SSC Strengthening Systems of Care for People with HIV & Opioid Use Disorder

RYAN WHITE HIV/AIDS PROGRAM
SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

JSI NASTAD

STATE STRATEGIES IN ACTION:

BUILDING RELATIONSHIPS WITH YOUR STATE MEDICAID AGENCY TO SUPPORT PEER SERVICES

The Health Resources and Services Administration (HRSA)-funded Ryan White HIV/AIDS Program Special Projects of National Significance (SPNS) initiative Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) provides coordinated technical assistance across HIV and behavioral health/ substance use service providers. The project aims to enhance system-level coordination and networks of care among Ryan White HIV/AIDS Program recipients and other federal, state, and local entities. The purpose of this initiative is to ensure that people with HIV and opioid use disorder (OUD) have access to care, treatment, and recovery services that are client-centered and culturally responsive.

SSC developed this resource in response to the needs of the nine state partners participating in the project. For more information about the project and to access additional resources, visit https://ssc.jsi.com/.

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This resource is part of the State Strategies into Action series; a compilation of strategies and lessons about a variety of topics related to strengthening systems of care for people with HIV and opioid use disorder (OUD). Each resource responds to common technical assistance (TA) needs identified across states partnering with JSI Research & Training Institute, Inc. as part of the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project.

THE ROLE OF PEERS IN HIV AND OPIOID USE DISORDER SERVICE DELIVERY

Expanding a workforce with lived experience

Peers have long been a cornerstone of both the Ryan White HIV/AIDS Program (RWHAP) and harm reduction delivery systems. Peers are an integral part of a care team and use their "shared life experiences" to connect with program participants, providing understanding and insight into the participant's own experience and self-directed goals. The experiences that peers share with participants across HIV, hepatitis C, and harm reduction programs provide credibility and trust. This established sense of trust allows peers to provide coaching, education, and resource linkage services that are often more effective than when they are provided by clinicians or other medical providers.[1]

Peers work in a variety of settings, including non-clinical community-based and syringe services programs; community health centers; clinics; and hospitals. Intentional investment in how the public health workforce is structured and reimbursed is a good value proposition and a step toward acknowledging that hierarchical clinical systems can fuel racial and ethnic inequities. Historic and present-day systemic racism and inequities mean many marginalized community members do not trust the health care system. Expanding a public health workforce with lived experience and community connection helps clients make choices about their lives, including decisions about HIV management and harm reduction pathways for those with opioid use disorder (OUD).[2]

Peer definitions

Professional requirements for peers—including training and credentialing—vary by state and across the Centers for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration HIV/AIDS Bureau (HRSA/HAB), as do reimbursement mechanisms for services provided by peers (see Figure 1).

While these groups of peers certainly overlap, there are also distinctions that are important to keep in mind as efforts to better integrate HIV and OUD services are made. Both Medicaid and behavioral programs focus their definitions of peers on mental illness and substance use. The RWHAP focuses its definition of peers on people with HIV, with peers funded through RWHAP often living in or being deeply connected to communities with HIV. It is also important to distinguish peers from other public health professionals who provide similar services. For instance, community health workers (CHWs) are also an important part of the RWHAP[3] and HIV prevention delivery system and there is a growing movement to recognize and professionalize CHWs in Medicaid.[4] Training and credentialing requirements and scopes of work may overlap across CHWs and peers, but CHWs often have additional responsibilities that are important to recognize when trying to create a coordinated (and equitably reimbursed) system across programs that use a mix of peers, CHWs, and other community-facing public health professionals.

