Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem Blue Cross and Blue Shield integrated care model

Indiana Medicaid Whole Health Director

Sherry Mukasa Matemachani brings 20 years of community health experience to her role as Medicaid whole health director for Anthem Blue Cross and Blue Shield (Anthem) in Indiana. Her work in Indiana began in 2003 with the Minority Health Coalition of Marion County and the Indianapolis Healthy Start program. From there, she spent nine years as an independent consultant, working on special projects in maternal, infant, and community health. In 2011, Sherry took a position with Goodwill of Central and Southern Indiana to support their implementation of the Nurse-Family Partnership model. Her most recent move was in 2022 to the Indiana Medicaid division for Anthem. Sherry received an undergraduate degree in Community Health Education from the University of Cincinnati in 2001, a graduate certificate in Strategic Communication from Purdue University in 2015, and she is a certified health education specialist.

What is whole-person integrated care?

Integrated health care: Integrated health care is an approach characterized by a high degree of collaboration and communication among health professionals:

- What makes integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the physical health (PH), behavioral health (BH), and social needs of the patient.[1]

Whole-person care: "The coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."[2]

1 Integrated Health Care (apa.org) https://apa.org/health/integrated-health-care
2 https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.

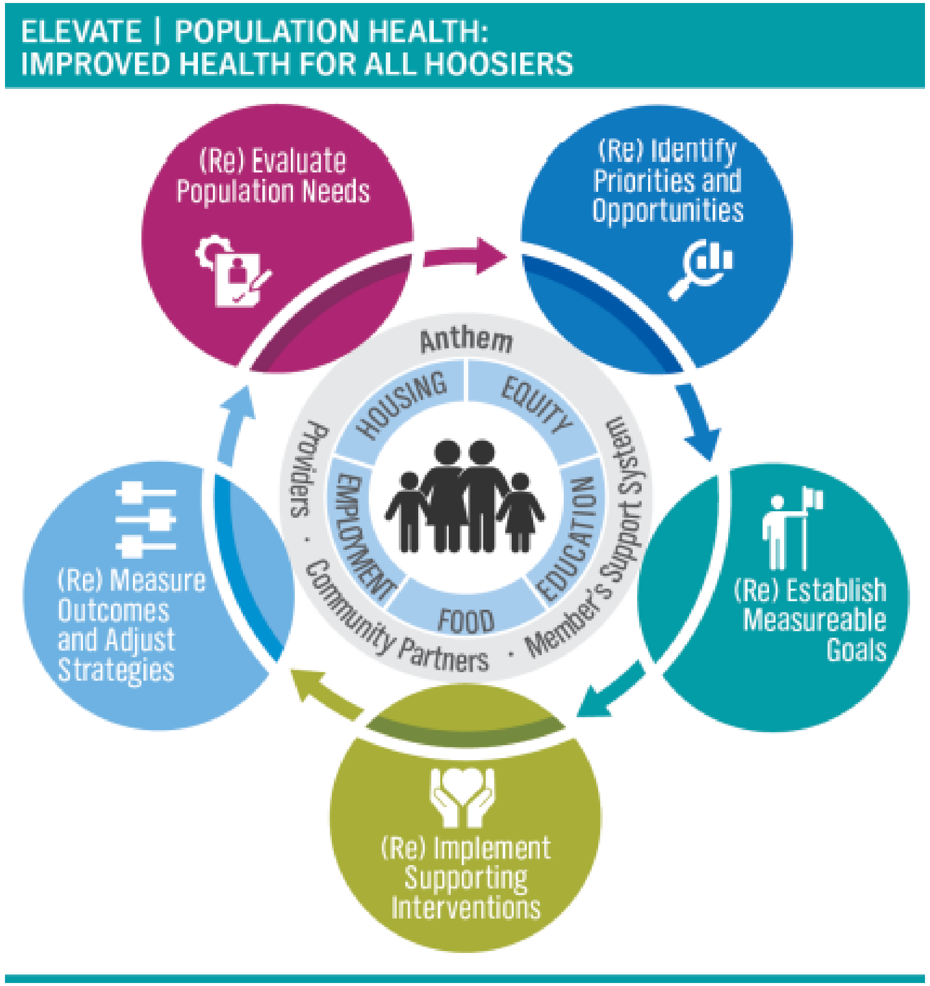
What is whole-person integrated care? (cont.)

