Convene.
Strategize.
Activate.

TRANSFORMATION
TODAY & TOMORROW

WellCare's Community Connections Model

Engaging and Improving Care

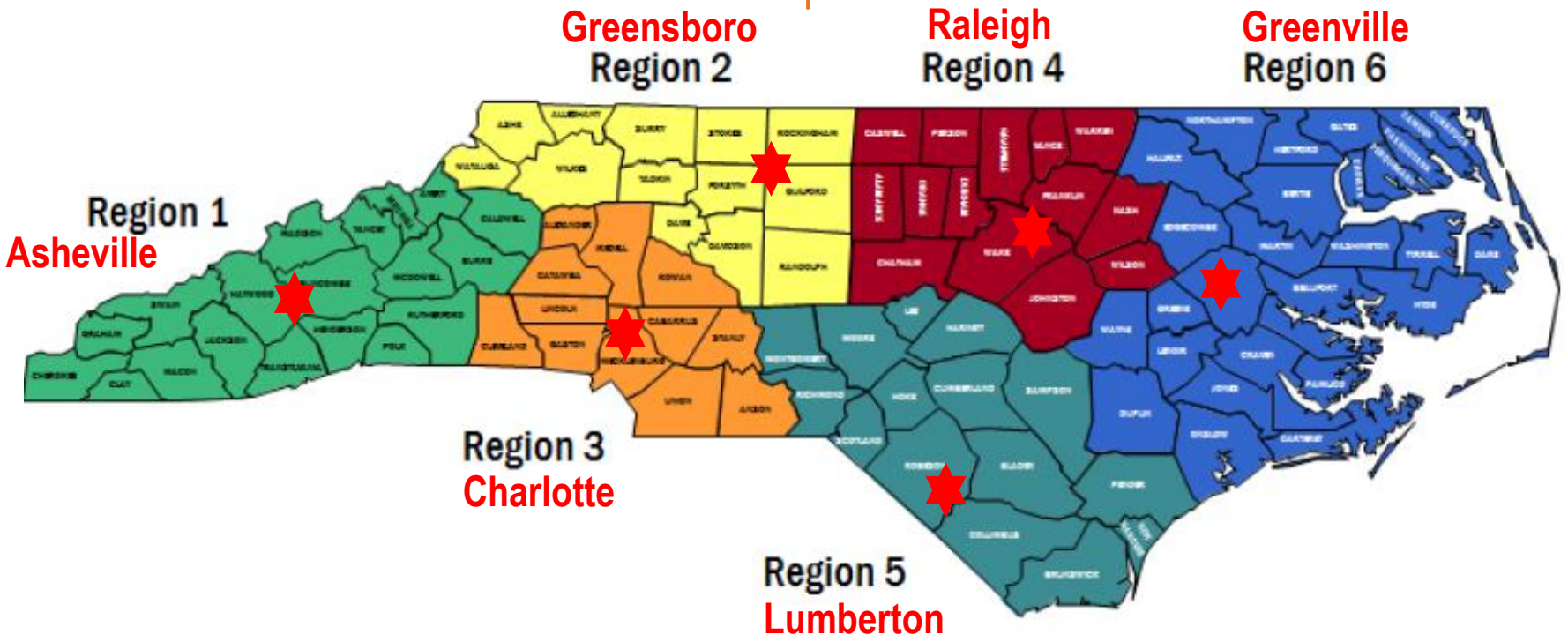
CENTER *for* INTEGRATIVE HEALTH
insight to innovation

i2iCENTER.org

North Carolina Leadership Team

- WellCare of NC Office Locations
  - Raleigh
  - Greensboro
  - Asheville
  - Greenville
  - Lumberton
  - Charlotte

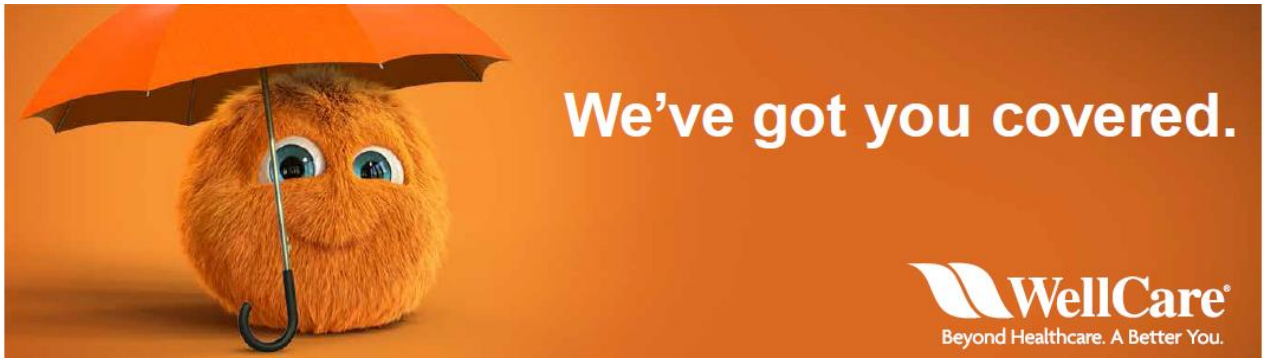
- Staffing across NC
  - Regional Leadership
  - Provider Relations
  - Care management support staff
  - Community engagement



