CBHA
Community Behavioral Healthcare Association

Community Behavioral Healthcare Association (CBHA)
Illinois FY25 Budget Analysis

May 29, 2024

Provided as a membership service.

Dear CBHA Members,

The Spring 2024 Session of the Illinois General Assembly included several bills aimed at reducing the behavioral workforce shortage, increasing reimbursement rates for psychiatric services, expanding opportunities for providers to give feedback and engage with state agencies, and expanding access to critical behavioral health services across the state. The House passed 207 bills and the Senate passed 258 bills, making a total of 465 bills passed by both chambers.

Three CBHA-initiated bills passed the General Assembly and made it to Governor Pritzker's desk. The Workforce Direct Care Expansion Act (**HB 5094**), which was championed by Rep. Lindsey LaPointe and Sen. Laura Fine, will substantially reduce administrative burdens on behavioral health providers by requiring state agencies to collaborate with stakeholders and systemically reduce unduly burdensome requirements. **HB 5353**, sponsored by Rep. Bob Morgan and Sen. Suzy Glowiak-Hilton, will establish military portability licenses for all professions and streamline the exam application process for behavioral health licensure. Finally, **HB 5457**, sponsored by Rep. Barbara Hernandez and Sen. Karina Villa, establishes exam accommodations for ESL students and completely decouples immigration status from professional licensure to protect immigrant clinicians.

Sen. Aquino and Leader Gabel passed the Medicaid Omnibus bill, which included substantial rate increases for psychiatric services, a priority advanced by CBHA, IARF, and IABH and championed by Rep. Lindsey LaPointe, House Majority Leader Robyn Gabel, Senators Karina Villa, Laura Fine, and Sara Feigenholtz. The Medicaid Omnibus also includes a ban on prior authorizations for medications treating serious mental illness (a full list of which mental illnesses are covered can be found in the analysis of the bill on page 10). Budget highlights can be found on page 4.

CBHA is pleased to provide you with our summary report from the most recent legislative session. This report includes an analysis of the FY25 budget and its implementation bill, the Medicaid omnibus, Gov. Pritzker's Healthcare Protection Act, CBHA-initiated legislation, and other key pieces of behavioral health legislation. Be sure to catch the **20th edition** of the Legislative Roundup in the coming weeks for a more detailed discussion of all the relevant behavioral health bills that passed this year.

We trust you will find this service an important tool in your administrative work plan and thank you for your advocacy and hard work.

Sincerely,

Blanca Campos, MPA, CAE
CBHA, Chief Executive Officer

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Illinois Fiscal Year 2025: Budget Analysis

The 103rd General Assembly adjourned its Spring 2024 session in the early hours of May 29th. Although the General Assembly did not meet its target adjournment date of May 24, it did conclude its spring session in advance of the usual May 31 deadline. Several bills were finalized after the May 24 target adjournment, including the FY25 operating and capital budget; omnibus packages on revenue, Medicaid, use taxes (including an elimination of the grocery tax), and election reforms; and the Governor's Healthcare Protection Act.

In total, 465 bills passed both Chambers, including 207 House Bills and 258 Senate bills.

Budget: The Fiscal Year 2025 Budget, SB 251 (Sims/Gordon-Booth) appropriates $53.1 billion in General Revenue Funds. The overall framework for administering the budget is addressed in the budget implementation bill, HB 4959 (Gordon-Booth/Sims). The 2024 Revenue Omnibus package, HB 4951 (Burke/Villanueva) includes key reforms for mental health boards and will generate an estimated $70 million in revenue for the state.

Fiscal Year 2025 runs between July 1, 2024 and June 30, 2025. Gov. Pritzker stated that this budget is "responsible and balanced while providing record investments" in child care and early childhood education, scholarship funding, workforce development, healthcare, and other critical social services.

New Investments in Psychiatric Services

The Fiscal Year 2025 budget includes new investments in psychiatric services. The funding level is projected at approximately $11 million in the form of rate enhancements for psychiatric services billed under Medicaid. A breakdown of the rate enhancements is included in the Medicaid Omnibus section of this report on page 8.

CBHA would like to thank the Pritzker Administration and General Assembly for prioritizing investments into (and reforms of) our behavioral health system and their commitment to expanding access to critical mental health and substance use services for children, adults, and families.

This is a deserved victory for you, community behavioral health providers, who work long hours in sometimes unideal conditions to ensure that there's always help available for clients in need.

BUDGET BILL

SB 251 (Sims/Gordon-Booth) appropriates $53.1 billion in General Revenue Funds.

Department of Healthcare and Family Services (HFS): $39.478 billion.

- $26.8 billion for FY25 Medicaid.
- **$497.9 million to annualize Medicaid program rate increases, including $11 million for psychiatric rate increases. (CBHA, IARF, IABH initiated measure)**
- $1 million for the Medicaid Technical Assistance Center.
- $6 million for administering the Breakthrough Therapies for Veteran Suicide Prevention Program including but not limited to, academic and medical institutions for purposes of studying emerging therapies.
- $10 million to support a program to relieve medical debt for more than 300,000 Illinoisans.
- $200 million for the healthcare transformation capital investment program.
- $440 million to two programs that provide Medicaid-like coverage for some undocumented adults. Officials have said they expect to bring in an additional $100 million from a federal emergency services match, as well as $50 million from drug rebate payments and $40 million from managed care organization taxes.

Department of Human Services (DHS): $14.248 billion.

- $846.6 million for the Division of Mental Health (DMH) and $570.6 million for the Division of Substance Use Prevention and Recovery (SUPR).
- $290.3 million for grants and administrative expenses of the Home Illinois Program, including pilot programs, to prevent and end homelessness in Illinois, including but not limited to homelessness prevention, emergency transitional housing, rapid rehousing, outreach, and related services and supports for individuals at risk or experiencing homelessness.
- $10 million for grants and administrative expenses associated with mental health services to first responders.
- $5 million for grants and administrative expenses associated with suicide prevention.
- $182 million to provide shelter, health care and other services for recently arrived migrants.

Department of Public Health (IDPH): $1.708 billion

- $400,000 for a Homelessness Mortality and Morbidity Report to address health issues of those who are housing insecure.

Department of Children and Family Services (DCFS): $2.36 billion.

- Funding to hire an additional 392 positions to support DCFS caseloads.
- $38.9 million to increase the rollout of the Comprehensive Child Welfare Information System.
- $100 million for one-time investments for the Level of Care Support Services, capital grants to providers which help increase capacity for youth placement in the most clinically appropriate settings.

