Sohini Gupta
Vice President
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November 29, 2019

The Honorable Richard Neal
Chairman
Committee on Ways and Means
1102 Longworth HOB
United States House of Representatives
Washington, D.C. 20510

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
1139 Longworth HOB
United States House of Representatives
Washington, D.C. 20510

Dear Chairman Neal and Ranking Member Brady:

WellCare Health Plans (WellCare) is pleased to respond to your *Request for Information* (RFI), dated November 15, 2019 inviting stakeholders to provide recommendations that will improve the delivery and financing of health care by addressing social determinants in urban and underserved areas. We applaud your efforts in examining this critical problem, and we look forward to working with you to implement strategies that address challenges that contribute to health inequities.

Founded in 1985 by a group of physicians in Tampa, Florida, today WellCare serves over 8.6 million members through Medicaid Managed Care, MA, and PDP, as well as 160,000 Medicare ACO beneficiaries, and partners with more than 607,000 health care providers, 136,000 health care facilities, 68,000 pharmacies, and more than 350,000 social support resources across the country.

We understand the needs and constraints faced by individuals in rural and underserved areas, and given the relevance to our membership- many of which are vulnerable and complex individuals- WellCare has deployed approaches to address social determinants of health.

Overall, we believe a multi-pronged approach towards reforming America's rural and underserved health care system can support better access to care for patients. This includes examining solutions that leverage telehealth and introducing new ways to identify and stratify members' needs into four areas (physical, social, behavioral, and pharmacy), which improves care coordination and appropriate utilization.

Below, we have outlined our input per your request:

1. **What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?**

Patient outcomes in rural and urban underserved areas are often impacted by social determinants of health (SDOH). SDOH are social and economic factors, such as food supply, housing, transportation, and education that have the ability to impact medical outcomes. In some cases, SDOH have been shown to impact health outcomes more than clinical factors. In some studies, clinical care has been shown to drive 20 percent of health outcomes while the remaining 80 percent is driven by SDOH.

Likewise, access to care is critical. Leveraging telehealth to meet network adequacy requirements would allow more providers and plans to serve in these areas and coordinate care. For many seniors, using telehealth would be more convenient than the distances they must drive for care, which can be addressed using current technological innovations.

2. **What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/ telemedicine/telemonitoring.**

Between 2015 and 2018, WellCare's Community Connections served 43,518 individuals. Through this effort, WellCare provided 132,549 referrals to social resources. Our initiatives focused on: 1) Access to Health care; 2) Homeless Health Care; and 3) Health Food Access.

As a result of these SDOH interventions, individuals were:

- 4.8 times more likely to schedule and attend a PCP visit;
- 2.4 times more likely to improve BMI; and
- 1.5 times more likely to have better diabetes-related treatment compliance

This year, WellCare's Medicare Advantage (MA) plans in six markets will be part of the Value Based Insurance Demonstration program and begin to collect SDOH use data for MA beneficiaries. In addition, we have been applying SDOH supports to our plans as needed beyond the demonstrations and know it decreases hospital readmissions and drug costs for seniors.

WellCare is encouraged by the Social Determinants Accelerator Act, (H.R. 4004), which would help states and communities devise strategies to leverage existing programs and authorities to address all aspects of health, and we look forward to working with our partners in moving this legislation.

Another possibility would be to include a demonstration across agencies to address SDOH and demonstrate the potential for shared savings. CMS could structure a pilot whereby a state, and its underlying agencies, would partner with health plans to provide SDOH benefits. Shared savings could be realized by plans if, as a result of providing SDOH, medical costs decrease. Likewise, quality bonuses could be provided if member outcomes increase. This would be instrumental in demonstrating the return on investment of SDOH.

With regard to telehealth, MA is now allowed to provide telehealth to its members as a benefit. Demonstrating its ability to increase access will, hopefully, establish it as an appropriate tool to complete a network.

3. **What should the Committee consider with respect to patient volume adequacy in rural areas?**

In rural areas, a lack of providers due to low reimbursement and low volume, makes building adequate networks challenging, whereas in underserved areas the increased population stresses the system because of the high volume. The Committee should consider leveraging telehealth to reduce geographic barriers that impact individuals' ability to access care.

Additionally, it is essential that rural communities recruit and retain a workforce that will can provide targeted and coordinated care to some of the nation's most vulnerable. This committee should consider supporting state and federal workforce programs (for example, the National Health Service Corps) that aim to incentivize providers to work in high-need areas, like rural communities.

Incentivizing managed care plans to enter rural markets will also help since together plans, providers, and technology companies can work together to build the workforce and infrastructure necessary to enhance care access and coordination.

