

SB1438



98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

SB1438

Introduced 2/6/2013, by Sen. David Koehler

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5
305 ILCS 5/5-5f

from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that one preventive dental visit a year shall be covered under the medical assistance program for pregnant women who are eligible for assistance. Provides that the Department of Healthcare and Family Services may (rather than shall) limit adult dental services to emergencies, except that this limitation shall not apply to pregnant women. Effective July 1, 2013.

LRB098 09557 KTG 39702 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 Sections 5-5 and 5-5f as follows:

6 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

7 Sec. 5-5. Medical services. The Illinois Department, by
8 rule, shall determine the quantity and quality of and the rate
9 of reimbursement for the medical assistance for which payment
10 will be authorized, and the medical services to be provided,
11 which may include all or part of the following: (1) inpatient
12 hospital services; (2) outpatient hospital services; (3) other
13 laboratory and X-ray services; (4) skilled nursing home
14 services; (5) physicians' services whether furnished in the
15 office, the patient's home, a hospital, a skilled nursing home,
16 or elsewhere; (6) medical care, or any other type of remedial
17 care furnished by licensed practitioners; (7) home health care
18 services; (8) private duty nursing service; (9) clinic
19 services; (10) dental services, including prevention and
20 treatment of periodontal disease and dental caries disease for
21 pregnant women, provided by an individual licensed to practice
22 dentistry or dental surgery; for purposes of this item (10),
23 "dental services" means diagnostic, preventive, or corrective

1 procedures provided by or under the supervision of a dentist in
2 the practice of his or her profession; (11) physical therapy
3 and related services; (12) prescribed drugs, dentures, and
4 prosthetic devices; and eyeglasses prescribed by a physician
5 skilled in the diseases of the eye, or by an optometrist,
6 whichever the person may select; (13) other diagnostic,
7 screening, preventive, and rehabilitative services, including
8 to ensure that the individual's need for intervention or
9 treatment of mental disorders or substance use disorders or
10 co-occurring mental health and substance use disorders is
11 determined using a uniform screening, assessment, and
12 evaluation process inclusive of criteria, for children and
13 adults; for purposes of this item (13), a uniform screening,
14 assessment, and evaluation process refers to a process that
15 includes an appropriate evaluation and, as warranted, a
16 referral; "uniform" does not mean the use of a singular
17 instrument, tool, or process that all must utilize; (14)
18 transportation and such other expenses as may be necessary;
19 (15) medical treatment of sexual assault survivors, as defined
20 in Section 1a of the Sexual Assault Survivors Emergency
21 Treatment Act, for injuries sustained as a result of the sexual
22 assault, including examinations and laboratory tests to
23 discover evidence which may be used in criminal proceedings
24 arising from the sexual assault; (16) the diagnosis and
25 treatment of sickle cell anemia; and (17) any other medical
26 care, and any other type of remedial care recognized under the

1 laws of this State, but not including abortions, or induced
2 miscarriages or premature births, unless, in the opinion of a
3 physician, such procedures are necessary for the preservation
4 of the life of the woman seeking such treatment, or except an
5 induced premature birth intended to produce a live viable child
6 and such procedure is necessary for the health of the mother or
7 her unborn child. The Illinois Department, by rule, shall
8 prohibit any physician from providing medical assistance to
9 anyone eligible therefor under this Code where such physician
10 has been found guilty of performing an abortion procedure in a
11 wilful and wanton manner upon a woman who was not pregnant at
12 the time such abortion procedure was performed. The term "any
13 other type of remedial care" shall include nursing care and
14 nursing home service for persons who rely on treatment by
15 spiritual means alone through prayer for healing.

16 Notwithstanding any other provision of this Code, one
17 preventive dental visit a year shall be covered under the
18 medical assistance program under this Article for pregnant
19 women who are eligible for assistance under this Article.

20 Notwithstanding any other provision of this Section, a
21 comprehensive tobacco use cessation program that includes
22 purchasing prescription drugs or prescription medical devices
23 approved by the Food and Drug Administration shall be covered
24 under the medical assistance program under this Article for
25 persons who are otherwise eligible for assistance under this
26 Article.

