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) Ryan White HIV/AIDS Program Special Projects of National Significance 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 project partners. For more information and additional resources, visit https://targethiv.org/ta-org/strengthening-systems-care-people-hiv-opioid-use-disorder**.**

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TABLE OF CONTENTS

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 substance use disorder service systems. Peers are an integral part of a care team and use their "shared life experiences" to connect with clients, providing understanding and insight into the client's own experience and self-directed goals. The lived experience that peers share with clients helps to build credibility and trust. This foundation of trust allows peers to provide coaching, education, and referral services that are often more effective than when they are provided by clinical providers.[1]

Peers work in a variety of settings, including community-based organizations and syringe services programs; community health centers; clinics; and hospitals. Intentional investment in how the peer 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 for those with opioid use disorder (OUD).[2]

Peer definitions

Professional requirements for peers—including training and credentialing—vary by state and across Federal agencies including 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). Reimbursement mechanisms for services provided by peers also vary (see Figure 1).

While these definitions of peers certainly overlap, there are also differences that are important to keep in mind. 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 deeply connected to communities with HIV. It is also important to distinguish peers from other public health staff who provide similar services. For instance, community health workers (CHWs) are also an important part of the HIV and substance use disorder service systems[6] and there is a growing movement to recognize and professionalize CHWs in Medicaid.[7] Training 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 and CHWs.

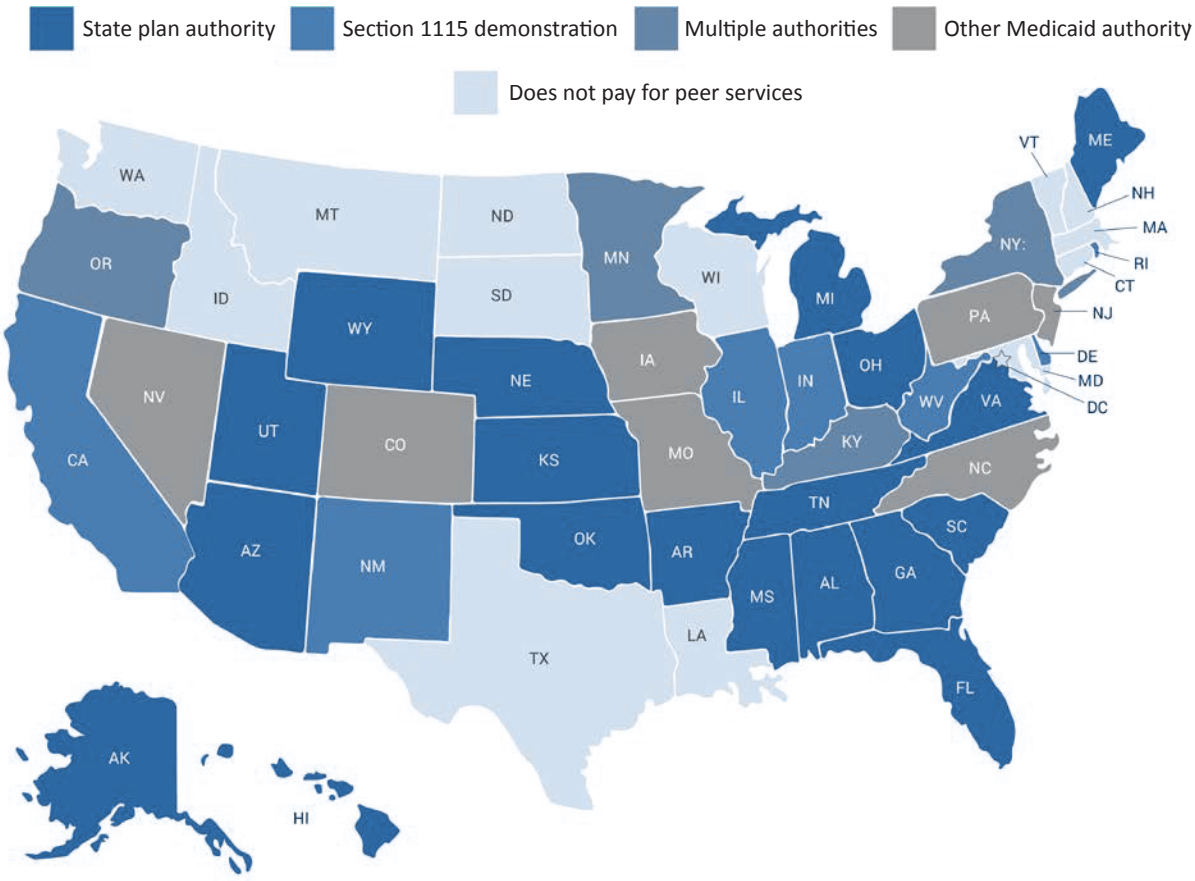
Again, it is important to note that current Medicaid coverage of peers primarily focuses on substance use and recovery services, not HIV or other infectious diseases. Given the intersection between substance use and HIV, there may be opportunities to integrate Medicaid-supported peer services across 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 also 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. Using Medicaid financing for peer services allows HIV and OUD service providers to use their own resources more effectively, including 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 are covering some peer support services (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