Population health:

- Addresses the needs of our Medicaid members at two levels:
  - As a **population.**
  - And focusing on the individual circumstances, health, and well-being of **each individual member**.

Our continuous improvement model elevates **physical health (PH) and behavioral health (BH)**, drives **health equity**, and builds capacity through community partnerships that address **social drivers of health**.

We **continuously** re-evaluate population needs, re-identify priorities, re-establish measurable goals, re-develop programs and interventions, and re-measure outcomes.

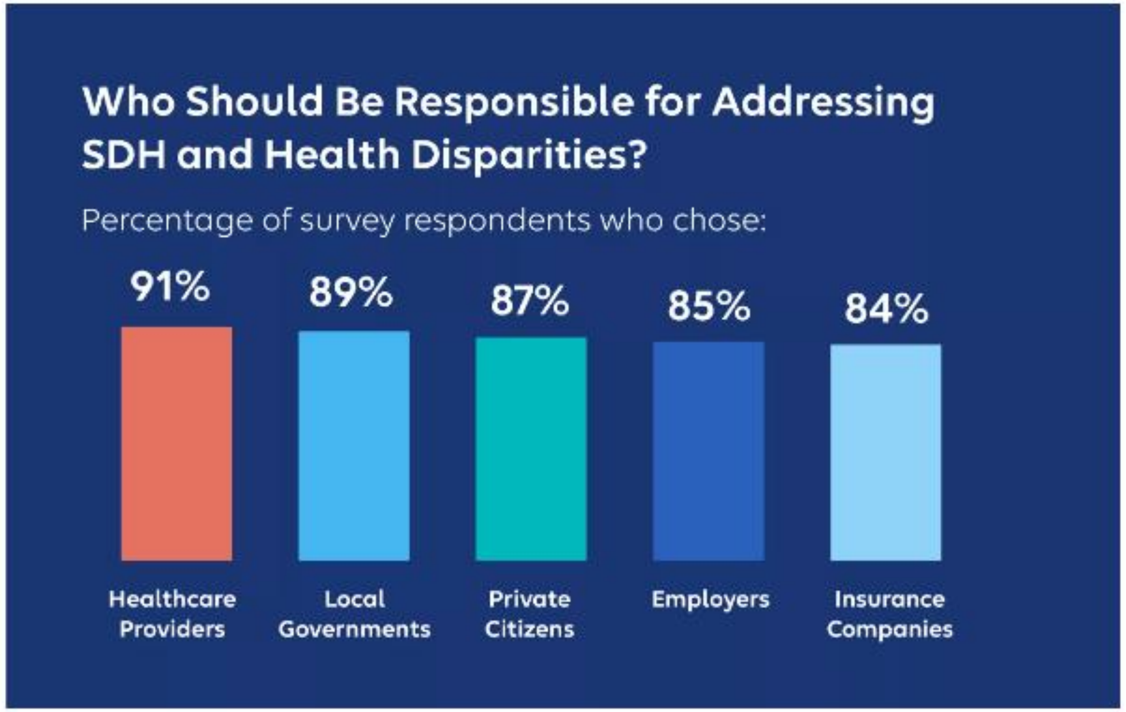


What is whole-person integrated care? (cont.)

- **Health equity:** Driven by data and compassion for the needs of our diverse membership. We meet with our members and their families in their communities with **customized solutions** for specific population groups, counties, and zip codes across the state.
- Anthem is the **only Medicaid managed care entity (MCE) in Indiana to hold the National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction**.
- Anthem will pursue and achieve NCQA's new Health Equity Accreditation once available.

What is whole-person integrated care? (cont.)

