NASMHPD
National Association of State Mental Health Program Directors
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August 13, 2014

Ms. Jolie H. Matthews
Senior Health and Life Policy Advisor and Counsel
Nation Association of Insurance Commissioners
Government Relations Office
444 N Capitol Street, NW, Suite 701
Washington, DC 20001-1509

RE: Model Legislation on Network Adequacy and Peer Support

Dear Ms. Matthews:

The National Association of State Mental Health Program Directors (NASMHPD) has reviewed the latest draft of the NAIC's Managed Care Plan Network Adequacy Model Act (#74) and is concerned about the lack of attention to the need to ensure access to peer support services, an increasingly critical element of care in behavioral health, both with regard to mental health care and substance use treatment services. NASMHPD is the member organization representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia.

It is important to note first that Medicaid programs in 32 states and the District of Columbia are reimbursing for behavioral health peer support specialist services, either as an independent service or as part of a more comprehensive service.[i] In fact, the Centers for Medicare and Medicaid Services (CMS) noted in an August 2007 State Medicaid Director Letter that "Peer support services are an evidence-based mental health model of care" and recognized 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."[ii]

This reflects the fact that in a growing number of behavioral health systems, peer support specialists are supplementing the work of increasingly scarce professional psychologists, psychiatrists, and social workers in providing behavioral health services by:

- using their lived experience using services to help model recovery, provide hope, and assist individuals who are experiencing their first psychotic break with obtaining necessary services to continue their treatment and support their recovery;
- collaborating with and working with consumers, their families, and mental health providers to support engagement in services;

- assisting consumers in obtaining clarification about their treatment and the expected recovery process;
- assessing the quality and appropriateness of care planned and provided; and
- working with consumers, their families, and hospital discharge and after-care planning staff to provide information, offer support, identify appropriate referral options, and assist in linking to care and other resources relevant to natural supports in their community.[iii]

Behavioral health peer support specialists are expected to have the following skills and training:

- knowledge of behavioral health recovery language and principles;
- knowledge of consumer supports and social networks;
- an ability to work effectively with others and resolve interpersonal conflict;
- Peer Support Specialist training and certification;
- at least a high school diploma, with a Bachelor's Degree or higher preferred.[iv]

Increasingly behavioral health peer support specialists are often asked to interact and/or work directly on teams with parole and probation officials, facilitate interactions within consumer peer support groups, bolster self-advocacy skills, work with consumers in developing individualized strategies for reducing the negative consequences of drug use and noncompliance with medication regimens, and promote problem-solving and decision-making skill development in the areas of drug use and sexual risk reduction.[v]

In Georgia, the Department of Behavioral Health Developmental Disabilities has, since 2012, trained the more than 1,000 peer specialists it employs in its Medicaid program in also promoting wellness and healthy lifestyles among their consumers. As a result, Department officials report that consumers seem more engaged in their own health, with anecdotal reports of obese and overweight individuals losing weight, hypertensive individuals achieving better blood pressure control, and individuals with diabetes achieving better glucose control.[vi] This is crucial, since individuals with serious mental illness die 25 years earlier than the general population largely due to modifiable risk factors such as smoking, obesity, substance use, and inadequate access to medical care.[vii]

A national survey of 250 certified peer support specialists[viii] found that those individuals worked in a variety of settings:

Where PSS Work – Program Type	**Respondents = 257**
Independent Peer Support Program	62
Case Management	50
Partial Hospitalization or Day Program, Inpatient or Crisis	28
Vocational Rehabilitation	21
Drop-In Center	20
Therapeutic Recreation in Psychiatric Rehabilitation	7
Residential	10
Education and Advocacy	15
Other	44

Further, the work of peer support specialists extends beyond the behavioral health field. Peer support specialists also work with cancer patients, cancer survivors, and their caregivers,[ix] and with individuals with diabetes on self-management of their disease.[x]

The research base strongly suggests that the use of peer support services in state psychiatric hospitals and in the community shortens lengths of stays; decreases re-admissions; increases people's engagement into care; improves community linkages; reduces substance use among people with co-occurring disorders; increases overall wellness and quality of life; and can help reduce the use of emergency departments and the overall need for mental health services in the long term.[xi]

Unfortunately, the current draft of the NAIC Network Adequacy Model Act does not reflect—nor does it appear to accommodate—the prevalent participation and influence of peer support specialists, particularly in the behavioral health field. The central definitions of "health care provider" and "provider" in § 3(J) define those terms to mean a "health care professional." Those defined terms are used subsequently in defining the two terms so central to the draft, "network" in § 3(P) and "participating provider" in § 3(R). "Health care professional" is defined in § 3(I) as a "physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law."

