Medicaid Managed Care in Illinois:
Developing Innovative Partnerships for Health
Forum Notes 6/27/13

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Policy Priorities Identified

- Integrate medical services with non-medical services (including behavioral health services, social services and more) through incentivizing and reimbursing non-medical services:
  - Paying for psychosocial/social-determinants of health services—this is important to ensuring that complex/specific needs populations reach the improved health outcomes envisioned by the state
  - Current Medicaid system does not cover social services although these services do impact an individuals’ health
  - Current Medicaid system does a poor job at integrating medical services with other types of Medicaid covered services (i.e. behavioral health)

- Development of Health Information Technology (HIT) and the ability to communicate broadly across providers, payers, consumers, etc. is essential.
  - This is especially important during the initial transition to a managed care system—managed care organizations (MCOs) must be able to locate their members in order to manage care
  - Consumers will always move between providers and MCOs, ongoing information exchange is essential to the success of Illinois’ health system
  - Electronic Medical Record (EMR) standardization across large health systems identified as a challenge; potential policy solutions to streamline EMR systems

- Evaluate current care coordination models being implemented in Illinois and decide what is working, and how to bring best practice models to scale
  - Must include ways to evaluate the extent to which medical and non-medical services are integrated and outcomes of integration

- Determine methods to maximize consumer control to enhance consumer experience and consumer outcomes

- Close the gap between the time of enrollment into Medicaid and the start of services for the prison-involved population

- Ensure the community-health workers are able to provide services through Medicaid

- Develop comprehensive behavioral health infrastructure that covers the entire continuum of behavioral health services (including substance abuse services) and does not only cover services for severe mental illness

- Ensure that nurses and other health professionals are able to work at the ‘top of their license’; may entail amending practice act legislation
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Next Steps

Managed Care Organizations

- Continuous education for community-based organizations (CBOs) and other providers broadly about managed care and about individual MCOs’ practices. The following areas were identified as important:
  - Billing systems, including how to submit a claim and count time spent providing services
- Develop/implement models of consumer engagement (potential area for collaboration with CBOs)
- Develop/implement care transition support from acute care to long-term services and supports
- Continuous education for CBOs and providers about the distinction between contractual/covered services and referred services—MCOs are not held accountable to all services a consumer may need not be healthy, only to Medicaid covered services
  - Begin/sustain outreach and relationship building with CBOs whether through contractual or referral relationships
- Continue to regularly convene contracted MCOs in Illinois to discuss ways to streamline the managed care system
  - Health Maintenance Organization (HMO) Association regularly meets with providers and other community entities on Fridays
  - HMO Association committed to interacting and educating providers about managed care and upcoming health system change
- Ensure that care coordination is happening across all types of care: primary, acute, behavioral health, long-term services and supports, etc.
- Be available to consumers and providers to answer questions if there is confusion; use social media and technology as way to do so
- Develop forum(s) to discuss with CBOs the many quality measures that must be collected

Community-based Organizations

- Develop innovative ways to collaborate with MCOs based on historic knowledge and expertise in serving complex needs populations; collaboration may be through a contractual or referral relationship. Challenging areas for MCOs include:
  - Developing models of consumer engagement
  - Transitional care from acute to long-term services and supports
- Begin or sustain outreach and education to MCOs about services offered; CBOs can’t wait on the sidelines for MCOs to reach out to them
- Be available to consumers and providers to answer questions if there is confusion; use social media and technology as way to do so
- Advocate for increased education from the State or MCOs when necessary
Next Steps, continued

State Government

- Provide continuous education for providers about the transition to and implementation of managed care. Building provider networks is a priority for the success of managed care in Illinois and identified as a challenge in Illinois’ Integrated Care Program
- Provide education for consumers who are new to the Medicaid program and unfamiliar with having access to care in order to minimize confusion and increase consumer engagement
- Ensure that care coordination processes are not duplicated across MCOs and CBOs
- Sustain stakeholder engagement in State government health reform initiatives—it should be a priority to keep stakeholders informed and engaged
- Develop contract requirements for MCOs to design referral processes to community-based organizations (CBOs) and providers for non-covered (i.e. non-Medicaid) services to ensure consumers’ needs are comprehensively met
- Assess the current implementation of quality measures; determine what quality measures are a priority in order to minimize unnecessary burden on providers and MCOs
- Provide training for CBOs on how best to work with MCOs
- Develop ways to measure:
  - Collaboration across providers (i.e. care coordination)
  - Collaboration more broadly: across payers, providers, consumers, etc.
  - Accountability of all members of the system: State government, payers, providers, consumers, MCOs, etc.
Welcome
Margie Schaps, Executive Director, Health & Medicine Policy Research Group