- **Social drivers of health (SDOH/ SDH):** Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes.[3]



3 https://www. elevancehealth.com/maintenance/home/research/social-drivers-of-health.html

What is whole-person integrated care? (cont.)

Why we're using the word **drivers** instead of **determinants:**
Social drivers, also known as social determinants of health, are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. However, *determinants* suggests nothing can be done to change our health fate*.* By saying social factors drive our health, **we reframe the conversation** about health. We show that social factors don't force health to be fated or destined, but rather they are something that people and communities can overcome or change.[4]

80% of health is driven by what happens outside the doctor's office.

Physical and behavioral health are deeply linked: 68% of adults with mental health disorders also have medical conditions.

1 in 4 Americans worry about losing their housing.

1 in 5 Americans say lack of transportation has kept them from medical appointments, work, or getting the things they need.

4 https:// www.elevancehealth.com/our-approach-to-health/health-equity

Why integration matters

PH, BH, and SDOH all impact health:

- One out of every five Medicaid beneficiaries has a diagnosed behavioral health condition, which includes mental health and substance use disorder.
- These individuals are often complex and may have chronic conditions such as COPD, asthma, and liver disease. Physical and behavioral comorbidities may exacerbate an individual's ability to access care leading to poor outcomes and inappropriate utilization.

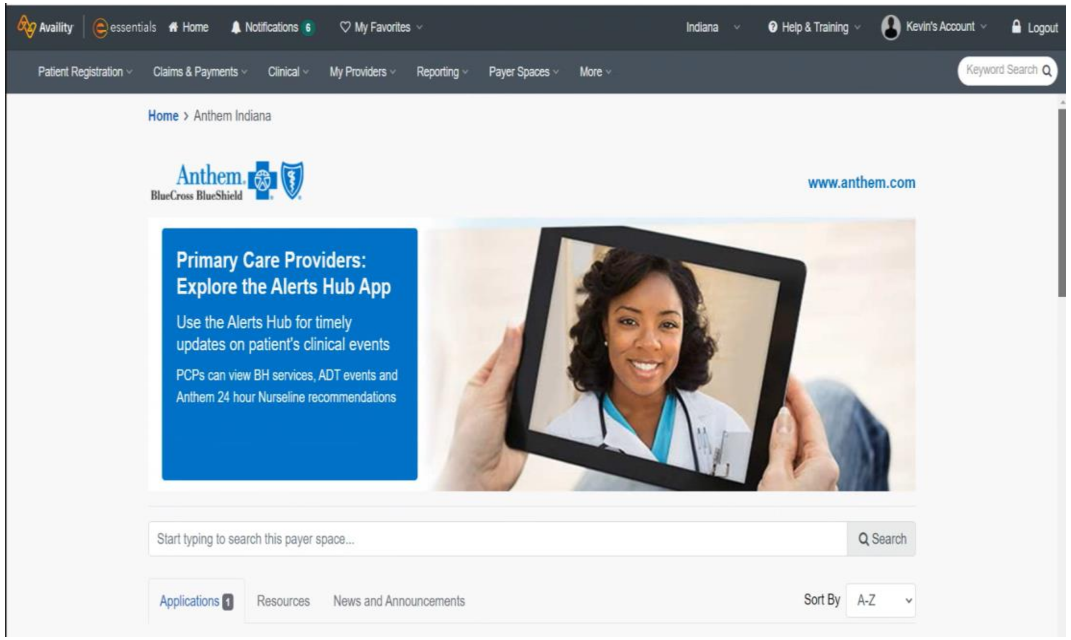
Cost drivers:

- Costs are not due to spending in behavioral health services:
  - Average annual costs for individuals with a BH diagnosis for physical health services were 2.8 to 6.2 times higher than such costs for individuals with no BH condition.
  - Majority of costs were driven by people with mild to moderate mental health and/or substance use conditions.
  - Only 4.4% of total healthcare costs were for behavioral health treatments.[5]