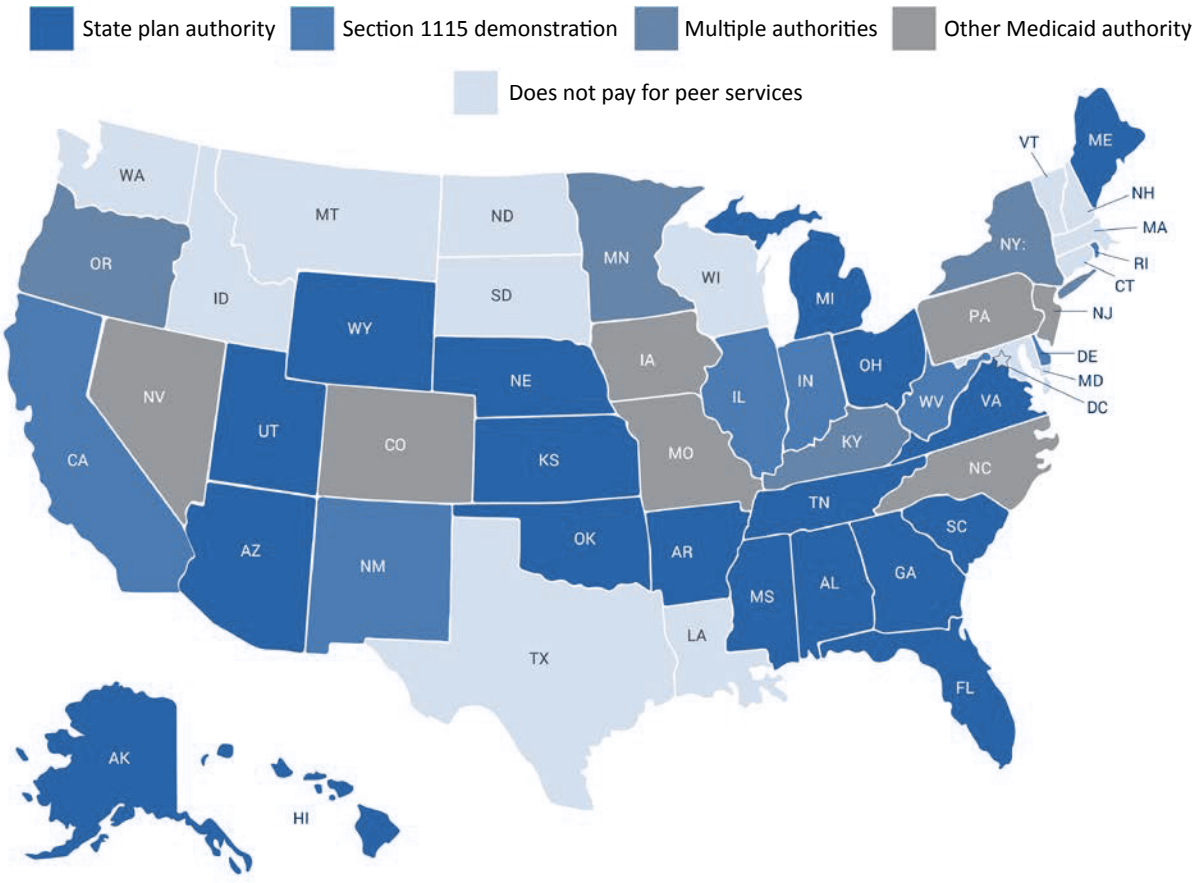
Again, it is important to note that current Medicaid coverage of peers primarily focuses on substance use and recovery services, not HIV or other infectious diseases. Given the intersection between substance use and HIV, there may be opportunities to integrate Medicaid-supported peer services across substance use and HIV moving forward. Examples are highlighted below.

Figure 1. Peer Services across Programs [5,6,7]

Medicaid and peer coverage

People with HIV are far more likely to be covered by Medicaid than the general population, with 42 percent of people with HIV in care on Medicaid coverage compared to 13 percent of the general population.[8] Medicaid has an equally outsized role in its coverage for OUD. Medicaid provides coverage for 38 percent of all adults under 65 with an OUD.[9] Ensuring coordination across state HIV and behavioral health programs and Medicaid is critical to creating integrated and seamless networks of care and services. Leveraging Medicaid financing opportunities for eligible peer services and providers allows HIV and OUD service providers to use existing resources more effectively, including the ability to fill service gaps and serve people who are not covered by public or private insurance. Medicaid has recognized the value of peers, particularly for mental and behavioral health services, and a growing number of state Medicaid programs have incorporated peer support services into their programs (see Figure 2).

Figure 2. Medicaid Coverage of Peer Support Services Using Various Medicaid Authorities, 2019



