

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
13 Care Act or the Specialized Mental Health Rehabilitation
14 Act of 2013; and adult chiropractic services.

15 (b) The Department shall place the following
16 limitations on services: (i) the Department shall limit
17 adult eyeglasses to one pair every 2 years; however, the
18 limitation does not apply to an individual who needs
19 different eyeglasses following a surgical procedure such
20 as cataract surgery; (ii) the Department shall set an
21 annual limit of a maximum of 20 visits for each of the
22 following services: adult speech, hearing, and language
23 therapy services, adult occupational therapy services, and

1 physical therapy services; on or after October 1, 2014, the
2 annual maximum limit of 20 visits shall expire but the
3 Department shall require prior approval for all
4 individuals for speech, hearing, and language therapy
5 services, occupational therapy services, and physical
6 therapy services; (iii) the Department shall limit adult
7 podiatry services to individuals with diabetes; on or after
8 October 1, 2014, podiatry services shall not be limited to
9 individuals with diabetes; (iv) the Department shall pay
10 for caesarean sections at the normal vaginal delivery rate
11 unless a caesarean section was medically necessary; (v) the
12 Department shall limit adult dental services to
13 emergencies; beginning July 1, 2013, the Department shall
14 ensure that the following conditions are recognized as
15 emergencies: (A) dental services necessary for an
16 individual in order for the individual to be cleared for a
17 medical procedure, such as a transplant; (B) extractions
18 and dentures necessary for a diabetic to receive proper
19 nutrition; (C) extractions and dentures necessary as a
20 result of cancer treatment; and (D) dental services
21 necessary for the health of a pregnant woman prior to
22 delivery of her baby; on or after July 1, 2014, adult
23 dental services shall no longer be limited to emergencies,
24 and dental services necessary for the health of a pregnant
25 woman prior to delivery of her baby shall continue to be
26 covered; and (vi) effective July 1, 2012, the Department

1 shall place limitations and require concurrent review on
2 every inpatient detoxification stay to prevent repeat
3 admissions to any hospital for detoxification within 60
4 days of a previous inpatient detoxification stay. The
5 Department shall convene a workgroup of hospitals,
6 substance abuse providers, care coordination entities,
7 managed care plans, and other stakeholders to develop
8 recommendations for quality standards, diversion to other
9 settings, and admission criteria for patients who need
10 inpatient detoxification, which shall be published on the
11 Department's website no later than September 1, 2013.

12 (c) The Department shall require prior approval of the
13 following services: wheelchair repairs costing more than
14 \$400, coronary artery bypass graft, and bariatric surgery
15 consistent with Medicare standards concerning patient
16 responsibility. Wheelchair repair prior approval requests
17 shall be adjudicated within one business day of receipt of
18 complete supporting documentation. Providers may not break
19 wheelchair repairs into separate claims for purposes of
20 staying under the \$400 threshold for requiring prior
21 approval. The wholesale price of manual and power
22 wheelchairs, durable medical equipment and supplies, and
23 complex rehabilitation technology products and services
24 shall be defined as actual acquisition cost including all
25 discounts.

26 (d) The Department shall establish benchmarks for

1 hospitals to measure and align payments to reduce
2 potentially preventable hospital readmissions, inpatient
3 complications, and unnecessary emergency room visits. In
4 doing so, the Department shall consider items, including,
5 but not limited to, historic and current acuity of care and
6 historic and current trends in readmission. The Department
7 shall publish provider-specific historical readmission
8 data and anticipated potentially preventable targets 60
9 days prior to the start of the program. In the instance of
10 readmissions, the Department shall adopt policies and
11 rates of reimbursement for services and other payments
12 provided under this Code to ensure that, by June 30, 2013,
13 expenditures to hospitals are reduced by, at a minimum,
14 \$40,000,000.

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

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

25 (g) For the Home Services Program operated by the
26 Department of Human Services and the Community Care Program

1 operated by the Department on Aging, the Department of
2 Human Services, in cooperation with the Department on
3 Aging, shall implement an electronic service verification
4 based on global positioning systems or other
5 cost-effective technology.

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

13 As used in this subsection (h):

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

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

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

1 savings.

2 (j) The Department shall ensure that beneficiaries
3 with a diagnosis of epilepsy or seizure disorder in
4 Department records will not require prior approval for
5 anticonvulsants.

6 (Source: P.A. 97-689, eff. 6-14-12; 98-104, Article 6, Section
7 6-240, eff. 7-22-13; 98-104, Article 9, Section 9-5, eff.
8 7-22-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14.)

9 Section 99. Effective date. This Act takes effect upon
10 becoming law.