All numbers are as of Dec. 31, 2018

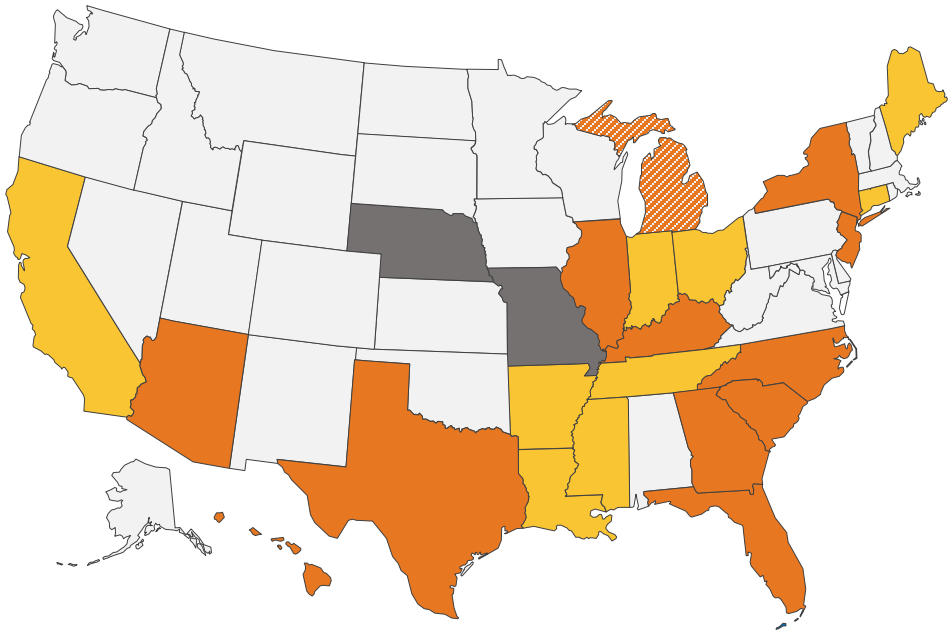
The WellCare Story

- WellCare was founded in 1985 by a small group of physicians in Tampa, Florida.
- WellCare provides government-sponsored healthcare programs, including Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, to families, children, seniors and individuals with complex medical needs.
- WellCare serves 5.5 million members and partners with more than 68,000 pharmacies and 649,000 healthcare providers across the country.



All numbers are as of Dec. 31, 2018

WellCare's Presence



- Medicaid
- Medicare Advantage
- Medicaid & Medicare Advantage*
- Medicare Prescription Drug Plans (50 U.S. states & D.C.)
- Health Insurance Marketplace

5.5M
MEMBERS

649K
PROVIDERS

68K
PHARMACIES

13K
ASSOCIATES

#170
FORTUNE 500

FORTUNE WORLD'S MOST ADMIRED COMPANIES 2018

THE CIVIC 50

*Includes states where the company receives Medicaid and Medicare revenues associated with Dual Eligible Special Needs Plans (D-SNPs)

All numbers are as of Dec. 31, 2018

Mission

Our members are our reason for being. We help those eligible for government-sponsored healthcare plans live better, healthier lives.

Vision

To be a leader in government-sponsored healthcare programs in collaboration with our members, providers and government partners. We foster a rewarding and enriching culture to inspire our associates to do well for others and themselves.

Core Values

- Partnership
- Integrity
- Accountability
- One Team

WellCare's Approach

WellCare
Beyond Healthcare. A Better You.

Four Pillars to WellCare's Approach to Managed Medicaid

WELLCARE'S APPROACH

Provider Partnerships
Fostering strong partnerships with select providers

Integrated Care Model
Integrating medical, behavioral, social and pharmacy operations

Government Partnerships
Establishing trust with our state and federal partners

Community Connections
Empowering members to reach optimal social health and independence

"Effective collaboration with our key providers is vital to our success. We actively engage our providers and respond quickly to their issues and concerns resulting in a partnership that ultimately helps our members lead healthier lives." Ken Burdick, CEO

RFP Results

- 1st overall
- 1st on nearly 70% of all scored components

WellCare Community Connections

2019

WellCare Community Connections

Our Mission

Meeting members where they are, to support them in **removing social barriers to improve health outcomes and systemic, organic change** through data informed decision-making and program evaluation, strategic local community partnerships, industry leading innovation pilots and a national peer support team.

Why Community Connections

- Individuals and families with socio-economic needs **have higher healthcare needs and costs**
- **Vulnerable populations cannot prioritize their health when their basic needs go ummet**
- **80% of a persons health is a result of what happens *outside the doctor's office***
- The US has unsustainable rising health and social service costs, and social service organizations are constantly facing funding cuts

What We Do

- Integrate socio-economic solutions into the **whole-person care model**
- **Support community partners** in preparing for more formal integration into the health care system

Referral and Staffing Model

- Database that connects our members to social services
- Tracking of all referrals to disposition
  - Referrals through Call Center and other member-facing teams
- Using data to drive engagement in the community
- Using data to drive strategic giving of dollars around needed services and gaps in the safety net
- Grassroots community mobilizing based on data
- Bilateral data sharing to quantify and demonstrate impact

  - Teen Pregnancy Support in Missori
  - UTC members and Street Medicine in Kentucky
  - Transportation gaps in Rural Georgia

Community Connections Overview

Community Connections Help Line (CCHL)

National, **peer-based** call center providing member, caregiver and provider support in **removing social barriers through connectivity to national and local resources**. Peer Coaches listen to callers' needs and refer them to existing resources both locally and nationally.

- Represents **diverse cultures** including individuals with disabilities, seniors, caregivers, students, veterans, military families and more
- **First-hand experience** in navigating social services and/or have "lived" the experience
- Expertise in **social needs assessment**, goal setting and action planning to **drive sustainable change and success**

Community Engagement

Field-based, national reporting team focused on **building grassroots, strategic, and data-informed value-based outcome contracting and community partnerships.** Using the social service data, the Community Engagement Team:

- Identifies when services are needed and then **mobilizes resources to (re)create the needed service**
- Forms **community planning councils** to expand innovative community-based programs or **introduce new programs**
- **Establishes community contracts** to assess impact and pilot new **outcome-focused payment models** with community partners
- Information is **constantly updated and audited** through **local teams** with **boots on the ground**, **deep partnerships** in the community, and **formalized contracts** with community organizations

Tools & Technology

Integrated social service management platform:

- **Bilateral data exchange** capability allows for **constant-flowing live information**
- Ability to **triage members based on need and risk**
- **Integrated follow-up surveys** help us **gauge participants' satisfaction** with an organization and **ensure closure of needs**

Data & Evaluation

National **data collection and analytics** team focused on:

