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Assistant Secretary for Planning and Evaluation, Room 415F
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Information: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

To Whom It May Concern:

WellCare Health Plans (WellCare) is pleased to submit the enclosed information in response to the request for information (RFI) opportunity "IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors."

For more than 30 years, WellCare has served families, children, seniors and individuals with complex medical needs. We partner with state and federal governments to coordinate managed care services for those eligible for Medicaid, Medicare Advantage, Medicare Prescription Drug Plans and Medicare ACO beneficiaries.

Founded in 1985 by a group of physicians in Tampa, Florida, today, WellCare serves more than 5.5 million members as well as ~160,000 Medicare ACO beneficiaries and partners with more than 636,000 healthcare providers and 68,000 pharmacies across the country.

WellCare's vision is to be a leader in government-sponsored healthcare programs in collaboration with our members, providers, government partners and social resource organizations. We have a long-standing commitment to our federal and state partners to deliver value, access, quality, cost savings, and budget predictability. It is from this vantage point that we offer these responses.

Overall Question

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

WellCare is working to improve outcomes for our members and communities by deploying an integrated care model that harnesses both supplemental benefits and social services outside of the benefit structure to address the needs of members and their households. We do not disentangle social and medical risks; instead, we assess members holistically to determine all of their co-morbidities (including social needs) and deploy tailored, integrated solutions for their specific needs.

On the front end, we assess the needs of our members by administering a health risk assessment (HRA). We then layer on the Protocol for Responding to and Assessing Patients' Assets, Risks, and

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Experiences (PRAPARE) assessment tool, if needed, to assess the member's social service needs. Finally, we use our own internal risk assessment and screening process to determine the member and their household's eligibility for wrap-around social services.

Based on the results of this exercise, we are able to provide members and their households with a package of both benefited and non-benefited services that work in tandem to improve their health outcomes and wellbeing. By leveraging both supplemental benefits and social services and tracking the detailed interactions associated with each, we are able to reach beyond the individual to power national systemic transformation.

Delivery of Services

Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

Yes, social risk and social resource utilization data are being used in tandem to target engagement strategies as well as identification and stratification. Additionally, public social health data are leveraged to predict gaps in available social resources in our communities.

Members with social risk factors are identified based on the results of the HRA and PRAPARE tool assessments described in the prior question. A member may also self-identify by calling our Community Connections Help Line directly for assistance. The Community Connections Help Line is national call center for members, their families and the community-at-large to find and connect with social resources. WellCare's Community Connections model spans 70 different topics including housing, food, transportation, medication assistance, employment/training, volunteerism, and literacy.

Are there especially promising strategies for improving care for patients with social risk?

WellCare's Community Connections model offers particularly promising strategies for improving care in three areas:

1) WellCare employs a team of community coaches to engage with callers to our Community Connections Help Line. Hired through workforce innovation programs, our community coaches bring lived experience to their roles. For example, to ensure we have all beneficiary peer groups represented, the ages on our team range from 18 through 72 years old, they may have a disability themselves or care for someone enrolled on Medicare, Medicare or both and so on. WellCare employs more than 100 people to support the Community Connections model.

2) Supplemental benefits present a valuable opportunity for plans to provide benefits that address social risk factors, even if they are not covered by traditional Medicare. Using flexible supplement benefits, health plans may provide benefits to members that support their ability to live more independently. Examples of WellCare's benefit offering includes, in-home

support services, Personal Emergency Response System, and in-home fitness for those who cannot go to a gym.

Overall, high-performing Care Coordination and Care Management (CC/CM) programs are fundamental to WellCare's approach. We employ a fully integrated model customized for a wide variety of geographies, cultures, and diverse settings of care. Our care model, WellCare at Home, includes addressing social determinants of health through local Care Management. The WellCare at Home fully integrated care model factors in a member's physical health, behavioral health (BH), pharmacy, long-term services and supports (LTSS), and unmet social service needs under a single fully in-sourced infrastructure with a single line of accountability, single integrated technology system, and fully integrated local and national staff. WellCare at Home is grounded in our organizational mission to help members live better, healthier lives. Person-centered care reflects the choice and voice of each member and their family/caregiver and addresses a member's personal goals.

How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

WellCare tracks social service use by consumer, by organization, and by intervention. Using this information, we have evaluated the impact of removing social barriers on cost, quality, and access. We looked at data on over 100,000 consumers that were referred to more than 350,000 services over a 7year period. We have found:

- Reduction in Cost. Removing a social barrier led to an aggregated savings from:
  - Reduced inpatient spending (53%)
  - Reduced emergency department use (17%)
  - Reduced emergency department spending (26%)
- Improved Access and Outcomes. Members with a social barrier removed are:
  - 4.8x more likely to schedule and visit their annual PCP visit
  - 2.4x more likely to have a better adult BMI score
  - 2.2x more likely to have completed a diabetes retinal exam
  - 1.9x more likely have complete a colorectal cancer exam

Additionally, WellCare collaborated with the University of South Florida to complete a study[1] that found that members who received social service assistance through our model experienced a $2,443 per-member-per-year savings after social needs were met. This study was also cited in the HHS

[1] Pruitt, Zachary, Nnadozie Emechebe, Troy Quast, Pamme Taylor, and Kristopher Bryant, "Expenditure Reductions Associated with a Social Service Referral Program," Population Health Management, April 2018, pp. 1–8.

ASPE research report entitled “Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans”.

Thus far, our model has been recognized as advanced in over 10 peer-reviewed studies.