4. **If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?**

WellCare believes that as a result of promoting timely access to care and consumer choice, telehealth delivers convenient, quality care to patients in rural areas. As such, we suggest that policies promote coverage for the capital/infrastructure costs and/or mobile devices needed to make telehealth successful in rural areas. We also would support policies that incorporate telehealth into network adequacy assessments, given telehealth's ability to close care gaps.

Currently, there is no federal standard of clinical guidelines for telehealth; medical boards and state regulatory boards across the country are each responsible for setting the standards for the appropriate practice of medicine via telehealth in their state. WellCare suggests that policymakers consider approaches for encouraging states to ease reciprocity for physician licensure as it relates to telehealth.

In addition, telehealth is a not able to be used to meet network adequacy requirements. Policy changes should remove these restrictions and allow consumers to have choice on how they engage with providers and what constitutes "convenient, access to care."

5. **Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?**

Telehealth is a useful tool that can be used to bridge access gaps for individuals in rural and underserved communities with providers specializing in behavioral and substance use disorder. Via direct video conferencing, beneficiaries can engage in real time with behavioral health practitioners.

6. **The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?**

Medicare spends $6.7 billion annually as a result of individuals being socially isolated. Older individuals who are socially isolated and/or lonely often suffer

from co-occurring chronic conditions such as diabetes, chronic heart failure, and depression, leading to greater utilization of potentially avoidable health care services. As such, the continued work by stakeholders, including communities, health plans, States, and the Federal government, to address social isolation is critical in mitigating the associated health care costs and outcomes.

In particular, WellCare applauds the House passed Dignity in Aging Act, which will provide support for screening for the prevention of social isolation and the coordination of supportive services and health care to address social isolation and loneliness; and increase the Assistant Secretary on Health's focus on social isolation through the development of a long-term plan for supporting State and local efforts.

Additional suggestions for addressing social isolation include:

- Promote care in the home by leveraging care at home or outside of a clinical setting with support from federal initiatives offered through combined Medicare and Medicaid funding
- Build out Social Connections by helping members build a stronger community by offering support that keep them connected
- Improve support for caregivers with paid training courses, and certifications to enable pay for services and care management support
- Consider new technology and use of social media communities, especially for those with low mobility
- Support policies to expand access to technology (tablets and phones)

7. **There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?**

WellCare suggests the development of a consistent and thorough needs assessment to guide industry standards for collecting data across a diverse range of partners, including state agencies, community organizations, and managed care organizations to address data gaps. Such assessments should be program agnostic and applicable across Medicaid and Medicare. In addition, given feedback that data sharing is further complicated by inconsistent terminology across stakeholders, a standardized lexicon should be developed to further these efforts.

The assessment should include questions that underscore social isolation, falls prevention, and other SDOH topics, including access to food, transportation, and housing. Moreover, policies should strive to increase transparency among community organizations and promote data sharing on resource availability and usage across all relevant stakeholders.

8. **Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?**

One programmatic effort that would strengthen the quality of care for rural populations would be increased access, availability, and funding for SDOH, such as transportation, food security, and housing.

As indicated earlier, vulnerable patients in rural communities tend to struggle with attending scheduled appointments or getting timely care because of the distance and lack of reliable transportation. The ability to deploy telehealth and include it in network adequacy assessments could help to bridge this gap.

Additionally, adjustments in the MA Star Rating Quality Bonus Program will also help to make sure plans serving vulnerable populations are not disadvantaged. As it currently stands, the Categorical Adjustment Index that is employed does not go far enough to address the impacts of SDOH on member outcomes.

Policy makers could pursue strategies for reforming quality and reimbursement to incentivize and rewards plans that meaningfully improve outcomes for beneficiaries exhibiting social risk factors, including non-duals, by:
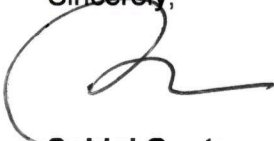
- Considering whether there are additional at risk populations that would warrant quality and reimbursement adjustments, such as those on the cusp of low income subsidy / dual eligible status and those that exhibit numerous SDOH
- Incorporating quality and reimbursement adjustments for social determinants of health, socioeconomic factors, and chronic conditions
- Basing quality adjustments off of an industry benchmark that also factors in regional differences, as opposed to within contract variation

Employing such adjustments would ensure that plans providing care for the most complex members are provided with the resources commensurate to driving meaningful improvement in outcomes.

Thank you for the opportunity to provide our input based on our experience with serving the Medicare, Medicaid, and Dually Eligible populations. We look forward to working with you to tackle

these important issues. Please do not hesitate to reach out to me, if you need any additional information.

Sincerely,

Sohini Gupta
Vice President, Federal Government Affairs & Advocacy

Cc: Representative Danny Davis
Representative Terri Sewell
Representative Brad Wenstrup
Representative Jodey Arrington