internships are evaluated. A 2016 survey of working COAPS (about 75 individuals) was conducted. Depression and substance use outcomes were measured for a COAPS wellness group of about 15 individuals in a 200-resident Housing and Urban Development-funded senior high-rise apartment. The results showed symptoms improved across the group. The study also looked at community integration and found that participants left their apartments to integrate into the community for daily activities.

And outcomes from the program are often bi-directional, with the peers themselves having many of their needs met by providing the service.

Ninety percent of the 350 to 400 COAPS coaches trained have been employed, with the program getting requests for COAPS training that have to be turned away due to a lack of personnel and funding.

But once the older adult peer support workers are trained, they are able to receive reimbursement for their work with older Medicaid enrollees only under the state Medicaid program or through state Offices on Aging block grants. Where the older adult is not a dual eligible, but is instead covered only under the Medicare program, reimbursement for services is limited.

Peer support caseloads in Pennsylvania are dictated by the organizations with whom the specialists work. One Pittsburgh managed care organization limits caseloads to no more than 25 patients per specialist, while another limits caseloads to no more than 15. In Pennsylvania, visits are scheduled every week or every other week; at the very least, visits are scheduled once or twice each month. A few peer support agencies take a more intensive approach, with per-specialist caseloads of 8 to 10 people and 4 hours each week per individual, utilizing an Intensive Care Management-type model.

The NASMHPD Older Adults Peer Support Roundtable of experts gathered on April 10, 2017 to work through what the barriers to Medicare reimbursement for older persons peer support might be, and how those barriers might be surmounted. As noted previously, the Roundtable experts came from the Medicaid and Medicare programs, CMMI, ACL, Medicare SNP insurers, provider associations, NAMD, NASUAD, State Mental Health Agencies, and peer support specialist programs and agencies. The roundtable was co-moderated by the co-author of this report, Director of the University of Pennsylvania Perelman School of Medicine Psychiatry Department's Center for Mental Health Policy & Services Policy Research & Evaluation Dr. Cynthia Zubritsky, who runs the COAPS program.

## **Restrictive Designations of Medicare Providers, Services**

To be covered under Medicare, which is perceived as medical-only care, the service must be a covered service and the provider providing the service must be a covered provider. Medicare regulation 42 Code of Federal Regulations § 411.115 lists the services covered under Medicare and excluded, and the practitioners covered under Medicare and excluded. Under 42 CFR § 400.202, a “provider” is a hospital, a critical access hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice with an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency with a similar agreement to furnish outpatient physical therapy or speech pathology services, or a community mental health center with a similar agreement to furnish partial hospitalization services. A “supplier” is a physician or other practitioner, or an entity other than a provider that furnishes health care services. A “practitioner” is defined under 42 CFR § 480.101 as an individual credentialed within a recognized health care discipline and involved in providing the services of that discipline to patients.

Medicare Part B covers treatment for mental illness provided by a psychiatrist or other physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, or physician's assistant. Part B specifically covers outpatient mental health services, including for treatment of inappropriate alcohol and drug use.<sup>28</sup>

The outpatient mental health services covered under 42 CFR § 411.115 include:

- one depression screening per year performed in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals;
- individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state;

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<sup>28</sup> [Medicare.gov: Official U.S. Government Site for Medicare, Mental Health Care \(Outpatient\)](https://www.medicare.gov).

- family counseling to help with treatment;
- psychiatric evaluation;
- medication management;
- physician-administered medications;
- diagnostic tests;
- partial hospitalization;
- a one-time “Welcome to Medicare” preventive visit which includes a review of potential risk factors for depression; and
- an annual “Wellness” visit.<sup>29</sup>

## Why Partial Hospitalization is Likely Not the Key to Coverage

Because fee-for-service coverage is so restrictive, the only potential service that might be open to integration of peer support services is the coverage of partial hospitalization services covered under 42 United States Code § 1395x(ff). Partial hospitalization services must be prescribed by a physician and provided under a program under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by the physician (in consultation with appropriate staff participating in such program). The treatment plan must set forth the physician’s diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

The items and services to be provided under partial hospitalization by a hospital to its outpatients or by a community mental health center can include (*with potential targets for peer support integration indicated here in italics*):

- individual and group therapy with physicians or psychologists (*or other mental health professionals to the extent authorized under State law*);
- occupational therapy requiring the skills of a qualified occupational therapist;
- services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients;
- drugs and biologicals furnished for therapeutic purposes (which cannot be self-administered);
- individualized activity therapies that are not primarily recreational or diversionary;
- family counseling (the primary purpose of which is treatment of the individual’s condition);
- *patient training and education (to the extent that training and educational activities are closely and clearly related to individual’s care and treatment)*;
- diagnostic services; and
- other items and services the Secretary may designate, but never meals and transportation.<sup>30</sup>