5 CHCS (April 2016) Key Reasons to Integrate Physical and Behavioral Health Services in Medicaid. https://www.chcs.org/resource/key-reasons-to-integrate-physical-and-behavioral-health-services-in-Medicaid

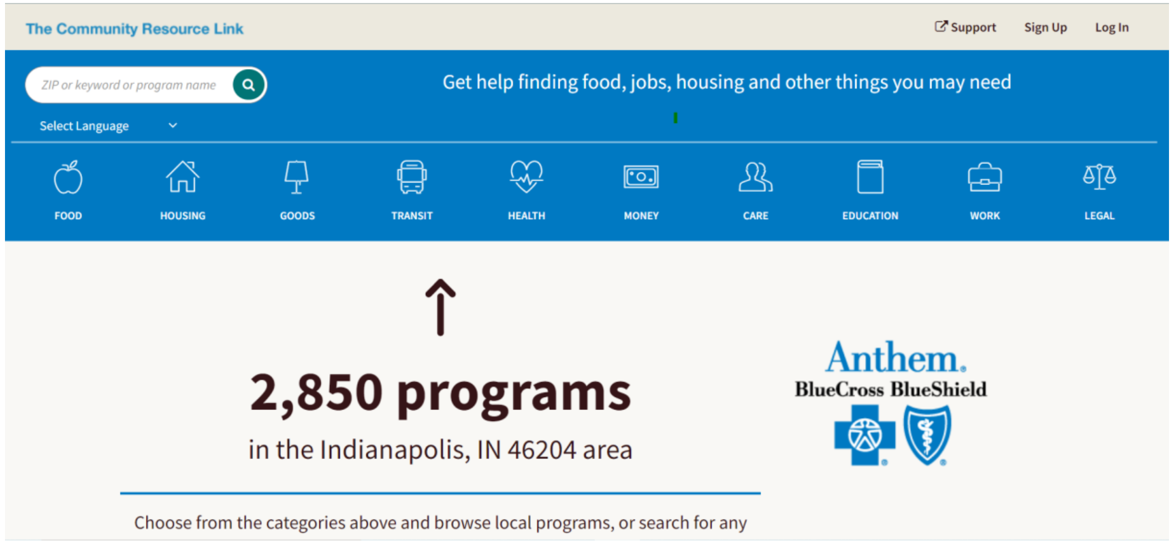
Our integrated care approach

- Keys to success:
  - Provider partnership – mindset shift to whole-person care.
  - Bidirectional exchange of data to drive interventions:
    - Member level gaps in care and claims data shared with BH and PH providers.
    - Availity* Alerts Hub for BH and PH providers:
      - Includes Admission, discharge, and transfer (ADT) notifications, 24-hour RN line notifications, quarterly health profile alerts, and 90-day behavioral health reviews.
    - *Behavioral Health and Physical Health Treatment Coordination of Care and Data Sharing Form.*



Our integrated care approach (cont.)

- Keys to success (cont.):
  - Integrated care coordination between BH and PH providers:
    - Member and provider focused
  - Community mental health center (CMHC) and Primary medical provider (PMP) coordination for members receiving carved out services:
    - CMHC rounds
  - Smooth transitions and coordination through the continuum of care.
  - Closed loop referral process through Anthem's community resource link to address SDOH.



Integrated whole-person health programs

Integrated care management (CM):

