Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:

Connecting Members to Social Supports

_____

DECEMBER 2016

Contents

Anthem®

Public Policy Institute

EXECUTIVE SUMMARY

Anthem's affiliated health plans and other managed care organizations (MCOs) increasingly are helping Medicaid members who are diagnosed with mental health conditions and substance use disorders (MH/SUD) find stable housing, secure meaningful employment, and address a range of financial and daily life challenges. Evidence demonstrates that assisting individuals with social and economic factors, in addition to providing health care, directly affects overall health outcomes. As a result, many states are increasingly requiring and paying for managed care organizations to address these social and economic issues for Medicaid members.

> **Playing a larger role in addressing social and economic issues of Medicaid members raises new challenges for MCOs, including the need to identify the most effective ways of facilitating access to social supports.**

Playing a larger role in addressing social and economic issues of Medicaid members raises new challenges for MCOs, including the need to identify the most effective ways of facilitating access to social supports; build new kinds of partnerships with social service organizations such as housing agencies or employment programs; offer new benefits for members; hire staff with different expertise and life experiences; and respond to the lack of housing, education, job training, and other social supports in many parts of the country.

MCOs are working to connect members to these critical supports by venturing outside of the clinical domain to build strong partnerships with community-based organizations and developing more sophisticated tools and strategies for connecting members to tools that will support them to control their own care, services, and decision-making. As states look to implement and pay for managed care models that include requirements to connect individuals with MH/SUD to housing, employment, and other non-medical services, they should evaluate the critical supports required to actively engage members and link them to care and services that will improve their long-term stability, resiliency, and recovery.

IMPORTANCE OF CONNECTING MEMBERS WITH MH/SUD TO SOCIAL SUPPORTS

Recent evidence suggests that housing, food access, employment status, and other critical socioeconomic factors can have an impact on an individual's health status. For Medicaid members with a MH/SUD diagnosis, the importance of social and peer supports is more pronounced because these individuals face a complex set of health and socioeconomic issues.[1] In order to qualify for Medicaid, an individual must have an income near or below the poverty line. As a result, members often face a lack of safe and affordable housing, have difficulty paying for food, and must cope with any unexpected financial setbacks, such as a particularly high utility bill. In some cases, individuals must live in transient settings such as homeless shelters. If they do find housing, it is often in impoverished neighborhoods that lack grocery stores, parks, and other "public amenities" that contribute to a healthier lifestyle.

> ### What Are "Social Supports"?
>
> Social supports are non-medical services that can play a role in improving an individual's physical and mental health. Informal social supports are provided by family, friends, or faith-based organizations as part of an individual's social network. These informal arrangements assist individuals with MH/SUD in their recovery and resiliency through financial and emotional support. Formal supports are often provided by government programs (e.g., Supplemental Nutrition Assistance Program, Housing Choice Voucher Program) or non-profit or charitable organizations. Formal social supports can include community-based services related to housing, food assistance, employment programs, educational attainment and vocational training, peer networks, legal and financial services, transportation, and other services that assist individuals in meeting their day-to-day needs and becoming engaged members of their communities.

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

2

Role of Socioeconomic Factors in Driving Health Outcomes

Researchers, payers and providers are increasingly recognizing that social and economic circumstances often drive health outcomes as much, if not more, than clinical interventions:

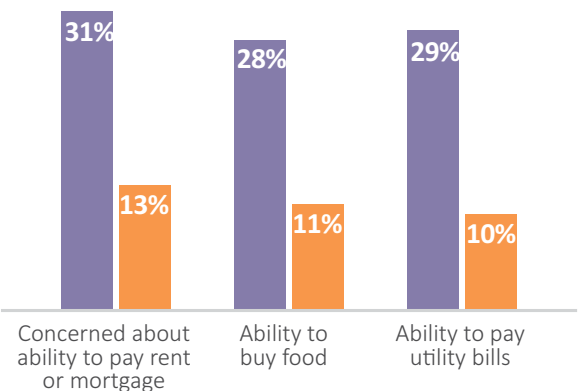## Social and economic circumstances often drive health outcomes[2]