Department of Financial and Professional Regulation (IDFPR): $149.915 million.

- $11,470,900 to administer licensure acts for general professions.
- $395,000 for the implementation of a new licensing system.

Board of Higher Education (IBHE): $2.55 billion.

- $10 million in increases to the Monetary Award Program (MAP), which increases total MAP funding to $711 million.
- **$10 million for the Community Behavioral Health Workforce Education Center. (CBHA initiated measure)**

Illinois Student Assistance Commission (ISAC): $977.331 million.

- $5.5 million for the Human Services Loan Repayment Program.
- $6 million in scholarships and loan repayments for social workers.
- **$7.5 million for the Community Behavioral Health Professional Loan Repayment Program. (CBHA initiated measure)**

Illinois Criminal Justice Information Authority (ICJIA): $561.9 million.

- $13.4 million for Adult Redeploy and diversion programs.

Children's Behavioral Health Transformation: $35 million.

- $1.5 million for BEACON (Behavioral Health Care and Ongoing Navigation), the portal developed in partnership between Illinois and Google Public Sector.
- $31.3 million for Comprehensive Community Based Youth Services (CCBYS) Expansion.
- $2 million for Pediatric Mental Health Testing.

NEW Department of Early Childhood: Nearly $13 million.

FY25 BUDGET IMPLEMENTATION ACT

HB 4959 (Gordon-Booth/Sims) contains the substantive language to administer the FY25 budget.

Highlights for behavioral health include:

- **Requires DHS to establish a supplemental substance use disorder treatment locator that can compare and assess addiction treatment facilities for clients.** The treatment locator will be integrated with the Illinois Helpline and provide annual surveys on both provider and patient experiences.
- **Sets annual increases for reimbursement rates for licensed or certified provider of ASAM Level 3 residential/inpatient services.** The adjustment will be equal to the Consumer Price Index-U (CPI-U) from the previous year, capped at 2% per fiscal year. If the CPI-U decreases, the rate will remain the same for that fiscal year rather than decreasing.
- **Allows money in the Fund for Illinois' Future to be given to community-based providers.** These funds can be used for costs associated with violence prevention, community development, educational programs, social services, community programs, and operational expenses.
- **Creates the Professions Licensure Fund**. This fund will be used by the Department of Financial and Professional Regulation to procure new software and for tasks related to the granting, renewal, or administration of all licenses under the Department's jurisdiction.
- **Allows the Board of Higher Education to establish and administer a grant program under the Early Action on Campus Act.** These funds will go to universities to raise mental health awareness on college campuses.

Pretrial Success Act

- **Establishes DHS grants for local government agencies and community-based organizations to support pretrial success.** The first round of grants will be awarded by January 1, 2025, and in following years, grants will be awarded by September 1 of each fiscal year. Grant terms will be for a period of three years beginning fiscal year 2028.
    - **Use of Funds:** Organizations must use the funds to provide case management for mental health and substance use disorders, detoxification services or referrals, medication-assisted treatment or referrals, child care to facilitate court appearances, and transportation to court appearances if not provided by other stakeholders. Funds may be also used for harm reduction, clinical and crisis interventions, group counseling, short-term individual sessions, and motivational interviewing.
    - **Grant Amounts:** Initial grants in FY25 will range from $100,000 to $300,000 per organization. In subsequent years, grants will range from $100,000 to $500,000.
    - **Recipient Limits:** Grants will be awarded to 1-3 organizations in each service area, except in areas with a population over 2 million, where up to 10 organizations may receive grants.
- **Creates Local Advisory Councils to recommend fund distribution for maximizing pretrial success.** DHS will be required to establish these local advisory councils for each service area and each council will have at least 5 members.
- **Mandates evaluation of the grants' effectiveness via an annual report issued at least 24 months after the first round of grants.** This evaluation will use community-based participatory research methods and incorporate input from those directly impacted by the Act. When

possible, the evaluation should involve outside experts. It will also include recommendations for building community-based capacity, including mental health and substance use disorder treatment services.

Other Provisions of Interest

- **Increases wages for DSPs and other frontline staff in residential and community day services by $1/hr.** Out of this increase, $0.75 must be allocated directly to base wages and the remaining $0.25 can be used flexibly for additional wage increases.
- **Requires the Department of Public Health to designate a healthcare telementoring entity.** Healthcare telementoring will be a program using interactive video or phone technology to connect local health care providers (including community-based behavioral health providers) with specialists for real-time collaborative sessions. The goal of the program is to help local providers gain the expertise necessary to more effectively provide services.
- **Establishes the UIS Innovation Center.** The Center, located at the University of Illinois at Springfield, is intended to foster innovation in areas such as academics, entrepreneurship, workforce development, policy development, and non-profit activities.

MEDICAID OMNIBUS BILL

The Medicaid Omnibus bill, SB 3268 (Aquino/Gabel), contains several provisions to strengthen the behavioral health industry, including increased reimbursement rates for psychiatric services and crucial prior authorization restrictions for the treatment of those with serious mental illness.

Highlights for behavioral health include:

Psychiatric Rate Increases

Increasing Medicaid rates for behavioral health services is crucial to address the workforce shortage facing providers statewide. This session, the trade associations (CBHA, IARF, and IABH) worked together to address rate add-ons for services billed by psychiatrists and APNs with behavioral health certificates. Rate add-ons were created in 2016 to mitigate the elimination of DHS's psychiatric leadership grants. These add-ons were expanded in July 2018 as part of the 2020 budget implementation and have not been updated since. The following is the finalized language:

> "Subject to federal approval, for dates of service on and after January 1, 2025, the Department shall make a one-time adjustment to the add-on rates for services delivered by physicians who are board-certified in psychiatry and advanced practice registered nurses who hold a current certification in psychiatric and mental health nursing. The one-time adjustment shall increase the add-on rates so that the sum of the Department's base per service unit rate plus the rate add-on is no less than $264.42 per hour adjusted for time and intensity as determined by the work relative value units in the 2024 national Medicare physician fee schedule, indexed to 60 minutes of individual psychotherapy."