1 Notwithstanding any other provision of this Code, the
2 Illinois Department may not require, as a condition of payment
3 for any laboratory test authorized under this Article, that a
4 physician's handwritten signature appear on the laboratory
5 test order form. The Illinois Department may, however, impose
6 other appropriate requirements regarding laboratory test order
7 documentation.

8 On and after July 1, 2012, the Department of Healthcare and
9 Family Services may provide the following services to persons
10 eligible for assistance under this Article who are
11 participating in education, training or employment programs
12 operated by the Department of Human Services as successor to
13 the Department of Public Aid:

14 (1) dental services provided by or under the
15 supervision of a dentist; and

16 (2) eyeglasses prescribed by a physician skilled in the
17 diseases of the eye, or by an optometrist, whichever the
18 person may select.

19 Notwithstanding any other provision of this Code and
20 subject to federal approval, the Department may adopt rules to
21 allow a dentist who is volunteering his or her service at no
22 cost to render dental services through an enrolled
23 not-for-profit health clinic without the dentist personally
24 enrolling as a participating provider in the medical assistance
25 program. A not-for-profit health clinic shall include a public
26 health clinic or Federally Qualified Health Center or other

1 enrolled provider, as determined by the Department, through
2 which dental services covered under this Section are performed.
3 The Department shall establish a process for payment of claims
4 for reimbursement for covered dental services rendered under
5 this provision.

6 The Illinois Department, by rule, may distinguish and
7 classify the medical services to be provided only in accordance
8 with the classes of persons designated in Section 5-2.

9 The Department of Healthcare and Family Services must
10 provide coverage and reimbursement for amino acid-based
11 elemental formulas, regardless of delivery method, for the
12 diagnosis and treatment of (i) eosinophilic disorders and (ii)
13 short bowel syndrome when the prescribing physician has issued
14 a written order stating that the amino acid-based elemental
15 formula is medically necessary.

16 The Illinois Department shall authorize the provision of,
17 and shall authorize payment for, screening by low-dose
18 mammography for the presence of occult breast cancer for women
19 35 years of age or older who are eligible for medical
20 assistance under this Article, as follows:

21 (A) A baseline mammogram for women 35 to 39 years of
22 age.

23 (B) An annual mammogram for women 40 years of age or
24 older.

25 (C) A mammogram at the age and intervals considered
26 medically necessary by the woman's health care provider for

1 women under 40 years of age and having a family history of
2 breast cancer, prior personal history of breast cancer,
3 positive genetic testing, or other risk factors.

4 (D) A comprehensive ultrasound screening of an entire
5 breast or breasts if a mammogram demonstrates
6 heterogeneous or dense breast tissue, when medically
7 necessary as determined by a physician licensed to practice
8 medicine in all of its branches.

9 All screenings shall include a physical breast exam,
10 instruction on self-examination and information regarding the
11 frequency of self-examination and its value as a preventative
12 tool. For purposes of this Section, "low-dose mammography"
13 means the x-ray examination of the breast using equipment
14 dedicated specifically for mammography, including the x-ray
15 tube, filter, compression device, and image receptor, with an
16 average radiation exposure delivery of less than one rad per
17 breast for 2 views of an average size breast. The term also
18 includes digital mammography.

19 On and after January 1, 2012, providers participating in a
20 quality improvement program approved by the Department shall be
21 reimbursed for screening and diagnostic mammography at the same
22 rate as the Medicare program's rates, including the increased
23 reimbursement for digital mammography.

24 The Department shall convene an expert panel including
25 representatives of hospitals, free-standing mammography
26 facilities, and doctors, including radiologists, to establish

1 quality standards.

2 Subject to federal approval, the Department shall
3 establish a rate methodology for mammography at federally
4 qualified health centers and other encounter-rate clinics.
5 These clinics or centers may also collaborate with other
6 hospital-based mammography facilities.

7 The Department shall establish a methodology to remind
8 women who are age-appropriate for screening mammography, but
9 who have not received a mammogram within the previous 18
10 months, of the importance and benefit of screening mammography.