Introduction and Conference Overview
Mike Gelder, Senior Health Policy Advisor to Governor Quinn

- We have too little dialogue between two groups that have so much in common and serve similar populations [Managed Care Organizations (MCOs) and Community-based Organization (CBOs)]
  - Together the MCOs (financing) and CBOs (delivery of care) will be serving the Medicaid population
  - No history or culture of these groups working together; CBOs need trust and confidence in the MCOs; this conference will hopefully stimulate the learning process
- There are so many things going on in terms of reforming our health care system, one overarching effort is the Centers for Medicare and Medicaid Innovation (CMMI) planning grant, awarded to Illinois through the Centers for Medicare and Medicaid Services (CMS) on April 1st, 2013
  - Through this grant we are looking at ways of transforming delivery of care, for consumers, commercial payers, and the uninsured. This is a 6-month planning grant after which time the State may apply for implementation funds
- Governor Quinn has focused on health and wellness, versus traditional system that’s focused on sickness
  - The fewer people that come into our system with chronic diseases, the healthier our population is, and the more we can spend on other population based wellness focused measures
  - Not about just paying bills, but how we keep people healthy

Art Jones, Principal, Health Management Associates [Forum Moderator]

- One of the things that’s really important to CMMI is to get broad stakeholder input, today’s conference is to do that
- Focusing dialogue on specific/complex needs populations; need input from our panel and our audience
- As we look back into the past to our experience on moving sub-populations of Medicaid beneficiaries into managed care, we say “we can do this better”
  - What can we do to work together and not repeat the same mistakes?
- Personal past experience: Lawndale partnered with MCOs and the state, and those communications/relationships were really important to success of the health center
  - Because we operate in teams, care can get really fragmented when it comes to complex diseases
  - Served population as an internist (M.D.) and has seen a lot of complex cases; familiarity with this population. Was pretty overwhelmed most of the time, was beyond expertise many times, because this population is very complex
  - Advantage of Lawndale was that they had some other support staff, social workers, etc.
Interactions with mental health providers; very little collaboration; that’s not ideal, hopefully we’re moving beyond that model

- Increasingly with the complex patients, there might be many CBOs for each patient, how do we communicate across the whole network?
  - Even CBOs don’t collaborate with each other; consumers get left in between providers

- Part of CMMI responsibility is to make the system more accountable and to integrate various provider groups with each other
  - What can we do to improve the model of care?
  - Need to measure impact of collaboration

- Once we come up with a model, how can we take this model, how can we replicate it, how can we make it grow to a larger scale?

- We have lots of experience in this room, we are moving into a new age where we have to collaborate with each other
MCO Panel Discussion

- **Greg Alexander, President of the Community Care Alliance of Illinois (CCAI)**
  - CCAI is a provider sponsored MCO called a Managed Care Community Network (MCCN), non-profit MCO
- **Dani Brazee, Vice President of Operations Administration, IlliniCare**
  - One of first MCOs to serve in the Suburban Cook and collar counties
- **Matt Collins, Chief Operating Officer of Cigna-Health Spring, Illinois HMO association Chair**
- **Sanjoy Musunuri, CEO of Aetna Better Health**
  - One of first MCOs to serve in the Suburban Cook and collar counties

Introductions

- **Alexander - CCAI** followed model of care from Boston’s Commonwealth Care Alliance: team based approach with Nurse Practitioners (NPs), CBOs, consumers
  - CCAI has contracted with several CBOs
- **Brazee- Illincare health plan** born on May 1, 2011. They have 18,000 members and 3,000 of which in long-term care (institutional) or community based care
  - Care teams with Registered Nurses (RNs), behavioral health worker, etc.
    - Patients with multiple comorbidities, the RN takes lead in coordinating
    - Recognize social needs that need to be met as well. Social worker helps facilitate this
    - Coordinate with long-term care teams
- **Collins- Health Spring** is the largest stand-alone Medicare Advantage plan in the country
  - 15,000 members who receive care through a Duals (Medicare + Medicaid) Special Needs Plan
  - 20% of membership are special-needs
- **Musunuri- Aetna Better Health in Illinois manages 18,000 and 3,000 are long-term care members**
  - Lots of work in both acute and long-term support and services (LTSS)
  - Aetna Better Health will participate in Duals program to launch in January 2014

Question: What lessons have you learned from the Integrated Care Program (ICP) and what can we anticipate in Chicago?