Illinois needs 25.9 psychiatrists per 100,000 residents but currently only has 10.5 per 100,000. However, rural counties average a shocking 1.2 psychiatrists per 100,000 residents. While the shortage of psychiatrists is severe, there are shortages across all levels of the behavioral health workforce. This shortage limits access to services. Dr. Kari Wolf, CEO of the Illinois Behavioral Health Workforce Center (BHWC) at SIU Medicine testified in a joint hearing of the House Mental Health & Addiction Committee and Senate Behavioral Health Committee. Dr. Wolf provided the following statistics about the workforce shortage:

- From 2017–2019, 53.6% of the 1.8 million Illinois adults who experienced a mental illness did not receive treatment.
- Only 43% of the 145,000 Illinois youth aged 12-17 who experienced a major depressive episode received any behavioral healthcare.
- In 2021, The American Association of Medical Colleges reported that Illinois has the capacity to meet just 24% of the mental health needs of the state with its current workforce.
- 13% of youth reported a suicide attempt and 3% reporte that they had been injured in an attempt to take their own lives in 2021.
- Over a quarter of adults in Illinois reported significant symptoms of anxiety or depressive disorder in 2023, compared with just 11% in 2019.

The final proposal set a total compensation per hour benchmark of $264.42. This benchmark was set using Bureau of Labor Occupational Wage Data for Illinois psychiatrists and adds benefit costs and adjusts for inflation. The estimated annual cost for this proposal is roughly $11 million, of which the state's share is $5 million.

These rate adjustments have an effective date of January 1, 2025.

Utilization Review Standardization, Reform, and Transparency

- **Bans prior authorizations for emergency services, including inpatient stabilization services.** Hospitals will be required to notify the MCO within 48 hours of the inpatient admission, but notification will be limited to advising the MCO that the patient has been admitted to a hospital inpatient level of care. If the hospital does not comply with this notice requirement, MCOs will be able to initiate concurrent review for the continuation of the stay. However, coverage for services provided during the 48-hour notification period cannot be retrospectively denied.
- **Requires MCOs to cover post-stabilization medical services under certain circumstances.** These include when the MCO or its utilization review organization (URO) authorized the service;, the services were provided within one hour of requesting authorization to maintain the enrollee's stabilized condition; the MCO or URO did not respond to the authorization request within one hour; the MCO or URO could not be contacted; or the MCO or URO and a non-affiliated treating provider couldn't agree on the enrollee's care, an affiliated provider wasn't available for consultation, and the non-affiliated provider rendered the services until an affiliated provider was reached and concurred with the plan of care or took over care.
- **Requires HFS, with input from MCOs and other stakeholders, to establish rules to standardize and make transparent the service authorization process for all individuals covered under Medicaid.** Additionally, beginning July 1, 2025, HFS will be required to adopt rules to regulate MCO practices, including the following reforms:
    - Guidelines for the publication of MCO authorization policies;
    - Procedures ensuring that medically complex procedures performed on an inpatient basis are reimbursed correctly and limits on repeat medical necessity reviews for services already authorized;
    - Standardized administrative forms for member appeals, peer-to-peer review processes and timelines, and criteria for authorizing admissions to long-term acute care hospitals; and
    - Defined criteria for urgent and standard post-acute care service authorization requests.
- **Broadens external quality review organization audits to include a variety of data related to MCOs.** These audits will include the following:
    - Analysis of MCO compliance with nationally recognized clinical decision guidelines;
    - Comparative analysis of service authorization outcomes among MCO plans and the state's fee-for-service model to enquire equitable standards of care;
    - Detailed analysis of service authorization requests, including initial denials, overturned decisions, approved requests at lower levels of care, and final denials; and
    - Annual reporting to the General Assembly on these analyses, with the first report due by April following the effective date of the new rules, and every April thereafter, to be made publicly available on the HFS website within 30 days of submission to the General Assembly.

Gold Card Providers & Service Authorization Exemptions

- **Establishes a Gold Card provider program for providers with at least 50 service authorization requests in the previous year, and at least a 90% approval rate for those requests.** Providers who are deemed Gold Card providers will be eligible for an exemption to service authorization requirements in inpatient or outpatient hospital settings.
    - Exemptions are valid for at least one year, but providers must document and submit medically necessary, clinically appropriate care.
    - If the provider's approval rate falls below 90%, the exemptions may be temporarily or permanently suspended. This is to be renewed bi-annually.
    - MCOs will be required to publish a list of Gold Card providers on their provider portal or indicate Gold Card status on the provider roster. Providers who qualified must be notified by December 1 of each year for an exemption for the following year.
    - MCOs must provide HFS with a list of providers who were denied an exemption or whose exception was suspended. An independent third-party URO will annually audit these denials to ensure appropriateness. The URO must be independent of any Medicaid MCO.
- **Sets standards for claims processing under the Gold Card Provider exemption program.** MCOs must have standard methods for processing claims for services rendered, prescribed, or ordered by exempt providers, except in cases of fraud. Authorization programs cannot deny, partially deny, reduce care levels, or limit reimbursement for services ordered by exempt providers.
- **Sets a sunset date of December 31, 2030.** This program is set to expire at the end of 2030 unless it is renewed by the General Assembly.

Utilization Management Ban for Serious Mental Illness

- **Bans prior authorization mandates and utilization management controls for certain FDA-approved prescription drugs used to treat serious mental illness under both the fee-for-service and Medicaid managed care programs.** Prior authorization and utilization management controls cannot be imposed if the patient changes providers (e.g. from inpatient to outpatient) and is stable on the drug previously prescribed and authorized; the patient changes insurance coverage and is stable on the drug previously prescribed and authorized under the former coverage; or the patient needs a modified dosage or frequency for the same treatment for which the drug was previously prescribed and authorized, subject to federal dosage limits and safety edits.
- **Permits some safety edits under reasonable conditions.** These include clinically appropriate drug utilization review (DUR) edits, including drug-to-drug, drug-age, and drug-dose interactions; generic drug substitution if a generic version is available in the same dosage and formulation; or utilization management controls are necessary to comply with consent decrees or federal waivers.
- **Defines serious mental illness.** Conditions covered under the ban include Delusional Disorder, Schizophrenia, Bipolar Disorders, Anorexia Nervosa, Bulimia Nervosa, Major Depressive Disorders, Obsessive-Compulsive Disorder, PTSD, Puerperal Psychosis, Postpartum Depression, Factitious Disorder Imposed on Another, and others listed by DMH using ICD-10-CM codes from the DSM-V.