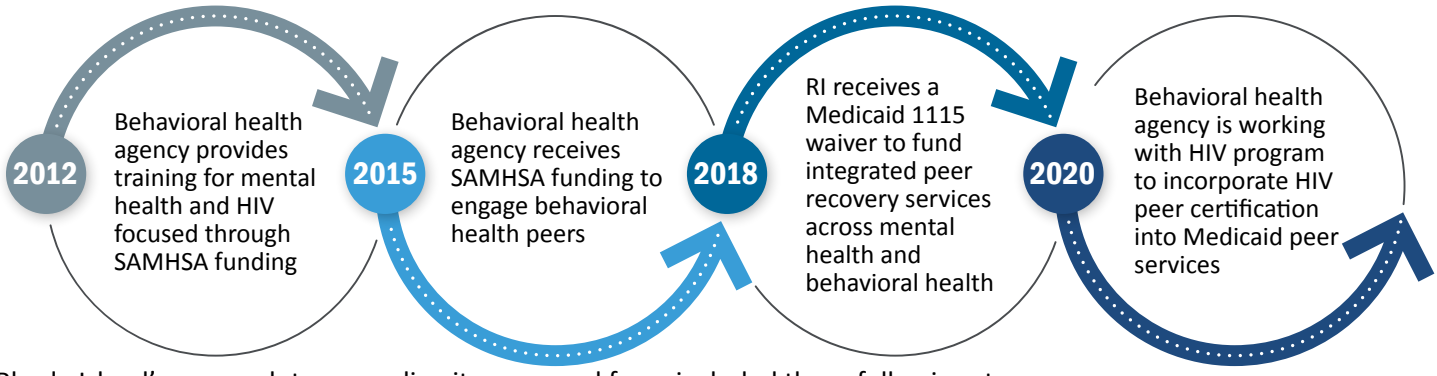
Source: MACPAC, Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder (July 2019), available at https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf

CASE EXAMPLES

Rhode Island

Rhode Island built a foundation of collaboration across its HIV, behavioral health, and Medicaid programs over time, laying the ground work for Medicaid to be an important financing and coverage partner for both HIV and OUD services. The lead-up to Rhode Island's coverage of peer recovery services in its Medicaid program shows how staggered and incremental relationship-building can lead to systemic changes. Uniquely situated alongside the Medicaid program, the HIV Provision of Care & Special Populations Unit serves the Secretariat of Health and Human Services in Rhode Island by being directly aligned with that office. Within this unit is the Ryan White HIV/AIDS Part B Program. Similarly, behavioral health, although not located within the secretariat's office, is under its purview. See Figure 3.

Figure 3. RI Timeline for Medicaid Coverage of Peer Services



Rhode Island's approach to expanding its peer workforce included these following steps:

Step 1. Rhode Island developed its peer recovery services model using SAMHSA funding.
Before approaching Medicaid, Rhode Island used SAMHSA resources to put in place service standards, credentialing requirements, and training, including SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy, which includes core competencies for peers and training modules for peers and supervisors. While there is no specific training requirement or pathway for peer recovery specialists focusing on HIV, there are many peer recovery specialists who have personal experience in substance use and HIV, which program leaders consider an asset. Understanding the landscape of state HIV resources and ability to refer individuals to them is also an important peer recovery specialist responsibility.

Step 2. Rhode Island's RWHAP Part B Program integrated the behavioral health and SAMHSA resources.
Rhode Island adapted its RWHAP Part B recipient guidance to create consistent terminology and service descriptions across behavioral health and the RWHAP. RWHAP resources in Rhode Island are not used to fund peer recovery specialists, but RWHAP grantees encourage access to these peers, who are funded through Medicaid and the state behavioral health agency.

Step 3. Rhode Island was approved for a Section 1115 Medicaid waiver to provide peer recovery support services through its Medicaid program.
In 2018, Rhode Island received approval for an 1115 Medicaid waiver, a demonstration project that allowed the state to implement innovative financing and service delivery models for substance use services. Rhode Island was able to use the models for peer recovery service credentialing and training it had built through its SAMHSA-funded initiative to develop a reimbursement pathway via Medicaid. The waiver allowed for coverage of services provided by peer recovery specialists, including education, navigation of state and local addiction and mental health treatment systems, mentorship, and empowerment and self-advocacy support. Peer recovery services focused on Medicaid clients with mental health or substance use challenges, including those at risk of hospitalization, overdose, and homelessness, and people who were recently released from institutions such as hospitals and prison.

Step 4. Rhode Island developed application and credentialing standards for peer recovery support.

To fully implement peer recovery support services in its Medicaid program, Rhode Island created peer recovery support application and credentialing standards. The application and credentialing process is conducted jointly by Medicaid and the behavioral health agency. The state also developed billing guidance for Medicaid, codifying professional requirements for peers as well as reimbursement rates for individual and group services (see Table 1).