- **40%** are driven by social and economic factors
- **30%** are driven by health behaviors
- **20%** are driven by clinical care
- **10%** are driven by physical environment
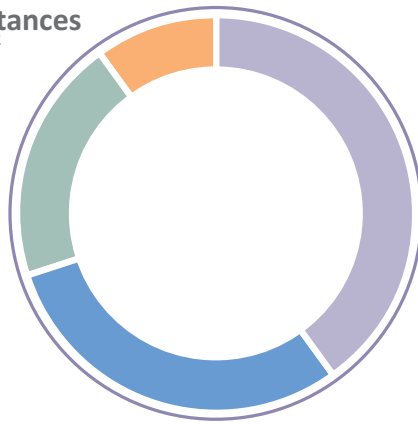
80% of physicians believe that addressing patients' social needs is as important to improving health and outcomes as addressing their medical conditions.[3]

Financial Problems Of Nonelderly Medicaid Beneficiaries, 1992[4]

- Non-elderly Medicaid Beneficiaries (ages 18-64)
- Non-elderly Americans (ages 18-64)

	Non-elderly Medicaid Beneficiaries	Non-elderly Americans
Concerned about ability to pay rent or mortgage	31%	13%
Ability to buy food	28%	11%
Ability to pay utility bills	29%	10%

Making the Health Care Case for Facilitating Access to Social Supports: New Research

As health plans and providers give more focused attention to addressing the social and financial issues of members, their efforts are generating new research on the impact on members' health outcomes. For example:

- A recent study at Massachusetts General Hospital found clinically meaningful improvements in patients' blood pressure and LDL cholesterol levels after they were connected to social supports.[5] The study suggests that building connections to social supports into the care delivery process can have an important effect on health outcomes.

- A May 2016 study showed a correlation between states with higher ratios of spending on social supports and services, such as housing, nutrition, and income support, compared to health spending and better health outcomes, including reduced mortality rates.[6] Another recent review of scientific evidence found several interventions, including housing and employment,that can improve population health and reduce health disparities.[7]

For those with MH/SUD, financial issues are only part of the challenge. Individuals may be living with anxiety or depression that can greatly exacerbate the complexity of navigating daily life. Individuals with a substance use disorder may not be able to prioritize their basic needs such as food and shelter above their addiction. Finally, many individuals with MH/SUD may have lost any connection they have to family or other informal social supports to assist them in their recovery.

There are a number of factors contributing to the heightened efforts of MCOs to connect members with community resources and services. For instance, there has been a sharp growth in the number of adults without children who now qualify for Medicaid and who are more likely to require a comprehensive array of social supports than the parents and children who long have been enrolled in managed care.[8] Likewise, states are expanding managed care to "non-traditional" and more complex populations such as individuals with disabilities, dual eligible beneficiaries, and children, youth and young adults in foster care who are

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

3

just as likely to require a comprehensive array of social supports. In light of these trends, states are increasingly requiring, and funding through the capitation rate, MCOs to provide assistance with housing, employment, financial issues, food security, nutrition, and a range of other social issues through additional care coordination and transitional services. Additionally, the focus on value-based payment models is encouraging MCOs to diversify and think more innovatively about the services that are necessary to improve health outcomes, including services and supports that were not historically part of the health care industry's purview.

A recent initiative launched by the federal Center for Medicare & Medicaid Innovation (CMMI) in January 2016 reflects the growing recognition that social supports are integral to better health outcomes. The five-year initiative, known as the "Accountable Health Communities Model," is the first to focus on addressing members' social needs.[9] Through the program, CMMI will award up to $157 million to "bridge organizations" that will be charged with screening members for social and mental health needs and connecting them with community-based services. In addition to providing funding, the initiative is also designed to measure how the interventions improve the quality and affordability of care and services. To this end, the model will test three approaches – community referral, community service navigation, and community service alignment – and assess each for its impact on total health care costs, emergency department visits, and inpatient hospital readmissions.[10]

ROLE OF MANAGED CARE PLANS IN PROVIDING SOCIAL SUPPORTS AND NON-TRADITIONAL SERVICES

Medicaid MCOs are responsible for using capitated payments as efficiently and effectively as possible to provide high quality care and services to improve members' health and wellbeing. MCOs have long recognized the value of integrating medical care and non-medical services to improve health outcomes and quality of life. MCOs, in many states, offer additional benefits to ensure individuals are connected to these non-medical services, including social supports. For individuals with a MH/SUD diagnosis, these kinds of connections can accelerate an individual's path to stability and long-term resiliency and recovery.