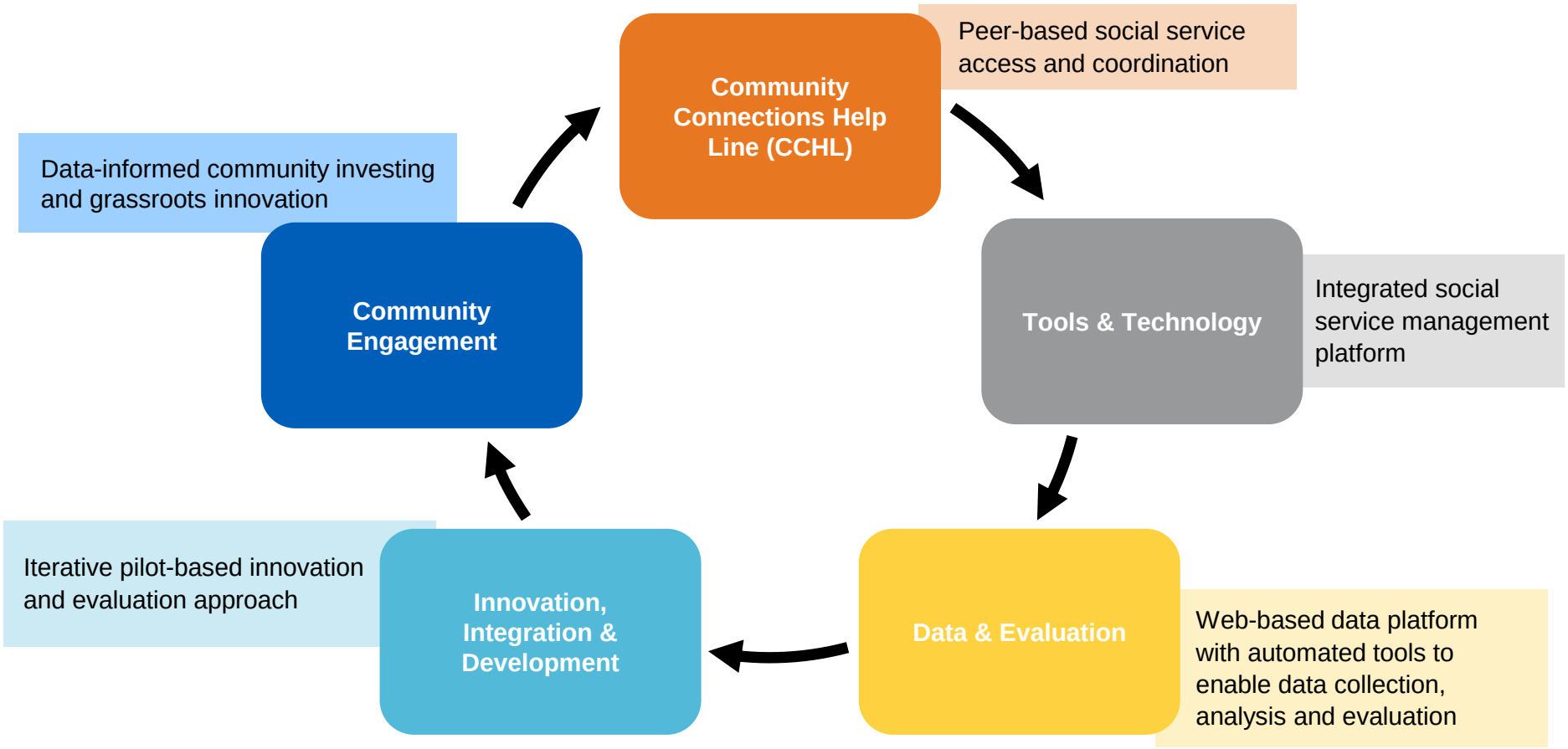
- Community level data analysis to **help drive decisions around priorities, investment and innovation opportunities**
- Connection to enterprise priorities including **quality outcome data**, **member retention**, **member and provider satisfaction**

Innovation, Integration & Development

National team developing and **implementing innovative pilot programs** focused on **systemic, industry-leading solutions** to drive **social determinant integration** into healthcare. Innovation pilot programs generate the data to **evaluate the impact** in local communities in three ways:

- **Improving health outcomes** and **increasing access to care**
- Reducing avoidable costs by **removing social barriers**
- **Evaluating system effectiveness** leading to social innovation

Solution-Focused Capabilities



Programmatic Outcomes: Our Impact

WellCare
Beyond Healthcare. A Better You.

Improved Access & Health

Compared to demographically similar members, individuals with **social barriers removed through CCHL** are:

4.8x More Likely to Schedule and Attend a PCP Visit

2.4x More Likely to Improve BMI

1.5x More Likely to have Better Diabetes-Related Treatment Compliance

Reduced Cost

Aggregated savings of **$2,400** per member per year by reducing preventable ER use, locating hard-to-find members, helping members transition home from a hospital stay and more:

53% Reduction in Inpatient Spending

17% Reduction in Emergency Room Use

26% Reduction in Emergency Department Spending

Community Innovation

The healthcare savings from removing social barriers are **reinvested back into the community** through **800+** investments designed to increase data-sharing capabilities or sustain critical social services.

Solution-Focused Capabilities

Community Connections Help Line (CCHL)

Who We Are

The Community Connections Help Line (CCHL) is a national, **peer-based** call center providing member, caregiver and provider support in **removing social barriers through connectivity to national and local resources**.

Our Peer Coaches:

- Listen to callers' needs and refer them to existing resources **all over the country** or right in the caller's **local area**
- Complete **social needs assessment**, goal setting and action planning to **drive sustainable change and success**
- Represent **many diverse cultures** including individuals with disabilities, seniors, caregivers, students, veterans, military families and more
- **First-hand experience** in navigating social services and/or have "lived" the experience
- Trained in **Trauma Informed Care** and **Interpersonal Violence**

What We've Done So Far

- Fielded an average of **4,000 to 6,000 calls per month**
- **Over 400k social services catalogued**
- Referred more than **100k people** to **400k services** to date
- Our model is recognized by the Commonwealth Foundation as an **"Innovative International Best Practice for Models of Care for Patients with Complex Health and Social Care Needs"**

Peer Support Models

- A majority of physicians acknowledge that unmet social needs contribute to poor health outcomes, but most report a lack of time during the clinical appointment to address patients' social needs in addition to their medical needs.
- According to social support theory, interactions with similar and valued peers can be protective of individuals' health in times of stress.