The services provided must be reasonable and necessary for the diagnosis or active treatment of the individual’s condition, reasonably expected to improve or maintain the individual’s condition and functional level and to prevent relapse or hospitalization, and furnished in accordance with a physician certification and plan of care, taking into account accepted norms of medical practice and the reasonable expectation of patient improvement.<sup>31</sup> Beneficiaries who participate in partial hospitalization programs must have mental disorders that severely interfere with multiple areas of

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<sup>29</sup> *Ibid.*

<sup>30</sup> 42 U.S.C. § 1395x(ff)(2); 42 CFR 410.43(a)(4).

<sup>31</sup> *Ibid.*; 42 CFR 410.43(a).

their daily lives, including social, vocational, and/or educational functioning.<sup>32</sup> Physicians are required to recertify beneficiaries' need for the services 18 days after their admission and at least every 30 days thereafter.<sup>33</sup>

The service itself must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care in a setting other than the individual's home or in an inpatient or residential setting.<sup>34</sup> Partial hospitalization programs are intended for patients who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care, are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment, have an adequate support system while not actively engaged in the program, have a mental health diagnosis, are not judged to be dangerous to self or others, and have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the partial hospitalization program.<sup>35</sup>

The fairly lengthy definition of services and covered provider included in the statute and regulations would seem to leave an opening for peer support services to be provided under partial hospitalization as a service "provided by other staff trained to work with psychiatric patients" that qualifies as "patient training and education closely and clearly related to individual's care and treatment." The services are—or could be—provided "under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by the physician."

The lone stumbling block to coverage under partial hospitalization could be that the patient must "have an adequate support system while not actively engaged in the program." Given that the whole purpose of peer support is to provide a support system to patients who might not otherwise have such a support system, that limitation might stand as a barrier to peer support integration, or conversely, could be determined by CMS to be not applicable within the context of the service.

Nevertheless, in 2010, 74 percent of service providers were located in only three southern states, Florida, Louisiana, and Texas. Massachusetts was the only other state in double figures in providers, with 10.<sup>36</sup> Billing for the service in those four states was \$196.7 million, 90 percent of the total \$218.6 million in Medicare payments made in that year to CMHCs in 25 states.<sup>37</sup> As a result, beneficiary participation in the service is limited in most of the country. In 2013, the last year for which there appears to be a readily available data breakdown, 84 percent of 52.5 million Medicare beneficiaries (approximately 44.1 million) were considered aged (as opposed to having a qualifying disability).<sup>38</sup> However, in 2010, approximately 206 community mental health centers billed for partial hospitalization services provided to only 25,000 (about 5.7 percent of) Medicare beneficiaries.<sup>39</sup> In 2011, there were about 48.9 million Medicare enrollees, of whom only 23,776 received any kind of hospital outpatient services (excluding beneficiaries in Medicare Advantage managed care).

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<sup>32</sup> Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 6, § 70.3, Centers for Medicare and Medicaid Services.

<sup>33</sup> Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 6, § 70.3.B.5.b., Centers for Medicare and Medicaid Services.

<sup>34</sup> 42 U.S.C. § 1395x(ff)(3)(A).

<sup>35</sup> 42 CFR § 410.43(c).

<sup>36</sup> Questionable Billing by Community Mental Health Centers, Office of the Inspector General for the Department of Health and Human Services, OEI-04-11-00100, (August 2012).

<sup>37</sup> *Ibid.*

<sup>38</sup> Kaiser Family Foundation State Health Facts, Total Number of Medicare Beneficiaries (2011) & Medicare Service Use: Hospital Outpatient Services.

<sup>39</sup> OIG: Questionable Billing by Community Mental Health Centers.

Wendy Tiegreen of Georgia Medicaid recalls that the Federal regulations on partial hospitalization were so rigorous—including a required square footage for facilities—that two community mental health centers (CMHCs) in Georgia walked away from the program. Only Georgia hospitals continue to provide partial hospitalization services; no CMHCs are still doing so in that state.