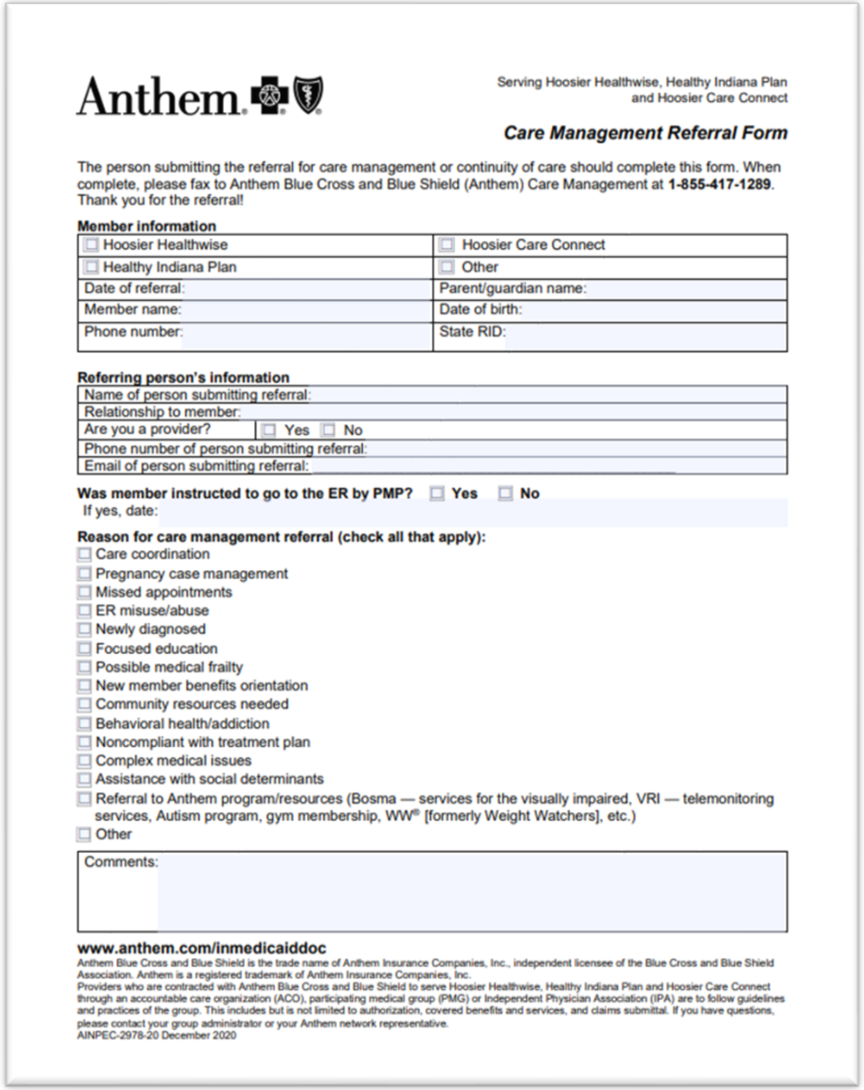
- Care management teams work alongside providers, doctors, therapists, and nurses to offer support through an integrated model ensuring behavioral health, physical health, and SDOH needs of our members are identified and met timely.

Case management approach:

- Strengths based, person-centered, individualized care plans.

How to refer to CM:

- Fax *Care Management Referral Form:* **855-417-1289**
- Call care management line: **866-902-1690**
- Call Member Services



Anthem.

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Care Management Referral Form

The person submitting the referral for care management or continuity of care should complete this form. When complete, please fax to Anthem Blue Cross and Blue Shield (Anthem) Care Management at **1-855-417-1289**. Thank you for the referral!

Member information

☐ Hoosier Healthwise	☐ Hoosier Care Connect
☐ Healthy Indiana Plan	☐ Other
Date of referral:	Parent/guardian name:
Member name:	Date of birth:
Phone number:	State RID:

Referring person's information

Name of person submitting referral:	
Relationship to member:	
Are you a provider?	☐ Yes ☐ No
Phone number of person submitting referral:	
Email of person submitting referral:	

Was member instructed to go to the ER by PMP? ☐ **Yes** ☐ **No**

If yes, date:

Reason for care management referral (check all that apply):

☐ Care coordination
☐ Pregnancy case management
☐ Missed appointments
☐ ER misuse/abuse
☐ Newly diagnosed
☐ Focused education
☐ Possible medical frailty
☐ New member benefits orientation
☐ Community resources needed
☐ Behavioral health/addiction
☐ Noncompliant with treatment plan
☐ Complex medical issues
☐ Assistance with social determinants
☐ Referral to Anthem program/resources (Bosma — services for the visually impaired, VRI — telemonitoring services, Autism program, gym membership, WW® [formerly Weight Watchers], etc.)
☐ Other

Comments:

www.anthem.com/inmedicaiddoc

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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Integrated whole-person health programs (cont.)