Community Connections Help Line

In 2014, WellCare launched the Community Connections Help Line to refer members to social services available in their community. The Community Connections Help Line (CCHL) is a national, peer-based call center providing member, caregiver and provider support in removing social barriers through connectivity to national and local resources. Peer Coaches listen to callers' needs and refer them to existing resources both locally and nationally. Peer Coaches represent diverse cultures including individuals with disabilities, seniors, caregivers, students, veterans and military families. The coaches leverage expertise in social needs assessment, goal setting and action planning to drive sustainable change and success.

CCHL is Helping Florida Members with Food Assistance

Food assistance is consistently one of the top community needs in Florida. In 2019, the CCHL referred more than **500** community members in Florida to food assistance.

A 56-year-old Florida Medicaid member had recently moved to a new city and was facing a challenging situation. She was homeless, living with multiple chronic conditions, and staying in a garage that was not air conditioned. At the time, her application for Social Security disability income was pending and she had no income other than food stamps. The member learned about the CCHL from her member Welcome Packet and decided to call in to request assistance.

During the conversation, a CCHL Peer Coach assessed her needs and identified local organizations in her area that could provide help. On the recommendation of the CCHL Peer Coach, the member contacted The Sharing Center of Central Brevard Merritt Island. Fortunately, they were able to provide her with a hot meal and groceries to take home. Additionally, she was able to receive personal items such as clothing, bedding, and a portable toilet.

When a CCHL Peer Coach called to follow up with the member, the member shared how grateful for the assistance, as she "couldn't get anything from anywhere and they helped." Today, she continues to work with CCHL to find new housing.

A State Against Addiction: Leveraging Community Connections and Peer Support models to address the opioid epidemic in New Jersey

WellCare uses a holistic, customized approach to care for our members based on their unique physical, behavioral, pharmaceutical and social needs

- WellCare uses a proprietary, clinical platform to identify and stratify members' needs into four areas (**physical, behavioral, pharmacy and social**), which improves care coordination and appropriate utilization.

- Addressing members' **social needs** is an important part of the solution. When members are connected to services like job, education and utility assistance, we see:
  - Improved medication adherence rates;
  - Increased independence;
  - Lower hospital admissions; and,
  - Improved physical and behavioral health outcomes.

New Jersey Community Connections, A Social Impact Program

Health outcomes improve when members social needs are met

- WellCare members were **4.2x** more likely to receive services from their PCP when a social service was accessed
- Social determinants of health are part of a members care management care plan

24/7 Community Connections Helpline and related social services database to make referrals and track accessed services

- Database of over **9,000 social service organizations** in NJ
- Open to both members and non-members
- In 2018 WellCare members accessed **5,451 social services** in NJ
- **170 of those were specifically for substance use disorder / drug addiction supports** that are not covered in the Medicaid benefit package

Community Health Improvement Grants: Sustaining the Social Services Safety Net

- Offer funding to social services agencies to further enhance, sustain or develop programing/services offered to the community
- Supported Eva's Village's Opioid Overdose Recovery Program (OORP), which closed a funding gap for certain Peer Recovery Coach efforts
- Additional grantees include: Apostle House (Newark), Bridgeway, Covenant House (Multiple Locations)

Example: Eva's Village, Paterson NJ Peer Support Opioid Overdose

NJ: Eva's Village partnership for recovery support	**Contact Name: Aviva Woog**	**Launch Date:**
	Contact Dept: New Jersey	**Market(s): NJ**

Overview	Our Community Connections partnership with Eva's Village in New Jersey received a community award for the Opioid Overdose Recovery Program (OORP), which placed Recovery coaches on call 24/7 and offered on-site support and recovery services to patients who have been administered Narcan and treated for opioid overdoses at St. Joseph's Regional Medical Center in Paterson and St. Mary's General Hospital in Passaic. WellCare's support expanded the state-funded program, which offered peer recovery coaches to those patients who had been given Narcan, by offering the peer supports to any overdose patient, not just those who were administered Narcan. The duration of the pilot also connected clients who had WellCare to WellCare Care Management and Behavioral Health services.
Member Engagement	The foundation of the program is a peer support model – a peer support specialist from Eva's Village was sent to the hospital to meet with the patient shortly after they gain consciousness to help them better manage through their addiction. This peer coach helped to create a care plan, address the patient's social needs (homelessness, finding a job, etc.), and offered 90 days of follow up to help the patient maintain accountability.
Provider Engagement	Partnership with hospitals is key in order to ensure access to the patient shortly after the overdose.
Community Engagement	Peer Support Coaches also connected clients to additional SDOH needs accessed on-site at Eva's Village or at partnering agencies throughout Paterson service area.
	Engagement and social support opportunities designed for the Member and their entire strength circle to encourage treatment adherence and ongoing recovery

Additional notes

- While the additional funding provided by WellCare extended this program to overdose patients that have not been administered Narcan is over, Alison Dorsey (WellCare Director of Government Affairs) continues to lobby the state for funding.
- WellCare has presented the Peer Support Recover Program model and the collaborative partnership between CBO and MCO as a best practice to stakeholders in the Department of Health and Human Services of NJ and other community partners and coalitions throughout Paterson.
- There are several reasons for the effectiveness of this program and recommendations to be made, but we believe the primary reason is the training of our Specialists and the genuine, peer to peer support they offer, given the fact they have lived the addiction experience. We are not only meeting clients at their hospital bedside, but we are able to immediately engage in recovery services by peers who have been in their position and are now in recovery from their own struggles with addiction. Peer services and support encourages an interaction with greater results in motivating a client to engage in support services and entering addiction treatment. Once individuals are engaged in our recovery supportive services, we can introduce them to peer recovery groups/workshops, recovery plans and mentoring, education and training, 12 step meetings, and may sober social/recreational events. The creation of a recovery community is a crucial part of achieving and maintaining lifelong sobriety.

Grantee Testimonials: Eva's Village

Eva's Village was able to provide services to an additional 72 clients, 94.4% of whom engaged in addiction recovery support services after meeting with Peer Recovery Coaches.