11 The Department shall establish a performance goal for
12 primary care providers with respect to their female patients
13 over age 40 receiving an annual mammogram. This performance
14 goal shall be used to provide additional reimbursement in the
15 form of a quality performance bonus to primary care providers
16 who meet that goal.

17 The Department shall devise a means of case-managing or
18 patient navigation for beneficiaries diagnosed with breast
19 cancer. This program shall initially operate as a pilot program
20 in areas of the State with the highest incidence of mortality
21 related to breast cancer. At least one pilot program site shall
22 be in the metropolitan Chicago area and at least one site shall
23 be outside the metropolitan Chicago area. An evaluation of the
24 pilot program shall be carried out measuring health outcomes
25 and cost of care for those served by the pilot program compared
26 to similarly situated patients who are not served by the pilot

1 program.

2 Any medical or health care provider shall immediately
3 recommend, to any pregnant woman who is being provided prenatal
4 services and is suspected of drug abuse or is addicted as
5 defined in the Alcoholism and Other Drug Abuse and Dependency
6 Act, referral to a local substance abuse treatment provider
7 licensed by the Department of Human Services or to a licensed
8 hospital which provides substance abuse treatment services.
9 The Department of Healthcare and Family Services shall assure
10 coverage for the cost of treatment of the drug abuse or
11 addiction for pregnant recipients in accordance with the
12 Illinois Medicaid Program in conjunction with the Department of
13 Human Services.

14 All medical providers providing medical assistance to
15 pregnant women under this Code shall receive information from
16 the Department on the availability of services under the Drug
17 Free Families with a Future or any comparable program providing
18 case management services for addicted women, including
19 information on appropriate referrals for other social services
20 that may be needed by addicted women in addition to treatment
21 for addiction.

22 The Illinois Department, in cooperation with the
23 Departments of Human Services (as successor to the Department
24 of Alcoholism and Substance Abuse) and Public Health, through a
25 public awareness campaign, may provide information concerning
26 treatment for alcoholism and drug abuse and addiction, prenatal

1 health care, and other pertinent programs directed at reducing
2 the number of drug-affected infants born to recipients of
3 medical assistance.

4 Neither the Department of Healthcare and Family Services
5 nor the Department of Human Services shall sanction the
6 recipient solely on the basis of her substance abuse.

7 The Illinois Department shall establish such regulations
8 governing the dispensing of health services under this Article
9 as it shall deem appropriate. The Department should seek the
10 advice of formal professional advisory committees appointed by
11 the Director of the Illinois Department for the purpose of
12 providing regular advice on policy and administrative matters,
13 information dissemination and educational activities for
14 medical and health care providers, and consistency in
15 procedures to the Illinois Department.

16 The Illinois Department may develop and contract with
17 Partnerships of medical providers to arrange medical services
18 for persons eligible under Section 5-2 of this Code.
19 Implementation of this Section may be by demonstration projects
20 in certain geographic areas. The Partnership shall be
21 represented by a sponsor organization. The Department, by rule,
22 shall develop qualifications for sponsors of Partnerships.
23 Nothing in this Section shall be construed to require that the
24 sponsor organization be a medical organization.

25 The sponsor must negotiate formal written contracts with
26 medical providers for physician services, inpatient and

1 outpatient hospital care, home health services, treatment for
2 alcoholism and substance abuse, and other services determined
3 necessary by the Illinois Department by rule for delivery by
4 Partnerships. Physician services must include prenatal and
5 obstetrical care. The Illinois Department shall reimburse
6 medical services delivered by Partnership providers to clients
7 in target areas according to provisions of this Article and the
8 Illinois Health Finance Reform Act, except that:

9 (1) Physicians participating in a Partnership and
10 providing certain services, which shall be determined by
11 the Illinois Department, to persons in areas covered by the
12 Partnership may receive an additional surcharge for such
13 services.

14 (2) The Department may elect to consider and negotiate
15 financial incentives to encourage the development of
16 Partnerships and the efficient delivery of medical care.

17 (3) Persons receiving medical services through
18 Partnerships may receive medical and case management
19 services above the level usually offered through the
20 medical assistance program.