Disease management (DM) program:

- Asthma
- Attention deficit hyperactivity disorder (ADHD)
- Autism/pervasive development disorder
- Bipolar disorder
- Chronic kidney disease (CKD)
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder (MDD) in adult and child/adolescent
- Schizophrenia
- Sickle cell
- Substance use disorder

Email:

DM-PHP-Provider-Referrals@anthem.com

Integrated whole-person health programs (cont.)

Quality management program: Integrated Care Quality Incentive Program (ICQIP)
Purpose: to encourage and incentivize network behavioral health providers to provide integrated care for our shared members to achieve optimal health outcomes:

- The Integrated Care Quality Incentive Program (ICQIP) is designed for BH providers, such as:
  - Community mental health centers (CMHCs).
  - Community service boards (CSBs).
  - Local mental health authorities (LMHAs).
  - Community-based outpatient providers.
  - Large provider groups.
- The ICQIP uses visit-based member attribution methodology:
  - Consists of quality performance indicators (efficiency, quality of care, and integration).
  - Rewards both absolute performance targets and year-over-year improvement.
  - Includes a year-end bonus incentive driven by performance indicators.

Integrated whole-person health programs (cont.)

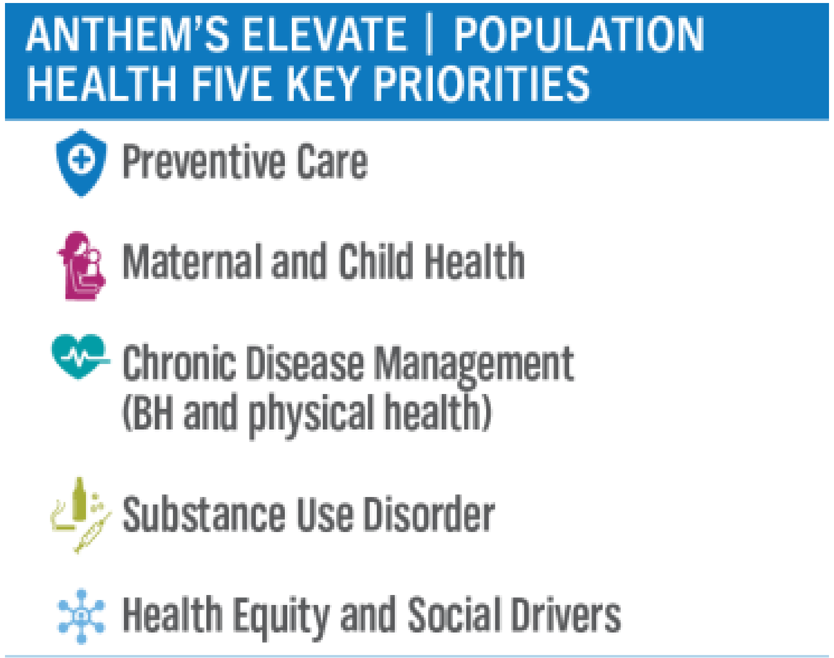
Integrated rounds and subject matter expert (SME) consultation:

- Autism spectrum disorder (ASD) rounds
- BH/PH multidisciplinary rounds
- Child psychiatry rounds
- CMHC rounds
- High risk OB/GYN rounds
- High utilizer rounds
- Integrated case management grand rounds
- NICU rounds
- SUD clinical consultation

Integrated whole-person health programs (cont.)