The key ingredients of these efforts include:

- Developing effective tools to assess an individual's needs
- Creating a plan with each member to meet those needs
- Providing a variety of care coordination services to assist members in obtaining supports
- Building partnerships with community-based organizations that can deliver the necessary social supports and services
- Providing support through non-medical professionals, particularly those who have personal experience living with a MH/SUD or otherwise have commonalities with the member

Integration Promotes Independent Living

Joe has a history of depression, cocaine dependence, schizophrenia, chronic obstructive pulmonary disease, hypertension, and dysphasia. He also has a history of incarceration and homelessness. Joe was enrolled in one of Anthem's affiliated plans' Complex Case Management Program following a hospitalization for withdrawal management and suicidal ideation. The plan's case manager arranged for supportive housing for Joe upon discharge. She also set up appointments with Joe's primary care physician, made arrangements for lab work and intensive outpatient services, and coordinated with Joe's community case manager. The case manager made home visits to provide support and monitor his progress. Joe resided in supportive housing for 18 months until he successfully transitioned to an independent living apartment. Joe now participates in a day program five days a week to help him build social and living skills, and continues to receive medication management and case management services at his community mental health center. Joe has not required hospitalization since January 2012 and remains drug free.

Note: Names are fictitious to protect the identity of the member

These efforts help members return to or continue to reside in their communities with connections to family members or others who can support them in their recovery.

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

4

Coordinating Connections to Social Supports

To better assist members with MH/SUD in choosing the services and supports they will access to address their needs, Anthem's affiliated plans and other MCOs around the country are expanding the role of case managers and thinking about new ways to assist in connecting high-need members with social supports and non-medical services. MCO case managers have always helped with scheduling follow-up medical appointments and making sure members understand their care plans, but many are now also helping members connect with housing, food assistance, child care, and other resources that can promote stability in their lives. If an individual requires more support and assistance, plans may engage case managers or peer support specialists to work directly with members in their homes or communities. Although the approach taken by individual plans may vary, the key elements of these efforts include:

- **Inclusion of social needs in initial assessments.** When assessing whether a member with a MH/SUD requires comprehensive care management, Anthem's affiliated plans consider a broad array of needs, including whether the member has concerns about financial stability (e.g., large unpaid bills, job loss), housing, employment, family/relationship issues, domestic violence, immigration status, language or cultural barriers to securing care, transportation problems, legal issues, parenting challenges and more. MCO case managers will also assess members' current social support network, including family or friends who can support them in their recovery.

- **Care management plans that include social supports.** With the consent and participation of the member, case managers conduct a comprehensive review of the member's medical and social support needs and develop a care management plan. Driven by the member and his/her priorities, the plan often includes goals such as maintaining or improving one's social support network, maintaining stable housing, or securing steady employment. If the member chooses, a family member or other member of his/her social support network can participate in these planning processes.

- **Comprehensive approaches to identifying social supports.** Since MCOs are often connecting members with social services and supports (rather than directly providing them), they are growing more sophisticated when it comes to leveraging tools that can help to identify available community resources. For example, Anthem's affiliated plans have begun using an online platform that allows case managers and members to find food assistance, peer support groups, legal aid and other social services in their area.

- **Case managers with experience in the community.** While some Medicaid members with MH/SUD can manage well with telephonic support, others are more likely to engage with face-to-face support from someone with whom they can build a trusting relationship. For high-need members, Anthem's affiliated plans increasingly are seeking to provide on-the-ground case management services that allow members to meet in-person with case managers. Case managers might visit members during an inpatient stay to begin to build or re-establish a relationship, conduct home visits, accompany members to medical or social service appointments, or connect individuals with community supports such as housing. To achieve this level of engagement, the plans look for case managers and peer-support specialists with deep roots in the communities that they will be serving, recognizing they may be particularly adept at understanding and using community resources to meet social service needs.