What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

WellCare’s offer the following best practices to support beneficiaries in effectively seeking and using social resources.

1) WellCare employs a team of community coaches to engage with callers to our Community Connections Help Line. Hired through workforce innovation programs, our community coaches bring lived experience to their roles. For example, to ensure we have all beneficiary peer groups represented, the ages on our team range from 18 through 72 years old, they may have a disability themselves or care for someone enrolled on Medicare, Medicare or both and so on. WellCare employs more than 100 people to support the Community Connections model.

2) WellCare also partners with social resource organizations to capture details on when beneficiaries seek social support directly. When a beneficiary approaches a partner organization for assistance, the organization will collection information, including whether the beneficiary is a current WellCare member. Our social resource partners share this and other relevant information with WellCare. We are able to leverage this information to inform how we target members for services that address their social risk factors.

What lessons have been learned about providing care for patients with social risk factors?

One key learning from our model has been that social service organizations have different infrastructures, lexicons and payment models from managed care. This can create barriers for organizations that are trying to build relationships and interoperability with social service providers. Through our experience, we have been able to learn how to meet social service organizations where they are, while teaching them how to work with managed care and migrate to a managed care environment. This has been especially important as it relates to collecting social service data that informs member care.

Another learning has been that the gaps reported by members might not always directly tie to the needed solution. For instance, if a member self-reports that they are recently unemployed, we might instead focus on how to introduce stability to their household through the provision of food, transportation, and housing assistance. In doing so, we can provide the member with the relevant supports needed to enable them to focus fully on their job hunt.

As previously mentioned, WellCare provides social service support to members outside of the benefit structure. For that reason, we cannot assume an individual’s eligibility for social services. As a result,

we have created a screening process for the member and their household to determine their potential eligibility for social resources across 70 different categories of support including housing, food, transportation, and so on.

What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

Barriers to tailoring services to members include the managed care payment structure, social service industry structure, individual level social risk barriers, and limitations to information sharing among stakeholders.

For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

In WellCare's experience, an individual's disability, functional status, and/or frailty does not affect the provision of services. However, it could affect their eligibility for various services and how we are able to connect them. For example, an individual with a disability and/or unable to work could be eligible for a different range of services than someone able-bodied.

Data

Which social risk factors are most important to capture?

WellCare currently screens and determines eligibility for 70 different social risk factors, including housing, healthy food access, medication assistance, non-medical transportation, child care, social engagement to combat isolation, education support, and more.

Although social service needs vary by individual and geography, our highest volume social support topics include:

- Transportation: 18% (of all social resource connections)
- Financial Assistance (like car payments, mobile phone, etc.): 15%
- Healthy Food Options: 14%
- Medication Assistance: 12%
- Housing / Shelter: 10%

Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

WellCare routinely collects basic demographic data on every enrollee (traditional MA and DSNP) via the HRA. We ask members questions about transportation (ability to get to the grocery store and

medical appointments), language preferences (primary language spoken at home and preferred language), tobacco and alcohol use, and questions regarding dependence.

Members who are eligible and choose to enroll in case management complete a more comprehensive assessment with their case manager. This assessment includes additional questions regarding their level of dependence, as well as an assessment on basic activities such as eating, bathing, toileting, and cleaning. WellCare has an algorithm that runs monthly data checks on items such as utilization patterns, pharmacy fills, and hospital discharges, to identify additional members for case management.

WellCare also houses a database that connects members to needed social supports outside of the medical benefit. As described earlier, we use HRA and PRAPARE tools to capture need. Then, we capture social resource use within a dedicated social resource electronic health record (SSEHR) that links to our centralized directory of more than 300,000 social support resource available across the United States.

Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Standardizing data elements of EHRs would be helpful in collecting social risk data. Nonetheless, determining how this information could be shared among stakeholders and used to determine social service eligibility would be also be relevant considerations.

Additionally, we should consider how standardizing data elements could help facilitate the codification of social services in the managed care payment structure.

What are barriers to collecting data about social risk? How can these barriers be overcome?

Medicare Star ratings present a barrier to collecting data. Specifically, HRA completion rates impact our scores. We historically conducted an extensive HRA with members. It included questions about a member's living arrangements and whether they had a caretaker. We have since removed some of these questions and shortened the HRA in an attempt to increase our completion rate.

Additionally, the nature of the select questions posed in the HRA also present a barrier. Some members are hesitant to share personal information about their circumstances via the HRA. It can also be difficult to collect this information within the first 90 days of the member's enrollment, especially if the member has a distrust of the healthcare system.

What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

Opportunities for improving data collection include evolving to a more sophisticated level of data sharing among all managed care and social service stakeholders and developing a common system for capturing social service requests and utilization. In terms of using data, we believe there is

opportunity to continue using data to ascertain risk while also increasingly leveraging it to screen for social service eligibility.

Additional Comments

Discussion of social risk factors should evolve to address managed care payment models. Since social services are not codified in managed care, plans are sometimes subject to financial risk because payments are not adjusted to represent the social risk factors of members. As a result, the administrative costs of linking members to social services is not reimbursed. Additionally, we look forward to the continued discussion on how to increasingly incorporate social risk factors into quality measures.

Conclusion

WellCare appreciates the opportunity to provide comments on these important issues and to partner with ASPE and HHS. If your staff would like further detail on any of our information, please feel free to contact me at (202) 902-2918. Thank you.

Sincerely,

Sohini Gupta
Vice President, Federal Government Affairs & Advocacy