Population health management program:

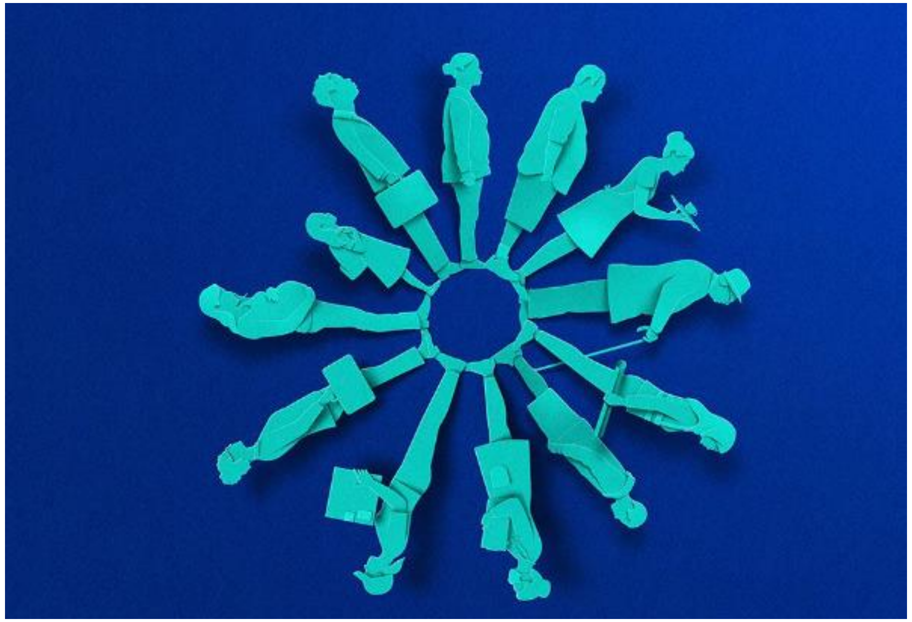
- Anthem established a Population Health Council in April 2021.
- Completed a comprehensive data analysis of the IN Medicaid landscape.
- Used this data to identify trends, gaps, and areas of opportunity that turned into our strategic priorities.
- Determined our strategic priorities based on our overarching data analysis and used 2020 year-end data as a baseline and established five-year *SMART* goals.
- Our data analysis also indicated an opportunity to tailor targeted inventions by geography (both rural and urban) as well as by other demographics, such as race and ethnicity.
- As we develop and implement supportive interventions to impact Indiana's priority areas, we consistently measure effectiveness, communicate progress across our organization and our partners, and shape the work we do to make our five-year goals a reality for all Hoosiers.



Integrated whole-person health programs (cont.)

SDOH team:

- SDOH specialists with expertise in social work and human services.
- Help with employment, housing, food, and transportation.
- Serve as subject matter experts and build relationships with key community organizations to develop programs and solutions.
- Help members navigate social drivers that present barriers to improved health.
- SDOH Member Flex Fund offers resources to pay for housing, food, utilities, employment, education, legal support, social isolation relief, and transportation-related expenses often not reimbursed through federal or state programs.



Integrated whole-person health programs (cont.)

Maternal Child Health and Indiana Pregnancy Promise Program (IPPP):

- Ensure pregnant women and their newborns have timely access to appropriate obstetrical, physical health, behavioral health, and social support services throughout the prenatal and postpartum period, promoting the best maternal and child health outcomes.
- Anthem is an IPPP participating MCE. The Anthem IPPP team consists of high-risk RN OB/GYN case managers with specialized training in opioid use disorders; an outreach care coordinator; and community health workers (CHWs) and certified recovery specialists (CRSs). This team implements the maternal opioid misuse model and provides enhanced case management to support recovery.

Integrated whole-person health programs (cont.)

Recuperative care/ medical respite program:

- Acute and post-acute care for individuals experiencing homelessness and do not require an admission to an inpatient hospital or skilled nursing facility.
- Provides short term residential care.
- Allows for individuals to rest and recuperate in a safe environment.
- Facilitates healing while ensuring access to follow-up healthcare and covered benefits such as home-care services.
- Provides connections to recommended health- and community-based organizations to address housing needs and other social risk factors.
- Maximizes opportunity for successful recovery, improves health outcomes, and reduces the risk for readmission or unnecessary utilization of emergency or in patient health care services.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

https://providers.anthem.com/in

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