Accountable Care Communities: A Health Plan Perspective

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Topics:

- Anthem: who we are, our value-based payment footprint
- Social determinants of health and why they matter to the future of value-based health care
- What we are doing today to address SDOH for health plan members
- Future state for payers and other stakeholders working on Accountable Care Communities and SDOH

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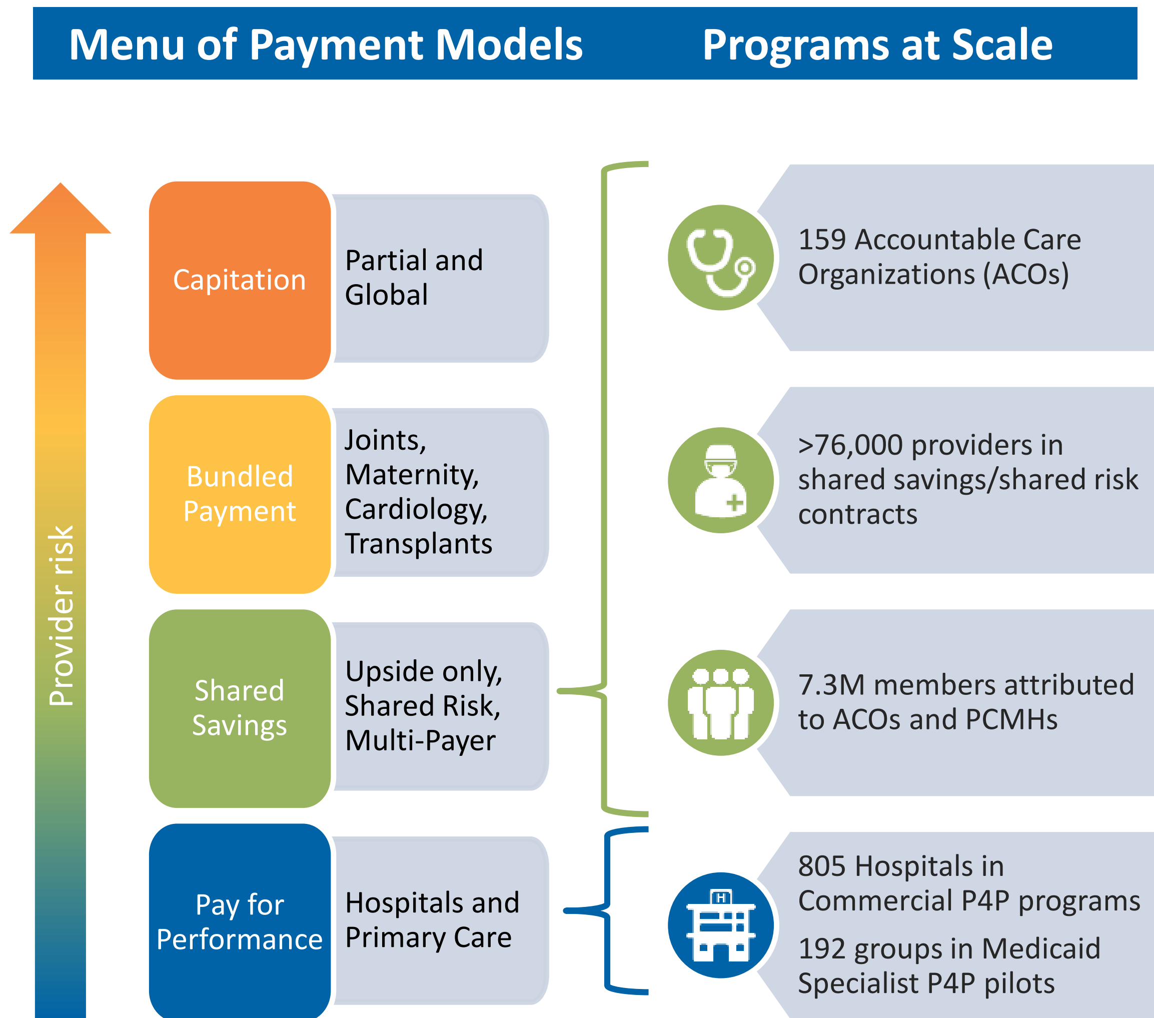
Anthem's Enterprise Commitment to Value-based Care



