



November 16, 2018

Ms. Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington DC, 20201

Submitted electronically via email to ASPEImpactStudy@hhs.gov

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

Dear Ms. Destro:

I am writing on behalf of Molina Healthcare, Inc. (“Molina”) to share information about how our health plans identify and address social risk factors for our Medicare members through an enterprise-wide Community Connector program and through pilot programs like the recuperative care program for homeless members in Southern California. These programs ensure that the basic needs of vulnerable Medicare and dually eligible members are met, helping to improve quality of life and health outcomes.

Molina was founded over 38 years ago to provide quality health services to financially vulnerable families and individuals covered by government programs. Through our Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), Medicare Advantage Prescription Drug Plans (MA-PDs), Medicare-Medicaid Plans (MMPs), as well as MLTSS and Medicaid programs, Molina works to improve the quality of care and health outcomes for some of our nation’s most vulnerable citizens. We have been serving dually eligible individuals for over a decade and currently serve approximately 100,000 Medicare-Medicaid members. We also have the largest membership of any MMP with 57,000 members in six of the nine demonstrations.

Community Connectors

To identify and care for our most vulnerable Medicare and dually eligible members, Molina utilizes an integrated and interdisciplinary care team led by a Molina Care Coordinator and comprised of the member, their family as applicable, all providers involved in the member’s care and often times, a Community Connector. Community Connectors are Community Health Workers trained by Molina and are the eyes and ears in the community for the Care Coordinators. They provide members with education, advocacy, and social support, and work closely with community based services like shelters, churches, adult day programs, and food banks.

Community Connectors are an important part of the integrated and interdisciplinary care team. They live in the communities they serve and work hard to develop trusting relationships with

members. Hiring individuals from the communities they serve helps Molina members feel comfortable sharing information with the Community Connector and inviting them into their home for in-person visits. These stories illustrate how Community Connectors work with the Care Coordinators and clinical care teams to identify and address social risk factors for dually eligible members.

1. A 47-year-old dual eligible member suffering from blindness in one eye, depression, high blood pressure, kidney disease and a history of brain cancer lived in a roach infested apartment with her fiancée. The apartment building was in very poor condition and scarcely occupied. There were no elevators in the building and the member struggled with the stairs every time she entered or exited the building. The member struggled with the idea of accepting help to find a safer living situation. The member's Care Coordinator explained that Molina could provide assistance and with the member's permission, the Care Coordinator introduced the member to a Molina Community Connector. The Community Connector worked with the member to understand her needs and preferences. She provided the member and her fiancée with listings of available low-income apartments in the area and helped them consider various options. The member and her fiancé moved into a new building directly across the street from the hospital where the member's medical providers are located. The new apartment building is bug-free and handicap accessible. The member and her fiancée now participate in social gatherings organized by the building staff and enjoy taking walks in their new, safe neighborhood.
2. A 68-year-old dual eligible member with a history of hypertension, COPD, opioid overdose, seizures, and depression expressed concerns to her Care Coordinator about feeling unsafe in her home and her desire to live in a community with other seniors. The Care Coordinator referred the member to a Community Connector who helped her apply for several assisted living and subsidized housing opportunities and as a result was placed on a wait list for low-income senior apartments. After a period of time on the wait list, the Community Connector was notified that one of the facilities the member applied for had a home available. The Community Connector advocated on the member's behalf and was successful in getting the member's application approved. She now lives in a senior apartment and is no longer fearful at home. The member has indicated that she is happy in her new apartment and her emergency department use has decreased. The Community Connector continues to work with the member to make her apartment a safe and comfortable place to live.
3. A 67-year-old dual eligible member had been sleeping in an apartment with no running water. The member did not speak English and was not engaged in his health care despite suffering from arthritis. The member's Care Coordinator referred the member to a Community Connector for housing support and assistance finding a primary care physician. The Community Connector met with the member and his English speaking sister and assisted them in finding a primary care physician who speaks Cantonese. The Community Connector also helped them identify a number of specialists and made sure a translator would be present during the appointments. During an in-person visit with the member, the Community Connector reviewed housing options in the area and helped the member submit several applications. The member secured housing in a nearby senior subsidized apartment, has an established medical home, and is engaged in his health care.

Recuperative Care Pilot Program

People need a safe, stable and supportive place to recover from illness and injury. Recuperative care programs provide a place for homeless members that are ready to be discharged from the hospital, who have a need for follow-up care but have no place to go. Recuperative care programs provide clinical oversight of a members medical discharge plans and a link to social services while ensuring the member's basic needs of housing, food and transportation to medical appointments are met. Recuperative care programs link members with mental health services, job training resources and can be a bridge to permanent housing through social services staff that facilitate and provide linkages to community resources.

Molina Healthcare of California partnered with the Illumination Foundation to provide recuperative care services to a limited number of homeless dual eligible members in Los Angeles and San Bernardino counties. When a homeless Molina member is hospitalized, a Care Coordinator (and other staff as appropriate) meets with the member in the hospital to explain the recuperative care program, address the member's questions and concerns, and assess their willingness to participate. If appropriate and upon approval, when the member is ready to leave the hospital they will enter the recuperative care program with a discharge plan and care team in place.

The goal of the program is to reduce unnecessary hospital lengths and stays and prevent inappropriate readmissions. In California, homeless adults and children stay in hospitals 4 days longer than the average hospital stay with each day costing close to \$3,000. The Illumination Foundation has a unique program designed specifically to care for homeless patients who do not have a place to recuperate after emergency room or hospital discharge. The program ensures that patients will have a place to stay off of the streets to properly recover and prevent a return to the emergency room. As a result, the program shows outcomes with 50% fewer readmissions within 90 days of being discharged to recuperative care than patients who are discharged to their own care¹.

Thank you for the opportunity to provide comments. Molina is committed to working with our state and federal partners to develop and implement programs that improve health and quality of care for our members in the most cost efficient ways. Through our experience serving at-risk members for close to four decades, we have seen that addressing the root causes of social issues can drastically improve members' experiences with the health care system, and ultimately alter their lives for the better.

Sincerely,



Carolyn Ingram
Senior Vice President, Policy and Government Affairs
Molina Healthcare, Inc.

¹ Illumination Foundation: <https://ifrecuperativecare.com/>