It is not clear to us—particularly since the term "practitioner" is not defined within the draft—that a peer support specialist would necessarily qualify as a "health care practitioner." Central to the peer support specialist's role is his or her prior personal experience as a consumer of relevant services. It is that personal experience, primary and foremost, that qualifies the individual as a peer support specialist. Training requirements vary by state, but in no instance do they rise to the level of the training required of a physician or even, under the pharmacists' proposed amendment, to the level of a pharmacist. Unless "practitioner" is defined within the draft to include peer support specialists, or to include a more general term indicative of peer support specialists, it is not clear that managed care plans would view the model as requiring the inclusion of such specialists in a provider network to meet network adequacy standards.

It is generally recognized that one of the most significant barriers to universal access under the Affordable Care Act is the health care workforce shortage. In few fields is that shortage as pervasive as the mental health field. The Health Resources Services Administration (HRSA) recognizes, at last count, 3,968 Mental Health Care Professional Shortage Areas (HPSAs) in the nation, constituting about 50 percent of population need. HRSA estimates that the number of additional psychiatrists needed to achieve a population-to-psychiatrist ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated) in all designated mental health HPSAs, would be more than 2,700 psychiatrists nationally.[xii]

Providers of behavioral health services supplement the services provided by recognized professionals through the use of peer support specialists. The absence of peer support specialists from plan networks could further aggravate already significant access issues. For this reason, we ask that NAIC amend the definition of "health care practitioner" to, in some way, acknowledge the need for peer support specialists to be included in a plan network to satisfy behavioral health provider network adequacy standards.

Thank you for your attention to this very significant issue. If you have additional questions

regarding the issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,

Robert W. Glover, PhD.
Executive Director
National Association of State Mental Health Program Directors

cc: Mary Fleming, M.A., Director of the Office of Policy, Planning, and Innovation (OPPI), Substance Abuse and Mental Health Services Administration (SAMHSA).
Barbara C. Edwards, Director, Disabled and Elderly Health Programs Group, Centers for Medicare and Medicaid Services (CMS)

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[i] National Association of State Mental Health Program Directors (NASMHPD), *State Survey on Peer Support Services*, 2014.

[ii] SMDL #07-011, Centers for Medicare and Medicaid Services (August 15, 2007).

[iii] Job Posting Notice #147636, New York City Department of Health and Mental Hygiene, "Peer Specialist / NYC Supported Transition and Recovery Team (NYCSTART), Bureau of Mental Health," March 25, 2014.

[iv] Ibid.

[v] Job Notice for Mental Health Peer Specialist, https://careers-sus.icims.com/jobs/2476/peer-specialist%2c-mental-health/job?mode=job&iis=Job+Board+-+Indeed.com&iisn=Indeed.com&mobile=false&width=1680&height=942&bga=true&needsRedirect=false.

[vi] Tiegreen, W., MSW, "State Medicaid Program Reimburses for Physical Health and Wellness Services Provided by Mental Health Peers, Leading to Anecdotal Reports of Improved Outcomes," (May 7, 2014), http://www.innovations.ahrq.gov/content.aspx?id=4084 (last accessed August 11, 2014).

[vii] Parks, J. et al., "Morbidity and Mortality in People with Serious Mental Illness," NASMHPD Medical Directors Council (October 2006).

[viii] Saltzer, et al., *Psychiatric Services* 61:520-523 (2010).

[ix] http://www.peersupportnetwork.org (last accessed August 11, 2014).

[x] Fisher, E.B. et al, "Peer support for self-management of diabetes improved outcomes in international settings,"*Health Affairs* (January 2012).

[xi] Sledge, W., Lawless, M., Sells, D., Wiedland, M., O'Connell, M., & Davidson, L., "Effectiveness of Peer Support in Reducing Readmissions of Person With Multiple Psychiatric Hospitalizations," *Psychiatric Services* 62(5) (May, 2011); Davidson, L., Bellamy, C., Guy, K., & Miller, R., "Peer support among persons with severe mental illnesses: A review of evidence and experience," *World Psychiatry* 11(2) (2012); Bouchard, L., Montreuil, M., & Gros, C., "Peer support among inpatients in an adult mental health setting," *Issues in Mental Health Nursing* 31(2010); and Sells, D., Davidson, L., Jewell, C., & Falzer, P., "The treatment relationship in peer-based and regular case management for clients with severe mental illness," *Psychiatric Services* 57(8) (2006).

[xii] Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, HRSA Data Warehouse: Designated Health Professional Shortage Areas Statistics, as of April 28, 2014, http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/ (last accessed August 11, 2014).