- **Musunuri - ICP** began with acute care and then added LTSS two years later.
  - Lessons include importance of provider recruitment and education, clinical information transfer and member engagement
  - In 2010, over 50% of members had claims with medical home providers
- **Collins- single biggest problem** is patient-provider disruption
  - Need to work with state and CMS to know historical patterns of care.
  - “Welcome to new plan, you need to find a doctor” is a terrible start to a new plan
Question: If integrated model is where we want to go, what are the challenges that health plans face in developing this model?

- Brazee: major challenge in finding members (old information) and people like to move around a lot
  - Need to partner with CBOs to help locate members, cannot find 30% of members
  - Second challenge comes from provider resistance, disruption of care.
    - Some consumers like new PCPs, better and different care offered by new PCP
  - 3rd challenge = difficult for some CBOs/providers to submit claims. The MCO billing process completely different billing process than working with the State
    - State uses hours, MCOs use units (15 minute increments; 1 hour = 4 units)
    - IlliniCare offers assistance for understanding this change and have webinars on Thursday afternoons to assist CBOs

- Alexander: greatest challenge is engaging members. CCAI model has 6 domains of care around which we are trying to fully engage our members-medical, psychological, functional, environmental, social, and financial
  - Unfortunately the health system is not currently designed around these domains, more limited to medical domain

- Collins: Chicago has uniquely self-contained delivery system. Should take advantage of existing organization that many hospitals and providers already have. Challenge with Electronic Medical Record standards

- Musunuri: 1) how we deal with fragmentation- hand off between acute and long-term is basis of fragmentation 2) behavioral health- biopsychosocial clinical model of care
  - Too few behavioral health providers available, and not necessarily working with medical and other providers. Exchanging of information among providers an ongoing challenge

Question: When you have a complex case or complex needs organization, what do you prefer: to take the lead or have the organization take the lead?

- Collins: Depends on organization
- Musunuri: Innovation is a 2-way street

Question: What are the common misconceptions community organizations have about MCOs?

- Brazee: the misconception is that MCOs don’t want to pay claims; the truth is that MCOs do not want to deny care
  - It is important for people to take preventative measures—MCOs want you to see your doctor, no one wants an unnecessary hospitalization
  - Another misconception is that people confuse MCOs with members of MCOs. Employees are people with feelings who care about the people they serve
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0 Musunuri: MCOs don’t provide all services or contract out for all services.
MCOs administer Medicaid services, as defined in contracts
  ▪ MCOs pay claims and procure providers for Medicaid services
  ▪ There are additional services that MCOs may refer to. There is a difference between a referral and contractual relationship

0 Collins: There was a time where MCOs were worse. Present misconceptions are based on an accurate past
  ▪ Historically providers had administrative hurdles and MCOs hammered providers to negotiate low reimbursement rates
  ▪ Now, MCOs are paying what the State has historically paid for care and access to care is far more efficient for providers financially
  ▪ MCOs also can’t keep all of their premium dollars, MCOs have to spend 85-88% of dollars on care (this is called the Medical Loss Ratio or MLR)

0 Alexander: A common misconception is that MCOs won’t ensure a high quality of care. In fact, there are a lot of quality measures MCOs are required to report on: 150 total! Most of this data is collected through claims

Question: Currently, medicine is what we pay no matter what the outcome. How do we transition to an outcomes based system? How do we hold providers (including community-based entities) and MCOs accountable?

0 Alexander: HFS is holding the MCOs (and therefore the providers) accountable to the same system as before: a fee-for-service system. MCOs will reimburse the providers fee-for-service. Eventually, after a year, MCOs will be able to design contracts with providers that reflect quality outcomes as well

0 Brazee: Agreed, MCOs will be moving towards contract designs that are all about quality

0 Musunuri: MCOs are contractually required to provide care coordination, this holds MCOs accountable to its member

Question: What lessons has the State not learned, yet?