Case Managers: Making Connections and Reducing Hospitalizations

In the year prior to being connected with a case manager, a member in one of Anthem's affiliated plans had over 15 emergency room visits and three inpatient psychiatric hospitalizations related to his mental health and physical health conditions. The member had a history of previous suicide attempts and drug abuse over the last ten years, and was at high risk for another suicide attempt and/or an overdose. He did not have stable housing and was not receiving medical care for a seizure disorder. The health plan case manager met the member during an inpatient hospitalization and assisted him in finding housing after discharge. The case manager also connected him to ongoing therapy, psychiatric, and rehabilitative services and assisted him in applying for Social Security Disability Income benefits. After several months in stable housing, the member has had only two hospitalizations that were a result of adverse reaction to his medications. This example shows the value of case managers engaging members and providing linkages to housing and outpatient care services that can positively impact members' lives.

> ### Hiring to Assist in Making Connections to Community Resources
>
> In 2015, New York launched Health and Recovery Plans (HARP), a new managed care program for adult Medicaid members with MH/SUD. As the health plan recruited new staff, it hired individuals who had direct experience working with the population and working within the social service organizations, shelters, or as part of Assertive Community Treatment (ACT) teams. This approach has assisted the health plan in developing connections with community-resources and more easily linking members to important supports.

Services Provided by Peers

MCOs increasingly are turning to peer support specialists to assist members with a variety of physical or mental health conditions. Non-medical professionals who have lived experience related to a specific MH/SUD condition can be critical in supporting individuals with MH/SUD in their recovery. Often called peers, peer support specialists, or peer navigators in the mental health field, these professionals leverage the commonality of their lived experiences to provide the emotional, social and practical assistance necessary for an individual to manage a given health condition and maintain recovery and resiliency. Peer support specialists do not replace the role of clinical care providers, but rather work in partnership with them to complement and extend formal primary care or MH/SUD services and to coordinate these services with community-based supports.[11]

For members with a MH/SUD diagnosis, peer support specialists can base their support and assistance on a shared affiliation and a deep understanding of the experience of having a MH condition or SUD. As such, they can offer concrete help translating clinical instructions into actionable steps for members, as well as serve as a mentor and coach when challenges arise.[12] There is early evidence that indicates peer support specialists can have a marked impact on clinical and quality-of-life outcomes and reduce utilization of inpatient services and related costs.[13] Over time, it can be expected that they will play an even more important role in providing members with MH/SUDs access to high quality, cost-effective care.

Anthem's affiliated plans and other MCOs offer peer support in two main ways. First, MCOs are hiring individuals with lived experience as peer support specialists for their internal operational teams. The employees who fill these roles work with care coordinators and others to conduct out- reach to members and participate in operational and policy development within the plan. Second, MCOs contract directly with peer support organizations to ensure peer support specialists are accessible to members as part of their provider networks. These organizations can extend the reach of peer support to additional members and work closely with MCO care coordinators to engage members who may be at high-risk for adverse events (e.g., an individual who is homeless and who was just discharged from the hospital).

Housing

In response to the high costs associated with individuals with MH/SUD who are homeless or are in unstable housing situations, state and local officials, health plans, providers, and social service organizations are looking to develop housing opportunities. It is well documented that individuals who are experiencing homelessness are at increased risk of developing or having chronic health conditions, mental health conditions, and substance use disorders.[14] They also are more likely to visit the emergency room (ER), have a longer hospital stay if admitted, and be readmitted to the hospital within 30 days of discharge.[15] There has been recent nationwide acceptance of Housing First policies, an evidence-based philosophy that acknowledges an individual is more likely to address health concerns and access services if they have a safe, stable home and are engaged as a member of their community. The Housing First approach preserves the dignity of the person by providing him/her with shelter; in addition, it has shown promise to reduce health care spending, decrease incarceration rates,[16] and improve recovery outcomes for individuals with MH/SUD.[17] For example, a 2016 study of a Housing First program in Oregon found an average annual reduction in Medicaid expenditures of $8,724 per enrollee, largely due to fewer ER visits and inpatient stays.[18] Of equal importance, participants reported a reduction in unmet medical needs, strengthened connections to primary care services, and improved outcomes on subjective measures of health and happiness.[19]