Other Provisions of Interest

- **Sets a monthly personal needs allowance at $120 per month for residents of supportive living facilities.** This allowance will be subject to federal approval and has an effective date of January 1, 2025.
- **Sets add-on payment amounts for each inpatient General Acute and Psychiatric day of care for safety-net hospitals.** These amounts are in addition to the statewide standardized amount and any other payments, excluding Medicare-Medicaid dual eligible crossover days. These add-on payments apply to any services administered between July 1, 2024 and December 31, 2026, after which the rates will be adjusted annually.
    - If the hospital's Medicaid inpatient utilization rate is greater than or equal to 70%, the add-on payment will be $425.
    - If the hospital's Medicaid inpatient utilization rate is between 50-69%, the add-on payment will be $300.
    - If the hospital's Medicaid inpatient utilization rate is between 40-49%, the add-on payment will be $225.
    - If the hospital's Medicaid inpatient utilization rate is 39% or less, the add-on payment will be $210.
    - For claims between July 1, 2024, and December 31, 2026, a safety-net hospital low volume add-on payment of $200 will be paid for each inpatient General Acute and Psychiatric day of care for any hospital that provided less than 11,000 Medicaid inpatient days of care, excluding Medicare-Medicaid dual eligible crossover days.
- **Requires DCFS to pay for all inpatient stays beginning the 3rd day a child is in the hospital beyond medical necessity.** This applies when the parent or caregiver has denied the child access to the home or has refused or failed to make provisions for another living arrangement for the child, or when the child's discharge is being delayed due to a pending DCFS investigation.
- **Establishes reimbursement for music therapy services under Medicaid.** Beginning July 1, 2025, HFS will be required to reimburse music therapy services provided by licensed professional music therapists.
- **Adds quality of life enhancements for specialized mental health rehabilitation facilities.** Beginning January 1, 2025, a payment of no less than $10 per day, per single room occupancy will be added to the existing $25.50 additional per day, per single room occupancy rate for a total of at least $35.50 per day, per single room occupancy.
- **Establishes a one-time payment to specialized mental health rehabilitation facilities that are licensed for only single occupancy rooms and have reduced their licensed capacity.** These facilities will receive a per diem add-on payment depending on the number of beds.
    - For facilities with less than 100 licensed beds, the add-on payment will result in a rate of at least $240 per day.
    - For facilities with 100 to 130 licensed beds, the add-on payment will result in a rate of at least $230 per day.
    - For facilities with more than 130 licensed beds, the add-on payment will result in a rate of at least $220 per day.
- **Requires the DHS Division of Developmental Disabilities to provide 100% of the per diem reimbursement to a 24-hour CILA provider for up to 20 days for any resident requiring a medical absence.** During the medical absence, the provider will hold the bed for the resident.
- **Sets a rate add-on for supportive living program home and community-based services to provide 2 meals per day, at least $6.15 per day.** This provision is in accordance with the waiver approved by the federal CMS and will take effect July 1, 2025.

- **Establishes reimbursement for legally responsible family caregivers for providing personal care or home health aide services to medically fragile and technology-dependent children.** By January 1, 2025, HFS is required to submit a state plan amendment and any necessary waivers. To be eligible for reimbursement, family caregivers must be a certified CNA or nurse aide and must provide services to a medically fragile relative who is receiving in-home shift nursing services coordinated by the University of Illinois at Chicago's Division of Specialized Care for Children.
- **Implements telehealth services for persons with intellectual and developmental disabilities.** This applies to individuals receiving CILA residential services under the HCBS Waiver Program for Adults with Developmental Disabilities for services provided on or after January 1, 2025. Telehealth services will be opt-in and cannot be used to replace in-person services for those who request them.

HEALTHCARE PROTECTION ACT

Gov. Pritzker announced during his 2024 Budget Address that a key priority for his administration is to expand access to critical health services, particularly inpatient behavioral health services, through a series of reforms targeting prior authorizations, so-called step therapy, and other practices employed by insurers and MCOs that may restrict access to care. The Healthcare Protection Act, HB 5395 (Moeller/Peters), contains numerous provisions, including several that affect the Medicaid Managed Care system.

Coverage for Inpatient Mental Health Treatment

(eff. January 1, 2026)

- **Prohibit policies from requiring prior authorization for admission for inpatient mental health treatment at participating hospitals.**
- **Establishes a 72-hour concurrent prohibition.** For the first 72 hours, coverage is not subject to concurrent review. Hospitals must notify insurers of the admission and initial treatment plan within 48 hours of admission. A discharge plan must be fully developed to ensure continuity of care.
- **Permits retrospective review of treatments but protects patients from retrospective billing.** However, while treatments may undergo retrospective review, if coverage is denied retrospectively, patients are protected from being billed for the treatment received up to the date of the adverse determination, except for applicable copayments, coinsurance, or deductibles.
- **Retains the ability of health plans to conduct reviews.** Health plans, including Medicaid managed care organizations, may still conduct reviews for fraud, waste, or abuse.

Step Therapy Ban

(eff. January 1, 2026)

- **Bans step therapy requirements starting January 1, 2026, except for certain drug substitution scenarios required under other laws.** This prohibition does not apply to Medicaid managed care plans for drugs not listed on the most recent Preferred Drug List.
- **Defines "step therapy" to mean a utilization review or formulary requirement that specifies, as a condition of coverage under a health care plan, the order in which certain health care services must be used to treat or manage an enrollee's health condition.** Step therapy does not include utilization review based on generally accepted standards of care; the removal of a drug from a formulary or changing the drug's preferred or cost-sharing tier to higher cost sharing; a requirement to obtain prior authorization for the requested treatment; or utilization controls or a preferred drug list required under the Public Aid Code.

CBHA-INITIATED BILLS

The United States is facing an unprecedented mental health crisis. According to research by the National Council for Mental Wellbeing, nearly 2 in 3 providers report increased client caseloads, and nearly 7 in 10 report that client severity has increased since COVID-19. People across the United States are traumatized from a pandemic that shut down society and killed the most vulnerable among us. In 2022, 12.7% of Illinois adults reported 14 or more days of poor mental health per month. Even the needs of children, whose mental health conditions have been declared a national emergency, are unable to be met in Illinois. Additionally, the opioid crisis continues to ravage Illinois communities. In 2014, approximately 9.77 people died from drug poisoning per 100,000 people. In 2022, that number has risen to 23.8 people who die per population of 100,000. This represents a 243.6% increase in the number of overdose deaths in the last ten years.