Roundtable participants also recalled that there had been questionable billing historically among partial hospitalization providers. In 2011, four CMHC owners and managers in Miami-Dade County, Florida, were convicted of fraudulently billing Medicare approximately \$200 million for medically unnecessary partial hospitalization services from 2002 to 2010. Providers manipulated patients' charts, diagnoses, and lengths of stay. Physicians and other providers and marketers who referred Medicare beneficiaries to these CMHCs received financial kickbacks.<sup>40</sup>

As a follow-up to that investigation, in 2010, the Office of the Inspector General for the Department of Health and Human Services (OIG) found that approximately half of CMHCs met or exceeded thresholds that indicated unusually high billing for at least one of nine questionable billing characteristics.<sup>41</sup> Approximately one-third of these CMHCs had at least two of the characteristics. Additionally, approximately two-thirds of CMHCs with questionable billing were located in eight metropolitan areas. Finally, 90 percent of CMHCs with questionable billing were located in States that did not require CMHCs to be licensed or certified.

The level of need for partial hospitalization was intended by policy-makers to be the most intensive for outpatient services, for the most highly acute 10 percent of the covered population who had a risk of hospitalization or re-hospitalization. Participating enrollees had to receive a minimum of 20 hours of service weekly. Yet many CMHCs were found by the OIG to have billed as partial hospitalization as little as two hours per day of day treatment for as long as four to five years.

This questionable history of billing under the program led Roundtable participants to conjecture that attempting to include a new non-medical service, such as older adult peer support services, as an integrated service within the partial hospitalization service might not be favored by policy-makers as an avenue for coverage.

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<sup>40</sup> *Ibid*, citing Department of Justice (DOJ), Owner of Miami-area mental health care corporation convicted on all counts for orchestrating \$205 million Medicare fraud scheme. Accessed at <http://www.justice.gov/opa/pr/2011/August/> on August 23, 2011

<sup>41</sup> (1) Beneficiaries who received only group psychotherapy during their partial hospitalization participation, (2) Beneficiaries who were not referred to partial hospitalization programs by health care facilities, (3) Beneficiaries who were not evaluated by physicians during their partial hospitalization program participation, (4) Beneficiaries with no mental health diagnoses a year prior to participating in partial hospitalization programs, (5) Beneficiaries who participated in programs at CMHCs outside their communities, (6) Beneficiaries who participated in programs at more than one CMHC, (7) Beneficiaries with cognitive disorders who participated in programs, (8) Beneficiaries with long stays of more than 147 days, and (9) Beneficiaries who were readmitted to inpatient treatment.

## Could Coverage for Peer Support Services be Included under the Medicare Psychiatric Collaborative Care Model?

In the November 15, 2016 *Federal Register*,<sup>42</sup> CMS finalized the 2017 Medicare Physician Fee Schedule, under which it included specific new, temporary payment G-codes for behavioral health services furnished under what it called an evidence-based Psychiatric Collaborative Care Model (CoCM). Under this model, patients are cared for through a team approach involving a primary care practitioner, behavioral health care manager, and psychiatric consultant. CMS also proposed at the same time to pay more broadly for other approaches to behavioral health integration services.

Under that model, CMS began paying for:

- Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:
  - Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
  - Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
  - Review by the psychiatric consultant with modifications of the plan if recommended;
  - Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
- Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:
  - Tracking patient follow-up and progress using the registry, with appropriate documentation;
  - Participation in weekly caseload consultation with the psychiatric consultant;
  - Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
  - Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; and
  - Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
- Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a

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<sup>42</sup> Final Rule: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Centers for Medicare and Medicaid Services, 81 *Federal Register* 80170,

psychiatric consultant, and directed by the treating physician or other qualified health care professional.

- Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month.

CMS also began authorizing reimbursement in 2017 for the following services provided outside the CoCM model:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.<sup>43</sup>

Although it would likely require separate recognition of a peer management specialist as a qualified Medicare practitioner, the care management services and the treatment coordination authorized for reimbursement under the CoCM model and outside the CoCM model under the 2017 Physician Fee Schedule regulations could arguably be provided by a certified peer specialist with appropriate training and with oversight by either the psychiatric consultant or the treating physician or other qualified health professional.

However, for this to be achieved, the Roundtable participants agreed that outreach to and partnering with the American Psychiatric Association, which championed the Medicare coverage of the CoCM model, would be essential.

### **Could Peer Support Services be Included in a Hospital-Based Team Reimbursement Approach?**

Peer support is already being piloted in hospital settings in states such as Delaware to help individuals with mental illness transition into the community, to be reintegrated into a community setting, and thereby prevent re-hospitalization. Including a certified peer support specialist as a staff cost on the Medicare cost report of Medicare-participating hospitals, warranted as a means to reduce hospital readmissions, would allow hospitals to, in turn, reimburse staff peer support workers generally and older adult peer support specialists in particular.