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

6

MCOs are working with their state partners to test and implement models that support individuals in finding and maintaining stable housing in order to improve health outcomes associated with their MH/SUD. While Medicaid funds cannot be used to pay for rent, the funds can be used to provide supportive services to assist individuals to stay and maintain their health and independence in an apartment or other rental arrangement. Anthem's affiliated plan in Louisiana currently pays experienced supportive housing organizations to offer housing support services, including housing case management, pre-tenancy/transition supports, housing maintenance, and crisis services. These services include helping a member look for housing by connecting them with the local affordable housing referral system; providing assistance with applications and collecting required documents (e.g., Social Security card, birth certificate, prior rental history, references); verifying disability or homelessness status for supportive housing eligibility; communicating with landlords; coordinating a move; contracting to install home modifications for accessibility; providing education on good tenancy; advocating for a member if problems arise with a landlord; and taking action to improve the safety and stability of a housing situation.

Engaging Individuals to Support Their Recovery

A Wellness and Recovery Specialist from Anthem's affiliated plan in Nevada recently visited a nineteen-year-old single mother in a local facility. She was refusing to participate in group sessions and refusing to eat because it required leaving her room. After a few minutes of engaging and sharing her story, she expressed how much she missed her son. The Wellness and Recovery Specialist was able to engage further with the member by sharing her lived experience, telling her that she had been a patient in the same facility when she was not much older than the young woman. She also shared that her children were toddlers when she was hospitalized and she knew how hard it was to be away from them. The conversation then shifted into how they, as mothers, have to take care of themselves so that they can take care of their children. The Specialist was also able to discuss the importance of aftercare, including seeing a psychiatrist, accessing therapy services, and using the expertise of a case manager to assist her when needed. The member was able to move forward with her recovery as a result of peer engagement.

Core Peer Support Competencies[20]

There are many peer support frameworks; for example, the Substance Abuse and Mental Health Services Administration articulates five core competencies to guide service delivery and promote best practice in peer support:

- **Recovery-orientation:** Peer support workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life.

- **Person-centered:** Peer recovery support services are always directed by the person participating in services and personalized to align with specific hopes, goals, and preferences of the individual.

- **Voluntary:** Peer support workers are partners or consultants to those they serve.

- **Relationship-focused:** The relationship between the peer support worker and peer is foundational to services and support provided. The relationship is respectful, trusting, empathetic, collaborative, and mutual.

- **Trauma-informed:** Peer recovery support uses a strength-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

7

Tarrant County Supportive Housing Pilot

Anthem's affiliated plan in Texas has recently joined with a number of local partners – including the Salvation Army, the local mental health authority (LMHA), John Peter Smith Hospital, and Tarrant County – to establish a supportive housing pilot program in Tarrant County, TX. Launched in November 2015, the program places eligible members in housing and provides them with a range of case management and other supportive services that can help reestablish them within the community.

- **Housing for Members with Complex Service and Support Needs.** The plan and the Salvation Army work together to identify members with complex needs who are receiving services from both entities and who meet the definition of "homeless" under the U.S. Department of Housing and Urban Development (HUD) guidelines. Members who qualify are placed in one of 14 apartments in Tarrant County that have been leased by the Salvation Army and reserved for program enrollees. The apartments are scattered across the county. Members can also get help from a county housing coordinator in filling out the forms and producing the documentation necessary for the rental, such as a driver's license, social security card, or housing application.

- **Connections to Social Supports.** Once the plan's members have moved in to their new homes, they are provided with care management services to connect them to needed social supports. The Salvation Army case manager completes a health assessment to determine the enrollee's full range of health and social support needs. The health plan provides a service coordinator as needed to assist the member in navigating available clinical and social support. If the individual has a MH/SUD, the health plan will also provide a case manager to collaboratively develop a care plan with the member and connect him or her to outpatient providers and social supports.