0 Brazee: 150 is way too many quality measures. Is it better to focus on 50, would allow us to excel in specific areas

0 Alexander: We understand why there are so many quality measures: State is listening to the concerns of advocates/stakeholders

0 Collins: state was really ambitious to move half of Medicaid into managed care, but we all have to get involved together to make it happen
  ▪ Need more involvement from all stakeholders working collaboratively (State, MCOs, CBOs, providers)

0 How to measure all stakeholders performance
Welcome Back
Linda Emanuel, Director, Buehler Center on Aging, Health and Society at Northwestern University

- We are in a moment of challenge but we are turning it into a moment of opportunity
- The earnestness of purpose, and the freedom of mind, to be truly innovative
- Buehler Center- cardinal principles of real education: it’s not about the answer, it’s about the question

Community-based Entities Panel Discussion
- Daisy Feidt, Executive Vice President of Access Living
  - Disability rights organization; mission is to help people with disabilities live in the community
  - Consumer controlled organization, driven by this philosophy
  - Combination of advocacy and service
- Pam Rodriguez, President, TASC Inc.
  - Serve justice-involved population; population is primary newly eligible under the Medicaid expansion under the Affordable Care Act (ACA)
    - Divert folks from prison and jail, keep people out of prisons and jails
  - Independent case management agency, behavioral health services, housing, employment, pre-release planning as people leave jail
  - Good understanding of the service system, what it takes to get care, and to stay in care
- Danise Habun, President, Coordinated Care Alliance
  - Created in anticipation of managed care, 28 organizations comprise the Coordinated Care Alliance (CCA) non-profit organization
  - Primarily Care Coordination Units (CCUs) that serve primarily seniors and other persons with needs
  - CCA acts as the hub between MCOs, CBOs, and a variety of organizations that deliver services
  - Member organizations offer comprehensive assessments, do pre-screening, care planning, work in the area of transitional care, will see people in hospitals and in nursing homes
- Karen Batia, Executive Director of Heartland Outreach
  - Work to end poverty.
  - Also provides leadership for Together4Health, a Care Coordination Entity (CCE).
    - Goal is not to recreate the wheel, but to truly innovate. Innovate is to do something NEW.
Question: **What lessons have you learned in your experience with ICP/MCOs; what unknowns or worries do you have?**

- MCOs and CBOs speak in different languages
- Contracts are written as if the CBOs are medical providers while they are not
- Personal relationships are really important; it’s really hard to have a collaboration if you don’t trust the MCO; suggests MCO representatives show up in person to begin the relationship, versus just sending over a contract with language that many don’t understand
- Consumer voice and consumer control, where is this in the new model?
- We are taking a very complex system, trying to simplify this complex system, and things just get more complicated
- Initially integrated care was exciting at first- What observed in reality was that the system perpetuated the same system, but put MCOs to coordinate the fractures in the system

Question: **How can MCOs simplify processes for providers?**

- It is an overwhelming prospect as a provider to enter into the MCO environment. Contracts are structured entirely differently. The idea of learning a whole new payment structure is equally daunting. MCOs could create contracts that are more applicable to CBOs
  - A single payer platform would be really great to minimize the number of MCOs CBOs work with
- A lot of CBOs are overwhelmed and sitting on the side, wondering what will happen. We should experiment and learn to learn in new environments
  - State could provide training on how to work with MCOs

Question: **We are moving towards outcomes based evaluation. What do you think could be done from a CBO perspective?**

- Many of the CBOs do a lot of research and evaluation in terms of what the outcomes are, not just process
- Active dialogue with MCOs about goals of outcomes; set common ground and express what your common goals are
- Lack of communication hinders progress
- No one feels like they have full responsibility
- Medicaid claims information is not real outcomes; so much of what we do is not measured or asked or reported in our claims database
  - We provide a lot of services that don’t go through a payer system, and perhaps they go unnoticed
  - We need to think creatively about how we broaden that system as well as free up dollars
  - Need more flexibility in how we are able to spend $$ as providers, as payers, and the State
- What we get paid for drives what we do; until that changes we cannot innovate
- Any conversation on data and outcomes has to be consumer driven
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- Process measures, contract language, etc. is a major challenge (reiterated several times throughout this session)
- The sense of trying to pull together how different provider disciplines use their expertise takes time, and we need to understand each of their expertise
- We need to utilize our medical staff as best we can