As one Massachusetts peer support specialist participating in the Roundtable suggested, “The beauty of peers is that they are connected to the community and they come from the community so there is—to use medical terms—there is aftercare after discharge. So there’s a much better transition when peers are there in the hospital and in the community for when you get discharged. ... That’s how we started the older adult peers support [in Massachusetts].” We got “peer bridgers” through *Olmstead* to transition people from the hospital to the community. We decided that older adults are a specialized community needing specialized skills from the peers to be able to know how to transition.<sup>44</sup>

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<sup>43</sup> *Ibid* at pages 80240 to 80243, 80365, and 80366.

<sup>44</sup> Robert Walker, External Consumer Engagement Liaison, Massachusetts Department of Mental Health.

However, it is unclear whether, as the hospital cost report is currently structured, peer support costs could qualify as a staff cost, and the inclusion of those costs might require either CMS clarifying guidance or a revision of Hospital Cost Report Form CMS-2552-10.<sup>45</sup> Nevertheless, given the increased emphasis by CMS on reducing hospital readmissions, this is an approach worth considering by policy makers and advocates.

## Pursuing a Managed Care Approach

The best approach to achieving reimbursement for older adult peer support services appears to be through various Medicare or Medicaid-Medicare managed care avenues:

- a Medicare Advantage managed care approach, using a plan’s “rebtable savings” from providing services at costs below the Medicare program-set county benchmark capitated reimbursement to provide “supplemental” peer support services;
- as a subset of MA supplemental coverage, coverage under the Medicare Special Needs Plan (SNP) models, either under a C-SNP for complex, chronic care patients with behavioral health needs or a D-SNP for dual eligibles with behavioral health needs;
- coverage, such as in Massachusetts,<sup>46</sup> under a state Financial Alignment Duals Demonstration program for individuals who are “dual eligibles,” eligible for both Medicaid and Medicare services; or
- coverage under a CMMI demonstration program, such as the Episode-Based Payment, Primary Care Transformation, and Best Practices Adoption models.

## Using Medicare Advantage Rebtable Savings to Provide Peer Support Services

A great deal of the four-hour discussion at the Roundtable centered on how to cover peer support services with the “rebtable savings” which Medicare Advantage managed care plans use to provide supplemental benefits—benefits ancillary to those required to be covered under the Medicare program. There seemed to be a variety of opinions on how related those supplemental benefits need be to those traditional Medicare benefits otherwise required. Roundtable participants agreed that one of the challenges would be to align with the concept of Medicare as a national program, given that some regions are relatively unfamiliar with the older adult peer support services model. In addition, any supplemental benefit must be available to any Medicare enrollee who needs it, raising the question of whether a supplemental peer support benefit could be restricted to only older enrollees.

Roundtable participants also emphasized that, because supplemental benefits are considered by Medicare managed care insurers to be a means to differentiate their plans and attract consumers to enroll in their plans, there is often competition among benefits and benefits providers to be included

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<sup>45</sup> Form CMS-2552-10, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf>.

<sup>46</sup> [Three-Way Contract for Capitated Model, Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with The Commonwealth of Massachusetts and XXX Issued December 28, 2015](#); and [Memorandum of Understanding \(MOU\) Between the Centers for Medicare & Medicaid Services \(CMS\) and The Commonwealth of Massachusetts Regarding A Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Demonstration to Integrate Care for Dual Eligible Beneficiaries.](#)

in any supplemental benefit package. Some roundtable participants suggested that other benefits and services—including routine hearing services, routine vision services, over-the-counter medications, telehealth, and medical transportation—are likely to be prioritized more highly by managed care insurers because they would appear to appeal to a greater number of potential insureds. Because of its lower priority, ongoing funding from year to year could be unreliable.

One roundtable participant also noted that the availability of rebatable savings is likely to vary among regions, depending on how the Medicare program sets its benchmark for that region. That variation would likely mean that plans in some regions might not have the funding to provide older adult peer support services as a supplemental benefit.

## Value-Based Insurance Design Presents an Opportunity

In January 2017, the Medicare program, as part of its Health Plan Innovation Initiatives, initiated a five-year Medicare Advantage Value-Based Insurance Design (VBID) pilot to afford Medicare Advantage plans the opportunity to offer supplemental benefits or reduced cost-sharing to enrollees with CMS-specified chronic conditions, focused on the services that are determined by CMS to be of the highest clinical value. In announcing the program, CMS said VBID approaches are increasingly used in the commercial market, and evidence suggests that the inclusion of clinically-nuanced VBID elements in health insurance benefit design could be an effective tool to improve the quality of care and health outcomes and reduce the cost of care for Medicare Advantage enrollees with chronic diseases.