- **Coordination with Partners.** Each partner in the pilot fulfills a distinct need. The Salvation Army holds the lease, finances the apartments, and assists enrollees through an onsite manager. John Peter Smith Hospital and the Tarrant County LMHA deliver inpatient care and recovery and resiliency services as needed. The health plan manages covered benefits and provides any necessary care management and service coordination across all of these entities, while the county provides funding and oversight in support of the project. These complementary services allow for the coordinated provision of health plan benefits, clinical care, housing services, and social supports.

Educational, Employment, and Vocational Services and Supports

As the Centers for Medicare & Medicaid Services (CMS) has said, "...work is a fundamental part of adult life for people with and without disabilities. It provides a sense of purpose, shaping who we are and how we fit into our community."[21] With CMS' strong encouragement and in recognition that work can increase the financial stability, health outcomes, and self-esteem of members with MH/SUD, MCOs work with providers to offer services to support members' employment and educational goals. The most intensive efforts are focused on individuals with severe mental illness enrolled in Medicaid home and community-based waiver programs. The range of services they may receive include: day habilitation services that increase their independence and interpersonal social skills; prevocational services that provide them with additional skills such as the soft skills (e.g., navigating schedules and directions, focusing on details, and problem solving); and supported employment in which they receive ongoing intensive supports to obtain and maintain a competitive, integrated job. For other members, case managers or peer support specialists may connect them to job search resources, preparation, and training opportunities.

> **Anthem's affiliated health plans have long recognized the value of integrating medical care and non-medical services to improve health outcomes and quality of life.**

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

8

> ### Connecting Individuals with Employment
>
> A number of Anthem's affiliated plans offer their members access to a benefit package that incorporates social supports. For example, Anthem's affiliated health plan in Tennessee recognized the need for more recovery-oriented services and worked with a non-profit to increase access to wellness and recovery services for adults. The partnership, called "Recovery Diner," now serves as a best practice in the areas of psychosocial rehabilitation and supported employment. Individuals who are interested in working receive supported employment services, even when they are experiencing symptoms of serious mental illness or SUD. The program has generated positive recovery outcomes, finding that individuals feel better when they work, no matter where they are in their recovery journey. Indeed, 88 percent of the plan's adult members with psychiatric disabilities who obtained a job retained it for at least 90 days.[22]

Increasing Access to Nutrition and Healthy Foods

A lack of access to healthy nutritious foods, like fresh fruit and vegetables, is associated with a number of health problems, including diabetes, heart disease, depression, obesity, and complications with pregnancy, such as gestational diabetes. Individuals struggling with food insecurity are often forced by limited resources to purchase food over necessary medications, postpone medical care, and forgo foods necessary for specialized diets to manage conditions like diabetes or high blood pressure. Thus, Medicaid MCOs and other entities are increasingly working to address the challenges that many members face in accessing affordable, healthy foods. Although not limited to members with MH/SUD, these efforts are often relevant given the high rates of co-morbid physical health conditions.

The efforts of MCOs to increase access to healthy foods include connecting members to food pantries and other food assistance programs in the community, assisting them in completing applications for the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) benefits, and providing educational support regarding how to choose affordable, healthy foods and cook nutritious meals.

EMERGING CHALLENGES AND OPPORTUNITIES

While Anthem's affiliated plans are expanding their role in providing and connecting members with social supports and services, there remain a number of challenges. Ensuring coordinated, effective care and services for members with a MH/SUD who face challenges with unstable housing, finances, employment, and food insecurity, requires a robust and personalized approach for each individual. MCOs must address the traditional "silos" that exist between health care and social service providers and the lack of access to key social supports such as housing, job training and educational opportunities in many parts of the country.

Despite these challenges, there are a number of promising opportunities and responses emerging from the work of Anthem's affiliated plans and other MCOs. As they track their members' clinical diagnoses, care utilization patterns, and increasingly, social support and non-medical needs, MCOs are uniquely positioned to partner with Medicaid agencies to evaluate innovative, holistic social support models. For example, they are able to assess whether their members are, in fact, reducing their ER use or inpatient hospital stays as they secure housing, peer support, or a range of other social supports. By doing so, MCOs can help to monitor and identify the non-medical services required to most efficiently support individuals with MH/SUD in their communities and address these needs earlier. The earlier these needs are addressed, the sooner individuals can focus more directly on their health and move to recovery.