**Question: What can be done to integrate the delivery system?**
- Difficult for medical providers and CBOs to integrate because so much focus is on the primary care provider and medical services. More focus must be on other types of care and services
- Medical field is only one perspective and it is not comprehensive. For example, medical field may say that a disabled person cannot live in the community; over focusing on the medical model will result in certain advancements for some population to regress
- We need to figure out how to use the experience/expertise/perspective of all disciplines delivering care to populations, not just medical staff
  - Doctors, psychologists, care coordinators, social workers, community outreach workers and all of the disciplines caring for people have different training perspective—all of this needs to be leveraged
- Complete behavioral health screening should be a first step in caring for patients.
- Allowing nurse practitioners to work as primary care providers is a good step in the right direction

**Question: What can the State do to help?**
- More broad support of mental health is needed; severe mental illness is a focus, but it is only one portion of the mental health population
  - Substance abuse, depression and anxiety are major problems and costs drivers
- For newly eligible Medicaid beneficiaries, the State should expect the costs to increase before costs decrease; this is especially true for people who were previously uninsured
- Newly eligible beneficiaries are also unsure how to engage with providers
- Providers should be trained on behavioral health so they can be paid properly
Facilitated Question and Answer

- Medicaid covered services vs. referred services
  - **Covered** services = Medicaid services = Hospital, physician services, nursing home, respite care, personal emergency response services, etc. Health plans are required to coordinate this
  - **Referred** services = finding housing, utility assistance, etc. are not Medicaid covered services, those MCOs refer
  - CBOs can play a role in 3 types of services:
    - Referral: MCOs refer consumers to CBOs for non-covered services
    - Provider: CBOs provide covered services for MCO consumers
    - Care coordination: this area is still not completely clear—MCOs are contractually required to coordinate care, it’s difficult to contract this service out to CBOs (despite their expertise and experience) due to issues with HIPAA/data exchange, etc.

- What barriers from the state need to be removed?
  - Batia: People w/ serious mental health issues will work toward recovery and cycle in and out of meetings – not a consistent recovery process
    - Because of the way our system has been allocated funding (State budget), it is hard to truly support these types of patients
    - We save money ultimately when we get somebody in to see a provider
    - Recognize that serious mental illness is only one portion of the overall services needed. Let’s work on things with people with less than 5 or 6 diagnoses
  - Rodriguez: Goal to reduce costs, but providing care to people who have not gotten adequate care previously will cost more money in the beginning (e.g. Mental health conditions, substance abuse, oral health)
    - We must expect that and anticipate that in the State’s budgets
  - Collins: One initiative from MCOs has been to address provider-specific questions: lots of questions about billing and how we pay for services. Once we break that down, let’s talk about population management and how to work with consumer who utilize hospital and health systems frequently

- Can MCOs define efforts to unify systems so providers can only jump through one hoop rather than 7? We want a commitment!
  - Collins: it will be an evolution. Some things plans can discuss together, some things like rates we can’t. Let’s get a common understanding of what requirements are. Very possible for MCOs to have different understandings of what a requirement is
• MCOs, any thoughts of hosting events where providers/CBOs can get to know MCOs better?
  o Collins: Absolutely! IL HMO Association a new organization, reformation of a defunct organization
    ▪ 2 arms of organization: policy activity, provider/community outreach. Part of time every Friday set aside to provider/community events. We want to get to know you better

• CBOs, we haven’t talked about CountyCare. How does it affect what you’re doing now and what can be done to improve upon it?
  o Rodriguez: funding from Chicago Community Trust (CCT) to bring together criminal justice system, community mental health providers, others to help with CountyCare enrollment
    ▪ TASC concerned that clients need access immediately in order to be released from jail. There is a gap between enrollment and initiation of services. Need to be able to predict what the timeframe will be
  o Batia: vulnerable populations can’t afford to have gap in benefits. People who have never had benefits now have them. They’re unsure what it means to be in an engaged relationship with providers, so they're bouncing all over the system. Difficult to coordinate their care
  o Rodriguez: people think they have insurance if they've gotten care from the County system

