HB4396

LRB09817252KTG52346b

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB4396

by Rep. David R. Leitch

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5f
305 ILCS 5/12-4.39

Amends the Medical Assistance Article of the Illinois Public Aid Code. Removes language requiring the Department of Healthcare and Family Services to (i) limit adult dental services to emergencies; and (ii) beginning July 1, 2013, ensure certain conditions are recognized as emergencies. Provides that (i) the Department shall limit the ALL KIDS school-based dental program; (ii) school-based dental providers must provide children receiving an oral health score of 2 or 3 (indicating the need for restorative or urgent follow-up care) with the diagnosed follow-up care by providing the care themselves at the school or at the provider's local clinic, or the children must be referred by the provider's case manager to a dental provider who is willing to accept each child into the provider's practice to perform required follow-up care and provide a dental home; (iii) the Department may limit dental coverage for children to 2 cleanings and 2 fluoride treatments per year regardless of where the services are performed and shall require prior approval for any requests exceeding this limit; and (iv) beginning July 1, 2014, the Department shall require all adults to pay a $20 encounter fee to the provider at the time of services. In a provision concerning a dental clinic grant program administered by the Department, adds dental school clinics to the list of dental entities that may apply for grant money. Provides that grant money must be used to support projects that develop dental services or training (rather than only dental services) to meet the dental health care needs of the Department's dental program clients. In addition to other specified expenses, provides that grant moneys must be used for those services provided as part of the educational process at State dental schools. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

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 Sections 5-5f and 12-4.39 as follows:

(305 ILCS 5/5-5f)

Sec. 5-5f. Elimination and limitations of medical assistance services. Notwithstanding 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; (iii) the Department shall limit adult podiatry services 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 the ALL KIDS school-based dental program; school-based dental providers must provide children receiving an oral health score of 2 or 3 (indicating the need for restorative or urgent follow-up care) with the diagnosed follow-up care by providing the care themselves at the school or at the provider's local clinic, or the children must be referred by the provider's case manager to a dental provider who is willing to accept each child into the provider's practice to perform required follow-up care and provide a dental home; in addition, the Department may limit dental coverage for children to 2 cleanings and 2 fluoride treatments per year regardless of where the services are performed and shall require prior approval for any requests exceeding this limit; beginning July 1, 2014, the Department shall require all adults covered for dental services under this Code to pay a $20 encounter fee to the provider at the time of services ~~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~~; 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; revised 9-19-13.)

(305 ILCS 5/12-4.39)

Sec. 12-4.39. Dental clinic grant program.

(a) Grant program. On and after July 1, 2012, and subject to funding availability, the Department of Healthcare and Family Services may administer a grant program. The purpose of this grant program shall be to build the public infrastructure for dental care and to make grants to local health departments, federally qualified health clinics (FQHCs), ~~and~~ rural health clinics (RHCs)<u>, and dental schools</u> for development of comprehensive dental clinics for dental care services. The primary purpose of these ~~new~~ dental clinics will be to increase dental access for low-income and Department of Healthcare and Family Services clients who have no dental arrangements with a dental provider in a project's service area. The dental clinic must be willing to accept out-of-area clients who need dental services, including emergency services for adults and Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-referral children. Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSAs) shall receive special priority for grants under this program.

(b) Eligible applicants. The following entities are eligible to apply for grants:

(1) Local health departments.

(2) Federally Qualified Health Centers (FQHCs).

(3) Rural health clinics (RHCs).

(4) Dental school clinics.

(c) Use of grant moneys. Grant moneys must be used to support projects that develop dental services or training to meet the dental health care needs of Department of Healthcare and Family Services Dental Program clients. Grant moneys must be used for operating expenses, including, but not limited to: insurance; dental supplies and equipment; dental support services, including those services provided as part of the educational process at State dental schools; and renovation expenses. Grant moneys may not be used to offset existing indebtedness, supplant existing funds, purchase real property, or pay for personnel service salaries for dental employees.

(d) Application process. The Department shall establish procedures for applying for dental clinic grants.

(Source: P.A. 96-67, eff. 7-23-09; 96-1000, eff. 7-2-10; 97-689, eff. 6-14-12.)

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