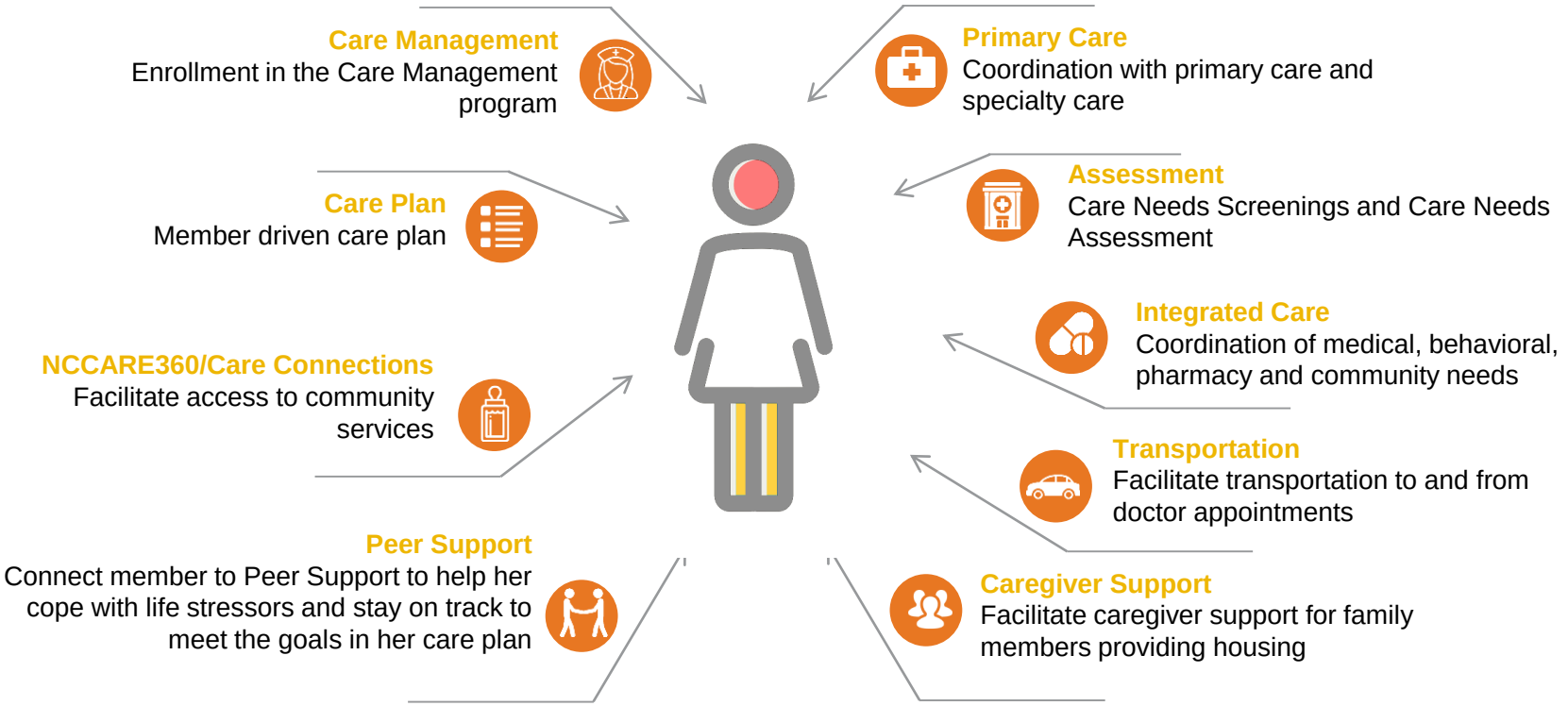
"The WellCare Grant has assisted our OORP program with one of our greatest challenges of not being able to compensate our Recovery Specialists for their services to non-Narcan and non-overdose clients who are suffering from substance use disorders. Thanks to this WellCare Grant, our Recovery Specialists were able to meet with and help community members (uninsured, WellCare and Non-WellCare members) in the emergency rooms at St. Joseph's Health in Paterson, St. Joseph's Health in Wayne, and St. Mary's Hospital in Passaic."

"There are several reasons for the effectiveness of this program and recommendations to be made, but we believe the primary reason is the training of our Specialists and the genuine, peer to peer support they offer, given the fact they have lived the addiction experience. We are not only meeting clients at their hospital bedside, but we are able to immediately engage in recovery services by peers who have been in their position and are now in recovery from their own struggles with addiction. Peer services and support encourages an interaction with greater results in motivating a client to engage in support services and entering addiction treatment. Once individuals are engaged in our recovery supportive services, we can introduce them to peer recovery groups/workshops, recovery plans and mentoring, education and training, 12 step meetings, and may sober social/recreational events. The creation of a recovery community is a crucial part of achieving and maintaining lifelong sobriety."

