10/30/19

Dear Esteemed Recovery Allies of North Carolina:

This letter is intended to present the Providers Perspectives of the PVNC Peer Support Standards Coalition, relative to the Proposed Medicaid Peer Support Service (hereafter "PSS" will refer to Peer Support Services) Definition. Below are concerns expressed by the PSS provider community about how the new proposed service definition would impact our peer support workforce and quality of Peer Support Services. Proposed solutions are also offered with requests for consideration.

Thank you in advance for your time and attention to the contents of this letter. On behalf of Medicaid funded Peer Support Providers of NC involved in this communication, there is significant concerns about the current proposed definition being implemented without an opportunity to work together to mitigate any unintended consequences that the changes would create for people served, Peer Support Specialists and providers, therefore a response is requested **BEFORE** the finalized new service definition is published for implementation.

First, concerns from PS Providers include:

1. A lack of involvement of peer support providers in drafting the new Medicaid funded Peer Support Definition is a very concerning approach to designing a service that must be effectively provided in the community. The peer support provider community welcomes opportunities to sit on committees to identify solutions and work through the realities of Medicaid parameters and providing the service. A written feedback period, after draft is written, is insufficient in ensuring that nuances of service provision is discussed, brainstormed and incorporated into the proposed definition. Further, impaired ability to comment or respond during the on-line webinar, made it impossible to engage in dialogue;
2. The proposed PSS Definition is clearly written from a clinical point of view. While it is recognized that medical necessity and Medicaid standards must be met, this can be

accomplished without compromising the integrity of peer support as an enhancement to clinical services without being a clinical service itself;

3. The proposed administrative requirements will require unreasonable burdens and expenses, likely resulting in reduction of access to the service and thereby negatively effecting network availability and choice in providers;
4. Clearly, there are PS providers that are not providing the service with integrity and attention to quality and there are MCO's that are not providing the adequate oversight to ensure that their provider network is not overusing or misusing the service. There are numerous ways to rectify this without disrupting access to people supported and employment of Peer Support Specialists. The provider community welcomes the opportunity to work together to identify these solutions.

Second, the proposed changes to the Medicaid PSS Definition leave many uncertainties and raise several issues, such as:

1. Compromised quality of services and negative outcomes;
2. Compromised flexibility and added administrative responsibilities and costs will result in some smaller providers being unable to continue providing the service or offer PSS at the current level of efficacy;
3. Compromised outcomes for people targeted for Transition to Community Living Initiative (TCLI) due to reduction in wrap around supports caused by proposed PSS Definition. Although the proposed CST service definition recommends adding CPSS to teams, it is not required. Currently the proposed CST Definition excludes PSS as standalone service when a person served is receiving CST. Peer support Specialists provide continuity in care that complements long term success for TCLI recipients to promote successful outcomes regarding the *Olmstead* agreement

Next, representative PS Providers request the following solutions:

1. Delay the "rollout" of the PSS definition until adequate attention is given to the concerns of the Peer Support provider community;
2. Meetings between DHHS, DMA and the PS providers and Peer Standards Coalition of Peer Voice of NC so those effected by new PSS definition are considered in its final version to reduce uncertainties and provide appropriate attention regarding concerns and solutions;
3. An appropriate response to this letter

Finally, these representative Providers herein request the following:

1. To be involved in the development of things that impact Peer Support Services in NC.
2. Remove stand-alone peer support as an exclusion to CST as peer support is a "recommended" but not a "required" component of CST.
3. Remove the service exclusion between PSR and PSS for the following reasons:

    a. PSS provides coordination of care to support whole person care as a bridge between mental health and medical providers,
    b. PSS is a one to one individual support that allows for in home as well as community inclusion supports
    c. TCLI reports indicate MORE wrap around services are needed to assist in long-term stability through transition rather than LESS
    d. PSR service is a daytime only model intended to support development of socialization onsite and does not require peer support embedded in the service
4. Peer support contracted through state funds for Peer Support, not only Comprehensive Care Centers, to provide for the needs of NC residents who are ineligible for Medicaid.
    a. The following LME/MCO's have limited peer support services from being delivered: Trillium, Cardinal, Partners

Related question as to what extent are block grant dollars being used in NC for Peer Support Services?

5. Peer support funded through Mental Health and Substance Use Block Grant dollars
6. A cost analysis of peer support services, including data on national rates and the costs associated with increased administration and training

Thank you for your consideration to these recommendations and a prompt response. The peer support providers of PVNC PSS Standards Coalition would like to serve as an active partner in matters related to the quality and future of peer support in NC.

PSS Standards Coalition Members,

Elliot Palmer Jr., NCCPSS, CEO of Share Hope, PVNC Strategic Planning Council Member
Kemi Amola-Hill, Ph.D, LPCS, NCC**,** CEO VOICE Therapeutic Solutions
Lisa Hainsworth, Genesis Project 1
Julie D. Hall, NCPSS, QP, NC Peer Support Specialists Coalition
Laurie Coker, Green Tree, NC CANSO
Dana Cea, MS, NCCPSS, CRC, NCLPCA, NCC, PVNC Strategic Planning Council Member
Dr. Trasha Black, CEO of Genesis Project 1

Toya Hooper, NCCPSS, CEO of Taking Care of Me, PVNC Strategic Planning Council Member
Cherene Caraco, NCCPSS, QMHP, QDDP, PVNC Project Director, CEO of PRN
Charlyne Boyette, NCCPSS, QP, LCASa, MDIV, JD, Universal Mental Health Services
Karen Gross CFAC, CPSS, PVNC Strategic Planning Council Member
Jennifer Whitfield, PSS Supervisor, SouthLight Healthcare