

HB5352



98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB5352

by Rep. Esther Golar

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5f

Amends the Medical Assistance Article of the Illinois Public Aid Code. Removes a provision requiring the Department of Healthcare and Family Services to limit adult podiatry services to individuals with diabetes. Effective immediately.

LRB098 18155 KTG 53284 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 5-5f as follows:

6 (305 ILCS 5/5-5f)

7 Sec. 5-5f. Elimination and limitations of medical
8 assistance services. Notwithstanding any other provision of
9 this Code to the contrary, on and after July 1, 2012:

10 (a) The following services shall no longer be a covered
11 service available under this Code: group psychotherapy for
12 residents of any facility licensed under the Nursing Home Care
13 Act or the Specialized Mental Health Rehabilitation Act of
14 2013; and adult chiropractic services.

15 (b) The Department shall place the following limitations on
16 services: (i) the Department shall limit adult eyeglasses to
17 one pair every 2 years; (ii) the Department shall set an annual
18 limit of a maximum of 20 visits for each of the following
19 services: adult speech, hearing, and language therapy
20 services, adult occupational therapy services, and physical
21 therapy services; (iii) (blank) ~~the Department shall limit~~
22 ~~adult podiatry services to individuals with diabetes;~~ (iv) the
23 Department shall pay for caesarean sections at the normal

1 vaginal delivery rate unless a caesarean section was medically
2 necessary; (v) the Department shall limit adult dental services
3 to emergencies; beginning July 1, 2013, the Department shall
4 ensure that the following conditions are recognized as
5 emergencies: (A) dental services necessary for an individual in
6 order for the individual to be cleared for a medical procedure,
7 such as a transplant; (B) extractions and dentures necessary
8 for a diabetic to receive proper nutrition; (C) extractions and
9 dentures necessary as a result of cancer treatment; and (D)
10 dental services necessary for the health of a pregnant woman
11 prior to delivery of her baby; and (vi) effective July 1, 2012,
12 the Department shall place limitations and require concurrent
13 review on every inpatient detoxification stay to prevent repeat
14 admissions to any hospital for detoxification within 60 days of
15 a previous inpatient detoxification stay. The Department shall
16 convene a workgroup of hospitals, substance abuse providers,
17 care coordination entities, managed care plans, and other
18 stakeholders to develop recommendations for quality standards,
19 diversion to other settings, and admission criteria for
20 patients who need inpatient detoxification, which shall be
21 published on the Department's website no later than September
22 1, 2013.

23 (c) The Department shall require prior approval of the
24 following services: wheelchair repairs costing more than \$400,
25 coronary artery bypass graft, and bariatric surgery consistent
26 with Medicare standards concerning patient responsibility.

1 Wheelchair repair prior approval requests shall be adjudicated
2 within one business day of receipt of complete supporting
3 documentation. Providers may not break wheelchair repairs into
4 separate claims for purposes of staying under the \$400
5 threshold for requiring prior approval. The wholesale price of
6 manual and power wheelchairs, durable medical equipment and
7 supplies, and complex rehabilitation technology products and
8 services shall be defined as actual acquisition cost including
9 all discounts.

10 (d) The Department shall establish benchmarks for
11 hospitals to measure and align payments to reduce potentially
12 preventable hospital readmissions, inpatient complications,
13 and unnecessary emergency room visits. In doing so, the
14 Department shall consider items, including, but not limited to,
15 historic and current acuity of care and historic and current
16 trends in readmission. The Department shall publish
17 provider-specific historical readmission data and anticipated
18 potentially preventable targets 60 days prior to the start of
19 the program. In the instance of readmissions, the Department
20 shall adopt policies and rates of reimbursement for services
21 and other payments provided under this Code to ensure that, by
22 June 30, 2013, expenditures to hospitals are reduced by, at a
23 minimum, \$40,000,000.

24 (e) The Department shall establish utilization controls
25 for the hospice program such that it shall not pay for other
26 care services when an individual is in hospice.

1 (f) For home health services, the Department shall require
2 Medicare certification of providers participating in the
3 program and implement the Medicare face-to-face encounter
4 rule. The Department shall require providers to implement
5 auditable electronic service verification based on global
6 positioning systems or other cost-effective technology.

7 (g) For the Home Services Program operated by the
8 Department of Human Services and the Community Care Program
9 operated by the Department on Aging, the Department of Human
10 Services, in cooperation with the Department on Aging, shall
11 implement an electronic service verification based on global
12 positioning systems or other cost-effective technology.

13 (h) Effective with inpatient hospital admissions on or
14 after July 1, 2012, the Department shall reduce the payment for
15 a claim that indicates the occurrence of a provider-preventable
16 condition during the admission as specified by the Department
17 in rules. The Department shall not pay for services related to
18 an other provider-preventable condition.

19 As used in this subsection (h):

20 "Provider-preventable condition" means a health care
21 acquired condition as defined under the federal Medicaid
22 regulation found at 42 CFR 447.26 or an other
23 provider-preventable condition.

24 "Other provider-preventable condition" means a wrong
25 surgical or other invasive procedure performed on a patient, a
26 surgical or other invasive procedure performed on the wrong

1 body part, or a surgical procedure or other invasive procedure
2 performed on the wrong patient.

3 (i) The Department shall implement cost savings
4 initiatives for advanced imaging services, cardiac imaging
5 services, pain management services, and back surgery. Such
6 initiatives shall be designed to achieve annual costs savings.

7 (j) The Department shall ensure that beneficiaries with a
8 diagnosis of epilepsy or seizure disorder in Department records
9 will not require prior approval for anticonvulsants.

10 (Source: P.A. 97-689, eff. 6-14-12; 98-104, Article 6, Section
11 6-240, eff. 7-22-13; 98-104, Article 9, Section 9-5, eff.
12 7-22-13; revised 9-19-13.)

13 Section 99. Effective date. This Act takes effect upon
14 becoming law.