In addition, as more and more hospitals, social service organizations, and health plans attempt to connect individuals to social support services, it sometimes creates inefficiencies and imposes a burden on members who find themselves repeatedly undergoing assessments of their social service needs.[23] In response, case managers at Anthem's affiliated plans often begin their engagement with members by first determining what is most important to the member and who is part of their support team, and then they plan how to "fill in the gaps" to improve quality of life, health and wellbeing without creating duplication for the member.

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

9

CONCLUSION

The evidence is clear that social and economic factors have an impact on individuals' health and wellbeing, particularly those with MH/SUD. Anthem's affiliated plans continue to employ strategies to help members with MH/SUD overcome challenges related to housing, finances, employment, and a range of other support needs. As they further develop tools and strategies for addressing social support needs, MCOs must evaluate how they improve health outcomes, lower the rate of growth in health care spending, and improve stability, quality of life, and wellbeing of their members.

Care management and peer support services that directly engage members through technology and/or in their own homes and communities are critical in linking members to housing, education and employment, and other needed supports. These linkages have yielded successful outcomes for many individual members with MH/SUD. These successes arose out of direct engagement with members and investments in community partnerships, such as the Tarrant County Housing example.

As more states begin to think about program changes that will shift additional populations, including individuals with MH/SUD, into managed care, they should identify both the medical and non-medical care and services required to support individuals in their recovery and resiliency.

This paper is one of several issue briefs focused on integrating care for physical health and mental health and substance use disorders; the others are available at http://anthempublicpolicyinstitute.com. The Anthem Public Policy Institute gratefully acknowledges the support of Manatt in the research and writing of this paper.

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

10

END NOTES

1. Mahadevan, R. and Houston, R. "Supporting Social Service Delivery through Medicaid Accountable Care Organizations: Early State Efforts," Center for Health Care Strategies, Inc., February 2015. Available at: http://www.chcs.org/media/Supporting-Social-Service-Delivery-Final_0212151. pdf. and DeCubellis, J. and Evans, L. "Investing in the Social Safety Net: Health Care's Next Frontier," Health Affairs Blog. July 2014. Available at: http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier.

2. Booske, B.C., Athens, J.K., Kindig, D. A., et al. "Different Perspectives for Assigning Weights to Determinants of Health," University of Wisconsin Population Health Institute, February 2010. Available at: https://uwphi.pophealth.wisc.edu/publications/other/different-perspectives-forassigning-weights-to-determinants-of-health.pdf.

3. Bachrach, D., Pfister, H., Wallis, K. and Lipson, M. "Addressing Patients' Social Needs: An Emerging Case for Provider Investment," Commonwealth Fund, May 2014. Available at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf.

4. Blendon, R.J., Donelan K., Hill C., Scheck A., Carter W., Beatrice D., Altman, D. "Medicaid beneficiaries and health reform." Health Affairs, 12, no.1 (1993): 132-143.

5. Berkowitz, S., Yelibi, C., Atlas, S. "Addressing Basic Resource Needs in Primary Care Improves Blood Pressure and Cholesterol Control: A Pragmatic Intervention," Society of General Internal Medicine. Study Abstract. http://healthleadsusa.org/wp-content/uploads/2015/06/SGIM-National-Health-Leads-Submission.pdf.

6. Bradley, E. Canavan, M., Rogan, E., Talbert-Slagle, K., Ndumele, C., Taylor, L., and Curry, L. "Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09," Health Affairs, 35 No. 5 (2016), 760-768 doi: 10.1377/hlthaff.2015.0814.

7. Thornton, R., Glover, C., Cene, C., Glik, D., Henderson, J., and Williams, D. "Evaluating Strategies for Reducing Health Disparities by Addressing the Social Determinants of Health," Health Affairs 35, no. 8 (2016): 1416-1423 doi: 10.1377/hlthaff.2015.1357.