In 2017, CMS is testing the VBID model in 11 Medicare Advantage and Medicare Advantage-Prescription Drug plans in seven states—Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. Beginning in 2018, CMS will also test the model in Alabama, Michigan and Texas. In 2017, the categories of chronic care conditions identified by CMS for targeting included mood disorders and combinations of conditions which include mood disorders.<sup>47</sup>

Beginning in 2018, CMS will allow supplemental benefits to be provided with greater flexibility in targeting the same array of mood disorders as in 2017. Organizations will be permitted to select from among the listed ICD-10 codes to create a smaller group suitable to the proposed intervention. Organizations exercising this option must select all ICD-10 codes from within a chosen code category.<sup>48</sup>

Although it is unknown which, if any, of the participating MA plans chose in 2017 to cover older adult peer support services as a mode for treating mood disorders, or to include coverage for those services in their 2018 plan bids submitted to CMS, the Medicare Advantage focus on mood disorders within the VBID pilot presents an important opportunity for plans to consider covering those services.

## Coverage under Medicare Advantage Special Needs Plans

A subset of Medicare Advantage plans, Special Needs Plans (SNPs) for dual eligibles (D-SNPs) and SNPs for enrollees with severe and disabling chronic conditions (C-SNPs), also offer a specific

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<sup>47</sup> Delusional disorders, shared psychotic disorders, various levels of manic episodes, various levels of major depressive disorder, various levels of bipolar disorder, affective disorders, panic disorders, anxiety disorders, and adjustment disorders.

<sup>48</sup> Medicare Advantage Value-Based Insurance Design Model Request for Applications for CY 2018, Centers for Medicare and Medicaid Services, <https://innovation.cms.gov/Files/x/vbid-rfa2018.pdf>.

but limited opportunity to provide enrollees with behavioral health issues with older adult peer support services as a supplemental service. While approximately one-third of the 55 million Medicare beneficiaries are in Medicare Advantage plans, only about 2.1 million (12 percent) are in SNPs nationally. Of those, approximately 1.76 million were in D-SNPs in 2016 and 55,000 were in C-SNPs. The remaining 326,000 were in institutional special needs plans, or “I-SNPs.”<sup>49</sup>

However, in five states and the District of Columbia, enrollment in SNPs comprises more than one-fifth of Medicare Advantage enrollment (35 percent in D.C., 28 percent in South Carolina, 22 percent in Arizona, 21 percent in Arkansas, and 20 percent in Alabama and Mississippi). Enrollment of dually eligible beneficiaries in D-SNPs is particularly prevalent in Hawaii (50 percent) and Arizona (40 percent).<sup>50</sup> So, while the D-SNP structure and C-SNP structures and their potential to provide supplemental benefits offer an avenue for covering older adult peer support services, the opportunity is limited in scope nationally, but more extensive in a limited number of states.

A potential further limiting factor is that Congressional authorization for Special Needs Plans has been temporary since their creation in 2003. Current authorization is due to expire in December 31, 2018, but while the Medicare Payment Advisory Commission (MedPAC) recommended in 2013 that authorization for C-SNPs be eliminated for all but a small number of conditions, the conditions exempted from the MedPAC recommendation for elimination included chronic and disabling mental health conditions.<sup>51</sup>

## **Coverage of Older Adult Peer Support Services under the Financial Alignment Demonstrations for Dual Eligibles**

Roundtable participants suggested that older adult peer support advocates and providers should be convincing the 10 states participating in the Medicaid-Medicare Capitated Financial Alignment Demonstration to require plans to include older adult peer support services in the array of services provided by the plans for dual eligibles. While the Financial Alignment demonstration utilizes Medicare monies as well as Medicaid monies to fund services provided by the participating plans, the statutory restrictions otherwise requiring Medicare monies be spent on more medical-type services do not apply to the mixed pool of funds paid the plans participating in the Financial Alignment demonstrations for services provided to enrollees.

In fact, the template for the Memoranda of Understanding between states and CMS outlining the services being provided under the state’s duals demonstration specifically states that peer support, which the template calls one of the “core services” of recovery-oriented services for behavioral health, may be provided in small groups or may involve one peer providing support to another peer to promote and support the individual's ability to participate in self-advocacy. The template says that one-to-one peer support, which is instructional, not counseling, enhances the skills of the individual to function in the community and/or family home.