21 Medical providers shall be required to meet certain
22 qualifications to participate in Partnerships to ensure the
23 delivery of high quality medical services. These
24 qualifications shall be determined by rule of the Illinois
25 Department and may be higher than qualifications for
26 participation in the medical assistance program. Partnership

1 sponsors may prescribe reasonable additional qualifications
2 for participation by medical providers, only with the prior
3 written approval of the Illinois Department.

4 Nothing in this Section shall limit the free choice of
5 practitioners, hospitals, and other providers of medical
6 services by clients. In order to ensure patient freedom of
7 choice, the Illinois Department shall immediately promulgate
8 all rules and take all other necessary actions so that provided
9 services may be accessed from therapeutically certified
10 optometrists to the full extent of the Illinois Optometric
11 Practice Act of 1987 without discriminating between service
12 providers.

13 The Department shall apply for a waiver from the United
14 States Health Care Financing Administration to allow for the
15 implementation of Partnerships under this Section.

16 The Illinois Department shall require health care
17 providers to maintain records that document the medical care
18 and services provided to recipients of Medical Assistance under
19 this Article. Such records must be retained for a period of not
20 less than 6 years from the date of service or as provided by
21 applicable State law, whichever period is longer, except that
22 if an audit is initiated within the required retention period
23 then the records must be retained until the audit is completed
24 and every exception is resolved. The Illinois Department shall
25 require health care providers to make available, when
26 authorized by the patient, in writing, the medical records in a

1 timely fashion to other health care providers who are treating
2 or serving persons eligible for Medical Assistance under this
3 Article. All dispensers of medical services shall be required
4 to maintain and retain business and professional records
5 sufficient to fully and accurately document the nature, scope,
6 details and receipt of the health care provided to persons
7 eligible for medical assistance under this Code, in accordance
8 with regulations promulgated by the Illinois Department. The
9 rules and regulations shall require that proof of the receipt
10 of prescription drugs, dentures, prosthetic devices and
11 eyeglasses by eligible persons under this Section accompany
12 each claim for reimbursement submitted by the dispenser of such
13 medical services. No such claims for reimbursement shall be
14 approved for payment by the Illinois Department without such
15 proof of receipt, unless the Illinois Department shall have put
16 into effect and shall be operating a system of post-payment
17 audit and review which shall, on a sampling basis, be deemed
18 adequate by the Illinois Department to assure that such drugs,
19 dentures, prosthetic devices and eyeglasses for which payment
20 is being made are actually being received by eligible
21 recipients. Within 90 days after the effective date of this
22 amendatory Act of 1984, the Illinois Department shall establish
23 a current list of acquisition costs for all prosthetic devices
24 and any other items recognized as medical equipment and
25 supplies reimbursable under this Article and shall update such
26 list on a quarterly basis, except that the acquisition costs of

1 all prescription drugs shall be updated no less frequently than
2 every 30 days as required by Section 5-5.12.

3 The rules and regulations of the Illinois Department shall
4 require that a written statement including the required opinion
5 of a physician shall accompany any claim for reimbursement for
6 abortions, or induced miscarriages or premature births. This
7 statement shall indicate what procedures were used in providing
8 such medical services.

9 The Illinois Department shall require all dispensers of
10 medical services, other than an individual practitioner or
11 group of practitioners, desiring to participate in the Medical
12 Assistance program established under this Article to disclose
13 all financial, beneficial, ownership, equity, surety or other
14 interests in any and all firms, corporations, partnerships,
15 associations, business enterprises, joint ventures, agencies,
16 institutions or other legal entities providing any form of
17 health care services in this State under this Article.

18 The Illinois Department may require that all dispensers of
19 medical services desiring to participate in the medical
20 assistance program established under this Article disclose,
21 under such terms and conditions as the Illinois Department may
22 by rule establish, all inquiries from clients and attorneys
23 regarding medical bills paid by the Illinois Department, which
24 inquiries could indicate potential existence of claims or liens
25 for the Illinois Department.