Compounding the issue, the United States as a whole is facing a behavioral health workforce crisis. Each year, the number of licensed behavioral health professionals fails to meet increasing demand for services. By 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that the United States will be short about 31,000 full-time practitioners. These impacts are particularly felt in rural areas, where some counties have little to no provider options at all. Furthering the problem, almost half (48%) of providers surveyed indicated that the impacts of workforce shortages have caused them to consider leaving the field entirely.

For these reasons, CBHA passed **three pieces of legislation** in the Spring 2024 session. Our goal was to expand access to care, address the workforce shortage, reduce provider burnout, increase reimbursement for behavioral health services, and ensure efficiency in Medicaid billing.

Workforce Direct Care Act, HB 5094 (LaPointe/Fine)

The Workforce Direct Care Expansion Act was drafted in response to significant provider feedback about the impact that administrative burdens have on providers' ability to serve clients. Provider administrative burden refers to a wide range of administrative activities. These can include processes that require behavioral health professionals and their clients to repeat data collection processes and adhere to a vast and uncoordinated array of requirements.

Despite burgeoning mental needs across the state, unruly administrative tasks prevent clients from receiving direct care. Over two-thirds (68%) of providers report that the amount of time they spend on repetitive administrative tasks takes away from time they could be providing direct client support. Both those new and experienced in the field report that the heavy documentation requirements directly impact the amount of care they are able to provide. Simply put, excessive administrative burdens create a worse behavioral health system where providers are at capacity and clients' needs are unmet.

In late 2023 and again in early 2024, CBHA surveyed our membership about the administrative burdens they face. Overall, the community behavioral health industry reports spending half the working day for each professional on administrative tasks, which, as discussed above, greatly reduces appointment availability. Our providers highlighted the following as examples of administrative burdens:

- Extreme and duplicative documentation requirements.
- Separate administrative requirements for the treatment of those with substance use disorder than those with general mental health conditions, even though these are often co-occurring issues.
- Billing issues that come about as a result of not having the Medicaid behavioral health fee schedule released by the effective date.
- Audit processes that ask for hundreds of pages of documentation per client.
- Requiring clients to complete documents at each visit, even when doing so could re-traumatize the client.
- The development of behavioral health programming without sufficient provider input, which leads to confusion and program redevelopment during the implementation stage.
- Training staff on how to comply with Medicaid-specific requirements, which can take hours per week and furthers the divide between private insurance and Medicaid-funded clients.

The combination of unruly administrative burdens, an extreme workforce shortage, and an unprecedented mental health crisis nationwide have led to providers experiencing burnout at levels never before seen. Nearly every provider surveyed (93%) admitted to experiencing burnout, and almost two-thirds (62%) of providers reported that they experience moderate or severe burnout. Even despite severe burnout, providers are just as devoted as ever to the success of the field. About 83% of providers have anxiety that shortages in the field will negatively impact society as a whole. Six in ten say they lose sleep over the thought of those not able to access care, and 76% fear the number of lives that will be lost due to workforce shortages nationwide.

The Workforce Direct Care Expansion Act accomplishes the following:

- **Creates a Behavioral Health Administrative Burden Task Force.** Between unruly documentation standards, competing funding requirements, and duplicative reporting processes, providers are facing an unprecedented burnout crisis. The Task Force will be established within the Office of the Illinois Chief Behavioral Health Officer to study and make recommendations to lower administrative burdens faced by behavioral health providers across the state. The aim of the Task Force is to get providers and various state bodies in the same room to make a coordinated plan to remove barriers between patients and providers.
    - **Membership:** The Task Force members will be appointed by the Illinois Chief Behavioral Health Officer (CBHO) and will include representatives from various behavioral health associations across the state. Membership should be tailored by the CBHO to include a variety of providers across settings. In addition to provider perspectives, membership will include representatives from various state agencies with enforcement powers related to behavioral health, including DMH/SUPR, HFS, DCFS, and IDPH, among others. The Task Force will meet at least monthly.
- **Requires the creation of an Administrative Burden Reduction Plan.** After the Task Force's first year of study, it will prepare and submit an Administrative Burden Reduction Plan. The Plan will be submitted to any relevant state bodies whose participation would be necessary to carry out the Plan. Within 90 days of receiving the Plan, each state body must submit a detailed response to the Plan and explain the feasibility of any proposed changes.

Military Portability & Streamlined Exams, HB 5353 (Morgan/Glowiak Hilton)

HB 5353 came about through the result of months of negotiation and collaboration with the Department of Financial and Professional Regulation (IDFPR). Although IDFPR is facing substantial delays in the processing of professional licenses, the Department was a reliable partner in the 2024 session in attempting to address the inefficiencies of the licensure process.

HB 5353 accomplishes the following:

- **Requires IDFPR to approve applications to take behavioral health licensing exams.** When an individual applies to take a professional licensing exam, they send the application to IDFPR, who reviews it and notifies the relevant testing authorities that the applicant is authorized to take the exam. Just as the Department faces delays in granting initial licensure, many individuals have reported delays in receiving permission to test. By establishing an immediate approval process, IDFPR can spend more time reviewing other application types, including applications for original licensure. Additionally, examinees will get more immediate access to
- **Establishes portable licenses for military members and their spouses.** When a member of the United States Armed Forces is stationed in Illinois, they are able to apply for expedited licensure. However, their spouse must follow traditional licensure processes, which could result in a 6 to 8 month wait for licensure. Under the updated language, both military members and their spouses will be able to practice under newly established military portability licenses without facing interruptions in their ability to practice. This applies to all professions regulated by IDFPR, including license types unrelated to behavioral health.

ESL Accomodations & Immigrant Clinician Protections, HB 5457 (B. Hernandez/Villa)

The ability to express oneself, particularly when trying to explain emotions or analyze/interpret life events, is crucial to the successful provision of behavioral health services. Studies show that the delivery of services in a client's language is crucial to the development of trust and the comfort of the client. The American Psychological Association's official position is that, due to professional ethics and governmental guidelines, behavioral health services "should be provided in the preferred language of clients with limited English proficiency." Every major behavioral health profession highlights the ethical need for practitioners to enhance cultural sensitivity and competency.

More than one-in-five Illinois households (23.2%) primarily speak a language other than English at home. The most common non-English languages spoken in Illinois are Spanish (1,627,789 or 13.5% of households), Polish (174,381 or 1.44% of households), and dialects of Chinese (including Mandarin and Cantonese at 105,919 or 0.877% of households). Additionally, an estimated 1.8 million people, or 14.1% of Illinois residents, were born outside the country. These individuals are more likely to face issues of discrimination, racism, and xenophobia, all of which are social determinants of health and can lead to negative behavioral health outcomes. This population is also likely to be uniquely traumatized due to sociopolitical turmoil in specific parts of the world, uncertainty about immigration status, and grief over family and homeland separation.