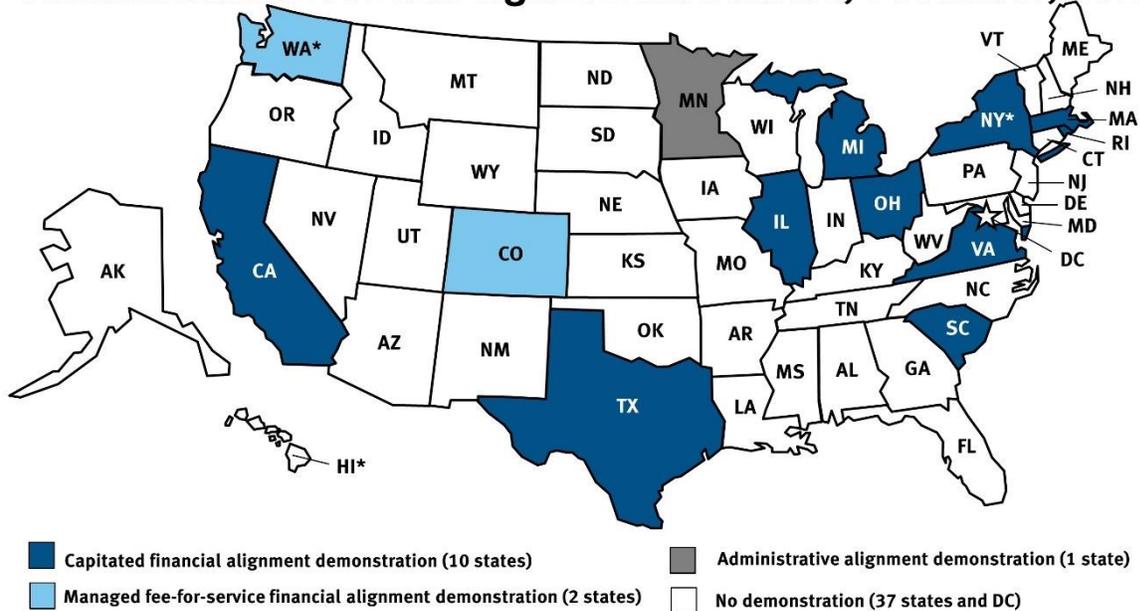
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<sup>49</sup> Medicare Advantage 2016 Spotlight: Enrollment Market Update, Kaiser Family Foundation (May 11, 2016), <http://www.kff.org/report-section/medicare-advantage-2016-spotlight-enrollment-market-update-appendices/>.

<sup>50</sup> *Ibid.*

<sup>51</sup> Report to the Congress: Medicare Payment Policy, Medicare Payment Advisory Commission, Chapter 14, Medicare Advantage Special Needs Plans (March 2013), <http://www.medpac.gov/docs/default-source/reports/chapter-14-medicare-advantage-special-needs-plans-march-2013-report-.pdf?sfvrsn=0>.

## State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, December, 2015



NOTES: \*WA received approval for two demonstrations, but subsequently withdrew its capitated model. NY withdrew its managed FFS proposal and has approval for 2 capitated demonstrations.

SOURCE: [CMS Financial Alignment Initiative, State Financial Alignment Proposals](#) and state websites.



Thus, the Massachusetts Memorandum of Understanding between the Commonwealth of Massachusetts and CMS for that state’s Capitated Financial Alignment Demonstration requires peer support designed to provide training, instruction, and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community.<sup>52</sup> Even though other state MOUs do not currently require the inclusion of peer support services, most at least leave open the option or imply inclusion of the services. The Illinois MOU states that “enrollees identified to have low levels of risk and/or needs may be assigned Care Coordinators with non-clinical backgrounds, such as counselors or peer support counselors.”<sup>53</sup> While the Michigan MOU does not specifically require the inclusion of peer support services, it does require the participating plan’s care coordinator to “communicate, coordinate, and monitor peer support/peer health navigator services, including enrollee engagement, health advocacy, and

<sup>52</sup> Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Massachusetts Regarding A Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Demonstration to Integrate Care for Dual Eligible Beneficiaries, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassMOU.pdf>.

<sup>53</sup> Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Illinois Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Illinois Medicare-Medicaid Alignment Initiative, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/ILMOU.pdf>.

training in self-management of chronic illness.”<sup>54</sup> And the Rhode Island MOU mandates the use of an interdisciplinary care team that may include “peer supports appropriate for the enrollee’s medical diagnoses and health condition, co-morbidities, and community support needs.”<sup>55</sup>

## Center for Medicare and Medicaid Innovation Demonstrations as a Potential Avenue for Coverage

One additional open-ended avenue for achieving coverage and reimbursement for older adult peer support services would be through a CMMI demonstration project.

Under its statutory authority,<sup>56</sup> CMMI develops innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to enrollees of those programs. The agency is required to give preference to models that also improve the coordination, quality, and efficiency of health care services. CMMI is required to select models to be tested that show evidence of addressing a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of specific demonstrations to be conducted.