Table 1. Reimbursement Rates for Mental Health and SUD Services

SERVICE	MENTAL HEALTH SERVICES	SUD SERVICES	RATE (1 UNIT = 15 MINUTES)
Face-to-face Peer Services	H0038 U2	H0038 U3	$13.50 per unit
Group	H0038 U2 HQ	H0038 U3 HQ	$4.00 per unit
Activities within Group	H0038 U2 HQ HH	H0038 U3 HQ HH	$2.50 per unit

Step 5. Rhode Island's HIV program is working to integrate HIV services into the peer recovery model.

Given the overlap across HIV and substance use in the state, Rhode Island's HIV program is working with the behavioral health program and Medicaid to develop an HIV-specific peer recovery support credentialing process. This process will hopefully create a reimbursement pathway to integrate HIV into Medicaid-covered peer recovery support. This would allow peer recovery specialists who currently focus exclusively on substance use to broaden their activities to include an HIV population focus. This is an important step to ensure that Medicaid clients living with HIV have access to tailored services that meet HIV and substance needs and are provided by people with similar lived experience. Ensuring that reimbursement adequately supports this workforce and complements existing RWHAP service categories and funding streams will be critical.

A history of collaboration between the HIV and behavioral health programs in Rhode Island and the HIV program's location within the state Medicaid program fostered an integrated approach to peer service delivery. That allowed inclusion of both HIV and OUD focus areas from the inception.

Virginia

Virginia has taken a similar incremental approach to building peer recovery support services into its Medicaid program.

Step 1. Virginia developed its peer recovery services model using SAMHSA funding.

The Department of Behavioral Health and Developmental Services developed an extensive array of resources, including credentialing criteria, a code of ethics, supervision requirements, and a training curriculum, to support a robust peer recovery specialist workforce.

Step 2. Virginia integrated peer recovery services into its Medicaid State Plan.

In 2017, Virginia received approval to expand Medicaid coverage of SUD services to include a new Addiction and Recovery Treatment Services (ARTS) benefit. The ARTS category is a holistic service package that includes case management, office-based opioid treatment, residential treatment, and peer recovery support. Reimbursement for ARTS peer services is provided in Table 2 below.

Table 2. Reimbursement Rates for ARTS Peer Services

PEER SUPPORT SERVICES & FAMILY SUPPORT PARTNERS	UNIT VALUE	PROCEDURE CODE	RATE
ARTS Individual	1 unit = 15 minutes	T1012	$6.50 per unit
ARTS Group	1 unit = 15 minutes	S9445	$2.70 per unit/per member

Step 3. Virginia integrated peer recovery services into a new CMS funding opportunity.
In 2019, the state received a CMS Substance Use-Disorder Prevention that Promoted Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act grant. These grants allow state Medicaid programs to develop approaches to SUD services, including expansion of a peer workforce into emergency room settings and broader integration of community-based organizations and harm reduction networks into Medicaid delivery systems.

The sequence here is important; incorporating the ARTS benefit into Medicaid several years before the SUPPORT Act initiative allowed the state to expand the Medicaid OUD workforce gradually, creating space for novel partnerships. Virginia's SUPPORT Act allowed the state to fund a network of community-based providers through a sub-award program that made partnerships with harm reduction networks (that include a robust peer workforce) easier to implement (see Figure 4). Engaging these new partners required intentional community involvement and dialogue to understand how this network of harm reduction community providers operated, the communities they served, and potential challenges (including client privacy and confidentiality concerns) in partnering more extensively with Medicaid. These small sub-awards are a stepping stone to a more formal relationship between harm reduction networks and Medicaid and have generated integrated HIV, hepatitis C, and OUD services that meet people where they are.

Establishing formal relationships with harm reduction networks also fostered Medicaid enrollment and education efforts, particularly with individuals eligible for Medicaid who had not yet signed up for coverage. Subsequent phases of the SUPPORT Act grant work include fostering connections between community-based providers (including harm reduction networks providing integrated HIV and OUD services) and Medicaid managed care plans in the state, with a focus on provision of care coordination services. This type of engagement could allow the community-based organizations that are receiving SUPPORT Act grant funding to expand partnerships with Medicaid into something more permanent, including a more integrated approach to a Medicaid-funded peer workforce across HIV and OUD.

Figure 4. SUPPORT Act-Funded Community Providers

Step 4. Virginia continues to identify ways to support more collaboration across infectious disease and behavioral health.