In addition, Illinois has a particularly high population of international students. Illinois has the fifth highest number of international students in the country, with over 55,000 students traveling to Illinois for its educational and vocational opportunities. In 2022, the University of Illinois system announced a

record 11,548 international students enrolled in their programs. With the recent influx of migrant children attending Chicago public schools, Chicago teachers have highlighted the severe need for bilingual social workers and counselors to address the needs of traumatized children.

However, despite the pressing need for bilingual providers, the shortage of bilingual therapists prevents communities from adequately addressing issues related to migrant trauma. The lack of bilingual professionals is particularly felt in rural areas. For example, although immigrants account for 7% of the population of McLean County, there are only a handful of clinical professionals who speak Spanish and an even smaller amount who speak other languages. This means clients must rely on translators, which take precious time from the client's therapy session, or wait months and travel great distances for appointments with local bilingual therapists. Bilingual clients often opt to receive services in English due to severe availability gaps of services in their language of origin.

CBHA advanced HB 5457 to increase the number of bilingual providers in the state and to protect immigrant clinicians, whose lived experience is immeasurably valuable to the industry's ability to help vulnerable immigrant populations.

HB 5457 accomplishes the following:

- **Requires IDFPR to grant exam accommodations for people whose first language is not English and for people with disabilities.** IDFPR will be required to ensure accommodations are available when entering into contracts with the relevant testing authorities. These accommodations will include giving students extra time on the exam and allowing ESL students to use a word-to-word dictionary to translate words. These accommodations may look slightly different for each profession because the major clinical professions have different options provided by the respective national accreditation board. No matter their form, however, these provisions are intended to ensure that every student, regardless of their proficiency in English or disability status, can successfully complete the licensing exam to become a behavioral health professional.
- **Prohibits licensing boards from disciplining anyone based solely on an immigration violation.** United States Citizenship and Immigration Services (USCIS) faces substantial delays in issuing, renewing, and converting immigration applications. The vast majority of applications take well over a year to adjudicate, and there are situations where individuals face a lapse in status due to administrative delays through no fault of their own. Immigration violations are non-criminal violations, and no one should face professional discipline in addition to uncertainty about their immigration status.
- **Clarifies that an Individual Taxpayer Identification Number (ITIN) can be submitted in lieu of the Social Security Number (SSN) on social worker, counselor, and marriage and family therapist applications.** This is a clean-up provision intended to clarify current law. P.A. 100-1078 allowed the Department of Financial and Professional Regulation to accept an ITIN in place of the SSN, but the individual licensing statutes have not been updated to reflect this option. This means students who review the laws before becoming counselors, social workers, and marriage and family therapists might be unaware that they don't need an SSN to get a license.
- **Adds language prohibiting immigration status discrimination to the individual licensing statutes.** Like above, this provision is a clean-up provision intended to clarify current law. Immigration status discrimination is already prohibited under P.A. 100-1078, but this language has not been added to the individual licensing statutes. By adding this language, interested individuals can have a clearer picture of their rights when reviewing the licensing statute of their chosen profession.

KEY BEHAVIORAL HEALTH LEGISLATION

These bills passed both chambers and are headed to the Governor's desk. A comprehensive 2024 Legislative Roundup report will be sent to CBHA membership in the coming weeks.

Mental Health Board Updates (Revenue Omnibus), HB 4751 (Burke/Villanueva)

(information provided by Jodi Dart of ACMHAI)

708 boards have for decades existed in numerous cities, townships, and counties across Illinois and serve as an important resource to help its residents access critical treatment and services for substance use disorders, intellectual/developmental disabilities, and mental health issues at the local level. The following changes are made to the Community Mental Health Act (CMHA):

- **Report Deadlines:** Extends the deadline to publish the annual budget and report from 120 to 180 days. This also modifies the deadline to submit the annual report from within 90 days to within 180 days from the end of that fiscal year.
- **Board Representation:** Updates community mental health board member composition to prioritize representation from individuals with professional or lived expertise in mental health, developmental disabilities, and substance use. General public representation may also be considered when there are gaps in board duties/qualifications from within CMHA stated categories.
- **Vacancies:** Updates language allowing for vacant seats to be filled in the same manner as original appointments with the advice of the community mental health board, who may establish a policy and procedure for the acceptance and review of applications from interested residents prior to making a recommendation to the appointing authority.
- **Governmental Authority:** Modernizes language so that references to the Illinois Department of Human Services also includes any other appropriate local or state governmental agency supporting these services.
- **Workforce Development:** Allows 708 boards to fund and support local efforts regarding educational assistance, student loan repayment, professional certification and licensure assistance, and internship stipends to address workforce shortages.
- **Ballot Language:** Provides guidance and specificity around ballot language to be used when a municipality is seeking to establish a new 708 board.
- **Property Tax Extension Law Limit (PTELL):** Emphasizes language in the CMHA that was adopted in 1998 as an amendment (P.A. 90-652) to the Property Tax Extension Limitation Law (PTELL) that distinguishes that taxes collected through mental health boards shall not be included in any limitation.

Early Childhood Education Act, SB 0001 (Lightford/Canty)

- **Creates the Department of Early Childhood.** The DEC will be responsible for administering and providing early childhood education and care programs and services to children and families.
- **Centralizes early childhood services statewide.** The Act is intended to centralize home-visiting services, early intervention services, preschool services, child care services, licensing for day care centers, day care homes, and day care group homes. These functions were historically administered by the ISBE, DHS, and DCFS.

Universal Student Mental Health Screenings, SB 0726 (Feigenholtz/LaPointe)

- **Requires ISBE, in collaboration with stakeholders, to develop a strategy to implement universal mental health screenings for students.** The strategy will build on existing efforts to understand the needs of school districts concerning resources, technology, training, and infrastructure. It will include a framework for supporting districts through a phased approach to universal mental health screenings.
- **Establishes one-on-one in-home respite behavioral health aides.** The Children's Behavioral Health Transformation Team, in collaboration with DHS, will be responsible for developing a program to provide in-home services to youth who require intensive supervision due to their behavioral health needs.

