

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.