SB2302

LRB09918875KTG43260b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB2302

Introduced 1/27/2016, by Sen. Heather A. Steans

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5f

Amends the Illinois Public Aid Code. Makes a technical change in a Section concerning elimination and limitations of medical assistance services.

LRB099 18875 KTG 43260 b

A BILL FOR

AN ACT concerning public aid.

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

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

(305 ILCS 5/5-5f)

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

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

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language therapy services, adult occupational therapy services, and physical therapy services; on or after October 1, 2014, the annual maximum limit of 20 visits shall expire but the Department shall require prior

approval for all individuals for speech, hearing, and language therapy services, occupational therapy services, and physical therapy services; (iii) the Department shall limit adult podiatry services to individuals with diabetes; on or after October 1, 2014, podiatry services shall not be limited to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; (v) the Department shall limit adult dental services to emergencies; beginning July 1, 2013, the Department shall ensure that the following conditions are recognized as emergencies: (A) dental services necessary for an individual in order for the individual to be cleared for a medical procedure, such as a transplant; (B) extractions and dentures necessary for a diabetic to receive proper nutrition; (C) extractions and dentures necessary as a result of cancer treatment; and (D) dental services necessary for the health of a pregnant woman prior to delivery of her baby; on or after July 1, 2014, adult dental services shall no longer be limited to emergencies, and dental services necessary for the health of a pregnant woman prior to delivery of her baby shall continue to be covered; and (vi) effective July 1, 2012, the Department shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60

days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals, substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than $400, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting documentation. Providers may not break wheelchair repairs into separate claims for purposes of staying under the $400 threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In

doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

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

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

(g) For the Home Services Program operated by the Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the Department on Aging, shall implement an electronic service verification

based on global positioning systems or other cost-effective technology.

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

As used in this subsection (h):

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

"Other provider-preventable condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

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

(j) The Department shall ensure that beneficiaries with a diagnosis of epilepsy or seizure disorder in

Department records will not require prior approval for anticonvulsants.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, Article 6, Section 6-240, eff. 7-22-13; 98-104, Article 9, Section 9-5, eff. 7-22-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14.)