26 Enrollment of a vendor shall be subject to a provisional

1 period and shall be conditional for one year. During the period
2 of conditional enrollment, the Department may terminate the
3 vendor's eligibility to participate in, or may disenroll the
4 vendor from, the medical assistance program without cause.
5 Unless otherwise specified, such termination of eligibility or
6 disenrollment is not subject to the Department's hearing
7 process. However, a disenrolled vendor may reapply without
8 penalty.

9 The Department has the discretion to limit the conditional
10 enrollment period for vendors based upon category of risk of
11 the vendor.

12 Prior to enrollment and during the conditional enrollment
13 period in the medical assistance program, all vendors shall be
14 subject to enhanced oversight, screening, and review based on
15 the risk of fraud, waste, and abuse that is posed by the
16 category of risk of the vendor. The Illinois Department shall
17 establish the procedures for oversight, screening, and review,
18 which may include, but need not be limited to: criminal and
19 financial background checks; fingerprinting; license,
20 certification, and authorization verifications; unscheduled or
21 unannounced site visits; database checks; prepayment audit
22 reviews; audits; payment caps; payment suspensions; and other
23 screening as required by federal or State law.

24 The Department shall define or specify the following: (i)
25 by provider notice, the "category of risk of the vendor" for
26 each type of vendor, which shall take into account the level of

1 screening applicable to a particular category of vendor under
2 federal law and regulations; (ii) by rule or provider notice,
3 the maximum length of the conditional enrollment period for
4 each category of risk of the vendor; and (iii) by rule, the
5 hearing rights, if any, afforded to a vendor in each category
6 of risk of the vendor that is terminated or disenrolled during
7 the conditional enrollment period.

8 To be eligible for payment consideration, a vendor's
9 payment claim or bill, either as an initial claim or as a
10 resubmitted claim following prior rejection, must be received
11 by the Illinois Department, or its fiscal intermediary, no
12 later than 180 days after the latest date on the claim on which
13 medical goods or services were provided, with the following
14 exceptions:

15 (1) In the case of a provider whose enrollment is in
16 process by the Illinois Department, the 180-day period
17 shall not begin until the date on the written notice from
18 the Illinois Department that the provider enrollment is
19 complete.

20 (2) In the case of errors attributable to the Illinois
21 Department or any of its claims processing intermediaries
22 which result in an inability to receive, process, or
23 adjudicate a claim, the 180-day period shall not begin
24 until the provider has been notified of the error.

25 (3) In the case of a provider for whom the Illinois
26 Department initiates the monthly billing process.

1 For claims for services rendered during a period for which
2 a recipient received retroactive eligibility, claims must be
3 filed within 180 days after the Department determines the
4 applicant is eligible. For claims for which the Illinois
5 Department is not the primary payer, claims must be submitted
6 to the Illinois Department within 180 days after the final
7 adjudication by the primary payer.

8 In the case of long term care facilities, admission
9 documents shall be submitted within 30 days of an admission to
10 the facility through the Medical Electronic Data Interchange
11 (MEDI) or the Recipient Eligibility Verification (REV) System,
12 or shall be submitted directly to the Department of Human
13 Services using required admission forms. Confirmation numbers
14 assigned to an accepted transaction shall be retained by a
15 facility to verify timely submittal. Once an admission
16 transaction has been completed, all resubmitted claims
17 following prior rejection are subject to receipt no later than
18 180 days after the admission transaction has been completed.

19 Claims that are not submitted and received in compliance
20 with the foregoing requirements shall not be eligible for
21 payment under the medical assistance program, and the State
22 shall have no liability for payment of those claims.

23 To the extent consistent with applicable information and
24 privacy, security, and disclosure laws, State and federal
25 agencies and departments shall provide the Illinois Department
26 access to confidential and other information and data necessary

1 to perform eligibility and payment verifications and other
2 Illinois Department functions. This includes, but is not
3 limited to: information pertaining to licensure;
4 certification; earnings; immigration status; citizenship; wage
5 reporting; unearned and earned income; pension income;
6 employment; supplemental security income; social security
7 numbers; National Provider Identifier (NPI) numbers; the
8 National Practitioner Data Bank (NPDB); program and agency
9 exclusions; taxpayer identification numbers; tax delinquency;
10 corporate information; and death records.