8. Paradise, J. "Medicaid Moving Forward," Kaiser Family Foundation Issue Brief, May 2015. http://files.kff.org/attachment/issue-brief-medicaid-moving-forward.

9. Department of Health and Human Services. "First-ever CMS Innovation Center pilot project to test improving patients' health by addressing their social needs." January 2016. Press Release. http://www.hhs.gov/about/news/2016/01/05/first-ever-cms-innovation-center-pilot-project-test-improving-patients-health.html.

10. Community referral is Track 1 and is intended to increase beneficiary awareness of availability of community services and provide information dissemination and referral. Community services navigation refers to assisting high-risk beneficiaries with accessing services (Track 2) and community services alignment is intended to create partnerships that align organizations to ensure access to services (Track 3). Source: Centers for Medicare and Medicaid Services, "Accountable Health Communities Model," https://innovation.cms.gov/initiatives/AHCM.

11. Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., Goodale, L. (Ed). Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services. January 2010. Available at: http://www.pillarsofpeersupport.org/final%20%20PillarsofPeerSupportService%20Report.pdf.

12. Druss, B.G., et al. "The Health and Recovery Peer (HARP) Program: A Peer-Led Intervention to Improve Medical Self-Management for Persons with Serious Mental Illness." Schizophr Res. 2010 May; 118(1-3): 264–270. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2856811. and Kelly, E., et al. "A Pilot Test of a Peer Navigator Intervention for Improving the Health of Individuals with Social Illness." Community Mental Health Journal. 2013. http://www.integration.samhsa.gov/workforce/Brekke_Research.pdf.

13. Peers for Progress, 2014.

14. Wright, B.J., Vartanian, K., Hsin-Fang, L., Royal, N., Matson, J.K. "Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing." Health Affairs, 35, no.1 (January 2016).

15. Moses, K., Davis, R. "Housing is a Prescription for Better Health." Health Affairs Blog. July 2015. http://healthaffairs.org/blog/2015/07/22/housing-is-a-prescription-for-better-health.

16. Larimer ME, Malone DK, Garner MD, Atkins DC, Burlingham B, Lonczak HS, et al. "Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems." JAMA. 2009;301(13):1349–57. and Srebnik D, Connor T, Sylla L. "A pilot study of the impact of housing first–supported housing for intensive users of medical hospitalization and sobering services." Am J Public Health. 2013;103(2):316–21.

17. Padgett DK, Stanhope V, Henwood BF, Stefancic A. "Substance use outcomes among homeless clients with serious mental illness: comparing Housing First with Treatment First programs." Community Ment Health J. 2011;47(2):227–32. and Collins SE, Malone DK, Clifasefi SL, Ginzler JA, Garner MD, Burlingham B, et al. "Project-based Housing First for chronically homeless individuals with alcohol problems: within subjects analyses of 2-year alcohol trajectories." Am J Public Health. 2012;102(3):511–9.

18. Wright, et al., 2016.

19. Wright, et al., 2016.

20. Adapted from, "Core Competencies for Peer Workers", www.samhsa.gov/brss-tacs/core-competencies-peer-workers, downloaded 03/21/2016.

21. CMCS. "Updates to the §1915(c) Waiver Instructions and Technical Guide regarding employment and employment related services." CMCS Informational Bulletin, September 2011. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-16-2011.pdf.

22. Interview with Anthem affiliated health plan subject matter experts, November 16, 2015.

23. Span, Paula. "The Tangle of Coordinated Health Care." The New York Times. April 13, 2015. http://www.nytimes.com/2015/04/14/health/the-tangle-of-coordinated-health-care.html?_r=0.

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:
Connecting Members to Social Supports

11

About the Anthem Public Policy Institute

The Anthem Public Policy Institute was established to share data and insights to inform public policy and shape the health care programs of the future. The Public Policy Institute strives to be an objective and credible contributor to health care innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem's innovative programs.

About Anthem, Inc.

Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With over 73 million people served by its affiliated companies, including more than 40 million enrolled in its family of health plans, Anthem is one of the nation's leading health benefits companies. For more information about Anthem's family of companies, please visit www.antheminc.com/companies.

Anthem®

Public Policy Institute