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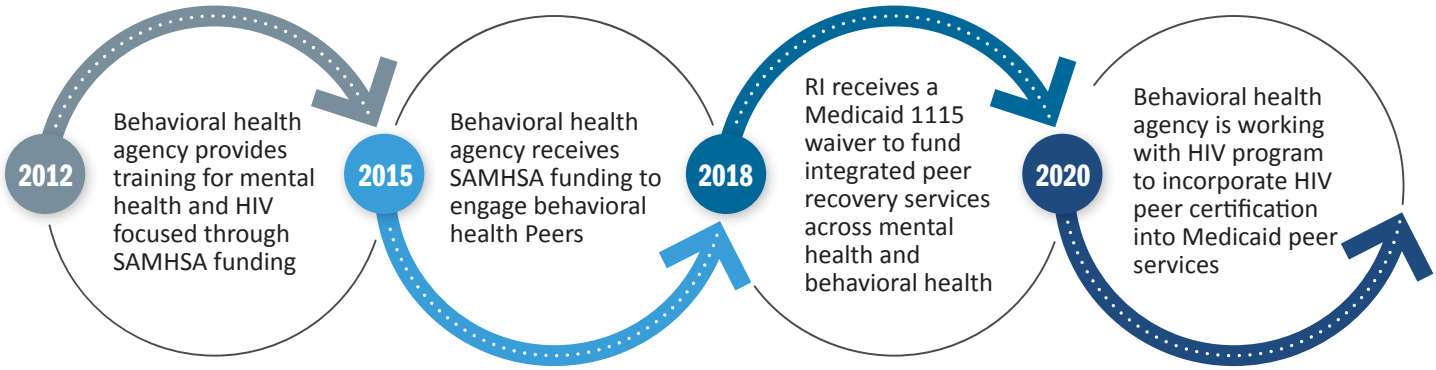
CASE EXAMPLES

Rhode Island

Rhode Island built a foundation of collaboration across its HIV, behavioral health, and Medicaid programs over time, laying the groundwork for Medicaid to be an important source of coverage for both HIV and OUD services. The lead-up to Rhode Island's coverage of peer services in its Medicaid program shows how incremental relationship-building can lead to systemic changes. Both the Medicaid program and the HIV Provision of Care & Special Populations Unit sit within the Secretariat of Health and Human Services in Rhode Island. Within this HIV 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. Rhode Island Timeline for Medicaid Coverage of Peer Services



Rhode Island's approach to expanding its peer workforce included the 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 programs for "peer recovery specialists". These standards and requirements are based on 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 focusing on HIV for peer recovery specialists, many peer recovery specialists have lived experience of both substance use and HIV. The ability to refer clients to HIV services is an important component of peer recovery specialist responsibilities in Rhode Island.

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 service descriptions across state behavioral health programs and the RWHAP. RWHAP resources in Rhode Island are not used to fund peer recovery specialists, but RWHAP-funded providers 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 try out innovative financing and service delivery models for substance use services. Rhode Island was able to use the model for peer recovery specialist credentialing it had built through its SAMHSA-funded initiative (see Step 1) to develop a reimbursement pathway in Medicaid. The waiver allowed for coverage of services provided by peer recovery specialists, including education, service navigation, mentorship, and empowerment and self-advocacy support. Peer recovery specialist services focused on Medicaid clients with mental health or substance use challenges, 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 specialist services in its Medicaid program, Rhode Island created a peer recovery support application and credentialing standards. The credentialing process is conducted jointly by Medicaid and the state behavioral health agency. The state also developed billing guidance for Medicaid, including reimbursement rates for individual and group peer services (see Table 1).