Shortened Endorsement Period for LMFTs, SB 3211 (Cervantes/LaPointe)

Reduces the time an LMFT is required to be licensed in another state before they can apply for Illinois licensure. Currently, LMFTs who want to move to Illinois and provide services here must be licensed for 5 consecutive years prior to applying. Those who don't meet this requirement must apply through the traditional application process and must take the licensure exam. Now, those out of state applicants must only be licensed for 2.5 of the last 5 years.

CESSA Extension, SB 3648 (Peters/Cassidy)

Extends the implementation of CESSA mobile mental health provisions by one year. The pieces of CESSA that regulate mobile mental health providers were set to go into effect on July 1, 2024. However, CBHA has been working hard with industry partners to clarify components of the language that may be difficult for providers to implement. To give the industry more time to plan for implementation, the effective date of these provisions will now be July 1, 2025.

Health Care Background Check Reforms, SB 3661 (Murphy/Mussman) - *CBHA INITIATIVE*

Allows DHS to establish a waiver process for background checks for mental health. This is a long-time initiative of CBHA. This bill amends the Health Care Worker Background Check Act that will include CMHCs under the definition of "healthcare worker." This will allow CMHC staff to be eligible for the waiver process. CBHA has requested that DMH amend the FY25 contracts to include a waiver process for CANTS background checks. DMH indicated they are still looking at small changes in Attachment B for FY25 contracts. The emergency rule for VP-CST (joint process between DMH and HFS) was filed and they will be following up with permanent rulemaking.

AGENCY BUDGETS

DMH Budget FY25

(DHS Division of Mental Health)

DMH Budget Item	FY24	FY25	Change
Grants and administrative expenses to expand home and community-based services, including rebalancing and transition costs associated with compliance with consent decrees, including prior years' costs	$57,781,500	$60,481,500	**+$2,700,000**
SOMHF or the costs associated with services for the transition of SOMHF residents to alternative community settings	$306,887,900	$316,387,900	**+9,500,000**
Community Transition and System Rebalancing for the Colbert Consent Decree, including prior years' costs	$56,677,500	$59,677,500	**+$3,00,000**
Purchase and Distribution of Psychotropic Medications	$1,381,800	$1,381,800	**$0**
Evaluation Determinations, Disposition, and Assessment	$1,200,000	$1,200,000	**$0**
Supportive MI Housing	$22,713,800	$22,713,800	**$0**
Community Service Programs for Persons with Mental Illness, Child With Mental Illness, Child and Adolescent Mental Health Programs, and Mental Health Transitions or SOMHFs, including prior years' costs	$169,761,900	$183,095,233	**+$13,333,333**
Mental Health Treatment (from the Mental Health Reporting Fund)	$5,000,000	$5,000,000	**$0**
Mental Health Home-Based Program (from the HHS Medicaid Trust Fund)	$1,300,000	$1,300,000	**$0**
Community Service Programs (from the DHS Community Services Fund)	$15,000,000	$15,000,000	**$0**
Community Service Programs (from the DHS Federal Projects Fund)	$16,036,100	$16,036,100	**$0**
Medicaid Services (from the Community Mental Health Medicaid Trust Fund)	$70,000,000	$70,000,000	**$0**
Community Service Programs (from the Community Mental Health Services Block Grant Fund)	$50,000,000	$50,000,000	**$0**

DMH Budget Item	FY24	FY25	Change
American Rescue Plan Act Mental Health Block Grant (from the Community Mental Health Services Block Grant Fund)	$25,000,000	$25,000,000	**$0**
Community Services Program for Children & Adolescents (from the Community Mental Health Services Block Grant Fund)	$4,341,800	$4,341,800	**$0**
First Responder Behavioral Health Grant Program	$10,000,000	$10,000,000	**$0**
9-8-8 Call Centers and Crisis Response Services (from the Statewide 9-8-8 Trust Fund)	$5,00,000	$5,000,000	**$0**
Total	**$813,082,300**	**$846,615,633**	**+$33,533,333**

SUPR Budget FY25

(DHS Division of Substance Use Prevention & Recovery)

SUPR Budget Item	FY24	FY25	Change
Medicaid Eligible and AllKids Clients (from GRF)	$16,521,100	13,521,100	**-$3,00,000**
Community-Based Addiction Treatment Services and related services, including prior years' costs (from GRF)	$104,208,900	$95,208,900	**-$9,000,000**
Addiction Treatment for DCFS Clients (from GRF)	$5,802,400	$2,802,400	**-$3,000,000**
Addiction Treatment for Special Populations (from GRF)	$6,098,200	$6,098,200	**$0**
Pilot for Medication Assisted Treatment for Relapse Prevention (from GRF)	$500,000	$500,000	**$0**
Addiction Prevention and Related Services (from GRF)	$1,674,000	$1,674,000	**$0**
Addiction Treatment and Related Services (from the federal Prevention and Treatment of Alcoholism and Substance Abuse Block Grant Fund)	$107,100,000	$85,000,000	**-$22,100,000**
ARPA Substance Use Prevention and Treatment Block Grant (from the federal Prevention and Treatment of Alcoholism and Substance Abuse Block Grant Fund)	$25,000,000	$30,000,000	**+$5,000,000**
Addiction Prevention and Related Services (from the federal Prevention and Treatment of Alcoholism and Substance Abuse Block Grant Fund)	$24,000,000	$24,000,000	**$0**
Group Home Loans (from the federal Prevention and Treatment of Alcoholism and Substance Abuse Block Grant Fund)	$300,000	$300,000	**$0**