The statutory authority<sup>57</sup> provides a lengthy non-exclusive list of the types of models which can be authorized. They include *inter alia* a number of models into which older adult peer support services would fit nicely:

1. contracting directly with groups of providers of services and suppliers to promote innovative care delivery models;
2. utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of individuals with multiple chronic conditions and at least either cognitive impairment or an inability to perform two or more activities of daily living;
3. establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities;
4. assisting individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools...that improve individual and caregiver understanding of medical treatment options; and
5. utilizing a diverse network of providers of services and suppliers to improve care coordination for individuals with two or more chronic conditions and a history of prior-year

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<sup>54</sup> Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Community Health Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIMOU.pdf>.

<sup>55</sup> Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Rhode Island Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Medicare-Medicaid Alignment Integrated Care Initiative Demonstration, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RIMOU.pdf>.

<sup>56</sup> 42 U.S.C. § 1315a (§ 1115A of the Social Security Act).

<sup>57</sup> 42 U.S.C. § 1315a(b)(2)(B).

hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project.

CMMI's current Innovation Models are organized into seven categories:

- **Accountable Care Organization Models**, designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality, and efficient service delivery.
- **Episode-Based Payment Initiatives**, under which health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event and extends for a limited period of time thereafter.
- **Primary Care Transformation**, under which primary care providers are the key point of contact for patients' health care needs, utilizing a team-based approach, while emphasizing prevention, health information technology, care coordination, and shared decision-making among patients and their providers.
- **Initiatives Focused on the Medicaid and CHIP Populations**
- **Initiatives Focused on the Medicare-Medicaid Enrollees**, which incorporate a fully integrated, person-centered system of care that ensures that all their needs are met in a high quality, cost effective manner.
- **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models**
- **Initiatives to Speed the Adoption of Best Practices**, under which CMMI partners with a broad range of health care providers, federal agencies, professional societies, and other experts and stakeholders to test new models for disseminating evidence-based best practices and significantly increasing the speed of adoption.

Each of these demonstration model categories—with the exception of initiatives focused on the Medicaid and CHIP populations—have the potential for providing coverage and reimbursement for integrated older adult peer support services, although the Episode-Based Payment, Primary Care Transformation, and Best Practices Adoption models probably offer the most immediate and readily achievable opportunities. Recent studies have indicated that Accountable Care Organization models likely have the least potential for effectively incorporating older adult peer support services for individuals with mental illness or substance use disorders, as two recent studies have cast doubt whether those entities, as currently structured and within current behavioral health technological parameters, are able to improve outcomes for those populations.<sup>58</sup>

## Conclusions & Recommendations

Roundtable members concluded that, while the more viable approach for evolving and expanding access to, and reimbursement for, older adult peer support services is within the Medicaid program, the more immediate opportunity for Medicare coverage and funding should be available through integrated products that focus on behavioral health issues. Coverage under traditional Medicare fee-for-service appears unlikely to occur in the immediate future without legislation to define peer

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<sup>58</sup> Busch A.B., Huskamp H.A., and McWilliams J. M., Early Efforts by Medicare Accountable Care Organizations Have Limited Effect on Mental Illness Care and Management, *Health Affairs*, July 2016, pp.1247-56; Lewis V.A., Colla C.H., Tierney K., Van Citters A.D., Fisher E.S., and Meara E., Few ACOs Pursue Innovative Models that Integrate Care for Mental Illness and Substance Abuse with Primary Care, *Health Affairs*, October 2014, pp. 1808-16.

support workers as qualified medical professionals or as the supervised delegates of qualified medical professionals and without legislation defining peer support services as a Medicare-covered service.

The lone Medicare fee-for-service possibility—and it is a likely remote possibility absent a restructuring of the hospital cost report or clarifying guidance from the Medicare program—would be for Medicare-participating hospitals to include older adult peer support services in their patient-centered team approach, in a function designed to prevent re-hospitalization, reimbursing peer support workers as hospital staff.

Given those considerations, it would appear that expansion of peer support services for older adults through Medicare coverage and reimbursement is most likely to be achievable in the immediate future through the following approaches:

- Encouraging Medicare Advantage plans generally, and D-SNPs and C-SNPs particularly, to include older adult peer support services in the supplemental services funded through their rebatable savings, by showing that the return-on-investment to the plans in covering those services is superior—more cost-effective and resulting in increased enrollment—to the ROI the plans might otherwise achieve by covering other potential supplemental services;
- Encouraging Medicare Advantage plans participating in the BVID demonstration to provide older adult peer support services to the individuals with mood disorders they target;
- Reaching out to CMS and participating states to encourage the inclusion of older adult peer support services in the benefits states mandate for inclusion by plans operating under the Capitated Financial Alignment Demonstrations for dual eligible enrollees; and
- Encouraging CMMI to require coverage of, and reimbursement for, older adult peer support services in Episode-Based Payment, Primary Care Transformation, and Best Practices Adoption models already in existence or in development.