Table 1: Reimbursement Rates for Mental Health and SUD Services

SERVICE	MENTAL HEALTH SERVICES	SUBSTANCE USE DISORDER SERVICES	RATE
Face to Face Peer Services	H0038 U2	H0038 U3	$13.50
Group	H0038 U2 HQ	H0038 U3 HQ	$4.00
Activities w/in Group	H0038 U2 HQ HH	H0038 U3 HQ HH	$2.50

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

Rhode Island's HIV program is working with the state behavioral health program and Medicaid to develop an HIV-specific peer recovery support credentialing process. The aim is to create a reimbursement pathway to integrate HIV into Medicaid-covered peer recovery specialist services. This would allow peer recovery specialists who now focus only on substance use to broaden their activities to include HIV. This is an important step to ensure that Medicaid clients with HIV have access to tailored services that meet HIV and substance use needs, and are provided by people with similar lived experience. Ensuring that Medicaid reimbursement adequately supports this workforce and complements existing RWHAP funding 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 services that allowed a focus on both HIV and substance use disorder from the beginning.

Virginia

Virginia has also taken a step-by-step approach in building peer recovery support services into its Medicaid program.

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

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

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. ARTS is a holistic service package that includes case management, office-based opioid treatment, residential treatment, and peer recovery support. Reimbursement rates for ARTS peer services are shown in Table 2.

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 15 minute unit
ARTS Group	1 unit = 15 minutes	S9445	$2.70 per 15 minute unit/per member

Step 3. Virginia integrated peer recovery services into a new CMS funding opportunity.
In 2019, the state received a CMS SUPPORT Act grant. SUPPORT stands for Substance Use-Disorder Prevention that Promoted Opioid Recovery and Treatment for Patients and Communities. These grants allow state Medicaid programs to develop approaches to SUD services, including placement of peers into emergency rooms, and broader integration of community-based organizations and harm reduction programs 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 spaces for novel partnerships. Virginia's SUPPORT Act grant allowed the state to fund a network of community-based providers through a sub-award program for harm reduction networks, including a robust peer workforce (see Figure 4). Engaging these new harm reduction partners required intentional community involvement and dialogue to understand how this network of harm reduction programs operates, the communities they serve, and potential challenges (including client 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. They help to support integrated HIV, hepatitis C, and OUD services that meet people where they are.

Establishing formal relationships with harm reduction networks also strengthened Medicaid enrollment efforts for eligible individuals 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) and Medicaid managed care plans in the state, with a focus on care coordination services. This type of engagement could allow the community-based organizations to expand partnerships with Medicaid into something more permanent, including an 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

Peer services reimbursed by Medicaid in VA are focused on SUD 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 service delivery across HIV, hepatitis C, and OUD). This type of cross-training and integration has been essential to providing whole-person care that recognizes the complexity of clients' lives. Virginia is also grappling with ensuring pay equity across CHWs peers, and navigators. CHWs are an important part of the HIV workforce in Virginia and the state has sought to expand reimbursement opportunities for CHWs, including through Medicaid. Continued efforts to support an expanded peer workforce will have to explore the nuances of how peers and CHW operate 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.
To make a case for an expanded HIV and OUD peer workforce in Medicaid start with an analysis of unmet needs and service gaps. Data-gathering could focus on people with HIV and OUD served by Medicaid; estimates of the "eligible but not enrolled" Medicaid population, stratified by demographics; and descriptions of harm reduction services 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, supervision requirements, and training. Similarly, RWHAP funds can be used to develop HIV-specific training modules and certification programs for peers to serve people with HIV and SUD.[10] This type of model incubation can 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 investment 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 for these staff can also vary. In behavioral health programs, for instance, peers are focused on providing recovery support. 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 staff working in different settings. Pay equity across these staff positions 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 to the people who need them. Community forums and listening sessions can help to identify the types of delivery models that are working in communities to connect people with HIV and OUD to Medicaid services. This in turn will help with 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

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