Illinois' Ever-Changing Health Care Landscape: We stay on top of the mess so you don't have to

Status of the Illinois State Budget

What You Should Know: The political stalemate shows no signs of ending. About $14 B in court-mandated spending will continue, which includes funding for Medicaid and its waiver programs. Expect cuts in most social programs.

Why This Matters: If your clients receive home and community-based Medicaid waiver services (for persons with disabilities, adults with developmental disabilities, residential services for children with developmental disabilities, in-home services and adult day care, etc.) they should see minimal changes in those services. However, funds for other social supports important to health and independence, such as home delivered meals, are being cut.

What Can You Do? Call, write and email your elected State legislators. Urge them to end the grid-lock and support funding for vital social service programs. Find the State representative for your area by entering your zip code and address through this link: http://il--nea.capwiz.com/nea/il/directory/statedir.tt?state=IL&lvl=state
Also, joining The Responsible Budget Coalition is a great way to stay on top of the budget battle and send a message to Springfield: http://www.responsiblebudget.org/

Licensed Clinical Social Worker (LCSW) Medicaid Billing Legislation

What You Should Know: Currently in committees, two bills (**SB2332 and HB4526**) will require the Department of Healthcare and Family Services to adopt rules allowing Medicaid reimbursement directly to licensed, clinical social workers for behavioral health services. Currently, LCSWs must be employed by a qualifying organization.

Why This Matters: Passage of these bills could increase the number of qualified mental health service providers in the State, making it easier for you to find resources for your clients.

What Can You Do? You can support the bills by contacting your elected officials through the National Association of Social Workers (NASW) IL: http://www.naswil.org/advocacy/advocacy-alerts/

Managed Long Term Services and Supports Roll Out

What You Should Know: Starting July 1, dual eligibles (people on both Medicare and Medicaid) in the greater Chicago area who have chosen to opt out of the Medicare Medicaid Alignment Initiative and who reside in a nursing facility or receive home and community-based Medicaid waiver services will now have to enroll in a Managed Long Term Services and Supports plan that will coordinate care for Medicaid-covered transportation, behavioral health services and long-term care services. The State will begin sending notices on June 1 to people who have opted out of MMAI and are required to enroll in a MLTSS plan.

Why This Matters: People who do not respond to the notice right away could be auto-enrolled into a plan that does not include their nursing facility or waiver services provider. To receive LTSS from the same provider or agency, people must select a plan within 60 days of receiving the letter from the State.

What Can You Do? Ask clients if they have received a notice after opting out. If you have any problems with the new rules, please contact Bryce Marable: bmarable@hdadvocates.org.

Balancing Incentive Program (BIP)

What You Should Know: BIP will incentivize States to increase access to non-institutionally based long-term services and supports. It is intended to lower costs through improved system performance and efficiency, facilitate person-centered assessment and care-planning, and increase quality of care and improved oversight. A big part of BIP will be improving access to community and home-based services for beneficiaries requiring LTSS.

Why This Matters: You will have to familiarize yourself with three important elements of BIP:

- "No Wrong Door" Coordinated Entry Points (CEPs) will make it easier for you and your clients to access care through a coordinated network of agencies, an informative LTSS website, or the 1-800 BIP Call Center.
- Conflict-Free Case Management will ensure that clinical or non-financial eligibility determination is separated from direct service provision and that the development of the service plan and arrangement of services and supports receives ongoing monitoring to assure that services and supports are delivered to meet the client's needs and achieve the intended outcomes, all while creating more focus on client-centered care.
- The Uniform Assessment Tool (UAT) will be discussed under the next heading.

What Can You Do? Urge your organization to stay abreast of changes via the BIP Stakeholder Group and provide any updates to you. Additional questions can be sent to HFS.BIP@illinois.gov

Uniform Assessment Tool (UAT)

What You Should Know: The UAT will be used across all Coordinated Entry Points (CEPs) and assessment sites to increase consistency, efficiency and transparency. There are two components: 1) the BIP Initial Screen and 2) the comprehensive assessment (interRAI-CHA) which will cover five domains:

- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)
- Medical Conditions/Diagnoses
- Cognitive Functioning/Memory/Learning
- Behavioral Concerns

Why This Matters: The UAT will be rolled out in the late summer/early fall of 2016 to a subset of CEP and assessment sites in order to incorporate user feedback into the new system. It is anticipated that the use of the UAT will go "live" in the spring of 2017. You and your organization will receive instructional materials for the new UAT software sometime in 2016.

What Can You Do? Urge your organization to stay abreast of changes via the BIP Stakeholder Group. Additional questions can be sent to HFS.BIP@illinois.gov

Managed Care & Network Adequacy Bills (State)

What You Should Know: Two State bills, currently in committee, would enforce network adequacy requirements for Medicaid managed care health plans and require MCOs to provide plan information in an accessible, easy-to-understand format.

HB6213 requires that Managed Care Organizations provide an accurate, updated list of all health care providers and professionals in their networks and prescription drugs covered on their formularies. These lists will be provided in various, easily searched formats. It also requires that a quality of care comparison tool be created for the Integrated Care Program and Family Health Plan/ACA Adult managed care plans.

HB5559 requires that Managed Care Organizations maintain an adequate network of providers and that network directories be tested on a regular basis for accuracy. Also tests for ability of patients to obtain appointments and the timeliness of appointments offered.

Why This Matters: Clients will be assured of getting the services they need and were promised. Making appointments for needed services will become easier as clients and case managers will have access to accurate and up-to-date information regarding those services

What Can You Do? You can support the bills by contacting your elected officials. Find a link to their offices: http://www.naswil.org/advocacy/advocacy-alerts/

Change to DOL Overtime Regulation

What You Should Know: The State of Illinois must comply with new Department of Labor regulations regarding overtime pay for workers providing home services to older adults and people with disabilities. In response, the State says it will cap the number of hours worked to 35, with an additional 5 hours of travel time.

Why This Matters: Some people with disabilities currently receiving home services need more than 35 hours. They may not be able to piece together the needed number of hours using multiple personal assistants, threatening their ability to continue living in the community.

What Can You Do? If you know clients who qualify for more than 35 hours per week of home care, speak with them about the possibility of having to find additional home care workers when and if the new rules go into effect. Advise your clients to obtain a copy of their DON score for them to keep on file.

Medicare Observation Status

What You Should Know: Hospitals must inform patients who have been on observation status for 24 hours that they are an outpatient on observation status. Once the person has been on observation status for 24 hours, the hospital has 12 hours to give the notice.

Why This Matters: The law ensures that patients are more informed about the costs of their care, but does not set up a formal process for appealing the decision while in the hospital. You may be asked to help with an appeal of status or long-term care eligibility after a patient is discharged.

What Can You Do? Familiarize yourself with the new observation-status requirements. The Center for Medicare Advocacy has put together an excellent guide: http://www.medicareadvocacy.org/self-help-packet-for-medicare-observation-status/

Community Care Program and the Community Reinvestment Program

What You Should Know: The 2017 State budget proposes a big change to the Community Care Program (CCP). If adopted, Non-Medicaid eligible older adults would be served under the proposed Community Reinvestment Program (CRP) which will be implemented by Area Agencies on Aging, instead of through the Community Care Program.

Why This Matters: People over the Medicaid eligibility level may see a reduction or change in available services.

What Can You Do? Urge your organization to stay abreast of changes and provide any updates to you. If a client is adversely affected by this change, please notify Bryce Marable: bmarable@hdadvocates.org.

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