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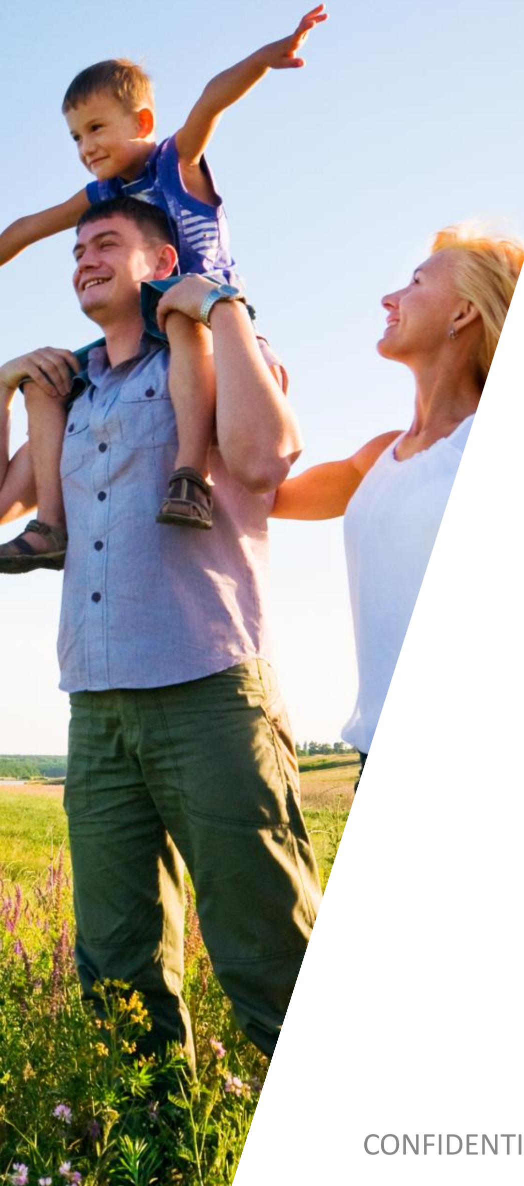

Social Determinants of Health

- We understand that social and economic factors have an impact on health and well-being – for example, housing, employment, transportation, food security and health literacy
- Many states are requiring and paying for MCOs to address social determinants of health for Medicaid members
- Our Medicaid health plans have made significant investments in addressing SDOHs for their members
- We know we must address SDOH as we expand value-based payment and patient-centered care models

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Our investments in SDOH

A case management program that includes assessment and creation of plans for addressing social needs, care coordination services, and community social services coordination

Partnerships with community-based organizations that address social needs

Housing Liaisons, Employment Liaisons and other corporate resources to coordinate housing and employment programs

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A new model:
Washington State Foundational Community Support Award for Housing and Employment

Washington State 1115 Medicaid Transformation Demonstration

Demonstration Goals:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs;
- Convert 90% of Medicaid provider payments to reward outcomes instead of volume;
- Support provider capacity to adopt new payment and care models;
- Implement population health strategies that improve health equity; and
- Provide new targeted services that address the needs of our aging populations and address key determinants of health

Transformation through Accountable Communities of Health

Foundational Community Supports

Long-term services and supports

Our role

Statewide targeted home and community-based services managed by an MCO.

Intended to help Medicaid beneficiaries with complex health needs transition to and maintain community placements

FCS Program Objectives and Components

Objectives

- Collaborate with community resources **to build and maintain a statewide provider network** and community supports for each benefit;

- Deliver **supportive housing and supported employment benefits** to eligible Medicaid individuals in Washington State through contracted networks;

- Implement **innovative member engagement strategies** that are culturally and linguistically appropriate, in coordination with existing delivery systems;

- Demonstrate that provision of these benefits to individuals with complex health needs **improves health outcomes and reduces dependence** on more intensive service settings;

- Ensure **seamless transition of individuals** receiving services through existing programs into the newly contracted program; and

- Prepare to **transition the administrative functions of the program to a sustainable model by the end of the contract period**, by aligning contracting, credentialing, billing, and payment structures with the current Apple Health Managed Care Organizations (MCOs) and Fee for Services processes.

Components

One-time Community Transition Services (CTS), that assist an individual to transition from institutional to community settings, or to help those at imminent risk of institutionalization to remain in community settings;

Community Support Services (CSS) that provides ongoing services and supports to help eligible individuals obtain and maintain stable housing

Individual Placement and Supports (IPS) services that help eligible individuals obtain and maintain stable employment.

Health insurers and MCOs can power accountable care communities

We can rely on our strengths and expertise:

- Scale and understanding of individual markets
- Integrated care management services allow to identify needed services
- Data collection and reporting
  - Analysis to identify and track population health needs
- Provider relationships
- Social service agency relationships under two models:

  1) connect member to agency

  2) we contract with the agency and directly fund the agency's work

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On the horizon: payment models that account for provider engagement in SDOH

Challenges:

- Tracking and measuring interventions and improvements
- Risk adjustment
- Prioritization of needs and interventions
- State Medicaid policy

Reasons to move ahead:

- Return on investment
- Compatibility with the patient-centered care model
- Social and economic barriers limit what we can achieve if we work only in the clinical sphere

Accountable care payers and conveners: present and future

Medicare

Today: Accountable Care Communities Program initiated and funded

Future: traditional Medicare with case managers

Medicaid

Today: State Medicaid agencies asking for MCOs to take on SDOH

Future: Addressing SDOH a standard requirement of MCOs

Future: more states adopt managed care to take advantage of ability to address SDOH

Conveners:

Multi-payer coalitions, Public Health Agencies

Today: Conveners bring together and assist payers and providers to work together to design and implement accountable care communities

Future:

Value-based payment accounting for SDOH interventions

Questions and Discussion

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