State of Illinois
Illinois Department on Aging

Older Adult Services Advisory Committee

Finance Work Group

Date: February 7, 2008
Attending: Stephanie Altman (co-chair), Pat Comstock (co-chair), Ryan Gruenenfelder, Phyllis Mitzen, Bette Schoenholtz, Barbara Wylie. **Staff:** Janice Cichowlas.

Welcome to new members.

A letter is being sent to every legislator with a link to the Primer which was completed at the end of 2007. OASAC is working to restructure the direction of the workgroups. Face-to-face meetings will be planned in the future to meet in Pontiac.

Pat Comstock reviewed the legislature's schedule in order to set the next meeting of this Workgroup. The next meeting is tentatively set for Monday, March 3, 2008 in Pontiac, 10-2.

HB652 (mandatory Medicaid enrollment for CCP services): fears and barriers for older adults is an issue. Recommendations to OASAC from Finance Committee: educating providers and consumers through brochures; educating what cannot be recovered such as an estate that does not go through probate; possible waivers of the requirement.
Change legislation and HB4574, sponsored by Sara Feigenholtz (scheduled for 2/14 in committee) – removes asset recovery by Medicaid – could you exempt certain assets (i.e., $17,000). Rules changes could be made by IDoA and HFS that might allow an income producing asset to be waived and not recovered. Recommended that individual organizations support Sarah's bill. IL adds that Medicaid recovery can include health-related program expenses.

We are one of the few states where state could recover from people who just enrolled in a medicare savings program, such as when the state pays the monthly premiums (as in the Extra Help program). We are looking at getting people OFF IL Cares Rx and getting them on Extra Help. Every medicare beneficiary would get expanded Pharm benefit. Looking at how much this might cost the state, if anything.

Stephanie is going to do a fact sheet: IL CARES RX has two benefits: Basic and Plus. She says they are trying to get everyone on PLUS. Maine and Wash D.C. has raised state medicare rates to get plus program for everyone?

HB4449 The state has moved maximum income up from the Federal Poverty level so amending this bill to 225 - 250% of poverty level.

Why was Jack Franks the sponsor for this bill? It is part of the "make medicare work coalition". This coalition talked to Franks about doing this. Pat Comstock thinks it's unusual that he would be on an

issue like this, though she says he is a great spokesperson for senior issues. She thinks he's a great choice. Bette is in his district and is encouraged to talk to him to help with this bill. The bill does not have a fiscal note yet. Strategy to pay for this: those getting basic are already getting the 10 classes of drugs. There's already an administrative function paid to do this. In addition, there are the HIV drugs. QMB/SLMB bill would help move more people to extra help and thus reduce our costs.
The fiscal notes are usually ridiculous, says Pat Comstock.

We need to know average cost for someone on basic vs plus for the State. It depends on amount of prescriptions they are on.

There are now 5 eligibility categories: 0-200% get plus, above 250% get basic, etc. 210% person would get covered for one medication and not for another.

SB1925, Sen Schoenberg (with Rep Coulsen) – to provide health insurance for people under 100% of poverty. It would include adults under age 65 (which includes 60-64).
Leg breakfast 2/21 w/Sen. Dave Koehler, Schoenberg and Rep Coulsen

This is the poorest population with no access to health care. They don't have access to Medicaid (old "aid to medically indigent" pop) and at least 1/3 of medically insured.

Federally Qualified Health Centers are filling some of this gap. The Governor's office Amendment 9 to SB005 had cost estimates: 302,000 people - $200 million
Some are disabled but not processed as disabled but State would be more willing to look at this if they realized these people could be covered federally.

Uninsured, unemployed woman who needs knees surgery in S. IL. Under 100% poverty but not disabled and not over 65.

Pat Comstock: The notion of predictable payments impacts N.H. providers. State is always a certain amount of time behind. Providers go months without any check at all. It's becoming increasingly difficult with bank lending crisis and reliable lines of credits. There's no bill # yet but Pat will share. She wants predictability in the payment cycle. There needs to be a check issued every month, even if not everything they are owed.
N.H. have only been paid through Sept services and it's now February. It's nearly impossible for people to operate. No check at all since November.

Days are counted when services end at end of month and state sends a voucher of who they think was in their facility at the end of that month and N.H. has to send it back. Dept starts counting after they get the verified voucher back. Most other Medicaid service providers consider $'s due when month ends. Here, October services wouldn't seem to be started in the payment cycle until mid-November. You have to add 30 days, just because of the way our billing works.

Other states guarantee a check on the same day each month.

Pat – of 850 skilled facilities about 120 have expedited payment. % of Medicaid has to do with whether they are expedited (more Medicaid, faster because no private pays to help those facilities). The problem is that because of the change in the nature of the N.H. business where there are more

and more options for other kinds of care, the services required for these individuals is getting more and more complex. This is additional strain on providers.