Virginia is still exploring opportunities to integrate HIV and OUD in Medicaid. Peer services reimbursed by Medicaid are focused on recovery, but there may be opportunities to expand the reach of peer recovery specialists into HIV systems of care (similar to the way the SUPPORT Act network of sub-awardees is integrating delivery across HIV, hepatitis C, and OUD). This type of cross-training and integration has been essential to providing whole-person care and recognizing the complexity of clients' lives. Virginia is also grappling with ensuring pay equity across community-focused public health professionals, including CHWs and peers. CHWs are an important part of the HIV care and delivery workforce in Virginia and the state has sought to expand reimbursement opportunities for CHWs, including through Medicaid. Continued efforts to create a more integrated community-based workforce will have to explore the nuances of these professionals within HIV, hepatitis C, and OUD programs.

CONSIDERATIONS FOR STATE ACTION

The following are possible action steps for states to build a peer workforce that better integrates HIV and OUD services within Medicaid.

1. Start with the data.

Making a case for an expanded HIV and OUD peer and community-based workforce in Medicaid should start with an analysis of unmet needs and provider gaps. Data-gathering could include analysis of people living with HIV and OUD served by Medicaid; estimates of the "eligible but not enrolled" Medicaid population, stratified by demographics; and descriptions of harm reduction networks and service provision throughout the state.

2. Use grant funds to build exportable models.

Grant funds (e.g., through SAMHSA) may help state behavioral health programs develop peer services delivery models, including service definitions, application criteria, supervision requirements, and training. Similarly, RWHAP funds could be used to develop HIV-specific training modules and certification programs that bridge substance use and HIV populations. This type of model incubation could help programs develop a proof-of-concept for Medicaid and allow HIV and behavioral health programs to work with community-based providers to build a pipeline for a peer workforce.

3. Understand and build on existing Medicaid initiatives.

Over the past five years, the federal government has invested significant resources into new Medicaid initiatives to mitigate the opioid crisis. This has included specific demonstration project opportunities focused on OUD services; Medicaid grants that prioritize innovative delivery models and community partnerships; and State Plan Amendment flexibility to provide care coordination services for vulnerable populations. Understanding the landscape for how a state's Medicaid program covers HIV and OUD services and how community-based providers and peers are or are not included in existing models will help stakeholders develop a tailored approach to meet their needs.

4. Assess community-focused workforce definitions across programs to understand gaps and opportunities.

The community-focused public health workforce—including peers, CHWs, and navigators—are defined differently across programs, and reimbursement rates can also differ across these professions. In Medicaid and behavioral health programs, for instance, peers are focused on recovery supports. This may be very different from the role of a peer in a harm reduction site, or the role of a CHW in a RWHAP or HIV prevention site. HIV, behavioral health, and Medicaid programs should assess the entire community-focused public health workforce to identify opportunities for overlap and integration, while preserving the unique focus areas of professionals working in different settings. Pay equity across the community-focused public health work force is also important.

5. Engage communities early and often.

An advantage of incorporating peers into HIV and OUD service delivery models is that they are connected to the communities they serve. HIV, behavioral health, and Medicaid programs should look first to communities most affected by HIV and OUD to assess needs and identify gaps in how Medicaid provides services and reaches vulnerable populations. This type of engagement should include community forums and dialogue opportunities to identify the types of delivery models that are working in communities and that could help connect people to HIV and OUD to Medicaid services. This engagement is critical to understanding community-based professional infrastructure across programs (e.g., the differences between peers and CHWs) and identifying pay equity principles to ensure adequate reimbursement.

RESOURCES

[1] Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6585590/; https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peer-support-2017.pdf

[2] Strengthening Systems of Care for People with HIV & Opioid Use Disorder, Connecting Care: The Intersection of HIV & Opioid Use Disorder, available at https://ssc.jsi.com/resources/podcasts

[3] HRSA/HAB, Using Community Health Workers to Improve Linkage and Retention in Care, available at https://targethiv.org/chw.

[4] Institute for Public Health Innovation, Community Health Worker Initiatives, available at https://www.institutephi.org/our-work-in-action/community-health-worker-initiatives/.

[5] State Medicaid Director Letter SMDL #07-011, available at https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd081507a.pdf.

[6] SAMHSA, Bringing Recovery Supports to Scale Technical Assistance Strategy Center, available at https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

[7] HRSA/HAB, RWHAP Peer Programs, available at https://targethiv.org/library/topics/peer-programs

[8] Kaiser Family Foundation, Medicaid and HIV (October 2019), available at https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/

[9] Kendal Orgera and Jennifer Tolbert, Kaiser Family Foundation, The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment (May 2019), available at https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/