11 The Illinois Department shall enter into agreements with
12 State agencies and departments, and is authorized to enter into
13 agreements with federal agencies and departments, under which
14 such agencies and departments shall share data necessary for
15 medical assistance program integrity functions and oversight.
16 The Illinois Department shall develop, in cooperation with
17 other State departments and agencies, and in compliance with
18 applicable federal laws and regulations, appropriate and
19 effective methods to share such data. At a minimum, and to the
20 extent necessary to provide data sharing, the Illinois
21 Department shall enter into agreements with State agencies and
22 departments, and is authorized to enter into agreements with
23 federal agencies and departments, including but not limited to:
24 the Secretary of State; the Department of Revenue; the
25 Department of Public Health; the Department of Human Services;
26 and the Department of Financial and Professional Regulation.

1 Beginning in fiscal year 2013, the Illinois Department
2 shall set forth a request for information to identify the
3 benefits of a pre-payment, post-adjudication, and post-edit
4 claims system with the goals of streamlining claims processing
5 and provider reimbursement, reducing the number of pending or
6 rejected claims, and helping to ensure a more transparent
7 adjudication process through the utilization of: (i) provider
8 data verification and provider screening technology; and (ii)
9 clinical code editing; and (iii) pre-pay, pre- or
10 post-adjudicated predictive modeling with an integrated case
11 management system with link analysis. Such a request for
12 information shall not be considered as a request for proposal
13 or as an obligation on the part of the Illinois Department to
14 take any action or acquire any products or services.

15 The Illinois Department shall establish policies,
16 procedures, standards and criteria by rule for the acquisition,
17 repair and replacement of orthotic and prosthetic devices and
18 durable medical equipment. Such rules shall provide, but not be
19 limited to, the following services: (1) immediate repair or
20 replacement of such devices by recipients; and (2) rental,
21 lease, purchase or lease-purchase of durable medical equipment
22 in a cost-effective manner, taking into consideration the
23 recipient's medical prognosis, the extent of the recipient's
24 needs, and the requirements and costs for maintaining such
25 equipment. Subject to prior approval, such rules shall enable a
26 recipient to temporarily acquire and use alternative or

1 substitute devices or equipment pending repairs or
2 replacements of any device or equipment previously authorized
3 for such recipient by the Department.

4 The Department shall execute, relative to the nursing home
5 prescreening project, written inter-agency agreements with the
6 Department of Human Services and the Department on Aging, to
7 effect the following: (i) intake procedures and common
8 eligibility criteria for those persons who are receiving
9 non-institutional services; and (ii) the establishment and
10 development of non-institutional services in areas of the State
11 where they are not currently available or are undeveloped; and
12 (iii) notwithstanding any other provision of law, subject to
13 federal approval, on and after July 1, 2012, an increase in the
14 determination of need (DON) scores from 29 to 37 for applicants
15 for institutional and home and community-based long term care;
16 if and only if federal approval is not granted, the Department
17 may, in conjunction with other affected agencies, implement
18 utilization controls or changes in benefit packages to
19 effectuate a similar savings amount for this population; and
20 (iv) no later than July 1, 2013, minimum level of care
21 eligibility criteria for institutional and home and
22 community-based long term care. In order to select the minimum
23 level of care eligibility criteria, the Governor shall
24 establish a workgroup that includes affected agency
25 representatives and stakeholders representing the
26 institutional and home and community-based long term care

1 interests. This Section shall not restrict the Department from
2 implementing lower level of care eligibility criteria for
3 community-based services in circumstances where federal
4 approval has been granted.

5 The Illinois Department shall develop and operate, in
6 cooperation with other State Departments and agencies and in
7 compliance with applicable federal laws and regulations,
8 appropriate and effective systems of health care evaluation and
9 programs for monitoring of utilization of health care services
10 and facilities, as it affects persons eligible for medical
11 assistance under this Code.

12 The Illinois Department shall report annually to the
13 General Assembly, no later than the second Friday in April of
14 1979 and each year thereafter, in regard to:

15 (a) actual statistics and trends in utilization of
16 medical services by public aid recipients;

17 (b) actual statistics and trends in the provision of
18 the various medical services by medical vendors;

19 (c) current rate structures and proposed changes in
20 those rate structures for the various medical vendors; and

21 (d) efforts at utilization review and control by the
22 Illinois Department.