Medicaid is paid first by the state and then comes to the state quarterly. State must already have paid it.

On Medicare side, payment is very prompt.

Issue for Gov's office is that Gov's budget is based on 40 day payment schedule and budget by leg is based on 77 day payment schedule. Gov's office isn't sure who is putting the strain on this.

AAA didn't use to have problems with getting prompt payment and now they are having a problem.

Pat Ahern: Hospice waits 6-9 months to get paid. Hospice has a pass through respon for patients dually eligible for room and board.

Pat Comstock says we have at least started the discussion.

Stephanie surveyed MDs and payment cycle/delays were tied with payment rates. Delays are just as bad if not worse than actual rates.

You can operate a business if you know the state will be 30-60-90 days out. You can plan for that. But you can't plan for the unknown.

30 day guarantee and interest???

N.H. not allowed to recoup interest they pay on lines of credit to bridge this gap.

There is a process in IL where you can apply to get that interest back, such as for the MDs.

If it were awarded to the N.H., it would come out of the N.H. line item.

In MN, Medicaid is billed after the end of the month and the payment cycle is every two weeks. They could be paid within 1-2 weeks after submittal of the bill.

This problem has been growing since the early 90's. Borrowing from Medicaid at a State level eventually catches up to you. This was a problem before this Administration.

Pat Comstock is hesitant to start a bill about this because of the consternation. Maybe it would be better to sit around the table first. A bill that requires the state to pay within 30 days might be impossible.

How can this get better if it is not addressed? (Phyllis)

It hasn't been this bad since the early 90's (Comstock). If there is any talk of a tax increase, we might want to add a little more to the Medicaid program to get the program righted.

HB1350: Adding CM and assisted living to OAA

HB4823: Amends the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act. Provides for a one-time increase in the household income eligibility limits for property tax relief grants and pharmaceutical assistance to take into account cost-of-living increases designated under the Social Security Act for 2005, 2006, and 2007. Provides for annual increases thereafter in an amount equal to the amount of the annual cost-of-living increase designated under the Social Security Act. Effective immediately.

Stephanie says this bill won't be necessary anymore with the amendment that Franks added, and the change the state has made.

HB1350: paying for incontinence supplies

Money Follows the Person: state is developing protocol which is due 4/08 It's for Medicaid enrollees only. Plan to provide extra services to persons in N.H. longer than 6 months and less than 2 years. Services can only be provided for 1 year.

6 workgroups: JAN TO SEND THIS AROUND TO THE GROUP (Steering committee is closed)
Contact Person: Shelly running Service Workgroup
Housing
Disabilities
Service

Jean Summerfield is overall contact person.

Benchmarks: State and agencies looking at setting benchmarks for L-T-C in IL. OASAC has realized that after 3 years we have momentum but we don't know what it will look like if it is successful.

MFTP has a built in benchmark (it is not a grant but an enhanced Medicaid payment), over the next 5 years would change % of funding that would go to H&CBS vs institutional care. 7% increase over the 5 years.

P. Mitzen gave some ideas of benchmarks that could be considered in the effort to reform or rebalance LTC in IL such as: reducing beds, converting beds, moving $'s to community-based services

Ahern: Caregiving resources concerns when N.H.s reduce their beds. Could N.H. employees be community resource people vs facility resource people. Workforce issues.

Quality of life when person returns home. Concern about isolation.

Changes in offerings at N.H. facility such as ADS.

New services available in the community.

Measurement of public and private initiatives for Family Medical Leave Rules. Watch for upcoming changes to the Rules, perhaps re: intermittent leave for chronic health problems/or that of family members.

What about community code enforcement issues, paramedicals, recidivism in the ER/N.H.

Hospice end of life side, will #'s change in terms of serving at home vs N.H./Hospital. 50% currently are served in LTC facilities and rising.

MFTP can move people to assisted living (it's not a facility they are leaving via this program). People in Assisted Living are receiving services that are different from the NH and so as people move to Assisted Living, it could change the look of Assisted Living to that of a N.H.

IDPH has not been funded for the oversight for Assisted Living even though PH regulates Ass't Living.

HFS regulates the SLFs, which is essentially the Assisted Living for Medicaid persons.

"Wider Opportunities for Women" based in Washington DC. Based on family of 4 living a modest life in cities, rural areas; determined minimum amount it would cost to live in various zip codes around the state.

Now looking at older people in 5 states. The data is now available. They also try to include LTC expenses. Data is on their website.

Martha Holstein should attend and present this info to this committee at the next meeting. Carol Erinson has been working on this.

HMPRG 3-part series: April 14, May 5, June 2nd
National leaders and local leaders to think about our vision for LTC. Flyer was sent to all Finance Workgroup members.