SUPR Budget Item	FY24	FY25	Change
Addiction Prevention and Related Services (from the Youth Alcoholism and Substance Abuse Prevention Fund)	$2,050,000	$2,050,000	**$0**
Treatment and Prevention of Compulsive Gambling (from the State Gaming Fund)	$10,000,000	$10,000,000	**$0**
Addiction Treatment and Related Expenses (from the Drunk and Drugged Driving Prevention Fund)	$3,212,200	$3,212,200	**$0**
Addiction Treatment and Related Services (from the Drug Treatment Fund)	$5,105,800	$5,105,800	**$0**
Grants and expenses associated with the Cannabis Regulation and Tax Act (from the Drug Treatment Fund)	$8,000,000	$10,000,000	**+$2,000,000**
Prevention of Prescription Overdose Deaths (from the DHS Federal Projects Fund)	$2,000,000	$2,000,000	**$0**
Grants and administrative expenses associated with the COVID-19 Emergency (from the DHS Federal Projects Fund)	$5,000,000	$5,000,000	**$0**
Opioid Overdose Prevention Program (from the DHS State Projects Fund)	$300,000	$300,000	**$0**
Grants and administrative expenses associated with the national opioid settlement (from the DHS State Projects Fund)	$20,000,000	$20,000,000	**$0**
Addiction Treatment, Prevention, and Related Services (from the Alcohol and Substance Abuse Fund)	$71,500,000	$56,500,000	**-$15,000,000**
Tobacco Enforcement Program (from the Tobacco Settlement Recovery Fund)	$3,800,000	$3,800,000	**$0**
Prevention and Related Services (from the Youth Drug Abuse Prevention Fund)	$530,000	$530,000	**$0**
Grants and administrative expenses associated with the national opioid settlement (from the Illinois Opioid Remediation State Trust Fund)	$88,000,000	$88,000,000	**$0**
Cannabis Regulation and Tax Act (from the DHS Community Services Fund)	$105,000,000	$105,000,000	**$0**
Total	**$615,702,600**	**$570,602,600**	**-$45,100,000**

FCS Budget FY25

(DHS Division of Family and Community Services)

Selected FCS Budget Item	FY24	FY25	Change
Homeless Youth Services (from GRF)	$7,403,100	$7,403,100	**$0**
Comprehensive Community-Based Services to Youth (from GRF)	$31,309,900	$31,309,900	**$0**
Redeploy Illinois (from GRF)	$14,373,600	$14,373,600	**$0**
Homelessness Prevention (from GRF)	$5,000,000	$5,000,000	**$0**
Supportive Housing Services (from GRF)	$16,490,100	$16,490,100	**$0**
Supportive Housing (ARPA)	$20,639,024	$17,795,965	**-$2,843,059**
Homelessness Prevention (from the Illinois Affordable Housing Trust Fund)	$4,000,000	$4,000,000	**$0**
Emergency and Transitional Housing (from the Illinois Affordable Housing Trust Fund)	$10,383,700	$10,383,700	**$0**
Supportive Housing (from the HHS Medicaid Trust Fund)	$3,382,500	$3,382,500	**$0**
Supportive Housing Services (ARPA)	$1,595,568	$1,595,568	**$0**
Teen Reach After School Programs (ARPA)	$4,443,189	$1,293,193	**-$3,149,996**
Parents Too Soon / Maternal and Child Home Visiting Program and Healthy Families (ARPA)	$9,991,260	$8,288,354	**-$1,702,906**
Parents Too Soon / Maternal and Child Home Visiting Program (from GRF)	$9,850,300	$27,926,300	**+$18,076,000**
Parents Too Soon / Maternal and Child Home Visiting Program (from the DHS Special Purposes Fund)	$2,505,000	$2,505,000	**$0**
Teen Reach After School Programs (from GRF)	$17,812,400	$17,812,400	**$0**
Home Illinois Program	$200,300,000	$290,300,000	**+$90,000,000**
Total	**$359,379,641**	**$459,859,680**	**+$100,380,039**

DCFS Budget FY25

(Department of Children and Family Services)

DCFS Budget Item	FY24	FY25	Change
Specialized Foster Care and Prevention	$399,257,200	$399,257,200	**$0**
Specialized Foster Care and Prevention (from the Children's Services Fund)	$226,615,900	$226,615,900	**$0**
Counseling and Auxiliary Services	$15,184,100	$15,184,100	**$0**
Counseling and Auxiliary Services (from the Children's Services Fund)	$19,269,100	$19,269,100	**$0**
Institution and Group Home Care and Prevention	$215,172,600	$215,172,600	**$0**
Institution and Group Home Care and Prevention (from the Children's Services Fund)	$71,475,100	$71,475,100	**$0**
Services Associated with the Foster Care Initiative	$6,139,900	$6,139,900	**$0**
Services Associated with the Foster Care Initiative (from the Children's Services Fund)	$1,705,600	$1,705,600	**$0**
Adoption and Guardianship Services	$153,274,000	$153,274,000	**$0**
Adoption and Guardianship Services (from the Children's Services Fund)	$48,104,700	$48,104,700	**$0**
Cash Assistance and Housing Locator Services	$3,313,700	$3,313,700	**$0**
Cash Assistance and Housing Locator Services (from the Children's Services Fund)	$6,071,300	$6,071,300	**$0**
Youth in Transition Program (from GRF)	$2,708,600	$2,708,600	**$0**
Development of Children's Advocacy Centers	$1,998,600	$1,998,600	**$0**
Development of Children's Advocacy Centers (from the Children's Services Fund)	$5,290,600	$5,290,600	**$0**
Family Preservation Services	$37,912,600	$37,912,600	**$0**
Court Appointed Special Advocates	$0	$2,000,000	**+$2,000,000**
Family Preservation Services (from the Children's Services Fund)	$44,125,300	$44,125,300	**$0**

DCFS Budget Item	FY24	FY25	Change
Psychological Assessments (from the Children's Services Fund)	3,100,400	$3,100,400	**$0**
Total	**$1,260,719,300**	**$1,262,719,300**	**+$2,000,000**

ICJIA Budget FY25

(Illinois Criminal Justice Information Authority)

ICJIA Budget Item	FY24	FY25	Change
Adult Redeploy and Diversion Programs (from GRF)	$13,000,000	$13,000,000	**$0**
Adult Redeploy and Diversion Programs (from the ICJIA Violence Prevention Special Projects Fund)	$400,000	$400,000	**$0**
Total	**$1,260,719,300**	**$13,400,00**	**+$0**

ISAC Budget FY25

(Illinois Student Assistance Commission)

ICJIA Budget Item	FY24	FY25	Change
Human Services Loan Repayment Program (from GRF)	$0	$250,000	**+$250,000**
Human Services Loan Repayment Program (from the Education Assistance Fund)	$0	$250,000	**+$250,000**
Human Services Loan Repayment Program (from the ISAC Contracts and Grants Fund)	$0	$5,000,000	**+$5,000,000**
Community Behavioral Health Care Provider Loan Repayment Program (from the ISAC Contracts and Grants Fund)	$5,000,000	$7,500,000	**+$2,500,000**
Social Worker Scholarships and Loan Repayment Assistance (from GRF)	$6,000,000	$6,000,000	**$0**
Total	**$11,000,000**	**$19,000,000**	**+$8,000,000**