23 The period covered by each report shall be the 3 years
24 ending on the June 30 prior to the report. The report shall
25 include suggested legislation for consideration by the General
26 Assembly. The filing of one copy of the report with the

1 Speaker, one copy with the Minority Leader and one copy with
2 the Clerk of the House of Representatives, one copy with the
3 President, one copy with the Minority Leader and one copy with
4 the Secretary of the Senate, one copy with the Legislative
5 Research Unit, and such additional copies with the State
6 Government Report Distribution Center for the General Assembly
7 as is required under paragraph (t) of Section 7 of the State
8 Library Act shall be deemed sufficient to comply with this
9 Section.

10 Rulemaking authority to implement Public Act 95-1045, if
11 any, is conditioned on the rules being adopted in accordance
12 with all provisions of the Illinois Administrative Procedure
13 Act and all rules and procedures of the Joint Committee on
14 Administrative Rules; any purported rule not so adopted, for
15 whatever reason, is unauthorized.

16 On and after July 1, 2012, the Department shall reduce any
17 rate of reimbursement for services or other payments or alter
18 any methodologies authorized by this Code to reduce any rate of
19 reimbursement for services or other payments in accordance with
20 Section 5-5e.

21 (Source: P.A. 96-156, eff. 1-1-10; 96-806, eff. 7-1-10; 96-926,
22 eff. 1-1-11; 96-1000, eff. 7-2-10; 97-48, eff. 6-28-11; 97-638,
23 eff. 1-1-12; 97-689, eff. 6-14-12; 97-1061, eff. 8-24-12;
24 revised 9-20-12.)

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

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

9 (b) The Department shall place the following limitations on
10 services: (i) the Department shall limit adult eyeglasses to
11 one pair every 2 years; (ii) the Department shall set an annual
12 limit of a maximum of 20 visits for each of the following
13 services: adult speech, hearing, and language therapy
14 services, adult occupational therapy services, and physical
15 therapy services; (iii) the Department shall limit podiatry
16 services to individuals with diabetes; (iv) the Department
17 shall pay for caesarean sections at the normal vaginal delivery
18 rate unless a caesarean section was medically necessary; (v)
19 the Department may ~~shall~~ limit adult dental services to
20 emergencies, except that this limitation shall not apply to
21 pregnant women; and (vi) effective July 1, 2012, the Department
22 shall place limitations and require concurrent review on every
23 inpatient detoxification stay to prevent repeat admissions to
24 any hospital for detoxification within 60 days of a previous
25 inpatient detoxification stay. The Department shall convene a
26 workgroup of hospitals, substance abuse providers, care

1 coordination entities, managed care plans, and other
2 stakeholders to develop recommendations for quality standards,
3 diversion to other settings, and admission criteria for
4 patients who need inpatient detoxification.

5 (c) The Department shall require prior approval of the
6 following services: wheelchair repairs, regardless of the cost
7 of the repairs, coronary artery bypass graft, and bariatric
8 surgery consistent with Medicare standards concerning patient
9 responsibility. The wholesale cost of power wheelchairs shall
10 be actual acquisition cost including all discounts.

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

25 (e) The Department shall establish utilization controls
26 for the hospice program such that it shall not pay for other

1 care services when an individual is in hospice.

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

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

15 (h) The Department shall not pay for hospital admissions
16 when the claim indicates a hospital acquired condition that
17 would cause Medicare to reduce its payment on the claim had the
18 claim been submitted to Medicare, nor shall the Department pay
19 for hospital admissions where a Medicare identified "never
20 event" occurred.

21 (i) The Department shall implement cost savings
22 initiatives for advanced imaging services, cardiac imaging
23 services, pain management services, and back surgery. Such
24 initiatives shall be designed to achieve annual costs savings.
25 (Source: P.A. 97-689, eff. 6-14-12.)

26 Section 99. Effective date. This Act takes effect July 1,

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1 2013.