WellCare Member Centered Care

2019

Member Centered Care

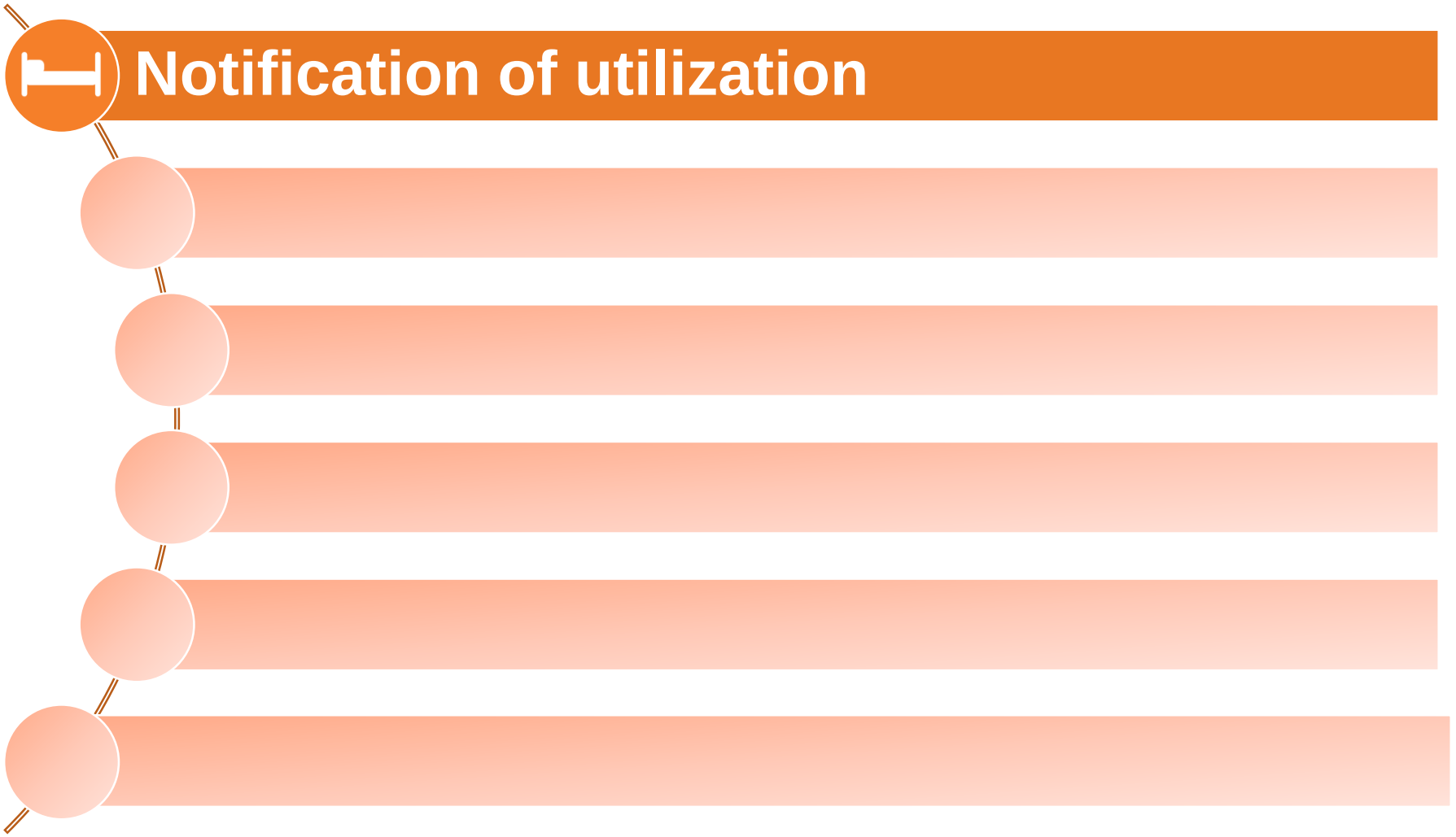


Member Centered Care

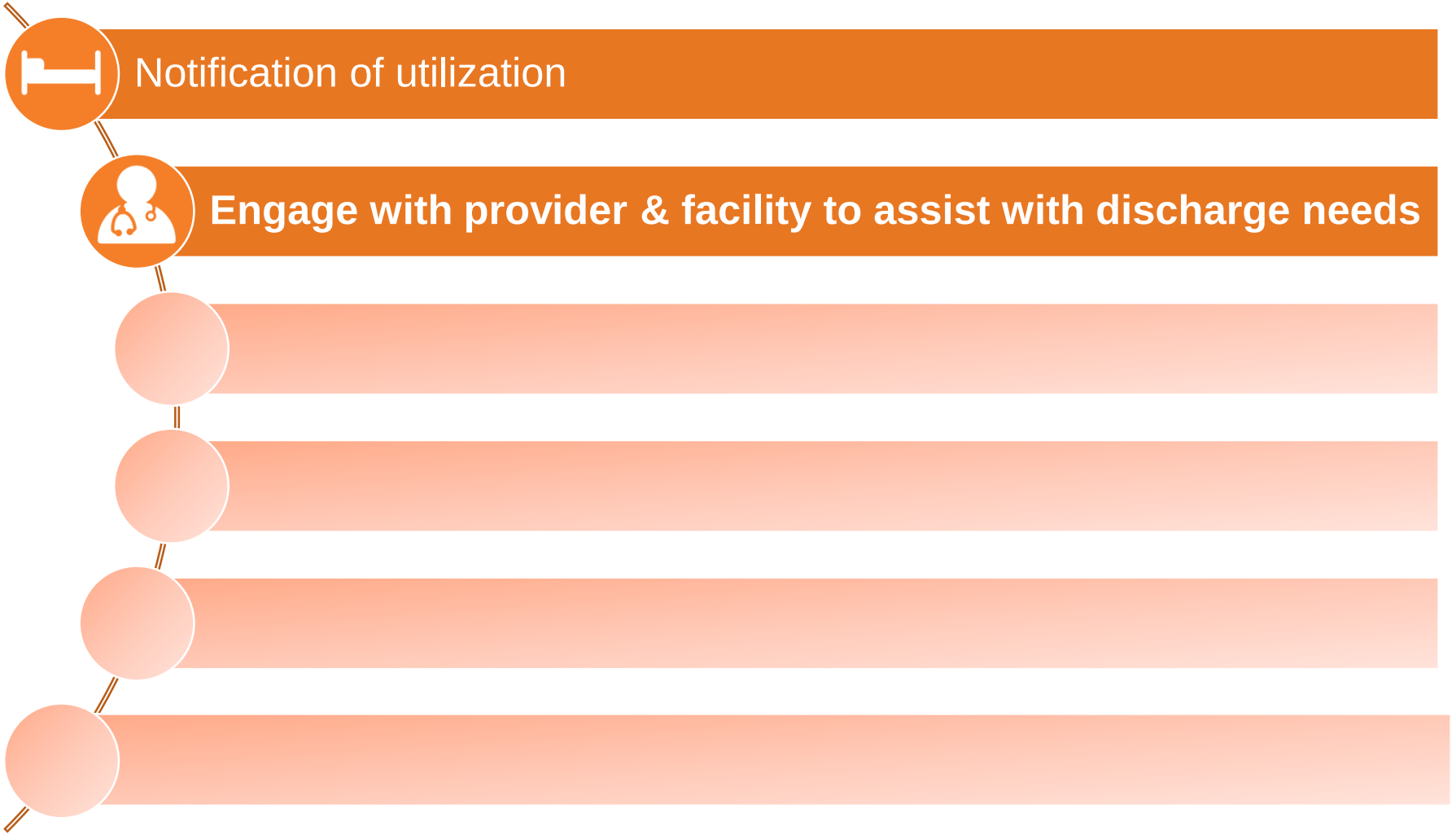
- Alice, 32 year old female
  - Currently inpatient at local psychiatric facility
  - History of: Bipolar, substance abuse, Type II diabetes, obesity and smoker
  - Utilization history: 3 psychiatric admission this year, Last admission 5 weeks ago with suicide ideation after greater than 7 days of heavy drinking
  - Social determinants: Facing displacement from apartment, 8th grade education, unemployed, limited support network, transportation limitations