• State is committed to medical necessity as a criteria to authorize services – medical model. How to balance this with the ACA and its more social model of care?
  o Feidt: referral services often for social things, coverage of services often for medical things. If there are dwindling resources, what do you choose?
  o Gelder: Value is a big word. Initial interest in capitated care was to get State out of business of paying for anything. We did it poorly, reacted badly. Not in anyone’s best interest
    ▪ Money goes to medical side, but if social things help save money from medical side, social side should get some funds
    ▪ This is where managed care comes in. ICP program didn’t have great results with MCOs rewarding the value of social things, but we’re going to keep working on it
  o Let’s define value more broadly than savings in health care. Comes in savings in justice system. State can recognize cost offsets and reinvest in services that have kept people out of jail
    ▪ Recognize that MCOs are primarily responsible for addressing healthcare though
  o MCOs graded on how patients feel they were treated. This is a value
  o CBOs need the flexibility to pay for things that they don’t normally pay for, and let’s see what value that adds to the system. Hard to make this case because there is no evidence of this, but it won’t be developed unless we try
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- Changing timelines: what’s the latest version of rollout of ICP and managed care?
  - ICP Phase 1 began 2011 (Acute/Primary medical services)
  - ICP Phase 2 began February 2013, with a 6 month (180-day) transition period (LTSS)
  - January 1, 2014: Medicare-Medicaid Alignment Initiative (Dual Eligible demonstration program) to launch voluntary enrollment; passive enrollment begins April 1, 2014 – Cook and Collar Counties
  - ICP in Chicago: March/April 2014. Still don’t know if it will be staggered.
  - End of 2014: TANF population in care coordination: Accountable Care Entities (ACEs), Managed Care Community Networks (MCCNs)
  - 2013: expansion of ICP (Rockford, east St Louis, quad cities)
  - Batia: Together4health timeline:
    - CCE a provider-led network to coordinate care across multiple types of organizations. Challenging to innovate and create something new from nuts to bolts. Up and running in the next few months (summer 2013)
  - State working hard but it’s a bureaucracy
    - People working 16-18 hours a day trying to make it work and to stick to timelines, we’ll need a little patience

- Regarding care plans that MCOs start for patients, how do consumers know about them? How are providers involved? How do we communicate?
  - Brazee: MCOs meet face-to-face with the consumer. Can’t do assessment/care planning over the phone
    - Take existing care plans and slowly transition to the MCOs making care plans through home visits
    - In home visit, talk through care plan, find out who providers are, do own assessment to see about any other needs
    - Also doing some education
    - Starts face to face, starts in the home
  - Alexander: care coordination Nurse Practitioner and member identify needs together. Care team has representation from all areas of identified needs. Give CBOs access to care plan – they’re part of the care team, so it makes sense

- Do MCOs recognize NPs are primary care providers?
  - CCAI recognizes NPs as PCPs. Recognize growing need for this
  - Other MCOs in agreement

- Since I work for a company that provides home maker services for seniors, where and how does a company like ours fit into this conversation?
  - Home maker services covered under all Medicaid waivers and based on Determination of Need score for eligibility. MCOs will contract with these providers
  - Care plans based off of what client chooses
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- Coordinated care is a way to provide comprehensive quality care. Are we at risk for duplicating coordination and having too much administration? Who should be providing the coordination?
  - Batia: yes, there is concern of duplication. Many bring to the table different models of coordination. State trying to test out different models of care coordination
  - Yes, some duplication. Let’s not reinvent the wheel
  - Should **not** have separate care coordination (one for LTSS, one for acute care, etc.) otherwise we’ll still have same fragmentation

- What is role of community health workers (CHWs) on teams?
  - MCOs have CHWs on staff. CHWs important way of getting to know patients and have best care plan. Out of cubicles and into the community
  - Use CHWs as a way to reach out to the 30% of the clients you can’t reach/have difficult locating

- MCOs, what are you going to do differently than what was done in the past?
  - Language barrier: not just translating, but make sure things are written at appropriate reading level, aim for comprehension, use pictures, etc. Some things have to stay in legal writing, but we’re hoping to make things better to understand
    - Some MCOs have partnered with CBOs to do this, including partnering with the Coalition for Limited English Speaking Elderly (CLESE)
  - State has done some outreach to Rockford hospitals to participate in ICP, but still in process
  - Provider education, webinars, open houses: draw interest in joining the MCO
  - Clinical model: incorporate folks into training regimen; invite CBOs

- How do we communicate health information to patients we serve that they can trust, understand, and use? How to empower them through access to info?
  - Rodriguez: repeat information, often. Language that people aren’t used to using. Has to be online and integrated in everything we do
  - Feidt: be available for people to talk through any confusion. Keep being available
  - Habun: have settings be client friendly and break down language into regular words
  - MCOs and social media: Facebook page with events, highlighted health topics; keep website up to date; getting into Twitter; but still prioritize in-person interactions; measure PCPs on in-person interactions