Whatever approach or approaches are taken, the Roundtable participants all agreed that any advocacy focused on achieving full Medicare funding would require a massive and potentially prolonged education effort by a broad coalition of organizations, and that the education effort would need to include supportive data showing quantifiable positive patient and program outcomes through the use of evidence-based practices. Roundtable participants also suggested that older adult peer support strategy mirror the strategies utilized by advocates for other services in achieving Medicare coverage in recent years.

## Appendix - April 10, 2017 Older Adult Peer Support Roundtable Attendees

### On-Site

1. Kirsten Beronio (Senior Policy Advisor for Behavioral Health, Center for Medicaid and CHIP Services)
2. Rich Bringewatt (CEO, SNP Alliance)
3. Lindsey Browning (Program Director, National Association of Medicaid Directors)
4. Arthur Evans (CEO, American Psychological Association)
5. Ellen Garrison (Senior Policy Advisor, American Psychological Association)
6. Lisa Goodale (Consulting Services Vice President, Depression and Bipolar Support Alliance)
7. Pamela Greenberg, MPP (CEO, Association of Behavioral Health and Wellness)
8. William J. Hudock (Senior Public Health Advisor for Financing, SAMHSA)
9. Amy Ingham (Public Policy Analyst, Anthem)
10. Rhys Jones (Vice President of Medicaid Advocacy, America's Health Insurance Plans)
11. John O'Brien (Senior Consultant, Human Services Group, Technical Assistance Collaborative)
12. Sherry Peters (Pennsylvania Director Bureau of Policy, Planning and Program Development, Office of Mental Health and Substance Abuse Services, Department of Human Services)
13. Eric Scharf (Organizational Development and Public Policy Advocacy, Depression and Bipolar Support Alliance)
14. Shawn Terrell (Administration for Community Living)
15. Lisa St. George (RI International)
16. Damon Terzaghi (Senior Director of Medicaid Policy and Planning, National Association of States United for Aging and Disabilities)
17. Wendy Tiegreen (Director for Medicaid Coordination, Provider Services, Georgia Department of Behavioral Health and Developmental Disabilities)
18. Kevin Trenney (Peer Support and Advocacy Network)
19. Sara Vitolo (Deputy Director, Medicare-Medicaid Coordination Office)
20. Robert Walker (External Consumer Engagement Liaison, Massachusetts Department of Mental Health)
21. Debbie Webster (Mental Health Program Manager, Division of Mental Health, Developmental Disabilities and Substance Abuse Services North Carolina Division of Mental Health) (Chair, NASMHPD Older Persons Division)
22. Cynthia Zubritsky (Research Professor at University of Pennsylvania Perelman School of Medicine Department of Psychiatry)

### Remote

1. Susan Bergeson (National Vice President for Consumer and Family Affairs, Optum Government Programs)
2. Tom Betlach (State Mental Health Director, Arizona Department of Behavioral Health Services)
3. Ellen W. Blackwell (Senior Advisor, Quality Measurement & Value-Based Incentives Group, Center for Clinical Standards and Quality, Center for Medicare and Medicaid Services)
4. Hillary Cantiello
5. Lyvia Davis (Vice President, Center for Social Innovation)

6. Larry Fricks (Deputy Director, SAMHSA/HRSA Center for Integrated Health Solutions)
7. John Delman (CEO, Technical Assistance Collaborative)
8. Donelle McKenna (Division of Health Care Payment Models in CMMI's Patient Care Models Group)
9. Octavia Byrd (Division of Health Care Payment Models in CMMI's Patient Care Models Group)
10. Nathan Mitchell (Center for Medicare and Medicaid Innovation, CMS)
11. Virginia Mastrine (Human Services Program Specialist, Pennsylvania Department of Human Services/Older Persons Division)
12. Dan O'Brien-Mazza (National Director of Peer Support Services, Veterans Administration)
13. Dena Stoner (Texas Medicaid)

**NASMHPD Staff**

1. Stuart Gordon (Director of Policy and Communications, NASMHPD)
2. Christy Malik (Senior Policy Associate, NASMHPD)
3. David Miller (Director of Projects, NASMHPD - remote)
4. Aaron Walker (NASMHPD - remote)