Member Centered Care

Notification of utilization



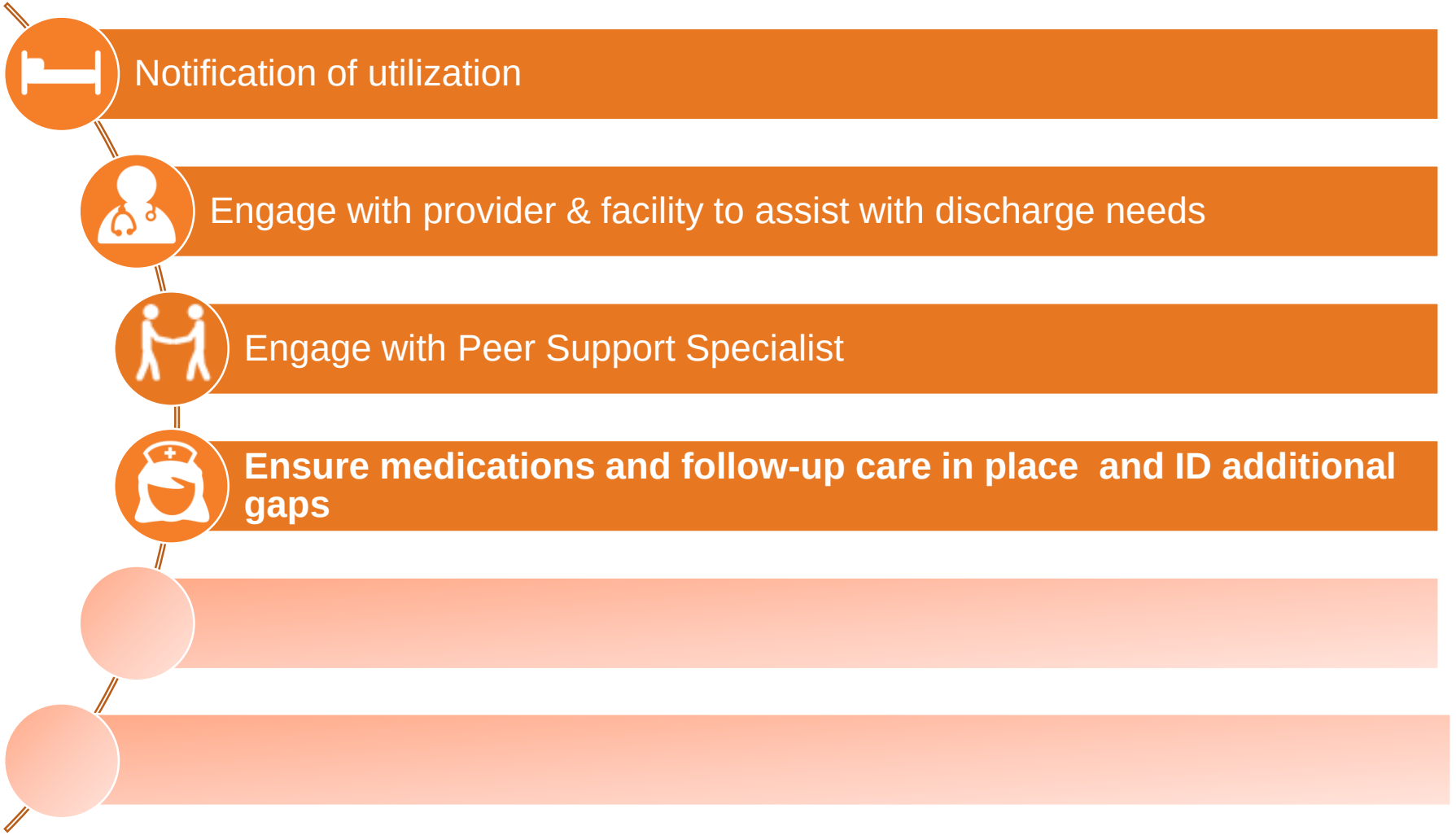
Member Centered Care



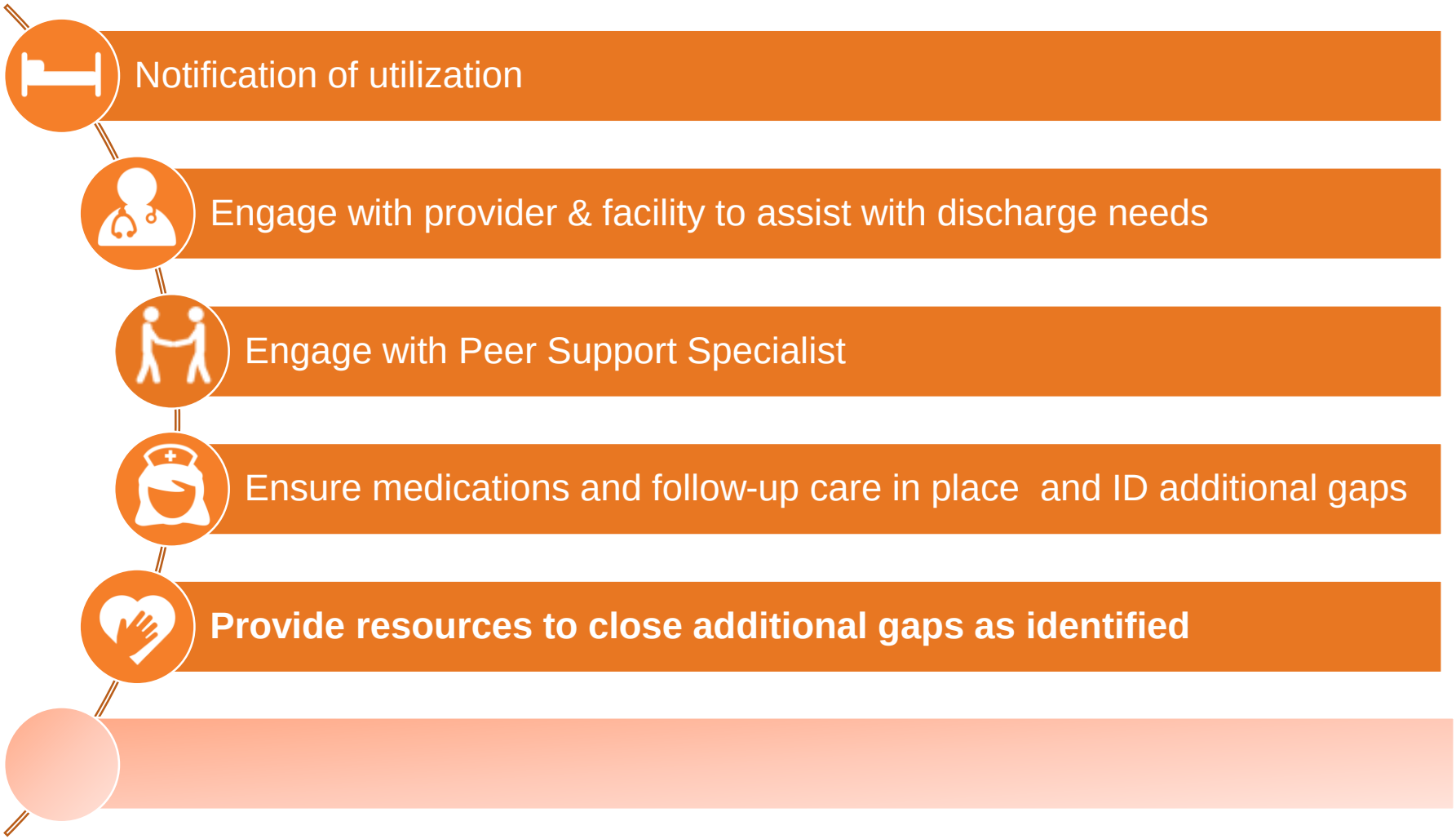
Member Centered Care

- Notification of utilization
- Engage with provider & facility to assist with discharge needs
- **Engage with Peer Support Specialist**

Member Centered Care

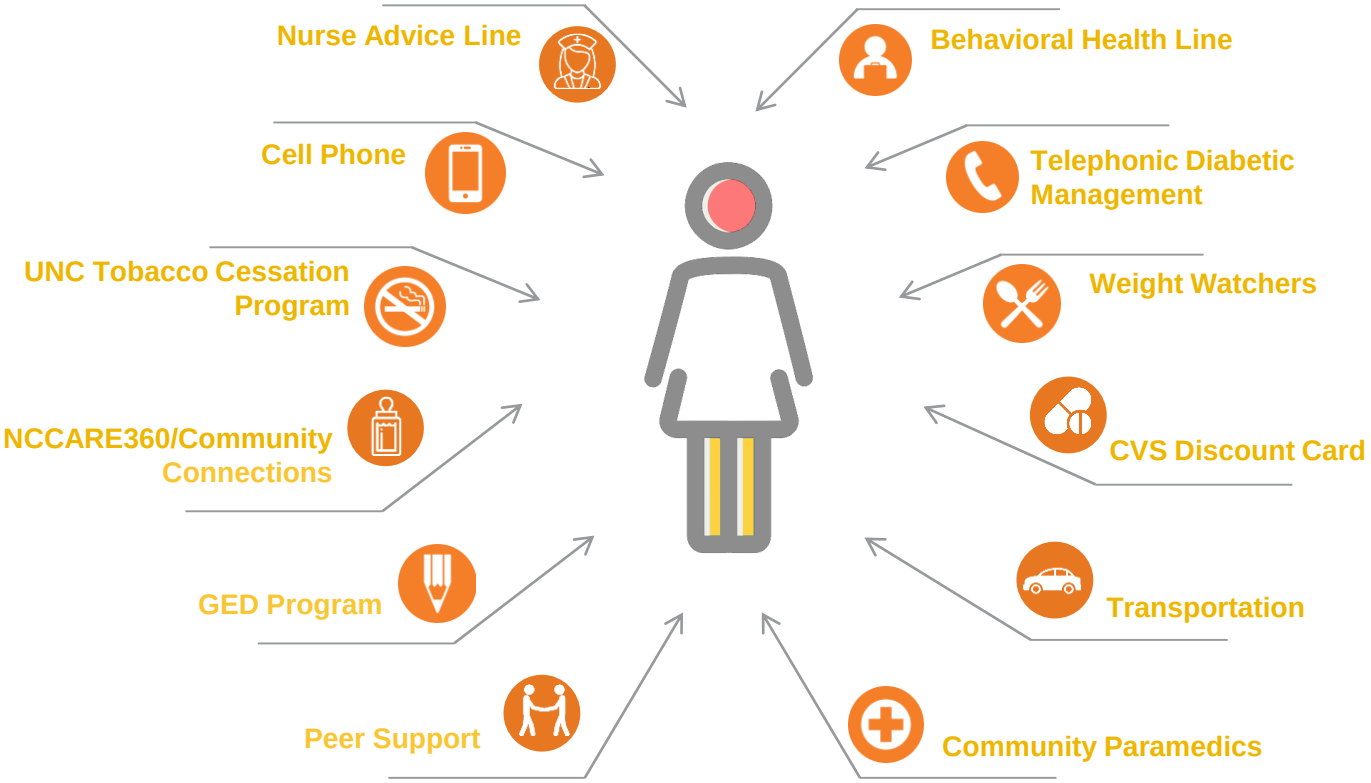


Member Centered Care



Member Centered Care

Standard & Value Added Benefits



30

Contacts

For a contract, email: **networkexpansion@wellcare.com**

Director of Community Engagement
Shaune Lancit: Shaune.lancit@wellcare.com

Director for Field Health Services:
Sue Lynn Ledford: Sue.Ledford@wellcare.com

Director of Behavioral Health for NC:
Courtney Cantrell: Courtney.Cantrell@wellcare.com

Sr. Manager of Care Management for NC:
Heather Wilman: Heather.Wilman@wellcare.com